STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465057	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Four Corners Regional Care Center	818 North 400 West Blanding, UT 84511

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47431 Based on interview and record review, the facility did not ensure that alleged violations involving abuse were reported immediately but not later than two hours after the allegation was made, if the events that caused the allegation involved abuse or resulted in serious bodily injury, or not later than 24 hours if the events that caused the allegation did not involve abuse and did not result in serious bodily injury to officials including the State Survey Agency (SSA) and Adult Protective Services (APS). Specifically, for 6 out of 39 sampled residents, allegations of resident to resident abuse and injuries of unknown origin were not reported timely to the SSA or APS. In addition, allegations of resident to resident sexual abuse and neglect were not reported to the SSA or APS. Resident identifiers: 13, 17, 31, 36, 49, and 53. Findings included: 33215 1. Resident 13 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, hypertensive chronic kidney disease, asthma, heart failure, major depressive disorder, essential hypertension, and pressure ulcer stage two. On 1/6/25 at 2:56 PM, an interview was conducted with resident 13. Resident 13 stated she had a resident to resident incident in the dining room the other day. Resident 13 stated that one little old man that ate in the dining room was a little on the horny side and he gave resident 13 a big kiss on the mouth. Resident 13 stated the Assistant Director of Nursing (ADON) saw the incident and the Social Services Supervisor spoke to the male resident about the incident. Resident 13 stated it embarrassed her to pieces. Resident 13 stated that she thought he was going to do it again the other day but he did not. Resident 13 stated that she thought she was going to have to eat in her room to avoid the male resident. (Note: Resident 13 was unable to recall the male resident's name.) Resident 13's medical record was reviewed on 1/7/25 through 1/9/25. A quarterly Minimum Data Set (MDS) assessment dated [DATE], documented that resident 13 had a Brief Interview for Mental Status (BIMS) score of 12. A BIMS score of 8 to 12 indicated moderate cognitive impairment. (continued on next page)

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/7/25 at 2:09 PM, an interview was conducted with the Social Services Supervisor. The Social Services Supervisor stated that yes the kissing incident did happen in the dining room with resident 13 and resident 36. The Social Services Supervisor stated that she had reported the incident to the Administrator (Admin) because the incident was observed by a Certified Nursing Assistant (CNA) and the CNA reported the incident to the nurse. The Social Services Supervisor stated that the incident happened recently possibly within the last month. Resident 36 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included, but were not limited to, dementia, chronic kidney disease, essential hypertension, senile degeneration of brain, legal blindness, and dorsalgia. Resident 36's medical record was reviewed on 1/7/25 through 1/9/25. A quarterly MDS assessment dated [DATE], documented that resident 36 had a BIMS score of 14. A BIMS score of 13 to 15 indicated intact cognition. On 1/8/25 at 8:17 AM, an interview was conducted with CNA 2. CNA 2 stated that she remembered the incident between resident's 13 and 36 and she had wrote a report and gave it to the ADON. CNA 2 stated she could not remember the day or time but she was thinking it was either lunch or dinner. CNA 2 stated she was taking a resident to the dinning room and had seen resident's 13 and 36 to her right out of her peripheral talking. CNA 2 stated that she heard a smooching sound like kissing and saw resident's 13 and 36 kissing and holding hands. CNA 2 stated that she told resident 36 hey. CNA 2 stated that she was shocked, she told the nurse right away, and wrote an incident report. CNA 2 stated that staff were told to observe the residents more often and make sure they were not sitting together in bingo or other activities. On 1/8/25 at 8:29 AM, an interview was conducted with the ADON. The ADON stated that she was standing at the nurses station by the medication cart when the CNA came out of the dining room and told her what happened. The ADON stated that she went into the dining room and resident 36 was still at resident 13's table and nothing was going on. The ADON stated that she stood by the table hoping that resident 36 would walk away. The ADON stated that after resident 36 walked away she asked resident 13 what happened and resident 13 stated that nothing happened. The ADON stated she asked resident 13 if she was sure nothing happened and resident 13 stated that she was fine. The ADON stated that resident 13 made a kissing sound and laughed. The ADON stated that resident 13 was child like about the incident. On 1/8/25 at 10:52 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that she was at the facility when the incident happened and the CNA came to her office and reported what had happened. The DON stated she did not talk to the residents but she knew about the situation. On 1/8/25 at 11:02 AM, an interview was conducted with the Admin. The Admin stated that they talked about the incident in morning meeting. The Admin stated that resident 13 was not quite sure if anything had happened and kind of giggled about the incident. The Admin stated that resident 36 stated the incident did not happen and kind of giggled about the incident. The Admin stated that yes the incident should have been reported to the SSA. The Admin asked if the incident should be reported even if the residents did not know anything about the incident? (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/8/25 at 12:11 PM, a follow up interview was conducted with the Admin. The Admin stated if she received a statement regarding abuse, it would be an official statement of what happened and if the staff spoke to her it would be official. The Admin stated the time line for reporting to the SSA was two hours. The Admin stated she would start investigating the allegation right away. The Admin stated she would interview the person it happened to, the person who came upon the scene, people down the hall, the nurses, and other residents. The Admin stated that she would try to get a general idea if it was neglect, a systemic problem, or isolated. 2. Resident 53 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included, but were not limited to, chronic obstructive pulmonary disease, nondisplaced intertrochanteric fracture of left femur, encounter for other orthopedic aftercare, senile degeneration of brain, dementia, mood disorder, visual hallucinations, essential hypertension, and history of falling. Resident 53's medical record was reviewed on 1/9/25. On 8/27/23 at 1:19 PM, a Nurses Note documented Note Text: Resident was in the dining hall when [resident 31] moved passed [sic] her and resident got out of her wheelchair to hit [resident 31] (Resident believes she has been sleeping with her husband) and fell , resident is crying and was wheeled back to room where she was checked for bruising, no bruising apparent, did not hit head, will continue to evaluate. On 8/27/23 at 5:28 PM, a Fall Note documented Note Text: 1330 [1:30 PM]-Patient resting in bed and appeared to want to be left alone, would not allow nurse to assess. Kept eyes closed and appeared to ignore presence of nurse. Denied pain medication at this time. Kept checking on patient, pt [patient] sleeping. 1416 [2:16 PM]-[name redacted] (daughter) notified of pt's fall and no injuries noted at this time, will continue to monitor. 1630 [4:30 PM]-Pt appeared to have calmed down. Tylenol 650 mg [milligrams] administered at this time. No bruising to BLE [bilateral lower extremities] noted. Pt c/o [complains of] pain to left hip/upper thigh region. Patient reports that she is not able to lift her leg. Patient grimacing and cries out when attempting to move left leg. DON notified at 1636 [4:36 PM]. Non-emergency transport called at 1640 [4:40 PM]. Report given to [name redacted] at [name redacted] ER [emergency room] at 1648 [4:48 PM]. Attempted to update daughter, [name redacted] on pt's condition and transfer to ER but no answer at this time. Left a message to return phone call at 1652 [4:52 PM]. MD [Medical Director] updated on pts condition and transfer to ER at 1723 [5:23 PM]. Patient left facility at 1715 [5:15 PM]. On 8/27/23 at 6:49 PM, a Nurses Note documented Note Text: Patient had x-ray done, has a fractured femur (neck). MD notified at 1836 [6:36 PM]. Form 358 Facility Reported Incidents documented that staff became aware of the event on 8/27/23 at 1:19 PM. The Admin became aware of the event on 8/28/23 at 8:58 AM. The SSA was notified of the event on 8/28/23 at 10:49 AM, and APS was not notified. On 1/9/25 at 8:48 AM, an interview was conducted with the Admin. The Admin stated any time abuse was suspected we should be contacting APS. The Admin stated with the past two Administrators they were told if we had anything happen during the night it could wait until the next morning and discuss the incident during the morning meeting. The Admin stated she would get report in the morning meeting and would then report within two hours to the SSA. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	43212 3. Resident 49 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease, dementia without behavioral disturbance, severe protein-calorie malnutrition, epilepsy, and insomnia. Resident 49's medical record was reviewed on 1/6/25 through 1/9/25. On 6/19/23 at 9:46 AM, a nurse's progress note revealed, Note text: resident noted to have c/o pain in right shoulder and arm. Dr. [Doctor] [name redacted] notified new order for x-ray of right shoulder and humerus. On 6/19/23 at 1:58 PM, a nurse's progress note revealed, Note text: notified by social services that resident did have a dislocated right shoulder and was sent to the ER. On 6/19/23 at 6:00 PM, a nurses progress note revealed, Note text: resident returned from ER right arm in a sling .new order for resident to keep right arm for support to decrease changes of dislocating. Form 358 Facility Reported Incidents documented that staff became aware of the incident on 6/19/23 at 9:14 AM. The Admin was notified on 6/21/23 at 9:00 AM. The SSA was notified of the incident on 6/21/23 at 7:56 PM. On 1/8/25 at 12:50 PM, an interview was conducted with the DON who stated the facility policy for reporting injuries of unknown origin was that when a nurse became aware of a resident's injury, after assessing for the safety of the resident, the nurse would notify the DON and the Admin. The DON stated the Admin was responsible for reporting to the SSA as soon as she was made aware of the incident. The DON stated if the incident happened during the day, the DON and the Admin would be notified verbally during the day. The DON stated if an incident happened during the night time hours, the DON and Admin would be notified the following day. The DON stated the Admin reported to the SSA as soon as she was made aware of the incident. On 1/8/25 at 1:16 PM, an interview was conducted with the Admin who stated if abuse was suspected she would report the incident within two hours. The Admin stated if abuse was not suspected, she would find out the next morning and then submit the report. The Admin stated she found out about incidents that happened during the night at the morning stand up meeting. The Admin stated all staff were aware that she was the abuse coordinator and who to report to. 44640 4. Resident 17 was admitted to the facility on [DATE] with diagnoses which included hemiplegia affecting right dominant side, traumatic brain injury, protein calorie malnutrition, dementia, unsteadiness on feet, foot drop of right foot, adult failure to thrive, sexual dysfunction, bilateral primary osteoarthritis of hip, and insomnia. Resident 17's medical record was reviewed on 1/6/25 through 1/9/25. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A care plan focus of Activities of Daily Living (ADLs) Self-care deficits related to impaired cognition, hemiplegia, impaired mobility and balance documented that resident 17's strength, coordination, and mobility had deteriorated. He would maintain current level of function in ability to participate in adls through the review date of 10/24/24. With an intervention that included monitor resident and report any changes, any potential for improvement, reasons for self-care deficit, expected course, and declines in function. A nursing progress note dated 11/9/24 at 4:37 PM, documented, Heard resident yelling and swearing in his room around 1500 [3:00 PM]. Entered room and resident was lying on his back with head resting on drawers across from bed. Blood smear noted on drawer face. Assisted to wheelchair x [by] 3 staff members and assessed resident. There was 1/4 cm [centimeter] lac [laceration] to back of scalp and was no longer bleeding. Started frequent VS [vital signs] and neuro [neurological] checks. DON, ADON, Dr. [name redacted] and brother [name redacted] were notified. Exhibit 358 was not located in the abuse log provided by the facility. On 1/7/25 at 9:30 AM, an interview was conducted CNA 4. CNA 4 stated resident 17 had experienced some falls with injuries but had not had any recently. CNA 4 stated that when a resident was on a one on one that meant the staff member was always with the resident. On 1/9/25 at 8:00 AM, an interview was conducted with Licensed Practical Nurse (LPN) 2. LPN 2 stated the resident was on a one on one but she was unsure if the staff were with him when he had his falls, he fell a lot. LPN 2 stated that when he fell she did report it to the administration as she was supposed to with any incident like that. On 1/9/25 at 9:15 AM, an interview was conducted with the Admin. The Admin stated she may have reported the fall on 11/9/24, but she could not remember. The Admin stated that she probably did not report it because she did not think she needed to report anything unless it was a fracture. The Admin stated she did not have a report for the fall. The facility Resident Abuse Procedural Summary documented . REPORTING The supervisor will be responsible for taking immediate triage actions and once the resident's safety is insured, to report the abuse to the appropriate individuals along with the individual that discovered the incident. 1. All employees and contractors who suspect that a resident has been abused, such as yelled at or intimidated, pushed or hit, or sexually assaulted must IMMEDIATELY report their suspicions to the supervisor on duty in the facility. This also includes incidents when a resident or someone else tells you about possible abuse, and also includes whether the abuse may have happened from facility staff (which includes all employees of [name redacted] and its facilities, including corporate employees, officers and director), other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends or other individuals. 2. The same is true for suspected neglect, such as when a resident does not receive the care he or she should, if the resident's property is taken, if they have bruising or other injuries, or if they are being taken advantage of. 3. The Supervisor will be responsible to make sure the Administration and Director of Nursing is made aware of your concerns. