STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465067	A. Building B. Wing	04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rocky Mountain Care - Clearfield	1481 East 1450 South Clearfield, UT 84015

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43212 Based on observation and interview, for 4 of 55 sampled residents, the facility did not treat each resident with respect and dignity and care for each resident in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. Specifically, a staff member did not have an appropriate response to a resident statement, a resident was not provided a dignified dining experience and call lights were not answered in a timely manner. Resident identifiers: 12, 20, 50, and 259. Findings include: 1. Resident 259 was admitted to the facility initially on 3/13/24, and readmitted on [DATE] with diagnoses that included cellulitis of the right leg, chronic respiratory failure with hypercapnia and hypoxia, heart failure, chronic obstructive pulmonary disease, bipolar disorder, anxiety disorder, and morbid obesity. On 4/9/24 at 9:09 AM, an interview was conducted with resident 259. Resident 259 stated she had not had a shower in two weeks, prior to a hospitalization and then after returning. Resident 259 stated that her skin was dry and itching. The Unit Manager (UM 1) entered the room and resident 259 proceeded to tell UM 1 that she had not showered in two weeks and wanted to take a shower. UM 1 stated, I'm pretty sure that is not true, you have had a shower in the past 2 weeks and that he would have to go check it out. The tone that UM 1 used toward the resident was condescending. Resident 259 stated she would shower herself, and UM 1 stated the resident should not be bearing weight on her leg and needed assistance. Resident 259's medical record was reviewed between 4/8/24 and 4/17/24. An admission Minimum Data Set (MDS) dated [DATE] revealed resident 259 had a Brief Interview for Mental Status (BIMS) of 15, indicating resident 259 was cognitively intact. The MDS assessment also revealed that resident 259 required supervised or touching assistance for bathing. Resident 259's care plan initiated on 3/14/24 included the following problems: (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. Falls; [resident's name removed] has had actual fall(s) secondary to Parkinson's, weakness, Urinary Tract Infection (UTI). The goal stated, [resident's name removed] will have no untreated injuries r/t [related to] falls through next review. Approaches included, Keep room free of clutter and tripping hazards; Encourage the use of the call light. b. Activities of Daily Living [ADL's] Functional Status/Rehabilitation Potential; [resident's name removed] is at risk for altered ADL function secondary to Parkinson's, weakness, UTI. The goal stated, [resident's name removed] will not have any unaddressed complications secondary to decreased ADL self-performance through next review. Approaches included, Assist in completing ADL tasks each day; Provide dignity and respect and encourage independence .Encourage use of call lights when ADL assistance is needed. On 4/17/24 at 12:50 PM, an interview was conducted with the Director of Nursing (DON). The DON stated if a resident stated they had not showered, her expectation of the staff member would be to try to resolve the concern. The DON stated she could not imagine a staff member saying something like that to a resident. The DON asked who the staff member was and stated she did not like that at all. The DON stated she would look into the concern. 2. Resident 20 was admitted to the facility on [DATE] with diagnoses that included [NAME] Sachs disease, anxiety disorder, seizures, dysphagia, lack of coordination, moderate and protein-calorie malnutrition. Resident 20's medical record was reviewed between 4/8/24 and 4/17/24. An annual MDS assessment dated [DATE] revealed that resident 20 required substantial/maximal assistance with upper and lower body dressing. The assessment also revealed that resident 20 required moderate assistance with eating. A physician order dated 2/10/23 revealed, [resident's name removed] uses weighted utensils and may need increased assistance with meals. Resident 20's care plan initiated on 7/29/2020 included: a. Nutrition Status; [resident's name removed] is at risk for nutritional deficits secondary to hx [history] of wt [weight] loss, and decreased dexterity of limbs. She has PO [by mouth] intake, and artificial nutrition via peg tube. The goal was [resident's name removed] weight will remain stable, through next review. Approaches included, Bolus enteral feeds as allowed; Diet/Supp [supplement] as ordered. Peg tube in place .[resident's name removed] has a non-spill cup available for use and foods as finger-style food per preferences. b. Cognitive Loss; [resident's name removed] has impaired decision making r/t [NAME] Sachs disease. The goal was [resident's name removed] will have positive experiences in daily routine without overly demanding tasks and without becoming overly stressed. Approaches included, .Provide cues and supervision for ADLs PRN [as needed]. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/10/24 at 9:00 AM, resident 20 was observed to be in a wheelchair sitting by the nurses station. A bedside table was in front of resident 20 with a breakfast tray containing 2 boiled eggs, an orange slice, and another breakfast item that appeared to be a small breakfast burrito. Resident 20 picked up one of the boiled eggs and held it in her hand. With her other hand, resident 20 pushed the orange slice onto the bedside table. The Certified Nursing Assistant Coordinator (CNAC) wheeled resident 20 down to the dining room, where breakfast was being served, and placed her at a table by herself. UM 1, who was passing drinks in the dining room, approached resident 20 and asked if she would like some orange juice. Resident 20 nodded in the affirmative and UM 1 poured 1/2 of a small cup of orange juice and put it on the table. Resident 20 reached for the cup, putting 3 fingers into the cup, and attempted to drink from it. Resident 20 could not properly tip the glass to drink from it. UM 1 took the cup from resident 20's hand and put it on the table and walked away to continue pouring beverages to other residents. Resident 20 was observed to put her fingers around the cup, pick it up, and consume the entire cup of juice. Resident 20 continued to hold the cup and move it around on her lap. UM 1 returned to resident 20's table with some napkins and sat down at the table with resident 20, then got back up again. At 9:06 AM, UM 1 returned to the table with a regular fork. UM 1 put the fork into resident 20's hand. UM 1 asked resident 20 if she liked her eggs sunny-side up. UM 1 then got up from the table again and began bussing tables from the resident's who had finished their meals and left the room. Resident 20 dropped her cup onto the floor. A staff member brought a clothing protector to resident 20 and placed it on her. UM 1 brought an open Styrofoam container to resident 20's table and placed it in front of her, removing the plate further away. UM 1 sat down again next to resident 20. UM 1 asked resident 20 if she would like for him to dice or cut up her food. UM 1 attempted to take the fork out of resident 20's hand, but she held on tight to it. Resident 20 began to push around the Styrofoam container on the table with her free hand. UM 1 picked up a small cup containing cut up fruit and placed it in front of resident 20. Resident 20 picked up the fruit cup and placed it on top of her other hand a few times, then placed her fingers into the cup. Resident 20 was unable to properly hold the fruit cup and eventually dumped the contents on to the floor. UM 1 attempted to feed resident 20 a fork with what appeared to be scrambled eggs on it. Resident 20 did not open her mouth, so UM 1 put the fork down and closed the Styrofoam container. UM 1 then got up and left the table. UM 1 returned to the table with a wet cloth and put the cloth on the table. UM 1 left the table and began bussing tables again. At 9:18 AM, UM 1 put another 1/2 cup of orange juice on resident 20's table. UM 1 then picked up his mobile phone and adjusted the volume of the music that was being played in the dining room. At 9:20 AM, resident 20 was pushing the Styrofoam container around on the table and knocked the cup of orange juice into her lap, getting her dress wet, and spilling the juice onto the table and the floor. UM 1 walked over to the table where resident 20 was sitting, and picked the plate, the Styrofoam container, the fork and tray and returned them to the kitchen. Resident 20 continued to hold the cup in her hand. At 9:28 AM, UM 1 returned to the table and began wiping resident 20's hands with the cloth he had put on the table earlier. UM 1 attempted to give resident 20 her toy back, but then began to play with it himself, bending it into different shapes. At 9:31 AM, resident 20 started to slide out of her chair. UM 1 got up from the table and prevented resident 20 from sliding to the floor. Resident 20 then pulled her legs up to her chest and tried to sit in the chair with her legs up against her. UM 1 repositioned resident 20 into the wheelchair, took off the clothing protector and began to wheel her down the hallway. A staff member walking by asked resident 20 what happened to her (referring to the large wet spot on her dress). UM 1 responded [Note: it is unknown what UM 1 said in the response], the staff members began to laugh. UM 1 continued down the hallway with resident 20. At 9:35 AM, UM 1 wheeled resident 20 into her room and pulled the curtain. At 9:40 AM, resident 20 was observed to be laying on her bed in the dress that was wet, and her legs were partially covered with a sheet. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/10/24 at 10:08 AM, resident 20 was observed to be in her bed with the same dress on that she was wearing at breakfast time. On 4/10/24 at 10:33 AM, resident 20 was observed to be in her bed with the same dress on. On 4/10/24 at 10:34, a continuous observation was started. On 4/10/24 at 12:29 PM, Certified Nursing Assistant (CNA) 1 entered resident 20's room. CNA 1 checked on resident 20's roommate. On 4/10/24 at 12:31 PM, CNA 1 checked on resident 20. Resident 20 was positioned perpendicular to the bed, was curled up with her dress scrunched up. Resident 20's head was close to the edge of the bed and her feet were on the opposite side of the bed. Resident 20 was observed to have taken the pillow case off of the pillow. CNA 1 repositioned resident 20 and checked her brief. CNA 1 adjusted and straightened resident 20's clothing. On 4/10/24 at 12:40 PM, an interview was conducted with CNA 1. CNA 1 stated resident 20 likes to wiggle and move while on her bed. CNA 1 stated they put a fall mat next to her bed and keep the bed next to the wall and close to the floor. CNA 1 stated she tried to go in and reposition resident 20 as needed. On 4/10/24 at 12:46 AM, an observation was made of resident 20 who was still in the position on the bed as before. On 4/10/24 at 12:56, the continuous observation was discontinued. On 4/17/24 at 12:24 PM, an interview was conducted with CNA 1. CNA 1 stated resident 20 was dependent for all Activities of Daily Living (ADLs), and could not do anything on her own. CNA 1 stated resident 20 was moderately able to communicate her needs. CNA 1 stated resident 20 could answer yes or no questions. CNA 1 stated resident 20 would rip her brief off if she was in need of a brief change. CNA 1 stated resident 20 did require assistance for eating, but she mostly refused food. CNA 1 stated at meal time once the tray is placed down, staff would ask if she wanted a bite of food. CNA 1 stated once the utensil got close to resident 20's mouth, she would turn her head away and refuse to eat. CNA 1 stated resident 20 would eat bananas and some yogurt, but mostly she drank the MedPass the nurses provided her. CNA 1 stated staff were required to hold the cup for resident 20 because if she held it herself, she would pour it out. 45470 3. Resident 12 was admitted to the facility on [DATE] with diagnoses which included hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage, paroxysmal atrial fibrillation, lack of coordination, hypothyroidism, urinary tract infection, protein-calorie malnutrition, Alzheimer's disease, hypokalemia, major depressive disorder, and essential hypertension. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/16/24 at 1:04 PM an observation was made of the call lights. The call light for room [ROOM NUMBER] was turned on at 1:04 PM. At 1:25 PM, the call light was still on, and an interview of resident 12 was conducted. Resident 12 stated that she was waiting for someone to come in and help her find her toothbrush and toothpaste. At 1:37 PM a staff member answered the call light. The call light was on for a total of 33 minutes. 4. Resident 50 was admitted to the facility on [DATE] with diagnoses which included schizoaffective disorder, chronic kidney disease, morbid obesity, abnormalities of gait and mobility, lack of coordination, anxiety disorder, protein-calorie malnutrition, dementia, hyperlipidemia, unspecified convulsions, insomnia, need for assistance with personal care, and hypertension. On 4/16/24 at 1:15 PM an observation was made of the call lights. The call light for room [ROOM NUMBER] was turned on at 1:15 PM. At 1:27 PM, an interview with resident 50 was conducted. Resident 50 stated that he was wanting someone to bring him some food because he was hungry. At 1:54 a staff member answered the call light. The call light was on for a total of 39 minutes.

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46232 Based on interview and record review it was determined that the facility did not provide written notice, including the reason for the change, before the resident's room or roommate in the facility was changed. Specifically, for 2 out of 55 sampled residents, residents did not receive written notice prior to the room change. Resident identifiers: 166 and 259. Findings Included: 1. Resident 166 was initially admitted to the facility on [DATE] and readmit to the facility on [DATE] with the diagnosis of Periprosthetic fracture around internal prosthetic right hip joint, subsequent encounter, Acute kidney failure, Neoplasm of unspecified behavior of bladder, Fall on same level from slipping, tripping and stumbling without subsequent striking against object, subsequent encounter, Human immunodeficiency virus [HIV] disease. Resident 166's medical records were reviewed on 4/15/24. Resident 166's medical record was reviewed, and it documented resident 166 had been moved from room [ROOM NUMBER] A to room [ROOM NUMBER] B on 11/21/23. It should be noted that written notification informing resident 166 of a room change was not located in the medical record. On 4/16/24 at 9:43 AM, an interview was conducted with Certified Nursing Assistant (CNA) 10. The CNA 10 stated they did not believe residents needed to sign a consent when their room was changed. The CNA 10 stated residents were notified of the room change with a 24 hour notice. The CNA 10 stated residents were given the change of viewing their new room before being moved. On 4/16/24 at 10:35 AM, an interview was conducted with the Social Service Worker (SSW). The SSW stated both family and residents were given verbal notification of room changes prior to changing rooms. The SSW stated a room change notification was documented in the electronic medical record. The SSW stated the formed documented that family had been notified of the room change and that the resident was okay with the change. On 4/16/24 at 12:04 PM, an interview was conducted with the Unit Manager (UM) 2. The UM 2 stated the social worker was the one to notify residents of a room change. The UM 2 stated when a resident was issued a room change, they were in charge of making sure the new room was ready for the resident, moving the resident belongings and notifying the dietary department. The UM 2 stated they reminded the nurses to write a progress note when residents were moved. On 4/16/24 at 1:31 PM, an interview was conducted with the Resident Advocate (RA). The RA stated a resident was given a 24 hour notice prior to a room change. The RA stated family was only notified if a resident was not alert and orient. The RA stated the room change notification should be documented with every room change. The RA stated there was no written notification given to residents about room changes; only verbal notifications were given. (continued on next page)

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/16/24 at 1:40 PM, an interview was conducted with the Administrator (ADM). The ADM stated residents were only given verbal notifications for room changes. The ADM stated they were recently informed residents needed written notification and they were in the process of fixing the notification process. 43212 2. Resident 259 was admitted to the facility initially on 3/13/24, and readmitted on [DATE] with diagnoses that included cellulitis of the right leg, encephalopathy, chronic respiratory failure with hypercapnia and hypoxia, heart failure, chronic obstructive pulmonary disease, bipolar disorder, anxiety disorder, and morbid obesity. Resident 259's medical records were reviewed between 4/8/24 and 4/17/24. On 4/9/24 at 9:09 AM, resident 259 was interviewed in her room [ROOM NUMBER]-A. On 4/16/24, a review of resident 259's medical record revealed that the resident had been moved to room [ROOM NUMBER]-A. It should be noted that written documentation informing resident 259 of a room change was not found in the resident's medical record. On 4/17/24 at 10:55 AM, an interview was conducted with Licensed Practical Nurse (LPN 1). LPN 1 stated she did not know much about resident 259 and did not know why she had been moved from the 300 hallway to the 700 hallway.

