STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445331	A. Building B. Wing	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Graceland Rehabilitation and Nursing Care Center	1250 Farrow Road Memphis, TN 38116

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44724 Based on facility policy review, medical record review, and interviews, the facility failed to obtain consent for administration of psychotropic medications for 2 of 5 sampled residents (Resident #13 and #52) reviewed for unnecessary medications. The findings include: 1. Review of the facility policy titled, Psychotropic Medication Use, dated ,d+[DATE], revealed .Residents will not receive medication that are not clinically indicated to treat a specific condition .A psychotropic medication is any mediation that affects brain activity associated with mental processes and behavior .Drugs in the following categories are considered psychotropic medications .Anti-psychotics .Anti-depressants . Anti-anxiety medications .Residents, families and/or the representative are involved in the medication management process .Residents who have not used psychotropic medications are not prescribed or given these medications unless the medication is determined to be necessary to treat a specific condition that is diagnosed and documented in the medical record . 2. Review of the medical record revealed Resident #13 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including Acute Cerebrovascular Insufficiency, Psychosis and Unspecified Dementia with Behavioral Disturbance. Review of the [Named Psychiatric Services] Follow Up dated [DATE], revealed .Psychosis, Anxiety, Adjustment Disorder, Dementia .Resident is being seen for follow up. He states I'm okay; just waiting for lunch. He denies depression or anxiety. He reports that his sleep and appetite are stable .No behavioral issues or concerns reported by staff .Continue current treatment regimen . Review of the [Named Psychiatric Services] Follow Up dated [DATE], revealed .Medication Management . Seroquel [Antipsychotic medication primarily used to treat mental health conditions] 25 mg PO [by mouth] BID [twice per day] .Resident with a history of depression, anxiety, psychosis being seen for follow up .He denies depression or anxiety. He reports that his sleep and appetite are stable .No behavioral issues or concerns reported by staff .Continue current treatment regimen . (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the [Named Psychiatric Services] Follow Up dated [DATE], revealed .Medication Management . Seroquel 25 mg PO BID .Resident with a history of depression, anxiety, psychosis being seen for follow up, staff request related to depression, recent death of daughter. He stated, My daughter died . He is tearful during today's evaluation related to recent death of his daughter. He reports that his sleep and appetite are stable .GDR [Gradual Dose Reduction] is not appropriate at this time .Start Sertraline [Zoloft, an Antidepressant medication used to treat depression] 25 mg PO QDay [every day]; Will follow up in 2 weeks or sooner if needed . The follow up note revealed a new antidepressant was started for Resident #13. Review of Medication Administration Record (MAR) from [DATE]-[DATE] revealed Resident #13 received Zoloft 25 mg daily and Seroquel 25 mg two times daily. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #13 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated severe cognitive impairment. Continued review revealed no mood or behaviors noted during the assessment reference dates. Further review revealed Resident #13 received an antipsychotic and antidepressant medication over the last 7 days. Review of Resident #13's Order Summary Report dated [DATE] revealed .Seroquel Oral Tablet 25 MG [milligram] Give 1 tablet by mouth two times a day for Mood swings related to UNSPECIFIED DEMENTIA WITH BEHAVIORAL DISTURBANCE .Order Date [DATE] . Zoloft Oral Tablet 25 MG Give 1 tablet by mouth one time a day for Depression .Order Date XXX[DATE] . Review of the MAR from [DATE]-[DATE] revealed Resident #13 received Zoloft 25 mg daily and Seroquel 25 mg two times daily. Review of the MAR from [DATE]-[DATE] revealed Resident #13 received Zoloft 25 mg daily and Seroquel 25 mg two times daily. During a telephone interview on [DATE] at 3:43 PM, Family Member (FM) MM stated, .I don't know anything about his medications he takes . 3. Review of the medical record revealed Resident #52 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including Diabetes Mellitus, Bipolar Disorder, Depression, and Anxiety. Review of the quarterly MDS dated [DATE] revealed a BIMS score of 13, which indicated no cognitive impairment. Continued review revealed no mood or behaviors noted during the assessment reference dates. Further review revealed Resident #52 received an Antipsychotic, Antianxiety, and Antidepressant over the last 7 days. Review of the MAR dated [DATE]-[DATE] revealed Resident #52 received Ativan (an Antianxiety medication given for Anxiety) 0.5 mg PRN (as needed) 58 times during the month of ,d+[DATE]. Continued review revealed Resident #52 did not receive PRN Diazepam (an Antianxiety medication) during the month of , d+[DATE]. Further review revealed Resident #52 received Risperidone (an Antipsychotic medication) 2 mg daily and Trazodone (an Antidepressant medication) 100 mg at bedtime daily. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #52's Order Summary Report dated [DATE], revealed .Ativan Oral Tablet 0.5 MG (Lorazepam) Give 1 tablet by mouth every 6 hours as needed for Anxiety .Order Date XXX[DATE] .diazepam Oral Tablet 5 MG (Diazepam) Give 1 tablet by mouth every 6 hours as needed for anxiety .Order Date XXX[DATE] .risperidone [used to treat mental illness] Oral Tablet 2 MG (Risperidone) Give 1 tablet by mouth one time a day for bipolar [A disorder associated with episodes of mood swings ranging from depressive lows to manic highs] .Order Date [DATE] . trazodone HCL (Hydrochloride) 100 MG (Trazodone HCL) Give 1 tablet by mouth at bedtime for insomnia [difficulty sleeping] .Order Date XXX[DATE]. Review of the MAR dated [DATE]-[DATE], revealed Resident #52 received Ativan 0.5 mg PRN 52 times during the month of ,d+[DATE]. Continued review revealed Resident #52 did not receive PRN Diazepam during the month of ,d+[DATE]. Further review revealed Resident #52 received Risperidone 2 mg daily and Trazadone 100 mg at bedtime daily. Review of the MAR dated [DATE]-[DATE], revealed Resident #52 received Ativan 0.5 mg PRN 10 times during the review period. Continued review revealed Resident #52 did not receive PRN Diazepam. Further review revealed Resident #52 received Risperidone 2 mg daily and Trazadone 100 mg at bedtime daily. During an interview on [DATE] at 1:27 PM, The Regional Director of Clinical Services was asked where consents would be for psychotropic medications. The Regional Director stated, .I will ask the Director of Nursing (DON) where the consents are at . During an interview on [DATE] at 10:30 AM, the Social Service Director (SSD) was asked if she was involved in reviewing the medications, treatment options, and obtaining consents from resident or resident representative for psychotropic drugs. The SSD stated, .I have never done consents signed by the family . During an interview on [DATE] at 10:45 AM, the DON was asked if she had consents for the use of psychotropic medications for Resident #13 and Resident #52. The DON stated, .we do not have any consents right now .we started doing them last Friday [[DATE]] after the Consultant looked into the situation .

