STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445220	A. Building B. Wing	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spring Gate Rehab & Healthcare Center	3909 Covington Pike Memphis, TN 38135

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48285 Based on policy review, facility investigation, medical record review, and interview, the facility failed to follow up and honor a resident's right to request a room change for 1 of 6 residents (Resident #118) sampled for resident rights. The findings include: 1. Review of the facility's undated policy titled, Residents Rights, revealed, .As a company we place a top priority on preserving resident rights, ensuring their rights are not violated . Review of the facility's policy titled, Change of Room or Roommate, dated 10/30/2023, revealed .It is the policy of the facility to conduct room changes or roommate assignments when considered to be necessary by the facility and/or when requested by the resident or resident representative .Requests for changes in room or roommate should be communicated to the Social Service Designee . 2. Review of the medical record revealed Resident #118 was admitted to the facility on [DATE], with diagnoses including Non-Traumatic Intercranial Hemorrhage, Need Assistance with Personal Care, Muscle Wasting and Atrophy, Difficulty Walking, Aphasia, and Cerebral Infarction. Review of a facility's Alleged Abuse Incident Report dated 10/16/2024, revealed .Resident alleged that DON [Director of Nursing] told him he couldn't move to new room . Review of the quarterly Minimum Data Set, dated dated dated [DATE], revealed Resident #118 had a Brief Interview for Mental Status score of 15, which indicated the resident was cognitively intact. Review of a facility incident reporting system (IRS) report with an investigation completed date of 10/28/2024, revealed .He [Resident #118] informed me [Administrator] that he had spoke with [DON] and requested a private room .later as he was eating breakfast in the dining room he asked her about it and she said, No . During an interview on 12/4/2024 at 11:09 AM, the Administrator confirmed that Resident #118 told him that he had asked the DON to be moved to a private room and the DON told him he could not move. During an interview on 12/2/2024 at 12:57 PM, Resident #118 confirmed that he asked the DON if he could move to another room, and she told him no. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/4/2024 at 2:35 PM, the Social Service Director (SSD) confirmed that the Social Service Department are responsible for correlating with nursing regarding resident room changes. The SSD confirmed that she was made aware of Resident #118's request for the private room on 10/16/2024 and she has never followed up with him regarding the room change. The SSD was asked should you have followed back up with Resident #118 regarding his request for a room change. The SSD stated, Yes .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48285 Based on policy review, medical record review, observation, and interview, the facility failed to ensure the residents' right to retain and use their personal possessions for 1 of 1 (Resident #20) sampled residents. The findings include: 1.Review of the facility policy titled, Quality Assistance Procedure revised 10/30/2023, revealed .Residents, their representatives (sponsors), other interested family members, or resident advocates may file a Quality Assistance Form .concerning treatment, medial care, behavior of other residents, staff members, theft of property, etc., without fear or threat or reprisal in any form .Quality Assistance requests may be submitted orally or in writing. The administrator may delegate the responsibility of Quality Assistance investigation to appropriate department manager .Upon receipt .the department manager will investigate the allegations and submit a written report of such findings to the administrator .The resident .will be informed of the findings of the investigation and the actions that will be taken to correct any identified problems . Review of the undated facility policy titled FEDERAL RIGHTS OF NURSING CENTER RESIDENTS REQUIREMENTS FOR NURSING FACILITIES revealed .The resident has a right to be treated with respect and dignity including .The right to retain and use personal possessions .unless to do so would infringe upon the rights or health and safety of other residents . 2. Review of the medical record revealed Resident #20 was admitted to the facility on [DATE], with diagnoses including Chronic Obstructive Pulmonary Disease, Need for Assistance with Personal Care and Muscle Weakness. Review of the Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating Resident #20 was cognitively intact. Review of the facility QUALITY ASSISTANCE FORMS (Grievance Log) for August 2024 and September 2024, revealed there was no documentation the facility had completed a form related to Resident #20 missing perfume. During an interview on 9/24/2024 at 10:13 AM, Resident #20 stated that perfume was missing from a bag she had covered with a towel on her nightstand last week. Resident #20 stated she reported it to Unit Manager S and has not heard anything back. During an interview on 9/26/2024 at 9:21 AM, the Social Services Director was asked if she had replaced Resident #20's perfume. The Social Services Director stated, not yet we are working on it. During an interview on 9/30/2024 at 10:30 AM, the Social Services Director confirmed that missing items should be on the QUALITY ASSISTANCE FORMS when they are reported to staff.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48285 Based on policy review, medical record review and interview, the facility failed to notify the resident representative in advance of a change in room for 1 of 1 (Resident #305) sampled residents reviewed. The findings include: 1. Review of the facility policy titled, Change of Room or Roommate dated 10/30/2023, revealed .Prior to making a room change or roommate assignment, all persons involved in the change/assignment, such as residents and their representatives, will be given advance notice of such a change as is possible .The Social Service designee or Licensed Nurse should inform the resident's sponsor/family in advance of a change in the resident's room or roommate . 2. Review of the medical record revealed Resident #305 was admitted to the facility on [DATE], with a readmitted [DATE], with diagnoses including Ventricular Tachycardia, Myoclonus, Cognitive Communication, Seizures, Severe Protein- Calorie Malnutrition, and Severe Hypoxic Ischemic Encephalopathy. Review of the census in the medical record revealed Resident #305 was moved from one room number to a different room number on 3/5/2024. Review of Progress Notes dated 3/6/2024 at 6:49 AM, revealed Son notified of room change. Son is in agreement with room change. Resident transferred from [one room number] to [another room number] with all personal belongings. Review of the annual Minimum Data Set (MDS) assessment dated [DATE], revealed the Brief Interview for Mental Status (BIMS) score was not assessed, indicating severely impaired cognition. During a phone interview on 10/15/2024 at 5:05 PM, Unit Manager N confirmed that she did not notify the family until the resident was in new room. The facility failed to notify the resident representative in advance of a room change.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49269 Based on review of the Quality Safety Organization (QSO) - 20 -30 - Nursing Home (NH), policy review, medical record review, observation, and interview, the facility failed to maintain a clean, safe, comfortable, and sanitary environment on 4 of 4 (100, 200, 400, and 500) Hallways that included Resident #s 6, 8, 15, 17, 22, 27, 28, 32, 33, 34, 36, 38, 39, 41, 48, 49, 55, 57, 58, 61, 62, 63, 66, 68, 69 70, 71, 74, 75, 77, 79, 80, 83, 84, 87, 88, 90, 93, 97, 99, 105, 113, 116, 117, 120, 123, 129, 131, 144, 133, 139, 304, 348, and 349. The 400 and 500 Hall was the tracheostomy/ventilator units with vulnerable, high risk, and compromised residents. Observations made from 9/23/2024 through 10/2/2024 revealed there were observations of dried dark brown and tan hardened substances on the residents' bed frames and side rails, enteral feeding pumps, poles, walls, window blinds, and floors. The residents' oxygen concentrators were dirty, had dirty filters, and heavy dust build up. The Heating Ventilation Air Conditioning (HVAC) units were dirty and dusty. The housekeeping department failed to have cleaning disinfectant at all times and/or had to use the disinfectant sparingly per interview. There was a hole observed in the wall in a resident's room, and a gap around the HVAC unit at the end of the 100 Hall by the exit door exposing the facility to the outside. The findings include: 1. Review of QSO-20-30-NH Updates and Initiatives to Ensure Safety and Quality in Nursing Homes - Actions to Improve Infection Prevention and Control, .Environmental cleaning and disinfection. Clean and disinfect the resident's care environment and shared equipment with agents effective against the identified organism or products on an EPA [Environment Protection Agency]-registered antimicrobial list recommended by public health authorities. It is important to follow all manufacturer's directions for use for a surface disinfectant including applying the product for the correct contact time. Facilities need to ensure adequate access to supplies and proper instruction for staff (nursing or housekeeping/environmental services) responsible for cleaning pieces of equipment . Review of the facility policy titled, Routine Cleaning and Disinfection dated 2/1/2022, revealed, .It is the policy of this facility to ensure the provision of routine cleaning and disinfection in order to provide a safe, sanitary environment and to prevent the development and transmission of infections to the extent possible . Cleaning refers to the removal of visible soil from objects and surfaces and is normally accomplished manually or mechanically using water and detergents or enzymatic products .Consistent surface cleaning and disinfection will be with a detailed focus on high touch areas to include, but not limited to .bed rails, tray tables, call buttons . resident chairs .IV [intravenous] poles .Cleaning of walls, blinds, and window curtains will be conducted when visibly soiled .Privacy curtains in resident rooms will be changed when visibly dirty . (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the undated facility policy titled, Daily Cleaning Procedures revealed .empty trash .disinfect the waste basket and insert a can liner .High Dust .work your way clockwise around the room (starting at the door and finishing at the door) and dust all high surfaces .this includes but not limited to pictures/prints, televisions, over the bed lights, blinds, vents and all corners .Disinfect .work your way clockwise around the room .disinfect flat surfaces .high touch items .door knobs, light switches, call lights, TV [television] remotes, bed siderails, bed frame, foot board and headboard, bedside tables, closet handles, window sills, chairs, heating unit, and any flat surfaces .if resident has a fan in his/her room, check and clean routinely to avoid buildup of dust .Spot Clean Walls and Inspect Privacy Curtains .work your way clockwise around the room . spot cleaning walls and vertical surfaces that are visibly soiled .inspect all privacy curtains in room .if dirty notify your supervisor which curtains need to be changed .Clean Restroom .restock all supplies .empty trash . high dust lights, vents .disinfect sink area .disinfect toilet area-including handrails, call lights and tub/shower . Dust Mop .dust mop the perimeter of the room first .then start at back of room and use a figure 8 motion to dust mop entire floor working your way back to the door .don't forget the restroom .Damp Mop .damp mop the perimeter of the room .then start at the back of the room and use a figure 8 motion to damp mop the entire floor while working your way back to the door .don't forget the restroom . (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the undated facility policy titled, Deep Cleaning Procedures revealed Check the posted deep clean schedule in the morning and inform the Nursing Supervisor of the appropriate room number that will be deep cleaned today Clean the scheduled deep clean room .room should be emptied .if it is not, contact the nursing Supervisor to assist the situation .in a clockwise rotation from .door, clean, polish, scrub, scrape, dust, disinfect, sweep, wipe and mop everything in the room including: waste baskets .remove liner, wipe down can with disinfectant and remove all excess build-up .insert new can liner .Dressers-pull dresser completely away from the wall so that you can mop the floor where the dresser was sitting .spot scrub wall behind dresser and wipe down the rear of the dresser .sweep and damp mop floor and baseboard making sure to remove all build-up from these areas .clean all sides with disinfectant cleaner, including drawers and tracks, and remove bottom drawers to clean interior shelf .Chairs .remove cushions and scrub with brush or pad . scrub and polish frame .Closet .floor and edges around the closet floor, and spot check walls and shelf . Windows .clean window tracks and clean blinds .report any soiled or damaged curtains to your supervisor . Heating Unit .wipe top and all sides, check top vents for any accumulation of dust or other debris .remove build-up from floor under heating unit, sweep and damp mop .Nightstand .follow same procedure as Dressers .Bed .pull bed at least three feet away from wall .spot scrub the wall, remove build-up from floor and baseboards .sweep and damp mop floor and baseboards .thoroughly clean and disinfect all parts of the resident's bed .remove mattress (pay special attention to the bed frame, headboard, footboard, legs and side rails) .disinfect all areas of the mattress and return it to the frame .place bed in original position against the wall .Bed Side Tables .scrub all areas of table .polish if necessary .Privacy Curtains .check and report any soiled or damaged curtains to supervisor .clean lights above bed and all call lights and cords .Check all corners, ceiling and floor for cobwebs .Spot scrub all walls .Entrance of room .scrub both sides of door and door knob .Remove build-up on floor between room and hallway .Dust mop and damp mop entire room . Clean restroom by moving in a clockwise rotation from the restroom door .restock all supplies .Vents .use high duster to clean vents .Light cover .dust and disinfect .Walls .spot scrub all walls .Clean the light switch and cover plate .Sink .disinfect all porcelain on sink, both top and bottom .scrub all fixtures and drains .be sure to scrub wall under sink .Plumbing .clean spray hose and all pipes under sink .Toilet .scrub and disinfect toilet bowl .remove all stains and build-up .Safety bar and toilet paper holder .clean and polish .Call light and plate .clean and polish .Mirror .clean edges of mirror and shelf .clean mirror and use paper towel to dry . Check all corners for cobwebs .high and low .spot scrub door, frame and knob .Remove all build-up from floor around bowl, door frame, corners and edges .Dust mop the entire floor .Damp mop the entire floor . Review of the facility policy titled, Preventive Maintenance Program dated 3/12/2022, revealed A Preventive Maintenance Program shall be developed and implemented to ensure the provision of a safe, functional, sanitary, and comfortable environment for residents, staff, and the public .The Maintenance Director is responsible for developing and maintaining a schedule of maintenance services to ensure that the buildings, grounds, and equipment are maintained in a safe and operable manner .The Maintenance Director shall assess all aspects of the physical plant to determine if Preventative Maintenance (PM) is required . 