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. The Administrator and Director of Nursing will be responsible for reporting the concerns, as required by law, and conducting the investigation. 5. Any time you have a concern about possible abuse, you MUST bring your concern to the supervisor immediately. If you suspect that your supervisor has abused a resident, contact the Administrator or DNS [Director of Nursing Services] directly. Do not make the decision yourself about whether abuse may have occurred or not. You will not be retaliated against for reporting you [sic] concerns.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33215 Based on interview and record review, the facility in response to allegations of abuse, neglect, or mistreatment did not have evidence that all alleged violations were thoroughly investigated. Specifically, for 13 out of 39 sampled residents, allegations of resident to resident sexual abuse, injuries of unknown origin, and neglect were not investigated or the allegations were not investigated thoroughly. Resident identifiers: 13, 17, 32, 36, 46, 47, 48, 49, 50, 52, 51, 54, and 55. Findings included: 1. Resident 13 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, hypertensive chronic kidney disease, asthma, heart failure, major depressive disorder, essential hypertension, and pressure ulcer stage two. On 1/6/25 at 2:56 PM, an interview was conducted with resident 13. Resident 13 stated she had a resident to resident incident in the dining room the other day. Resident 13 stated that one little old man that ate in the dining room was a little on the horny side and he gave resident 13 a big kiss on the mouth. Resident 13 stated the Assistant Director of Nursing (ADON) saw the incident and the Social Services Supervisor spoke to the male resident about the incident. Resident 13 stated it embarrassed her to pieces. Resident 13 stated that she thought he was going to do it again the other day but he did not. Resident 13 stated that she thought she was going to have to eat in her room to avoid the male resident. (Note: Resident 13 was unable to recall the male resident's name.) Resident 13's medical record was reviewed on 1/7/25 through 1/9/25. A quarterly Minimum Data Set (MDS) assessment dated [DATE], documented that resident 13 had a Brief Interview for Mental Status (BIMS) score of 12. A BIMS score of 8 to 12 indicated moderate cognitive impairment. On 1/7/25 at 2:09 PM, an interview was conducted with the Social Services Supervisor. The Social Services Supervisor stated that yes the kissing incident did happen in the dining room with resident 13 and resident 36. The Social Services Supervisor stated that she had reported the incident to the Administrator because the incident was observed by a Certified Nursing Assistant (CNA) and the CNA reported the incident to the nurse. The Social Services Supervisor stated that the incident happened recently possibly within the last month. Resident 36 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included, but were not limited to, dementia, chronic kidney disease, essential hypertension, senile degeneration of brain, legal blindness, and dorsalgia. Resident 36's medical record was reviewed on 1/7/25 through 1/9/25. A quarterly MDS assessment dated [DATE], documented that resident 36 had a BIMS score of 14. A BIMS score of 13 to 15 indicates intact cognition. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/8/25 at 8:17 AM, an interview was conducted with CNA 2. CNA 2 stated that she remembered the incident between resident's 13 and 36 and she had wrote a report and gave it to the ADON. CNA 2 stated she could not remember the day or time but she was thinking it was either lunch or dinner. CNA 2 stated she was taking a resident to the dinning room and had seen resident's 13 and 36 to her right out of her peripheral talking. CNA 2 stated that she heard a smooching sound like kissing and saw resident's 13 and 36 kissing and holding hands. CNA 2 stated that she told resident 36 hey. CNA 2 stated that she was shocked, she told the nurse right away, and wrote an incident report. CNA 2 stated that staff were told to observe the residents more often and make sure they were not sitting together in bingo or other activities. On 1/8/25 at 8:29 AM, an interview was conducted with the ADON. The ADON stated that she was standing at the nurses station by the medication cart when the CNA came out of the dining room and told her what happened. The ADON stated that she went into the dining room and resident 36 was still at resident 13's table and nothing was going on. The ADON stated that she stood by the table hoping that resident 36 would walk away. The ADON stated that after resident 36 walked away she asked resident 13 what happened and resident 13 stated that nothing happened. The ADON stated she asked resident 13 if she was sure nothing happened and resident 13 stated that she was fine. The ADON stated that resident 13 made a kissing sound and laughed. The ADON stated that resident 13 was child like about the incident. On 1/8/25 at 10:52 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that she was at the facility when the incident happened and the CNA came to her office and reported what had happened. The DON stated she did not talk to the residents but she knew about the situation. On 1/8/25 at 12:11 PM, an interview was conducted with the Administrator (Admin). The Admin stated if she received a statement regarding abuse, it would be an official statement of what happened and if the staff talked to her it would be official also. The Admin stated the time line for reporting to the State Survey Agency (SSA) was two hours. The Admin stated she would start investigating the allegation right away. The Admin stated she would interview the person it happened to, the person who came upon the scene, people down the hall, the nurses, and other residents. The Admin stated that she would try to get a general idea if it was neglect, a systemic problem, or isolated. The abuse allegation was not reported to the SSA and an investigation was not conducted. 43212 2. Resident 46 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included left femur fracture, heart failure, asthma, iron deficiency anemia, and hypokalemia. Resident 46's medical record was reviewed on 1/6/25 through 1/9/25. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/24/23 at 12:25 PM, a Form 358 Facility Reported Incident was received by the SSA. The report documented, Resident was complaining of pain to left hip. After taking Ibuprofen, pain continued. Resident did not want to get back into bed. Assessment was given by MD [Medical Director] for further evaluation. Resident taken to ER [emergency room] for x-ray. The incident report documented the resident sustained a fractured left hip with no change in behaviors until the pain started. The report also noted that the resident's odd behavior was refusing to get into bed. The report documented that no other agencies were notified of the resident's injury. On 5/30/23 at 1:45 PM, a Form 359 Follow-up Investigation Report was received by the SSA. The 359 report documented, Resident mentally is aware and would remember falls. Resident complained of pain in the left hip. [Resident 46] does not remember falling or hitting anything that would have broken her hip. The summary of witness and staff interviews stated, Nurse on shift, gave resident ibuprofen and the pain continued. Resident did not want to get into bed. After further evaluated, nurse contacted MD for further evaluation. The investigative summary revealed, Resident was transferred back from ER. Waiting on x-ray but hip has potential FX [fracture]. Resident given Eliquis Oral Tablet 2.5 MG [milligrams] (Apixaban); Give 1 tablet by mouth two times a day for ORIF [Open reduction and internal fixation] procedure for 42 days. The investigative finding stated, Inconclusive .injury source is unknown, and resident cannot remember the cause of injury. Corrective action included, Staff have been instructed to be quicker to call lights and inservice planned for falls and non-witnessed falls. On 1/8/25 at 1:21 PM, an interview was conducted with the Admin who stated she did not know how resident 46 fractured her hip. On 1/8/25 at 1:55 PM, an interview was conducted with the MDS Coordinator who stated the cause of resident 46's hip fracture was that she sat down onto the toilet really hard and after that began to complain of hip pain. It should be noted that additional investigation interviews and documentation was requested, but not provided. 3. Resident 47 was admitted to the facility on [DATE] with diagnoses that included senile degeneration of brain, type 2 diabetes, dementia with moderate agitation, heart failure, peripheral vascular disease, atrioventricular block, osteoarthritis, and major depressive disorder. Resident 47's medical record was reviewed on 1/6/25 through 1/9/25. On 12/17/23 at 7:10 AM, Fall note: Note text: Aide reports to LN [licensed nurse] last rounds, patient found on floor. Initiate assessment. LN asked patient questions on his fall. Patient gestured he fell out of bed. Patient has a bump to top, back of head. Small skin tear, 1.5 cm [centimeters] x [by] 1.5 cm to right great toe. Site cleansed and applied band-aid. Patient moves all extremities. Denied pain. Got patient back in his bed and started neuro checks and vital signs. Neuro [neurological] checks and vital signs WNL [within normal limits]. MD notified. ADON notified. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/27/23 at 10:42 AM, a Form 359 Follow-up Investigation Report was received by the SSA. The report documented, No additional harm to the resident has occurred. The report also documented other agencies had not been notified. In the summary of the interviews with the resident it was documented, When [resident 47] was first found after the fall he gestured that he had fallen and was okay. When resident advocate went to talk to resident he did not remember the fall. The summary of interviews with witnesses revealed, Shift nurse stated that resident had fell and when they were helping the resident, back up and get comfortable. He was able to tell them what happened. The summary of interviews with responsible staff revealed, Shift nurse stated that resident had fell and when they were helping the resident, back up and get comfortable. He was able to tell them what happened. They were able to do neuros and vitals. Nurse was able to find a small skin tear on the toe, closed would with bandage. Under investigative summary it documented, Resident is at baseline and safe. The report documented the allegation was inconclusive as resident was able to gesture what happened however we could not exactly see how the resident fell . Corrective action taken stated, fall mat has been placed, we have also put resident on more frequent checks throughout the night. The plan for oversight included, increased training on residents that are not non-verbal or speak another language that is not common for most. It should be noted that additional investigative documentation was requested and not provided. 4. Resident 49 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease, dementia without behavioral disturbance, severe protein-calorie malnutrition, epilepsy, and insomnia. Resident 49's medical record was reviewed on 1/6/25 through 1/9/25. Resident 49's physician orders included, X-ray of right shoulder and right humerus due to right upper extremity pain. one time only for 1 day no known injury. On 6/19/23 at 9:46 AM, Note text: resident noted to have c/o [Complains of] pain in right shoulder and arm Dr. [doctor] [name redacted] notified new order for x-ray of right shoulder and humerus. On 6/19/23 at 1:58 PM, Note text: notified by social services that resident did have a dislocated right shoulder and was sent to ER. A Form 358 Facility Reported Incident Report dated 6/21/23 at 7:56 PM, was received by the SSA. Resident 49 notified the shift nurse of pain in her right shoulder and could lift her arm. The nurse notified the MD and received an order for x-ray of right shoulder and humerous. Shoulder dislocation was documented as the injury that occurred. No other injury types were documented. There were no changes in resident 49's behavior. Steps taken to immediately ensure residents safety were, Resident was immediately, inspected by shift nurse and MD was notified of possible injury. Immediately taken to ER for x-ray. No witnesses were identified. No other agencies were notified. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Form 359 Follow-up investigation report was received on 6/27/23 at 3:24 PM by the SSA. The report documented, Dislocated shoulder at the time off [sic] of the event as updated information. No agencies were notified. Steps to investigate the incident included, Resident has no memory of the incident other than her shoulder began to have pain when being transported in the sling. The summary of interviews from responsible staff included, Shift believes that she was not placed properly in sling when being transported resulting in dislocated shoulder. Additional interview summary stated, Oversight staff believe that when being transferred on the lift, she was not properly lifted causing shoulder to be in pain. An investigation summary included, na [not applicable] at this time. The incident was inconclusive citing, could not verify if resident was in lift improperly or if other issues cause the injury. Corrective action taken included, Inservice on how to properly use the lifts when transferring a resident around the facility. Systemic actions included,Inservice on how to properly use the lifts when transferring a resident around the facility. aid will double up on resident that need extra care to make sure lift is done properly. Additional investigative documentation and inservice information was requested but not provided. On 1/8/24 at 2:04 PM, an interview was conducted with the Admin who stated she did not know the root cause of resident 49's shoulder dislocation. 5. Resident 51 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included hemiplegia and hemiparesis affecting non-dominant side, vascular dementia, type 2 diabetes, protein-calorie malnutrition, major depressive disorder, congestive heart failure, hypoxemia, and iron deficiency anemia. Resident 51's medical record was reviewed on 1/6/25 through 1/9/25. On 6/24/24 at 7:41 PM, a nurses progress note revealed, Note text: resident c/o left hand pain, new order for xray. resident taken to [name redacted] for xray tolerated well. On 6/25/24 at 1:26 PM, a nurses progress note revealed, Note text: L [left] hand xray results received from [name redacted] hospital. No fx or dislocations noted. MD notified. No new orders at this time. On 6/25/24 at 10:45 AM, a Form 358 Facility Reported Incidents report was received by the SSA. The resident reported to the resident advocate [RA] that that lady grabbed her on the hand and wrist causing a bruise on her left hand. Resident 51 stated that her hand hurt. Resident 51 was unable to describe details of the person she was referring to or what exactly happened. The incident occurred on 6/23/24 at 4:45 PM, in the resident's bedroom. The report documented the resident was at baseline when describing changes in behavior. Steps taken to ensure the resident's safety was, Resident hand evaluated, xray scheduled. CNA on that shift will be moved to a different hall no suspected abuse. No witnesses were identified. No other agencies were notified. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/2/24 at 3:48 PM, a Form 359 Follow-up investigation report was received by the SSA. The report stated the resident was at baseline and did not sustain physical or mental harm. No agencies were notified of the incident. Steps taken to investigate the incident were documented as, Resident came to RA's office, with bruising on left hand. When asked what happened she said that lady grabbed my hand. When asked when it happened she said 'today'. [Resident 51] was unable to describe any individual. Witness interview summary included, upon investigation we spoke to shift aid, [initials redacted] who stated during the NOC [night] shift [resident 51] was on the call light multiple times requesting to changer [sic] her clothes. [Name redacted] was changing [resident 51] clothes when she felt a slight pinching on her arm, causing [name redacted] to jump from being startled. Resident was biting [name redacted] CNA arm and when she jumped from being startled, her hand hit [Resident 51] hand. Aid finish changing clothes and left the room. Summary of other resident interviews revealed, No residents had contact during noc shift. Summary of responsible staff interviews revealed,Speaking with RA she stated that [resident 51] has a pattern of accusing residents or staff of small things. However RA finds that most of these are lies and does not occur. A summary of the investigation related to the incident revealed, Resident sent out for xray. L hand xray results received from [name redacted] hospital. No fx or dislocations noted. MD notified. No new orders at this time. The conclusion of the investigation stated, Upon investigation we found that no abuse or neglect has taken place, staff reacted causing a slight bruising to resident. Resident at baseline. Corrective action taken included, Staff member has been moved to new hall, if staff member needs to go into [resident 51's] room, we currently are having her go with a second aid as a caution during this investigation. Implementation of corrective action stated, DON created a training on acting calm during all interactions with resident and to remain calm if situation like a bite happens. Steps to address systems stated, Training being planned to train staff on remaining calm in all interactions. On 1/8/25 at 2:30 PM, an interview was conducted with the Admin who stated the cause of resident 51's left had bruise had not been determined. The Admin stated staff members were being very deliberate and aware as a result of the incident. The Admin stated the staff member was moved to another area to ensure she was not triggering anything for the resident to cause behaviors. It should be noted that additional information regarding the investigation and actions taken was requested but not provided. 6. Resident 52 was admitted to the facility on [DATE] with diagnoses that included Parkinson's Disease with dyskinesia, dementia, insomnia, monoplegia of upper limb, dysphagia, myalgia, and muscle spasms. Resident 52's medical record was reviewed on 1/6/25 through 1/9/25. On 8/14/23 at 3:43 PM, a Form 358 Facility Reported Incidents report was received by the SSA. The floor nurse reported, Found patient trying to get into his closet with his pillows and blankets during pill pass at 0430 [4:30 AM]. Patient had dried blood around his right eye. Has bump to right side of right eyebrow with dry blood. Asked patient what happened? He replied, 'riding a horse.' I questioned-Horse? He replied, 'yes', I fell off the horse.' Patient had minimal swelling noted to right top of hand. Started neuro checks and VS [vital signs]. Cleansed and left open to air. The report documented there were no changes in the resident's behavior and no witnesses to the fall. The report stated no other agencies were notified. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/21/23 at 11:08 AM, a Form 359 Follow-up Investigation Report was received by the SSA. Outcomes revealed, No additional harm or change in physical condition has occurred. The report stated the facility attempted to contact the resident's family, and as of 5:00 AM on 8/14/23, there was no answer from the resident's representative. In the interview with the resident, the report revealed, When I spoke to the resident, he does not remember the incident happening or what I am talking about. However, at the time of the incident he was riding a horse and fell off. He was found on the ground with all of his pillows and blankets. The summary of the witness interview revealed, Shift nurse-[name redacted] found [resident 52] on the ground during a room round/pill pass. Was trying to get into the closet and was on the ground. Patient stated he was riding a horse. He had dry blood, and bumps on the side of his eyebrow. A summary of the incident revealed, X-ray came back with no injuries. Patient has no pain in hand and face. In conclusion, the incident was, Inconclusive - resident was either dreaming or not in the correct mental state. Insufficient information to verify or refute anything. Corrective actions taken included, we are doing more frequent checks on room and specifically resident 52. We are doing another training on falls and how to mitigate them. Actions for oversight included, Shift nurses and admin clinical staff will monitor event and training to insure [sic] possible reduction of incidents. On 1/8/25 at 12:50 PM, an interview was conducted with the DON who stated that CNA's were the first line for information about the residents. The Regional Nurse Consultant (RNC) stated information was passed verbally, and they were encouraging staff to stop and watch the resident to get as much information as they could at the time of the event, and then alert the nurses. The RNC also stated that nurses passed information about the residents verbally as the next nurse came on shift. The RNC stated if a CNA became aware of a particular behavior for a resident they would put it in the point of care in the medical record so other staff members could see it. The RNC stated she was teaching nurses to look at the medical record Bell for updates. On 1/8/25 at 1:21 PM, an interview was conducted with the Admin who stated after submitting the Form 358 Facility Reported Incident, she would talk with the resident, the witness if there was one, and if no witness, the person who came upon the incident. The Admin then stated she would start interviewing staff and residents in the area. The Admin stated she would start implementing interventions to ensure the incident did not happen again. The Admin stated she documented all witness interviews that were conducted. The Admin stated she would have to call someone to see if an event was reportable. The Admin stated all residents were screened for fall risk upon admission, post fall, and quarterly. 44640 7. Resident 17 was admitted to the facility on [DATE] with diagnoses which included hemiplegia affecting right dominant side, traumatic brain injury, protein calorie malnutrition, dementia, unsteadiness on feet, foot drop of right foot, adult failure to thrive, sexual dysfunction, bilateral primary osteoarthritis of hip, and insomnia. Resident 17's medical record was reviewed on 1/6/25 through 1/9/25. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A nursing progress note dated 11/9/24 at 4:37 PM, documented, Heard resident yelling and swearing in his room around 1500 [3:00 PM]. Entered room and resident was lying on his back with head resting on drawers across from bed. Blood smear noted on drawer face. Assisted to wheelchair x 3 staff members and assessed resident. There was 1/4 cm lac [laceration] to back of scalp and was no longer bleeding. Started frequent VS and neuro checks. DON, ADON, Dr. [doctor] [name removed] and brother [name removed] were notified. Exhibit 359 was not located in the abuse log provided by the facility. For the allegation no investigation was provided by the facility. On 1/8/24 at 11:30 AM, an interview was conducted with resident 17. Resident 17 was not interviewable at the time and answers were indiscernible. On 1/9/25 at 8:45 AM, an interview was conducted with the DON. The DON stated the resident was on a one on one observation at the time of the fall and that she was not made aware of the incident or that the resident had been injured during the fall. On 1/9/25 at 9:15 AM, an interview was conducted with the Admin. The Admin stated she may have reported the fall on 11/9/24, but she could not remember. The Admin stated that she probably did not report it because she did not think she needed to report anything unless it was a fracture. The Admin stated she did not have a report on it or did not do an investigation for the incident. The Admin stated she now knows that she should have done an investigation for the incident. 47431 8. Resident 32 was admitted to the facility on [DATE] with diagnoses which included senile degeneration of brain, epilepsy, cardiomegaly, bilateral presbycusis, and bilateral age-related cataracts. Resident 32's record was reviewed on 1/6/25 through 1/9/25. On 4/19/24 at 7:05 PM, a Nurses Note documented Note Text: 1905: [7:05 PM] CNA to nurses station stating that resident is calling out in pain when attempting to remove socks and shoes. Nurse to resident room. Pt [patient] pointing to top of foot and speaking in Navajo. Pt tells CNA that he tripped and fell and now his foot hurts. CNA translating that Pt reports pain on top of left foot. Socks and shoes removed for comparison. Pt is guarded and yells out in pain. Swelling and 2x2 bruise to lateral left foot. 1920 [7:20 PM]: ER contacted and report given to ER nurse, [name redacted]. 1925 [7:25 PM]: Resident loaded in van and transported to ED [emergency department]. [Name redacted], CNA, accompanies to act as translator. 1930 [7:30 PM]: Arrived to ED, X-rays done with confirmation of fx, boot placed, and discharge instructions received. Ibuprofen 400 mg q [every] 4 hours PRN [as needed] and Tylenol 650 mg PO [by mouth] to be alternated for pain. Dr. [name redacted] is pt PCP [primary care physician] as well as ER MD [medical doctor]. 1033 [10:33 PM]: Arrived at care center. Boot to be worn during wake hours and removed while sleeping. Pt declines pain medication at this time. Will continue to monitor. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/20/23 at 3:25 PM, the facility reported to the SSA that on 4/19/23 at 7:15 PM, the Resident reported pain to his left foot. The Resident was assessed and increased bruising and pain were noted. The ER was contacted and the Resident was transported to ED. The ED evaluated the pain sight and completed an Xray. The Resident received Ibuprofen and Tylenol for pain. The Resident was placed in a boot. Resident is wearing boot during wake hours and removed while sleeping. No other agencies notified. (Note: Form 358 was not located in the abuse log provided by the facility.) For the allegation no investigation was provided by the facility. 9. Resident 48 was admitted to the facility on [DATE] with diagnoses which included type 2 diabetes mellitus with hyperglycemia, senile degeneration of brain, dislocation of right shoulder joint, multiple fractures of ribs, right side, and dislocation of right hip. Resident 48's record was reviewed on 1/6/25 through 1/9/25. On 12/3/23 at 5:30 AM, a Fall Note documented Note Text: Aide report, patient was found on floor at the foot of bed with her left arm caught in the bed (between mattress and foot board, of the bed), and laying face down by the bed. Wearing no clothes, but left sock and shoe on and had only sock on right foot. She said, 'I was going to go to the bathroom, but I got my arm caught in the bed. I didn't hit my head, I slowly went down to the floor. I didn't hurt myself any where else, but my left arm getting caught in the bed.' Assessment started, assist patient back to bed, Neuro checks and Vital signs started. MD notified. ADON notified. Patient responsible for self. Call light in easy reach. Will continue to monitor. On 12/3/23 at 7:00 PM, a Nurses Note documented Note Text: Left arm is bruised the whole arm. When she moves her arm no c/o pain. Will continue to monitor. Used both hands when eating today. Form 358 Facility Reported Incidents documented on the incident summary, Shift Aid, found resident on the floor, Leg and foot was stuck in the foot of the bed. Resident was naked, with only one shoe and one sock on. Aid ran to get nurse. Resident stated that she was going to go to the bathroom and caught her arm on the bed, stated she did not hit her head. Shift nurse check vitals and neuros, ADON, MD. Form 359 Facility Reported Incidents documented a summary of interviews with the alleged victim and/or the victim's responsible party revealed, Resident does not remember the details of the incident of the event as clear as she did at the time of the event. She just remembers trying to go to the restroom and then an aid finding her and helping. She states she 'is not hurt and is fine' No psychological harm or distress at this time. Summary of interviews with witnesses and staff responsible for oversight revealed, Aids states that she found resident - left arm stuck, facing face down on the bed. Resident was without clothes on. She immediately ran and got the nurse. Nurse was able to see the situation that the nurse on shift was able to get the resident in a proper position and make sure she was safe. Performed neuros and vitals. Conclusion: the situation is inconclusive, and insufficient evidence on how resident fell . Corrective Actions Taken: Changes to bed are being made to trying to mitigate potential falls. For the allegation on 12/3/23, no investigation was provided by the facility. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/31/24 at 7:16 PM, a Nurses Note documented Note Text: Aide came and got LN, aide found resident on the floor by her chair face down, resident was conscious and breathing, turned resident on side bruising on R [right] cheek and on R hand noted, resident was alert. Moved patient to the bed, cleaned and bandaged wounds and took vitals, initiated neuro checks all VS and neuro checks were normal at this time. Form 358 Facility Reported Incidents documented on the incident summary, On 03/31/2024 at 8:28 PM, the facility reported that on 03/31/2024 at 6:55 PM, the Resident had an unwitnessed fall out of her chair and was found by a CNA. The Resident had hit her face and slight bruising was noted on her face and wrist. The CNA was able to successfully get the Resident up and assessed. The Resident stated feeling safe and wanted to rest in bed. Neuro check was conducted and DON, Admin and MD were notified. The Resident's bed area was checked for potential items to cause a fall is not available at this time. Form 359 was not located in the abuse log provided by the facility. For the allegation on 3/31/24, no investigation was provided by the facility. On 1/8/25 at 3:09 PM, an interview was conducted with the Admin. The Admin stated that the facility was unable to provide investigations for Resident 48 regarding the events from 12/3/23 and 3/31/24. 10. Resident 50 was admitted to the facility on [DATE] with diagnoses senile degeneration of brain, epilepsy, and unilateral primary osteoarthritis, Left hip. Resident 50's records were reviewed between 1/6/25 through 1/9/25. On 12/3/23 at 2:00 AM, Fall Note documented Note Text: Aide report, patient on floor. Patient has laceration by left eyebrow and has a bump with skin tear on top of his nose. He said he fell off the bed and hit his nose on bed rail. Assessment started. Vital signs and neuro checks started. MD notified. ADON notified. Will notify Son in the morning after 8 am. Form 358 Facility Reported Incidents documented, Shift Aide found resident on the floor, with laceration by left eyebrow. Skin is elevated with a bump and a skin tear on his nose. Resident stated that he fell off the bed and hit his nose on the railing of the bed. Shift nurse performed vitals and neuros MD [Medical Doctor] and ADON [Assistant Director of Nursing] notified. Son notified in the late morning. Form 359 was not located in the abuse log provided by the facility. For the allegation on 12/4/23, no investigation was provided by the facility. On 1/8/25 at 3:09 PM, an interview was conducted with the Admin. The Admin stated that the facility was unable to provide the investigation for Resident 50 regarding the event on 12/4/23. 11. Resident 54 was admitted to the facility on [DATE] with diagnoses which included displaced bimalleolar fracture of left lower leg, type 2 diabetes mellitus, pressure ulcer of left heal, peripheral vascular disease, and urinary tract infection. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 54's record was reviewed on 1/6/25 through 1/9/25. Form 358 Facility Reported Incidents documented, Family stated that resident told her she had gotten up to use the restroom, that aid did not come quickly when she pressed the call light. She went to the restroom and upon returning to her bed se fell before entering the bed. After she had fallen, she was able to get back into bed.[TRUNCATED]