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38439 Based on policy review, medical record review, and interview, the facility failed to provide education and written information to resident and/or family representative to formulate an Advance Directive for 27 of 35 sampled residents (Resident #4, #22, #28, #29, #30, #37, #39, #42, #48, #66, #69, #75, #87, #91, #100, #102, #112, #119, #125, #129, #137, #139, #143, #146, #151, #265, and #465) reviewed for Advance Directives. The findings include: 1. Review of the facility policy titled, Advance Directives, dated 2001, revealed .The resident has the right to formulate an advance directive .Prior to or upon admission of a resident, the social services director or designee inquires of the resident, his/her family and/or his or her legal representative, about the existence of any written advance directives .The resident or representative is provided with written information concerning the right .to formulate an advance directive if he or she chooses to do so . 2. Review of the medical record revealed Resident #4 was readmitted to the facility on [DATE], with diagnoses including Diabetes, Hemiplegia/Hemiparesis, Dementia, Anxiety, Cerebrovascular Disease, and Colostomy. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 1, which indicated Resident #4 was severely cognitively impaired. The facility was unable to provide completed documentation in the medical record that the resident and/or resident representative was educated regarding advance directives and/or to formulate an advance directive. 3. Review of the medical record revealed Resident #22 was admitted to the facility on [DATE], with diagnoses including Chronic Respiratory Failure, Anoxic Brain Damage, Sudden Cardiac Arrest, Heart Failure, and Quadriplegia. Review of the quarterly MDS assessment dated [DATE], revealed Resident #22 was in a persistent vegetative state/no discernible consciousness. The facility was unable to provide completed documentation in the medical record that the resident and/or resident representative was educated regarding advance directives and/or to formulate an advance directive. 4. Review of the medical record revealed Resident #28 was admitted to the facility on [DATE], with diagnoses including Metabolic Encephalopathy, Diabetes and Dementia. Review of the quarterly MDS assessment dated [DATE], revealed a BIMS score of 3, which indicated Resident #28 was severely cognitively impaired. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility was unable to provide completed documentation in the medical record that the resident and/or the resident representative was educated regarding advance directives and/or to formulate an advance directive. 5. Review of the medical record revealed Resident #29 was admitted on [DATE], with diagnoses including Chronic Kidney Disease, Cerebral Infarction, Dependent on Renal Dialysis. Review of the admission MDS assessment dated [DATE], revealed staff did not perform a BIMS due to Resident #29 was severely cognitively impaired. The facility was unable to provide completed documentation in the medical record that the resident and/or resident representative was educated regarding advance directives and/or to formulate an advance directive. 6. Review of the medical record revealed Resident #30 was admitted to the facility on [DATE], with diagnoses including Chronic Respiratory Failure, Diabetes and Anoxic Brain Injury. Review of the quarterly MDS assessment dated [DATE], revealed Resident #30 was in a persistent vegetative state/no discernible consciousness. The facility was unable to provide completed documentation in the medical record that the resident and/or resident representative was educated regarding advance directives and/or to formulate an advance directive. 7. Review of the medical record revealed Resident #37 was readmitted to the facility on [DATE], with diagnoses including Hypertensive Chronic Kidney Disease, Malnutrition, and Dysphagia. Review of the significant change MDS assessment dated [DATE], revealed a BIMS score of 0, which indicated Resident #37 was severely cognitively impaired. The facility was unable to provide completed documentation in the medical record that the resident and/or resident representative was educated regarding advance directives and/or to formulate an advance directive. 8. Review of the medical record revealed Resident #39 was admitted to the facility on [DATE], with diagnoses including Trisomy 21 and Chronic Kidney Disease. Review of the quarterly MDS dated [DATE], revealed a BIMS score of 3, which indicated Resident #39 was severely cognitively impaired. The facility was unable to provide completed documentation in the medical record that the resident and/or resident representative was educated regarding advance directives and/or to formulate an advance directive. 9. Review of the medical record revealed Resident #42 was admitted to the facility on [DATE], with diagnoses including Epilepsy, Diabetes, Hemiplegia, and Aphasia. (continued on next page)

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F 0578 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 8, which indicated Resident #42 was moderately cognitively impaired. The facility was unable to provide completed documentation in the medical record that the resident and/or resident representative was educated regarding advance directives and/or to formulate an advance directive. 10. Review of the medical record revealed Resident #48 was readmitted to the facility on [DATE], with diagnoses including Diabetes, End Stage Renal Disease, Heart Failure, and Traumatic Amputation of Left Knee and Ankle. Review of the annual MDS assessment dated [DATE], revealed a BIMS of 15, which indicated Resident #48 was cognitively intact. The facility was unable to provide completed documentation in the medical record that the resident and/or resident representative was educated regarding advance directives and/or to formulate an advance directive. 11. Review of the medical record revealed Resident #66 was admitted to the facility on [DATE], with diagnoses including Diabetes, Atherosclerotic Heart Disease and Adjustment Disorder. Review of the quarterly MDS assessment dated [DATE], revealed a BIMS score of 14, which indicated Resident #66 was cognitively intact. The facility was unable to provide completed documentation in the medical record that the resident and/or resident representative was educated regarding advance directives and/or to formulate an advance directive. 12. Review of the medical record revealed Resident #69 was admitted to the facility on [DATE], with diagnoses including Osteoarthritis, Chronic Obstructive Pulmonary Disease, and Atherosclerotic Heart Disease. Review of the quarterly MDS assessment dated [DATE], revealed a BIMS score of 9, which indicated Resident #69 was moderately cognitively impaired. The facility was unable to provide completed documentation in the medical record that the resident and/or resident representative was educated regarding advance directives and/or to formulate an advance directive. 13. Review of the medical record revealed Resident #75 was admitted to the facility on [DATE], with diagnoses including Diabetes, Malnutrition, Schizoaffective Disorder, Hypertension, and Bipolar Disorder. Review of the quarterly MDS assessment dated [DATE], revealed a BIMS score of 13, which indicated Resident #75 was cognitively intact. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility was unable to provide completed documentation in the medical record that the resident and/or resident representative was educated regarding advance directives and/or to formulate an advance directive. 14. Review of the medical record revealed Resident #87 was admitted to the facility on [DATE], with diagnoses including Diabetes, Malnutrition, Schizoaffective Disorder, and Bipolar Disorder. Review of the quarterly MDS assessment dated [DATE], revealed a BIMS score of 13, which indicated Resident #87 was cognitively intact. The facility was unable to provide completed documentation in the medical record that the resident and/or resident representative was educated regarding advance directives and/or to formulate an advance directive. 15. Review of the medical record revealed Resident #91 was admitted to the facility on [DATE], with diagnoses including Chronic Respiratory Failure, Malnutrition, Tracheostomy, and Pressure Ulcer of Sacral Region. Review of the quarterly MDS assessment dated [DATE], revealed staff did not perform a BIMS due to Resident #91 was severely cognitively impaired. The facility was unable to provide completed documentation in the medical record that the resident and/or resident representative was educated regarding advance directives and/or to formulate an advance directive. 16. Review of the medical record revealed Resident #100 was admitted to the facility on [DATE], with diagnoses including Malignant Neoplasm of Colon (Cancerous tumor in the colon), Diabetes, Dementia, Psychotic Disturbance, and Anxiety. Review of the admission MDS assessment dated [DATE], revealed a BIMS score of 10, which indicated Resident #100 was moderately cognitively impaired. The facility was unable to provide completed documentation in the medical record that the resident and/or resident representative was educated regarding advance directives and/or to formulate an advance directive. 17. Review of the medical record revealed Resident #102 was admitted to the facility on [DATE], with diagnoses including Hemiplegia, Depression and Diabetes. Review of the annual MDS assessment dated [DATE], revealed a BIMS score of 14, which indicated Resident #102 was cognitively intact. The facility was unable to provide completed documentation in the medical record that the resident and/or resident representative was educated regarding advance directives and/or to formulate an advance directive. 18. Review of the medical record revealed Resident #112 was admitted to the facility on [DATE], with diagnoses including Anoxic Brain Damage and Diabetes. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the quarterly MDS assessment dated [DATE], revealed the staff did not perform a BIMS due to Resident #112 was severely cognitively impaired. The facility was unable to provide completed documentation in the medical record that the resident and/or resident representative was educated regarding advance directives and/or to formulate an advance directive. 19. Review of the medical record revealed Resident #119 was admitted to the facility on [DATE], with diagnoses including Chronic Respiratory Failure, Anoxic Brain Injury, Gastrostomy, and Tracheostomy. Review of the quarterly MDS assessment dated [DATE], revealed staff did not perform a BIMS due to Resident #119 was severely cognitively impaired. The facility was unable to provide completed documentation in the medical record that the resident and/or resident representative was educated regarding advance directives and/or to formulate an advance directive. 20. Review of the medical record revealed Resident #125 was admitted to the facility on [DATE], with diagnoses including Epilepsy, Dysphagia, Cerebral Infarction, Dementia, and Viral Hepatitis. Review of the admission MDS assessment dated [DATE], revealed a BIMS score of 6, which indicated Resident #125 was severely cognitively impaired. The facility was unable to provide completed documentation in the medical record that the resident and/or resident representative was educated regarding advance directives and/or to formulate an advance directive. 21. Review of the medical record revealed Resident #129 was admitted to the facility on [DATE], with diagnoses including Chronic Respiratory Failure, Diabetes, Dysphagia, and Schizoaffective Disorder. Review of the admission MDS assessment dated [DATE], revealed a BIMS score of 10, which indicated Resident #129 was moderately cognitively impaired. The facility was unable to provide completed documentation in the medical record that the resident and/or resident representative was educated regarding advance directives and/or to formulate an advance directive. 22. Review of the medical record revealed Resident #137 was admitted to the facility on [DATE], with diagnoses including Chronic Respiratory Failure, Chronic Obstructive Pulmonary Disease, and Chronic Kidney Failure. Review of the quarterly MDS assessment dated [DATE], revealed a BIMS score of 7, which indicated Resident #137 was severely cognitively impaired. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility was unable to provide completed documentation in the medical record that the resident and/or resident representative was educated regarding advance directives and/or to formulate an advance directive. 23. Review of the medical record revealed Resident #139 was admitted to the facility on [DATE], with diagnoses including Hemiplegia, Chronic Respiratory Failure, Diabetes, and Anxiety. Review of quarterly MDS assessment dated [DATE], revealed a BIMS score of 15, which indicated Resident #139 was cognitively intact. The facility was unable to provide completed documentation in the medical record that the resident and/or resident representative was educated regarding advance directives and/or to formulate an advance directive. 24. Review of the medical record revealed Resident #143 was admitted to the facility on [DATE], with diagnoses including Anoxic Brain Injury, Chronic Respiratory Failure, Diabetes, and Malnutrition. Review of the significant change MDS assessment dated [DATE], revealed a BIMS was not performed due to Resident #143 was severely cognitively impaired. The facility was unable to provide completed documentation in the medical record that the resident and/or resident representative was educated regarding advance directives and/or to formulate an advance directive. 