STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465086	A. Building B. Wing	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Health Services	5865 South Wasatch Drive Ogden, UT 84403

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 47432 Based on observation and interview, the facility did not ensure that residents have a right to a dignified existence. Specifically, for 3 out of 30 sampled residents, the facility served resident meals on disposable dishware, there were long call lights, there was a resident with socks with holes, and there were observations of staff talking down to residents in the facility. Resident identifiers: 12, 15, and 22. Findings Included: 1. On 7/28/24 at 11:46 AM, an observation was conducted of the lunch meal tray service. The mobile hot buffet was observed in the 300 hallway. Staff were observed preparing the lunch meal for residents eating in their rooms. The lunch meal was served on Styrofoam plates, disposable plastic cups, Styrofoam cups, and disposable cutlery. On 7/30/24 at 12:18 PM, an observation was made of the lunchtime hallway meal tray service. It was noted that residents that chose to eat in their bedroom received their meal on a Styrofoam plate with disposable cutlery. On 8/10/24 at 1:56 PM, an observation was made of resident 22. Resident 22 was observed to be eating in his room from a Styrofoam plate and disposable utensils. Resident 22 stated it was alright to eat off of Styrofoam. On 7/30/24 at 13:33 PM, an interview was conducted with Dietary Aide (DA) 1. DA 1 stated that residents who eat in their room were always served meals on disposable plates with disposable cutlery because it was easier for the residents and the Certified Nursing Assistants (CNA). DA 1 stated that sometimes normal dishware would get thrown away or go missing when it was used for residents that eat in their rooms. DA 1 stated that residents that eat in the dining room received their meal on reusable dishware and with reusable utensils. 33215 2. Resident 15 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, type 2 diabetes mellitus with foot ulcer, schizoaffective disorder bipolar type, generalized anxiety disorder, post-traumatic stress disorder, borderline intellectual functioning, stimulant dependence, and attention-deficit hyperactivity disorder. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/12/24 at 1:53 PM, an observation was conducted of resident 15. Resident 15 was observed to walk to the nurses station and asked the Business Office Manager (BOM) if she would check her account to see how much money she had in the account. The BOM stated to resident 15, the account that you have almost spent everything. Resident 15 stated to the BOM that she did not need to be lectured by her and she just needed to know. The BOM stated to resident 15 that she needed the receipts and that resident 15 and the case worker had been spending down resident 15's money. Resident 15 stated to the BOM that she had never asked for receipts. The BOM was observed to walk away from resident 15 towards the front entrance of the facility. Resident 15 stated to the State Survey Agency (SSA) Lead Licensor that the BOM would not even talk to her and the BOM just walks off. Resident 15 stated to the SSA Lead Licensor that she had been at the facility for eight months before she got any of her money and the BOM had not asked for receipts ever. Resident 15 stated to the SSA Lead Licensor that the doctor had only been to the facility on ce in the last few months and the Nurse Practitioner never came and visited with her. 30563 3. On 8/10/24 at 1:40 PM, an observation was made of resident 12. Resident 12 was observed to have non-skid socks on that had holes and resident 12's heels and bottom of his feet were exposed. Resident 12 stated that he had those socks for a while and it was hard to get his socks over his heel. 43212 4. On 8/9/24 at 8:00 PM, an observation was made of a call light illuminated at resident room [ROOM NUMBER]. At 9:04 PM, the call light was observed to still be illuminated. On 8/9/24 at 8:00 PM, on observation was made of a call light illuminated at resident room [ROOM NUMBER]. At 9:04 PM, the call light was observed to still be illuminated. 50200 On 8/10/24 at 1:53 PM, an observation was made of the call light on for resident room [ROOM NUMBER]. At 2:16 PM, an observation was made of the call light answered for resident room [ROOM NUMBER]. On 8/12/24 at 10:28 AM, an observation was made of the call light on for resident room [ROOM NUMBER]. On 8/12/24 at 10:36 AM, an observation was made of CNA 3 stating she needed to pass ice to the other hall before she could help the resident in room [ROOM NUMBER]. The call light for resident room [ROOM NUMBER] remained on. On 8/12/24 at 10:40 AM, an observation was made of the resident from room [ROOM NUMBER] leaving their room and coming to answer a phone call. On 8/12/24 at 10:54 AM, an observation was made of CNA 1 turning off the call light for resident room [ROOM NUMBER] and assisting the resident from room [ROOM NUMBER]. On 8/13/24 at 9:25 AM, an observation was made of the call light on for resident room [ROOM NUMBER]. At 9:45 AM, an observation was made of the call light being answered for room [ROOM NUMBER].

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22992 Based on interview and record review, the facility did not inform the resident representative for 2 of 30 sample residents when there was a significant change in the residents' physical, mental or psychosocial status; or when there was a need to alter treatment significantly. Specifically, two residents had a change in condition, but the facility did not attempt to contact the representative when the change of condition occurred. Resident identifiers: 25 and 46. Findings include: 1. Resident 46 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included hemiplegia and hemiparesis, chronic obstructive pyelonephritis, severe sepsis without shock, aspiration pneumonitis, acute kidney failure, supraventricular tachycardia, and bipolar disorder. Resident 46's medical record was reviewed from [DATE] through [DATE]. Progress notes for resident 46 indicated that on [DATE] at 9:24 AM, resident 46 was .having black tarry vomit, constant diarrhea, respirations 40, hunched over more than usual . MD notified and ordered resident to be sent to hospital for eval (evaluation). attempted to notify family with no response from only contact. A History and Physical for resident 46 dated [DATE] documented that resident 46 presented to the local emergency room after facility staff observed resident 46 to have some coffee-ground looking emesis and acute hypoxic respiratory failure. The hospital physician documented that resident 46 had a history of deep vein thromboses and was currently receiving a blood-thinning medication. Resident 46 was diagnosed with sepsis with acute hypoxic respiratory failure and a gastrointestinal bleed at that time. The document also stated, Patients (sic) previous power of attorney was his sister, but we are being told she has unfortunately passed away. SW (social work) looking into other family members. Progress notes for resident 46 revealed the following entries: a. On [DATE], resident 46 was seen by Nurse Practitioner (NP) 2. NP documented that resident 46 . is a [AGE] year-old male with a history of CVA (cerebrovascular accident), COPD (chronic obstructive pulmonary disease) and multiple previous hospitalization s. Today patient was seen for his recertification visit. He was resting in his bed and appeared comfortable, no signs of distress. Patient reports he is doing fine. He is eating well, sleeping good, no issues with bowels or bladder, no anxiety or depression, no uncontrolled pain, anxiety or depression. He denied any current issues or concerns. Floor staff reports he is doing well. NP 2 did not document any acute health concerns upon assessment of resident 46. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. On [DATE] at 9:30 PM, Registered Nurse (RN) 2 documented that there was a New order for Rocephin 1 Gm (gram) IM (Intramuscular) tonight, Sat (Saturday) [and] Sun (Sunday). for possible cholecystitis. Zofran 4 mg (milligrams) SL (sublingual) q (every) 6 hrs (hours). prn (as needed) N/V (nausea/vomiting). Schedule Tylenol 650 mg TID (three times a day) c (?) 3 days for abdominal pain. Stat (immediate) ultrasound of abdomen RUQ (right upper quadrant) and LLQ (left lower quadrant). No documentation was included in the note to indicate what occurred to prompt staff to contact the physician. c. On [DATE] at 6:15 AM, RN 2 documented, Resident was heard by nurse urping (sic) up fluid. I went into his room and his roommate said he kept doing this. I checked him over and he had some brown- black fluid on the left side of his mouth. I told him not to swallow the fluid and to cough it into an emesis basin which I [NAME] (sic) to him. His VS (vital signs) were taken. T (temperature) 98.1, P (pulse) 112, R (respirations) 16 B/P (blood pressure) ,d+[DATE] and 02 (oxygen) sats (saturations) 94% on room air. I could hear bowel sounds in upper quadrant but minimal in lower quads. He stated that his pain was above his right navel and below it. Fluid brought up was a dark brownish color. MD PA (Physician Assistant) notified at 2200 (10:00 PM) with Rocephin, Zofran and scheduled Tylenol order. See MAR (Medication Administration Record) and progress noted (sic). Also a stat (immediate) ultrasound was ordered. Call was made to [name of contracted radiology provider] this AM (morning) and they stated that they donot (sic) do ultrasounds on the weekends. MD to be notified by day nurse, which was agreed in report this AM. [Note: The facility had been performing weekly vital signs on Resident 46. Per facility documentation, on [DATE], Resident 46's blood pressure was , d+[DATE] and his pulse was 67. Per the facility's vital sign records for Resident 46, between [DATE] and [DATE], Resident 46's blood pressure was generally consistent with the reading obtained on [DATE]. Resident 46's pulse had ranged from 58 to 85.] d. On [DATE] at 12:50 PM, RN 3 documented that resident 46 . has vomitted (sic) once this shift, it was a light brown color. He has requested more prune juice, but I denied that request and explained that we want to see why his vomit is brown. [Resident 46] had been laying in his vomit all night, we got him up to the shower and changed his bedding. His entire left arm, side of torso, and hip are very red. Cleaned well and put on hydrocortisone cream and barrier cream. Texted pic (picture) to provider of his inflamed skin. RN 3 did not document whether she had informed resident 46's physician of the ongoing brown emesis that resident 46 was experiencing. In addition, RN 3 did not document any indication that she was aware of the stat ultrasound order, or what the status was in obtaining the ultrasound. e. On [DATE] at 4:36 PM, RN 4 documented that resident 46 had a Small amount of dark brown emesis early this morning. No other episodes this shift. f. On [DATE] at 10:21 PM, RN 5 documented, Res (resident) currently on ABX (antibiotics) IM, (2nd dose) Medication was administered per MD orders. Res tolerated procedure well, there has been no ASE (adverse side effects) observed or reported. Fluids encouraged. RN 5 did not document any assessment with regard to resident 46's abdominal pain, nausea or vomiting. [Note: This note was entered as a late entry on [DATE] at 8:24 AM.] (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	g. On [DATE], at 11:00 AM, RN 4 documented that the contracted radiology provider . cannot ultrasound until [DATE]. Medical directorship notified and ordered to have ultrasound done at [name of local hospital]. Scheduled with [name of local hospital] [DATE] at 0900 (9:00 AM) check in 0845 (8:45 AM). NPO (nothing by mouth) 8hrs (hours) prior to procedure. Medical directorship notified. No emesis on this shift and no reports of emesis on night shift. Resident states he does still have abdominal pain but is able to eat. h. On [DATE] at 8:25 PM, RN 5 documented that resident 46, . continues on ABX IM, (final dose) Medication was administered per MD orders. Res tolerated procedure well, there has been no ASE observed or reported. Res instructed to move RUE (right upper extremity) often to decrease stiffening in the muscle/pain. Fluids encouraged. RN 5 did not document any assessment with regard to resident 46's abdominal pain, nausea or vomiting. [Note: This note was entered as a late entry on [DATE] at 8:28 AM.] i. On [DATE] at 3:00 AM, RN 5 documented, CNA (Certified Nursing Assistant) completed rounds at 12:30am at which time resident was A&O (alert and oriented), brief was changed, resident was talking with staff. CNA started rounds at 02:30 (2:30 AM) upon entering residents' room, CNA exited notified nurse via radio to come down to res room. This nurse immediately went down, performed a quick assessment w/ (with) visual observation. Res had no pulse, eyes open, pale/ash color. No heart sounds. resident feet and hands cold with modeling. (02:45) (2:45 AM) Res was upright HOB (head of bed) ,d+[DATE]-degree, emesis was observed down L (left) side of resident's shirt. There had been no emesis throughout this shift or reported from day shift, resident had no complaints after dinner, other than some abdominal pain, Tylenol offered, res declined. Res took all medication w/o (without) difficulty. Res was scheduled for an abdominal ultrasound this morning at 08:45 (8:45 AM). Appt (appointment) has been cancelled. Facility CNA provided post-mortem care, and reported resident continued to excrete emesis from mouth. Res has emergency contacted listed, who since has passed away. [Name of mortuary] was contacted. Body was received from this facility at 05:45 am (5:45 AM). MD, DON (Director of Nursing) and administrator notified. Progress notes documented that the facility staff had not attempted to contact the resident's power of attorney (POA)/only family member about resident 46 between [DATE] and [DATE]. In addition, the facility did not attempt to contact the resident's power of attorney/only family member about resident 46's change in condition preceding his death. No progress notes were located to indicate that the facility was aware that the resident's POA was deceased or made any attempts to identify another POA. 48709 2. Resident 25 was admitted to the facility on [DATE], and readmitted on [DATE] with diagnoses which included sepsis, acute respiratory failure, type 2 diabetes mellitus, vascular dementia, pneumonia, pressure ulcer of left heal, metabolic encephalopathy, hypertension, and atrial fibrillation. Resident 25's medical record was reviewed from [DATE] through [DATE]. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Health Status Note dated [DATE] at 10:33 PM indicated, Res [resident] lungs assessed this shift, resident c/o [complained of] pain with inhalation, lower lobes junky to auscultation, wheezing heard from chest, resident unable to maintain 02 [oxygen] sats [saturation] above 90 w/o [without] use of oxygen concentrator 02 91% 3L [liters]/min [minute]. MD [medical doctor] notified, Order given, routine CXR [chest xray] to r/o [rule out] pneumonia. [Company name redacted] notified; X-ray technician will be out to facility in the morning [DATE], to perform diagnostic request. Order has been written, unable to print, copy saved under documents for day shift to print. Will pass on to upcoming shift nurse to forward results to MD. An Administration Note dated [DATE] at 8:40 AM indicated, sent to hosp [hospital]. On [DATE] at 1:42 PM, an interview with the Director of Nursing (DON) was conducted. The DON stated when she came in on [DATE] at 6:00 AM, resident 25 was ashen and struggling to breathe. The DON stated she notified the nurse practitioner and he was sent to the hospital at 7:30 AM. The DON stated she should have done a progress note for his change of condition and transfer, but she did not have time. There was no documentation provided in the medical record that indicated the resident's physician and resident's representative was notified of the change of condition and transfer.