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F 0689 Level of Harm - Actual harm Residents Affected - Some	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** 50200 Based on observation, interview, and record review, the facility did not ensure that the resident's environment remained as free of accident hazards as was possible; and that the resident received adequate supervision and assistance devices to prevent accidents. Specifically, for 7 out of 39 samples residents, residents that had falls with injuries did not have interventions implemented to prevent future falls with injuries, a resident sustained an injury during cares provided by staff that resulted in the resident rolling out of bed, a resident that was provided a one on one with staff had falls with injuries, and residents that required a two person Hoyer lift had staff only use one person. Resident identifiers: 17, 19, 23, 29, 41, 52, and 296. Finding included: 1. Resident 41 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included other pulmonary embolism without acute cor pulmonale, type 2 diabetes mellitus with diabetic neuropathy, atherosclerotic heart disease, unspecified disorientation, essential hypertension, and mixed hyperlipidemia. On 1/6/25 at 4:53 PM, an observation was made of resident 41. Resident 41 was observed to have a greenish-purple discoloration to her left cheek and around her left eye. Resident 41's medical record was reviewed on 1/6/25 through 1/9/25. An admission Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 6. A score of 0 to 7 indicated severe cognitive impairment. A care plan Focus initiated on 7/9/24 and revised on 7/25/24 documented, [Resident 41] is at Moderate Risk for Falls per standardized fall scale. The care plan Goal initiated on 7/9/24, documented [resident 41] will be free of minor injury through the review date. The care plan Interventions included: a. Fall mat times one. Date initiated: 11/5/24, Revision on: 12/4/24. b. Fall 11/25/24: Tilt in space wheelchair d/t [due to] pt [patient] poor posture, trunk control. Date initiated: 12/4/24. c. Be sure bed was in lowest position and locked in place. Date initiated: 11/5/24. d. Keep room free of clutter and ensure objects the resident may need are within use. Date initiated: 7/25/24. e. Monitor for any changes in mental, emotional, or physical condition. Monitor medications for side effects that could contribute to a fall. Date initiated : 7/25/24. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	f. (High Risk) Assess need for laboratory test to rule out hypo-hyperglycemia, abnormal electrolytes, urinary tract or other types of infections and hemoglobin/hematocrit to assess for anemia. Date initiated: 7/9/24. g. (High Risk) Encourage the resident to wait for assistance. Anticipate needs by assessing normal routines and times of increase risk. Provide routine scheduling for bathroom use. Date initiated: 7/9/24 h. RESOLVED: 11/19/24, Certified Nursing Assistant (CNA) and Registered Nurse (RN) to check on patient more frequently, every 30 minutes rather than q two hours. Date initiated: 11/19/24 Revision on: 12/4/24 Resolved: 12/4/24. A care plan Focus initiated on 8/5/24, documented [Resident 41] has a behavior of crawling out of bed on hand and knees and crawling around on the floor looking for her belonging [sic] and going to the bathroom. does not use call light for staff assist. The care plan Goal initiated on 8/5/24, documented [resident 41] will remain safe and have preferences honored The care plan Interventions initiated on 8/5/24, were Assist in meeting resident's preferences as able. Notify applicable staff of resident's preference as able. A review of resident 41's progress notes revealed the following: a. On 7/1/24 at 3:17 PM, a nurses note documented, At 1425 [2:25 PM] aide reports that patient had fallen at side of bed hitting head on side rail has a small bump of 3 mm [millimeter] on right upper eyebrow. she is moving arms and legs she require minimal assist when getting up. Dr [doctor] [name redacted] notified. b. On 7/17/24 at 4:02 PM, a nurses note documented, notified that resident was on the floor in her room assessment was done has a bump on the top of her she [sic] stated that she fell trying to get to the bathroom is moving all extremities with out any problems Neuro [neurological] checks started. c. On 7/23/24 at 6:19 PM, a nurses note documented, Alerted by CNA that dietary aide went into room passing snacks and resident slid out of bed onto floor. Assisted resident to wheelchair and assessed for injuries. No injuries noted. d. On 9/23/24 at 2:30 PM, a nurses note documented, Nurse called to resident room. Resident lying on the right side on the floor. Nurse assessed resident and complains of pain on the right side of the head and right side of pelvic. Nurse asked resident what she was trying to do, Resident claims she was trying to transfer self from bed to WC [wheelchair] and the WC went running from resident. LPN [Licensed Practical Nurse] assisted resident back into WC. Neuros were started. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	e. On 11/15/24 at 1:30 AM, a nurses note documented, Patient yell out for help. Aide check on patient and found her on the floor. Patient had an unwitnessed fall. Patient rolled from bed. Patient was face down, body half off bed onto floor, both lower extremities twisted and caught on side rail, laying on her right arm and bed was in lowest position, upon LN [licensed nurse] entering patient's room. Assist patient back onto bed after Neurologic assessment, and VS [vital signs] started. B/P [blood pressure]= 141/90, P [pulse]= 69, R [respirations]= 16, T [temperature]= 97.7, O2sat [oxygen saturations]= 95% on RA [room air]. Noted hematoma to left side top of head, patient alert with some confusion noted, Right pupil size 6 and non-reactive, left pupil size 3 and reactive, can follow my finger with left eye, follows simple commands, ask patient if she has any pain? She stated, 'my head hurts and my body hurts,' Pain level right now? she said, '7', 7/10 pain level. Moves all extremities. Tylenol 650 mg [milligrams] given for pain to body and headache. Patient sent to ER [emergency room] for further evaluation @ [at] 0200 [2:00 AM], . f. On 11/15/24 at 5:37 AM, a nurses note documented, [local hospital] called with update. Patient going to be flown out to [hospital name redacted] in [city name redacted]. Patient has a minor brain bleed. Will let on coming LN know patient's status. g. On 11/18/24 at 4:55 PM, an interdisciplinary team (IDT) note documented, IDT Review: Reviewed fall 11/15/24, patient was sleeping in bed and was checked on during normal rounds by CNA and was found by CNA on floor with hematoma front and top of head. Patient neuro checks done and pupils noted to be unequal. Patient transportedto [sic] ER at [local hospital] via EMS [emergency medical services] and subsequently flown out to higher level of care. Findings are frequently turns around to sleep with head at the FOB [foot of bed], sleeps with body half on and half off the bed with feet on mat. Does not utilize call light although she is frequently reminded to do so. Resident has increased confusion NOC [nocturnal] and has hallucinations including 'dead people' men 'flying through the room and out the window'. Initial intervention: send to ER, was flown to different location and was admitted . A pressure call light mat was placed on her bed, and will alert staff to check on her if pressure is taken off of the mat. Alarm has been placed at the nurses station. All staff has been shown and trained on how this mat works for this patient. h. On 11/25/24 at 3:57 PM, a nurses note documented, Heard screaming coming from hall 2 and when investigated found resident face down on floor in front of her wheelchair. With the help of staff resident was assisted back up to wheelchair. VS, FSBS [fasting blood sugar], and neuro checks were completed. DON [Director of Nursing] and ADON [Assistant Director of Nursing] were notified and it was decided that resident would be taken to the ER for evaluation. i. On 11/26/24 at 4:23 AM, a nurses note documented, PT has been supervised all night due to her rolling around in her bed and attempting to stand without assistance. Pt is a HIGH fall risk and has not had any sleep during the night. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	j. On 11/26/2024 at 3:01 PM, an IDT note documented, IDT Review: . Patient recently has declined quickly to a state of being non-verbal and restless. Resident is on coumadin therapy. Resident is WC bound and becomes agitated at night, restless and often gets out of bed at night. Patient was heard calling for help and in her room during the afternoon and was found to have fallen from her WC forward motion, appeared to be face down. Patient was lifted to a sitting position with help of RN, DON, ADON and two CNA's. Patient assessed and did not appear to have any new bruising, abrasions, or other injuries. Resident did not complain of pain. Resident is on blood thinning medications and was sent to the ER as a precautionary measure. A WC that tilts back will be implemented to assess if the resident does better in this position and can be comfortable close to the nurses station. k. On 1/5/25 at 7:44 PM, a nurses note documented, 1855 [6:55 PM] resident up in w/c to come for supper had just been brought from dining room to foyer resident leaned forward to pick up something on floor and fell from w/c landed on left side and hit left side of forehead on floor resident was assisted to lay on back RN did assessment resident is alert and responsive. resident to be sent to ER to be evaluated due to history of brain bleed and being on coumadin. resident had refused pm medication no coumadin given. 1900 [7:00 PM] 911 called and resident sent to ER at 1935 [7:35 PM]. l. On 1/6/25 at 9:24 AM, an IDT note documented, IDT Review: Resident has history of dementia, hallucinations and falls in the near past. This day resident was not in her normal wheelchair due to the resident having had a large BM [bowel movement] that made it necessary to wash the wheelchair. Resident was placed in another WC temporarily. Resident was placed at the nurses station with many other residents in the common area. Resident fell forward from her chair. Other residents that witnessed the fall reported it looked as if she was reaching for something and lost her balance. Resident did hit her head on the right side, as well as her shoulder. Several people were there to help her up and to take VS immediately. VS were WNL [within normal limits] and resident C/O [complaining of] pain in areas where she reports pain often. Due to resident being on warfarin the ambulance was called and resident transported to [hospital name redacted] as a precautionary measure. Resident was sent back to [facility] with CT [computed tomography] Scan results sent to facility. A review of IDT word documents provided by the facility revealed the following: a. Name: [Resident 41]. Date of Event: 7/17/2024. Preventive measures prior to event: assisted with all adls [activities of daily living] as needed daily, medications administered per orders. Risk Factors: forgetfulness, poor safety awareness, impulsive. The following areas reviewed: Cognition Impairment: yes, intermittent confusion and forgetfulness. Summary of event: [resident 41] was found on the floor in her room, she stated that she fell trying to get to the bathroom and reported that she hit her head on the dresser. No injuries noted. Rehab/RNA [Restorative Nursing Assistant] Program: no. Medication Regimen Review: no issues found. Diagnostic Tests/Labs: no. Pain: Bowel & Bladder Incontinence: occasional Root Cause: Interventions: neuro checks and vital signs per protocol, monitor x3 days for injuries r/t [related to] fall, . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	b. Name: [resident 41]. Date of Event: 7/23/2024. Preventive measures prior to event: assisted with adls daily, call light within reach, medications administered per orders. Risk Factors: confusion, forgetfulness, did not ask for assist with transfer, not wearing socks or shoes. The following areas reviewed: Cognition Impairment: yes confusion, poor memory recall. Summary of event: staff witnessed pt slide from the bed to the floor while attempting to transfer to wheelchair, pt remained in sitting position and landed on the floor on her bottom, checked for injuries and none found, pt stated her feet were slippery, she did not use call light for assist with transfer. Rehab/RNA Program:PT [physical therapy] and OT [occupational therapy]. Medication Regimen Review: no issues found. Diagnostic Tests/Labs: no. Pain: no. Bowel &amp [sic]; Bladder Incontinence: occasional. Root Cause: pt attempted self-transfer without staff assist and was not wear proper footwear. Interventions: educate staff to ensure pt has proper footwear on (non-slip socks, shoes) vital signs per fall protocol, checked for injuries. It should be noted that resident 41's care plan did not show any interventions for the falls on 9/23/24, 11/15/24, and 1/5/25. Additionally, no IDT was held for resident 41's falls on 7/1/24 and 9/23/24. On 1/7/25 at 1:31 PM, an interview was conducted with the Certified Nurse Assistant Coordinator (CNAC). The CNAC stated that resident 41 had declined mentally since she first arrived at the facility and did not remember to use the call light when needing assistance. The CNAC stated that resident 41 would crawl around on the floor and tried to get out of bed often. The CNAC stated that resident 41 was given a fall mat for the floor and her bed should be in the lowest position. The CNAC stated that resident 41 was dependent on staff for all cares. On 1/8/25 at 8:31 AM, an interview was conducted with LPN 2. LPN 2 stated that if a resident was a fall risk, then all interventions should be care planned. LPN 2 stated that she would not know what interventions a resident had unless it was documented in the care plan. On 1/8/25 at 8:46 AM, an interview was conducted with CNA 3. CNA 3 stated that resident 41 was a fall risk. CNA 3 stated that resident 41 had a pad on her bed that would beep if she tried to get up. CNA 3 stated that resident 41 was dependent on staff for all cares and she was unable to ambulate on her own. CNA 3 stated that resident 41 required more frequent rounding than other residents due to the fall risk. On 1/8/25 at 9:50 AM, an interview was conducted with the DON. The DON stated that resident 41 liked to sleep with her head at the end of the bed and would bump her head on the foot board. The DON stated that resident 41's health had declined so a floor mat was placed next to the bed. The DON stated that resident 41 would sit slumped over in her wheelchair due to poor upper body control and would fall out of the wheelchair. The DON stated that resident 41 had done much better in the tilt wheelchair and had not fallen out of the tilt wheelchair. The DON stated that resident 41 now had a pressure alarm on her bed that would alarm if resident 41 tried to get out of bed. On 1/8/25 at 11:05 AM, an interview was conducted with LPN 1. LPN 1 stated that resident 41 was a fall risk and that she fell a lot. LPN 1 stated that the big bosses talked about the interventions for residents and she was not involved. LPN 1 stated that resident 41 was not cognitive enough to use a call light on her own. LPN 1 stated that she was not aware of what fall interventions resident 41 had. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	On 1/8/25 at 3:07 PM, an interview was conducted with the ADON. The ADON stated that if a resident had fallen they usually received a fall mat next to the bed. The ADON stated that the IDT team came up with specific fall interventions for each resident. The ADON stated that a physician's order would be placed for the intervention in the resident's medical record. The ADON stated that the MDS coordinator would add the intervention to the care plan and the Kardex for the CNA's. On 1/8/25 at 3:12 PM, an interview was conducted with the MDS Coordinator. The MDS Coordinator stated that she updated care plans. The MDS Coordinator stated that she used to care plan for every fall but that became convoluted and now the care plan just reflected the date of the fall. The MDS Coordinator stated that she did not update the Kardex. The MDS Coordinator stated that the IDT tried to come up with interventions after every fall, but if there was not a new intervention the care plan would reflect to continue with the current interventions. The MDS Coordinator stated that IDT meeting notes used to be kept on a word document and not charted in the residents' medical records. On 1/8/25 at 3:20 PM, a follow-up interview was conducted with the DON. The DON stated that after every fall there was an IDT meeting held the next day. The DON stated that the MDS Coordinator updated the care plans for residents with new interventions after the IDT meetings. The DON stated that she would tell the staff verbally about what new fall interventions were put into place. The DON stated that she expected staff to know what fall interventions residents had and ensure they were being followed. On 1/8/25 at 4:02 PM, an interview was conducted with the Administrator (Admin) and Regional Nurse Consultant (RNC). The Admin stated that the IDT team tried to find out what the root cause for the fall was so that interventions for the falls made sense. The Admin stated that there needed to be an intervention put in place after every fall. The Admin stated that the DON was responsible for letting the floor staff know of the fall interventions for the residents. The Admin stated that resident 41 fell a lot. The Admin stated that a fall mat was placed on the floor next to resident 41's bed and was placed in the lowest position. The Admin stated that resident 41 received a new tilt wheelchair to help her stay up in the chair because resident 41 did not have good upper body control. The Admin stated that resident 41's latest fall out of a wheelchair was because resident 41 was placed in a normal wheelchair and not the tilt wheelchair. The Admin stated that she was not sure what staff member placed resident 41 in the wrong wheelchair. The Admin stated that she expected the floor staff to know what all interventions were for residents. The RNC stated that the new intervention after the fall on 1/5/25, was placed in risk management notes and had not been added to resident 41's care plan. The RNC stated the new intervention would include that resident 41 would need one on one monitoring if in a manual wheelchair. 43212 2. Resident 52 was admitted to the facility on [DATE] with diagnoses that included Parkinson's Disease with dyskinesia, dementia, insomnia, monoplegia of upper limb, dysphagia, myalgia, and muscle spasms. Resident 52's medical record was reviewed on 1/6/25 through 1/9/25. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	A care plan Focus initiated on 7/31/19, documented [Resident 52] is High risk for falls r/t Parkinson's disease, poor safety awareness, impaired balance, impaired mobility, impulsiveness frequently taking all of his clothing out of the closet and drawers and throwing them on the floor. The Focus was revised and canceled on 12/27/23. No new fall interventions were implemented in 2023. An annual MDS assessment dated [DATE], revealed resident 52 had a BIMS score of 3, indicating significant cognitive impairment. The assessment also revealed resident 52 required one person extensive assistance for transfers, walking, and locomotion in the facility, and toileting. A fall risk assessment dated [DATE], determined that resident 52 was a high fall risk. On 2/10/23 at 6:44 PM, a Nurses note revealed, Note text: The patient is impulsive and has poor safety awareness, attempts to walk without assistance and forgets to use a wheelchair. [Resident 52] is monitored continuously for safety due to his hx [history] of falls resulting in trauma. Pt is continent of bowel and bladder. However, due to Parkinson's has accidents when he cannot move. [Resident 52] is learning safe transferring techniques and maintaining ROM [range of motion]. On 7/27/23 at 6:22 AM, a Nurses note revealed, Note text: Pt was up majority of the night attempting to rearrange his rooms furniture. Pt was very energetic and impulsive, in [sic] was unable to reason with the patient to lie down and rest. Pt was checked on throughout the night and was found moving his bed and climbing in and out of his closet. On 8/14/23 at 4:30 AM, a fall note revealed, Note text: Found patient trying to get into his closet with his pillows and blankets during pill pass at 0430 [4:30 AM]. Patient had dry blood around his right eye. Has bump to right side of right eyebrow with dry blood. Ask patient what happened? He replied, 'riding a horse.' I questioned- Horse? He replied, 'yes, I fell off the horse.' Patient had minimal swelling noted to right top of hand. Started Neuro checks and VS. Cleansed and left open to air. On 8/14/23 at 10:07 AM, a nurses note revealed, Note text: Dr. [name redacted] here this am to see resident due to unwitnessed fall during night. new order for x-ray of right hand. On 8/15/23 at 6:23 PM, a nurses note revealed, Note text: Results from XR [x-ray] right hand received. MD [Medical Director] notified at 1000 [10:00 AM]. No new orders at this time. Patient has had no c/o [complaints of] pain this shift. Patient was using right hand to feed himself during meals. On 9/14/23 at 6:02 PM, a nurses note revealed, Note text: Small laceration noted to pt L [left] eyebrow. Pt stated he had hit his head yesterday, but was unable to say where. Neuro assessment revealed no deficits. Site cleaned and left open. MD notified. Will continue to monitor. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	On 9/30/23 at 12:01 AM, a fall note revealed, Note text: I and another nurse were in another resident's room across the hall when an aide yelled that [resident 52] had fallen and she needed help. I went into the room and [resident 52] was lying on the floor with his arm stuck in-between where the bed meets the frame. We immediately started calling out [resident 52's] name to see if he was conscious which he responded to his name by grunting. The aide lifted his body and I dislodged his arm from the frame and where the bed meet. We sat him on the bed and I asked the aide to get the vital cart and I looked at his arm to check for injuries. I asked him if he had hit his head and he stated, 'yes.' We began neuro checks q [every] 15 mins [minutes] and I inspected his head for injuries which I did not notice any bruising on his arms or his head at that time. He had equal hand grasps, [NAME] [Pupils equal, round, reactive to light and accommodation] was not reactive to light and his pupils were pinpoint. He was able to move all extremities. His arm was red and an indentation was noticeable from where his arm was struck. On 10/4/23 at 9:28 PM, a nurses note revealed, Note text: patient was found on the floor, face down in his room approx [approximately] 2000 [8:00 PM]. He appeared to have hit his head on the corner of the dresser in his room. There was some fairly fresh bleeding. He was helped up onto the bed and when I asked how long he had been on the floor he very quietly said 'a while.' Neuro checks and VS were started immediately. He was not out of normal limits. He was put in his WC and taken into the dining room so he could safely eat his snack. The small wound on his forehead was cleaned and antibiotic ointment was placed on the wound with a band-aid. He did deny pain. He denies LOC [loss of consciousness]. An event/alert was created. The patient was seat belted into his WC due to him constantly getting up and attempting to walk. On 10/5/23 at 10:26 PM, an event/alert charting note revealed, Type of event: Unwitnessed fall. Assessment/Observations: Vital signs and neuros are stable. Patient was up walking around without wheelchair and fought staff when we tried to redirect him back to his wheelchair. Interventions: assisted patient into wheelchair and put the seatbelt on to help with decrease the occurrence of falls. Resident reaction to interventions: noncompliant. Improvement/Decline: stable. On 10/26/23 at 2:15 PM, a Skin/Wound note revealed, Note text: CNA approaches this nurse to report resident standing in room with a 'bloody gash' to his face. Upon inspection, injury is approximately 3 cm [centimeters] in length located at the distal end of L eyebrow. Area is cleaned, TAO [Troleandomycin] and bandage applied. Denies pain at site. Resident is questioned in regards to how injury occurred; points toward sink and cabinets only. VS WNL; 134/72, P 82, RR [respiratory rate] 17, T 98.2. Bed remains in low and locked position. Frequent rounding by staff continues. On 11/2/23 at 11:02 PM, a fall note revealed, Note text: CNA found patient on floor of room, with his door closed and it appeared that he had fallen from his wheelchair and hit his head on the door knob. He was alert and oriented, did nod yes when asked if he was in pain. His pupils are PERRLA motor function WNL for patient but he does have Parkinson's. Will begin neuro checks and VS protocol. On 8/14/23, a physician progress note revealed, . HPI [History and Physical Information]: [AGE] year-old nursing home resident who fell today and has pain and swelling in his right hand. He also had a small laceration on the side of his eyebrow.Physical exam: Patient appeared unchanged except for, very small laceration on the side of his eyebrow. Patient's right had had some mild swelling. The skin was intact. There was no ecchymosis . Assessment/plan: 1. Injury of hand- Right-patient will have an x-ray of the right hand will follow-up with results. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	It should be noted that fall interventions were not implemented after each fall. On 1/8/25 at 12:50 PM, an interview was conducted with the DON who stated every resident was evaluated for fall risk during the admission assessment. The DON did not know the frequency that residents were evaluated for falls. The DON stated falls were documented in the care plan. The DON stated after a resident fall, an IDT meeting would be held and the staff would go through the risk management process and try to figure out what the cause of the fall was. Interventions would be changed and documented in the resident's care plan. The DON stated staff checked on the residents at least every two hours. The DON stated recently staff had been checking hourly due to so many residents having falls. The DON stated during the night when resident doors were closed, the CNA would still peek into the room to check on the resident. On 1/8/25 at 2:39 PM, an interview was conducted with the Admin who stated if a resident had an unwitnessed fall it would be reported because staff did not know what happened. The Admin stated fall risk assessments were conducted on admission, post fall, and quarterly. The Admin stated after a resident sustained a fall, they would be monitored for several days afterwards. On 1/9/25 at 8:02 AM, an additional interview was conducted with the DON who stated resident 52 had bad Parkinson's and often got frozen. The DON stated resident 52 wanted to do everything by himself including feeding himself even though it was messy. The DON stated resident 52 was non-verbal, and could not walk although he thought he could. The DON stated resident 52 was in a wheelchair about 99% of the time. The DON stated resident 52 would sit on the side of his bed while in his room. The DON stated she thought resident 52 was an old bronco rider. The DON stated resident 52 was a fall risk in the sense that he had really bad Parkinson's. The DON stated she never saw resident 52 fall, but also was not in the facility much at the time resident 52 was a resident. The DON stated resident 52's bed was in the lowest position and at one point the staff moved all the furniture away from the bed. The DON stated resident 52 had a fall mat next to his bed. The DON stated staff padded everything with corners on it in his room to prevent resident 52 from bumping and injuring his head. The DON stated staff watched resident 52 like a hawk. The DON stated resident 52 was also moved close to the nurses station so he could be checked on more frequently. The DON stated both staff and residents checked on resident 52 frequently as resident 52 became increasingly impulsive and stubborn. The DON stated she was not included in the IDT meetings when resident 52 was in the facility. The DON stated she never looked at care plans, but staff would get text messages when new interventions were put into a resident's care plan. The DON stated she did not remember monitoring resident 52 for his behaviors and if resident 52 was freezing up more often, she would tell the ADON or the administrator. On 1/9/25 at 8:20 AM, an additional interview was conducted with the Admin who stated resident 52, at one time, had knee pads and a helmet to prevent injuries when he fell . The Admin stated after a while, resident 52 refused to wear the helmet. The Admin stated resident 52 slept most of the night, and staff would give him snacks during the day to keep him busy. The Admin stated resident 52 could not toilet independently, but tried occasionally. The Admin stated resident 52 was able to use the call light, but it was not always in line with when he needed care. The Admin stated their current DON did not participate in resident 52's care planning because she was not the DON at that time. The Admin stated the IDT meeting staff tried to put common sense interventions in place for resident 52. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	On 1/9/25 at 8:25 AM, an interview was conducted with the MDS Coordinator who stated she had been the coordinator for [AGE] years. The MDS Coordinator stated when changes were made to the care plan she was the person who put the information into the care plan. The MDS Coordinator stated when a resident had a fall, the fall would be discussed in the IDT meeting the following morning. The MDS Coordinator stated the IDT tried to put new interventions into the care plan every time a resident fell . The MDS Coordinator stated for resident 52, it was hard to find new things that could be put into place. The MDS Coordinator stated it was difficult adding actual falls each time, putting interventions in, and resolving the intervention. The MDS Coordinator stated the nurse on the floor would do the risk management documentation at the time of a fall and she would look each morning to see if there had been any events for the IDT meeting. The MDS Coordinator stated the DON was responsible for writing the note about the incident, and then the incident note would be scanned into the resident's medical record. The MDS Coordinator stated resident 52 was a high fall risk. The MDS Coordinator stated they were always trying to put new things into resident 52's care plan and put every thing they could think of. The MDS Coordinator stated the only CNA's that would remember resident 52 would be working at night. On 1/9/25 at 8:55 AM, an interview was conducted with CNA 5 who stated if she came upon a resident who had sustained an unwitnessed fall, she would ask the resident if they knew how they fell , how long they had been down, and if they hit their head. CNA 5 also stated she would contact a nurse to have the resident evaluated. CNA 5 stated she would ensure the resident's bed was lowered to the floor so they did not fall again, and put a protective padding down so if another fall was sustained, the resident would have a soft landing area. CNA 5 stated she would check the resident's vital signs after the nurse had assessed the resident. CNA 5 stated she found out how much assistance the resident needed by looking in the area of the resident's chart where nurses were able to leave notes for them. On 1/9/25 at 9:07 AM, an interview was conducted with the Medical Records (MR) staff who stated resident 52 had Parkinson's and dementia. The MR stated resident 52 would get up and walk, and then his legs would freeze up on him and he would fall to his knees, then get back up and went. The MR stated resident 52 had hallucinations quite a bit, and would fall a lot. The MR stated resident 52 was very impulsive and would jump up and start walking. The MR stated resident 52 was more confused at night. The MR stated the IDT and the MDS Coordinator were the staff who would [TRUNCATED]

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33215 Based on interview and record review, the facility did not ensure that residents maintained acceptable parameters of nutritional status unless the resident's clinical condition demonstrated that this was not possible. Specifically, for 1 out of 39 sampled residents, a resident who had experienced a significant weight loss did not have recommendations from the Registered Dietitian (RD) implemented. Resident identifier: 4. Findings included: Resident 4 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included, but were not limited to, pneumonia, type 2 diabetes mellitus (DMII), asthma, essential hypertension, major depressive disorder, chronic pain, legal blindness, and adjustment disorder with depressed mood. Resident 4's medical record was reviewed on 1/7/25 through 1/9/25. A care plan Focus initiated on 4/14/21 and revised on 12/26/24, documented [name redacted] has nutritional problem or potential nutritional problem r/t [related to], therapeutic diet. She has DMII, she is legally blind, has major depression and disease of stomach and duodenum. She is very picky with her meals. She thinks the meat is not real unless it has a bone in it. Significant WT [weight] loss. The care plan Interventions initiated on 4/14/21, included: a. Encourage her to not hoard food especially perishable foods. b. Provide and serve diet as ordered. c. RD to evaluate and make diet change recommendations as needed. d. Set up plate in clock so she knows where her food is during meals. A Prospective Payment System 5-day scheduled Minimum Data Set assessment dated [DATE], documented that resident 4 had a Brief Interview for Mental Status (BIMS) score of 9. A BIMS score of 8 to 12 indicates moderate impaired cognition. On 9/27/24, a Diet: Nutritional Assessment documented At nutritional risk related to being blind and inadequate PO [by mouth] intake evidence by use of a plate guard to ensure PO intake and leaving more than 25% of food uneaten. On 11/24/24, a Diet: Nutritional Assessment documented At nutritional risk related to being blind, altered mental status and inadequate PO intake evidence by use of a plate guard to ensure PO intake, Dx [diagnosis]: Depressive disorder and leaving more than 25% of food uneaten. On 11/20/24, resident 4 had a documented weight of 133.4 pounds (lbs). On 12/15/24, resident 4 had a documented weight of 124 lbs. With these reference weights, resident 4 experienced a documented significant weight loss of 7.05 % during a one month interval. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/14/24 at 10:58 AM, a Nutrition/Dietary Note documented Note Text: Current WT: 126.2 lbs (12/1/24), WT: 137.6 lbs (11/3/24), WT: 141.6 lbs (9/2/24), WT: 143.2 lbs (6/2/24), BMI [Body Mass Index]: 24.3, current dietary order Reg [regular] /Reg, current PO intake is around 50%, resident has been refusing meals the last couple of days, has experienced a -8.3% WT change at 30 days, -10.9% WT change at 90 days and -11.9% WT change at 180 days which is a significant WT loss, BMI is WNL [within normal limits], encourage high kcal [kilocalorie] supplement Mighty Shake or Ensure if resident refuses a meal, continue to observe and f/u [follow up] prn [as needed]. The Order Summary was reviewed and a high kcal supplement Mighty Shake or Ensure was not ordered. On 12/26/24, a Diet: Nutritional Assessment documented At nutritional risk related to GI [gastrointestinal], distress, inadequate PO intake, altered mental status evidence by Dx: Constipation and Major Depressive Disorder, leaving more than 25% of food uneaten and Blind. On 7/7/24, resident 4 had a documented weight of 142.4 lbs. On 1/5/25, resident 4 had a documented weight of 124.4 lbs. With these reference weights, resident 4 experienced a documented significant weight loss of 12.64 % during a six month interval. On 10/6/24, resident 4 had a documented weight of 137.8 lbs. On 1/5/25, resident 4 had a documented weight of 124.4 lbs. With these reference weights, resident 4 experienced a documented significant weight loss of 9.72 % during a three month interval. On 1/7/25 at 8:52 AM, a Nutrition/Dietary Note documented Note Text: Current WT: 124.4 lbs (1/5/25), WT: 126.2 lbs (12/1/24), WT: 137.8 lbs (10/6/24), WT: 142.4 lbs (7/7/24), current dietary order Reg/Reg, current PO intake is around 50%, has been refusing meals, has experienced a -1.5% WT change at 30 days, -9.8% WT change at 90 days and -12.6% WT change at 180 days, WT changes at 90 and 180 days are significant, current BMI is WNL and experienced no significant WT change at 30 days, encourage staff to offer a Ensure or other substitute when resident refuses a meal, continue to observe and f/u prn. The Order Summary was reviewed and Ensure or other substitute was not ordered. On 1/7/25 at 10:34 AM, an interview was conducted with Licensed Practical Nurse (LPN) 3. LPN 3 stated if a resident was receiving Ensure or a supplement it would be documented on the resident's Medication Administration Record. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/8/25 at 8:32 AM, an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated that yes they had skin and weight meetings but it had been hard to have them because the Director of Nursing (DON) needed to be oriented. The ADON stated the skin and weight meetings were not formal yet but they were trying. The ADON stated that the skin and weight meetings use to be every Wednesday. The ADON stated they would talk with the dietary manager every week and they would talk to the physician to add supplements. The ADON stated that supplements were added immediately if the resident had a low weight on admission. The ADON stated the RD would send recommendations and would monitor the enteral feedings and the physician did those things also. The ADON stated that resident 4 got sick with the flu and resident 4 was very picky about her weight. The ADON stated that she thought the 120's would be resident 4's new baseline. The ADON stated that resident 4 would not do supplements but the ADON was unsure if that was resident 4's choice. The ADON stated that the RD was not there in the facility and would email recommendations. The ADON stated that resident 4 was happy with her weight loss. The ADON stated that resident 4 looked good and did not look to skinny. The ADON stated that they looked at the recommendations from the RD and would talk with the resident prior to implementing the recommendations. The ADON stated the RD was putting the orders in but the orders had to be approved and the orders would be missed. The ADON stated that staff put the orders in if it was going to work for the resident and we give the recommendations to the physician to see if it was okay. The ADON stated nutrition recommendations were wrote on paper and given to the physician to sign. On 1/8/25 at 9:17 AM, an interview was conducted with the RD. The RD stated that he did a report with the resident name, recommendations, and follow up plan. The RD stated he would forward the report to the DON and ADON. The RD stated in the past he would put the orders in the resident's electronic medical record but his access had been limited and he did not know why. The RD stated that resident 4 had been refusing a few meals. The RD stated that resident 4's weight had been stable the past 30 days. The RD stated that he would expect the staff to implement the dietary recommendations because that was the process. The RD stated that since he did not have access to put the orders in the resident's electronic medical record he would expect the staff to input those orders. The RD stated that the last couple months resident 4 had been stable with her weight and he would be okay if resident 4 maintained the current weight. On 1/8/25 at 10:03 AM, an interview was conducted with the DON. The DON stated that recommendations were emailed to her by the RD but she was unsure on how the recommendations were implemented. The DON stated that she would print the RD recommendations and would forward the recommendations to the dietary manager. The DON stated they also got recommendations from the Speech Therapist. The DON stated that herself and the ADON would work together for the skin and weight meetings. The DON stated they would talk about weights and if wounds were healing. On 1/8/25 at 10:14 AM, a follow up interview was conducted with the ADON. The ADON stated resident 4 would request an alternate meal if she did not like what was served. The ADON stated there was a template for the skin and weight meeting that listed any resident under 100 lbs, new admissions, pressure sores, and residents that triggered for significant weight loss. The ADON stated that residents were weighed weekly on admission and after four weeks if the resident had no triggers then the resident would be weighed monthly. The ADON stated the skin and weight meetings were documented in her head.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Post nurse staffing information every day. 48709 Based on observation and interview, the facility did not have the nurse staffing information posted. The facility must post the following information on a daily basis: Facility name, the current date, the total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: Registered Nurses, Licensed Practical Nurses, Certified Nursing Assistant, and resident census. The facility must post the nurse staffing data on a daily basis at the beginning of each shift and maintain the posted daily nurse staffing data for a minimum of 18 months. Specifically, the nurse staffing data was not posted on a daily basis and the nurse staffing data was not complete. Findings included: On 1/6/25 at 4:21 PM, an observation of the nurse staffing information was completed. The nurse staffing information was dated 1/5/25, and did not include the actual hours of the licensed and unlicensed nursing staff. On 1/8/25 at 8:00 AM, an observation of the nurse staffing information was completed. The nurse staffing information was dated 1/5/25, and did not include the actual hours of the licensed and unlicensed nursing staff. On 1/8/25 at 9:14 AM, an interview was conducted with the Director of Nursing (DON). The DON stated Medical Records (MR) was responsible to post the nurse staffing information. The DON stated MR worked Sunday through Thursday and was not sure who did the post when she was off. On 1/8/25 at 9:18 AM, an interview was conducted with MR. MR stated she was responsible for posting the nurse staffing information. MR stated she worked Sunday through Wednesday and on Sundays she worked on the floor as a nurse and was not always able to post the nurse staffing information. On 1/9/25 at 10:13 AM, an interview was conducted with the Administrator (Admin). The Admin stated she was not aware that the nurse staffing information had to be posted.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 44640 Based on observation, interview, and record review, the facility did not provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biological's) to meet the needs of each resident. Specifically, the facility staff were taping narcotic medications back into the medication cards. Findings included: On 1/8/25 at 8:00 AM, an observation was made of the facility Team 1 medication cart with Licensed Practical Nurse (LPN) 2. The following medications were observed in the medication cart: a. A multi dose medication card which held Oxycodone 5 milligram (mg) had the back of pocket numbers 26 and 27 that were opened with tape now closing them, there were no medications observed in the pockets. b. A multi dose medication card which held Hydrocodone - Acetaminophen 5-325 mg had the back of pocket number 34 that was opened with tape now closing it, there was no medication observed in the pocket. An immediate interview was conducted with LPN 2. LPN 2 stated the nurses would do the narcotic count at change of shift. LPN 2 stated the nurses waste narcotics in the sharps container and were not supposed to tape the medications back into the medication cards. On 1/8/25 at 8:18 AM, an observation was made of the facility Team 2 medication cart with LPN 1. The following medications were observed in the medication cart: a. A multi dose medication card which held Pregamblin 100 mg had the back of pocket number 44 that was opened with tape now closing it, there was no medication observed in the pocket. b. A multi dose medication card which held Hydrocodone 10/325 mg had the back of pockets 4, 5, 6, 10, 16, 23, 24, and 25 that were opened with tape now closing them, there were no medications observed in the pockets. On 1/8/25 at 8:25 AM, an interview was conducted with LPN 1. LPN 1 stated that sometimes if a medication was accidentally pushed through the backing, then the nurse would tape it, so the medication was not lost. LPN 1 stated she was unsure how the staff would know if the medication was still clean or if the correct medication had been taped back into the medication card. LPN 1 stated she was unsure why there was tape on the medication cards in the cart. On 1/8/25 at 10:19 AM, an interview was conducted with the Administrator (Admin). The Admin stated the nurses were not supposed to tape the back of the narcotic cards, they were expected to waste the narcotic in the sharps container. The Admin stated the staff would not know if the medication was clean or if the medication was the correct medication if it had been taped back into the medication card. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/8/25 at 1:36 PM, an interview was conducted with the Director of Nursing (DON). The DON stated there should be two witnesses to waste narcotics. The DON stated the nurses do not waste the medication if it had not touched anything or if the resident refused to take it. The medication could be taped back into the medication card, and they would hopefully be able to use it again. The DON stated the risks of taping medications back into the medication cards where the medications could potentially fall out, the medications could be dirty, and there was a chance for medication diversion.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44640 Based on interview and record review, the facility did not ensure that the pharmacist reported irregularities to the attending physician, the facility's Medical Director (MD), and the Director of Nursing (DON) were acted upon. Specifically, for 1 out of 39 sampled residents, a pharmacy recommendation to discontinue hydroxyzine was not acted upon timely. Resident identifier: 17. Findings included: Resident 17 was admitted to the facility on [DATE] with diagnoses which included hemiplegia affecting right dominant side, traumatic brain injury, dementia, unsteadiness on feet, foot drop of right foot, adult failure to thrive, sexual dysfunction, bilateral primary osteoarthritis of hip, and insomnia. Resident 17's medical record was reviewed on 1/6/25 through 1/9/25. A review of resident 17's physician orders revealed, hydrOXYzine HCl [hydrochloride] Oral Tablet 25 MG [milligrams] (Hydroxyzine HCl) Give 25 mg by mouth every 6 hours as needed for antianxiety. A review of resident 17's Patient Recommendations Summary - Practitioner recommendations documented on 11/24/24, This resident has a current order for Hydroxyzine 25 mg as needed (PRN) every 6 hours for anxiety since 10/24/24. This as needed medication has been utilized 12 times in the past 30 days. Of note, the resident has had 20 documented falls in this same month. There were notes documenting behaviors of the resident wanting to give other residents a hard time and was subsequently given hydroxyzine. If an agent was truly needed for anxiety, buspirone may be a better alternative, with less cognitive side effects than hydroxyzine. The following intervention has been preapproved by the attending medical team through verbal communication and/or protocols: 1. Discontinue hydroxyzine 2. Replace with Buspirone 5 mg PRN The interventions on the patient recommendations summary were noted to be with the verbiage circled Verbal Order next to it. A secure text message revealed the medical provider was made aware of the medication change on 11/25/24, by the pharmacist and agreed to the immediate discontinuation of the Hydroxyzine and the initiation of the Buspar. A written physician phone message dated 11/29/24, revealed, I had previously approved changing the Hydroxine to buspar, (but watch for insomnia getting worse after the change), the change didn't happen when I rounded the following day . (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/8/24 at 10:00 AM, an interview was conducted with the DON. The DON stated they have a corporate pharmacist who went through each resident's medications monthly. The DON stated herself and the Assistant Director of Nursing would then go through the recommendations and contact the MD. The DON stated the pharmacist had usually already talked with the doctor about the recommendations. The DON stated it took about one week for the recommendations to be put into effect. The DON stated resident 17's Hydroxine was not discontinued as recommended because the doctor was on vacation and communication was limited.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44640 Based on interview and record review, the facility did not ensure that each resident's drug regimen was free from unnecessary drugs. An unnecessary drug was any drug when used in excessive dose; or for excessive duration; or without adequate monitoring; or without adequate indication for its use; or in the presence of adverse consequences which indicated that the dose should be reduced or discontinued. Specifically, for 1 out of 39 sampled residents, a resident's medication was not discontinued per pharmacy and provider recommendations. Resident identifier: 17. Findings included: Resident 17 was admitted to the facility on [DATE] with diagnoses which included hemiplegia affecting right dominant side, traumatic brain injury, protein calorie malnutrition, dementia, unsteadiness on feet, foot drop of right foot, adult failure to thrive, sexual dysfunction, bilateral primary osteoarthritis of hip, and insomnia. Resident 17's medical record was reviewed on 1/6/25 through 1/9/25. A review of resident 17's physician orders revealed, hydrOXYzine HCl [hydrochloride] Oral Tablet 25 MG [milligrams] (Hydroxyzine HCl) Give 25 mg by mouth every 6 hours as needed for antianxiety. The physician's order was initiated on 10/24/24 and discontinued on 12/10/24. A review of resident 17's Patient Recommendations Summary - Practitioner recommendations documented on 11/24/24. This resident has a current order for Hydroxyzine 25 mg as needed (PRN) every 6 hours for anxiety since 10/24/24. This PRN medication has been utilized 12 times in the past 30 days. Of note, the resident has had 20 documented falls in this same month. There were notes documenting behaviors of the resident wanting to give other residents a hard time and was subsequently given hydroxyzine. If an agent was truly needed for anxiety, buspirone may be a better alternative, with less cognitive side effects than hydroxyzine. The following intervention had been preapproved by the attending medical team through verbal communication and/or protocols: 1. Discontinue hydroxyzine 2. Replace with Buspirone 5 mg PRN Review of resident 17's November 2024 Medication Administration Record (MAR) revealed that the Hydroxyzine 25 mg was administered when it should have been stopped on 11/28/24 at 9:17 PM; 11/29/24 at 6:22 AM, 12:10 PM, 6:08 PM; 11/30/24 at 12:26 AM, 7:46 AM, 3:58 PM, and 11:58 PM. Review of resident 17's December 2024 MAR revealed that the Hydroxyzine 25 mg was administered when it should have been stopped on 12/1/24 at 6:42 AM, 1:17 PM, 7:18 PM; 12/2/24 at 3:35 PM; 12/4/24 at 7:41 AM; 12/5/24 at 7:36 AM, 5:11 PM; 12/6/24 at 5:26 AM, 5:37 PM; 12/7/24 at 5:28 AM; 12/8/24 at 3:40 PM; 12/9/24 at 5:46 AM and 6:06 PM. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A secure text message revealed the medical provider was made aware of the medication change on 11/25/24, by the pharmacist and agreed to the immediate discontinuation of the Hydroxyzine and the initiation of the Buspar. A written physician phone message dated 11/29/24, revealed, I had previously approved changing the Hydroxyzine to buspar, (but watch for insomnia getting worse after the change), the change didn't happen when I rounded the following day . On 1/8/24 at 10:00 AM, an interview was conducted with the Director of Nursing (DON). The DON stated they have a corporate pharmacist who went through each resident's medications monthly. The DON stated herself and the Assistant Director of Nursing would then go through the recommendations and contact the doctor. The DON stated the pharmacist had usually already talked with the doctor about the recommendations. The DON stated it took about one week for the recommendations to be put into effect. The DON stated resident 17's Hydroxyzine was not discontinued as recommended because the doctor was on vacation and communication was limited.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33215 Based on interview and record review, the facility did not ensure that residents who used psychotropic drugs received gradual dose reductions (GDR) unless clinically contraindicated, in an effort to discontinue these drugs. A GDR must be attempted in two separate quarters, with at least one month between attempts, within the first year in which an individual was admitted on a psychotropic medication or after the facility had initiated such medication, and then annually. Specifically, for 1 out of 39 sampled residents, a resident taking an anticonvulsant medication for behavioral disturbance had not received a GDR on that medication since 2023, and the medication was not clinically contraindicated. Resident identifier: 24. Findings included: Resident 24 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, senile degeneration of brain, dementia, essential hypertension, atrial fibrillation, and mood disorder. Resident 24's medical record was reviewed on 1/7/25 through 1/9/25. On 9/11/23, a physician's order documented CarBAMazepine Tablet 200 MG [milligrams] Give 1 tablet by mouth two times a day for behavior disturbance. A physician documented clinical contraindication was unable to be located. On 1/8/25 at 3:30 PM, an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated for the psychotropic meeting they would talk with the pharmacy, go through the resident behaviors, the pharmacist would recommend stuff, and we take the recommendations to the physician for approval. The ADON stated the physician would approve the recommendation by signing the form but the pharmacist had already spoken with the physician prior to us sending the recommendations. The ADON stated the Director of Nursing would put in the orders from the recommendations after the approval of the physician. The ADON stated the first year they had to do two GDRs and yearly after that. The ADON stated the pharmacist would tell us when the medications were up for a GDR.

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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** 44640 Based on observation and interview, the facility did not label all drugs and biological's used in the facility in accordance with currently accepted professional principles, and include appropriate accessory instructions and the expiration date when applicable. Specifically, two vials of insulin were open and available for use past the expiration date. Findings included: On [DATE] at 7:40 AM, an observation was made of the Team 2 medication cart with Licensed Practical Nurse (LPN) 1, the following medications were located in the medication cart: a. A bottle of Lantus 100 units/milliliter (ml) was open and available for use and labeled with an open date of [DATE], wrote on the vial and a date of ,d+[DATE], written on the box. The vial was opened 8 days past the 28 day open date. b. A bottle of Tresiba 100 units/ml was open and available for use and labeled with an open date of [DATE], wrote on the vial and a date of ,d+[DATE], wrote on the box. This vial was opened 6 days past the 28 days open date. An immediate interview was conducted with LPN 1. LPN 1 stated the insulin that was in the cart was being used for the residents. LPN 1 stated the insulin was good for 14 days after it was pulled out of the fridge from the medication room. LPN 1 stated the nurses were supposed to write the date on the insulin when it was taken out of the fridge. LPN 1 stated she was unsure why there was a ,d+[DATE], date wrote on the outside of the box and a different date wrote on the vial, LPN 1 stated it was not like that the day prior. An observation was made of LPN 1 as she placed the insulin vials back into the medication cart for future use. On [DATE] at 9:45 AM, an interview was conducted with the Director of Nursing (DON). The DON stated the expectation of the facility was for the nurses to administer the correct medications to the correct residents. The DON stated insulin was good for 30 days after being opened. The DON stated the medications should not be expired and the nurses were supposed to date the insulin when they got a new one out of the fridge from the medication room. The DON stated she was unsure why the insulin had two different dates wrote on them.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44640 Based on interview and record review, the facility did not provide or obtain laboratory services to meet the needs of its residents. Specifically, for 1 out of 39 sampled residents, a resident had a urinalysis (UA) ordered and the urine was not collected for five days after the order was given. Resident identifier: 17. Findings included: Resident 17 was admitted to the facility on [DATE] with diagnoses which included hemiplegia affecting right dominant side, traumatic brain injury, protein calorie malnutrition, dementia, unsteadiness on feet, foot drop of right foot, adult failure to thrive, sexual dysfunction, bilateral primary osteoarthritis of hip, and insomnia. Resident 17's medical record was reviewed on 1/6/25 through 1/9/25. A physician's order revealed, Urine to reflex to culture ordered on 9/25/24 and discontinued on 9/26/24. The progress notes revealed: a. On 9/25/24 at 1:20 PM, .2) UA with reflex to Cx [culture]. b. On 9/30/24 at 4:40 PM, UA collected on resident with clean urinal. UA sent to labs and awaiting results. c. On 10/1/24 at 11:40 AM, [Staff name redacted] from [Provider's name redacted] office called to let us know that resident's recent UA shows UTI [urinary tract infection]. She stated that order for Bactrim DS [double strength] was sent to the pharmacy. Will Pick it up when ready. On 1/7/25 at 2:56 PM, an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated they had standing orders for the UA, if needed. LPN 1 stated the staff would text the doctor and let them know about the symptoms the resident was experiencing and collect the sample. LPN 1 stated the sample was usually collected within 24 hours. LPN 1 stated the Medical Records watched for the results of any lab work. On 1/8/25 at 10:10 AM, an interview was conducted with the Medical Records (MR). The MR stated she was in charge of getting results to the staff after they returned to the facility. The MR stated the nurse on duty was in charge of putting the order in the computer and collecting the sample, if needed. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/8/25 at 1:51 PM, an interview was conducted with the Director of Nursing (DON). The DON stated the resident was peeing in the sink and that they could not get the urine sample. The DON stated after they moved the resident to another room, so the resident could not pee in the sink, they were able to obtain the sample. The DON stated that it took them five days to get the urine, in a hat. The DON stated she thought the staff put the hat in the sink to catch the urine. The DON stated he was a difficult resident, and they did not want to use other measures to collect the urine. The DON stated it was not routine to wait five days to collect a urine sample after it was ordered by a provider.