25. Review of the medical record revealed Resident #146 was admitted to the facility on [DATE], with diagnoses including Myopathy, Chronic Respiratory Failure, Diabetes, Gastrostomy, and Adult Failure to Thrive. Review of the quarterly MDS assessment dated [DATE], revealed a BIMS score of 6, which indicated Resident #146 was severely cognitively impaired. The facility was unable to provide completed documentation in the medical record that the resident and/or resident representative was educated regarding advance directives and/or to formulate an advance directive. 26. Review of the medical record revealed Resident #151 was admitted on [DATE], with diagnoses including Chronic Respiratory Failure, Tracheostomy, Schizophrenia, and Traumatic Brain Injury. Review of the admission MDS assessment dated [DATE], revealed a BIMS score of 13, which indicated Resident #151 was cognitively intact. The facility was unable to provide completed documentation in the medical record that the resident and/or resident representative was educated regarding advance directives and/or to formulate an advance directive. 27. Review of the medical record revealed Resident #265 was admitted to the facility on [DATE], with diagnoses including End Stage Renal Disease, Diabetes, and Depression. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the admission MDS assessment dated [DATE], revealed a BIMS score of 4, which indicated Resident #265 was severely cognitively impaired. The facility was unable to provide completed documentation in the medical record that the resident and/or resident representative was educated regarding advance directives and/or to formulate an advance directive. 28. Review of the medical record revealed Resident #465 was admitted to the facility on [DATE], with diagnoses including Diabetes, Adjustment Disorder, Malnutrition, and Heart Failure. Review of the quarterly MDS assessment dated [DATE], revealed a BIMS score of 15, which indicated Resident #465 was cognitively intact. The facility was unable to provide completed documentation in the medical record the resident and/or resident representative was educated regarding advance directives and/or to formulate and advance directive. During an interview on 5/12/2025 at 11:18 AM, the Marketing Director was asked the process for advance directives. The Marketing Director confirmed that there was not a process in place prior to last week for educating residents and/or representatives on how to formulate an advance directive. 38909 46252 47127 47835 49269 51740 51992

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44724 Based on facility policy review, medical record review, observation, and interview, the facility failed to ensure as needed (PRN) psychotropic medications for 1 of 5 (Resident #52) sampled residents reviewed for unnecessary medications were limited to 14 days duration. The facility failed to obtain a physician's assessment or document rationale for continued use of the medication. The findings include: 1. Review of the facility policy titled, Psychotropic Medication Use, dated 7/2022, revealed .Residents will not receive medication that are not clinically indicated to treat a specific condition .A psychotropic medication is any mediation that affects brain activity associated with mental processes and behavior .Drugs in the following categories are considered psychotropic medications .Anti-psychotics .Anti-depressants . Anti-anxiety medications .Psychotropic medication management includes .indications for use .dose .duration . adequate monitoring for efficacy and adverse consequences .preventing, identifying and responding to adverse consequences .Psychotropic medications are not prescribed or given on a PRN basis unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record .Prn orders for psychotropic medications are limited to 14 days .if the prescriber or attending physician believes it is appropriate to extend the PRN order beyond 14 days, he or she will document the rationale for extending the use and include the duration for the PRN order . 2. Review of the medical record revealed Resident #52 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including Diabetes Mellitus, Bipolar Disorder, Depression, and Anxiety Disorder. Review of the quarterly Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 13, which indicated Resident #52 was cognitively intact. Continued review revealed no mood, or behaviors were noted during the assessment reference dates. Further review revealed Resident #52 received an Antianxiety over the last 7 days. Review of the Medication Administration Record (MAR) dated 3/1/2025-3/31/2025, revealed Resident #52 received Ativan (Antianxiety medication given for Anxiety) 0.5 milligram (mg) PRN 58 times during the month of 3/2025. Continued review revealed Resident #52 did not receive Diazepam (Antianxiety) during the month of 3/2025. Review of Resident #52's Order Summary Report dated 4/1/2025, revealed .Ativan Oral Tablet 0.5 MG (Lorazepam) Give 1 tablet by mouth every 6 hours as needed for Anxiety .Order Date .3/10/2025 .diazepam Oral Tablet 5 MG (Diazepam) Give 1 tablet by mouth every 6 hours as needed for anxiety .Order Date . 8/22/2024 . Review of the MAR dated 4/1/2025-4/30/2025, revealed Resident #52 received Ativan 0.5 mg PRN 52 times during the month of 4/2025. Continued review revealed Resident #52 did not receive PRN Diazepam during the month of 4/2025. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the MAR dated 5/1/2025-5/6/2025, revealed Resident #52 received Ativan 0.5 mg PRN 10 times in the last 6 days. Continued review revealed Resident #52 did not receive PRN Diazepam in the last 6 days. Review of the Pharmacist Consultant Note dated 5/7/2025, revealed Resident #52 received monthly pharmacy reviews from 10/2024 to 3/2025 with no new recommendations. During an interview on 5/12/2025 at 10:30 AM, the Social Service Director (SSD) stated, .we have GDR [Gradual Dose Reduction] meeting monthly . SSD was asked what the rationale for Resident #52 having two prn orders for an antianxiety and why were they ordered over (for longer than) 14 days. SSD stated, .I didn't really know anything about them being ordered over 14 days. Review of the Patient Information Report from Hospice #1 Agency with print date 5/12/2025, revealed no documentation for the rationale for prn Ativan and prn Diazepam. During an interview on 5/12/2025 at 3:50 PM, the Medical Director (MD) was asked the reason or rationale for Resident #52 having orders for Ativan and Diazepam over 14 days. The MD stated, .she is under hospice care that doctor would be reviewing her medications . During a telephone interview on 5/12/2025 at 4:04 PM, the Pharmacist was asked why Resident #52 would have an order for prn Ativan and prn Diazepam, two different Antianxiety medications. The Pharmacist stated, .I honestly don't have the answer for you .one of those should be discontinued . The Pharmacist was asked if a PRN psychotropic medication should have a stop date. The Pharmacist stated, .they don't have to have a stop date is my understanding .

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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 the facility policy review, medical record review, Incident Reporting System (IRS), and interview the facility failed to report sufficient information to describe the results of all investigations to the State Survey Agency within 5 working days of the incident for 1 of 2 (Resident #515) sampled residents reviewed for an injury of unknown origin. The findings include: 1. Review of the facility policy titled, Abuse Investigations, dated 4/2010, revealed .Policy Statement .All reports of resident abuse, neglect and injuries of unknown source shall be promptly and thoroughly investigated by facility management .Should an incident .of unknown source be reported, the Administrator . will appoint a member of management to investigate the alleged incident .The Administrator will provide a written report of the results of all .investigations and appropriate action taken to the state survey and certification agency .within five (5) working days of the reported incident . Review of the facility policy titled, ACCIDENT & [and] INCIDENT DOCUMENTATION & INVESTIGATION RESIDENT INCIDENT, dated 7/2018, revealed .Accidents and/or incidents involving resident care will be investigated and documented on the Resident Incident Report entry form in the LTC [Long Term Care] system. An incident is defined as an occurrence which is not consistent with the routine operation of the facility or the routine care of a particular resident. Accidents and incidents will be analyzed for trends or patterns to enable the facility to enhance preventative measures to reduce the occurrence of incidents .The Executive Director/Director of Nursing will notify the State Department of Health in accordance with reporting guidelines in the event the accident/incident is reportable . 2. Review of the medical record revealed Resident #515 was admitted to the facility on [DATE], with diagnoses which included Parkinson's Disease, Lack of Coordination, Muscle Weakness, and Repeated Falls. Review of Resident #515's care plan dated 12/5/2023, revealed .Focus .is at risk for falls r/t [related to] new and unfamiliar environment, poor safety awareness, unsteady gait, weakness .Interventions .Be sure the call light is within reach and educate the resident on use. Reinforce and encourage resident to call for assistance. Respond promptly to all requests for assistance as needed . Review of the Admission Minimum Data Set (MDS) dated [DATE], revealed Resident #515 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated moderate cognitive impairment. Continued review revealed Resident #515 required substantial/maximal assistance with sit to stand, chair/bed-to-chair transfer, toilet transfer was not attempted due to medical condition or safety concerns and dependent for walking 10 feet. Further review revealed Resident #515 had a fall in the last month. (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 Progress Notes dated 1/7/2024 at 4:00 PM, revealed .Resident [#515] in room screaming 'help'. Upon entering room resident observed on floor leaning on left side a few feet from restroom door. Resident's w/c [wheelchair] observed on left side of resident's bed. Call light clipped onto resident's bed. No call light in use. Prior to fall this nurse witnessed resident sitting up on left side of bed. Resident c/o [complained of] pain to right hip and leg, requesting X-ray stating 'I can't move this side.' No redness/swelling nor abnormalities noted to right hip and leg at this time. No abnormalities noted to resident's head. ROM [Range of Motion] WNL [Within Normal Limit] to left leg and BUE [Bilateral Upper Extremity]. Resident assisted to w/c from bed via [by way of] total lift, staff x [times] 2. RP [Responsible Party] made aware. Unable to reach MD [Medical Doctor]. PRN [As needed] Tylenol admin [administered] for pain . Review of the Progress Notes dated 1/7/2024 at 6:40 PM, revealed, .New order per NP [Nurse Practitioner] to transfer resident [#515] to ER [emergency room] for eval. Medical transport contacted with 1.5hour ETA [Estimated Time of Arrival]. RP made aware . Review of the Progress Notes dated 1/7/2024 at 10:28 PM, revealed .Resident [#515] transferred to [Named Hospital #1] ER for eval. s/p [status post] fall . Review of the IRS revealed .Allegation Type .Other Not Listed .Facility became aware of the incident . 1/8/2024 11:00 AM .Name [Named Administrator] .Alleged Victim .[Named Resident #515] .Allegation Details .unwitnessed Fall .Date and time when the alleged incident occurred .1/07/2024 4:00 PM .residents [resident's] room .Provide details of any physical harm .resident complaints of right shoulder and hip pain . Provide all steps taken immediately to ensure resident(s) are protected .On 1/7/24 [2024] [Named Resident #515] was noted yelling for help in her room. Upon the nurse's arrival resident was noted lying on the floor on her left side in front of the bathroom door. The wheelchair was noted on the left side of the bed where the resident was last reported sitting on her bed. Resident was assisted to bed where full body audit was performed. Resident did report c/o [complaint of] right shoulder and hip pain. MD [Medical Doctor] notified and resident was sent to ER [emergency room] for evaluation per MD orders .ATTENTION: PLEASE INCLUDE ENOUGH INFORMATION IN THIS BOX TO EXPLAIN BRIEFLY WHAT OCCURRED AND WHAT YOUR IMMEDIATE INTERVENTION/S WAS .ADD also: Investigation initiated . The IRS box for the information was blank with no investigation submitted. Review of the complaint intake dated 1/8/2024 revealed, Follow up submitted the same day Right femoral fracture. Mrs. [Responsible Party] made aware @ 1600 [4:00 PM]. The intake revealed no interventions or investigation was noted in the follow up submission. The facility reported 1 sentence as their follow-up investigation and failed to provide in its report sufficient information to describe the results of the investigation, and indicate any corrective actions taken. During a telephone interview on 5/12/2025 at 6:51 AM, State Agency Intake Staff stated, .the facility did not submit a final investigation . During an interview on 5/13/2025 at 5:16 PM, the Administrator was asked if the facility had reported incident to the state agency, when would the facility submit the final investigation. The Administrator stated, .In 5 days .