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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, the facility did not provide a safe, clean, comfortable, and homelike environment. Specifically, there were several brown carpet stains found in multiple residents' rooms, there was a television antenna hanging from the ceiling of a resident room, there were damaged blinds in a resident's room, and a resident had dirty wheelchair tires from being pushed through a brown substance found on the floor of the facility. Findings Included: 50200 On 7/28/24 at 10:26 AM, an observation was made of resident room [ROOM NUMBER]. There was a large discolored area under the air conditioner near the window. There was a brownish stain on the carpet to the right side of the bed. On 7/28/24 at 12:15 PM, an observation was made of a brown substance on the floor of the bathroom in resident room [ROOM NUMBER] which had been run over by the wheelchair. The brown substance was observed to be on the wheelchair tires. On 7/28/24 at 12:30 PM, an observation was made of the floors throughout the 100 hallway to be sticky. On 7/28/24 at 12:32 PM, an observation was made of a television antenna box hanging from a curtain hook in resident room [ROOM NUMBER]. On 7/28/24 at 12:50 PM, an observation was made of the brown substance to be removed from the bathroom floor but remained on the wheelchair tires. On 7/29/24 at 7:54 AM, an observation was made of resident room [ROOM NUMBER]. The carpet had a brownish stain on the right side of the bed. The carpet had multiple stains of varying size and food debris scattered throughout. On 7/29/24 at 8:15 AM, the window blinds in resident room [ROOM NUMBER] were observed to broken and missing pieces. On 7/29/24 at 1:11 PM, an observation was made of resident room [ROOM NUMBER]. The carpet had a brownish stain on the right side of the bed. The carpet had multiple stains of varying size and food debris scattered throughout and the resident's nasal cannula was on the floor. On 7/30/24 at 7:36 AM, an observation was made of the carpet of resident room [ROOM NUMBER]. The carpet had a brownish stain on the right side of the bed. The carpet had multiple stains of varying size and food debris scattered throughout. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/30/24 at 10:42 AM, an observation was made of the carpet in resident room [ROOM NUMBER]. The carpet had a brownish stain on the right side of the bed. The carpet had multiple stains of varying size and food debris scattered throughout. On 7/31/24 at 7:31 AM, an observation was made of the carpet in resident room [ROOM NUMBER]. The carpet had a brownish stain on the right side of the bed and multiple stains of varying sizes. On 8/10/24 at 1:45 PM, an observation was made of resident room [ROOM NUMBER]. The carpet was observed to have large stains on it. On 7/30/24 at 9:29 AM, an interview was conducted with Housekeeper (HK) 1. HK 1 stated that the residents' rooms were cleaned every day at the facility. On 7/30/24 at 10:15 AM, an interview was conducted with HK 2. HK 2 stated that housekeeping used cleaning supplies to clean rooms and that they were provided with all of the necessary supplies to complete their job. On 7/30/24 at 10:40 AM, a follow up interview was conducted with HK 1. HK 1 stated housekeeping cleaned all the rooms in the 100 hallway daily. HK 1 stated that they vacuumed the carpets and tried to clean the floors. HK 1 stated that it was hard to keep the floors clean. On 7/30/24 at 10:43 AM, an interview was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 stated that housekeeping came everyday to clean. CNA 1 stated the facility wanted the CNAs to attempt to clean up any messes. On 7/30/24 at 11:11 AM, a follow up interview was conducted with HK 2. HK 2 stated that housekeeping cleaned the bathrooms and took out the trash. HK 2 stated that she thought the large discoloration in resident room [ROOM NUMBER] was from the heater or air conditioner unit. On 7/30/24 at 11:26 AM, an interview was conducted with the Administrator (ADM). The ADM stated the sprinkler had been turned the wrong way and flooded the carpet of resident room [ROOM NUMBER]. The ADM stated the discoloration had been on the floor for two months. The ADM stated that the carpet was not a super high priority because it was just sprinkler water. The ADM stated that the discoloration looked bad, but did not smell. The ADM stated that the television antenna box in resident room [ROOM NUMBER] was hung by maintenance. The ADM stated he did not think it would fall down off the hook and he thought it looked secure. On 7/30/24 at 11:35 AM, an observation was made of the ADM asking HK 2 to clean the floors on the 100 hallway because they were sticky. On 7/31/24 at 7:33 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that the hanging antenna box was a safety hazard and should never been hung like that. The DON stated that a resident could knock it off the hook and get hurt. 33215 30563

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47432 Based on interview and record review, the facility did not ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than two hours after the allegation was made if the events that cause the allegation involve abuse or result in serious bodily injury. Specifically, for 2 out of 30 sampled residents, an entity report of a physical abuse allegation was not submitted to the State Survey Agency (SSA) until three days after the incident and an entity report of a neglect allegation was not reported to the SSA until 14 days after the incident. Resident Identifiers: 29 and 41. Findings Included: 1. Resident 41 was admitted to the facility on [DATE] with diagnoses including cellulitis of left lower limb, methicillin resistant staphylococcus aureus infection unspecified site, malaise, venous insufficiency, localized edema, morbid severe obesity due to excess calories, chronic atrial fibrillation unspecified, essential hypertension, anxiety disorder, and obsessive-compulsive disorder. Resident 41's medical record was reviewed from 7/28/24 through 8/14/24. On 6/14/24 at 12:28 PM, a nursing progress note documented, CNA [Certified Nursing Assistant] in to give resident a shower and resident was agitated. Relieved CNA and finished shower and had no issues. Patient does refuse showers and this was an exceptional opportunity for her as she did her own with min [minimum] assist. No other issues and she currently has a visitor at this time. On 6/17/24 at 1:01 PM, a facility initial notification, form 358, was submitted to the SSA. The form documented an incident of physical abuse. The form documented that staff had become aware of the incident on 6/14/24 at 12:00 PM. The form documented that the incident was reported by CNA 2 to Licensed Nurse 4 that CNA 2 had attempted to shower resident 41. During the shower, resident 41 became resistant and started to hit and scratch at CNA 2. Resident 41 slapped CNA 2 in the face and scratched the tops of both of CNA 2's arms. Documentation showed that Adult Protective Services, police, and the ombudsman were not notified of the incident. On 6/21/24 at 4:32 PM, a facility follow-up notification, form 359, was submitted to the SSA. The form indicated that the allegation of physical abuse was not substantiated. The form documented that the incident was, . a series of events that quickly escalated out of control. The form documented that resident 41 had become upset during her shower because she wanted to wash herself using baking soda instead of soap provided by the facility. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/31/24 at 11:32 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that during the incident she had been called into the shower room to de-escalate resident 41 and CNA 2. The DON stated that she was able to calm resident 41 down and complete the shower. The DON stated that after the incident, she wrote up an incident report and reported the incident to the facility Administration. Documentation showed that an incident report was completed for the incident on 6/14/24 at 5:55 PM. Documentation showed that the nursing home Administrator was notified of the incident on 6/14/24 at 12:00 PM. On 7/31/24 at 2:50 PM, an interview was conducted with the Administrator (ADM). The ADM stated that the incident was submitted late because the online submission portal did not provide him with a confirmation email when it was first submitted, so he later resubmitted the form. (Note: Documentation showed that the SSA provided an incident intake number to the facility through email on 6/20/24 at 9:02 AM.) The ADM stated that during the incident resident 41 became aggressive and told CNA 2 to stop. The ADM stated that CNA 2 tried to rinse the soap off of resident 41, but resident 41 slapped CNA 2 in the stomach and face, then scratched CNA 2's arms. The ADM stated that after the incident staff were provided training on bathing, resident rights, encouragement, and conflict resolution. 50200 2. Resident 29 was admitted to the facility on [DATE] with diagnoses which included, but not limited to, dysarthria and anarthria, gastro-esophageal reflux disease without esophagitis, dysphagia, nonruptured cerebral aneurysm, major depressive disorder, chronic kidney disease, anemia in chronic kidney disease, muscle weakness, cognitive communication deficit, and history of falling. Resident 29's medical record was reviewed on 7/29/24. On 5/27/24 at 12:13 AM, a general note documented, Resident yelling at staff. She thinks she didn't get her HS [at bedtime] medications. This nurse explained to her she did, and another resident told her she witnessed her getting her HS meds [medications]. Resident then put herself on the floor. Unwitnessed fall, This nurse and CNA tried to start neuro [neurological] checks and vitals and she refused. Night CNA on 100 Hall signed refusal on neuro check sheet with this nurse. Assessment done and no injuries and no c/o [complaining of] pain. Resident put back to bed and she is calm now. WCTM [will continue to monitor]. On 5/27/24 at 12:36 AM, a general note documented, [Nurse Practitioner 2] Notified VIA phone text message of fall. Day nurse to notify family. On 6/10/24 at 5:05 PM, facility exhibit 358 entity report documented, that on 6/6/2024 the Resident's nephew began yelling at staff and stated staff were abusing the Resident because of a bruise on the Resident's buttocks from a fall. The Resident had an unwitnessed fall on 5/26/2024 at 11:55 PM and was found on the floor next to her bed. No injuries were noted after the fall and the Resident refused neuro checks. Resident is [resident 29's name redacted]. On 6/18/24 at 4:40 PM, facility exhibit 359 was submitted to the SSA. Facility exhibit 359 entity report documented, no evidence was found of neglect based on the interviews with Nurse and Multiple CNAs. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility exhibit 358 entity report documented that the Administrator was notified of the incident on 5/26/24, via text message and the incident was not reported to the SSA until 6/10/24 at 5:05 PM. Facility exhibit 359 entity report was not submitted to the SSA until 6/18/24 at 4:40 PM. On 7/31/24 at 7:17 AM, an interview was completed with the DON. The DON stated that the Administrator was supposed to do thorough investigations when there were allegations of neglect with residents. The DON stated that she was unsure of the facts regarding the allegation. On 7/31/24 at 2:55 PM, an interview was conducted with the ADM. The ADM stated that this became a reportable incident because the resident did not get her medications and threw a fit and ended up on her floor and the nephew came in a week and a half later and screamed at staff about abusing and neglecting the resident. The ADM stated that based off of what was told the resident was found on the floor and staff tried to assist her back into bed. The ADM stated that he viewed the incident as just a fall and wondered if he really needed to report it to the SSA. The ADM stated that he had five calendar days to submit the 359.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33215 Based on interview and record review, in response to allegations of neglect the facility did not have evidence that all alleged violations were thoroughly investigated. Specifically, for 1 out of 30 sampled residents, a resident that had multiple falls and sustained an acute complete femoral neck fracture with partial displacement did not have the fracture investigated for neglect. Resident identifiers: 298. Findings included: Resident 298 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included, but were not limited to, dementia, essential hypertension, acute kidney failure, and anxiety disorder. Resident 298's medical record was reviewed on 8/7/24. A Baseline Care Plan signed by the Director of Nursing (DON) on 3/28/24, documented that resident 298 did not have a history of falls and a Fall Management Care Plan was not implemented. On 3/29/24, a Morse Fall Scale documented that resident 298 was a High Risk for Falling with a score of 50. A resident was considered a High Risk with a score of 45 and higher. An admission Minimum Data Set (MDS) assessment dated [DATE], documented that resident 298 had a Brief Interview for Mental Status (BIMS) score of 13. A BIMS score of 13 to 15 would indicate intact cognition. The Care Area Assessment Summary of the MDS documented that falls had triggered to be care planned. On 4/11/24 at 8:29 AM, a Fall Incident Report documented Staff radio nurse, to report resident fell . Nurse knocked and entered res [resident] room. Staff reported fall was witnessed. Res was assessed, res cognitive to baseline, A&O [alert and oriented] x2, name and situation. PERRLA [pupils are equal, round, and reactive to light and accommodation] WNL [within normal limits], ROM [range of motion] completed without difficulty, res assisted into bed. Res was painful r/t [related to] skin tear to R [right] elbow., res had a reddened area R lateral side just below hair line. Staff reported that redness to forehead was there earlier before the fall. Res had a large skin tear to R elbow, wound Tx [treatment] provided, affected area was cleansed with wound cleaner, pat dry. using steri strips tear was close and approximated well. Bacitracin applied, covered with non-adherent dressing, and wrapped. Neuro's [neurological's] started per protocol. MD [Medical Director], family notified via voicemail, and DON 04/12/2023. Res stated his feet fell out from under him and he fell to the ground. Res stated he hit head and touched over red area to R side of forehead. [Note: Neuro's were unable to be located.] A care plan Focus initiated on 4/12/24, documented The resident has had an actual fall with minor injury d/t [due to] Hypotension and Unsteady gait. The interventions included: a. Anticipate patients needs and monitor for unsteady balance. Date Initiated 4/11/24. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Continue interventions on the at-risk plan. Date initiated 4/12/24. [Note: The at-risk plan was unable to be located.] On 5/18/24 at 3:59 AM, a Health Status Note documented Note Text: Resident fell in his room about 1900 [7:00 PM]. It was an unwitnessed fall lost his balance and went down on his left side. Able to move all his extremities without pain. A small red mark was found on his left back shoulder. He was too weak to get up on his own. Three maximum assist to left [sic] him onto his lounge chair. Vital signs taken and T [temperature] 98.0, P [pulse] 64, R [respirations] 28 B/P [blood pressure] 96/56 and 02 [oxygen] sats [saturations] 92% on room air. MD notified of low B/P and fall at 2238 [10:38 PM]. Administrator and DON notified at 0345 [3:45 AM] and 0348 [3:48 AM] this morning. Morning nurse to be notified in am and family. Neuro checks and VS [vital signs] doing well no changes. [Note: No new interventions were implemented to prevent falls after the fall 5/18/24.] On 5/19/24 at 9:00 AM, an Incident Follow up documented Date of Incident: 5/19/2024 Type of Incident: Fall Root Cause: Unsteady gait Treatment Required: None Interventions put into place: Neuros, call light given to resident, rounds every 15 minutes Referrals Made: None. [Note: No new interventions were implemented to prevent falls after the fall on 5/19/24. An assessment after the fall was unable to be located.] On 5/19/24 at 11:00 PM, an encounter documented Date of Service: 05/20/2024 Visit Type: Acute Transition of Care: No transition occurred. Progress Note . Chief Complaint / Nature of Presenting Problem: Fall History Of Present Illness: Patient is a [AGE] year-old male with a past medical history significant for Alzheimer's dementia. He was previously a resident at the [name redacted] and was admitted here one month ago. He has tried to escape multiple times and constantly packs his things to leave. He often waits by the locked door of the unit to leave. Today CNA [Certified Nursing Assistant] reported that patient had 2 falls over the weekend. Denied hitting his head. Patient reports that he is fine. He denied any uncontrolled pain. He denied any issues or concerns. The Nurse Practitioner (NP) signed the note on 5/20/24 at 8:39 AM. On 5/19/24 at 4:45 PM, a Fall Incident Report documented . Client had an unobserved fall out of dining room chair. Client pulled tablecloth halfway off. When CNA walked into dining room to check on clients, other residents were helping client off of floor. Client stated 'I feel. I am okay.' Client was put on neuros and observed every 15 minutes. [Note: No new interventions were implemented to prevent falls after the second fall on 5/19/24.] On 5/20/24 at 2:50 PM, an Orders - General Note from electronic record (eRecord) documented Note Text: CNA comes to nurse and stated resident had an assisted fall and was lowered to ground after being toileted. He lost his balance and she grabbed him and lowered him. Both South and North nurse in to assist resident and transfer him to his w/c [wheel chair]. He did not appear to be in pain but rather confused. He sustained a small r elbow tear to his arm from the w/c during transfer. Cleaned and dressed. He then rested quietly throughout the rest of the shift. [Note: No new interventions were implemented to prevent falls after the fall on 5/20/24.] (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/20/24 at 11:00 PM, an encounter documented Date of Service: 05/21/2024 Visit Type: Acute Transition of Care: No transition occurred. Progress Note . Chief Complaint / Nature of Presenting Problem: Right hip pain History Of Present Illness: [Resident 298] is a [AGE] year-old long-term care resident here at [name redacted]. Per the nurses report he has had a couple of falls over the weekend. He was evaluated yesterday but denied any significant pain. It is unclear if he had another fall since yesterday's evaluation but currently he has complaints of right hip pain. He has been unable to stand. Most of his pain is localized to the anterior and lateral right hip. General: Elderly male in mild distress. Does appear confused which is his baseline Musculoskeletal: Patient does have tenderness to palpation over the right hip laterally anteriorly. He does have pain with internal and external rotation of the right hip. This localizes anteriorly. Acute right hip pain Patient's right hip pain appears to be acute and it is unclear whether this is related to a fall over the weekend or a new fall today. Given his acute right hip pain and evaluation today I do recommend x-rays of the right hip stat [immediately]. These were ordered today. Plan to follow-up after x-rays. Fall On fall precautions. The MD signed the note on 5/21/24 at 11:17 AM. On 5/21/24 at 11:40 AM, a Health Status Note documented Note Text: NEW ORDER: Pt [patient] is not bearing any wt [weight] on rt [right] leg has a lg [large] skin tear on rt elbow. md notified ordered a xray it has been ordered and they stated it wil [sic[be done today. pt had a shr [shower] today. On 5/21/24, the Diagnostics report documented . Right hip, 2 views Comparison: None. Findings: There is an acute complete femoral neck fracture with partial displacement compatible with a Garden Classification III fracture. IMPRESSION: 1. Garden classification III acute femoral neck fracture. The diagnostics report was signed by the diagnostics radiologist on 5/21/24 at 6:23 PM. On 5/22/24 at 2:51 AM, a Health Status Note documented Note Text: Follow up on res x-ray: Impressions noted; There is an acute complete femoral neck Fx [fracture] with partial displacement compatible with a Garden class III. Mild degree of osteopenia. Moderate osteoarthritis. X-ray results sent to MD, response pending. WCTM [will continue to monitor]. On 5/22/24 at 5:30 AM, a Health Status Note documented Note Text: Staff reported res, has been up all night did not sleep a [NAME], trying to wiggle his way out of bed. Staff has continuously throughout shift had to re center res into bed and remind resident that he, could not walk d/t broken femur. will pass on to upcoming shift nurse for monitoring and follow-up. On 5/22/24 at 6:54 AM, an Orders - General Note from eRecord documented Note Text: MD notified of results of Xray and new order for resident to be sent to ER [emergency room] for eval/tx [evaluation and treatment]. Preparing paperwork. On 5/22/24 at 3:01 PM, a Health Status Note documented Note Text: Received call from [hospital name redacted]. They will do surgergy [sic] this afternoon and resident to be admitted to med [medical] surg [surgical] floor. On 8/7/24 at 12:23 PM, an interview was conducted with NP 2. NP 2 stated she saw resident 298 because he had a fall. NP 2 stated that resident 298 was walking around pushing his recliner around and had no pain. NP 2 stated the MD came in the next day and said that resident 298 had a broken femur. NP 2 stated that she did not do a full hip exam because resident 298 was moving fine. NP 2 stated that she did not expect a break. NP 2 stated that the MD sent resident 298 out and resident 298 did have a break. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/8/24 at 11:50 AM, an interview was conducted with the DON. The DON stated that resident 298 had an unwitnessed fall on 5/18/24 at about 3:00 AM. The DON stated that resident 298 had another fall on 5/19/24 at 9:00 AM. The DON stated the fall on 5/20/24, was an assisted fall at 3:00 PM. The DON stated at that time herself and the CNA lowered resident 298 to the floor and the DON stated that she did not notice anything. The DON stated that the NP saw resident 298 the morning of 5/21/24, and noted we need an xray. The DON stated that resident 298 somehow had a shower during that time on 5/21/24. The DON stated the facility called the x-ray company at 11:34 AM, and they arrived at the facility at 5:41 PM, to do the x-ray on 5/21/24. The DON stated at 6:23 PM, the x-ray company either faxed the results or notified the facility of the results. The DON stated that the nurse on 5/22/24, made a progress note that results were pending from the doctor. The DON stated at the end of the shift the nurse made a note that resident 298 was up all night and passed the information to the oncoming nurse which was the DON. The DON stated at 6:55 AM, she notified the doctor and resident 298 was sent out to the hospital. On 8/14/24 at 7:29 AM, an interview was conducted with CNA 3. CNA 3 stated that if a resident was a fall risk the resident would have something on there door like a color indicating if they were a fall risk or a runaway risk. CNA 3 stated that she started at the facility in May or June 2024. CNA 3 stated that she met resident 298 after her second day and resident 298 had fallen and broken his femur. CNA 3 stated resident 298 would try and roll out of bed or get up. CNA 3 stated there were interventions after the fracture to keep resident 298 in bed and resident 298 had a wedge pillow. CNA 3 stated that resident 298 would try and get up even though he had a broken femur. CNA 3 stated that she would get in report if a resident was a fall risk. CNA 3 stated that she did not know if there was a kardex for residents or where to see interventions. CNA 3 stated that 15 minute checks were done with neuros. CNA 3 stated that 15 minute checks we done for the first hour, then 30 minute checks, then 45 minute checks, and then every hour for three days. CNA 3 stated the nurse had a form at the nurses station that the CNAs would document the neuro checks. CNA 3 stated that neuros were done after every fall. CNA 3 stated if a resident had an intervention to anticipate needs she would observe what the resident was like and what the resident needed. CNA 3 stated if the resident was cold then she would get them a blanket, if the resident was dirty she would give them a shower regardless if it was the residents shower day. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/14/24 at 7:39 AM, an interview was conducted with the DON. The State Survey Agency (SSA) Lead Licensor asked the DON what an At Risk Plan was and how was that a fall care plan intervention. The DON stated why was that there and that should not be there. The DON stated that was assuming that the nurses knew what the at risk plan was for the resident. The DON stated that she had no idea why that was on the care plan. The DON stated to her an at risk plan was why the resident fell . The DON stated the at risk plan did not tell her anything if that was on the care plan as an intervention. The DON stated where did they get that. The DON stated the facility used to have a form that was stapled to the incident form and would document why the resident was falling and would go more in depth. The DON stated that she would not recommend the at risk plan as an intervention because you need to fix the problem. The DON stated the at risk told the staff nothing. The SSA Lead Licensor asked the DON what the intervention 15 minute checks meant. The DON stated that 15 minute checks meant neuros and vital signs every 15 minutes. The DON stated that neuros were conducted with an unwitnessed fall. The DON stated that 15 minute checks were done in four sets. The DON stated that anticipate needs meant that the resident was a high fall risk and the staff need to have eyes more on the resident. The DON stated to have eyes more on the resident meant to make sure staff were watching the resident and a little bit more eyes on the resident. The DON stated it was impossible to do a one on one in the facility. The DON stated that all the nurses should be doing the care plans. The DON stated that interventions could be customized. The DON stated that staff needed to find out why the fall happened and if the fall fell into any of the categories on the computer then great if not the intervention could be customized. On 8/14/24 at 8:42 AM, a follow up interview was conducted with the DON. The SSA Lead Licensor asked the DON if she had details regarding resident 298's fracture. The DON stated that resident 298 was not in any pain that day and had no signs of a fracture. The DON stated the CNA was getting resident 298 ready to toilet and the DON went in to assist and resident 298 was lowered to the ground. The DON stated that she had been told if the fall was assisted she did not have to do a fall. The DON stated there may have been a fall the next day also but she was not sure. The DON stated that neuro checks were only done if the resident hit their head. The DON stated that she usually kept the neuro checks and she had record of them. On 8/14/24 at 9:14 AM, an interview was conducted with the Administrator. The SSA Lead Licensor asked the Administrator if he considered investigating resident 298's fall as neglect. The Administrator stated his reasoning for not investigating for neglect was due to resident 298 had a fall and the NP was in the building, assessed resident 298, and there were no injuries or complaints of pain. The Administrator stated that resident 298 had a lot of falls. The Administrator stated that resident 298 had an assisted fall prior to the fracture. The Administrator stated that resident 298 had a fall matt but resident 298 would roll out of bed. The Administrator stated that resident 298 would roll out of bed frequently.