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents have reasonable access to and privacy in their use of communication methods. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38031 Based on interview and record review it was determined, for 1 of 55 sampled residents, that the facility did not ensure that the resident had the right to send and receive mail including the right to privacy of such communications. Specifically, a resident received two letters via the postal service and facility staff opened the letters. Resident identifier: 26. Findings included: Resident 26 was admitted to the facility on [DATE] with diagnoses which consisted of cellulitis, orthopedic aftercare following surgical amputation, osteomyelitis, chronic kidney disease, acquired absence of right leg above knee, hyperlipidemia, hypertension, atrial fibrillation, peripheral vascular disease, gastroparesis, and type 1 diabetes mellitus. On 4/08/24 at 12:56 PM, an interview was conducted with resident 26. Resident 26 stated that the lady in the front office was opening his mail and it happened two times. Resident 26 stated that the mail was part of his divorce paperwork and dealt with his 401K. Resident 26 stated that he had to request the same information again when he did not receive the first letter. Resident 26 stated that the staff member had said it was an accident and resident 26 replied that it happened twice and that was not an accident. Review of the grievance logs from November 2023 through April 2024 revealed a concern log for resident 26 on 3/27/24. The department involved was identified as Administration. The concern form documented the incident as Does NOT want his mail opened by staff. The form further documented that the resident was missing important mail that contained legal documents. The form documented that the actions taken to prevent recurrence was that staff was educated. The form was signed by the Administrator (ADM) on 3/28/24. On 4/15/24 at 10:06 AM, an interview was conducted with Resident Advocate (RA) 1. RA 1 stated that anyone could fill out a resident grievance form on behalf of the resident. RA 1 stated that once the grievance form was filled out it would go to the department head to resolve it. RA 1 stated that ultimately all grievance forms went to the ADM. RA 1 stated that the activities department was responsible for resident mail. RA 1 stated that there had never been any time that she received mail or packages for resident 26. On 4/15/24 at 10:17 AM, an interview was conducted with the Activities Director (AD). The AD stated that they delivered the resident's mail. The AD stated that the mail was delivered to the reception desk, and they picked it up daily and delivered it to the residents. The AD stated that if a resident was not available when they attempted to deliver the mail, they would store it in the resident mail bin until they were able to deliver the items. The AD stated that she does not recall any mail being opened for resident 26. The AD stated that the resident would have to sign permission in the business office to allow any mail to be opened for them. The AD stated sometimes with Medicaid documents the residents would sign over permission for that mail to be opened for them. The AD stated that they were not supposed to open any mail unless directed by the resident. (continued on next page)

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/15/24 at 12:29 PM, an interview was conducted with the ADM. The ADM stated that she took over the grievance process in December 2023, but prior to that a licensed Administrator assistant handled them. The ADM stated that issues with resident mail would be investigated by herself. The ADM stated that the Business Office Manager and receptionist dispersed the mail to the activities department staff for delivery to the residents. The ADM stated that if a resident gave permission for the facility staff to open mail, then staff could do that. Otherwise, staff should not open mail without the resident or Power of Attorney (POA) consent. The ADM stated that resident 26 had a letter that was opened by the Business Office Manager Assistant (BOMA). The ADM stated that the letter said in care of Rocky Mountain Care (RMC) Clearfield and then it had resident 26's name underneath. The ADM stated that the letter was delivered to resident 26 but not immediately. The ADM stated that the BOMA said she opened the letter because it was in care of the facility, and she had been helping resident 26 with his Medicaid paperwork and thought it was that. The ADM stated that once she determined what it was, the Medicaid paperwork was scanned into the resident file. The ADM stated that resident 26 was frustrated with the situation and the ADM responded that they were doing education with the staff. The ADM stated that resident 26 told her that it was divorce paperwork and it was regarding money from Medicaid for his divorce. The ADM stated that the BOMA knew there was Medicaid paperwork coming because she had talked to resident 26 about it, so she scanned the letter over to the Medicaid case worker. The ADM stated that the BOMA did not realize that it was related to a divorce until the resident came and asked for it. The ADM stated that the resident should still have been informed of its delivery because it was his letter. The ADM stated that as far as she was aware the resident and the BOMA had an agreement for her to open the mail because she had been helping him in the past. The ADM stated that she was not sure what the process was for the BOMA to open resident mail, even if a resident gave consent. The ADM stated that she was not aware of two letters being opened and resident 26 having to request a second letter. (continued on next page)

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/15/24 at 12:44 PM, an interview was conducted with the BOMA. The BOMA stated that resident 26 received something in the mail and it said RMC as well and she knew that she needed it for Medicaid. The BOMA stated that she scanned the letter and then it sat in a file at her desk for maybe 5 days or so until resident 26 asked about it. The BOMA stated that she knew resident 26 was looking for a piece of mail regarding his divorce and he was getting some of his wife's 401K. The BOMA stated that when resident 26 came to ask for it that was when she gave the letter to him. The BOMA stated that she read the documents before she scanned them into her computer. The BOMA stated that she had a hard time finding resident 26 to deliver the letter and then spaced it off. The BOMA stated that she scanned the letter and sent it to the Medicaid representative for the facility to determine what to do with it. The BOMA stated that the letter was specifically for resident 26 and his records. The BOMA stated that she apologized 100 times to resident 26. The BOMA stated that they revised the mail opening process, and she would not open any of resident 26's mail again. The BOMA stated that she was told if the package or letter said RMC she could open it, but she did not have any specific resident consent to open them. The BOMA stated that now they have a resident consent form, and if it says RMC they were to obtain a verbal consent to open the letter. The BOMA stated that the documents were not scanned into the resident medical records but were contained in her email. The BOMA stated that she did not think it was pertinent to be in the resident's medical records, because it was for money that needed to be spent down so Medicaid did not close his case. The BOMA confirmed that she received a second letter for resident 26 and she opened it also. The BOMA stated that she gave resident 26 the second letter the same day she received it. The BOMA stated that resident 26 had requested a second copy because he had not received the first letter. The BOMA stated that the error was not talking to resident 26 first. It was just an error on my part. The BOMA stated that usually they put resident financial documents into the resident medical records, but she did not think this was pertinent to resident 26's chart. The BOMA stated that resident 26 had $7000 to spend down for Medicaid and usually the resident had a month to spend down. The BOMA stated that resident 26 thought he was losing his Medicaid, and this was a time sensitive issue. The BOMA stated that he had to complete a couple more steps before he had possession of his money. The BOMA stated that resident 26 did not want help with his Medicaid finances now and he had his attorneys working on it.

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38031 Based on interview and record review it was determined, for 2 of 55 sampled residents, that the facility did not ensure that the resident's right to formulate an advanced directive, including implementing the advanced directive per the facility policy was completed. Specifically, two residents' electronic medical records (EMR) documented that the residents' code status was Do Not Resuscitate (DNR) when the resident's Provider Order for Life-Sustaining Treatment (POLST) form documented full treatment. Resident identifiers: 19 and 92. Findings included: 1. Resident 92 was admitted to the facility on [DATE] with diagnoses which consisted of osteoarthritis, schizoaffective disorder, depression, anxiety disorder, hypertension, and chronic obstructive pulmonary disease. On 4/8/24, resident 92's medical records were reviewed. Resident 92's EMR dashboard documented DNR, and that the resident was a hospice patient. Resident 92's physician orders documented Resident POLST Status=FULL CODE. On 11/10/23, resident 92's POLST form documented Full Treatment: Prolonging life by all medically effective means. Medical care may include endotracheal intubation, mechanical ventilation, defibrillation/cardioversion, vasopressors, and any other life-sustaining care that is required. The form indicated that Cardiopulmonary resuscitation was to be attempted. The form declined the use of artificial nutrition. Review of the facility policy on Communication of Code Status documented, It is the policy of this facility to adhere to residents' rights to formulate advance directives. In accordance to these rights, this facility will implement procedures to communicate a resident's code status to those individuals who need to know this information. The policy further stated that the nurse who notated the physician order was responsible for documenting the directions in all the relevant sections of the medical record. The policy was last revised in June 2023. On 4/17/24 at 9:25 AM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated that the residents code status was located on the dashboard in the EMR and that resident 92 was DNR. On 4/17/24 at 10:04 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that there was a binder at each nurse's station that contained the resident POLST forms. The DON stated that all staff should know to look there for the resident code status. The DON stated that the code status was also in a general order in each resident chart, and it displayed on the banner at the top of the EMR. The DON confirmed that resident 92's banner documented DNR and the POLST documented full treatment. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/17/24 at 10:57 AM, a follow-up interview was conducted with the DON. The DON stated that she contacted resident 92's hospice provider and confirmed that the resident's code status was still full treatment. The DON stated she was not sure why the banner showed DNR. The DON stated that the potential risk was that chest compressions would be delayed or not provided at all. The DON stated that she would have to conduct an audit to make sure there were no other inaccuracies. 45470 2. Resident 19 was admitted to the facility on [DATE] with diagnoses which included Alzheimer's disease, type 2 diabetes mellitus, major depressive disorder, lack of coordination, abnormalities of gait and mobility, protein-calorie malnutrition, dysfunction of bladder, retention of urine, muscle weakness, glaucoma, essential hypertension, anxiety disorder, bipolar disorder, hyperlipidemia, insomnia, dementia, long term use of aspirin, and chronic obstructive pulmonary disease. Resident 19's medical records were reviewed. A document titled Observation Detail List Report dated 3/25/24 documented resident 19's Brief Interview for Mental Status (BIMS) score as a 3, which indicated severe cognitive impairment. On 4/9/24 Resident 19's advanced directives were reviewed. Resident 19's advanced directives were documented on the Face Sheet as Do Not Resuscitate. A Progress Note from 3/01/24 at 2:11 PM documented [Resident 19] exhibits facial drooping, drooling, unable to speak, pupils unresponsive, and pale. RN [registered nurse] unable to get ahold of provider nor family, nor DON [Director of Nursing], nor ADON [Assistant Director of Nursing]. RN called 911 to d/c [discharge] to hospital. POLST form states FULL code, EMAR [Electronic Medication Administration Record] states DNR. After about 10 minutes [resident 19's] signs subsided. Provider arrived and again called family. Unable to reach family. Provider orders [resident 19] to stay. A Progress Note from 3/1/24 at 7:06 PM documented, RN was able to contact Hospice who were then able to provide ADON a copy of her most recent POLST form. RN placed POLST form in binder. After leaving shift, RN realized no copy was submitted to medical records for scanning into the system. RN placed nursing order to make a copy of form to submit to Medical records box this evening.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47432 Based on observation and interview, it was determined that, for 3 of 55 sampled residents, that the facility did not provide a safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. Specifically, there were multiple instances where the facility was dirty and not homelike. Resident identifiers: 20, 80, and 259. Findings Include: 1. Resident 259 was admitted to the facility initially on 3/13/24, and readmitted on [DATE] with diagnoses that included cellulitis of the right leg, encephalopathy, chronic respiratory failure with hypercapnia and hypoxia, heart failure, chronic obstructive pulmonary disease, bipolar disorder, anxiety disorder, and morbid obesity. On 4/9/24 at 9:20 AM, an interview was conducted with resident 259. Resident 259 stated she went out to smoke twice daily. Resident 259 stated in the smoking area, the cigarette ashtray was broken with cigarette butts overflowing with cigarette butts all over the ground. On 4/8/24 at 1:42 PM, an observation was made of the facility courtyard. There were two cigarette ashtray towers that were full of cigarette butts and the butts were overflowing onto the ground. The two garbage cans in the courtyard were full of trash and the trash was spilling onto the ground. There was also a 6 foot long piece of a metal rain gutter strewn in the middle of the cement walkways in the courtyard. On 4/10/24 at 9:15 AM, an additional observation was made of the facility courtyard. The cigarette ashtray towers were still full of cigarette butts and the two garbage cans were still full of trash. The piece of rain gutter that had been on the ground was now laying in one of the tulip beds in the courtyard. On 4/17/24 at 12:30 PM, an observation was made of the smoking area. The cigarette ashtray tower was not secured on the base and there were several cigarette butts surrounding the ashtray tower. On 4/17/24 at 2:15 PM, an interview was conducted with Housekeeper (HK) 1. HK 1 stated that she has never had to clean the courtyard. HK 1 stated that she was unsure whether or not housekeeping is responsible for cleaning the courtyard. HK 1 stated that resident rooms should be cleaned every day. On 4/17/24 at 2:20 PM, an interview was conducted with HK 2. HK 2 stated that housekeeping is not responsible for the courtyard. On 4/17/24 at 2:23 PM, an interview was conducted with HK 3. HK 3 stated that maintenance is responsible for the courtyard. HK 3 stated that resident rooms should be cleaned daily. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/17/24 at 2:40 PM, an interview was conducted with the Assistant Director of Maintenance (ADOM). The ADOM stated that maintenance is responsible for cleaning out the cigarette butt towers and maintaining the courtyard. The ADOM stated that typically the towers are cleaned once a week, but that due to the winter weather the cleaning has not occurred. 43212 2. Resident 20 was admitted to the facility on [DATE] with diagnoses that included [NAME] Sachs disease, pseudobulbar affect, anxiety disorder, dysphagia, abnormality of gait and mobility, lack of coordination, and bipolar disorder. Resident 20's medical records were reviewed between 4/8/24 and 4/17/24. On 4/10/24 at 8:55 AM, an observation was made of resident 20 sitting in her wheelchair across from the 300-400 hallway nurses station. The staff had placed a bedside table across her lap while the breakfast trays were being passed. While resident 20 sat there, she was observed to be pulling at the plastic covering to the bedside table that was cracked and broken in multiple places on the table. The plastic was rigid and jagged with sharp edges. On 4/17/24 at 11:56 PM, an observation was made that the damaged bedside table was still at the 300-400 hallway nurses station available for use. On 4/17/24 at 12:42 PM, an observation was made of a second bedside table in the hallway outside the door of the resident advocate. The table was damaged with the plastic covering being cracked and broken in several places on the table. 45470 3. Resident 80 was admitted to the facility on [DATE] with diagnoses which included encounter for other orthopedic aftercare, unspecified fracture of upper end of right tibia, dementia, unspecified fracture of upper end of left tibia, unspecified fracture of shaft of right fibula, unspecified fracture of shaft of left fibula, chronic obstructive pulmonary disease, chronic respiratory failure, type 2 diabetes mellitus, weakness, abnormalities of gait and mobility, depression, and insomnia. On 4/8/24 at 10:48 AM an interview with resident 80 was conducted. Resident 80 stated that he had a fall at the facility when he was transferring from the bed to the chair, and his bed had slipped out from underneath him. Resident 80 stated that he bed locks were not locked. Resident 80 stated that he had smashed his finger. An observation of resident 80's right ring finger was made. Resident 80's right ring finger was missing the right half of the nail. The skin appeared to be healed. Resident 80 stated that after he fell and smashed his finger, there was no bleeding, but part of the nail turned black and fell off. Resident 80's medical records were reviewed. An incident report with an Event Date of 3/8/24 documented, Residents bed was not locked, bed rolled while he was sitting on edge of bed and he fell . The resident description of the fall was documented as, sitting on side of bed, wheels not locked, bed rolled and I fell on my bottom. The incident report documented that there were no injuries noted. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Progress Note from 3/8/23 at 10:24 PM documented, This LN [Licensed Nurse] was doing med pass when I was informed by CNA that resident was on the floor, on arrival in residents room I observed him lying on floor in supine position with a pillow under his head, I assessed him for injuries, no apparent injury noted, he was A/O [alert and oriented] x 4, able to tell this writer what happened, he stated, I was sitting up on bed with my feet on floor, CNA was assisting me, she observed me fall, my bed doesn't lock and it rolled causing me to fall and I did not hit my head, just fell on my bottom. CNA [name redacted] stated the same, I saw him fall, he did not hit his head, he fell on his bottom, I helped him lie down and put pillow under his head for comfort. ROM [range of motion] was at baseline, staff assisted resident up off the floor and back into bed . A Progress Note from 3/9/24 at 2:46 PM stated, Patient encouraged to use call light for transferring assistance this shift. Patient tolerates well and is observed using call light and waiting for staff to assist him. On 4/17/24 at 2:38 PM an interview with the Director of Nursing (DON) was conducted. The DON stated that staff should be checking that the breaks are working every time prior to transferring a resident in or out of their bed. The DON stated that all of the beds have wheels and have breaks, and that the breaks should always be locked. The DON stated that the locking mechanism was broken on resident 80's bed when he fell . The DON stated that nobody had noticed that the locking mechanism was broken until resident 80 had fallen. The DON stated that maintenance immediately fixed the breaks on resident 80's bed. The DON stated that there were no routine checks completed by maintenance to ensure that the beds were safe. On 4/17/24 at 2:46 PM an interview with the Assistant Director of Maintenance (ADOM) was conducted. The ADOM stated that there were no routine checks on residents' beds. The ADOM stated that he could not recall if he had fixed resident 80's bed. The ADOM stated that maintenance only looked at the beds if there was a work order placed. 4. On 4/8/24 an observation of room [ROOM NUMBER] was made. A puddle of liquid was observed on the floor next to a resident's bed. A blanket, condiment packets, and tissues were observed on the floor in the room. The floor underneath the bed appeared to be dusty and had pieces of trash on it. 5. On 4/8/24 at 1:09 PM an observation was made of room [ROOM NUMBER]. A disposable nursing glove and a washcloth was observed to be on the ground. The floor had crumbs and debris on it. 6. On 4/9/24 at 8:51 AM an observation was made of room [ROOM NUMBER]. The floor around the bed had trash and crumbs on it.