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49269 Based on policy review, record review, and interview, the facility failed to notify the resident's representative or family member of the intent to discharge for 1 of 3 (Resident #316) sampled residents reviewed for discharge. The findings include: 1. Review of the facility policy titled, Transfer or Discharge ., dated 8/2018, revealed .Should it become necessary to make an emergency transfer or discharge to a hospital or other related institution, our facility will implement the following procedures .Notify the representative (sponsor) or family member . 2. Review of the medical record revealed Resident #316 was admitted to the facility on [DATE], with diagnoses including Pulmonary Embolism, Myocardial Infarction, and Acute Kidney Failure. Review of the admission Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 8, which indicated Resident #316 was severely cognitively impaired. Review of the Nurse's Note dated 8/2/2023, revealed Resident discharged to [Named] Psychiatric Care, left via (by way of) stretcher in stable condition, denies pain and discomfort. Resident left with all his belonging. Community Service transport resident to [Named] Psychiatric Care . Review of the Social Services Note dated 8/2/2023, revealed Phone call made to [Named facility] .we will not be able to accept him back because of his elopement risk and that he's needing a lock down unit for his safeness [safety] . During a telephone interview on 5/8/2025 at 12:56 PM, the Resident's representative (RP) confirmed she was unaware of the facility's decision to discharge the resident, and the facility would not be accepting the resident back. During an interview on 5/12/2025 at 10:59 AM, the Social Services Director (SSD) confirmed that Resident #316's representative was not informed of the facility's intent to discharge the resident from the facility. The SSD confirmed that Social Services was responsible for informing the resident's representative of intent to discharge from the facility and the refusal to accept the resident back. During an interview on 5/13/2025 at 3:58 PM, the Director of Nursing (DON) confirmed that Social Services was responsible for informing residents and/or representative of intent to discharge. The DON confirmed that the communication with the representative regarding the facility's decision to discharge should be documented in the resident's medical record.

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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, and interview, the facility failed to follow physician's orders and obtain lab work for 2 of 5 (Resident #4 and #100) sampled residents reviewed for unnecessary medication use. The findings include: 1. Review of the facility policy titled, Laboratory Services and Reporting, dated 11/24/2024, revealed .The facility must provide or obtain laboratory services when ordered by a physician, physician assistant, nurse practitioner, or clinical nurse specialist in accordance with state la .The facility is responsible for the timeliness of the service . 2. Review of the medical record revealed Resident #4 was readmitted to the facility on [DATE], with diagnoses including Diabetes, Urinary Tract Infection, and Colostomy. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 1, which indicated Resident #4 was severely cognitively impaired and received hypoglycemic medications. Review of the Care Plan dated 2/21/2025, revealed .diagnosis of Diabetes Mellitu .Labs as ordered per MD [Medical Doctor] . Review of the Physician Orders dated 1/26/2025, revealed .every 3 months-HgbA1c [Hemoglobin A1C is a blood test that measures average blood sugar levels over 2 to 3 months] .December .March . Review of the medical record revealed the facility failed to obtain a HgbA1C level for March 2025 for Resident #4. During an interview on 5/7/2025 at 10:45 AM, the Administrator confirmed that labs should be obtained per physician orders. 3. Review of the medical record revealed Resident #100 was admitted to the facility on [DATE], with diagnoses including Malignant Neoplasm of Colon (Cancerous tumor in the colon), Diabetes, Vitamin D Deficiency, Anemia, Convulsions, and Hypertension. Review of the admission MDS assessment dated [DATE], revealed a BIMS score of 10, which indicated Resident #100 was moderately cognitively impaired. Review of the quarterly Care Plan for Resident #100 dated 2/26/2025, revealed .Obtain and monitor lab/diagnostic work as ordered . Review of the Physician Orders dated 5/5/2025, revealed .drawn every year .PSA [Prostate-Specific Antigen] .Labs to be drawn every 6 months .CK [Creatine Kinase is a lab to measure the amount of metabolism of muscle] .November .May .Labs to be drawn every 3 months .HgbA1C .February . (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record revealed the facility failed to obtain a CK level and a PSA level for Resident #100 for October 2024 and failed to obtain a HgbA1C level for February 2025. During an interview on 5/12/2025 at 4:45 PM, the Director of Nursing (DON) confirmed that labs should be obtained as ordered by the physician. 51740

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** 44724 Based on facility policy review, medical record review, facility investigation review, hospital record review, medical transport services record review, and interview, the facility failed to ensure residents remained free from accident hazards for 2 of 5 (Resident #415 and #515) sampled residents reviewed for accident hazards. The facility failed to ensure a vulnerable, non-verbal, cognitively impaired resident who required 2-person assistance with bed mobility and care, remained free from accident hazards as evidenced by failure to provide the required amount of assistance for safe repositioning and/or transfer, resulting in a significant injury and hospitalization for Resident #415. On 3/7/2025 at approximately 11:20 AM, Resident #415, a cognitively impaired Resident who was totally dependent on staff for mobility and required 2-person assistance with activities of daily living (ADLs) was receiving care from Certified Nursing Assistant (CNA) A and CNA B. CNA A and CNA B repositioned Resident #415 in the bed on to her side, CNA B then exited the Resident's room to get more supplies, and left CNA A in the room alone with Resident #415 who was still positioned on her side. According to staff, Resident #415's weight shifted, which caused the Resident to fall from the bed to the floor, and hitting her head which resulted in a large hematoma to the Resident's left side of the forehead. Resident #415 was transported to the emergency roiagnom on [DATE] and remained hospitalized until 3/19/2025, with the admitting diagnosis of Focal Hemorrhagic Contusion of Cerebrum (a bruise to the brain caused by a head injury with bleeding and swelling). The facility's failure to provide an environment that was free from accident hazards resulted in an Immediate Jeopardy (IJ) (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) for Resident #415. The facility also failed to provide an environment free from accident hazards when Resident #515, a moderately cognitively impaired resident, who required assistance with mobility, sustained an unwitnessed fall. Resident #515 was found by staff on the floor, reported to staff right leg pain and the inability to move her right leg and asked staff for an x-ray of her leg. Staff assisted the Resident to the bed then used a mechanical lift to move the Resident from the bed to a wheelchair. Staff waited a total of 6 hours and 28 minutes later to call Emergency Transport Services to transport the Resident to the hospital. At the hospital, Resident #515 was diagnosed with a Displaced Subcapital Right Femoral Neck Fracture (hip fracture that occurs when the bone in the neck of the thighbone breaks, and the bone fragments are no longer in proper alignment) which resulted in actual HARM to Resident #515. The Administrator was notified of the Immediate Jeopardy on 5/7/2025 at 4:55 PM, in the Conference Room. The facility was cited at F-689 at a scope and severity of J, which is substandard quality of care. An extended survey was conducted from 5/8/2025 to 5/13/2025. An acceptable Removal Plan which removed the immediacy of the Jeopardy for F-689 was received on 5/9/2025, and the Removal Plan was validated on-site by the surveyors on 5/13/2025 by medical record review, in-service record review, audit review, observation, and staff interviews. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Immediate Jeopardy for F689 began on 3/7/2025 through 5/8/2025, the IJ was removed on 5/9/2025. The facility's noncompliance at F-689 continues at a scope and severity of D for monitoring of the effectiveness of the corrective actions. The facility is required to submit a Plan of Correction. The findings included: 1. Review of the facility policy titled, Safety and Supervision of Residents, dated July 2017, revealed .Our facility strives to make the environment as free from accidents and hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility wide priorities .Safety risks .are evaluated on an ongoing basis through a combination of employee training, employee monitoring and reporting processes . QAPI [Quality Assurance and Performance Improvement] review of safety and incident/accident data .when accident hazards are identified, the QAPI/safety committee shall evaluate and analyze the cause(s) of the hazards and develop strategies to mitigate or remove the hazards .Employees shall be trained on potential accident hazards and demonstrate competency on how to identify and report accident hazards, and try to prevent avoidable accidents .Monitoring the effectiveness of interventions shall include the following . Ensuring that interventions are implemented correctly and consistently . Review of the facility policy titled, Repositioning, dated May 2013, revealed .The purpose of this procedure is to provide guidelines for evaluation of resident repositioning needs, to aid in the development of an individual's care plan for repositioning .review the resident's care plan to evaluate for any special needs . assemble the equipment and supplies as needed .encourage the resident to participate if able .two people . Review of the undated facility policy titled, Pain Management, revealed, .most common painful conditions occurring in long-term care residents .Fractures .Effective symptomatic treatment should not be withheld while a definitive diagnosis or cause of pain is identified .The Pain Evaluation prompts the licensed nurse to elicit from the resident or family members' approaches that make the resident's pain better or worse .factors that may increase pain include .Anxiety .Position .Just as the experience of pain is subjective, assessing another in pain is subjective .We must rely on behaviors observations, as well as intuition and personal judgment . 