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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. 43212 Based on observation and interview, the facility did not store, prepare, distribute and serve food in accordance with professional standards for food service safety. Specifically, food items in the walk-in freezer, walk-in refrigerator, and dry food storage room were open to the air and several areas throughout the kitchen had floor tiles that were damaged. Findings included: On 1/6/25 at 1:50 PM, an initial walk-through of the kitchen was conducted. In the walk-in refrigerator, three containers with green lids were observed to be without labels or dates. The tall container contained a thin, creamy liquid. One of the short containers contained a meat patty, and the other short container contained what appeared to be sliced meat. In the walk-in freezer, a box of cinnamon roll dough was found to be open to air. In the dry storage room, a box of bacon bits was open to air. An observation in the dish machine area revealed a large area from the drain on the floor to under the dish machine that had damaged floor covering and the cement was exposed. On 1/8/25 at 11:27 AM, a second walk-through of the kitchen was conducted. In the walk-in freezer, a package of baked biscuits was open to air and a box of cookie dough was open to air. In the dry storage room, a box of dry lasagna noodles was found to be open to air. The floor covering near the three sink area was chipped and the cement was exposed. The floor covering by the walk-in refrigerator was damaged and the cement was exposed. The floor covering by the food preparation area was damaged and the cement was exposed. The floor covering by the bulk storage containers was damaged, and the floor covering under the fire extinguisher was damaged. On 1/9/25 at 10:28 AM, an interview was conducted with the Dietary Manager (DM) who stated when food deliveries were made, food was initially put into the refrigerator, freezer, and dry storage areas. The DM stated after taking temperatures on the milk that was delivered, the boxed items were put away as soon as possible in their respective areas. The DM stated as food items were put away, the staff member should be putting the delivery date on the container. The DM stated when the container was opened, an open date should be put on the container and a use by date also put on the container. The DM stated she also had a reference book that she referred to so the proper expiration date could be documented on the food item. The DM stated if food was not stored correctly, the food quality decreased. The DM stated if she found a food item that was not stored properly, she would get rid of it. The DM stated she tried to conduct in-services with the dietary staff monthly to educate them about what was expected in the kitchen. The DM stated kitchen staff had been requesting repairs to the floor in the kitchen for years. The DM stated she had discussed the floor with the current Administrator. The DM stated the previous Administrator was going to have the floor replaced, but it never got done. The DM stated having rough surfaces on the floor, and open cement was a contamination issue. The DM stated the consultant Registered Dietitian (RD) came to the facility every three months. The DM stated when the RD came to the facility he would conduct a kitchen audit, including sanitation reviews, and would meet with her when finished. The DM stated the RD would email the audit to her and she would correct the necessary items. The DM stated the Administrator and the Assistant Director of Nursing were involved in making sure corrections from the audit were maintained.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47431 Based on interview and record review, the facility did not maintain medical records on each resident that were accurately documented. Specifically, for 2 out of 39 sampled residents, a resident's medical record contained another resident's appeal discussion. Resident identifiers: 246 and 247. Findings included: 1. Resident 246 was admitted to the facility on [DATE] with diagnoses which included paraplegia, chronic obstructive pulmonary disease, spinal stenosis, anxiety disordered, intraspinal abscess, and granuloma. Resident 246's medical record was reviewed on 1/8/25. The review revealed that a medical record for resident 247 labeled KEPRO_5.23.23.pdf was in resident 246's medical record. 2. Resident 247 was admitted to the facility on [DATE] with diagnoses which included polyneuropathy, dementia of brain, spinal stenosis, anxiety disorder, and senile degeneration of the brain. Resident 247's medical record was reviewed on 1/8/25. On 5/23/23, resident 247's medical record had patient identifying information including resident's name and appeal status. On 1/8/25 at 2:10 PM, an interview with the Medical Records (MR) was conducted. The MR stated that she attached the documents to the medical record. The MR stated that she would do regular audits, that included making sure the correct documentation was attached to the correct resident's medical record. The MR stated that if she did find that a resident's documentation was in the wrong medical record, she would remove the document and place it in the correct medical record. The MR stated that as long as she remembered you should never put another resident's name or information in someone else's chart. On 1/8/25 at 2:57 PM, an interview was conducted with the Administrator (Admin). The Admin stated that when documenting in a resident's chart, you could write their name in the chart, but you could not write another resident's name in the chart or have records with another residents identifying information, due to a Health Insurance Portability and Accountability Act.

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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** 50200 Based on observation and interview, the facility did not maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Specifically, for 5 out of 39 sampled residents, a residents feeding tube was not capped when not in use, staff did not wear Personal Protective Equipment (PPE) while providing high contact care for residents on Enhanced Barrier Precautions (EBP), staff were not performing hand hygiene between resident care, and the Hoyer lift was not sanitized between resident use. Resident identifiers: 5, 19, 23, 29, and 348. Findings included: 1. Resident 348 was admitted to the facility on [DATE] with diagnoses which included, but not limited to, encounter for surgical aftercare following surgery on the nervous system, hemiplegia, traumatic subarachnoid hemorrhage with loss of consciousness, gastrostomy status, pressure ulcer of right buttock stage 2, essential hypertension, and alcohol abuse. On 1/6/25 at 2:50 PM, an observation was made of resident 348. Resident 348 had a feeding tube running. Resident 348's room did not have an EBP sign posted. On 1/7/25 at 11:43 AM, an observation was made of resident 348. Resident 348 was observed to be sitting up near the nurses station in a wheelchair. Resident 348 was disconnected from her tube feeding. On 1/7/25 at 11:44 AM, an observation was made of resident 348's feeding tube. Resident 348's feeding tube did not have a cap connected to the end of the line. On 1/8/25 at 8:39 AM, an observation was made of an EBP sign on resident 348's door. On 1/8/25 11:33 AM, an observation was made of Licensed Practical Nurse (LPN) 1 unhooking resident 348 from her tube feed. LPN 1 was not wearing a gown when she provided cares to resident 348. On 1/8/25 11:39 AM, an observation was made of resident 348's feeding tube. Resident 348's feeding tube was not capped on the end of the line. On 1/8/25 at 2:59 PM, an observation was made of resident 348's tube feed not running and the feeding tube was not capped on the end of the line. On 1/7/25 at 03:38 PM, an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated that resident 348 was getting out of bed more often and her tube feedings were paused. The ADON stated resident 348's feeding tube should be cleaned daily with soap and water. The ADON stated that the feeding tube should be capped on the end of the line when not in use. The ADON stated that resident 348 did not have any transmission precautions for a gastrostomy tube. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/8/25 at 8:53 AM, a follow up interview was conducted with the ADON. The ADON stated that she did some research and found out that tube feedings required EBP. The ADON stated that she placed an EBP sign on resident 348's door. On 1/8/25 at 8:55 AM, an interview was conducted with LPN 1. LPN 1 stated that resident 348's feeding tube was cleaned daily with wipes. LPN 1 stated that when resident 348's tube feed needed to be disconnected, she would unhook the tube and flush the tube. LPN 1 stated that she would then hang the tube on a clamp. LPN 1 stated she would only wear gloves when she provided care for resident 348. On 1/8/25 at 9:48 AM, and interview was conducted with the Director of Nursing (DON). The DON stated that a Certified Nursing Assistant (CNA) would alert the nurse when a resident needed to be unhooked from their tube feed. The DON stated that she expected the nursing staff to at least wear gloves when they performed cares for a resident with a tube feed. The DON stated that when disconnected the feeding tube should be clamped and plugs placed on the end of the line. On 1/8/25 at 2:11 PM, an interview was conducted with the Certified Nursing Assistant Coordinator (CNAC). The CNAC stated that she only wore gloves when providing cares for resident 348 and that resident 348 did not have any precautions. 44640 2. On 1/6/25 at 4:14 PM, an observation was made of CNA 4. CNA 4 took the Hoyer lift from resident 5's room to resident 29's room. The Hoyer lift was not cleaned prior to resident use. Resident 29 was placed in a wheelchair using the Hoyer lift. The Hoyer lift was not sanitized after use. No Hand Hygiene (HH) was observed after resident cares. On 1/6/25 at 4:21 PM, an observation was made of CNA 4. CNA 4 took the Hoyer lift from resident 29's room into resident 23's room and stated, Hey [resident name redacted] you ready to get up? The Hoyer lift was not observed to be cleaned prior to use. Resident 23 was placed in a wheelchair from his bed. The Hoyer lift was not sanitized after use. Resident 23 was observed to be on EBP. No HH was observed after resident cares. On 1/6/25 at 4:32 PM, an observation was made of CNA 4. CNA 4 took the Hoyer lift from resident 23's room into resident 19's room. Resident 19 was observed to be lying in bed, CNA 4 closed the door. Upon opening the door, resident 19 was in a wheelchair with the Hoyer sling underneath him. The Hoyer lift was not observed to be sanitized after use. No HH was observed after resident cares. On 1/6/25 at 5:10 PM, an interview was conducted with CNA 4. CNA 4 stated he was the only CNA down the 400 hallway, it was a pretty busy hallway and he was able to complete most of the task by himself. On 1/7/25 at 11:15 AM, an observation was made of CNA 4. CNA 4 took the Hoyer lift into resident 29's room. Resident 29 was observed to by lying in bed. Resident 29 was observed to be brought out of the room in a wheelchair. The Hoyer lift was not sanitized after use. No HH was used after resident cares. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/7/25 at 11:24 AM, an observation was made of CNA 4. CNA 4 took the Hoyer lift into resident 23's room. Resident 23 was observed to by lying in bed prior to the door closing. Resident 23 was observed to be brought out of the room in a wheelchair. The Hoyer lift was not sanitized after being used in resident 23's room. No HH was observed after resident cares. On 1/7/25 at 11:32 AM, an observation was made of CNA 4. CNA 4 took the Hoyer lift into resident 19's room. Resident 19 was observed to by lying in bed prior to the door closing. Resident 19 was observed to be brought out of the room in a wheelchair. The Hoyer lift was not sanitized after being used in resident 19's room. No HH was observed after resident cares. On 1/7/25 at 1:49 PM, an interview was conducted with Nursing Assistant (NA) 1. NA 1 stated the Hoyer lifts were cleaned everyday but she was not sure if it was recorded anywhere. NA 1 stated hand hygiene was done before and after resident cares. On 1/7/25 at 2:31 PM, an interview was conducted with CNA 4. CNA 4 stated that basically, he can use the Hoyer lift on some of these guys by myself. CNA 4 stated he was the only CNA down the 400 hallway so he did it himself without any help. CNA 4 stated the Hoyer lifts were cleaned every night shift, he thought. CNA 4 stated that he did not clean the Hoyer lifts. CNA 4 stated everyone should clean their hands after they help the residents. On 1/7/25 at 2:50 PM, an interview was conducted with the CNAC. The CNAC stated the Hoyer lift was cleaned by housekeeping but she was not sure how often. The CNAC stated the staff were expected to clean their hands with sanitizer or by washing them after each resident's cares. On 1/8/25 at 10:08 AM, an interview was conducted with Housekeeper (HSK) 1. HSK 1 stated they did not have regularly scheduled cleaning that they were in charge of for the Hoyer lifts. HSK 1 stated she would wipe the Hoyer lift down if she saw that it was dirty but she did not clean them routinely. On 1/8/25 at 11:00 AM, an interview was conducted with the Administrator (Admin). The Admin stated the Hoyer lift should be cleaned in between each resident use. The Admin stated the staff should always keep their hands clean. On 1/8/25 at 4:44 PM, an interview was conducted with the DON. The DON stated the staff should be cleaning the Hoyer lifts in between each resident usage and if they were dirty. The DON stated there were some resident rooms with EBP so we need to make sure they were being cleaned, especially if the Hoyer lifts were used in those rooms. The DON stated she encouraged the staff to wash their hands with soap and warm water after caring for the residents but if they could not do that then hand sanitizer should be used. 3. On 1/6/24 at 4:21 PM, an observation was made of CNA 4. CNA 4 entered resident 23's room with the Hoyer lift, CNA 4 did not don PPE. Signage on the door documented the resident was on EBP and Everyone needed to wash hands, wear gloves and a gown when performing high contact resident activities. Which included: dressing, transferring, providing hygiene, device care . Resident 23 was observed to by lying in bed. No PPE was observed outside of the resident's room. CNA 4 was observed to then exit resident 23's room with the resident who was now in a wheelchair. No HH was performed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/7/24 at 11:24 AM, an observation was made of CNA 4. CNA 4 entered resident 23's room with the Hoyer lift, CNA 4 did not don PPE. Resident 23 was observed to by lying in bed. No PPE was observed outside of the resident's room. EBP signage was in place. CNA 4 was observed to then exit resident 23's room after cares with resident 23 now in a wheelchair. No HH was performed.