2. Review of the Housekeeping Vendor undated checklist titled DEEP CLEAN CHECKOFF LIST, revealed . Inform the resident you are deep cleaning their room. Let resident (s) know you will be in their room for 30 minutes .you must move the bed, dresser, and any large objects so you can clean behind it. This room must be sanitized, dusted, and dirt-free when you are done .CHECK OFF THE FOLLOWING AREAS AS WHEN COMPLETED: (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	a. Pull out bed (s) and sweep, vacuum under, wipe down bed frames and springs as well b. Pull out dresser (s) and sweep, vacuum under, do not forget to wipe down sides as well c. Dust and wipe down T.V. [television] and underneath d. Clean and dust bed frame, pillows, and springs e. Clean ceilings, vents, and light fixtures f. Clean windowsills and inside of window g. Clean and wipe down heater/radiator units, remove trash from inside of units h. Clean and wipe down pictures / prints on walls i. Clean and wipe down garbage can inside and out j. Clean and wipe down all walls (PAY SPECIAL ATTENTION TO WALLS NEXT TO TRASH CANS AND UNDER SOAP DISPENSERS) k. Check bed linens for rips and tears l. Check skid strips for damage and alert management so they can be replaced m. Clean and wipe down doors, door jams, and door frames n. Clean and wipe down closets and shelves inside and outside o. Clean and wipe down all tables, nightstands, and rolling tables p. Clean and wipe down all chairs q. Clean and wipe down baseboards/edges (Use scraper to remove dirt in corners) r. Clean and disinfect floors s. Clean and disinfect toilet t. Clean and disinfect sink u. Disinfect and wipe down bathroom pull cords v. Clean and disinfect shower stall/tub w. Clean and wipe down vents x. Clean and wipe down ANY wheelchairs in the room (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	y. Inspect curtains for spills or damage and alert management so they get replaced z. Clean and disinfect refrigerators aa. CLEAN AND DISINFECT ANY PHONES, REMOTES, CALL LIGHTS AND ANYTHING ELSE THAT MAY BELONG TO THE ROOM . 3. Review of the medical records revealed Resident #6 and Resident #15 shared a room. a. Review of the medical record revealed Resident #6 was admitted to the facility on [DATE], with diagnoses including Chronic Obstructive Pulmonary Disease, Acute Upper Respiratory Disease, and Muscle Weakness. Review of Resident #6's quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview of Mental Status (BIMS) score was not assessed, and Resident #6 was dependent on staff for Activities of Daily Living (ADLs). b. Review of the medical record revealed Resident #15 was admitted to the facility on [DATE], with diagnoses including Cerebral Infarction, Weakness, Contracture Left Hand, Muscle Weakness, Arthritis, and Lack of Coordination. Review of Resident #15's quarterly MDS assessment dated [DATE], revealed a BIMS score of 10, which indicated Resident #15 was moderately cognitively impaired and required dependent on staff for ADL care. c. Observation in Resident #6 and #15's shared room on 9/23/2024 at 9:45 AM and 9/30/2024 at 4:27 PM, revealed the following: A dark black build-up around base board of closet door on the floor and in the corner of the door facing of the closet. A dark black build-up behind the entrance door in the corners leading up the wall and leading to the facing of the closet door. A dark black build-up leading out of the room into the hallway. A dark black build-up around the base board of the bathroom entrance and in the corners of the facing of the bathroom door. Missing floor tile around base of the bathroom vanity and dark black build-up around in the tile flooring on the bathroom floor. 4. Review of the medical records revealed Resident #22 and Resident #90 shared a room. a. Review of the medical record revealed Resident #22 was admitted to the facility on [DATE], with diagnoses including Respiratory Failure, Tracheostomy, Anoxic Brain Damage, Persistent Vegetative State, Muscle Weakness, Anxiety, and unspecified Convulsions. Resident #22 had a Percutaneous Endoscopic Gastrostomy (PEG) tube. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of Resident #22's annual MDS assessment dated [DATE], revealed a BIMS score that was unable to be completed, staff assessed the resident as severely cognitively impaired for daily decision making, and totally dependent on staff for ADLs. Review of Resident #22's care plan dated 5/3/2024, revealed .Resident has impaired pulmonary/respiratory status related to respiratory failure, tracheostomy, ventilator use .Resident will have reduced complications related to their altered pulmonary/respiratory status . Review of Resident #22's [Named] Hospital History and Physical Examination dated 9/3/2024, revealed . DATE OF ADMISSION: 8/31/2024 .CHIEF PRESENTING COMPLAINT: Fever with lethargy .The patient was evaluated in the emergency room and subsequently was admitted for severe sepsis with acute respiratory failure. The resident was admitted to the intensive care unit . Review of the facility Progress Note for Resident #22 dated 9/6/2024, revealed .Chronic General Debility, Deterioration .malaise .chronic respiratory failure s/p [status post] tracheostomy, Seizure do [disorder], Myasthenia Gravis [autoimmune disease caused by a breakdown in communication between nerves and muscles] quadriplegia .presented to the hospital with persistent fever .found to be septic [serious condition in which the body responds improperly to an infection] due to pneumonia .finished her course of antibiotics in the hospital . b. Review of the medical record revealed Resident #90 was admitted to the facility on [DATE], with diagnoses including Respiratory Failure, Tracheostomy, Gastrostomy tube, and Seizures. Review of Resident #90's quarterly MDS assessment dated [DATE], revealed a BIMS score that was unable to be completed, staff assessed the resident as rarely/never understood for daily decision making, and was dependent on staff for all ADLs. Review of Resident #90's [Named] Hospital History and Physical Examination dated 7/30/2024, revealed . DATE OF ADMISSION: 7/30/2024 .CHIEF PRESENTING COMPLAINT: Wound infection with bleeding from sacral wound .The patient was brought to the emergency room from the nursing home because they stated that she was having fever and also was bleeding from her sacral wound .to be evaluated for possible sepsis . she was subsequently admitted after intravenous antibiotic therapy initiation . c. Observations in Resident #22 and #90's shared room on 9/23/2024 at 10:30 AM, 9/25/2024 at 11:00 AM, 10/1/2024 at 2:20 PM, and 10/2/2024 at 3:00 PM, revealed dark brown marks on the floor at the doorway of room, tan and brown spots under the base of Resident #90's enteral feeding pump pole, and right side of Resident #90's bed frame contained a thin, brown substance smeared from the head of the bed to the foot of the bed. d. During an interview on 9/25/2024 at 11:15 AM, LPN U was asked what was on Resident #90's feeding pump pole and what was on Resident #22's bedframe. LPN U stated, .could be dried feeding on the pole and feces on the bed . LPN U was asked who should clean the pump pole and the bedframe. LPN U stated, . whoever makes the mess . LPN U was asked if that (the feeding pole and bedframe) was supposed to be cleaned. LPN U stated, Yes. 5. Review of the medical record revealed Resident #27 was admitted to the facility on [DATE], with diagnoses including Encephalopathy, Dementia, Bipolar Disorder, Muscle Weakness, and Depression. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the Resident #27's quarterly MDS assessment dated [DATE], revealed Resident #27 was severely cognitively impaired and was dependent on staff for Activities of Daily Living (ADLs). Observation in Resident #27's room on 9/23/2024 at 10:47 AM, and on 10/1/2024 at 7:27 AM, revealed dirty black build-up on the flooring at the threshold entrance of the Resident's room. 6. Review of the medical record revealed Resident #28 was admitted to the facility on [DATE], with diagnoses including Chronic Respiratory Failure, Tracheostomy, and Gastrostomy tube and received feedings. Review of Resident #28's admission MDS assessment dated [DATE], revealed a BIMS score of 15, which indicated the resident was cognitively intact and needed partial/moderate assist with ADLs. Observations in Resident #28's room on 9/30/2024 at 10:47 AM and 10/2/2024 at 8:50 AM, revealed dark drips and splatters on the wall by the resident's bed and yellowish tan drip stains on the wall by the unoccupied bed in Resident #28's room. 7. Review of the medical records revealed Resident #34 and Resident #116 shared a room. a. Review of the medical record revealed Resident #34 was admitted to the facility on [DATE], with diagnoses including Chronic Respiratory Failure, Cerebral Infarction, Tracheostomy Status, Hemiplegia, and Gastrostomy tube. Review of Resident #34's quarterly MDS assessment dated [DATE], revealed a BIMS score of 13, which indicated the resident was cognitively intact, and dependent on staff for all ADL's. b. Review of the medical record revealed Resident #116 was admitted to the facility on [DATE], with diagnoses including Respiratory Failure, Subdural Hemorrhage, Muscle Weakness, Diabetes, Congestive Heart Failure, and Gastrostomy tube. Review of Resident #116's significant change MDS assessment dated [DATE], revealed a BIMS score was unable to be completed due to Resident #116 was rarely/never understood. Resident #116 was assessed by staff to be severely cognitively impaired. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spring Gate Rehab & Healthcare Center	3909 Covington Pike Memphis, TN 38135

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	c. Observations in Resident #34 and Resident #116's shared room on 9/23/2024 at 9:47 AM and 3:45 PM, 9/25/2024 at 10:30 AM, and 10/2/2024 at 2:30 PM, revealed the vanity mirror was cracked and had brown smears under it, the base of both bed frames had brown smears. Resident #34's right quarter side rail had brown scattered smears on the top and on the side of the side rail. Resident #116's suction cannister contained brown slimy mucus and was not covered, a layer of dust was observed on top of the chest in the corner of the room to the left of Resident #116's bed. Resident #116's feeding pole displayed smears of a tan substance, and the base of the feeding pole was rusted with orange residue and a dried tan substance on it. The floor under the base of the pole revealed a dried brown substance on the floor. The privacy curtain between the 2 residents had splattered brown spots on each side of the curtain. The garbage can under the sink was overflowing with trash and incontinent pads. A thick, dark brown smear appeared on the corner of the bathroom door. The top, right, front edge of Resident #116's nightstand was chipped with sharp edges and jagged wood pieces. The HVAC unit's front vent cover displayed a thick layer of white fuzzy substance, a fuzz ball of dirt, grime and hair. The baseboard behind the base of the rusted brown enteral pump pole contained a smeared brown substance. A dried, thick, dark brown substance was observed on the right side of Resident #116's bed frame. During an interview on 9/25/2024 at 10:36 AM, Certified Nursing Assistant (CNA) P was asked what was on Resident #116's bedframe and Resident #34's side rail and what was the black smear on the corner of the wall beside the bathroom. CNA P stated, .looks like stool . CNA P was asked who was responsible for cleaning that. CNA P stated, .if I do it, I clean it .if I don't do it, I don't clean it . CNA P was asked who was responsible for cleaning the resident rooms. CNA P stated, .doesn't look like no one . CNA P was asked should the resident rooms be clean. CNA P stated, Yes. During an interview on 9/25/2024 at 11:05 AM, LPN C was asked who cleans the rooms. LPN C stated, .we [nursing staff] clean the resident equipment, housekeeping cleans the rooms . LPN C was asked if Resident #34 and Resident #116's room was clean. LPN C stated, No. LPN C was asked should the resident rooms be clean. LPN C stated, Yes. 8. Review of the medical record revealed Resident #36 was admitted to the facility on [DATE], with diagnoses including Senile Degeneration of the Brain, Dementia, Muscle Weakness, and Alzheimer's Disease. Review of Resident #36's quarterly MDS assessment dated [DATE], revealed Resident #36 had a BIMS score of 3, which indicated Resident #36 was severely cognitive impaired and was dependent on staff assistance with ADLs. Observation in Resident #36's shared bathroom on 9/23/2024 revealed: A black build-up on the floor at the entrance to the room and around the base board of the entrance to the room leading to the bathroom. A black build-up on base boards and around bathroom door and the base board and entrance to the close. Missing tile around the base of the bathroom vanity exposing cracked tiles and ground, and brown and gray build up. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A black build-up around the closet door and behind the entrance door, with black build up on the bottom of the closet door. Cracked tile behind the entrance door. 9. Review of the medical records revealed Resident #39 and Resident #41 shared a room. a. Review of the medical record revealed Resident #39 was admitted to the facility on [DATE], with diagnoses including Muscle Weakness, Dementia, Acute Respiratory Infection, Hemiplegia and Hemiparesis, Difficulty Walking, Absolute Glaucoma Right Eye, and Legal Blindness. Review of Resident #39's quarterly MDS assessment dated [DATE], revealed a BIMS score of 14, which indicated Resident #39 was cognitively intact and required moderate staff assistance with ADLs. b. Review of the medical record review revealed Resident #41 was admitted to the facility on [DATE], with diagnoses including Dementia, Hemiplegia and Hemiparesis, Muscle Weakness, Acquired Absence of Left Leg and Right Leg Below Knee, and Obesity. Review of Resident #41's annual MDS assessment dated [DATE], revealed Resident #41 was severely cognitively impaired and was dependent on staff for ADL care. c. Observation in Resident #39 and #41's shared room on 9/23/2024 at 9:45 AM, and on 9/30/2024 at 4:27 PM, revealed the following: A dark black build-up in the corner of the closet door leading round the base board leading into the resident's room. Missing base board on the corner of the closet door, and the floor in front of the closet door with black substance build-up going up the wall near closet door. A black build-up in the corners of the entrance door leading from the room to the hallway. A dark black build-up in the grout of the bathroom tile floor and around the base board of the bathroom vanity. 10. Review of the medical record revealed Resident #48 and Resident #57 shared a room. a. Review of the medical record review revealed Resident #48 was admitted to the facility on [DATE], with diagnoses including Cerebral Infarction, Dementia, Cognitive Communication Deficit, and Muscle Weakness. Review of Resident #48's quarterly MDS assessment dated [DATE], revealed a BIMS score of 3, which indicated Resident #48 was severely cognitively impaired, and was dependent on staff for ADLs. b. Review of the medical record review revealed Resident #57 was admitted to the facility on [DATE], with diagnoses including of Parkinson's Disease, Dementia, Schizophrenia, Dysphagia, and Insomnia. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of Resident #57's quarterly MDS assessment dated [DATE], revealed a BIMS score of 12, which indicated Resident #57 was moderately cognitively impaired and was dependent on staff for ADLs. c. Observation in Resident #48 and Resident #57 's shared room on 9/23/2024 at 9:45 AM, and on 9/30/2024 at 4:27 PM, revealed the following: A dark black build-up around in the corners of the entrance door leading into the Residents' room and in the corner behind the entrance door. A dark black build-up around the base board of the closet doors and in the corners of the closet doors going up the wall in the corners. A dark black build-up in the grout of the tile floor in the room and in the bathroom around the base of the bathroom vanity. 