2. Review of the medical record revealed Resident #415 was admitted to the facility on [DATE], with diagnoses including Chronic Respiratory Failure, Cerebral Infarction, Chronic Obstructive Pulmonary Disease, and Dysphagia. Review of the Care Plan revealed .[1/02/2025] .[Resident #415] at risk for falls r/t [related to] unsteady gait . has bladder incontinence r/t limited mobility .has an ADL self-care deficit r/t .cerebral infarct [infarction/stroke] .has bowel incontinence r/t limited mobility .has dx [diagnosis] of Cerebral Vascular Accident [stroke] . impaired cognitive function or impaired thought processes r/t cognitive communication deficit . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the significant change Minimum Data Set (MDS) dated [DATE], revealed staff did not perform a Brief Interview for Mental Status (BIMS) score due to Resident #415's severe cognitive impairment. Resident #415 had short and long-term memory problems and cognitive skills for daily decision making indicated the resident had severe cognitive impairment. Resident #415 was dependent on staff for bathing, toileting, and personal hygiene, and was always incontinent of bowel and bladder. Review of the Progress Notes dated 3/7/2025 at 12:17 PM, revealed LPN (Licensed Practical Nurse) G documented .CNA x2 [times 2] was assisting res [Resident #415] with ADLs .res was assisted onto her right side and [had] BM [bowel movement] CNA cleaned BM off of res. res had additional BM after clean linen was applied to bed. one cna [CNA B] stepped out of [the] room to get extra linen/towels. cna [CNA A] that remained in room continued to hold res onto her side. res tilted forwarded and fell on to floor. writer [LPN G] assessed res and noted raised area on left side of res' head. Writer [LPN G] called res' daughter/RP [responsible party] .at 1120 [11:20 AM] to report fall and that res would be transported to hospital foreval [for evaluation]. writer contacted [Medical Transport 1] for res to be transferred to [Named hospital 1] per hospital choice on profile. 1123 [11:23 AM] writer called [responsible party] back to answer additional questions after transportation was called . Review of the Situation Background Assessment and Recommendation (SBAR) Physician/Nurse Practitioner (NP)/Physician Assistant (PA) Communication Tool dated 3/7/2025 at 3:24 PM, revealed Resident #415 fell and was transported to the hospital because of a recent fall. Resident #415 had some confusion, a blood pressure of 172/91, and non-verbal indicators of pain were present. Review of the facility's investigation dated 3/7/2025, confirmed there were 2 staff in the room, 1 staff left the room to retrieve some linen, and Resident #415 fell from the bed, while the second staff member was out of the room. Review of the Hospital Medical Records Radiology results dated 3/11/2025, confirmed Resident #415 had a Traumatic Brain Injury (TBI) with left frontal (lobe of the brain), right temporal (lobe of the brain), parenchymal (the tissue that performs the organ's primary function; indicates damage or problem in the brain tissue) and subarachnoid hemorrhage (bleeding in the space between the brain and covering the tissue in the brain). Review of Hospital #1's HOSPITALIST DISCHARGE SUMMARY dated 3/19/2024, revealed Named Resident #415 was discharged to the facility on [DATE]. During a telephone interview on 5/7/2025 at 1:05 PM, CNA B stated, [Named Resident #415] required a 2 person assist on the day of the fall. CNA B confirmed she went to assist CNA A, Resident #415 had a large bowel movement, they did not have enough supplies in the room at that time, and CNA B was asked to go out of the room to get some rags [linens]. CNA B stated, I was in the hallway and CNA A called out 'She fell , she fell '. CNA B stated LPN G was called and nurse LPN G and CNA B went to the room after Resident #415 had fallen from the bed. CNA B stated, Resident #415 was too close to the edge of the bed, I guess. During a telephone interview on 5/7/2025 at 1:45 PM, CNA A stated CNA B exited the room to get supplies because Resident #415 had a bowel movement. CNA A stated she was standing behind Resident #415 when CNA B exited the room. CNA A stated Resident #415 shifted her weight away from her and she couldn't catch Resident #415, and the Resident fell to the floor. CNA A stated the Resident's bed height was waist high. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Graceland Rehabilitation and Nursing Care Center	1250 Farrow Road Memphis, TN 38116

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 5/13/2025 at 3:58 PM, the Director of Nursing (DON) was asked what occurred when Resident #415 fell out of the bed on 3/7/2025. The DON stated 2 CNAs were providing care to the Resident, they ran out of supplies, and one CNA stepped out of the room to get more supplies. The DON stated that the Resident's weight shifted, and the Resident fell out of bed onto the floor. During an interview on 5/13/2025 at 4:48 PM, the Administrator was asked what they determined the root cause was that resulted in Resident #415 falling out of the bed. The Administrator stated there were 2 CNAs in the Resident's room giving care to Resident #415 and one CNA exited the room to get additional supplies leaving one CNA with the Resident. The Administrator stated Resident #415's weight shifted, and the Resident fell from the bed onto the floor. The facility failed to maintain 2-person assistance while providing care to Resident #415 resulting in a fall with injury which placed the Resident in Immediate Jeopardy. 3. Review of the medical record revealed Resident #515 was admitted to the facility on [DATE], with diagnoses including Parkinson's Disease, Lack of Coordination, Muscle Weakness, and Repeated Falls. Review of the Care Plan dated 12/5/2023, revealed .Focus .[Resident #515] is at risk for falls r/t new and unfamiliar environment, poor safety awareness, unsteady gait, weakness . Review of the admission MDS assessment dated [DATE], revealed Resident #515 had a BIMS score of 11, which indicated moderate cognitive impairment, and she required maximal assistance with ADLs. Review of the Progress Notes dated 1/7/2024 at 4:00 PM, for Resident #515 revealed .Resident in room screaming 'help'. Upon entering room resident observed on floor leaning on left side a few feet from restroom door .Resident c/o [complained of] pain to right hip and leg, requesting X-ray stating 'I can't move this side.' . Resident assisted to w/c [wheelchair] from bed via [by way of] total lift [mechanical device used to lift resident], staff x [times] 2. RP made aware. Unable to reach MD [Medical Director]. PRN [As needed] Tylenol admin [administered] for pain . The Progress Notes revealed the nurse moved Resident #515 using a mechanical lift after she voiced inability to move the right side and complained of pain. Review of the SBAR dated 1/7/2024, revealed .Situation .fall .1/7/2024 .Identify whether the problem/symptom has gotten worse/better/stayed the same since it started .Worse .Recent fall .Resident Reports Pain .Yes .Non-verbal indicators of pain evident .Yes .Describe appearance .in pain post fall . Review of the Progress Notes dated 1/7/2024 at 6:40 PM, revealed .New order per NP to transfer resident to ER [emergency room] for eval. Medical transport contacted with 1.5hour ETA [Estimated Time of Arrival]. RP made aware . Review of the Progress Notes dated 1/7/2024 at 10:28 PM, revealed .Resident transferred to [Named Hospital #1] ER for eval. s/p [status post] fall . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Progress Notes revealed the nurse did not make any further calls to other ambulance service transports or call 911 to address Resident #515's immediate needs. Review of the Progress Notes revealed Resident #515 stayed at the facility for 6 hours and 28 minutes before she was transferred to the hospital. Review of the Prehospital Care Report Summary from Medical Transport #2 revealed, .1/07/2024 Call# [number]: 0645 [6:45 PM] .Transport by This EMS [Emergency Management Services] Unit .Initial Patient [Resident #515] Acuity: Critical (Red) .Dispatched: 21:18 [9:18 PM] .Left Scene .22:03 [10:03 PM] . Falls/Back Injuries (Traumatic) .Patient Physical Limitations: Right Leg Paresis [a partial or incomplete loss of muscle function] .distal femur [thighbone] swelling pain 8/10 [pain scale of 1 being lowest and 10 being highest pain level] .unwitnessed fall with injuries Duration: 6 Hours .Extremity Trauma .AOSTF [Arrived on scene to find] [age in years of female] seated in wheelchair by door .stated pain 15 [when asked pain level on scale of 1 to 10] when moving, alert daughter and son-in-law present in pt [patient] room .pt fpund [found] seated in wheelchair, should not be seated until fracture/injury determined . Review of the typed facility investigation for Resident #515 revealed, .On 1/7/24 [2024], [Named Resident #515] was noted yelling for help in her room. Upon the nurse's arrival resident was noted lying on the floor on her left side in front of the bathroom door .MD notified and resident was sent to ER for evaluation per MD orders. 