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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** 45490 Based on interview and record review, the facility failed to thoroughly investigate an allegation of abuse for 3 of 55 sample residents. Specifically, a resident stated they had been abused and not follow up investigation was documented, interviews were not documented with all staff members involved in the investigation, and a through investigation was not conducted. Resident identifier: 79, 82 and 86. Findings include: 1. Resident 79 was admitted to the facility on [DATE] with diagnoses which included acute respiratory failure with hypoxia, critical illness myopathy, tracheostomy status and anxiety disorder. Resident 79's medical record was reviewed from 4/8/24 through 4/17/24. Resident 79 quarterly Minimum Data Set (MDS) assessment dated [DATE] documented that the resident's Brief Interview for Mental Status (BIMS) score was 14 indicating cognition is intact. A form titled exhibit 358 revealed an employee reported that resident 79 had been unchanged for sometime by CNA 6, who knew that the resident was soiled. The employee also reported CNA 6 used vulgar language while speaking with resident 79. The document revealed, resident 79 doesn't feel unsafe in the facility. A form titled exhibit 359 revealed a follow up interview was completed with the witness. The witness was asked what vulgar language [CNA 6] used toward the resident . When asked why [resident 79] was left wet, she stated that her and [CNA 6] were performing a bed bath for a different resident that lasted 1.5 hours then made their way back to [resident 79] to change her. The conclusion documented based on the inconsistency of the witness interviews, resident interviews, resident chart reviews, and staff interviews the allegation could not be verified or refuted. A review of the facilities internal investigation revealed an interview was conducted with resident 79. Resident 79 was asked the following questions: a. Have you every felt abused, neglected, or exploited at this facility? Resident 79 responded, Yes, ignored, not listened too, put off multiple. b. Do you know who to report abuse, neglect, exploitation, or theft to in this facility? Resident 79 responded, no, a written note stated, I educated on who to report too. Resident nodded 'yes' in understanding. c. Has anyone every inappropriately touched you at this facility? Resident 79 responded yes. If yes did you report it? Resident 79 responded no. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	If they did not report it, what happened? Get more information/statement Resident 79 respond I'm on my own. d. Do you feel safe at this facility? Resident 79 respond No. e. Do you feel like you are getting good care at this facility? Resident 79 responded No. [It should be noted that the internal investigation documentation did not include follow up investigations regarding resident 79's responses of abuse, inappropriate touch, and feeling unsafe.] On 4/11/24 at 1:56 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that resident 79 is nonverbal and uses a white board to communicate. When resident 79 was asked if she had been abused and answered yes. The DON stated that after that question was asked she got the Administrator (ADM). The DON stated resident 79 did not say any names. The DON stated that when the ADM asked resident 79 about it, resident 79 would touch her trach [trachea] and motion head no and touch her trach. On 4/11/24 at 2:22 PM, an interview was conducted with the Administrator (ADM). The ADM stated that resident 79 uses her whiteboard to communicate. ADM stated when she asked about inappropriate touch, and what that meant to to her, resident 79 kept pointing to her trach and saying 'I'm on my owe, I'm left here on my own.' We were unable to substantiate. 2. Resident 82 was admitted to the facility on [DATE] with diagnoses which included chronic respiratory failure with hypoxia, personal history of traumatic brain injury, zoster encephalitis, and adjustment disorder with mixed anxiety and depressed mood. A form titled exhibit 358 revealed resident 82 was receiving a brief change by an employee and was rolled into the wall while providing cares. Resident 82 had a small scratch to left wrist. A form titled exhibit 359 revealed an employee alleged that during a brief change CNA 6 hit resident 82's knees against the wall during a brief change. When witness was asked about brief change on 82 and whether the bed was moved away from the wall, she stated that it was. They moved bed away from wall to ensure that resident didn't bump into wall during brief change. The employee states that while CNA 6 was checking the residents brief at a different time, his knees did bump into the wall. Resident 82 was not rolled into the wall during cares. An interview was conducted with CNA 6 stated that she did change resident 82. During the process she pulled his bed away from the wall to ensure that he wouldn't hit it. She pulled it so far from the was that she accidentally unplugged the bed. She completed the brief change with no incidents. In a section titled summary of interviews with staff responsible oversight and supervision of the alleged perpetrator if staff or resident documented Nurse manager and charge nurses that are responsible for oversight of the alleged perpetrator state that they have never had any complaints about [CNA 6] as a CNA. They state that she is thorough when working and completes her job. The conclusion documented, Based on the inconsistency of the witness interviews, resident interviews, resident chart reviews, and staff interviews the allegation could not be verified or refuted. [It should be noted that the facilities internal investigation was reviewed. The investigation did not contain the documented interviews conducted with the nurse manager and charge nurse.] (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/11/24 at 2:22 PM, an interview was conducted with the ADM. The ADM stated that if there were interviews conducted during an investigation, they would be located with the investigation and that she did not usually keep documents in any other place. The ADM stated that for the investigation she interviewed CNA 6, CNA 7 and that she did talk to a nurse and nurse manager. The ADM stated that she did not type up the interview conducted with the nurse and nurse manager. 45470 3. Resident 86 was admitted to the facility on [DATE] with diagnoses which included traumatic subdural hemorrhage, pulmonary embolism, type 2 diabetes mellitus, protein-calorie malnutrition, essential hypertension, weakness, lack of coordination, abnormalities of gait and mobility, dysphagia, insomnia, anxiety disorder, depression, anemia, and chronic pancreatitis. Resident 86's electronic medical record was reviewed. A Progress Note from 3/31/24 at 1:18 PM stated, One of the residents came up to this nurse and said that a patient [sic] fell . Went into the room where is implied was someone on the floor. Found this resident layin [sic] on the floor. One of his shoes was half way on and half way off. Assessed the patient and asked him where his pain was. He said that it was in his back. He did not complain of any pain when touching him to see where the pain was. The aide and this nurse assisted getting him back into his wheelchair. He was asked to do some ROM [Range of Motion] and he then complained that his left shoulder was hurting him. He had ice applied. MD [Medical Director] was notified at 1945 [2:45 PM] and On call management was notified. This nurse was informed to monitor the patient. Family representative was notified late by text message after some monitoring had been done. The next nurse will continue to monitor. A Progress Note from 4/1/24 at 12:22 PM documented, Distal clavicle Minimally displaced fracture and arthritic changes present. Provider notified. Orders from provider to get an ortho consult and apply a sling to patient. Since pt [patient] cont [continues] to c/o [complain of] pain to L [left] shoulder and at this time shows limited ROM to shoulder (states im sore) - admin [administer] prn [as needed] Tylenol with positive effects and also repositioned pt and redirected as pt is baseline confused and oriented to name only. At this time pt is resting comfortably in bed, eyelods [sic] closed, resp [respiratory] rate even and unlabored, [NAME] [sic] aroused . A Progress Note from 4/7/24 at 5:25 PM documented, .Had ortho appointment today after falling and suffering a L clavicular fracture. Not a surgical candidate . States he has had pain with activity . (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Facility Reported Incident Document 359 was reviewed. The summary of interviews with the alleged victim was documented as, Resident is not interviewable. When asked how he fell , resident was not able to verbalize any details regarding the incident. The summary of interviews with witnesses documented, Resident roommate notified nurse that [resident 86] fell , as he was in his room with him. He was not able to very the details regarding the incident, just that he heard [resident 86] fall in his room and saw him on the ground. The summary of interviews with the alleged perpetrator was documented as, NA [not applicable]. The summary of interviews with staff responsible for oversight and supervision of the location where the alleged victim resides was documented as, Nurse that was overseeing [resident 86]'s care was interviews. Nurse states that his roommate came out of the room and said that he heard somebody fall, and checked the other side of the curtain and found resident on the floor. When nurse went into resident room, resident was close to his wheelchair with a show half on/half off. It appeared that resident was trying to self transfer. The allegation was not verified by the facility and it was documented that, residents interviews, staff interviews, chart reviews, and care plan review refute the allegation. This allegation is not verified. The 359 report included the interview Registered Nurse (RN) 7. The interviewer asked two questions; How did you know that [Resident 86] fell ? And What did you witness?. RN 7 reported, His roommate came out and said that he had heard somebody fall and that his roommate was on the ground. He said he didn't know what happened. I walked into the patient room and found [Resident 86] on the floor by his wheelchair. His shoe was half on and half off. I asked his what happened, he said he didn't know what happened or why he was on the floor. No staff members in the room when it happened. It looks like he was trying to self transfer. On 4/16/24 at 10:55 AM an interview with the Administrator was conducted. The Administrator explained that she interviewed RN 7 because RN 7 was the one who was standing by the room, and she was the one who assessed the resident when it happened. The Administrator stated that she did not interview any other staff members because RN 7 was able to see that there were no other staff around or in the area when resident 86 fell . The Administrator was asked if she was investigating abuse or neglect for this incident, to which the administrator responded, neither, well if I had to pick one, I would say possible neglect. The administrator stated that because it was an unwitnessed fall, there were not any staff to interview about it because they did not witness the fall. The Administrator stated that prior to the fall, resident 86 may have been in the dining room eating lunch, and then walked back to his room. The Administrator stated that she did not know this for certain. The Administrator stated that she did not know when the last cares were performed for resident 86 prior to the fall. The Administrator stated that she did not know if resident 86 was exhibiting any different behaviors from his baseline prior to the fall. The Administrator stated that after each time a resident had a fall, new interventions are implemented to try to prevent future falls.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22992 Based on interview, record review, and observation, the facility did not ensure that for 3 of 55 sample residents, the appropriate treatment and services were provided to maintain or improve the residents' ability to carry out activities of daily living. Specifically, residents were not provided showers in a timely manner. Resident identifiers: 3, 46, and 60. Findings include: 1. Resident 46 was admitted to the facility on [DATE] with diagnoses that included right knee flail joint, morbid obesity, weakness, insomnia, schizoaffective disorder, depression, osteoarthritis, and chronic pain. On 4/8/24 at 3:16 PM, an interview was conducted with resident 46. When asked if he was receiving assistance with showers, resident 46 stated, a shower? What's that? and then laughed. Resident 46 stated that he was supposed to receive a shower with staff assistance on Mondays, Wednesdays, and Fridays. Resident 46 stated that he was only receiving showers once a week, and that he once went three weeks without a shower. Resident 46's medical record was reviewed from 4/8/24 through 4/17/24. Resident 46's Admission Minimum Data Set (MDS) dated [DATE] indicated that resident 46 had impairment on both upper extremities, and was dependent on staff for showering/bathing. Resident 46's care plan did not reference the resident's need for assistance with showering/bathing. Review of resident 46's showers documented in the electronic medical record revealed that from admission to 4/15/24, resident 46 received showers on the following dates: a. 2/6/24 (Note: This was the 12th day of the resident's stay.) b. 2/14/24 (Note: This was 8 days after the previous shower). c. 2/16/24 d. 2/19/24 e. 2/26/24 (Note: This was a week after the previous shower). f. 3/1/24 g. 3/3/24 h. 3/5/34 (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	i. 3/8/24 j. 3/13/24 k. 3/18/24 l. 3/22/24 m. 3/25/24 n. 3/29/24 o. 4/1/24 p. 4/5/24 q. 4/8/24 r. 4/10/24 s. 4/12/24 t. 4/15/24 [Note: According to the schedule, resident 46 should have also received showers on 2/28/24, 3/11/24, 3/15/24, 3/20/24, 3/27/24, and 4/3/24.] Resident 46's medical record indicated that only one shower refusal form had been completed during this time frame, and was signed on 2/25/24. 45490 2. Resident 3 was admitted to the facility on [DATE] with diagnosis which included fracture of the left femur, morbid obesity, abnormalities of gait and mobility, weakness, and pain. On 4/16/24 at 1:34 PM, an interview was conducted with resident 3. Resident 3 stated that she was not getting bed baths as often as she would like. Resident 3 stated she felt that she had gone a week without a bed bath. Resident 3's Admission MDS dated [DATE] indicated that resident 3 was dependent on staff for showering/bathing. Resident 3's care plan did not reference the resident's need for assistance with showering/bathing. Resident 3's orders included showers Monday, Wednesday, Friday. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of resident 3's showers documented in the electronic medical record revealed that from 3/1/24 to 3/30/24, resident 3 received showers on the following dates: a. 3/11/24 Complete bed bath b. 3/26/24 Partial bed bath c. 3/28/24 Complete bed bath Resident 3's medical record indicated that no shower refusal forms had been completed during this time frame. On 4/16/24 at 1:55 PM, an interview was conducted with CNA 5. CNA 5 stated that resident 3 will normally get a bed bath and that the facility is responsible for her bed baths. CNA 5 stated that if resident 3's hospice company completes a bed bath they will let the staff know and the staff will document the bed bath was completed. CNA 5 stated that if a resident refuses a bed bath then it will be documented on a refusal sheet. 47432 3. Resident 60 was admitted [DATE] with diagnoses including end stage renal disease, insomnia unspecified, essential (primary) hypertension, peripheral vascular disease unspecified, other intervertebral disc degeneration lumbosacral region, dependence on renal dialysis, displaced avulsion fracture (chip fracture) of left talus, subsequent encounter for fracture with routine healing, type 2 diabetes mellitus with diabetic polyneuropathy, and dementia in other diseases classified elsewhere unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Resident 60's medical record was reviewed from 4/8/24 through 4/17/24. Resident 60's most recent Brief Interview for Mental Status (BIMS) Score from her most recent quarterly Minimum Data Set (MDS) assessment dated [DATE] was a 15, indicating no cognitive impairment. Resident 60's MDS Assessment also indicated that Resident 60 required partial/moderate assistance to shower and bathe herself. Resident 60's care plan was reviewed. A focus dated 7/3/23 revealed, [Resident 60 is at risk for altered ADL [activities of daily living] function secondary to ESRD [end stage renal disease], impaired mobility, morbid obesity, vision impairment. This focus was last revised on 4/8/24. The goal for this focus was documented as, .will not have any unaddressed complications secondary to decreased ADL self performance, through next review. The target date for this goal was listed as 4/30/24. The interventions for this goal were documented as: Requests medications at bedside to promote independence. This intervention was initiated on 2/6/24. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assist in completing ADL tasks each day. Provide dignity and respect, and encourage independence. The intervention was initiated on 7/3/23. Encourage use of call lights when ADL assistance is needed. This intervention was initiated on 7/3/23. Encourage PT/OT [physical therapy/occupational therapy] services as prescribed. This intervention was initiated on 7/3/23. Resident 60's shower schedule was reviewed. Resident 60 was scheduled to have showers or baths on Mondays, Wednesdays, and Fridays. Review of Resident 60's showers documented in the electronic medical record revealed that from admission to 4/10/24, Resident 60 received showers on the following dates: a. 6/30/23 b. 7/5/23 c. 7/7/23 d. 7/10/23 e. 7/13/23 f. 7/17/23 g. 7/24/23 (Note: This was 7 days after the previous shower or bath.) h. 7/26/23 i. 7/28/23 j. 8/4/23 (Note: This was 7 days after the previous shower or bath.) k. 8/9/23 l. 8/14/23 m. 8/18/23 n. 8/23/23 o. 8/25/23 p. 8/29/23 q. 8/30/23 (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	r. 9/1/23 s. 9/4/23 t. 9/8/23 u. 9/15/23 (Note: This was 7 days after the previous shower or bath.) v. 9/22/23 (Note: This was 7 days after the previous shower or bath.) w. 9/25/23 x. 9/29/23 y. 10/2/23 z. 10/4/23 aa. 10/6/23 ab. 10/9/23 ac. 10/13/23 ad. 10/23/23 (Note: This was 10 days after the previous shower or bath.) ae. 10/25/23 af. 10/27/23 ag.11/1/23 ah. 11/6/23 ai. 11/8/23 aj. 11/15/23 (Note: This was 7 days after the previous shower or bath.) ak. 11/27/23 (Note: This was 12 days after the previous shower or bath.) al. 12/4/23 (Note: This was 7 days after the previous shower or bath.) am. 12/13/23 (Note: This was 9 days after the previous shower or bath.) an. 12/15/23 ao. 12/29/23 (Note: This was 14 days after the previous shower or bath.) (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ap. 1/5/24 (Note: This was 7 days after the previous shower or bath.) aq. 1/10/24 ar. 1/12/24 as. 1/19/24 (Note: This was 7 days after the previous shower or bath.) at. 1/24/24 au.1/25/24 av. 1/29/24 aw. 2/5/24 (Note: This was 7 days after the previous shower or bath.) ax. 2/9/24 ay. 2/14/24 az. 2/16/24 ba. 2/26/24 bb. 2/29/24 bc. 3/8/24 (Note: This was 7 days after the previous shower or bath.) bd. 3/11/24 be. 3/15/24 bf. 3/20/24 bg. 3/22/24 bh. 3/27/24 bi. 4/1/24 bj. 4/7/24 (Note: This was 6 days after the previous shower or bath.) bk. 4/8/24 (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[Note: According to the shower schedule, resident 60 should have also received showers or baths on 7/19/23, 7/21/23, 7/31/23, 8/2/23, 8/7/23, 8/11/23, 8/16/23, 8/21/23, 9/6/23, 9/11/23, 9/13/23, 9/18/23, 9/20/23, 9/27/23, 10/11/23, 10/16/23, 10/18/23, 10/20/23, 11/3/23, 11/13/23, 11/17/23, 11/20/23, 11/22/23, 11/24/23, 11/29/23, 12/1/23, 12/6/23, 12/8/23, 12/11/23, 12/13/23, 12/15/23, 12/18/23, 12/20/23, 12/22/23, 12/25/23, 12/27/23, 1/1/24, 1/3/24, 1/8/24, 1/17/24, 1/22/24, 1/26/24, 1/31/24, 2/2/24, 2/7/24, 2/12/24, 2/19/24, 2/21/24, 2/23/24, 3/1/24, 3/4/24, 3/6/24, 3/13/24, 3/18/24, 3/25/24, 3/29/24, 4/3/24, and 4/5/24] Resident 60's medical record indicated that only four shower refusal forms had been completed during this time frame, and they were signed on 10/30/23, 11/10/23, 12/30/23, 1/15/24. On 4/8/24 at 2:48 PM, an interview was conducted with Resident 60. Resident 60 stated that she feels like she never gets her showers. Her most recent shower had been a bed bath the previous day, but prior to that she had not had a shower for over a week. Resident 60 stated that staff will tell her they will complete her shower, but then never follow through with their promises. Resident 60 stated that she requires staff assistance to use the restroom. On 4/16/24 at 1:16 PM, an interview was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 stated that when a resident refuses a shower, a refusal sheet needs to be completed. CNA 1 stated that the completed refusal sheet is supposed to be given to the nurse on duty for the shift. CNA 1 stated that if a resident says that they do not want a shower when prompted, then the CNA should ask again later during their rounds. CNA 1 stated that showers are documented on paper or in the electronic medical record. CNA 1 stated that Resident 60 requires limited 1 person assistance when she showers and that typically one staff member will help Resident 60 shower. On 4/16/24 1:18 PM, an interview was conducted with Registered Nurse (RN) 2. RN 2 stated that each time a resident refuses a shower a refusal sheet should be filled out. RN 2 stated that the nurse on duty is required to sign the shower refusal sheet. RN 2 stated that if a CNA tells her that a resident is refusing a shower, she is required to go investigate why the resident is refusing the shower and see if she can convince the resident to shower. RN 2 stated that after she signs a shower refusal sheet, she gives the refusal sheet back to the CNA. RN 2 stated that the CNA either puts the refusal sheet under the CNA coordinator's office door or gives it directly to the CNA coordinator. On 4/16/24 1:57 PM, an interview was conducted with the Certified Nursing Assistant Coordinator (CNAC). The CNAC stated that refusal sheets on the long term care side of the building are turned into him and that refusal sheets on the rehabilitation side of the building are turned in directly to the Director of Nursing (DON). The CNAC stated that shower refusals should be documented in the electronic charting. The CNAC stated that before a refusal sheet is completed, a CNA should try at least 3 times to get a resident to shower. The CNAC stated that the nurse needs to be notified that a resident has refused a shower and that the nurse should attempt to get the resident to shower before signing the refusal sheet. The CNAC stated that all shower sheets eventually make it the DON. On 4/16/24 at 2:02 PM, an interview was conducted with the DON. The DON stated that shower refusal sheets should be uploaded to the resident's medical record and a progress note should be entered stating that the resident refused a shower. The DON stated that if there are no refusal sheets uploaded to a resident ' s chart and if there are no progress notes documenting a shower refusal, then there is no proof the shower refusal occurred. The DON was unable to find any refusal sheets or progress notes in Resident 60's medical record.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43212 Based on interview and record review, for 4 of 55 sampled residents, the facility did not ensure that a resident who was unable to carry out activities of daily living received the necessary services to maintain good personal and oral hygiene. Specifically, residents requiring assistance with bathing were not provided regular showers or bed baths. Resident identifiers: 2, 34, 82, and 259. Findings include: 1. Resident 2 was admitted to the facility on [DATE] with diagnoses that included orthopedic aftercare following surgical amputation, cellulitis of lower limb, chronic non-pressure ulcer of foot, urinary incontinence, hemiplegia and hemiparesis on left non-dominant side, dysphagia, and abnormal gait and mobility. Resident 2's medical records were reviewed between 4/8/24 and 4/17/24. A review of resident 2's Minimum Data Set (MDS) admission assessment dated [DATE] revealed that it was very important for resident 2 to choose between a tub bath, shower, bed bath or sponge bath. The MDS also revealed that resident 2 was dependent for bathing activities. For the 7 day look-back period, it was documented that the activity had not occurred due to medical conditions and safety concerns. Physician orders dated 3/5/24 revealed resident 2's shower days to be Sundays, Mondays and Thursdays. Resident 2's care plan did not reference the need for assistance with bathing/showering. A review of resident 2's POC [point of care] bathing/showering documentation revealed: a. 3/7/24; Thursday, Physical help in part of bathing/1 person physical assist/shower. b. 3/11/24; Monday, 1 person assistance/total dependence/complete bed bath. c. 3/25/24; Monday, 1 person assistance/total dependence/complete bed bath. [Note: this was a lapse of 14 days since the previous shower.] d. 3/28/24; Thursday, 1 person assistance/physical help in part of bathing/shower. e. 4/1/24; Monday, 1 person assistance/total dependence/shower. f. 4/4/24; Monday, 2 person physical assistance/help limited to transfer/shower. 2. Resident 259 was admitted to the facility initially on 3/13/24, and readmitted on [DATE] with diagnoses that included cellulitis of the right leg, encephalopathy, chronic respiratory failure with hypercapnia and hypoxia, heart failure, chronic obstructive pulmonary disease, bipolar disorder, anxiety disorder, and morbid obesity. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/9/24 at 11:41 AM, an interview was conducted with resident 259 who stated she had not had a shower in 2 weeks since before she was admitted to the hospital. Resident 259 stated she was itching all over. Resident 259's medical record was reviewed between 4/8/24 and 4/17/24. A review of resident 259's Minimum Data Set (MDS) admission assessment dated [DATE] revealed it was very important for resident 259 to choose between a tub bath, shower, bed bath or sponge bath. The MDS also revealed that resident 259 required substantial/maximal assistance transferring into the shower, and required supervision or touching assistance while in the shower. A physician order dated 4/4/24 revealed resident 259's shower days were Thursdays and Mondays between 6:00 AM and 6:00 PM. A review of resident 259's POC tasks revealed resident 259 received a shower: a. 3/17/24; 1 person physical assist/ physical help in part of bathing/shower. b. 3/28/24; 1 person physical assist/ physical help in part of bathing/shower. [Note: a lapse of 11 days since previous shower] c. 3/30/24; shower per progress note. d. 4/11/24; set up help only/tub bath. [Note: a lapse of 7 days since resident 259 was readmitted from the hospital] e. 4/13/24; physical help in part of bathing/shower. f. 4/15/24; Resident refused. [It should be noted that resident 259 was admitted to the hospital between 4/1/24 and 4/4/24.] On 4/10/24 at 9:45 AM, an interview was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 stated she had not worked much with resident 259 or resident 2. CNA 1 stated that after a shower was given to a resident the shower sheet was given to the nurse to sign. CNA 1 stated the shower book at the nurses station had refusal sheets that the residents were required to sign if they refused a shower. CNA 1 stated she would check with the resident a couple of times before having them sign the shower sheet. CNA 1 stated on some days there was a float CNA that would be willing to help out with showers, but the CNA assigned to the hallway was responsible for making sure the residents received showers on their shower days. CNA 1 stated showers were documented in the resident's POC within the medical record. CNA 1 stated showers were usually given when the resident wanted to have one. CNA 1 stated she felt there was enough time to complete showering tasks during her shift. On 4/10/24 at 9:50 AM, an interview was conducted with Registered Nurse (RN) 2 who stated the CNA should be having the residents fill out a refusal form every time the resident refused a shower. 45490 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Resident 82 was admitted to the facility on [DATE] with diagnoses which included chronic respiratory failure with hypoxia, personal history of traumatic brain injury, zoster encephalitis, and adjustment disorder with mixed anxiety and depressed mood. An admission Minimum Data Set (MDS) dated [DATE] documented, resident 82 was Dependent- Helper does ALL of the effort. Resident does none of the effort to complete the activity. for oral hygiene, Toileting, shower/bathe, dressing, and mobility. Resident 82's care plan did not reference the resident's need for assistance with showering/bathing. Resident 82's medical records were reviewed from 4/8/24 through 4/17/24. The following dates were charted for resident 82's showers: a. 2/1/24 Total dependence b. 2/2/24 Activity did not occur c. 2/5/24 Total dependence d. 2/7/24 (unanswered) e. 2/9/24 Activity did not occur f. 2/12/24 Activity did not occur g. 2/14/24 Activity did not occur h. 2/16/24 Activity did not occur i. 2/19/24 (unanswered) j. 2/20/24 Total dependence k. 2/22/24 Total dependence l. 2/24/24 Total dependence m. 2/26/24 Activity did not occur n. 2/29/24 Total dependence On 2/14/24 at 11:17 PM, a nursing progress note documented, resident noted with dried spit to face. wet cloth given and resident attempted to wash own face. resident then clearly stated shower. shower bed obtained, attempted to wash self as staff completed cares. resident was already asleep by the time placed back in bed. resident allowed RT[Respiratory Therapist] to place trach back in and trach cares performed. no s/s[signs/symptoms] of distress. medications tolerated well. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[It should be noted resident 82 had a shower documented on 2/5/24 then a progress note documented a shower on 2/14/24 a 9 day gap between showers. The next shower documented on 2/20/24, a 6 day gap between showers.] On 2/15/24 at 4:35 AM, a respiratory note documented, Resident appears stable at this time .Resident can't use the call light; several checks are done throughout shift .Resident requested shower; this RT [Respiratory Therapist] at standby for shower [It should be noted resident 82 requested a shower, but there is no documentation of a shower being completed until 5 days after this request.] On 4/16/24 at 1:57 PM, an interview was conducted with Certified Nursing Assistant Coordinator (CNAC). CNAC stated that showers are a hot topic in every CNA meeting and that they need to get done. He stated that when a resident shower is documented as 'activity did not occur', it does not count as a refusal. CNAC stated that some CNAs thought 'activity did not occur' is a refusal but it was not. On 4/16/24 at 3:20 PM, an interview was conducted with CNA 6. CNA 6 stated that dependant nonverbal residents were not able to refuse, unless the resident seemed agitated or anxious, but the residents would still get a bed bath with just a wipe. CNA 6 stated that if a resident was wiped down it would be charted as a partial bed bath. CNA 6 stated that the importance of the dependant nonverbal residents receiving showers were important because they often are not mobile and more prone to infections. She stated that the showers would help the residents feel like a person and are beneficial to prevent infections, skin break down and bed sores. On 4/16/24 at 3:33 PM, an interview was conducted with the DON. The DON stated that there was not a good reason for a dependent nonverbal resident to miss a scheduled shower day, unless the resident was combative then that would count as a refusal. The DON stated that the dependant nonverbal residents should get their scheduled showers because the resident could get sweaty and build up bodily oils and the showers help with checking the skin for changes or sores. 47432 4. Resident 34 was admitted [DATE] with diagnoses including other lack of coordination, chronic respiratory failure with hypercapnia, chronic obstructive pulmonary disease unspecified, morbid (severe) obesity due to excess calories, other abnormalities of gait and mobility, muscle weakness (generalized) and major depressive disorder recurrent unspecified. Resident 34's medical record was reviewed from 48/24 through 4/17/24. Resident 34's most recent Brief Interview for Mental Status (BIMS) Score from his most recent quarterly Minimum Data Set (MDS) assessment dated [DATE] was a 15, indicating no cognitive impairment. According to this same MDS, Resident 34 was completely dependent on staff to complete baths or showers. According to the MDS, Resident does none of the effort to complete the activity. Resident 34's shower schedule was reviewed. Resident 34 was scheduled to have showers on Tuesdays, Thursdays, and Saturdays. Review of Resident 34's showers documented in the electronic medical record revealed that from 1/1/24 to 4/17/24, Resident 34 received showers on the following dates: (continued on next page)