11. Review of the medical records revealed Resident #49 and Resident #71 shared a room. a. Review of the medical record revealed Resident #49 was admitted to the facility on [DATE], with diagnoses including Respiratory Failure, Chronic Obstructive Pulmonary Disease, Diabetes, Tracheostomy, and Chronic Kidney Disease. Review of the facility infection tracking report dated June 2024, revealed Resident #49 was diagnosed with a Respiratory Infection on 6/4/2024. Review of Resident #49's quarterly MDS assessment dated [DATE], revealed a BIMS score of 15, which indicated the Resident was cognitively intact. Review of the Progress Note dated 10/1/2024, revealed Resident #49 was started on antibiotic therapy due to pneumonia. b. Review of the medical record revealed Resident #71 was admitted to the facility on [DATE], with diagnoses including Respiratory Failure, Anoxic Brain Damage, Intellectual Disabilities, Convulsions, Tracheostomy, and Gastrostomy tube. Review of the facility infection tracking reports dated April 2024 revealed Resident #71 was diagnosed with a Respiratory Infection on 4/17/2024. Review of the facility infection tracking reports dated June 2024 revealed Resident #71 was diagnosed with a Respiratory Infection on 6/14/2024. Review of Resident #71's quarterly MDS assessment dated [DATE], revealed the Resident was not assessed for a BIMS score and had a stage 4 pressure ulcer on the sacrum. c. Observations in Resident #49 and Resident #71's shared room on 9/23/2204 at 10:57 AM and 4:13 PM, and 9/24/2024 at 7:00 AM, revealed the following: (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A large area on the floor by Resident #71's bed with dried tan liquid, spots of dried tan liquid and dust build up on the enteral feeding pole, dried tan liquid on the right grab bar of the bed and bed frame, a fan on a stand blowing toward Resident #49 with thick dust on the back side of the fan. Observation in Resident #49 and #71's shared room on 10/2/2024 at 8:57 AM, revealed the filter of Resident #71's oxygen concentrator covered with thick whitish dust and a missing wheel. 12. Review of the medical record revealed Resident #55 was admitted to the facility on [DATE], with diagnoses including Atrial Fibrillation, Depression, Hypertension, and Muscle Weakness. Review of Resident #55's quarterly MDS assessment dated [DATE], revealed a BIMS score of 14, which indicated Resident #55 was cognitively intact and was dependent on staff to perform ADLs. Observation in Resident #55's room on 9/23/2024 at 10:50 AM and on 10/1/2024 at 7:27 AM, revealed dirty black build-up on the flooring at the threshold entrance of the resident's room. 13. Review of the medical records revealed Resident #62 and Resident #123 shared a room. a. Review of the medical record revealed Resident #62 was admitted to the facility on [DATE], with diagnoses including Acute Respiratory Failure, Dependence on Respirator, Tracheostomy, and Gastrostomy tube. Review of Resident #62's quarterly MDS assessment dated [DATE], revealed Resident #62 was not assessed for a BIMS score and was severely cognitively impaired, and dependent on staff for ADLs. Review of the Tracking and Trending worksheet revealed Resident #62 was started on antibiotic therapy on 7/10/2024 for a Respiratory Infection. b. Review if the medical record revealed Resident #123 was admitted to the facility on [DATE], with diagnoses including Acute Respiratory Failure, Tracheostomy, and a Peg tube. Review of Resident #123's quarterly MDS assessment dated [DATE], revealed Resident #123 was not assessed for a BIMS score and was dependent on staff for all care. c. Observations in Resident #62 and Resident #123's shared room on 9/23/2204 at 10:42 AM and 3:36 PM, 9/24/2024 at 7:34 AM, 9/25/24 at 4:07 PM, and 10/2/2024 at 9:16 AM, revealed splatters and drips on the bottom of Resident #62 and Resident #123's enteral feeding pump poles and a dried pool of yellowish tan substance on the ground under each resident's feeding pole. 14. Review of the medical record revealed Resident #63 was admitted to the facility on [DATE], with diagnoses including Respiratory Failure, Chronic Obstructive Pulmonary Disease, and Severe Persistent Asthma. Review of Resident #63's quarterly MDS assessment dated [DATE], revealed a BIMS score of 13, which indicated the Resident was cognitively intact. Observation in Resident #63's room on 9/23/2024 at 11:08 AM and 10/01/2024 at 8:18 AM, revealed dried tan liquid on the floor and the HVAC unit vents contained a thick build up of dust. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	15. Review of the medical record revealed Resident #68 was admitted to the facility on [DATE], with diagnoses including Diabetes, Heart Failure, Hypertension, and Stage 4 Pressure Ulcer. Review of Resident #68's quarterly MDS assessment dated [DATE], revealed BIMS score of 11, which indicated Resident #68 was moderately cognitively impaired. Observation in Resident #68's room on 9/24/2024 at 9:10 AM and on 10/1/2024 at 7:27 AM, revealed a dirty black build-up on the floor at the threshold entrance of the Resident's room. 16. Review of the medical record revealed Resident #70 and #97 shared a room. a. Review of the medical record revealed Resident #70 was admitted to the facility on [DATE], with diagnoses including End Stage Renal Disease, Muscle Weakness, Visual Loss, and Quadriplegia. Review of Resident #70's admission MDS assessment dated [DATE], revealed a BIMS score of 15, which indicated Resident #70 was cognitively intact, had impaired vision, and required maximal assistance with ADLs. b. Record revealed Resident #97 was admitted to the facility on [DATE], with diagnoses including Dementia, Muscle Weakness, Difficulty Walking, and Altered Mental Status. Review of Resident #97's admission MDS assessment dated [DATE], revealed a BIMS score of 9, which indicated Resident #97 was moderately impaired, with impaired vision, and was dependent on staff for ADLs. c. Observation in Resident #70 and #97's shared room on 9/23/2024 at 9:45 AM, and on 9/30/2024 at 4:27 PM, revealed the following: A dark black build-up around corner of the entrance of the door leading into the Residents' room, in the corners going up the wall. A dark black build-up behind the entrance of the room door leading around the corner of the closet door entrance going up the wall. Chipped and hollowed out wall around base of the entrance of the closet facing leading into the resident room on the A side. A dark brown and black build-up around the base of the toilet. A dark brown and black build-up in the grout of the bathroom floor tile. Missing fl [TRUNCATED]

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49269 Based on policy review, medical record review, Facility Reported Incident (FRI) review, and interview the facility failed to report allegations of abuse and neglect related to injury of unknown origin within 2 hours for 1 of 3 (Resident #248) sampled residents. The Findings include: 1.Review of the facility policy titled Abuse, Neglect and Exploitation revised 1/10/2024, revealed .It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property .establish policies and procedures to investigate any such allegations: and include training for new and existing staff on activities that constitute abuse, neglect .reporting procedures .and resident abuse prevention .the facility will designate an Abuse Prevention Coordinator in the facility who is responsible for reporting allegations or suspected abuse, neglect, or exploitation to the state survey agency and other officials in accordance with state law .reporting process for abuse, neglect . including injuries of unknown sources .physical injury of a resident, of unknown source .psychological abuse of a resident observed .failure to provide care needs such as comfort, safety, feeding, bathing, dressing, turning & positioning .an immediate investigation is warranted when suspicion .reporting alleged violations to the administrator, state agency, adult protective service and to all other required agencies within specified timeframes as required by state and federal regulations .immediately but not later than 2 hours after the allegation is made if the allegation involve abuse or result in serious bodily injury .not later than 24 hours if the events do not involve abuse and do not result in serious bodily injury .the administrator will follow up with government agencies, during business hours, to confirm the initial report was received, and to report the result of the investigation when final within 5 working days of the incident, as required by state agencies . 2.Review of the medical record revealed Resident #248 was admitted to the facility on [DATE], with diagnoses including Cerebral Infarction, Hypertension, Diabetes, Anxiety, and Psychotic Disorder. Review of the quarterly Minimum Data Set, dated dated dated [DATE], revealed a Brief Interview of Mental Status (BIMS) score of 2 indicating that Resident #248 was severely cognitively impaired, was dependent on staff for activities of daily living activities and required assistance with toileting, bathing, dressing, and bed mobility. Review of the Radiology Interpretation report dated 5/26/2023, revealed .Left Scapula X-Ray complete . Findings .Left scapula .Fontal and scapular Y views [xray taken at an angle] .Anterior gleno-humeral [ball and socket allows for range of motion] dislocation .Impression . Anterior dislocation .Left shoulder X-Ray complete .Findings .Left Shoulder .Frontal and scapular Y views .Anterior gleno-humeral dislocation .Anterior dislocation . (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Nurse Note dated 5/26/2023, revealed 15:30 [3:30 PM] Abnormal Xray results received on left scapula and shoulder. Results forwarded to DON [Director of Nursing] .and [named provider] Dr .Orders received to send to [named facility emergency room] for further evaluation. 16:18 [4:18 PM] writer called POA [Power of Attorney] .and informed her of results and that she would be transferred to [Named facility emergency room] for further eval. POA agreed with transfer. Lifecare ambulance service called with estimated ETA [Estimated time of Arrival] of 2 hours. [Named facility emergency room (ER)] called and report given to nurse .to inform of arrival in approximately 2 hours . Review of the Facility's Reported Incident dated 5/27/2023 at 1:14 AM, revealed .Resident frequently yells out due to cognitive deficit. The resident began to yell out more frequently the past 24 hours. NP [Nurse Practitioner] was notified. Labs and x-ray ordered due to c/o [complaints of] left arm [pain]. Resident has c/o left arm pain at times with mobility since admission .5 day follow up added 6/5/2023 .Resident remains in the hospital . There was no documentation the injury of unknown origin was reported per facility policy. During an interview on 10/10/2024 at 10:04 AM, the DON confirmed that an injury of unknown origin should be reported within 2 hours.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46047 Based on policy review, medical record review, facility investigation review and interview, the facility failed to thoroughly investigate an allegation of abuse and failed to report to the government agency the results of the facility investigation within 5 working days for 4 of 13 residents (Resident #58, #248, #298, #300) reviewed for abuse incidents. The findings include: 1. Review of the facility policy titled, Abuse, Neglect and Exploitation, revised 1/10/2024, revealed .It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation .the facility will designate an Abuse Prevention Coordinator in the facility who is responsible for reporting allegations or suspected abuse, neglect, or exploitation to the state survey agency and other officials in accordance with state law . Possible indicators of abuse include .resident, staff or family report of abuse . Physical marks such as bruises or patterned appearances .on resident's body .physical injury of a resident, of unknown source .written procedures for investigations include: identifying staff responsible for the investigation .investigating different types of alleged violations .identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations .focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred providing complete and through documentation of the investigation .protection of resident .reporting alleged violations to the administrator, state agency, adult protective service and to all other required agencies within specified timeframes as required by state and federal regulations .the administrator will follow up with government agencies, during business hours, to confirm the initial report was received, and to report the result of the investigation when final . 2. Review of the medical record revealed Resident #58 was admitted to the facility on [DATE], with diagnoses including Alzheimer's, Dementia, Anxiety, Psychotic Disorder, Insomnia, Hypertension, and Depression. Review of the Other Skin note dated 10/28/2023, revealed .called to Resident #58's room, by CNA (Certified Nursing Assistant) at approximately 06:00 AM, to look at resident's left hand .noted left hand and digits to be bruised and swollen .Upon assessment, resident noted moaning, when touched . Review of Nurses Note dated 10/28/2023, revealed writer called to resident's room, by CNA, at approximately 06:00 AM, to look at resident's left hand .Upon entry, writer noted left hand and digits to be bruised and swollen .Upon assessment, resident noted moaning when area is touched .Writer notified supervisor on duty .NP [Nurse Practitioner] notified .X-ray ordered . DON [Director of Nursing] notified. Resident's guardian notified . Review of the hospital's History and Physical report revealed .ER [emergency room] 10/28/2023, with some left hand pain swelling-mechanism of injury not known .found to have proximal fourth and fifth digit fractures on her left hand . (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Progress Note dated 10/30/2023 at 10:58 AM, revealed .SW [Social Worker] contact MPD [Memphis Police Department] non-emergency police number to report allegation of abuse related to resident with bruises all over her body and 2 broken fingers; spoke with .dispatcher . APS [Adult Protective Service] contacted .someone will be out to investigate incident . Review of Nurses Note dated 10/30/2023, revealed bruises noted to left chin, left cheek, left shoulder, left wrist along with a red-looking rash to right buttocks .Wound care nurse notified of rash along with NP notified of all new bruises and new rash to right buttocks. New order from NP for aptt [activated partial thromboplastin time], pt [prothrombin time], inr. [INR - international normalized ratio] .Wound care nurse to evaluate rash on right buttocks . Review of Pertinent Charting-Skin note dated 10/30/2023, revealed Event Date: 10/30/2023 Location of skin area being documented: Bruises noted to left cheek, left chin, left shoulder and left wrist .Rash to right buttocks Description: Rash to right buttocks red raised. No drainage or foul odor noted from rash site. Interventions: Wound care to evaluate area .Physician notification: DR [Doctor], Responsible Party notification .conservator .Referrals: New orders: PT WITH INR APPT. Review of Nurses Note dated 10/30/2023 at 2:28, revealed This residents' conservator here to see resident R/T [related to] bruising noted on resident which was reported to her .conservator spoke to Adon [Assistant Director of Nursing] and DON before leaving facility .New orders for entire left side of upper body plus skull series R/T bruising of unknown origin . Review of the Nurse's Note dated 10/30/2024, revealed Resident #58 resting quietly in bed at this time. NAD [No apparent distress] noted. Lt.[left] hand with splint intact. Will continue to monitor . Review of Pertinent Charting-Skin on 10/31/2023, revealed Location of skin area being documented: bruises to left upper extremity .Brace to left hand r/t finger fractures and broken left wrist .Resident currently sleeping, call light within reach bed in lowest position and locked . Review of the annual Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview of Mental Status (BIMS) score was not coded. Resident #58 had short-term memory and long-term memory problems and was dependent upon staff for activities of daily living including bed mobility and transfers. Review of quarterly MDS assessment dated [DATE], revealed a BIMS score was not coded. Resident #58 had short-term memory and long-term memory problems and was dependent upon staff for activities of daily living including transfers. The facility reported the incident on 10/28/2023 but failed to submit the 5 day follow up report of the facility investigation within 5 working days of the incident. 3. Review of the medical record revealed Resident #248 was admitted to the facility on [DATE], with diagnoses including Cerebral Infarction, Hypertension, Diabetes, Anxiety, and Psychotic Disorder. (continued on next page)