1/8/24 [2024] DON were [was] notified that [Named Resident #515] had sustained a displaced subcapital right femoral neck fracture from the admitting hospital . During an interview on 5/7/2025 at 9:40 PM, the Nurse Practitioner (NP) #1 stated, .I raised up concerns in a recent meeting .I expressed concerns about patient safety .fall education on proper body mechanics .I know of issues with falls with injury . During an interview on 5/12/2025 at 3:23 PM, the MD was asked about Resident #415's fall. The MD stated, . she was supposed to be a 2 person assist someone left to go get supplies and then the resident fell .fall protocol that I expect them [referring to nursing staff] to follow, it hasn't changed, my fall protocol specifically follows what happens after the fall, the resident should not have been left, it would take the 3rd person getting the supplies . MD was asked if the fall was preventable for Resident #415. The MD stated, Yes, never, ever leave the person in the room alone . The MD was asked about Resident #515's fall and what the nurse should have done when she was unable to reach the NP. The MD stated, .we have the call process and text process if they follow those steps, shouldn't be a long period of time to get in contact with me .the nurse should have called me . The MD was asked when Resident #515 had an unwitnessed fall, expressed she was unable to move her leg, and she requested x-rays what would he expect the nurse to do. The MD stated, .expect to send the resident out for x-ray . During a telephone interview on 5/13/2025 at 8:55 AM, Family Member (FM) AA was asked about Resident #515's fall on 1/7/2025. FM AA stated, .Mom kept calling saying she was hurting after she fell .she was calling me on the phone .I got at [to] the facility .I told the nurse she is screaming in pain, I think we need an Xray and sent out to the hospital .the ambulance didn't come quick .I started to call 911 but the nurse told me it wasn't an emergency then we find out at the hospital her leg was broken . FM AA stated, .I stayed at the facility until she was transported out .she was in terrible pain and couldn't move her right leg .she was yelling . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on 5/13/2025 at 12:27 PM, Licensed Practical Nurse (LPN) KK was asked if she recalled a fall which involved Resident #515 on 1/7/2025 when she was on duty and assessed the resident. LPN KK stated, .I don't remember that incident . This surveyor read LPN KK's Progress Notes dated 1/7/2025. LPN KK stated, .now I remember .she was in pain .she kept hollering, eventually got transport to send her out .most times they [referring to the facility] don't want us to use 911 . LPN KK was asked when she would activate 911. LPN KK stated, .if patient was unresponsive . LPN KK was asked why she moved the resident from the floor with the lift. LPN KK stated, .She [Resident #515] wasn't assisting . During an interview on 5/13/2025 at 2:35 PM, the DON was asked if a resident had an unwitnessed fall, voiced the inability to move her leg, and complained of pain after being found on the floor would she expect the nurse to get the resident up. The DON stated, .I would expect the nurse to leave them in place . The DON was asked why she would not want the resident to be moved. The DON stated, .it could cause more injury and possibly cause the resident more pain . During an interview on 5/13/2025 at 5:16 PM, the Administrator was asked if an ambulance transport was unable to arrive for 1.5 hours for a resident who experienced an unwitnessed fall, was unable to move her leg, and experienced pain what would she expect the nurse to do. The Administrator stated, .call 911 . An acceptable Removal Plan which removed the immediacy of the Jeopardy was received on 5/9/2025 at 3:52 PM. The surveyors validated the Removal Plan by record review, review of facility audits, in-service sign-in sheets, observations, and interviews. An Assessment of Compliance (AOC) was conducted on 05/07/2025 to evaluate the appropriate implementation and documentation of 2-person assist with bed mobility at Graceland Rehabilitation and Nursing Center. This assessment included a fall incident audit and a review of care plans and Kardex's for accuracy and alignment with residents' current bed mobility needs. The facility immediately educated CNA A and CNA B on 2-person assist with bed mobility and positioning and repositioning the resident while providing care, reviewed all falls, policies, Kardex's and care plans to align with each resident's current bed mobility needs. Immediately began in-servicing on Fall Management Program, Safety and Supervision of the Resident and Positioning and Repositioning of the resident for all licensed Nurses, CNAs and Respiratory Therapist. The root cause was CNA B left the room to get more supplies leaving CNA A alone in the room with Resident #415. CNA A and B were aware that resident #415 was a 2-person assist with bed mobility. The facility has implemented Fall audits, Care plan audits, Kardex audits, Policy audits, and on-going education with Licensed Nurses, CNAs and Respiratory Therapist on 2-person assist with bed mobility to call for help and not leave the room if they need any supplies, skills competency with positioning and repositioning residents with return demonstration to prevent recurrence. The facility is monitoring all falls daily, ensuring all care plans and Kardex's are up to date and on-going competencies and education to ensure training is effective. The facility is measuring effectiveness of the in-services by monitoring the falls on a daily basis and observing return demonstrations through competency. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Fall Audit: A facility wide fall audit was conducted on 05/07/2025 from 03/07/2025 to current with no major injuries. No fall concerns with 2-person assist with bed mobility. Care Plan Audit: A facility wide care plan audit was conducted on 05/07/2025 to ensure any resident that is a 2- person assist reflects accurately and was found to be up to date. Kardex Audit: A facility wide Kardex audit was conducted on 05/07/2025 to ensure all residents had an up-to-date Kardex and aligning with current care plan with 2-person assist with bed mobility. All Kardex's were found to be accurate. Policy Audit: Policies on Fall Prevention Program, Safety and Supervision of Residents, and Repositioning were all reviewed by the Administrator and Director of Nursing on 05/07/2025 with no revisions needed. Education: All licensed Nurses, CNAs, Respiratory Therapist, any nursing agency personnel and any Nurses, CNAs, Respiratory Therapist on Leave of Absence (LOA) will be in-serviced on Fall Prevention, Safety and Supervision of Residents, and Repositioning starting on 05/07/2025. Quality Assurance Improvement Plan (QAPI): The facility is continuing its on-going Quality Assurance Plan to monitor facility performance and compliance with the Fall Prevention Program, Safety and Supervision of Residents, and Repositioning by continuing to monitor falls daily and implementing planned interventions and approaches appropriately. Conclusion: (Named facility) remains committed to ensuring resident safety through proper documentation and adherence to mobility assistance requirements. Continued monitoring and education will be conducted to maintain compliance and prevent future incidents. 47127

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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** 49269 Based on policy review, medical record review, observation, and interview, the facility failed to ensure medications were properly stored and secured when medications were found unsecured and unattended in 1 of 78 (Resident #83) resident occupied rooms. The findings include: 1. Review of the facility policy titled, Storage of Medications, dated 4/2007, revealed .The facility shall store all drugs and biologicals in a safe, secure, and orderly manner . 2. Review of the medical record revealed Resident #83 was admitted to the facility on [DATE], with diagnoses including Diabetes, Alzheimer's Disease, Depression, and Hypertension. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 5, which indicated Resident #83 was severely cognitively impaired. During a random observation in the Resident's room on 5/5/2025 at 10:36 AM and at 11:22 AM, an unsecure and unattended medication cup with 8 pills was observed on the Resident's dresser. Observation and interview in the Resident's room on 5/5/2025 at 11:27 AM, revealed Licensed Practical Nurse (LPN) BB confirmed that she was not assigned to the resident and was unaware of the medications in the medication cup and confirmed meds should not be left at bedside. During an interview on 5/13/2025 at 3:58 PM, the Director of Nursing (DON) confirmed that medications should not be left at the bedside.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 38439 Based on policy review, observation, and interview, the facility failed to ensure food was stored, handled, prepared, and served under sanitary conditions, when stainless steel tables and metal storage racks were found with rust on the legs and black buildup around the base, the ice machine contained a dark brown, rust colored substance on the metal inside flap, food stored in the reach in cooler was unlabeled and undated, food items left on top of stainless steel tables was unattended and uncovered, dust was observed on top of a reach in cooler and around the edges of the ceiling vents, and when a substance with the appearance of rust was found around the edges of the ceiling vent and metal grates, when 9 stainless steel trays with food were found in the reach in cooler unlabeled and undated, the can opener contained thick black gummy buildup around the blade, when food items were found on top of a stainless steel table opened and undated, when dry ingredient storage bins that contained sugar and flour were unlabeled and undated with the lids soiled with thick yellow sticky debris, when the ice cream freezer and milk cooler were without thermometers and the facility failed to maintain temperature logs, when staff used the same alcohol wipe to clean the thermometer numerous times in between taking tray line temperatures of different food items, and when the high temperature dish machine was being utilized to wash dishes and was not reaching appropriate temperatures and the facility failed to use paper products. The facility had a census of 158 with 133 of those residents receiving a tray from the kitchen. The findings include: 1. Review of the facility undated policy titled, Sanitation, revealed The food service area is maintained in a clean and sanitary manner .All kitchens, kitchen areas and dining areas are kept clean, free from garbage and debris, and protected from rodents and insects .All utensils, counters, shelves and equipment are kept clean, maintained in good repair and are free from breaks, corrosions, open seams, cracks and chipped areas that may affect their use or proper