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	465067	A. Building B. Wing	04/17/2024

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. 1/4/24 b. 1/13/24 (Note: This was 9 days after the previous shower or bath). c. 1/20/24 (Note: This was 7 days after the previous shower or bath.) d. 1/27/24 (Note: This was 7 days after the previous shower or bath.) e. 1/30/24 f. 2/3/24 g. 2/17/24 (Note: This was 14 days after the previous shower or bath.) h. 2/24/24 (Note: This was 7 days after the previous shower or bath.) i. 2/27/24 j. 3/1/24 k. 3/5/24 l. 3/7/24 m. 3/8/24 n. 3/12/24 o. 3/22/24 (Note: This was 10 days after the previous shower or bath.) p. 3/25/24 q. 3/29/24 r. 4/11/24 (Note: This was 13 days after the previous shower or bath.) s. 4/12/24 t. 4/13/24 [Note: According to the schedule, resident 34 should have also received showers or baths on 1/2/24, 1/9/24, 1/11/24, 1/16/24, 1/18/24, 1/23/24, 1/25/24, 2/1/24, 2/6/24, 2/8/24, 2/10/24, 2/13/24, 2/15/24, 2/20/24, 2/22/24, 2/29/24, 3/14/24, 3/16/24, 3/19/24, 3/21/24, 3/26/24, 3/28/24, 3/30/24, 4/2/24, 4/4/24, 4/6/24, and 4/9/24.] There were no shower refusals documented in Resident 34's progress notes for this time period nor were there any shower refusal sheets for this time period uploaded into Resident 34's electronic medical record. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/16/24 at 1:43 PM, Resident 34 was overheard complaining to the Certified Nursing Assistant Coordinator about not receiving a shower since the week prior. On 4/16/24 at 1:48 PM, Resident 34 was overheard complaining to the Director of Nursing about his showers. Resident 34 stated the aides at the facility will tell him they are coming right back to complete his shower and that they often do not return for two hours after saying this. On 4/16/24 at 1:16 PM, an interview was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 stated that when a resident refuses a shower, a refusal sheet needs to be completed. CNA 1 stated that the completed refusal sheet is supposed to be given to the nurse on duty for the shift. CNA 1 stated that if a resident says that they do not want a shower when prompted, then the CNA should ask again later during their rounds. CNA 1 stated that showers are documented on paper or in the electronic medical record. On 4/16/24 1:18 PM, an interview was conducted with Registered Nurse (RN) 2. RN 2 stated that each time a resident refuses a shower a refusal sheet should be filled out. RN 2 stated that the nurse on duty is required to sign the shower refusal sheet. RN 2 stated that if a CNA tells her that a resident is refusing a shower, she is required to go investigate why the resident is refusing the shower and see if she can convince the resident to shower. RN 2 stated that after she signs a shower refusal sheet, she gives the refusal sheet back to the CNA. RN 2 stated that the CNA either puts the refusal sheet under the CNA coordinator's office door or gives it directly to the CNA coordinator. On 4/16/24 1:57 PM, an interview was conducted with the Certified Nursing Assistant Coordinator (CNAC). The CNAC stated that refusal sheets on the long term care side of the building are turned into him and that refusal sheets on the rehabilitation side of the building are turned in directly to the Director of Nursing (DON). The CNAC stated that shower refusals should be documented in the electronic charting. The CNAC stated that before a refusal sheet is completed, a CNA should try at least 3 times to get a resident to shower. The CNAC stated that the nurse needs to be notified that a resident has refused a shower and that the nurse should attempt to get the resident to shower before signing the refusal sheet. The CNAC stated that all shower sheets eventually make it the DON. The CNAC stated that activity did not occur in the electronic medical record does not count as a shower refusal. On 4/16/24 at 2:02 PM, an interview was conducted with the DON. The DON stated that shower refusal sheets should be uploaded to the resident's medical record and a progress note should be entered stating that the resident refused a shower. The DON stated that if there are no refusal sheets uploaded to a resident's chart and if there are no progress notes documenting a shower refusal, then there is no proof the shower refusal occurred.