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	445220	A. Building B. Wing	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Radiology Report dated 3/11/2020, revealed WRIST .Results: Scaphoid [bone in the wrist] irregularity .Scapholunate widening suggests ligamentous injury. Degenerative changes. Possible scaphoid fracture, recommend scaphoid views or CT [computed tomography] .HUMERUS [bone in the arm] MINIMUM 2V [view], LEFT .Results. No acute fracture or dislocation. The osseous [bone] structures appear intact. Joint spaces are narrowed. Soft tissues are unremarkable. Conclusion . No acute osseous abnormality. Degenerative changes . Review of the quarterly MDS assessment dated [DATE], revealed a BIMS score of 2, indicating that Resident #248 was severely cognitively impaired, was dependent on staff for activities of daily living such as toileting, bathing, dressing, and bed mobility, and was always incontinent for bowel and bladder. Review of the Nursing Evaluation Summary dated 3/10/2023, revealed RESIDENT REQUIRE TOTAL CARE WITH ALL ADLS [Activities of Daily Living] X [Times] 1, INCONTINENT OF B/B [Bowel and Bladder], WEAR ADULT DIAPERS, ALERT AND ORIENTED X 1, DISORIENTED TO TIME AND PLACE. APPETITE GOOD PER FEEDING SELF .HAS LEFT SIDED WEAKNESS . Review of the Nurse Note dated 5/26/2023, revealed 15:30 [3:30 PM] Abnormal Xray results received on left scapula and shoulder. Results forwarded to DON [Director of Nursing] . and [named provider] .Orders received to send to [named hospital emergency room (ER)] for further evaluation. 16:18 [4:18 PM] writer called POA [Power of Attorney] .and informed her of results and that she [Resident #248] would be transferred to [Named hospital emergency room] for further eval. [evaluation] POA agreed with transfer . ambulance service called with estimated ETA [Estimated time of Arrival] of 2 hours. [Named hospital ER] called and report given to nurse .to inform of arrival in approximately 2 hours . Review of nurse's note dated 5/26/2023 revealed .RESIDENT YELLING OUT AGAIN, NOTED TWITCHING TO RT [Right] SIDE OF FACE AND RT. ARM, MENTAL STATUS CHANGE, FNP [Family Nurse Practitioner] NOTIFIED, RECIEVED FOR CBC [Complete blood count], CMP [Complete metabolic panel], MAGNESIUM, NARCO 7.5MG, [used to treat pain], 1 EVERY 6HRS [Hours] PRN [As needed] PAIN, X-RAY LT [Left] SHOULDER AND ARM. RADIOGRAPHICS NOTIFIED . Review of the hospital triage note dated 5/26/2023 at 5:48 PM, revealed .Chief Complaint: left shoulder dislocation .Additional assessment note - triage: pt [patient-Resident #246] is from [named long-term care facility]. Pt is bed bound and nursing home staff states that they think she was possibly turned wrong, and the shoulder was dislocated . Review of the hospital Emergency Department (ED) nurse's note dated 5/26/2023 at 6:44 PM, revealed .Pt [Resident #248] brought by EMS [Emergency Medical Service] and placed in RM [room] .Pt yelling and screaming. RN [Registered Nurse] attempted to reorient pt with no success. EMS reports pt from [named nursing home] and they [nursing home staff] moved her [Resident #248] the wrong way. Deformity noted to left shoulder .Pt taken to xray with RN. call light and personal items within reach. pending scans for further eval . Review of the Radiology Interpretation dated 5/26/2023, revealed .Left Scapula X-Ray complete .Findings . Left scapula . Fontal and scapular Y views .Anterior gleno-humeral [shoulder joint] dislocation . Impression . Anterior dislocation .Left shoulder X-Ray complete .Findings .Left Shoulder .Frontal and scapular Y views . Anterior gleno-humeral dislocation .Anterior dislocation . (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's investigation dated 5/27/2023, revealed . Resident frequently yells out due to cognitive deficit. The resident began to yell out more frequently the past 24 hours. NP [Nurse Practitioner] was notified. Labs and x-ray ordered due to c/o [complaints of] left arm [pain]. Resident has c/o left arm pain at times with mobility since admission .Resident c/o left arm pain. X-ray obtained that indicated a dislocated shoulder. Resident had a previous injury to this shoulder with a fracture [Resident #248 actually had a previous scaphoid or wrist fracture/injury]. There is no outward s/s [signs or symptoms] of trauma to the left shoulder. Resident is alert and oriented to person. She can make her needs known. She does yell out frequently due to cognitively impairment. Resident yelled out more frequently. No c/o [complaints] anyone hurting her. No change in baseline other than more frequently yelling out. Resident has an old injury to her left shoulder [actually an old injury to the scaphoid/wrist] and does c/o pain at times. Pain relieved with Tylenol. Due to her yelling out more frequently today, NP notified for x-ray. MD notified for follow up treatment and diagnostics at the ER .5/27/2023 at 1:38 AM Resident was yelling out more frequently today. She does yell out due to cognitive deficit. NP notified for x-ray. X-ray indicates a dislocation of the shoulder. Investigation in progress. Resident sent to the hospital for follow up. 5 day follow up dated 6/5/2023 Resident remains in the hospital. Diagnosis unknown. The dislocated left shoulder was an old injury. X-ray comparison and CT scans at the hospital verified the injury with an old fx [fracture] has been present previously [refers to an old scaphoid/wrist injury]. Multiple attempts to reduce the left shoulder dislocation have been unsuccessful. Employees that provide care report no falls or injuries. Resident refuses to get OOB [Out of Bed] Resident is alert and oriented to self. Cognitively impaired r/t [related to] hemorrhagic cva [cerebrovascular accident] . Requires one person for bed mobility. The unknown origin injury is not substantiated. The injury is chronic [the scaphoid/wrist injury] . Review of 3 witness statements provided with the facility investigation revealed one statement was undated and staff reported that she did not work with Resident #248. One statement was dated 5/5/2023 (prior to the incident). One statement was dated 6/5/2023 and staff stated that she did not work with Resident #248. During a telephone interview on 10/15/2024 at 10:49AM, the former DON was asked about the facility's investigation for Resident #248's injury of unknown origin and if she was aware of the difference between a scapular and a scaphoid fracture. The former DON stated that she thought the scapular and scaphoid were the same thing. The former DON stated since the scapular and scaphoid are two different areas of the body then the injuries should not have been related. The former DON confirmed a thorough investigation should include witness statements from staff who were assigned care of Resident #248 and statements should be dated and signed by staff. During an interview on 10/16/2024 at 2:13 PM, the Administrator confirmed a thorough investigation included interviewing and obtaining complete and accurate witness statements of staff who were assigned care of Resident #248 over the last 72 hours. The Administrator verified the witness statements should be signed and dated by staff, and the facility 5 day follow up should be submitted within 5 days of the facility reported incident. 4. Review of the medical record revealed Resident #298 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including Anxiety, Chronic Obstructive Pulmonary Disease, Aphonia and Tracheostomy. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the quarterly MDS assessment dated [DATE], revealed a BIMS score of 9 which indicated Resident #298 was moderately cognitively impaired. Review of the progress notes dated 3/5/2023 at 2:16 PM, revealed .Pt [Resident #298] has new skin issues on both breast r/t holding hands tightly up against chest. Interventions include placing a soft barrier between the Pt arm and breast to relieve the pressure. As well as monitoring the skin condition every day . Review of the nurses note dated 3/13/2023 at 8:20 PM, revealed CNA [Certified Nursing Assistant] discovered 2 bruises, one to each breast this evening during HS [bedtime] care and was reported to her nurse and then shown to me [RN E]. I then informed the DON, the RP and the MD . Resident was also medicated for pain . Review of the Incident Report dated 3/13/2023, revealed .Incident Description .CNA brought to [Named Nurse] attention two new bruises one on each breast her [Resident #298] arms held tightly to her chest . Review of the Skin assessment dated [DATE], revealed .Skin Evaluation .Are there any new abnormal skin areas .yes .site .Chest .2 discolored areas with slight excoriation noted to bilateral breasts. Resident noted holding her hand very tightly at her chest area .Area is caused from resident holding her hands so tight right at chest area causing discoloration . Review of the care plan revised 3/13/2023, revealed .Discoloration to bilateral breasts due to resident holding hands/arms tightly to her chest Date initiated .3/13/2023 .pad area between chest area and hands as allowed .Avoid scratching and keep hands and body parts from excessive moisture .educate .causative factors .to prevent skin injury . Review of the facility investigation revealed 3 witness statements dated 3/17/2023. Review of the witness statements revealed 2 statements verifying Resident #298 keeps her hands close to her chest and keeps her arms and fists balled up close to her chest. There was no documentation of further investigation or statements. During an interview on 10/16/2024 at 2:13 PM, the Administrator stated a thorough investigation would include talking with those who found it, looking at the shower schedules and talk with staff that worked with the resident in the last 72 hours. 5. Review of the medical record revealed Resident #300 was admitted to the facility on [DATE], with diagnoses including Malignant Neoplasm of Ovary, Anxiety, and Depression. Review of the admission MDS assessment dated [DATE], revealed a BIMS score of 5, which indicated Resident #300 was severely cognitively impaired. Review of Nurses' Notes dated 3/18/2023 at 4:40 AM, revealed .Residents daughter escorted out due to her arguing with resident and threatening to hit her [Resident #300] and at residents request, nurse explained to daughter that she could wait in family room for a ride but could not return to residents room causing a disturbance to her mother and the other residents . (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility investigation for family to resident abuse began on 3/18/2023. Review of the facility investigation revealed Resident #300's daughter visited the Resident and had asked for money form the Resident. Resident #300 refused to give the daughter money, and the daughter was heard threatening to hit Resident #300 and was yelling loudly. The staff removed the daughter from the Resident's room and the Police took the daughter away in the police car. A picture of the alleged perpetrator was shared with staff as a safeguard to keep the daughter from returning to her mother's room. There was no documentation the facility obtained witness statements and/or other residents for the investigation. During an interview on 10/16/2024 at 3:48 PM, the DON confirmed a thorough investigation was not done if there were no witness statements. 47835 48285 49269

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38439 Based on policy review, medical record review, observations, and interview, the facility failed to follow Physician orders related to blood glucose monitoring, missed medication doses, physician orders for parameters for the use of an anti-hypertensive medication (a medication given for high blood pressure) and failed to obtain vital signs before administering anti-hypertensive medication for 3 of 3 sampled residents (Resident #12, #68, and #73) reviewed for medication administration. The findings include: 1. Review of the facility's policy titled, Physician/Practitioner Orders-Consulting revised 3/20/2024, revealed . The attending physician shall authenticate orders for the care and treatment of assigned residents . 2. Review of the medical record revealed Resident #12 was admitted to the facility on [DATE], with diagnoses including Hypertension, Diabetes, End Stage Renal Disease, Hyperkalemia and Atrial Fibrillation. Review of the Physician Orders dated 4/23/2024, revealed .May obtain blood glucose as needed if symptoms of hypo/hyperglycemia & [and] notify MD [medical doctor] . Review of the Physician Orders dated 5/10/2024, revealed .blood glucose checks weekly one time a day every Mon [Monday] related to TYPE 2 DIABETES . Review of the admission Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 5, which indicated Resident #12 was severely cognitively impaired. Review of the Medication Administration Record (MAR) dated 8/2024, revealed . [blood glucose monitoring] - Every Monday one time a day every Mon related to TYPE 2 DIABETES MELLITUS WITH UNSPECIFIED COMPLICATIONS -Start Date 8/12/2024 0600 [6:00 AM] . Review of the Medication Administration Record (MAR) dated 8/2024, revealed blood glucose monitoring was not performed on 8/5/2024. During an interview on 10/09/2024 at 2:11 PM, Unit Manager B confirmed blood glucose monitoring was not performed on 8/5/2024. 3. Review of the medical record revealed Resident #68 was admitted to the facility on [DATE], with diagnoses including Diabetes, Heart Failure, Hypertension, and Stage 4 Pressure Ulcer. Resident #68 was cognitively impaired. Review of Physician's Orders dated 7/2/2024, revealed the following medication orders: a. Atorvastatin 20 milligram (mg), (used to treat cholesterol) give by mouth at bedtime. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Metoprolol Tartrate 25mg, (used to treat blood pressure), .hold for SBP [Systolic blood pressure less than 120, diastolic blood pressure less than 60 or Heart rate less than 60. c. Pantoprazole Sodium 40mg, (used to treat acid reflux), .give by mouth two times a day. d. Hydralazine 100mg, (used to treat blood pressure), . give 1 tab two times a day. Systolic blood pressure greater than 160 or less than 100, Diastolic blood pressure greater than 100 or less than 60, pulse less than 60. e. Lamotrigine 25mg, (used to treat mood disorder), give 1.5 tablet by mouth in the morning. f. Losartan Potassium 50mg, (used to treat blood pressure), give 2 tablets by mouth one time a day .Systolic blood pressure greater than 160 or less than 100, Diastolic blood pressure greater than 100 or less than 60, pulse less than 60. g. Albuterol Sulfate Inhalation Nebulization Solution, (used for shortness of breath), (2.5mg/(per)3ML [milliliters] .0.083% (percent) 1 application via mask one time a day. h. Humalog Solution, (used to treat blood glucose), 100unit/ml . Inject 8 unit subcutaneously one time a day. i. Multiple vitamins, (used as supplement), give 1 tablet by mouth one time a day. j. Oyster Shell Calcium 500 +D, (used as a supplement), give 1 tablet by mouth one time a day. k. Juven, (used as a nutritional supplement), two times a day. Review of Resident #68's Medication Administration Record (MAR) dated 7/2024, revealed the following medications were not administered as ordered on 7/25/2024. a. Hydralazine 100mg was not administered for the evening scheduled dose. b. Metoprolol 25mg was not administered for the evening scheduled dose. Review of the MAR dated 8/2024 for Resident #68 revealed the following medications were not administered as ordered on 8/24/2024: a. Albuterol Sulfate 0.083% 1 application via mask one time a day. b. Humalog Solution - 8 units subcutaneously one time a day. c. Lamotrigine 25mg - 1.5 tablet by mouth in the morning. d. Losartan 50mg - 2 tablets by mouth one time a day. e. Oyster Shell Calcium 500 +D - 1 tablet by mouth one time a day. f. Multiple vitamin - 1 tablet by mouth one time a day. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	g. Hydralazine 100mg was not administered for morning scheduled dose. h. Juven was not administered for morning scheduled dose. i. Metoprolol 25mg was not administered for morning scheduled dose. j. Pantoprazole 40mg was not administered for morning scheduled dose. Review of Resident #68's MAR dated 10/2024 revealed Metoprolol 25mg was administered outside of ordered parameters of hold for systolic blood pressure less than 120 and/or diastolic blood pressure less than 60 for the following dates: a. 10/2/2024 at 9:00 AM with blood pressure 111/82. b. 10/3/2024 at 9:00 AM with blood pressure 112/68. c. 10/4/2024 at 9:00 AM with blood pressure 116/53. d. 10/12/2024 at 9:00 AM with blood pressure 110/52. During an interview on 10/9/2024 at 9:53 AM, the Director of Nursing (DON) confirmed that staff should follow physician orders. 4. Review of the medical record revealed Resident #70 was admitted to the facility on [DATE], with diagnoses including Atrial Flutter, Alcohol Use, Muscle Weakness, Convulsions, Hypertension, Anxiety, and Psychosis. Resident #70 was severely cognitively impaired. Review of the Order Review History Report dated 8/25/2024 to 9/25/2024, revealed, .Metoprolol [medication used for high blood pressure] .Tablet Give 12.5 mg [milligrams] .one time a day .HYPERTENSION [medical term for high blood pressure] .hold for HR [heart rate] < [symbol for less than] 60 SBP [systolic blood pressure] <120 DBP [diastolic blood pressure] <60 . Review of the Care Plan dated 9/24/2024, revealed Resident #73 was care planned for impaired cardiovascular status related to hypertension. Review of the June 2024, July 2024, August 2024, and September 2024 MAR revealed the facility failed to document the Resident's blood pressure and heart rate for the use of daily administration of an antihypertensive medication. During an interview on 9/30/2024 at 9:53 AM, Licensed Practical Nurse (LPN) D was asked if a resident had parameters for the use of an antihypertensive medication, where was that information recorded prior to administering the antihypertensive medication. LPN D stated it should on the MAR. LPN D stated she would record the resident's blood pressure when she administered the medication under the vital sign tab on the electronic medical record. LPN D was asked to show where the blood pressure was recorded. LPN D stated she had not recorded any blood pressures for the use of the antihypertensive medication. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/30/24 at 9:40 AM, the DON confirmed nursing staff should follow physician orders for the use of an antihypertensive medications to include obtaining and recording the resident's blood pressure. 49269

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38909 Based on facility policy review, facility fall investigation review, medical record review, observation, and interview, the facility failed to ensure the resident environment remained free of accident hazards for 1 of 3 (Resident #77) sampled residents reviewed for accidents. On 8/9/2024, Resident #77, a vulnerable cognitively impaired resident, rolled out of the bed onto the floor and sustained a fracture to the right humerus, resulting in Actual Harm. Certified Nursing Assistant (CNA) W admitted to returning the resident to the bed without notifying the nurse. CNA W was assisted by CNA X, to get Resident #77 back in the bed. The findings include: 1. Review of the facility policy titled, Falls- Clinical Protocol, dated 11/2/2023, revealed .the staff will help identify individuals with a history of falls and risk factors for subsequent falling .Admission Evaluation Data Form, which includes the fall risk evaluation .this form is completed upon admission, quarterly, and with significant change in status .Based on the assessment an initial care plan will be developed and implemented to address identified risk .Goals of the plan of care may include interdisciplinary team, physician, resident and responsible party when possible .Goals may include, but not limited to reduction of falls, minimize injury from falls, and/or prevent falls while maintaining .or improving resident abilities and quality of life .Interventions should be developed and implemented per the assessed needs .Resident's abilities and deficits .Balance .Adaptive equipment needs .Proper use of mechanical lifts and transfer devices .interventions for direct care givers should be placed on the CNA [certified nursing assistant] Kardex [CNA care plan] .For an individual who has fallen, staff should attempt to define possible causes within 24 hours of the fall .Causes refer to factors that are associated with or that directly result in a fall .Once a fall occurs it is important to gather as much information as possible .Provide emergency care and assessments as indicated .The Physician and Responsible party should be notified as soon as the resident is stabilized .Document findings in the resident's medical record .Complete the Fall Re-evaluation .to determine if there are additional risk factors .Document falls on the 24-hour shift report .An accident/[or]incident report will be completed . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the facility policy titled, Incidents and Accidents Reporting, dated 8/11/2022, revealed .It is the policy of this facility for staff .to report, investigate, and review any accident or incidents that occur or allegedly occur, on facility property and may involve or allegedly involve a resident .'Accident' refers to any unexpected or unintentional incident, which result or may result in injury or illness to a resident .An 'Incident' is defined as an occurrence or situation that is not consistent with the routine care of a resident or with the routine operation of the organization .The purpose of incident reporting is: Assuring that appropriate and immediate interventions are implemented and corrective actions are taken to prevent recurrences and improve the management of resident care .Conducting root cause analysis to ascertain .contributing factors . Meet regulatory requirements for analysis and reporting of incidents and accidents .The following incidents/accidents require an incident/accident report .Falls .Unobserved injuries .In the event of an incident or accident, immediate assistance will be provided .Any injuries will be assessed by the licensed nurse or practitioner and the affected individual will not be moved until safe to do so .The supervisor or other designee will be notified of the incident/accident .The nurse will notify the resident's practitioner to inform them of the incident/accident .The resident's family or representative will be notified of the incident/accident and any orders obtained or if the resident is to be transported to the hospital .The nurse/designee will enter the incident/accident information into the appropriate form/system within 24 hours of occurrence and will document all pertinent information .Documentation should include the date, time, nature of the incident, location, initial findings, immediate interventions .and orders obtained or follow-up interventions .If an incident/accident was witnessed by other people, the supervisor or designee will obtain the witnesses' account .In the event that an incident must be recorded .the following should occur .Complete the paper form for the incident .Complete all other assessments .paper incident report should be entered electronically . Review of the facility policy titled, Safe Lifting and Movement of Residents, dated 1/1/2022, revealed .Each resident is assessed .to determine lifting and movement assistance needs .Mechanical lifting devices shall be used for heavy lifting .Except during emergency situations or unavoidable circumstances, manual lifting is not permitted . 2. Review of the medical record revealed Resident #77 was admitted to the facility on [DATE], with diagnoses including Acute Respiratory Failure with Hypoxia, Cerebral Infarction, Gastrostomy Status, Tracheostomy Status, and Atrial Fibrillation. Review of Resident #77's Care Plan date initiated on 8/30/2023, revealed .Resident has an ADL [Activities of Daily Living] self-care performance deficit related to CVA .BED MOBILITY: 2 person assist . Review of Resident #77's Physician orders dated 6/3/2024, revealed .Hydrocodone-Acetaminophen Tablet 5-325 mg [milligrams] Give 1 tablet by mouth every 8 hours for pain . There was no documentation in the medical record on 8/9/2024, when the incident occurred. Review of the Incident/Accident Report for Resident #77 dated 8/13/2024, revealed .Resident's CNA [CNA V] notified nurse of abnormal discoloration to resident's right upper arm .This nurse observed resident flinched and showed signs of discomfort upon her arm being touched/moved . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445220	A. Building B. Wing	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spring Gate Rehab & Healthcare Center	3909 Covington Pike Memphis, TN 38135

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the Physician Progress Note dated 8/13/2024, revealed .RUE [right upper extremity] swelling .79 y/o [year old] BF [black female] with hx [history of] multiple CVA, [Cerebrovascular Accident], Chronic Respiratory Failure with Hypoxia, Osteoarthritis .is seen today for RUE swelling .RUE upper arm to hand swelling noted, warm to touch with 2 dime size contusions to inner upper arm noted. Will xray due to hx of arthritis and eval for possible pathogenic fx [fracture] . Review of Resident #77's Care Plan dated 8/13/2024, revealed .Resident is at risk for falls/injury related to Cerebral Vascular Accident (CVA) needs assistance with ADL's [activities of daily living] .Reduce the risk of injury .8/13/2024 X-Ray doppler [test used to detect blood flow] .8/13/2024 ER [emergency room] evaluation and tx [treatment] .8/13/2024 pain meds as ordered .8/13/2024 immobilizer .monitor resident's position to reduce the risk of sliding/falling . Review of the Physician Progress Note dated 8/16/2024, revealed .FU [follow up] readmission .seen today s/p [status post] ER [emergency room] with RUE [right upper extremity] commuted [comminuted] displaced fracture through the right humeral neck, humeral shaft is displaced medially with respect to the humeral head, soft tissue of density surrounds the humeral head and proximal humerus suggestive of a component of hematoma seen on CT [computed tomography] scan. She was readmitted with dx [diagnosis] of arm reduction deformity. RUE remains swollen with RUE sling in place .stable .FU with [NAME] [orthopedics] . Resident #77 was evaluated in the ER and returned to the facility with an immobilizer to her right upper extremity and an order for an orthopedic consult. Review of the Incident Investigation Witness Statement from terminated CNA W dated 8/16/2024, for Resident #77 revealed .This incident happened on 8/9/2024 around 2 [2:00] PM .I went in to change [Named Resident] Resident #77 .I left her on her side to change her. I turned her facing the window. She had a large bowel movement. I went out of the room to get more linen .I was gone a couple of minutes. When I returned she was in the floor .I tried to get her up by myself with a sheet. The tubing to her trach was still hooked to her. I left her in the room to get some help .[Named staff] CNA X came in to help me get her back in bed .I never told [Named CNA X] that the [Named Resident] Resident #77 had fallen .we got her up from the floor using the sheet that was under her .I did not tell the nurse or anyone about this incident .I never thought she was hurt .I didn't try to hurt her . Review of Resident #77's Care Plan revised on 8/19/2024, revealed .Resident has an ADL self-care performance deficit related to CVA .BED MOBILITY: 2 person assist .TOILETING: 2 person assist . TRANSFERS: with 2 person assist AND use of mechanical lift . Review of the quarterly Minimum Data Set (MDS) dated [DATE], revealed Resident #77 was rarely/never understood. Brief Interview for Mental Status (BIMS) wasn't conducted due to Resident #77 was rarely/ never understood. Functional status was coded as dependent on staff for all activities of daily living (ADL's) care. Observation and interview in Resident #77's room on 10/2/2024 at 10:15 AM, revealed CNA V turned and repositioned Resident #77 by herself without using 2 staff assistance. CNA V was asked should Resident #77 have 2 person assistance with turning and repositioning. CNA V stated, .yes, but I don't have time to try to find someone .we are all so busy . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Attempted to call terminated CNA W on 10/2/2024 at 2:00 PM, to verify statement. CNA W did not return phone call. During an interview on 10/15/2024 at 1:40 PM, CNA V was asked if she witnessed a bruise on Resident #77. CNA V stated, .when I worked on Saturday 8/10/2024 I did not see a bruise and she didn't act like she was hurting .when I gave her a bath on Tuesday 8/13/2024 is when I seen the bruise on her upper right arm .I immediately went to get the nurse so she can see what I was talking about . CNA V was asked if she (Resident #77) can turn herself without assistance. CNA V stated, .she is total dependent on staff, she suppose [supposed] to have 2 people for turning, but I turn her by myself if I can't find someone to help me . During an interview on 10/15/2024 at 1:54 PM, CNA X was asked if she assisted Resident #77 off the floor. CNA X stated, .yes, [Named CNA W] asked me to help clean [Named Resident #77] .the resident was sitting up in the floor, her back against the bed .she had sheets under her .we lifted her up and put [her] back in the bed. I left out of the room. I didn't notify anyone she had fallen .I asked [Named CNA W] how she got on the floor, and she stated she didn't know .I was suspended pending the investigation and was re-educated .I thought the nurse had already been in the room . During an interview on 10/15/2024 at 3:10 PM, the Director of Nursing (DON) was asked how many staff should turn [Named] Resident #77, and how long until the fall was discovered. The DON stated, .[Named Resident #77] is a 2 person staff assist for turning, repositioning, and bed mobility .the occurrence was completed when we were made aware of the bruise, and after investigating and interviewing all staff we determined, and was told what exactly happened .I did not report because we realized soon with a matter of hours what had happened . The DON was asked during her investigation if Resident #77 appeared to be in pain. The DON stated, .No one stated she was in pain until the day the bruise was recognized, however the resident does receive pain medication every 8 hours, and has for several months related to her sacral wound .the physician initially thought it could have been a DVT [Deep Vein Thrombosis] due to her previous history . but also ordered an x-ray of her right humerus and it showed fracture of the lower end of the right humerus . we then sent her to the ER she was there for a few hours and she returned with an immobilizer to her right upper extremity and an order for orthopedic consult. The DON was asked what prompted the termed (terminated) CNA (CNA W) to leave the resident in the bed on her side and then after the fall out of the bed, not tell the nurse and then transfer her from the floor to the bed. The DON stated, .she [CNA W] stated to me it was just a bad judgement call. Both CNA's were suspended but [Named] CNA W was terminated for failure to follow company policy .[Named] CNA X returned to work and [was] given a written warning . The DON stated, The staff know they should report each incident including falls .they should never move the resident who has fallen, before the resident is assessed by the nurse .[Named Resident #77] is a 2 person assist for all bed mobility .with all falls, the CNA should get the nurse so she can assess the resident and then give further instruction to the CNA at that time .