cleaning. Seals hinges and fasteners are kept in good repair. All equipment, food contact surfaces and utensils are cleaned and sanitized using heat or chemical sanitizing solutions .Dishwashing machines are operated according to manufacturer's instructions. General recommendations for heat and chemical sanitization are .High Temperature Dishwasher (Heat Sanitization) . Wash temperature (150-165 F [Fahrenheit]) .Rinse temperature (180 F)-(160 degrees F .) .Ice Machines and ice storage containers are drained, cleaned and sanitized per manufacturer's instructions . Review of the facility undated policy titled, Refrigerators and Freezers, revealed This facility will ensure safe refrigerator and freezer maintenance, temperatures, and sanitation, and will observe food expiration guidelines .Monthly tracking sheets for all refrigerators and freezers are posted to record temperatures .Food service supervisors or designated employees check and record refrigerator and freezer temperatures daily with first opening and at closing in the evening .All food is appropriately dated to ensure proper rotation by expiration dates .Foods kept in the refrigerator/freezer are stored according to the Food Receiving and Storage policy .Refrigerators and freezers are kept clean, free of debris, and disinfected with sanitizing solution on a scheduled basis and more often as necessary .All foods stored in the refrigerator or freezer are covered, labeled and dated .Refrigerated foods are labeled, dated and monitored so they are used by their use by date, frozen or discarded . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility undated policy titled, Food Receiving and Storage, revealed Foods shall be received and stored in a manner that complies with safe food handling practices . Observation in the kitchen on 5/5/2025 at 9:21 AM, revealed the following: a. dark brown rust and black buildup on the legs and at the base of the legs of a stainless-steel metal table that the coffee machine and juice machine were sitting on. b. dark brown rust color particle and black dried particles on the legs at the base of the one compartment sink by the ice machine. c. dark brown rust color substance on the upper lid and metal tray inside the ice machine. d. 1 box of banana moon pies opened and undated, 1 box of 4 oz (ounce) apple sauce cups opened and undated, 1 box of [NAME] Krispies Treats opened and undated, and 1 box of Cheez Its crackers opened and undated on top of a stainless-steel metal rack located near the ice machine. e. 1 box of 8 oz foam cups with 25 cups laying in the bottom of a box uncontained with the box on the floor by the one compartment sink. Observation in the kitchen on 5/5/2025 at 9:25 AM, revealed the following: a. dried white streaks on the exposed left side of Reach in Cooler #1, dark gray dust particles visible on top of Reach in Cooler #1, and dark black dried particle build up around the base of Reach in Cooler #1. b. dark gray dust particles and dark brown rust around the edges of the air vent located over the Reach in Cooler #1. c. dark gray dust particles and dark brown rust around the edges of an air vent leading to the cooking stove area. d. a large serving spoon in a plastic container with a dried unidentified white substance on the spoon. e. 1 large metal pan containing dried cooked spaghetti on top of a metal table uncovered and undated. f. a stainless steel can opener with black gummy build up around the blade. g. 1 jar of grape jelly sitting on top of a metal stainless steel table opened and undated. h. a 5-pound (lb) plastic container of peanut butter opened and undated sitting on top of a metal table. Observation in the kitchen in the Reach in Cooler #2 on 5/5/2025 at 9:27 AM, revealed the following: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. Tray #1 with 34 bowls of cold slaw, unlabeled and undated. b. Tray #2 with 12 bowls of banana pudding, 2 bowls of crushed pineapple, 7 bowls of sliced chocolate cake, 3 bowls of apple sauce, and 4 bowls of butterscotch pudding, unlabeled and undated. c. Tray #3 with 35 bowls of chocolate pudding with whipped cream topping, unlabeled and undated. d. Tray #4 with 4 bowls of chocolate pudding with whipped cream topping, unlabeled and undated. e. Tray #5 with 33 bowls of chocolate pudding with whipped cream topping, unlabeled and undated. f. Tray #6 with 34 bowls of chocolate pudding without whipped cream topping, unlabeled and undated. Observation and interview at Reach in Cooler #2 on 5/5/2025 at 9:36 AM, revealed Dietary [NAME] EE confirmed the trays of food should have been dated and labeled prior to placing them inside of the cooler. Observation in the kitchen on the tray line on 5/6/2025 at 11:37 AM, revealed Dietary [NAME] FF calibrated the thermometer, cleaned the thermometer with an alcohol pad, and cook the temperature for the smothered chicken, the mashed potatoes, the lima beans, and the meat balls. Dietary [NAME] FF failed to use a clean alcohol pad between each food item prior to taking the temperature for the mashed potatoes, lima beans, and the meat balls. Dietary [NAME] FF obtained a clean alcohol pad, and took the temperature for the steamed rice, the green beans, the fried chicken, mechanical soft lima beans, mechanical soft meat, mechanical soft potatoes, pureed lima beans, and puree ham. Dietary [NAME] FF failed to obtain a clean alcohol pad in between each food item prior to taking the temperature for the green beans, fried chicken, mechanical soft lima beans, mechanical soft meat, mechanical soft potatoes, pureed lima beans, and pureed ham. During an interview on 5/6/2025 at 11:45 AM, Dietary [NAME] FF confirmed that she should have used a clean alcohol pad in between each food item prior to taking the temperatures. Observation and interview in the dish room on 5/7/2025 at 8:03 AM, revealed Dining Service Aide GG was in the dish room running dishes through the dish machine, this Surveyor asked Dining Service Aide GG if the dish machine was a high or low temperature dish machine. Dining Service Aide GG confirmed she was unaware if it was a high or low temperature dish machine. Dining Service Aide GG was asked to run a cycle through the machine. This Surveyor asked Dining Service Aide GG what should the wash cycle temperature rise to during the wash cycle to ensure adequate sanitation because the dial on the machine remained at zero. Dining Service Aide GG was unsure and asked staff to go get Dietary [NAME] FF. Dietary [NAME] FF returned and confirmed the dish machine was a high temperature machine and that it had not been in working order since 5/6/2025, the day prior, between 1:30 PM and 2:00 PM when she left at the end of her shift. Dietary [NAME] FF confirmed that maintenance was informed on that same day and that staff was instructed to use the 3-compartment sink until the dish machine was repaired. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview in the dish room on 5/7/2025 at 8:15 AM, the Maintenance Director confirmed that he was told on 5/6/2025 between 1:30 PM and 2:00 PM that the dish machine was not working properly and that he called to have it serviced. The Maintenance Director confirmed that staff was told on 5/6/2025 not to use the dish machine until it was repaired and that paper products would have to be used to serve the residents their meal. During an interview on 5/7/2025 at 8:24 AM, Dietary [NAME] FF, confirmed that she failed to inform staff to not use the dish machine on 5/6/2025 and to use paper products until the dish machine was repaired. Observation in the dish room on 5/7/2025 at 8:30 AM, confirmed resident meals were not served on paper product or plastic. Observation and interview in the kitchen on 5/7/2025 at 8:30 AM, revealed Dietary [NAME] FF was asked where was the thermometer in the ice cream freezer. Dietary [NAME] FF stated, I don't see it . Dietary [NAME] FF was asked how the temperatures are being recorded to ensure proper temperature levels if there is no thermometer. Dietary [NAME] FF did not answer. Dietary [NAME] FF was asked where the thermometer was for the milk cooler. Dietary [NAME] FF stated, I do not see one . Observation in the milk cooler revealed no thermometer present and observation of the temperature log for the milk cooler revealed the temperature was obtained at 5:30 AM at 30 degrees. Dietary [NAME] FF was asked how a temperature was recorded for 5:30 AM if there is no thermometer present. Dietary [NAME] FF stated, I pulled the milk out this morning, placed it on ice for breakfast and then checked the temperature . Dietary [NAME] FF was asked should there not be a thermometer in each cooler and freezer to ensure the appropriate temperature for the food items. Dietary [NAME] FF confirmed that there should be thermometers in the ice cream freezer and the milk cooler and that the temperature should be recorded. Observation and interview in the dry food storage area on 5/7/2025 at 8:35 AM, revealed 2 white plastic containers with lids containing thick yellow dried debris and a yellow sticky substance on top, both containers were unlabeled and undated. Dietary [NAME] FF confirmed that container #1 contained sugar and container #2 contained flour and both should be labeled and dated. Dietary [NAME] FF confirmed that the lids should be clean and free of debris to avoid any particles falling into the containers. During an interview on 5/7/2025 at 9:30 AM, the Administrator confirmed she was not informed the dish machine was not in working order on 5/6/2025 and that she should have been informed at that time. (continued on next page)

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	445331	A. Building B. Wing	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Graceland Rehabilitation and Nursing Care Center	1250 Farrow Road Memphis, TN 38116