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F 0687 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45470 Based on interview and record review it was determined that for 1 of 55 residents that the facility did not ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and if necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. Specifically, a staff member documented a problem with a resident's toe, and it was not addressed by a doctor for 27 days, at which point the toe had become necrotic and surgery was required. Resident identifier: 19. Findings include: 1. Resident 19 was admitted to the facility on [DATE] with diagnoses which included Alzheimer's disease, type 2 diabetes mellitus, major depressive disorder, lack of coordination, abnormalities of gait and mobility, protein-calorie malnutrition, dysfunction of bladder, retention of urine, muscle weakness, glaucoma, essential hypertension, anxiety disorder, bipolar disorder, hyperlipidemia, insomnia, dementia, long term use of aspirin, and chronic obstructive pulmonary disease. An interview was unable to be conducted with the resident due to the resident's low cognitive status and diagnoses of dementia. On 4/8/24 at 2:27 PM an interview with resident 19's family member was conducted. Resident 19's family member stated that resident 19 got an infected toe, and it went unnoticed by the staff for so long that it nearly went gangrene. Resident 19's family member stated that he believed the staff could have addressed the infected toe sooner. Resident 19's medical records were reviewed. A document titled Observation Detail List Report dated 3/25/24 documented resident 19's Brief Interview for Mental Status (BIMS) score as a 3, which indicated severe cognitive impairment. Resident 19's Care Plan was reviewed. Resident 19 had a care plan initiated 4/8/24 that documented, DIABETES: [resident 19] has Diabetes type 2. The goal, initiated on 4/8/24, documented, [Resident 19 will have no unaddressed complication r/t DM [diabetes mellitus] through next review. The interventions stated, [Resident 19] referred to Podiatrist as needed. Created 11/11/21, Nurse to administer DM medication to [resident 19] per MD [medical director] orders. Created 9/3/20., Nurse to monitor [resident 19's] BG [blood glucose] level per MD orders and PRN [as needed]. Resident 19 had a care plan initiated 3/16/21 that documented, [Resident 19] is at risk for alteration in skin impairment R/T dx chronic obstructive pulmonary disease, DM II, and Vitamin D deficiency. The goal stated, [resident 19]'s skin will have no unaddressed skin impairment . The intervention created 3/16/21 documented, Keep clean and dry as possible. Minimize skin exposure to moisture. (continued on next page)

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F 0687 Level of Harm - Actual harm Residents Affected - Few	A Progress Note from 1/23/24 at 1:47 PM documented, Some pain in R [Right] 1st & 2nd toe during cares. Toe nails are long and need to be cut. SW [Social Work] notified of podiatry need. A documented titled Observation Detail List Report from 2/3/24 documented, No wound present in the Skin Integrity section. A documented titled Observation Detail List Report from 2/8/24 documented, No wound present in the Skin Integrity section. A Physician Assistant note from 2/9/24 at 5:55 AM was reviewed and the Physician Assistant did not address the pain in the right 1st and 2nd toe as reported by a nurse in the progress note from 1/23/24. A documented titled Observation Detail List Report from 2/15/24 documented, No wound present in the Skin Integrity section. A Physician Assistant note from 2/19/24 at 8:27 AM documented, Nurse concerned about her toe. Right great toe very red and sore, 2nd toe now with redness. [Resident 19] seems sore when this area is examined. Has had a referral for podiatry pending for several weeks. Replaced this. No fever. Some honey colored crusting noted. A Progress Note from 2/19/24 at 4:17 PM documented, Provider orders podiatry referral (transport notified); Keflex 500mg [milligram] Po [by mouth] QID [four times a day] x 7 days (medication administered now), Wound care daily with Bactroban (Wound care performed). Orders placed . 2nd toe appears to have integument alteration but is difficult to fully assess d/t [due to] pain and [resident 19]'s inability to provide any hx [history] . A Progress Note from 2/20/24 at 3:43 PM documented, Appt [appointment] with podiatry . Provider writes: Significant R>L food PAD w/ [with] R 2nd toe necrosis and rubor on dependency. URGENT: recommend arterial vascular studies to the BLE's [bilateral lower extremities] before any procedures/debridement. Provider orders refer to vascular consult . A Progress Note from 2/22/24 at 6:33 PM documented, 2nd toe is getting deeper coloration today. Otherwise s/s [signs and symptoms] are the same. Wound care performed with great difficulty but dressing in place a [sic] this time. A Progress Note from 2/26/24 at 11:05 AM documented, 2nd toe vascular appt scheduled 3/8. She is taking IM [intermuscular] Rocephin QD currently. RN [registered nurse] concerned about [resident 19]'s abilities, comfort, and desires. She may endure a lot of distress and an extended process of appointments, surgery, and wound care should her toe need to be amputated. [Resident 19] may be candidate to return to hospice. ADON [Assistant director of nursing]/provider/hospice notified . A Progress Note from 3/4/24 at 12:43 documented, Wound care performed, Deep purple area on plantar and mesial aspect of 2nd toe, and beneath the toenail of the hallux . (continued on next page)