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38439 Based on policy review, medical record review, observation, and interview, the facility failed to provide care and services for residents with percutaneous endoscopic gastrostomy (PEG) tubes (plastic tube inserted into the stomach to administer medications, supplements and liquid food) when staff failed to ensure the enteral feedings and the flush solutions were properly labeled for 3 of 4 sampled residents (Resident #58, #72, and #304) reviewed for enteral feedings and failed to administer site care for 1 of 4 residents (Resident #498) reviewed for PEG tubes. The findings include: 1. Review of the facility policy titled, Feeding Tubes revised 6/30/2022, revealed .Feeding tubes will be used only as necessary to address malnutrition and dehydration, or when the resident's clinical condition deems this intervention medically necessary to maintain acceptable parameters of nutrition and hydration. Feeding tubes will be maintained in accordance with current clinical standards of practice, with interventions to prevent complications to the extent possible .Feeding tubes will be utilized according to physician orders . The plan of care will reflect the use of a feeding tube and potential complications . 2. Review of the medical record revealed Resident #58 was admitted to the facility on [DATE], with diagnoses including Alzheimer's, Nutritional Deficiency, and Dementia. Review of the care plan revised on 10/5/2023, revealed .Administer enteral nutrition per orders. (nocturnal) . Review of Physician's Order dated 11/6/2023, revealed .Change feeding syringe and /or container daily on night shift (label with resident name and date) . Review of the Minimum Data Sets (MDS) dated [DATE], revealed Resident #58's Brief Interview for Mental Status (BIMS) score was not coded, which indicated the resident was severely cognitively impaired, and was assessed as receiving enteral feedings. Review of the Physician's Order dated 8/23/2024, revealed .Two Cal 2.0 [nutritional supplement administered through a PEG tube] @ [at] 45 cc [cubic centimeters] /hr [per hour] x [times] 12 hours 6p [PM]-6a [AM] . Observation in the Resident's room on 9/24/2024 at 7:33 AM, revealed Resident #58's water bottle used for the PEG was not labeled with a date, rate for delivery via PEG, or initials. Observation in the Resident's room on 9/26/2024 at 8:47 AM, revealed Resident #58's enteral feeding was not labeled with a rate of delivery, and the water bottle for the PEG was not labeled with a delivery rate or time. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 10/7/2024 at 10:40 AM, in Resident #58's room the Assistant Director of Nursing (ADON) was asked what should be on the enteral feeding and water bottle labels. The ADON stated, It should be labeled with the resident's name, rate [of delivery], room number, date, amount and nurse initial. The ADON confirmed there was no rate or nurse initials on the enteral feeding. 3. Review of the medical record revealed Resident #72 was admitted on [DATE], with diagnoses including Adult Failure to Thrive, Dementia, and Dysphagia. Review of Physician's Order dated 5/23/2022, . [for the PEG] Change feeding syringe and/ or container daily on night shift (label with resident name and date) . Review of Physician's Order dated 6/26/2024, .enteral feed every shift Jevity 1.5 [nutritional supplement administered through a PEG tube] @ 60ml [milliliters] /hr x 22 hours . Review of the MDS dated [DATE], revealed Resident #72's BIMS score was not coded, which indicated the resident was severely cognitively impaired. Review of care plan dated 9/16/2024, revealed .Administer enteral nutrition per orders . Observation in the Resident's room on 9/23/2024 at 10:08 AM, revealed no date and rate of delivery on the water bottle for the PEG. Observation in the Resident's room on 9/24/2024 at 7:24 AM, revealed no start date, rate of delivery, or nurse's initials on the enteral feeding, and no date or rate of delivery on the water bottle. During an interview on 9/25/2024 at 10:35 AM, Licensed Practical Nurse (LPN) B confirmed enteral feedings should be labeled with a name, date, and time hung. Observation in the resident's room on 9/26/2024 at 8:27 AM, revealed no nurse initial, rate of delivery, or time on the enteral feeding and no nurse initial on the water bottle. Observation in resident's room on 9/30/2024 at 3:13 PM, revealed no nurse initials on enteral feeding. Observation in resident's room on 10/1/2024 at 9:37 AM, revealed no nurse initials on enteral feeding. Observations in resident's room on 10/2/2024 at 8:56 AM, revealed no date on the enteral feeding. 4. Review of the medical record revealed Resident #304 was admitted to the facility on [DATE], with diagnoses including Respiratory Failure, Hypoxia and Acute Kidney Failure. Review of the Medication Administration Record (MAR) dated September 2024, revealed .Enteral Feed Order every shift for Gastrostomy Flush tube with (150) ML's H20 [water] every (4) hours .Enteral Feed Order every shift for Gastrostomy Jevity 1.5 @65 ml/hr X 22 hours . (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the admission MDS assessment dated [DATE] revealed a BIMS score of 14 indicating Resident #304 was cognitively intact. Observation in the resident's room on 9/25/2024 at 11:35 AM, revealed Resident #304's enteral feeding was not labeled with a date or time. During an interview on 9/25/2024 at 11:39 AM, LPN B confirmed feedings and water should be labeled. 5.Review of the medical record revealed Resident #498 was admitted to the facility on [DATE] with diagnoses including Non-Traumatic Intracerebral Hemorrhage, Diabetes, Dysphagia, and Gastrostomy. Review of a Physician's Order dated 9/6/2024 revealed, .Two Cal HNT [high calorie formula] 1 can 5 times a day .via [by way of] gravity administration .start date 9/6/2024 .End date .9/11/2024. Review of a Physician's Order dated 9/11/2024 revealed, .Jevity 1.5 .1 can/carton bolus every 4 hours .via gravity . Review of the admission MDS assessment dated [DATE], revealed Resident #498 with a BIMS score of 14, indicating the resident was cognitively intact, and used a feeding tube. Review of the Care Plan dated 9/24/2024, revealed Resident #498 was care planned for impaired gastrointestinal status related to the use of a feeding tube. Review of the MAR dated September 2024 revealed no documentation the facility administered PEG site care for the use of a PEG tube. Review of the Treatment Administration Record (TAR) dated September 2024, revealed no documentation the facility administered PEG site care for the use of a PEG tube. Review of the Physician's Orders for September 2024 revealed the facility failed to obtain an order for PEG site care for the use of a PEG tube. Observation in the Resident's room on 9/25/2024 at 9:50 AM, the Resident confirmed he received his feedings through a PEG tube and raised his shirt to show the PEG tube site. The PEG site had no dressing. The facility failed to provide PEG tube site care for the use of a PEG tube to mitigate the risk of infection. During an interview on 10/2/2024 at 11:50 AM, the Director of Nursing (DON) confirmed that the facility failed to obtain a Physician Order for the care of the PEG tube site when the resident was admitted on [DATE] and one had been written with an effective date 10/2/2024. The DON confirmed that PEG tube site care should have been written and administered when the resident was admitted to the facility. 46047 (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	48285

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48285 Based on facility policy review, medical record review and interview, the facility failed to ensure physician visits were conducted according to facility policy for 9 of 11 residents (#8, #38, #56, #57, #67, #71, #73, #104, #305) reviewed for Physician visits. The findings include: 1. Review of the facility policy titled, Physician Visits and Physician Delegation dated 9/26/2024, revealed .It is the policy of this facility to ensure the physician takes an active role in supervising the care of the residents .The Physician should .see the resident within 30 days of initial admission to the facility .The resident must be seen at least once every 30 calendar days for the first 90 calendar days after admission and at least every 60 days thereafter by the physician or physician delegate as appropriate by State law .after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner, or clinical nurse specialist that is acting within scope of practice . 2. Review of the medical record revealed Resident #8 was admitted to the facility on [DATE], with diagnoses including Hepatic Failure, Acute Hepatitis, Hemiplegia and Hemiparesis. Review of the MD Progress Notes revealed the Physician visited Resident #8 on 11/3/2023 and 4/24/2024. There was no documentation Physician visits were conducted every other 60 days per facility policy. 3. Review of the medical record revealed Resident #38 was admitted to the facility on [DATE], with diagnoses including Cerebral Infarction, Dementia, and Alzheimer's. Review of the MD Progress Notes revealed Resident #38 had Physician visits on 10/21/2022, 11/3/2023, 5/24/2024, and 9/27/2024. There was no documentation Physician visits were conducted every other 60 days per facility policy. 4. Review of the medical record revealed Resident #56 was admitted to the facility on [DATE], with diagnoses including Multiple Sclerosis, Respiratory Failure, Paraplegia, and Cognitive Communication Deficit. Review of the MD Progress notes revealed Resident #56 had Physician visits on 11/10/2023 and 4/5/2024. There was no documentation Physician visits were conducted every other 60 days per facility policy. 5. Review of the medical record revealed Resident #57 was admitted to the facility on [DATE], with diagnoses including of Parkinson's Disease, Dementia, Schizophrenia, Dysphagia, and Insomnia. Review of the MD Progress notes revealed Resident #57 had Physician visits on 10/27/2023, and 4/5/2023. There was no documentation Physician visits were conducted every other 60 days per facility policy. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. Review of the medical record revealed Resident #67 was admitted to the facility on [DATE], with diagnoses including Dementia, Kidney Failure, Diabetes, and Schizophrenia. Review of the MD Progress notes revealed Resident #67 had Physician visits on 10/27/2023, and 4/5/2024. There was no documentation Physician visits were conducted every other 60 days per facility policy. 7. Review of the medical record revealed Resident #71 was admitted to the facility on [DATE], with diagnoses including Respiratory Failure, Anoxic Brain Damage, Intellectual Disabilities, Convulsions, and Tracheostomy. Review of the MD Progress notes revealed Resident #71 had Physician visits on 11/17/2023, 4/24/2024, and 8/24/2024. There was no documentation Physician visits were conducted every other 60 days per facility policy. 8. Review of the medical record revealed Resident #73 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including Atrial Flutter, Convulsions, Hypertension, and Psychosis. Review of the MD Progress notes revealed Resident #73 had Physician visits on 10/23/2023 and 4/24/2024. There was no documentation Physician visits were conducted every other 60 days per facility policy. 9. Review of medical record revealed Resident #104 was admitted to the facility on [DATE], with diagnoses including Respiratory Failure, Down's Syndrome, and Peripheral Vascular Disease. Review of the MD Progress notes revealed Resident #104 had Physician visits on 6/16/2023, 11/17/2023, and 8/3/2024. There was no documentation Physician visits were conducted every other 60 days per facility policy. 10. Review of medical record revealed Resident #305 was admitted to the facility on [DATE], and the most recent readmitted [DATE], with diagnoses including Ventricular Tachycardia, Myoclonus, Cognitive Communication, and Seizures. Review of the MD Progress notes revealed Resident #305 had Physician visits on 11/17/2023 and 4/12/2024. There was no documentation Physician visits were conducted every other 60 days per facility policy. 11. During an interview on 10/16/2024 at 2:14 PM, the Administrator was asked how often the Physician should make visits to residents. The Administrator replied, The regulations say after admission within 90 days .and every 60 days after that. The Administrator was asked if it was appropriate to not have MD visit for 5 months. The Administrator replied, .they should follow the federal guidelines . The facility failed to ensure Physician Visits were alternated with Nurse Practitioner visits therefore failing to ensure Physician visits were conducted every other 60 days per facility policy.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 49311 Based on facility policy review, observation, and interview, the facility failed to ensure posted staffing information was accurate and current for 5 of 15 days (9/23/2024, 9/25/2024, 10/1/2024, 10/15/2024 and 10/16/2024) during the survey. The findings include: 1. Review of the facility policy titled, Nurse Staffing Posting Information dated 3/4/2024, revealed .The Nurse Staffing Sheet will be posted on a daily basis and will contain the following information .The current date .The facility will post/update the Nurse Staffing Sheet at the beginning of each shift . 2. Observations in the front lobby on 9/23/2024 at 3:21 PM, revealed the posted Direct Care Staffing Hours was dated 9/20/2024. Observations in the front lobby on 9/23/2024 at 5:25 PM, revealed the posted Direct Care Staffing Hours was dated 9/24/2024. Observations in the front lobby on 9/25/2024 at 7:36 AM, revealed the posted Direct Care Staffing Hours was dated 9/24/2024. Observations in the front lobby on 10/1/2024 at 2:42 PM, revealed the posted Direct Care Staffing Hours was dated 9/30/2024. Observations in the front lobby on 10/15/2024 at 10:00 AM, revealed the posted Direct Care Staffing Hours was dated 10/14/2024. Observations in the front lobby on 10/16/2024 at 9:22 AM, revealed the posted Direct Care Staffing Hours was dated 10/14/2024. 3. During an interview on 10/16/2024 at 10:38 AM, the Staffing Coordinator was asked, who was responsible for posting the daily Direct Care Staffing Hours. The Staffing Coordinator replied, I complete it and leave it for the night nurse to post in the morning. Then I check to make sure its accurate when I get here in the mornings. The Staffing Coordinator confirmed that the daily staffing schedule should be updated and posted daily with the current date. During an interview on 10/16/2024 at 12:02 PM, the Director of Nursing confirmed that the posted daily staffing schedule should be updated daily and posted with the current date.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38439 Based on policy review, medical record review, observation, and interview, the facility failed to ensure medications were properly stored and secured for 2 of 2 sampled residents (Residents #49 and #70) when medications were found unattended and unsecured in the resident rooms, and when opened and undated medications were stored in 2 of 13 medication storage areas (100 Hall Medication Room). The findings include: 1. Review of the facility policy titled, Medication Storage reviewed and revised on 1/30/2024, revealed .It is the policy of this facility to ensure all medications housed on our premises will be stored according to manufacturer's recommendations and sufficient to ensure proper .segregation and security .all drugs and biologicals are stored in locked compartments .medication carts, cabinets, drawers .medication rooms . During a medication pass, medications must be under direct observation of the person administering medications or locked in the medication storage area/cart . 2. Review of the medical record revealed Resident #49 was admitted to the facility on [DATE], with diagnoses including Respiratory failure, Chronic Obstructive Pulmonary Disease, Diabetes, Tracheostomy and Chronic Kidney Disease. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #49 with a Brief Interview of Mental Status (BIMS) score of 15, which indicated Resident #49 was cognitively intact. Observations in Resident #49's room on 9/23/2024 at 10:57 AM, revealed a medication cup with 3 pills in it on the over the overbed table. During observation and interview on 9/23/2024 at 10:58 AM, Licensed Practical Nurse (LPN) C was asked what was in the medication cup. The LPN stated, Vitamin D (supplement), AZO (used for urinary tract infections) and [NAME] [Benzonatate] for cough. 3. Review of the medical record revealed Resident #70 was admitted to the facility on [DATE], with diagnoses including Cerebral Infarction, Diabetes, Visual Loss, Stage 5 End Stage Renal Disease, and Quadriplegia. Review of the admission MDS assessment dated [DATE], revealed a BIMS score of 15, which indicted Resident #70 was cognitively intact, required set up for eating, dependent on staff Activities of Daily Living, Visual Loss and Quadriplegia. Observation in Resident #70's room on 9/23/24 at 10:53 AM, revealed 1 large yellow oblong gel capsule, 1 small yellow capsule, 2 brownish yellowish tablets, and 2 small white tablets, in a plastic medication cup on top of the over the bed table, unsecured and unattended. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation and interview in Resident #70's room on 9/23/24 at 11:12 AM, LPN D was shown the plastic medication cup on the over the bed table containing medications. LPN D stated the medications were a Vitamin D, a Renal Vitamin (a supplement used for dialysis patients), Amlodipine (medication used for blood pressure), a Baby Aspirin, Carvedilol (medication used for blood pressure), and Vitamin B Complex (vitamin supplement). LPN D confirmed the medications should not have been left at the bedside unattended and unsecured. 4. During an observation on the 100 Hall Medication Storage Room on 10/8/2024 at 3:40 PM, revealed an opened and undated vial of Tubersol (used to perform Tuberculosis skin test) in the medication refrigerator. During an interview on 10/2/2024 at 2:33 PM, the Director of Nursing (DON) verified the medications should not be left at resident's bedside unattended and unsecured and should be locked in the medication cart until they are to be administered. During an interview on 10/9/2024 at 9:53 AM, the DON verified the Tubersol should be dated when opened. 48285 49269

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47835 Based on policy review, medical record review, and interview, the facility failed to ensure dental services were provided for 1 of 1 sampled resident (Resident #39) reviewed for dental services. The findings include: 1. Review of the facility policy titled, Dental Services Policy dated 11/28/2017, revealed .Routine and emergency dental services are available to meet the resident's oral health services in accordance with the resident's assessment and plan of care .Social Services personnel will be responsible for assisting the resident .family in making dental appointments . Review of the medical record revealed Resident #40 was admitted to the facility on [DATE], with diagnoses including Chronic Respiratory Failure, Dependence on Ventilator, Diabetes, and Congestive Heart Failure. Review of the annual Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #40 with a Brief Interview for Mental Status (BIMS) score of 15, which indicated Resident #40 was cognitively intact and had no dental problems present at the time of the assessment. During an observation and interview on 9/24/2024 at 1:52 PM, Resident #40 stated she had broken a tooth a few months ago and ever since she has had trouble eating and drinking anything hot or cold because it would cause her tooth to hurt. Resident #40 could not remember when it happened or who she told but stated she had told more than one person that it had been bothering her. During an interview on 09/26/2024 at 8:35 AM, Certified Nursing Assistant (CNA) P was asked to explain how oral/dental services, interventions, or treatments should be carried out, such as if someone tells you they are having trouble eating or drinking because of a broken tooth or toothache. CNA P replied, I go tell the nurse .for sure let the nurse know. During an interview on 9/26/2024 at 3:35 PM, the Social Services Director was asked on how follow-up visits or recommendations from a dentist are provided to the facility. The Social Services Director stated, We have a provider that comes in . if emergent we can refer them [residents] out .they [Dentists] come once a month . they [Dentist] were here Monday. Usually, the Unit Manager will report it to me .I haven't heard anything about [Resident #40[.No one has said anything about that. During an interview on 09/30/2024 at 10:30 AM, the Social Services Worker provided a list of Residents who were on the Dental list and confirmed Resident #40 was not on the list of those to be seen. During an interview on 10/07/24 at 11:20 AM, the Social Services Worker confirmed Resident #40 had not been added to the dental list on the sign-up board in the Social Services office. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/16/2024 at 12:08 PM, the Director of Nursing (DON) was asked if Social Services were made aware on 9/26/2024 that a resident was having dental pain which caused a resident to not be able to eat or drink hot or cold foods, should the resident have been added to the consult list by 10/7/2024. The DON replied, Depends .there are things that we could do .give them [residents] soft diet .Sometimes it takes a while for them [residents] to get it taken care of.