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **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 30 sample residents, the facility did not appropriately document the basis for the transfer or the discharge summary. In addition, appropriate documentation was not completed in order to ensure a safe and effective transition of care. Resident identifiers: 25, 47, and 298. Findings include: 1. Resident 25 was admitted to the facility on [DATE], and readmitted on [DATE] with diagnoses which included sepsis, acute respiratory failure, type 2 diabetes mellitus, vascular dementia, pneumonia, pressure ulcer of left heal, metabolic encephalopathy, hypertension, and atrial fibrillation. Resident 25's medical record was reviewed from 7/28/24 through 8/14/24. A Health Status Note dated 12/28/23 at 10:33 PM indicated, Res [resident] lungs assessed this shift, resident c/o [complained of] pain with inhalation, lower lobes junky to auscultation, wheezing heard from chest, resident unable to maintain 02 [oxygen] sats [saturation] above 90 w/o [without] use of oxygen concentrator 02 91% 3L [liters]/min [minute]. MD [medical doctor] notified, Order given, routine CXR [chest xray] to r/o [rule out] pneumonia. [Company name redacted] notified; X-ray technician will be out to facility in the morning 12/29/23, to perform diagnostic request. Order has been written, unable to print, copy saved under documents for day shift to print. Will pass on to upcoming shift nurse to forward results to MD. An Administration Note dated 12/29/23 at 8:40 AM indicated, sent to hosp [hospital]. On 08/7/24 at 1:42 PM, an interview was conducted with the Director of Nursing (DON). The DON stated when she came in on 12/29/23 at 6:00 AM, resident 25 was ashen and struggling to breathe. The DON stated he was sent to the hospital at 7:30 AM. The DON stated she should have done a progress note for his change of condition and transfer, but she did not have time. There was no documentation provided in the medical record that indicated the basis for the hospital transfer. 2. Resident 298 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included, but were not limited to, dementia, essential hypertension, acute kidney failure, and anxiety disorder. Resident 298's medical record was reviewed on 8/7/24. An admission Minimum Data Set assessment dated [DATE], documented that resident 298 had a Brief Interview for Mental Status (BIMS) score of 13. A BIMS score of 13 to 15 would indicate intact cognition. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/20/24 at 11:00 PM, an encounter documented Date of Service: 05/21/2024 Visit Type: Acute Transition of Care: No transition occurred. Progress Note . Chief Complaint / Nature of Presenting Problem: Right hip pain History Of Present Illness: [Resident 298] is a [AGE] year-old long-term care resident here at [name redacted]. Per the nurses report he has had a couple of falls over the weekend. He was evaluated yesterday but denied any significant pain. It is unclear if he had another fall since yesterday's evaluation but currently he has complaints of right hip pain. He has been unable to stand. Most of his pain is localized to the anterior and lateral right hip. General: Elderly male in mild distress. Does appear confused which is his baseline Musculoskeletal: Patient does have tenderness to palpation over the right hip laterally anteriorly. He does have pain with internal and external rotation of the right hip. This localizes anteriorly. Acute right hip pain Patient's right hip pain appears to be acute and it is unclear whether this is related to a fall over the weekend or a new fall today. Given his acute right hip pain and evaluation today I do recommend x-rays of the right hip stat [immediately]. These were ordered today. Plan to follow-up after x-rays. Fall On fall precautions. The Medical Director (MD) signed the note on 5/21/24 at 11:17 AM. On 5/21/24 at 11:40 AM, a Health Status Note documented Note Text: NEW ORDER: Pt [patient] is not bearing any wt [weight] on rt [right] leg has a lg [large] skin tear on rt elbow. md notified ordered a xray it has been ordered and they stated it wil [sic[be done today. pt had a shr [shower] today. On 5/21/24, the Diagnostics report documented . Right hip, 2 views Comparison: None. Findings: There is an acute complete femoral neck fracture with partial displacement compatible with a Garden Classification III fracture. IMPRESSION: 1. Garden classification III acute femoral neck fracture. The diagnostics report was signed by the diagnostics radiologist on 5/21/24 at 6:23 PM. On 5/22/24 at 2:51 AM, a Health Status Note documented Note Text: Follow up on res [resident] x-ray: Impressions noted; There is an acute complete femoral neck Fx [fracture] with partial displacement compatible with a Garden class III. Mild degree of osteopenia. Moderate osteoarthritis. X-ray results sent to MD, response pending. WCTM [will continue to monitor]. On 5/22/24 at 5:30 AM, a Health Status Note documented Note Text: Staff reported res, has been up all night did not sleep a [NAME], trying to wiggle his way out of bed. Staff has continuously throughout shift had to re center res into bed and remind resident that he, could not walk d/t [due to] broken femur. will pass on to upcoming shift nurse for monitoring and follow-up. On 5/22/24 at 6:54 AM, an Orders - General Note from electronic Record documented Note Text: MD notified of results of Xray and new order for resident to be sent to ER [emergency room] for eval/tx [evaluation and treatment]. Preparing paperwork. [Note: The facility transferred resident 298 to the hospital emergently due to a change in condition. The facility did not provide the hospital with the required information including the practitioners name responsible for the care of resident 298, the resident representative information, Advanced Directives, comprehensive care plan goals, and all other information necessary to meet resident 298's needs.] (continued on next page)

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Mountain View Health Services	5865 South Wasatch Drive Ogden, UT 84403

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/5/24 at 2:10 PM, a telephone interview was conducted with RN 5. RN 5 stated that there is no printer at the nurses station, and its embarrassing when people come in. We have to pull each piece of the MAR (medication administration record) and go copy it, but the copy machine did not provide a legible copy. RN 5 stated that the MARs that were printed and in the paper chart were not updated, so she would have to reconcile the medication list prior to sending a resident to the hospital, and this delayed the time the residents were seen at the hospital. RN 5 stated that the Director of Nursing (DON) had been bringing this and other issues to the attention of the management staff, but they don't care. On 7/29/24 at 10:47 AM, an interview was conducted with DON. The DON stated that things had been much better but she needed support in her program. The DON stated she had asked for the programs for the weekly and quarterly charting. The DON stated if a resident went out at night the staff could not send the required documents because the staff did not have access to a printer. On 7/31/24 at 3:46 PM, an interview was again conducted with the DON. The DON stated that the night shift nurses do not have access to a printer, only a fax machine in the back office. The DON stated that the night shift nurses are unable to print medication lists out and that on more than one occasion the emergency room has called asking for a copy of the resident's medication list. The DON stated that this has personally happened to her, and that she had to send the original paper orders to the hospital. On 8/11/24 at 10:37 AM, an interview was conducted with the Business Officer Manager (BOM). The BOM stated if staff needed access to the printer there was a whole process. The BOM stated when staff need something the staff were to call the Administrator and the Administrator would tell the staff where the keys were located. The BOM stated that staff could just make a copy on the fax machine in the medication room and resident facesheets were in the paper medical record. The BOM stated that staff had access to the front office. The BOM stated if the staff had an emergent need they were to call the Administrator and the Administrator had a code for a lock box that had the keys to everything. The BOM stated the lock box also had spare keys to the medication cart. The BOM stated if the key box was accessed the Administrator would come in the next time and change the code. On 8/11/24 at 10:42 AM, a follow up interview was conducted with the DON. The DON stated that when the BOM mentioned the lock box a few minutes prior, that was the first time she had ever heard about a lock box with keys. The DON stated there was a fax machine in the medication room but it did not print. The DON stated if staff had to send a resident out with a Medication Administration Record the staff could not print one and that was frustrating. 