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F 0687 Level of Harm - Actual harm Residents Affected - Few	A Progress Note from 3/7/24 at 6:01 PM documented, Pt [patient] saw vascular specialist today. Progress note from vascular physician stated: I attempted to call and speak with [resident 19]'s nurse, but no one would answer the phone. I am a previous provider for [resident 19] as I was a rounding nurse practitioner there at one time, so I am familiar with her past medical history. She has dementia, and is unable to give me info. I cannot feel good pulses in her bilateral feet unsure how long. Wound, but she expressed discomfort during evaluation and scans. Dx [diagnosis] PVD she is in need of bilateral angiogram for revascularization starting on the right side due to wounds her left lower extremity will follow a week later. A documented titled Observation Detail List Report from 3/7/24 documented, No wound present in the Skin Integrity section. A Progress Note from 3/27/24 at 2:24 PM documented, . Provider writes: angiogram of R leg - successful revascularization of occluded rt [related to] femoral & popular arteries. Also, successful angioplasty of RT anterior tibial artery. Now patient direct art [arterial] supply to foot . On 4/17/24 at 1:34 PM an interview with the Director of Nursing (DON) was conducted. The DON stated that if a resident required to be seen by a podiatrist, she was responsible for adding the resident to a list that was then sent to the podiatrist. The DON stated that she had recently taken over responsibility for this roll, and at the time of resident 19's infected toe, social work would have been responsible for it. The DON stated that all residents had weekly skin checks, and she would have expected staff to be looking at the residents fingernails and toenails as part of the skin check. The DON stated that she cannot speak for the nurses, and she stated maybe nurses were not including toenails as part of the weekly skin checks. The DON stated that she was not the nurse conducting the skin checks for resident 19 so she cannot speak to how resident 19's toe looked. The DON stated that she did not believe that anything was missed with resident 19's toe. On 4/17/24 at 1:55 an interview with the Resident Advocate (RA) was conducted. The RA stated that the old social worker used to be responsible for making podiatry referrals. The RA stated that staff often told her about the need for referrals to be made, and she would have passed that information along to the DON. The RA stated that at the time of resident 19's infected toe, the nurse informed her about it and the RA passed the information along to the DON, who would have made the referral.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45470 Based on observation, interview, and record review, the facility failed to ensure that the resident environment remained free of accident hazards as was possible and each resident received adequate supervision and assistance to prevent accidents. Specifically, for 4 of 55 sampled residents, a resident was left unsupervised with a damaged bedside table and the resident was observed pulling on the broken plastic with sharp edges; a resident bed was not locked in place resulting in a fall with a finger injury; a resident was being assisted with a transfer by a family member outside, resulting in the resident falling and dislocating a shoulder; and a resident with a history of falls was injured. These findings resulted in a citing of harm for 2 residents. Resident identifiers: 20, 60, 80, and 166. Findings include: HARM 46232 1. Resident 166 was initially admitted to the facility on [DATE] and readmit to the facility on [DATE] with the diagnoses of periprosthetic fracture around internal prosthetic right hip joint, acute kidney failure, neoplasm of unspecified behavior of bladder, fall on same level from slipping, tripping and stumbling without subsequent striking against object, subsequent encounter, Human immunodeficiency virus [HIV] disease. Resident 166 medical records were reviewed on 4/15/24. On 2/1/24, a Minimum Data Set (MDS) documented resident 166 had a Brief Interview for Mental Status (BIMS) score of 15. The activities of daily living section documented resident 166's bed mobility as partial/ moderate assist. A care plan problem area initiated on 10/31/23 documented, [Resident 166] is at risk for falls secondary to impaired mobility, generalized weakness, multiple wounds, total hip sx, hx GLF [ground level fall], rhabdomyolysis, new environment. Documented interventions included: Lab review. 2. Frequent rounding. 3. Encourage the use of the call light. 4. Keep room free of clutter and tripping hazards. On 1/22/24 at 12:11 PM, a TELS work order #2693 was created for resident 166's call light not working. The work order documented that call light had been fixed on 1/23 at 10:09 AM. [Note: resident had a fall on the night of 1/22, which resulted in a hip fracture.] Resident 166's progress notes and incident reports were reviewed and revealed the resident had fallen on 1/21 and 1/22 and documented the following fall notes: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	a. On 1/22/24 at 2:04 PM, a nurse note stated, Resident continues on neuro check r/t fall on 1/21 .dressing changed to left knee abrasion, knee cleaned with NS [normal saline], applied bacitracin and covered with bordered foam dressing. Resident tolerated changed of dressing with minimal discomfort, call light within reach, resident reminded to call for transfers and any other needs. Pt [patient] verbalized understanding. b. An incident report dated 1/21/24 with a recorded time of 10:57 AM, documented resident 166 had an unwitnessed fall on 1/21/24 at 6:51 AM. The following description was documented, Pt was found on the floor and called 911, so paramedics found him on the floor. It is unknown for how long pt was on the floor but he stated 'for an hour'. Pt was assisted back to bed. He stated he wanted to go back to bed from the wheel chair and fell . Not able to describe why he didn't try to call facility staff by yelling, or asking his room mate to push the call light. Pt is A&O [alert and oriented] X4, skin check performed. Pt has skin abrasions to both knees, and right wrist. Nurse applied Bacitracin to affected areas, covered w [with]/bordered foam. MD [medical doctor] on call notified. Family wasn't responding, VM [voice mail] left for sister to call back. Neuro check initiated, v/s [vital signs] being taken. PRN [as needed] pain medication administered. Education provided for pt to use call light for help with transfers. Pt verballized (sic) understanding. The incident report documented contributing factors to resident 166's fall. Those factors included ambulating without assistance, a change in mental cognition, gait imbalance and a current urinary tract infection. c. On 1/23/24 at 4:33 AM, a nurse note stated, At 1155 resident fell while attempting to just get out of bed and walk around. States he was restless. Resident fell while very close to other residents bed. Sustained skin tear injury to right forearm and right lateral eyebrow. Skin tear is from elbow to outer wrist and apx [approximately] 1 in [inch] open at its widest. Cleaned with wound cleaner, applied non stick fil and kerlix. Residents oxygen sats [saturation] during early part of neuro exams were noted at 84-87. Deep breathing attempted but resident didn't respond well. O2 [oxygen] delivered at 3 liters for about 2 hours. Resident has recovered a satisfacgory (sic) o2 saturation level. Notified NP [nurse practitioner] around 0145 and have not received orders or indication of what he would like do and no new orders at this time. [Resident 166] was given his prn [as needed] oxy [oxycodone] for a pain the right hip he remarks is at a 10/10. No bruising noted in are (sic). WCTM [will continue to monitor] d. An incident report dated 1/23/24 with a recorded time of 2:43 AM, documented resident 166 had a witness fall due to their roommate observing the fall. The MD was notified of the fall on 1/23/24 at 1 AM. The nursing description stated resident 166 had fallen in their roommate's room and it had taken 4 staff members to move resident 166 back into bed. The Incident report documented resident 166 had experience 8/10 pain to their right hip and leg. The contributing factors to the fall included confusion, weakness, and gait imbalance, and ambulating without assistance. e. On 1/24/24 at 2:02 AM, a nurse note stated, . While preparing resident for transport, radiology called stating that a mildly displaced fracture of greater trochanter. f. On 1/25/24 at 9:58 AM, a Nurse Practitioner note documented, .Xray showed femur fracture and he was sent to the ER [emergency room]. He returned 1/25/24 after being deemed not a surgical candidate. He is allowed TTWB [toe touch weight bearing] on the RLE [right lower extremity]. He continues weak and deconditioned and admitted here for ongoing care and therapy and management of his multiple medical conditions. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 4/17/24 at 9:44 AM, an interview was conducted with the Director of Nursing (DON). The DON stated when a resident fell , an assessment was done, vitals were taken, and family and providers were notified of the fall. The DON stated a fall event was opened and filled out. The DON stated a fall was only considered witnessed if it had been seen by staff. The DON stated when a resident fell , they were monitored by the nurse for 3 days. The DON stated after every fall, they tried to determine the root cause of the fall to prevent future falls from occurring. The DON stated if a resident's call light was not working then it was considered a high emergency and maintenance was called. The DON stated they did not want a resident to go without a call light since the resident would not be able to call for help. The DON stated the call light was a resident's lifeline. The DON stated on the day that resident 166 fell , they were confused and wanted to ambulate on their own. The DON stated resident 166 needed stand by assistance. The DON stated resident 166 had two fall very close to each other. The DON stated that with the first fall, resident 166 was reminded to call for help. The DON stated resident 166 was able to use the call light if they needed any assistance. The DON was made aware that resident 166's call light was not working on the night that the resident fell and fractured their hip. 47432 2. Resident 60 was admitted [DATE] with diagnoses including end stage renal disease, insomnia unspecified, essential (primary) hypertension, peripheral vascular disease unspecified, other intervertebral disc degeneration lumbosacral region, dependence on renal dialysis, displaced avulsion fracture (chip fracture) of left talus, subsequent encounter for fracture with routine healing, type 2 diabetes mellitus with diabetic polyneuropathy, and dementia in other diseases classified elsewhere unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Resident 60's medical record was reviewed from 4/8/24 through 4/17/24. Resident 60's most recent Brief Interview for Mental Status (BIMS) Score from her most recent quarterly Minimum Data Set (MDS) assessment dated [DATE] was a 15, indicating no cognitive impairment. Resident 60's quarterly MDS also indicated that Resident 60 is a limited assistance, one person assist for transfers. Resident 60's Care Plan was reviewed. A focus dated 7/3/23 revealed Problem: [Resident 60] is at risk for falls secondary to ESRD [end-stage renal disease] - (HTN [hypertension] potential with dialysis), weakness, impaired mobility, disc degeneration. This focus was last revised on 4/8/24. The goal listed for this focus was, [Resident 60] will have no untreated injuries r/t [related to] falls, through next review. The target date for this goal was listed as 4/30/24. The interventions listed for this goal were: Encourage the use of the call light. This intervention was initiated on 7/3/23. Keep room free of clutter and tripping hazards. This intervention was initiated on 7/3/23. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A focus dated 7/3/23 revealed, [Resident 60] is at risk for altered ADL [activities of daily living] function secondary to ESRD, impaired mobility, morbid obesity, vision impairment. This focus was last revised on 4/8/24. The goal listed for this focus was, .will not have any unaddressed complications secondary to decreased ADL self-performance, through next review. The target date for this goal was listed as 4/30/24. The interventions listed for this goal were: Requests medications at bedside to promote independence. This intervention was initiated on 2/6/24. Assist in completing ADL tasks each day. Provide dignity and respect, and encourage independence. This intervention was initiated on 7/3/23. Encourage use of call lights when ADL assistance is needed. This intervention was initiated on 7/3/23. Encourage PT/OT [physical therapy/occupational therapy] services as prescribed. This intervention was initiated on 7/3/23. A progress note dated 2/19/24 at 5:44 PM revealed, Residents [sic] husband was attempting to help transfer her from her wheel chair [sic] to her bed. He slipped and lost his grip. He attempted to prevent her from falling by grabbing her left shoulder. She states she felt it pop and it is out of socket. She has very little movement in any direction without excruciating pain. Physical therapy in to evaluate. Xray [sic] ordered stat. Resident had a bout of nausea and was given zofran and her pain pill. WCTM [will continue to monitor]. An incident report dated 2/19/24 revealed, See PN [progress note]. Husband attempted to assist in transfer, LUE [left upper-extremity] shoulder pain, immobility after incident. Complains of pain with movement. Therapy assessed, assisted resident back into bed. Awaiting XR [x-ray]. A progress note dated 2/20/24 at 4:21 AM revealed, Pt [patient] reports left shoulder pain. Husband was trying to avoid pt to fall last night and grabbed her by left arm. today pt reports pain with ROM [range of motion]. Xray ordered. does not look dislocated. Pt needs refill on her norco for pain. A progress note dated 2/21/24 at 3:05 AM revealed, Resident returned from Hospital at around 8pm. She has Left shoulder strain and Rib fx [fracture]. N/O [new order] for Hydrocodone 7.5-325mg [milligram] tab Q [every] 6 hrs PRN [as needed] for pain. Review of an emergency department note from the hospital dated 2/20/24 revealed The x-ray of her ribs showed that she has an acute fracture of the left 3rd and 4th rib. On 4/8/24 at 2:44 PM, an interview was conducted with Resident 60. Resident 60 stated that on the day of the incident, her husband was attempting to help her transfer from her chair, and he slipped and dropped her to the floor. Resident 60 stated that she hurt her ribs during the fall. Resident 60 stated that her husband attempted to help her transfer because no staff were available to assist. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 4/16/24 at 12:17 PM, an interview was conducted with Resident 60's husband. Resident 60's husband stated that on the night of the incident he slipped while trying to help Resident 60 move from her chair. Resident 60's husband stated that he tried to help Resident 60 transfer because Resident 60 needed to use the restroom, there were no staff around, and the two of them had waited for over an hour for staff after pushing Resident 60's call light. On 4/16/24 at 1:16 PM, an interview was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 stated that Resident 60 requires limited one person assistance to transfer. On 4/16/24 at 12:55 PM, an interview was conducted with Registered Nurse (RN) 8. RN 8 stated that from what she was told, when Resident 60's husband was attempting to transfer Resident 60, his foot slipped and he lost his grip on Resident 60 and tried to re-establish his grip by grabbing her shoulder. RN 8 stated that Resident 60's husband then dropped Resident 60 to the floor. RN 8 stated that Resident 60 requires assistance to complete transfers and that Resident 60 has declined since September of 2023. On 4/16/24 at 2:06 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that ideally staff should answer call lights within 5 minutes and if the issue cannot be resolved, the call light should be left on. The DON stated that she would not expect a family member to help a resident transfer from their chair to their bed. The DON stated that it is not acceptable for a resident to wait an hour for staff to assist with a transfer. 43212 POTENTIAL FOR HARM 3. Resident 20 was admitted to the facility on [DATE] with diagnoses that included [NAME] Sachs disease, pseudobulbar affect, anxiety disorder, dysphagia, abnormality of gait and mobility, lack of coordination, and bipolar disorder. Resident 20's medical record was reviewed between 4/8/24 and 4/17/24. On 4/10/24 at 8:55 AM, an observation was made of resident 20 sitting in her wheelchair across from the 300-400 hallway nurses station. The staff had placed a bedside table across her lap while the breakfast trays were being passed. While resident 20 sat there, she was observed to be pulling at the plastic covering to the bedside table that was cracked and broken in multiple places on the table. The plastic was rigid and jagged with sharp edges. On 4/17/24 at 11:56 AM, the damaged bedside table was still in the hallway near the 300-400 nurses station. 4. Resident 80 was admitted to the facility on [DATE] with diagnoses which included encounter for other orthopedic aftercare, unspecified fracture of upper end of right tibia, dementia, unspecified fracture of upper end of left tibia, unspecified fracture of shaft of right fibula, unspecified fracture of shaft of left fibula, chronic obstructive pulmonary disease, chronic respiratory failure, type 2 diabetes mellitus, weakness, abnormalities of gait and mobility, depression, and insomnia. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 4/8/24 at 10:48 AM an interview with resident 80 was conducted. Resident 80 stated that he had a fall at the facility when he was transferring from the bed to the chair, and his bed had slipped out from underneath him. Resident 80 stated that he bed locks were not locked. Resident 80 stated that he had smashed his finger. An observation of resident 80's right ring finger was made. Resident 80's right ring finger was missing the right half of the nail. The skin appeared to be healed. Resident 80 stated that after he fell and smashed his finger, there was no bleeding, but part of the nail turned black and fell off. Resident 80's medical records were reviewed. An incident report with an Event Date of 3/8/24 documented, Residents bed was not locked, bed rolled while he was sitting on edge of bed and he fell . The resident description of the fall was documented as, sitting on side of bed, wheels not locked, bed rolled and I fell on my bottom. The incident report documented that there were no injuries noted. A Progress Note from 3/8/23 at 10:24 PM documented, This LN [Licensed Nurse] was doing med pass when I was informed by CNA that resident was on the floor, on arrival in residents room I observed him lying on floor in supine position with a pillow under his head, I assessed him for injuries, no apparent injury noted, he was A/O [alert and oriented] x 4, able to tell this writer what happened, he stated, I was sitting up on bed with my feet on floor, CNA was assisting me, she observed me fall, my bed doesn't lock and it rolled causing me to fall and I did not hit my head, just fell on my bottom. CNA [name redacted] stated the same, I saw him fall, he did not hit his head, he fell on his bottom, I helped him lie down and put pillow under his head for comfort. ROM [range of motion] was at baseline, staff assisted resident up off the floor and back into bed . A Progress Note from 3/9/24 at 2:46 PM stated, Patient encouraged to use call light for transferring assistance this shift. Patient tolerates well and is observed using call light and waiting for staff to assist him. On 4/17/24 at 2:38 PM an interview with the Director of Nursing (DON) was conducted. The DON stated that staff should be checking that the breaks are working every time prior to transferring a resident in or out of their bed. The DON stated that all of the beds have wheels and have breaks, and that the breaks should always be locked. The DON stated that the locking mechanism was broken on resident 80's bed when he fell . The DON stated that nobody had noticed that the locking mechanism was broken until resident 80 had fallen. The DON stated that maintenance immediately fixed the breaks on resident 80's bed. The DON stated that there were no routine checks completed by maintenance to ensure that the beds were safe. On 4/17/24 at 2:46 PM an interview with the Assistant Director of Maintenance (ADOM) was conducted. The ADOM stated that there were no routine checks on residents' beds. The ADOM stated that he could not recall if he had fixed resident 80's bed. The ADOM stated that maintenance only looked at the beds if there was a work order placed.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22992 Based on interview and record review, the facility did not ensure that for 6 of 55 sample residents, the residents were seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. Specifically, residents were being seen by an alternate provider such as a Nurse Practitioner, instead of a physician. Resident identifiers: 19, 46, 49, 62, 102, and 166. Findings include: 1. Resident 46 was admitted to the facility on [DATE] with diagnoses that included right knee flail joint, morbid obesity, weakness, insomnia, schizoaffective disorder, depression, osteoarthritis, and chronic pain. Resident 46's medical record was reviewed from 4/8/24 through 4/17/24. Resident 46's progress notes indicated that although the resident had been seen by a Nurse Practitioner (NP) multiple times, the resident had not been seen by a physician since the resident's admission nearly 3 months prior. 45470 2. Resident 19 was admitted to the facility on [DATE] with diagnoses which included Alzheimer's disease, type 2 diabetes mellitus, major depressive disorder, lack of coordination, abnormalities of gait and mobility, protein-calorie malnutrition, dysfunction of bladder, retention of urine, muscle weakness, glaucoma, essential hypertension, anxiety disorder, bipolar disorder, hyperlipidemia, insomnia, dementia, long term use of aspirin, and chronic obstructive pulmonary disease. Resident 19's medical records were reviewed from 4/8/24 through 4/17/24. Progress notes revealed that resident 19 was seen by the MD on 4/24/23, 8/7/23, and 4/5/24. It should be noted that resident 19 went 9 months without seeing the MD from 8/7/23 to 4/5/24. 45490 3. Resident 62 was admitted to the facility on [DATE] with diagnoses which included nontraumatic intracranial hemorrhage, tracheostomy status, hydrocephalus, and acute respiratory failure with hypoxia. Resident 62's medical records were reviewed from 4/8/24 through 4/17/24. On 4/3/24 at 10:25 PM, the provider progress notes documented that resident 62 was seen by the Medical Director (MD). It should be noted that the visit occurred 69 days after resident 62's admission to the facility. 46232 (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Resident 166 was initially admitted to the facility on [DATE] and readmit to the facility on [DATE] and discharged from the facility on 2/15/24 with the diagnosis of Periprosthetic fracture around internal prosthetic right hip joint, subsequent encounter, Acute kidney failure, Neoplasm of unspecified behavior of bladder, Fall on same level from slipping, tripping and stumbling without subsequent striking against object, subsequent encounter, Human immunodeficiency virus [HIV] disease. Resident 166 medical records were reviewed on 4/15/24. Resident 166's progress notes were reviewed and there was no documentation to indicate resident 166 had been seen by the MD while a resident in the facility. It should be noted resident 166 had 22 documented nurse practitioner visits. 47432 5. Resident 102 was admitted [DATE] with diagnoses including metabolic encephalopathy, sepsis unspecified organism, acute kidney failure unspecified, alcohol dependence with withdrawal unspecified, type 2 diabetes mellitus with diabetic neuropathy unspecified, essential (primary) hypertension, and cellulitis of left lower limb. Resident 102's medical record was reviewed from 4/8/24 through 4/17/24 Resident 102's progress notes indicated that although the resident had been seen by a Nurse Practitioner (NP) multiple times, the resident had not been seen by a physician since the resident's admission. It should be noted resident 102 had 19 documented nurse practitioner visits. 38031 6. Resident 49 was admitted to the facility on [DATE] with diagnoses which included acute respiratory failure, pneumonia, type 2 diabetes mellitus, insomnia, hypertension, major depressive disorder, and dementia. On 4/8/24, resident 49's medical records were reviewed. On 4/16/24 at 8:40 AM, the provider progress notes documented that resident 49 was seen by the Medical Director (MD). It should be noted that the visit occurred 83 days after resident 49's admission to the facility. On 4/17/24 at 1:45 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that the Administrator (ADM) and the medical records staff ensured that the residents were seen by the MD within the first 30 days after admission. On 4/17/24 at 1:49 PM, an interview was conducted with the ADM. The ADM stated that the process for scheduling physician visits was that upon admission the medical records staff scheduled the resident for the 30-day, 60-day, and 90-day visits. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/17/24 at 1:52 PM, an interview was conducted with the Medical Records Staff (MRS). The MRS stated that she entered the resident into the electronic medical record (EMR) when they were admitted , and then scheduled the residents for their physician visits. The MRS stated that she printed out a report to see who was last seen and when each resident was due for their next physician visit. The MRS stated that she checked the schedule monthly, reviewed the progress notes for any physician visits, and then updated the scheduler for any needed appointments. The MRS stated that they had a turnover and vacancy for the Medical Director (MD). The MRS stated that the previous medical director (PMD) last day at the facility was March 1, 2024, and the new MD started April 1, 2024. The MRS stated that the whole month of March 2024 there would not be any visits completed by a MD. Probably a lot of missed visits in there. The MRS stated that resident 49 was admitted to the facility on [DATE] and the PMD missed a scheduled visit on 2/23/24. The MRS stated that resident 46 was admitted to the facility on [DATE] and the PMD missed a scheduled visit on 2/25/24. The MRS stated that resident 19 was admitted to the facility on [DATE] and she was not able to view the scheduled MD visits that far back. The MRS stated that resident 19's progress notes documented provider visits as follows: on 1/20/23 a visit by the Doctor of Osteopathic Medicine (DO); on 1/30/23 PMD visit; on 2/6/23 a DO visit; and on 3/13/23 a DO visit. The MRS stated that resident 166 was admitted to the facility on [DATE] and the PMD missed scheduled visits on 1/30/24 and 2/24/24. The MRS stated that resident 62 was admitted to the facility on [DATE] and the physician (MD 1) missed the scheduled visit on 2/24/24. The MRS stated that MD 1 visited resident 62 on 4/3/24. The MRS stated that resident 102 was admitted to the facility on [DATE] and the PMD missed a scheduled visit on 2/23/24.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 22992 Based on interview, observation and record review, the facility did not have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Specifically, multiple residents and staff voiced concern about the staffing level, showers were not provided as scheduled, call lights were not answered timely, and the environment was observed to be soiled. Resident identifiers: 19, 23, 26, 37, 46, 56, 60, 98, 99, 208, 259, and 309. Findings include: 45470 RESIDENT/FAMILY INTERVIEWS 1. On 4/8/24 at 2:27 PM an interview with resident 19's family member was conducted. Resident 19's family member stated that resident 19 slipped outside on ice when at the facility, and the fall resulted in a broken hip. Resident 19's family member stated that he was unhappy that there was ice in areas where residents could walk. Resident 19's family member stated that he believed there was not enough staff in the facility to keep the residents safe. Resident 19's family member stated that resident 19 had developed a sore on her toe that went unnoticed for so long that it required surgery, and he believed that the sore went unnoticed due to low staffing. 2. On 4/9/24 at 9:18 AM, an interview was conducted with resident 259. Resident 259 stated that the facility did not have enough staff and that during the evening it gets worse. 3. On 4/8/24 at 11:38 AM, an interview was conducted with resident 26. Resident 26 stated that he has had to wait up to 45 minutes for his call light to be answered. 4. On 4/8/24 at 12:00 PM, an interview was conducted with resident 99. Resident 99 stated that he has had to wait 30 to 45 minutes for his call light to be answered. Resident 99 also stated there were big differences between night and day with staffing Resident 99 stated that at night, his medications were late, sometimes as late as 2 hours. 5. On 4/8/24 at 3:25 PM, an interview was conducted with resident 37. Resident 37 stated that at nighttime especially, there was not enough staff. Resident 37 stated there were only 1 to 2 staff at night, which was not enough for the 100, 200, and 400 halls. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. On 4/8/24 at 12:11 PM, an interview was conducted with resident 60. Resident 60 stated, it would be nice if someone came when I turn on my call light. Resident 60 stated she often waited an hour for her call light to be answered. Resident 60 stated she had not had any staff enter her room since earlier that morning, and that staff did not check on residents unless residents pushed their call light. Resident 60 stated that there was not enough staff, especially on weekends. Resident 60 stated she was not receiving her showers as scheduled. Resident 60 stated that she fell on ce while waiting for staff to help her. [Cross refer to F676 and 689] 7. On 4/8/24 at 1:41 PM, an interview was conducted with resident 98. Resident 98 stated that she waited at least 40 minutes for her call light to be answered, and that there were not enough staff on any shift. 8. On 4/8/24 at 10:39 AM, an interview was conducted with resident 23. Resident 23 stated that sometimes there was only 1 CNA on shift, which is kind of frustrating, I've waited 4 hours one time. 9. On 4/9/24 at 11:35 AM, an interview was conducted with resident 309. Resident 309 stated that there was not enough staff, and that she often sat in a soiled brief for a long time especially at night. Resident 309 stated that she had recently been diagnosed with a urinary tract infection which she believed was from sitting in her feces for extended periods of time. Resident 309 also stated that her medications were late. 10. On 4/8/24 at 2:27 PM, an interview was conducted with resident 208. Resident 208 stated that she often has to yell out to get staff's attention. Resident 208 stated that when you are yelling for help they oughtta take two minutes and see what we are yelling about. Resident 208 also stated that her roommate has had to go to the nurses station in order to find help because the staff were not answering the resident's call light. Resident 208 stated that sometimes she got agitated but I wouldn't be so agitated if they would get my pain medicine quicker. 11. On 4/8/24 at 10:40 AM, an interview was conducted with resident 56. Resident 56 stated that at night he usually had to wait at least 30 minutes for his call light to be answered. 12. On 4/8/24 at 3:16 PM, an interview was conducted with resident 46. Resident 46 stated that the facility did not have enough staff. When asked for further clarification, the resident stated that he was waiting for one to two hours for his call lights to be answered. Resident 46 stated that even if his call light was answered promptly, the staff would turn off the light, and say they would be right back, but never returned. STAFF INTERVIEWS 13. On 4/16/24 at 2:58 PM an interview with CNA 9 was conducted. CNA 9 stated she previously worked at the facility. CNA 9 stated that the facility was always understaffed. CNA 9 stated that management did not think that the facility was understaffed, but CNA's were unable to get all of their work done CNA 9 stated that she used to work on the weekends. CNA 9 stated that she would notice that resident bed sores were getting worse each weekend that she worked, and CNA 9 believed it was due to low staffing and CNA's not having time to change resident's briefs or reposition residents. CNA 9 stated that she quit working at the facility because she did not agree with the work environment. 38031 (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	14. On 4/11/24 at 8:05 AM, a telephone interview was conducted with Certified Nurse Assistant (CNA) 4. CNA 4 stated that she stopped picking up shifts at the facility because administration would not listen to her. CNA 4 stated that the facility was very busy, short staffed, and residents were not getting the care that they needed or deserved. CNA 4 stated that on one occasion a licensed nurse asked for her assistance with a dressing change and during this time the dietary manager yelled at her for not answering call lights. CNA 4 stated that she was unavailable to answer the call lights because she was in the middle of assisting the nurse. CNA 4 stated that there were times that they were unable to complete resident showers because they were short staffed. CNA 4 stated she was told to put off resident showers and do other things like pass meal trays instead. 15. On 4/11/24 at 1:25 PM, a telephone interview was conducted with CNA 3. CNA 3 stated she was no longer employed at the facility. CNA 3 stated, I can't do it and reported that the facility overworked her. CNA 3 stated that the facility administration was not listening to what she had to say. CNA 3 stated that she was assigned to areas with residents that were 500 pounds and she would have to roll that resident by herself. CNA 3 stated that it was hard, she voiced this to management and asked for more training. CNA 3 stated that every once in awhile she was able to get some tasks completed. 16. On 4/17/24 at 9:49 AM, an interview was conducted with CNA 2. CNA 2 stated that she worked for an agency company and had worked several shifts at the facility. CNA 2 stated that sometimes when the facility was understaffed it was hard to complete tasks. CNA 2 stated that it took longer to answer call lights and residents could wait up to 30 minutes for help, especially if they were feeding someone or showering a resident. On 4/17/24 at 3:25 PM an interview with the Director of Nursing (DON) was conducted. The DON stated that she was responsible for the nurses schedule as of recently. The DON stated that the Certified Nursing Assistant Coordinator (CNAC) was responsible for the Certified Nursing Assistant (CNA) schedule. The DON stated that it was standard for the nurses to be staffed one nurse per hallway. The DON stated that the number of nurses did not change much, but the number of CNA's on staff was based on census. The DON stated that sometimes schedulers would take into account the level of cares required for the residents. The DON stated that the average ratio is 1 CNA per 9 residents. The DON stated that the max ratio was 1 CNA per 14 residents, however it was rare that the facility was staffed at the max ratio. On 4/17/24 at 3:28 PM an interview with the CNAC was conducted stated that if the facility was staffed at the max ratio, management would step in and help the CNA's. The CNAC stated that at night, the ratio was 1 CNA per 15 residents on average. The CNAC stated that he believed that if there was enough staff to complete all the required work of the staff managed their time appropriately. The CNAC stated that CNA's had monthly meetings along with all staff meetings where education was provided. The CNAC stated that the CNA's exceeded 12 hours of continuous education per year. The CNAC stated that examples of education given was dementia care, effective communication, specific resident needs, and infection control. 47432 17. Cross refer to F550 18. Cross refer to F584 (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	19. Cross refer to F676 20. Cross refer to F677 21. Cross refer to F689