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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** 30974 Based on review of the Quality Safety Organization (QSO) - 20 -30 - Nursing Home (NH), review of NursingHomeAbuse.org, policy review, medical record review, observation, and interview, the facility failed to maintain an infection prevention and control program which provided a safe, sanitary, and comfortable environment to help prevent the development and transmission of infections for 24 of 38 residents (Residents #22, #28, #34, #49, #62, #63, #71, #75, #77, #80, #83, #90, #116, #117, #120, #123, #129, #131, #133, #139, #144, #304, #348, and #349) reviewed for infection. The 400 and 500 Halls was the tracheostomy/ventilator units with vulnerable, high risk, and compromised residents who were exposed to unsanitary conditions. The findings include: 1. Review of QSO-20-30-NH Updates and Initiatives to Ensure Safety and Quality in Nursing Homes - Actions to Improve Infection Prevention and Control, .Environmental cleaning and disinfection. Clean and disinfect the resident's care environment and shared equipment with agents effective against the identified organism or products on an EPA [Environment Protection Agency]-registered antimicrobial list recommended by public health authorities. It is important to follow all manufacturer ' s directions for use for a surface disinfectant including applying the product for the correct contact time. Facilities need to ensure adequate access to supplies and proper instruction for staff (nursing or housekeeping/environmental services) responsible for cleaning pieces of equipment . 2. Review of the facility policy titled, Routine Cleaning and Disinfection, dated 2/1/2022, revealed .ensure the provision of routine cleaning and disinfection in order to provide a safe, sanitary environment and to prevent the development and transmission of infections to the extent possible .Cleaning .refers to the removal of visible soil from objects and surfaces .manually or mechanically using water and detergents or enzymatic products .Consistent surface cleaning and disinfection will be conducted with a detailed focus on high touch areas to include .bed rails .tray tables .Sinks and faucets .Staff will ensure cleaning carts are .stocked with necessary supplies at the beginning of each shift .Horizontal surfaces .window sills and hard surface flooring . should be cleaned .on a regular basis .when soiling and spills occur .when a resident is discharged from the facility Cleaning of walls, blinds, and window curtains will be conducted when visibly soiled .Privacy curtains in resident rooms will be changed when visibly dirty . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the undated facility policy titled, Daily Cleaning Procedures, revealed .High Dust .work your way clockwise around the room (starting at the door and finishing at the door) and dust all high surfaces .this includes but not limited to pictures/prints, televisions, over the bed lights, blinds, vents and all corners . Disinfect .clockwise around the room disinfect flat surfaces .high touch items .bed siderails, bed frame, foot board and headboard, bedside tables, window sills .heating unit, and any flat surfaces .if resident has a fan in his/her room, check and clean routinely to avoid buildup of dust .Spot Clean Walls and Inspect Privacy Curtains .work your way clockwise around the room .spot cleaning walls and vertical surfaces that are visibly soiled .inspect all privacy curtains in room .if dirty notify your supervisor which curtains need to be changed . Clean Restroom .restock all supplies .empty trash .high dust lights, vents .disinfect sink area .disinfect toilet area-including handrails, call lights and tub/shower .Damp Mop .damp mop the perimeter of the room .then start at the back of the room and use a figure 8 motion to damp mop the entire floor while working your way back to the door . Review of the undated facility policy titled, Deep Cleaning Procedures, revealed .check the posted deep clean schedule in the morning .Clean the scheduled deep clean room .room should be emptied .in a clockwise rotation from .door, clean, polish, scrub, scrape, dust, disinfect, sweep, wipe and mop everything in the room including .sweep and damp mop floor and baseboard making sure to remove all build-up from these areas .floor and edges around the closet floor, and spot check walls and shelf .report any soiled or damaged curtains to your supervisor .Heating Unit .wipe top and all sides, check top vents for any accumulation of dust or other debris .remove build-up from floor under heating unit, sweep and damp mop . Bed .pull bed at least three feet away from wall .spot scrub the wall, remove build-up from floor and baseboards .sweep and damp mop floor and baseboards .thoroughly clean and disinfect all parts of the resident's bed .remove mattress (pay special attention to the bed frame, headboard, footboard, legs and side rails) .disinfect all areas of the mattress and return it to the frame .Bed Side Tables .scrub all areas of table . polish if necessary .Privacy Curtains .check and report any soiled or damaged curtains to supervisor .clean lights above bed and all call lights and cords .Check all corners, ceiling and floor for cobwebs .Spot scrub all walls .Entrance of room .scrub both sides of door and door knob .Remove build-up on floor between room and hallway .Dust mop and damp mop entire room .Sink .disinfect all porcelain on sink, both top and bottom . scrub all fixtures and drains .be sure to scrub wall under sink .Mirror .clean edges of mirror and shelf .clean mirror and use paper towel to dry . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy titled, Cleaning and Disinfection of Resident-Care Equipment, dated 1/2/2024, revealed .Resident-care equipment can be a source of indirect transmission of pathogens. Reusable resident-care equipment will be cleaned and disinfected in accordance with current CDC [Centers for Disease Control and Prevention] recommendations in order to break the chain of infection .'Cleaning' is the removal of visible soil from objects and surfaces and normally is accomplished manually or mechanically using water with detergents or enzymatic products .'Reusable multiple-resident items' are items that may be used multiple times for multiple residents. Examples include stethoscopes, blood pressure cuffs, feeding tube pumps, and oxygen concentrators .non-critical items come in contact with intact skin, but not mucous membranes. These items require cleaning followed by low intermediate level disinfection .(use of EPA [Environmental Protection Agency]-registered disinfectants) following manufacturer's instructions .Staff shall follow established infection control principles for cleaning and disinfecting reusable, noncritical equipment . Each user is responsible for routine cleaning and disinfection of multi-resident items after each use, particularly before use for another resident .Multiple-resident use equipment shall be cleaned and disinfected before being used on another resident .Wear gloves when cleaning/disinfecting equipment .Use only EPA-registered disinfectants with kill claims for the common organisms found in the facility . 3. Review of the medical records revealed Resident #22 and Resident #90 shared a room. Review of the medical record revealed Resident #22 was admitted to the facility on [DATE], with diagnoses including Respiratory Failure, Tracheostomy, Anoxic Brain Damage, Persistent Vegetative State, Muscle Weakness, Anxiety, and unspecified Convulsions. Resident #22 had a Percutaneous Endoscopic Gastrostomy (PEG) tube. Review of Resident #22's annual Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score that was unable to be completed, staff assessed the resident as severely cognitively impaired for daily decision making, and totally dependent on staff for activities of daily living (ADLs). Review of Resident #22's care plan dated 5/3/2024, revealed .Resident has impaired pulmonary/respiratory status related to respiratory failure, tracheostomy, ventilator use .Resident will have reduced complications related to their altered pulmonary/respiratory status . Review of Resident #22's [Named] Hospital History and Physical Examination dated 9/3/2024, revealed . DATE OF ADMISSION: 8/31/2024 .CHIEF PRESENTING COMPLAINT: Fever with lethargy .The patient was evaluated in the emergency room and subsequently was admitted for severe sepsis with acute respiratory failure. The resident was admitted to the intensive care unit . Review of the facility Progress Note for Resident #22 dated 9/6/2024, revealed .Chronic General Debility, Deterioration .malaise .chronic respiratory failure s/p [status post] tracheostomy, Seizure do [disorder], Myasthenia Gravis [autoimmune disease caused by a breakdown in communication between nerves and muscles] quadriplegia .presented to the hospital with persistent fever .found to be septic [serious condition in which the body responds improperly to an infection] due to pneumonia .finished her course of antibiotics in the hospital . Review of the medical record revealed Resident #90 was admitted to the facility on [DATE], with diagnoses including Respiratory Failure, Tracheostomy, Gastrostomy tube, and Seizures. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #90's quarterly MDS assessment dated [DATE], revealed a BIMS score that was unable to be completed, staff assessed the resident as rarely/never understood for daily decision making, and was dependent on staff for all ADLs. Review of Resident #90's [Named] Hospital History and Physical Examination dated 7/30/2024, revealed . DATE OF ADMISSION: 7/30/2024 .CHIEF PRESENTING COMPLAINT: Wound infection with bleeding from sacral wound .The patient was brought to the emergency room from the nursing home because they stated that she was having fever and also was bleeding from her sacral wound .to be evaluated for possible sepsis . she was subsequently admitted after intravenous antibiotic therapy initiation . Observations in Resident #22 and #90's shared room on 9/23/2024 at 10:30 AM, 9/25/2024 at 11:00 AM, 10/1/2024 at 2:20 PM, and 10/2/2024 at 3:00 PM, revealed dark brown marks on the floor at the doorway of room, tan and brown spots under the base of Resident #90's enteral feeding pump pole, and right side of Resident #90's bed frame contained a thin, brown substance smeared from the head of the bed to the foot of the bed. During an interview on 9/25/2024 at 11:15 AM, LPN U was asked what was on Resident #90's feeding pump pole and what was on Resident #22's bedframe. LPN U stated, .could be dried feeding on the pole and feces on the bed . LPN U was asked who should clean the pump pole and the bedframe. LPN U stated, .whoever makes the mess . LPN U was asked if that (the feeding pole and bedframe) was supposed to be cleaned. LPN U stated, Yes. 4. Review of the medical record revealed Resident #28 was admitted to the facility on [DATE], with diagnoses including Chronic Respiratory Failure, Tracheostomy, and Gastrostomy tube and received feedings. Review of Resident #28's admission MDS assessment dated [DATE], revealed a BIMS score of 15, which indicated the resident was cognitively intact and needed partial/moderate assist with ADLs. Observations in Resident #28's room on 9/30/2024 at 10:47 AM and 10/2/2024 at 8:50 AM, revealed dark drips and splatters on the wall by the resident's bed and yellowish tan drip stains on the wall by the unoccupied bed in Resident #28's room. 5. Review of the medical records revealed Resident #34 and Resident #116 shared a room. Review of the medical record revealed Resident #34 was admitted to the facility on [DATE], with diagnoses including Chronic Respiratory Failure, Cerebral Infarction, Tracheostomy Status, Hemiplegia, and Gastrostomy tube. Review of Resident #34's quarterly MDS assessment dated [DATE], revealed a BIMS score of 13, which indicated the resident was cognitively intact, and dependent on staff for all ADL's. Review of the medical record revealed Resident #116 was admitted to the facility on [DATE], with diagnoses including Respiratory Failure, Subdural Hemorrhage, Muscle Weakness, Diabetes, Congestive Heart Failure, and Gastrostomy tube. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #116's Significant Change MDS assessment dated [DATE], revealed a BIMS score was unable to be completed due to Resident #116 was rarely/never understood. Resident #116 was assessed by staff to be severely cognitively impaired. Observations in Resident #34 and Resident #116's shared room on 9/23/2024 at 9:47 AM and 3:45 PM, 9/25/2024 at 10:30 AM, and 10/2/2024 at 2:30 PM, revealed the vanity mirror was cracked and had brown smears under it, the base of both bed frames had brown smears. Resident #34's right quarter side rail had brown scattered smears on the top and on the side of the side rail. Resident #116's suction cannister contained brown slimy mucus and was not covered, a layer of dust was observed on top of the chest in the corner of the room to the left of Resident #116's bed. Resident #116's feeding pole displayed smears of a tan substance, and the base of the feeding pole was rusted with orange residue and a dried tan substance on it. The floor under the base of the pole revealed a dried brown substance on the floor. The privacy curtain between the 2 residents had splattered brown spots on each side of the curtain. The garbage can under the sink was overflowing with trash and incontinent pads. A thick, dark brown smear appeared on the corner of the bathroom door. The top, right, front edge of Resident #116's nightstand was chipped with sharp edges and jagged wood pieces. The HVAC unit's front vent cover displayed a thick layer of white fuzzy substance, a fuzz ball of dirt, grime and hair. The baseboard behind the base of the rusted brown enteral pump pole contained a smeared brown substance. A dried, thick, dark brown substance was observed on the right side of Resident #116's bed frame. During an interview on 9/25/2024 at 10:36 AM, Certified Nursing Assistant (CNA) P was asked what was on Resident #116's bedframe and Resident #34's side rail and what was the black smear on the corner of the wall beside the bathroom. CNA P stated, .looks like stool . CNA P was asked who was responsible for cleaning that. CNA P stated, .if I do it, I clean it .if I don't do it, I don't clean it . CNA P was asked who was responsible for cleaning the resident rooms. CNA P stated, .doesn't look like no one . CNA P was asked should the resident rooms be clean. CNA P stated, Yes. During an interview on 9/25/2024 at 11:05 AM, LPN C was asked who cleans the rooms. LPN C stated, .we [nursing staff] clean the resident equipment, housekeeping cleans the rooms . LPN C was asked if Resident #34 and Resident #116's room was clean. LPN C stated, No. LPN C was asked should the resident rooms be clean. LPN C stated, Yes. The shared room was not cleaned until 10/3/2024, for the IJ Removal Plan. 6. Review of the medical records revealed Resident #49 and Resident #71 shared a room. Review of the medical record revealed Resident #49 was admitted to the facility on [DATE], with diagnoses including Respiratory Failure, Chronic Obstructive Pulmonary Disease, Diabetes, Tracheostomy, and Chronic Kidney Disease. Review of the facility infection tracking report dated June 2024, revealed Resident #49 was diagnosed with a Respiratory Infection on 6/4/2024. Review of Resident #49's quarterly MDS assessment dated [DATE], revealed a BIMS score of 15, which indicated the Resident was cognitively intact. Review of the Progress Note dated 10/1/2024, revealed Resident #49 was started on antibiotic therapy due to pneumonia. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medical record revealed Resident #71 was admitted to the facility on [DATE], with diagnoses including Respiratory Failure, Anoxic Brain Damage, Intellectual Disabilities, Convulsions, Tracheostomy, and Gastrostomy tube. Review of the facility infection tracking reports dated April 2024 revealed Resident #71 was diagnosed with a Respiratory Infection on 4/17/2024. Review of the facility infection tracking reports dated June 2024 revealed Resident #71 was diagnosed with a Respiratory Infection on 6/14/2024. Review of Resident #71's quarterly MDS assessment dated [DATE], revealed the Resident was not assessed for a BIMS score and had a stage 4 pressure ulcer on the sacrum. Observations in Resident #49 and Resident #71's shared room on 9/23/2204 at 10:57 AM and 4:13 PM, and 9/24/2024 at 7:00 AM, revealed the following: A large area on the floor by Resident #71's bed with dried tan liquid, spots of dried tan liquid and dust build up on the enteral feeding pole, dried tan liquid on the right grab bar of the bed and bed frame, a fan on a stand blowing toward Resident #49 with thick dust on the back side of the fan. Observation in Resident #49 and #71's shared room on 10/2/2024 at 8:57 AM, revealed the filter of Resident #71's oxygen concentrator covered with thick whitish dust and a missing wheel. 7. Review of the medical records revealed Resident #62 and Resident #123 shared a room. Review of the medical record revealed Resident #62 was admitted to the facility on [DATE], with diagnoses including Acute Respiratory Failure, Dependence on Respirator, Tracheostomy, and Gastrostomy tube. Review of Resident #62's quarterly MDS assessment dated [DATE], revealed Resident #62 was not assessed for a BIMS score and was severely cognitively impaired, and dependent on staff for all care. Review of the Tracking and Trending worksheet revealed Resident #62 was started on antibiotic therapy on 7/10/2024 for a Respiratory Infection. Review if the medical record revealed Resident #123 was admitted to the facility on [DATE], with diagnoses including Acute Respiratory Failure, Tracheostomy, and a Peg tube. Review of Resident #123's quarterly MDS assessment dated [DATE], revealed Resident #123 was not assessed for a BIMS score and was dependent on staff for all care. Observations in Resident #62 and Resident #123's shared room on 9/23/2204 at 10:42 AM and 3:36 PM, 9/24/2024 at 7:34 AM, 9/25/24 at 4:07 PM, and 10/2/2024 at 9:16 AM, revealed splatters and drips on the bottom of Resident #62 and Resident #123's enteral feeding pump poles and a dried pool of yellowish tan substance on the ground under each resident's feeding pole. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spring Gate Rehab & Healthcare Center	3909 Covington Pike Memphis, TN 38135

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8. Review of the medical record revealed Resident #63 was admitted to the facility on [DATE], with diagnoses including Respiratory Failure, Chronic Obstructive Pulmonary Disease, and Severe Persistent Asthma. Review of Resident #63's quarterly MDS assessment dated [DATE], revealed a BIMS score of 13, which indicated the Resident was cognitively intact. Observation in Resident #63's room on 9/23/2024 at 11:08 AM and 10/01/2024 at 8:18 AM, revealed dried tan liquid on the floor and the HVAC unit vents contained a thick build up of dust. 9. Review of the medical records revealed Resident #75 and Resident #83 shared a room. Review of the medical record revealed Resident #75 was admitted to the facility on [DATE], with diagnoses including Chronic Obstructive Pulmonary Disease, Muscle Weakness, and Gastrostomy tube. Review of Resident #75's quarterly MDS assessment dated [DATE], revealed a BIMS score was unable to be completed, staff assessed the resident as rarely/never understood for daily decision making. Review of the medical record revealed Resident #83 was admitted to the facility on [DATE], with diagnoses including Dysphagia, Cerebral Infarction, Hemiparesis, and Gastrostomy tube. Review of Resident #83's admission MDS assessment dated [DATE], revealed a BIMS score that was unable to be completed, staff assessed the resident as rarely/never understood for daily decision making. Observation in Resident #83's room on 9/23/2024 at 10:00 AM, revealed tan liquid running down the enteral feeding pump pole. Observation in Resident #83's room on 9/30/2024 at 10:29 AM, revealed tan liquid ran down the feeding pump pole and collected at the base of the pole, and tan liquid ran down onto the nightstand and pooled in the floor. Observation in Resident #75 and Resident #83's shared room on 10/1/2024 at 8:13 AM and 3:18 PM, revealed a tan liquid ran down Resident #75 and Resident #83's enteral feeding poles, pooled in the floor and dried on the floor. 10. Review of the medical records revealed Resident #77 and Resident #117 shared a room. Review of the medical record revealed Resident #77 was admitted to the facility on [DATE], with diagnoses including Acute Respiratory Failure with Hypoxia, Cerebral Infarction, Tracheostomy Status, Atrial Fibrillation, and Gastrostomy tube. Review of Resident #77's quarterly MDS assessment dated [DATE], revealed a BIMS score was unable to be completed, staff assessed the resident as moderately impaired for daily decision making, dependent on staff for all ADLs, and was coded for a feeding tube, oxygen therapy, suctioning, and tracheostomy. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medical record revealed Resident #117 was admitted to the facility on [DATE], with diagnoses including Respiratory Failure, Cerebrovascular Accident, Hemiplegia/Hemiparesis, Chronic Kidney Disease, Tracheostomy, Pressure Ulcer Sacrum Stage 4, Diabetes, and Gastrostomy tube. Review of Resident #117's quarterly MDS assessment dated [DATE], revealed a BIMS assessment was unable to be completed, staff assessed the resident as rarely/never understood for daily decision making. Resident #117 was dependent on staff for all ADLs, and was coded for an indwelling catheter, feeding tube, oxygen therapy, suction, and tracheostomy. Observations in Resident #77 and Resident #177's shared room on 9/23/2024 at 9:53 AM, revealed the vanity sink contained a dried, brown, chunky substance with the appearance of gastric contents. Observations in Resident #77's and #177's room on 9/25/2024 at 10:10 AM and 10/2/2024 at 2:15PM, revealed Resident #77's oxygen concentrator with white dust like residue blowing off the side of the front of the grill between the vents, the HVAC unit front cover with thick, white, fluffy residue on the vent. The base of Resident #77's enteral pump pole contained a thick, dried, tan substance, a black substance was on the floor in the corner beside the window, Resident #77's bed frame contained thick, black smears with a foul odor, and the floor tile at the head of the bed revealed a black, sticky substance. Resident #177's bed frame contained a thick, black smear with a foul odor on the side and the bottom of the bed frame. The floor under Resident #177's bed was covered with a layer of white dust, black tile grout, and debris. The residents' sink contained rust stains and standing water from a clogged sink, and chipped paint with black smears was observed in the right corner of the vanity with black sticky debris observed under the mirror. During an interview on 9/25/2024 at 10:20 AM, CNA P was asked when Resident #77 and Resident #117's sink was reported clogged. CNA P stated, .I'm not sure, it's been that way for a while . CNA P was asked what was under Resident #177's bed and bedframe. CNA P stated, .looks like dirt and feces .someone needs to clean that . During an interview on 9/25/2024 at 10:24 AM, LPN C was asked who was responsible for reporting clogged sinks. LPN C stated, .we tell maintenance .they will get to it . LPN C was asked who was responsible for cleaning the feeding pumps and poles. LPN C stated, .I would say the nurses . LPN C was asked what was on Resident #77's feeding pump. LPN C stated, .dried enteral feedings and dust . LPN C was asked what was on Resident #77's and #117's bedframe. LPN C stated, .could be dried stool . 11. Review of the medical record revealed Resident #80 was admitted to the facility on [DATE], with diagnoses including Chronic Respiratory Failure, Tracheostomy, and Gastrostomy tube. Review of Resident #80's 5-day MDS assessment dated [DATE], revealed a BIMS score of 14, which indicated the Resident was cognitively intact, and dependent on staff for all ADLs. Observations in Resident #80 's room on 9/23/2024 at 10:06 AM and 9/24/2024 at 9:30 AM, revealed a thick, dried, yellowish-tan stain on the floor next to the bed. 12. Review of the medical records revealed Resident #120 and Resident #129 shared a room. Review of the medical record revealed Resident #120 was admitted to the facility on [DATE], with diagnoses including Respiratory Failure, Tracheostomy, Diabetes, and Gastrostomy tube. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #120's quarterly MDS assessment dated [DATE], revealed a BIMS score of 13, which indicated the resident was cognitively intact. Review of the medical record revealed Resident #129 was admitted to the facility on [DATE], with diagnoses including Respiratory Failure and Tracheostomy. Review of Resident #129's quarterly MDS assessment dated [DATE], revealed Resident had no BIMS score, staff assessed the resident as severely cognitively impaired for daily decision making, and the resident was dependent on staff for all ADLs. Review of the Tracking and Trending, report dated August 2024, revealed Resident #129 was treated with antibiotics for Respiratory Infections on 8/6/2024 and 8/25/2024. Review of the Admission/Discharge Report dated 9/1/2024-10/2/2024, revealed Resident #129 was discharged to the hospital on 8/28/2024 after unsuccessful treatment of antibiotics for a respiratory Infection. Review of the Progress Notes dated 10/10/2024, revealed Resident #129 was readmitted to the facility (on 10/10/2024) after being discharged to the hospital on 10/5/2024 for acute respiratory distress. Observation in Resident #120 and Resident #129's shared room on 9/23/2024 at 11:08 AM and 10/01/2024 at 8:18 AM, revealed the HVAC vents contained a thick build up of dust and a dried tan liquid was observed on Resident #129's enteral feeding pump pole and the floor. 13. Review of the medical records revealed Resident #131 and Resident #144 shared a room. Review of the medical record revealed Resident #131 was admitted to the facility on [DATE], with diagnoses including Acute Respiratory Failure, Dependence on Ventilator, and Tracheostomy. Review of Resident #131's quarterly MDS assessment dated [DATE], revealed Resident #131 BIMS score was unable to be completed due to Resident #131 was rarely/never understood. Resident #131 was assessed by staff to be severely cognitively impaired and dependent on staff for all care. Review of the medical record revealed Resident #144 was admitted to the facility on [DATE], with diagnoses including Respiratory Failure, Dependence on Ventilator, Tracheostomy, and Gastrostomy tube. Review of Resident #144's admission MDS assessment dated [DATE], revealed a BIMS score of 15, which indicated the resident was cognitively intact, and dependent on staff for all care. Review of the Admission/Discharge Report dated 8/1/2024-8/31/2024, revealed Resident #144 was discharged to the hospital 8/15/2024 with a Respiratory Infection. Review of the Tracking and Trending report dated September 2024, revealed Resident #144 was treated with antibiotics for a respiratory infection on 9/5/2024 and 9/6/2024. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations in Resident #131 and Resident #144's shared room on 9/23/2024 at 10:50 AM and 3:48 PM, on 9/24/2024 at 7:34 AM, on 9/25/2024 at 4:10 PM, and on 10/1/24 at 8:10 AM, revealed a pool of a yellowish tan substance dried on the floor under the enteral feeding pole next to Residents #131's bed and yellowish tan dried drip spots on the floor leading toward the door. 14. Review of the medical record revealed Resident #133 was admitted to the facility on [DATE], with diagnoses including Respiratory Failure, Tracheostomy, Chronic Kidney Disease, and Gastrostomy tube. Review of Resident #133's admission MDS assessment dated [DATE], revealed a BIMS score was not completed and staff assessed the resident as cognitively impaired for daily decision making, received oxygen, required suctioning, and received tracheostomy care. Observations in Resident #133's room on 9/23/2024 at 11:02 AM and 4:15 PM, and 9/24/2024 at 7:15 AM, revealed a dried, tan liquid on the floor in front of the oxygen concentrator. Observation in Resident #133's room on 9/24/2024 at 1:56 PM, revealed a dried tan liquid on the floor by the nightstand, and a dried, tan liquid and dust on the feeding pump pole. Crumbs and dried, brown spots were observed on the floor under the unoccupied bed in Resident #133's room. Observations in Resident #133's room on 9/25/2024 at 10:39 AM and 9/25/2024 at 4:11 PM, revealed dried, brown drops on the floor by the oxygen concentrator, dried tan liquid on the floor in front of the nightstand, dried, tan liquid on the blinds, thick dust and cobwebs on the windows, and crumbs and brown spots remained on the floor under the unoccupied bed in the resident's room. Observation in Resident #133's room on 9/30/2024 at 9:40 AM, revealed a thick build up of dark brown substance by the wall molding, next to the nightstand along with a bottle of enteral feeding on the floor, an unopened Calcium Alginate Dressing, and a jar of odor eliminator between the nightstand and the wall. Observation in Resident #133's room on 10/2/2024 at 8:51 AM, revealed the oxygen concentrator back vent contained white fluffy dust. 15. Review of the medical records revealed Resident #139 and Resident #349 shared a room. Review of the medical record revealed Resident #139 was admitted to the facility on [DATE], with diagnoses including Acute Respiratory Failure, Quadriplegia, Tracheostomy, and Gastrostomy tube. Review of Resident #139's admission MDS assessment dated [DATE], revealed a BIMS score was unable to be assessed, staff assessed the resident with severe cognitive impairment, and the resident was dependent on staff for all care. Resident #139 was discharged on [DATE] to the hospital with severe sepsis secondary to pneumonia. The resident did not return to the facility during the survey. Review of the medical record revealed Resident #349 was admitted to the facility on [DATE], with diagnoses including Acute Respiratory Failure, Tracheostomy and Gastrostomy tube. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #349's admission MDS assessment dated [DATE], revealed a BIMS assessment was unable to be completed, staff assessed the resident as severely cognitively impaired for daily decision making, resident was rarely/never understood, and dependent on staff for all care. Observations in Resident #139's room on 9/30/2024 at 10:53 AM and 10/1/2024 at 8:04 AM, revealed the enteral feeding pump was covered with a dried, yellowish tan substance which had dripped and dried down the feeding pole, and a dried pool of the same substance was observed under the base of the enteral feeding pole. Resident #139 was discharged to the hospital on 9/25/2024 and no other patient had been admitted to that bed. Observation in Resident #349's room on 10/2/2024 at 8:47 AM, revealed large gray clumps of dust under the HVAC and tan spots on the floor. 16. Review of the medical record revealed Resident #304 was admitted to the facility on [DATE], with Respiratory Failure, Hypoxia, Tracheostomy, Acute Kidney Failure, and Gastrostomy tube. Review of Resident #304's admission MDS assessment dated [DATE], revealed a BIMS score of 14, which indicated the resident was cognitively intact. Observations in Resident #304's room on 9/23/2024 [TRUNCATED]