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/7/25 at 9:40 AM, the Registered Dietician (RD) confirmed that she was in charge since the Certified Dietary Manager (CDM) II was out of the facility for the week. The RD confirmed the CDM was in charge of the day-to-day operations of the kitchen including the cleanliness and that food should be served in a sanitary manner. The RD confirmed that the CDM and the dietary staff are to ensure that the kitchen is clean, and equipment is in working order. The RD confirmed that no kitchen equipment, including metal racks, stainless steel tables, and vents, should have rust or particle build up on them if they are cleaned as they should be. The RD confirmed that if food is opened, stored on racks, in cabinets, and in coolers and freezers, it should have an open date on it. The RD was asked who was responsible to ensure the ice machine is clean. The RD confirmed that she was unsure, but the CDM was ultimately responsible to ensure all equipment is in working order and free from dust and rust. The RD confirmed that no food should be left unattended and uncovered. The RD confirmed that the can opener should be cleaned after each use, each cooler and freezer should have a thermometer, and the temperature should be recorded at least twice a day. The RD confirmed that no carbon buildup should be on any cooking equipment such as baking sheets, pots, pans, skillets, or saucepans. The RD confirmed that all cooking utensils should be inspected for any dried food particles and should be rewashed if found. The RD confirmed that all dry ingredients such as sugar, flour, and meal should be stored in clean containers with lids and should be labeled and dated. The RD was asked if staff are working in the dish room should they know if the dish machine is high or low temperature and what process is used to determine the compliance with temperature readings to ensure dishes are cleaned and sanitized. The RD confirmed that staff should know if the dish machine is high or low, and what (temperature) the cycle should get up to, to ensure the dishes and utensils are sanitized. The RD confirmed that she was working in the kitchen on 5/6/2025 all day and was not informed that the dish machine was not in working order until 5/7/2025, and that she should have been informed. The RD was asked when staff should change the alcohol pad when taking tray line temperatures. The RD confirmed the alcohol pad should be changed in between taking each food item temperature. Observation and interview in the Conference Room on 5/7/2025 at 10:38 AM, revealed the Administrator was asked to review the temperature log for the ice cream freezer and the milk cooler and was asked how can staff record a temperature if there was no thermometer present in the ice cream freezer or the milk cooler. The Administrator confirmed that each cooler and freezer should have a thermometer inside so the temperature can be recorded and a record kept of the temperatures. During an interview on 5/7/25 at 11:31 AM, the Administrator and the Dishwasher Repairman was asked is the dish machine a high or low temperature machine. The Dishwasher Repairman confirmed the dish machine is a high temperature machine, and it should get up to 160-175 F degrees for the wash cycle and up to 140-160 F degrees for the rinse. The Dishwasher Repairman confirmed that he ran a cycle, the machine did not get above 60 F degrees, the Relay switch for the booster and the Transfer switch were not working, and after a hard reset it still wasn't working and a new part had been ordered.

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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** 38909 Based on policy review, medical record review, observation, and interview, the facility failed to ensure proper infection control practices were followed when 2 of 2 staff members (Licensed Practical Nurse (LPN) DD and Housekeeping CC) failed to wear Personal Protective Equipment (PPE) for Transmission-Based (Isolation) Precautions and failed to properly perform hand hygiene after exiting Transmission-Based Precautions resident rooms. The facility failed to limit interactions with other residents when 1 of 4 (Resident #74) sampled residents reviewed for contact precautions was allowed to interact outside of his room with other residents. The findings include: 1. Review of the facility policy titled, Handwashing/Hand Hygiene, dated April 2010, revealed .This facility considers hand hygiene the primary means to prevent the spread of infections .All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors .Employees must wash their hands for at least (15) fifteen seconds using antimicrobial or non-antimicrobial soap and water .Before and after direct resident contact .Before and after entering isolation precaution settings .After removing gloves .In most situations, the preferred method of hand hygiene is with an alcohol- based hand rub. If hands are not visibly soiled, use an alcohol-based hand rub .Before and after direct contact with residents .After contact with objects (medical equipment) in the immediate vicinity of the resident; and after removing gloves . Review of the undated facility policy titled, Transmission-Based (Isolation) Precautions, revealed .It is our policy to take appropriate precautions to prevent transmission of pathogens .'Contact precautions' refer to measures that are intended to prevent transmission of infectious agents which are spread by direct or indirect contact with the residents or resident's environment .Facility staff will apply Transmission-Based Precautions, in addition to standard precautions, to residents who are known or suspected to be infected or colonized with certain infectious agents requiring additional controls to prevent transmission .Residents on transmission-based precautions should remain in their rooms except for medically necessary care .Contact Precautions .Healthcare personnel caring for residents on Contact Precautions wear a gown and gloves for all interactions that may involve contact with the resident or potentially contaminated areas in the resident's environment . 2. Review of the medical record revealed Resident #60 was admitted to the facility on [DATE], with diagnoses including Chronic Respiratory Failure, Tracheostomy, Diabetes, and Seizures. Review of annual Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #60 was severely cognitively impaired, and was dependent on staff for all activities of daily living (ADLs). Review of the Physician's Order dated 2/11/2025, revealed Resident #60 had an order for Contact Isolation Precautions related to Candida Auris (an emerging fungus that can cause severe, often multidrug-resistant, infections. It spreads easily among patients in healthcare facilities). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation in the resident's room on 5/5/2025 at 10:11 AM, revealed LPN F entered into Resident #60's room without donning PPE gown or gloves, touched the enteral pump, moved the residents over the bed table, exited the resident's room, turned and went back into the same room without donning PPE gown or gloves, touched Resident #81's (Resident #60's roommate) enteral pump. LPN F exited the room and walked to her medication cart in the hallway without performing hand hygiene. During an interview on 5/5/2025 at 10:20 AM, LPN F was asked should PPE be worn in the isolation room and hand hygiene performed after exiting room. LPN F stated, Yes, I should have .they both are in contact isolation for Candida Auris .I should use gloves then perform hand hygiene . 3. Review of the medical record revealed Resident #74 was admitted to the facility on [DATE], with diagnoses including End Stage Renal Disease, Candidiasis, and Dependence on Renal Dialysis. Review of the quarterly MDS assessment dated [DATE], revealed Resident #74 had a BIMS score of 14 which indicated no cognitive impairment. Review of the Physician's Order dated 4/1/2025, revealed an order for .Contact Isolation for Candida Auris . Observation on 5/5/2025 at 12:25 PM, revealed Resident #74 was dressed, up in wheelchair, propelling self-exiting the main dining area with no PPE. Observation on 5/7/2025 at 8:15 AM, revealed Housekeeper CC entered Resident #74's room to clean the room and did not wear PPE. During an interview on 5/12/2025 at 4:10 PM, LPN DD was asked how contact isolation has been maintained with Resident #74. LPN DD stated, .he has been allowed to come out of his room if he wears the isolation gown. When asked why he would be out of his room without the isolation gown, LPN DD stated, .that at times he has been non-complaint with wearing the isolation gowns . 4. Review of the medical record revealed Resident #81 was admitted on [DATE], with diagnoses including Chronic Respiratory Failure, Hemiplegia and Hemiparesis, and Diabetes. Review of the annual MDS assessment dated [DATE], revealed Resident #81 was severely cognitively impaired, and was dependent on staff for all ADLs. Review of the Physician's Order dated 3/20/2025, revealed Resident #81 had an order for Contact Isolation Precautions related to Candida Auris. During an observation in Resident #81's room on 5/6/2025 at 2:35 PM, revealed Housekeeping CC entered the contact isolation room without donning PPE, moved the over the bed table, then cleaned the floor. Housekeeping CC then exited the room without performing hand hygiene. During an interview on 5/6/2025 at 2:40 PM, Housekeeping CC was asked should a PPE gown be donned prior to entering a contact isolation room and should staff perform hand hygiene after removing gloves. The Housekeeping CC stated, No, I don't think so . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Review of the medical record revealed Resident #119 was admitted to the facility on [DATE], with diagnoses including Chronic Respiratory Failure, Anoxic Brain Injury, Gastrostomy, and Tracheostomy. Review of the quarterly MDS assessment dated [DATE], revealed staff did not perform a BIMS because Resident #119 was severely cognitively impaired. Resident was dependent on staff to perform ADLs. Review of Physician's Order dated 8/19/2024, revealed .Contact isolation precautions for Candida Auris: Use proper PPE when performing patient care every shift . Observation in the resident's room on 5/6/2025 at 8:32 AM, revealed Housekeeping CC entered Resident #119's room without applying PPE to sweep and clean the resident's floor. Housekeeping CC exited Resident #119's room and entered another resident's room without performing hand hygiene. During an interview on 5/13/2025 at 4:01 PM, the Director of Nursing confirmed all staff should wear PPE when entering a contact isolation room and perform hand hygiene before and after entering a resident room. During an interview on 5/13/2025 at 5:09 PM, the Administrator confirmed the facility should follow Transmission-Based Protocol related to Candida Auris. 47127