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 45490 Based on observation, interview and record review it was determined that the facility did not ensure that all drugs and biological's were labeled in accordance with currently accepted professional principles, were stored under proper temperature controls, and included the expiration date when applicable. Specifically, a resident had insulin pens at bedside with out storage to prevent access to the insulin by other residents. Medication was left at the bedside of a resident who was not assessed for self administration of medication. A multi use vials of medications were opened and available for use date indicated medications were expired and still available for use. The medication fridge indicated temperatures too cold for safe medication storage. Resident identifiers: 15, 21, and 92. Findings included: 1. Resident 21 was admitted to the facility on [DATE] with diagnoses which included type 2 diabetes mellitus with diabetic polyneuropathy, chronic venous hypertension, acquired absence of right leg below knee. On 4/08/24 at 10:30 AM, an observation was made of resident 21. Resident 21 had 3 insulin injecting pens on his bedside table. An interview was conducted with resident 21. Resident 21 stated that he has had diabetes since 2009 and was able to take care of his own insulin injections. He stated that the nursing staff would check his blood sugar and tell him what the reading was, then he would inject his own insulin. Resident 21 stated that he often keeps the insulin pens on his bedside table. Resident 21's medical record was reviewed from 4/8/24 through 4/17/24. A physicians order dated 1/8/24, documented, May leave medications/insulins @ bedside. Pt may self administer insulin injections A document titled Self-Administration of Medication, revealed in the STORAGE OF MEDICATION section, Where will self-administered medications be stored? . Nursing Medication Cart was marked. The PLAN OF CARE was described as nurses to set-up meds [medications] & deliver to pt [patient] at each med pass. On 4/9/24 at 9:32 AM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated that if a resident wanted to self administer insulin the nurses would need to make sure that they resident could do it correctly. RN 1 stated that there were residents that were confused or depressed, if they would found the insulin at the bedside it could be problematic to leave it at bedside, the residents could give themselves a dose of insulin and die. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/9/24 9:43 AM , an interview was conducted with RN 5. RN 5 stated that for a resident to be able to administer medications on their own the resident must complete a self administration assessment. RN 5 stated that the assessment would be located in the residents chart. RN 5 stated that for resident 21 the nursing staff would check his blood sugar and take his insulin pens to the room, and that the nurses would place the correct does on the pen and would confirm the amount with resident 21. RN 5 stated that resident 21 would then take the insulin pen and was able to administer his own insulin, then the nurses would take the insulin pens and place them back in the medication cart until the next blood sugar check was due. On 4/9/24 at 9:51 AM, an interview was conducted with Resident 21. Resident 21 stated that the nurses could leave the insulin in his room. He stated that he would only administer insulin after his blood sugar had been checked by a nurse Resident 21 stated that the insulin pens have a removable safety needle for administration then he kept on his bedside table, and the needles were able to twist off of the insulin pen and are discard after use. Resident 21 stated that the nurses would bring him his insulin pens in the morning and place them on his bedside table and would leave the insulin in his room for the rest of the day. On 4/15/24 at 11:47 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that if a resident can self administer insulin, the expectation of the nursing staff is that insulin pens should be kept in the nurses medication cart. She stated that when the nurses check the resident blood sugar the nurse would prepare the insulin pen and then give the insulin to the resident to administer it. The DON stated that the removable needles should not be stored at the residents bedside. The DON stated that the nurses are expected to take the medication to the resident and should watch the resident administer the insulin. The DON stated that resident 21 is very particular about his insulin and was not sure if he had worked out something with the provider about keeping the insulin at the bedside, she stated that if he could keep them at the bedside it should be documented on how to store safely store the medication, to have storage so other residents don't have access to them. The DON stated that the concern with having insulin and insulin needles at the bedside is that residents could access them, she stated that if someone used insulin that was not diabetic could lower there blood sugar and could possibly cause death. 38031 2. Resident 92 was admitted to the facility on [DATE] with diagnoses which consisted of osteoarthritis, schizoaffective disorder, depression, anxiety disorder, hypertension, and chronic obstructive pulmonary disease. On 4/08/24 at 1:55 PM, an interview was conducted with resident 92. Resident 92 reported that she had diarrhea last night. Resident 92 stated that the nurse gave her a pill for her diarrhea and then pointed to a medication cup located on the bedside table. A medication pill was observed inside the cup. On 4/8/24, resident 92's medical records were reviewed. On 3/28/24 at 1:18 PM, resident 92's self-administration of medication assessment documented that the resident did not want to self-administer medications. No documentation could be found that the resident was assessed to be safe to self-administer medications. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Resident 15 was admitted to the facility on [DATE] with diagnoses which consisted of schizophrenia, hypothyroidism, laceration of head, chronic kidney disease, anxiety disorder, and fracture of skull and facial bones. On 4/8/24, resident 15's medical records were reviewed. On 10/2/23, a Montreal Cognitive Assessment (MOCA) score was 7/30 which would indicate that the resident was severely cognitively impaired. On 10/26/23 at 2:47 PM, resident 15's self-administration of medication assessment documented that the resident did not want to self-administer medications. No documentation could be found that the resident was assessed to be safe to self-administer medications. On 4/10/24 at 7:47 AM, an observation was made of Registered Nurse (RN) 1 administering medications to resident 15. RN 1 dispensed a Vitamin D3 2000 units tablet, a multivitamin tablet, and a fludrocortisone 0.1 milligram tablet into a medication cup. RN 1 delivered the medication to resident 15 and left the medication on the bedside table. On 4/10/24 at 7:53 AM, an interview was conducted with RN 1. RN 1 stated he was not going to check the medications off in the Medication Administration Record (MAR) until he verified that they had been taken. RN 1 stated that he did not have a physician order that stated that medications could be left at the resident bedside for self-administration. 4. On 4/10/24 at 7:05 AM, the medication cart on the front of the 100 hallway was inspected. A multidose Lispro insulin vial for resident 105 was observed open and dated 3/10/24. An immediate interview was conducted with RN 3. RN 3 stated that he thought the insulin was good for 28 days once opened. On 4/10/24 at 8:43 AM, the medication cart on the 400 hallway was inspected. A multidose vial of Insulin Aspart for resident 63 was observed open and dated 3/11/24. An immediate interview was conducted with Licensed Practical Nurse (LPN) 2. LPN 2 stated that the medication expired yesterday and confirmed it was still available for use. LPN 2 stated that she would give the vial to her manager, verify that it was expired and then have them discard it. 5. On 4/10/24 at 9:10 AM, the medication room for the 500 and 600 hallway was inspected. Initial inspection of the medication fridge revealed that the thermometer was reading a temperature of 16 degrees. The fridge was immediately closed, and RN 4 was asked to verify the temperature. RN 4 stated that the temperature was 20 degrees. RN 4 stated that the temperature was too cold and not safe to store medications. RN 4 stated that she was going to adjust the temperature a bit. RN 4 stated that she would contact the pharmacy to determine the safe temperature range for the medications that were stored inside the fridge. Review of the temperature log dated 4/10/24 documented the temperature as 34 degrees. Inventory of medications located inside the fridge were: a. Ceftriaxone 2 grams/50 milliliters, 3 bags for resident 163. b. Ceftriaxone 2 grams/50 milliliters, 8 bags for resident 360. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. Insulin Degludec injection, 3 pens. d. Humalog Lispro insulin multidose vial, 10 vials. e. Lantus Solostar pen, 2 auto inject pens for resident 62. f. Lantus Solostar pen, 5 auto inject pens for resident 24. g. Lispro insulin multi dose vial for resident 24. h. Victoza injection, 1 pen. i. Toujeo Max Solostar, 2 pens for resident 21. j. Humalog Insulin pen, 5 pens for resident 21. k. Insulin Aspart Flex pen- 4 pens for resident 31 l. Humalog Kwikpen, 1 pen for resident 31. m. Levemir Flex pen, 1 pen for resident 31. n. Humalog multidose vial for resident 43. o. Insulin Glargine pen for resident 43. p. Insulin Lispro Kwikpen, 4 pens for resident 79. q. Insulin Glargine pen for resident 79. r. Novolog Flex Pen RN 4 immediately contacted the pharmacy by telephone. The pharmacist informed RN 4 that they would have to replace all the insulin pens because they could not determine if they were frozen without opening the pen. The pharmacist stated that they could leave the multidose vials of insulin out of the fridge if they could verify that it was not frozen. RN 4 stated that the intravenous antibiotics were still good as long as they could visualize that they were not frozen. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/15/24 at 11:48 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that her expectation for licensed nurses (LN) was that they were present when a resident was administering the medication on their own. The DON stated that medications should be stored in the medication cart and the LN could give them to the resident to self-administer. The DON stated that it was the same process for insulin administration. The DON stated that the LN should prepare the insulin, give it to the resident to self-administer, and then take the used syringe and vial back. The DON stated that the expectation was that the insulin was not kept at the resident bedside, and supplies such as needles would not be at the bedside. The DON stated that the assessment for the resident to self-administer medication consisted of an observation of self-administration; verifying that the resident can say what the medication was, the dosage, and when and how it should be taken. The DON stated that once the resident could demonstrate these tasks they could self-administer medications with the physician's approval. The DON stated that she would expect to see this assessment completed for any resident who had medications left at the bedside. The DON stated that if the assessment was not completed, then medication should not be left at the bedside. The DON stated that the LN should observe that the medication was self-administered and not leave them at the bedside. Some residents can say all of those things and prefer to have it left at the bedside and could take it at lunch. The DON stated that resident 92's self-administration assessment documented no to self-administer, and everything else on the assessment grayed out and the observation was done. The DON stated that for resident 92 this meant that no medication should be left at the resident's bedside. The DON stated that RN 4 informed her of the observation of the medication fridge temperature. The DON stated that all the medications were taken out, and what needed to be destroyed was destroyed.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47432 Based on observation and interview, it was determined that the facility did not store, prepare, distribute and serve food in accordance with professional standards for food safety. Specifically, the facility did not label or date multiple food items in the walk-in fridge and refrigerator, there were physical food contamination hazards present in the kitchen, and kitchen staff did not prepare and serve food in a hygienic manner. Findings Include: On 4/8/24 at 8:54 AM, an observation was made of one of the facility's freezers. Inside was an undated tub of ice cream, a box of open undated Udi buns, undated pie crusts, a package of undated [NAME] Spunkmeyer cookie dough, a bag of undated whipped topping, 7 undated frozen pies, and 2 bags of undated frozen fruit. On 4/8/24 at 8:58 AM, an observation was made of a ceiling vent and the ceiling directly above a food preparation area. The vent was covered in dust and the ceiling paint was peeling and flaky. On 4/8/24 at 9:00 AM, an observation was made of the food dry storage. There were open, undated bags of breakfast cereal including Frosted Flakes, Cheerios, and Fruit Loops stored in a plastic tub. There was an open, undated box of spanish rice. On 4/8/24 at 9:03 AM, an observation was made of the walk in refrigerator. There was noted to be undated lemonade, apple juice, cranberry juice, chocolate milk, orange juice, fruit punch, grape juice, and 2% milk sitting in an ice bath on a cart. There was an undated bag of deli ham on one of the shelves. There was an entire undated, unlabelled whole ham stored on one of the shelves. There were undated cookies, undated carrot cups, and undated pear cups stored on a baking sheet. There was a bag of celery torn open with no dates. On 4/8/24 at 9:10 AM, an observation was made of the walk-in freezer. There was an undated frozen ham stored in the freezer. There were also undated frozen potatoes, an undated open box of beef patties, an undated open box of corn dogs, and an undated open bag of chicken drumsticks. On 4/9/24 at 1:24 PM an observation was made of the juice and beverage cart in the facility hallways. None of the juice carafes were dated. On 4/10/24 at 11:29 AM, an observation was made of the walk-in refrigerator. There was an undated carafe of purple liquid with the label Apple Juice written on it. There was no date on the carafe. There was a container of cream ranch dressing with the date 12/1/23 from the manufacturer on the lid. There was a bottle of chocolate syrup dated 2/23/24. There was a bottle of breakfast syrup dated 12/16/23. There was a bottle of prune juice with no date and a resident's name written on it. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/10/24 at 11:37 AM, an observation was made of the lunch tray line. [NAME] 1 was observed to scratch her hair and then touched the plate warmer and a cookie sheet used to hold prepared food. [NAME] 1 was observed leaning over the plate warmer to look at the menu for the day. [NAME] 1's visibly soiled sweatshirt came into contact with plates on the plate warmer. At 11:43 AM, [NAME] 1 touched her face and then touched a hotel pan containing corn dogs. At 11:50 AM, [NAME] 1's sweatshirt touched several of the plates on the tray line. At 11:54 Am, [NAME] 1's sweatshirt came into contact with plates on the plate warmer again. On 4/10/24 at 12:35 PM, an observation was made of [NAME] 2. [NAME] 2 dropped a food thermometer on the ground after taking the temperature of food in the oven. [NAME] 2 rinsed the thermometer under running water in a hand washing sink, and then put the thermometer back in its case without sanitizing it. On 4/10/24 at 12:39 PM, an interview was conducted with [NAME] 3. [NAME] 3 stated that staff used to use sanitizing wipes to sanitize food thermometers, but they ran out of the wipes and now staff sanitized thermometers by dipping them into a sanitizer solution. On 4/10/24 at 11:13 AM, an interview was conducted with the Dietary Manager (DM). The DM stated that the walk-in fridge and freezer should both be checked daily to see if anything needs to be thrown away. The DM stated that items should only be stored in the refrigerator for three days. The DM stated that both the walk-in fridge and freezer are cleaned out every Monday and Thursday. The DM stated that items in the fridge should be labeled and dated with the use by date. The DM stated that a maintenance order had been submitted for the peeling paint on the ceiling above food preparation areas. The DM stated that the kitchen used bleach in the sanitizing solution used to clean the kitchen.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 22992 Based on interview and record review, the facility did not ensure that for 3 of 55 sample residents, medical records were complete and accurately documented. Resident identifiers: 3, 19, and 46. Findings include: 1. Resident 46 was admitted to the facility on [DATE] with diagnoses that included right knee flail joint, morbid obesity, weakness, insomnia, schizoaffective disorder, depression, osteoarthritis, and chronic pain. Resident 46's medical record was reviewed from 4/8/24 through 4/17/24. Resident 46's progress notes indicated that on 2/25/24 a Psych (psychiatric) NP (Nurse Practitioner) eval (evaluation) done. per provider orders, discontinue seroquel, start ability 5mg (milligrams) QAM (every morning) x (for) 1 week then increase to 10 mg QAM. The psychiatric evaluation could not be located in resident 46's medical record. On 4/17/24 at 3:40 PM, an interview was conducted with the Director of Nursing (DON). The DON confirmed that the psychiatric evaluation completed for resident 46 on 2/25/24 was not in the resident's medical record. 45470 2. Resident 19 was admitted to the facility on [DATE] with diagnoses which included Alzheimer's disease, type 2 diabetes mellitus, major depressive disorder, lack of coordination, abnormalities of gait and mobility, protein-calorie malnutrition, dysfunction of bladder, retention of urine, muscle weakness, glaucoma, essential hypertension, anxiety disorder, bipolar disorder, hyperlipidemia, insomnia, dementia, long term use of aspirin, and chronic obstructive pulmonary disease. A documented titled Observation Detail List Report from 2/3/24 documented, No wound present in the Skin Integrity section. A documented titled Observation Detail List Report from 2/8/24 documented, No wound present in the Skin Integrity section. A Physician Assistant note from 2/9/24 at 5:55 AM was reviewed and the Physician Assistant did not address the pain in the right 1st and 2nd toe as reported by a nurse in the progress note from 1/23/24. A documented titled Observation Detail List Report from 2/15/24 documented, No wound present in the Skin Integrity section. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Physician Assistant note from 2/19/24 at 8:27 AM documented, Nurse concerned about her toe. Right great toe very red and sore, 2nd toe now with redness. [Resident 19] seems sore when this area is examined. Has had a referral for podiatry pending for several weeks. Replaced this. No fever. Some honey colored crusting noted. A Progress Note from 2/19/24 at 4:17 PM documented, Provider orders podiatry referral (transport notified); Keflex 500mg [milligram] Po [by mouth] QID [four times a day] x 7 days (medication administered now), Wound care daily with Bactroban (Wound care performed). Orders placed . 2nd toe appears to have integument alteration but is difficult to fully assess d/t [due to] pain and [resident 19]'s inability to provide any hx [history] . A Progress Note from 2/20/24 at 3:43 PM documented, Appt [appointment] with podiatry . Provider writes: Significant R>L food PAD w/ [with] R 2nd toe necrosis and rubor on dependency. URGENT: recommend arterial vascular studies to the BLE's [bilateral lower extremities] before any procedures/debridement. Provider orders refer to vascular consult . A Progress Note from 2/22/24 at 6:33 PM documented, 2nd toe is getting deeper coloration today. Otherwise s/s [signs and symptoms] are the same. Wound care performed with great difficulty but dressing in place a [sic] this time. A Progress Note from 2/26/24 at 11:05 AM documented, 2nd toe vascular appt scheduled 3/8. She is taking IM [intermuscular] Rocephin QD currently. RN [registered nurse] concerned about [resident 19]'s abilities, comfort, and desires. She may endure a lot of distress and an extended process of appointments, surgery, and wound care should her toe need to be amputated. [Resident 19] may be candidate to return to hospice. ADON [Assistant director of nursing]/provider/hospice notified . A Progress Note from 3/4/24 at 12:43 documented, Wound care performed, Deep purple area on plantar and mesial aspect of 2nd toe, and beneath the toenail of the hallux . A Progress Note from 3/7/24 at 6:01 PM documented, Pt [patient] saw vascular specialist today. Progress note from vascular physician stated: I attempted to call and speak with [resident 19]'s nurse, but no one would answer the phone. I am a previous provider for [resident 19] as I was a rounding nurse practitioner there at one time, so I am familiar with her past medical history. She has dementia, and is unable to give me info. I cannot feel good pulses in her bilateral feet unsure how long. Wound, but she expressed discomfort during evaluation and scans. Dx [diagnosis] PVD she is in need of bilateral angiogram for revascularization starting on the right side due to wounds her left lower extremity will follow a week later. A documented titled Observation Detail List Report from 3/7/24 documented, No wound present in the Skin Integrity section. 45490 3. Resident 3 was admitted to the facility on [DATE] with diagnosis which included polyneuropathy, weakness, type 2 diabetes mellitus, and other abnormalities of gait and mobility. Resident 3's medical record was reviewed from 4/8/24 through 4/17/24. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/17/24 at 3:45 PM, a nursing progress note indicated that resident 3 had REOPENED WOUND TO SACRUM REPORTED TODAY, HOSPICE NURSE . NOTIFIED . CLEANSED WITH NS [normal saline] . On 3/17/24 a physicians order documented, WOUND CARE: Sacrum-clean wound with wound cleaner or normal saline. Skin prep peri-wound. Apply collagen AG to wound base and cover with bordered foam. Change 3X (times)/WEEK and as needed if soiled or dislodged . A document titled Long Term Weekly assessment dated [DATE], revealed a section titled Integumentary documenting skin integrity as No wound present. A document titled Weekly Skin Assessment documented No wound present. On 4/17/24 at 3:24 PM, an interview was conducted with Registered Nurse (RN) 4. RN 4 stated that a weekly skin check is completed on the residents and the resident has a new skin condition it will be documented in there. RN 4 stated that if a wound already existed then it would still be documented on the assess to indicated the resident still has a skin issue. On 4/17/24 at 3:35 PM, an interview was conducted with the Director or Nursing (DON). The DON stated that if a resident has a skin issue or wound it would be documented it the chart. The DON stated that it wouldn't always be documented in the skin assessment, and that it just depends on the nurse if they will chart it. The wound would be charted as a progress note or it would be on the TAR (Task Administration Record).

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 22992 Based on interview, record review, and observation, the facility did not establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. In addition, the facility did not develop and implement appropriate plans of action to correct identified quality deficiencies. Resident identifiers: 19, 20, 60, 80, 166, and 260. Findings include: 1. Based on interview and record review it was determined that for 1 of 55 residents that the facility did not ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and if necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. Specifically, a staff member documented a problem with a resident's toe, and it was not addressed by a doctor for 27 days, at which point the toe had become necrotic and surgery was required. Resident identifier: 19. [Cross refer to F687] 2. Based on observation, interview, and record review, the facility failed to ensure that the resident environment remained free of accident hazards as was possible and each resident received adequate supervision and assistance to prevent accidents. Specifically, for 6 of 55 sampled residents, a resident was left unsupervised with a damaged bedside table and the resident was observed pulling on the broken plastic with sharp edges, a resident fell outside while smoking resulting in femur fracture, a resident bed was not locked in place resulting in a fall with a finger injury, a resident was being assisted with a transfer by a family member outside, resulting in the resident falling and dislocating a shoulder, a resident sustained an unwitnessed fall and remained on the floor for an extended period of time, and a resident with a history of falling was observed to be on the floor for more than 30 minutes. These findings resulted in a citing of harm for three residents. Resident identifiers: 19, 20, 60, 80, 166, and 260. [Cross refer to F689] 3. During the previous recertification survey completed on 8/9/22, the facility was cited for F584, F677, F725, F761, F842, and F867, among others. During the current recertification survey, these deficiencies were cited again. 45470 (continued on next page)

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	465067	A. Building B. Wing	04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rocky Mountain Care - Clearfield	1481 East 1450 South Clearfield, UT 84015

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/17/24 at 3:27 PM an interview with the Administrator was conducted. The Administrator stated that the QAPI team met at least quarterly but tried to meet monthly if possible. The Administrator stated that the QAPI team consisted of the Administrator, the Medical Director, the Dietary Manager, the Director of Nursing, the Resident Advocate, Social Work, Nurse Management, and Therapy. The Administrator stated that every month, members of the QAPI team would bring information including quarterly measures, grievances, infection control updates, among other assignments that the staff go over and determine what areas needed to be improved. The Administrator stated that once an improvement process had begun, monitors were put in place and were checked as needed. The Administrator stated that if the improvement process was not working, then they would change the process and continue to monitor until the improvement process met satisfactory levels. The Administrator stated that a recent process that the QAPI team worked on was increasing the Physician visits for residents.

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46232 Based on interview and record review, it was determined, the facility did not ensure that each resident's medical record included documentation that indicated that the resident or resident's representative was provided education regarding the benefits and potential side effects of the influenza and pneumococcal immunizations; and that the resident either received the influenza and pneumococcal immunizations or did not receive the influenza and pneumococcal immunizations due to medical contraindications or refusal. Specifically, for 3 sampled residents, the facility did not keep documentation within the residents' medical record regarding the residents' pneumococcal consent status or education of the benefits and potential risks associated with the immunization. Resident identifiers: 3, 15, and 19. Findings Included: 1. Resident 3 was admitted to the facility on [DATE] with the following diagnoses of polyneuropathy, unspecified fracture of left femur, type 2 diabetes mellitus without complications, gastro-esophageal reflux disease without esophagitis, and anxiety disorder. Resident 3's medical record was reviewed on 4/17/24. A review of the immunization section of the medial record documented that on 10/5/23, resident 3 had received their pneumococcal vaccine outside of the nursing home. A consent/refusal or education regarding the pneumococcal immunization was not provided or located in resident 3's medical record to indicate it had been offered. 2. Resident 15 was initially admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnoses of undifferentiated schizophrenia, hypothyroidism, chronic kidney disease, unspecified protein-calorie malnutrition, and anxiety disorder. Resident 15's medical record was reviewed on 4/17/24. On 10/25/23, an immunization forecast revealed that resident 15 was due for their pneumococcal immunization on 8/1/10. A consent/refusal or education regarding the pneumococcal immunization was not provided or located in resident 15's medical record to indicate it had been offered. 3. Resident 19 was admitted to the facility on [DATE] with the following diagnoses of Alzheimer's disease, Type 2 diabetes mellitus without complications, Major depressive disorder, Neuromuscular dysfunction of bladder, Chronic obstructive pulmonary disease, Generalized anxiety disorder, and insomnia. Resident 19's medical record was reviewed on 4/17/24. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The immunization record documented resident 19 had been administered the pneumococcal vaccine on 12/26/22 at the facility. A consent/refusal or education regarding the pneumococcal immunization was not provided or located in resident 19's medical record. On 4/17/24 at 1:59 PM, an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated when a resident was admitted to the facility, staff looked up their vaccination information in USIIS [Utah Statewide Immunization Information System] to see if the resident was up to date with their immunizations. The ADON stated resident records were updated when they received any immunization while in the facility. The ADON stated resident filled out forms to indicate if they accepted or denied the vaccine being offered to them. The ADON stated those forms were the consent forms and they were part of the acceptance or declination process for immunizations. The ADON stated if a resident had already received a vaccine elsewhere, then the resident was responsible for filling out a consent form declining the vaccine at the facility. The ADON stated if a resident declined a vaccine, it meant either the resident did not want it, or they have already received it. The ADON stated the pneumococcal vaccine was offered on a resident-by-resident basis and/ or upon request. The ADON they followed the CDC [center for disease control and prevention] guidelines on administering vaccines. On 4/17/24 at 2:41 PM, an interview was conducted with the Director of Nursing (DON). The DON stated resident consents forms for immunizations were in the resident medical record. The DON stated there was a process in place to get the immunization consents forms scanned into the resident's medical record. The DON stated the flu shot was offered from October to March and the pneumococcal vaccine was offered on admit. The DON stated they were working on improving their system with the covid and pneumococcal vaccines. The DON stated they were working on making sure residents were being offered their pneumococcal and covid when needed. The DON stated they were aware there were residents that had not been offered their pneumococcal vaccine for a while and were working on getting those residents up to date. The DON stated consent forms were done when residents were offered any kind of immunization, and it indicated if a resident wanted the vaccine or had refused it. The DON stated the main purpose of the consent form was to make sure resident consent was obtained prior to giving what was being offered to the resident.

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F 0923 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have enough outside ventilation via a window or mechanical ventilation, or both. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47432 Based on observation and interview, it was determined that the facility did not have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two. Specifically, there were numerous odors throughout the facility. Findings Include: On 4/8/24 at 10:30 AM an observation was made of the 200 hallway. There was a strong odor of bowel movement throughout the hallway. On 4/8/24 at 11:53 AM, an observation was made of the 300 hallway. There was a strong smell of urine throughout the entire hallway. On 4/10/24 at 8:22 AM, an observation was made of the 400 hallway. There was a strong odor of urine throughout the hallway. On 4/10/24 at 8:32 AM an observation was made in the 100 hallway. There was a strong odor of bowel movement throughout the entire hallway. On 4/10/24 at 8:42 AM, an observation was made of the 400 hallway. The strong odor of urine was still present. On 4/10/24 at 9:17 AM, an observation was made of the intersection between the 200 hall and the 300 hall. There was an odor of urine. On 4/10/24 at 2:30 PM, an observation was made of the hallway near room [ROOM NUMBER] and the soiled laundry entrance. There was an odor of garbage and feces. On 4/10/24 at 3:49 PM an observation was made in the 100 hallway. There was a strong odor of bowel movement throughout the entire hallway. On 4/16/24 at 1:05 PM, an observation was made of the hallway near room [ROOM NUMBER] and room [ROOM NUMBER]. There was an odor of urine. On 4/17/24 at 11:45 AM, an observation was made at the nurses station between the 300 and 400 hallways. There was a strong smell of feces. On 4/17/24 at 1:41 PM, an observation was made of the hallway near room [ROOM NUMBER] and room [ROOM NUMBER]. There were odors of urine and feces. On 4/17/24 at 1:42 PM, an observation was made of the nurse's station at the intersection of the 200 hall and 300 hall. There were odors of urine and feces. On 4/17/24 at 1:43 PM, an observation was made of the hallway outside rooms 107,109, 110, and 111. There were odors of feces and urine. (continued on next page)

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F 0923 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/17/24 at 1:50 PM, an observation was made of the 300 hall near room [ROOM NUMBER]. There was an odor of feces. On 4/17/24 at 1:51 PM, an observation was made of the hallway outside rooms 201, 202, 203, 204. 205, 207, and 208. There was an odor of urine. On 4/17/24 at 2:15 PM, an interview was conducted with Housekeeper (HK) 1. HK 1 stated that when housekeeping cleans, they use a natural odor freshener spray to remove odors. On 4/17/24 at 2:20 PM, an interview was conducted with HK 2. HK 2 stated that housekeeping staff use pine sol to clean the floor and remove odors and that housekeeping staff use a fresh bottle spray to manage odors throughout the building. On 4/17/24 at 2:23 PM, an interview was conducted with HK 3. HK 3 stated that housekeeping staff use Febreze and Pine Sol to remove odors throughout the facility. 43212 45470