3. Resident 47 was admitted to the facility on [DATE] with diagnoses that included anxiety disorder, edema, hyperlipidemia, major depressive disorder, pain in right hip, spinal stenosis, hypertension, low back pain, history of malignant neoplasm of prostate, and and genetic related intellectual disability. Resident 47's medical record was reviewed on 7/31/24. Resident 47's medical record that the resident discharged from the facility on 5/15/24. No discharge summary or basis for the discharge could be located in resident 47's medical record. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/31/24 at 3:25 PM, an interview was conducted with the Director of Nursing. (DON). The DON stated that the Administrator and Social Services Worker worker had a handy [NAME] discharge summary they would provide to the nurse and the nurse would complete the appropriate paperwork. The DON stated that this process has been sporadic since January of 2024. The DON stated that there was a discharge summary that could be completed in the electronic health record that could have been filled out as well. 47432 33215 48709

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50200 Based on interview and record review, the facility did not accurately assess residents. Specifically, for 1 out of 30 sampled residents, range of motion impairment was not documented on the Minimum Data Set (MDS) assessment. Resident identifier: 3. Findings included: Resident 3 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which include, paranoid schizophrenia, chronic obstructive pulmonary disease, chronic viral Hepatitis C, major depressive disorder, suicidal ideations, gastro-esophageal reflux disease, essential hypertension, hypothyroidism, chronic pain, type 2 diabetes mellitus, post traumatic stress disorder, low back pain, and hypo-osmolality and hyponatremia. On 7/29/24 at 8:30 AM, an interview was conducted with resident 3. Resident 3 stated that she could not get out of bed without extensive assistance from facility staff due to a stroke that she had which left her with weakness on the left side of her body. Resident 3 stated that she was unable to walk or use her left hand or arm. On 7/29/24 at 8:35 AM, an observation was made of resident 3's left hand which showed a contracture. Resident 3's medical record was reviewed on 7/29/24. On 6/14/24, a quarterly MDS assessment revealed that resident 3 had no impairment with range of motion for both upper and lower extremities. On 7/29/24 at 3:09 PM, an interview was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 stated that resident 3 always stayed in bed and had to be hoyer lifted anytime she needed to get out of bed. On 7/29/24 at 3:43 PM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated resident 3 liked to stay in bed. RN 1 stated that resident 3 could not position herself and did not have use of their lower legs. RN 1 stated that resident 3 had to be lifted with the hoyer lift. RN 1 stated that resident 3 had bilateral shoulder weakness, and both wrists and hands had arthritis. RN 1 stated that resident 3 had a contracture with her left hand. On 7/30/24 at 12:36 PM, an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated that she submitted the MDS assessments to the state. The ADON stated that she did not count an impairment if the facility helped the resident move. The ADON stated that when she filled out the assessments and it applied to range of motion questions and staff assisted the resident with movement, she counted it as no impairment with the resident. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/30/24 at 1:35 PM, a follow up interview was conducted with the ADON. The ADON stated that she had not read any guidelines with regards to range of motion with the MDS assessment. The ADON stated she thought it would count as no limitation if staff were helping with range of motion. The ADON stated that if it meant that resident 3 had to do things on her own then it would be an impairment and should be submitted as an impairment. On 7/31/24 at 7:13 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that resident 3 had physical therapy for increased strengthening. The DON stated that resident 3 had a contracture in her left hand and that had caused an impairment in range of motion.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48709 Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment. Specifically, for 6 out of 30 sampled residents, care plans were not created when there was a specified need and therefore were not reflective of the services required for the residents to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being. Resident identifiers: 7, 17, 24, 26, 32, and 35. Findings included: 1. Resident 32 was admitted to the facility on [DATE] with diagnoses which included acute and chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease (COPD) with acute exacerbation, fluid overload, hypertension, and hyperglycemia. Resident 32's medical record was reviewed from 7/28/24 through 8/14/24. The admission Minimum Data Set (MDS) assessment Section V: Care Area Assessment (CAA) Summary dated 3/19/24, indicated the following CAA Triggers: 2. Cognitive Loss/ Dementia; 5. Functional Abilities (Self-Care and Mobility); 6. Urinary Incontinence and Indwelling Catheter; 12. Nutritional Status; 15. Dental Care; 16. Pressure Ulcer/ Injury; and 19. Pain. The Initial Care Plan dated 3/19/24, indicated Problems: #3: Visual Function/ Altered Visual Function Impaired; #5 Activities of daily living (ADL) Ability Decrease ADL ability related to (r/t): COPD Assistance needed with: ADLs; #11: Falls Potential for fall r/t: COPD; #14: Dehydration/ Fluid Maintenance; and #15: Dental Care no teeth. The Care Plan indicated a Focus of Terminal care (hospice) Weight loss unavoidable Date Initiated: 04/12/2024 and Resident has the potential for social isolation. He say [sic] his O2 [oxygen] drops when he is to [sic] active. He says he has interest on group activities but has refused all invitations. He prefers in room activities. Date Initiated: 07/20/2024. There were no care plans developed for resident 32's visual function, ADL abilities, potential falls, dehydration, dental care, oxygen treatment or hospice. On 7/30/24 at 11:42 AM, an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated the care plan should be in the resident's chart. The ADON reviewed the current care plan during the interview and stated she saw a care plan was started but was never completed. The ADON stated the care plan should be completed already. On 7/31/24 at 12:16 PM, an interview was conducted with the Director of Nursing (DON). The DON stated resident 32's comprehensive care plan should have been completed and should have also included oxygen therapy. No additional information was provided. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident 35 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included artherosclerotic heart disease, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, gout, memory deficit following cerebral infarction, repeated falls, type 2 diabetes mellitus with diabetic polyneuropathy, cerebral infarction, dysphagia, Charcot's Arthropathy, and acquired absence of other right toe. On 7/28/24 at 1:05 PM, an observation and interview were conducted with resident 35. Resident 35 was observed sitting in his wheelchair in the dining room, he wore a white sock on his left foot with no brace. Resident 35's left foot appeared severely impaired and was rotated medially. Resident 35 stated he did wear a brace on his ankle, sometimes. Resident 35 stated that he did not currently receive physical or occupational therapy, nor did anyone do range of motion exercises with him for his left foot. On 7/29/24 at 11:03 AM, an observation of resident 35 was conducted. Resident 35 was in a manual wheelchair and self-propelled himself with the use of his right arm and foot around the nurse's station. Resident 35 wore a white sock on his left foot with no brace and his left hand and wrist had a contracture. Resident 35's medical record was reviewed from 7/28/24 through 8/14/24. The admission MDS assessment Section V: CAA Summary with an Assessment Reference Date/Target Date of 3/5/24, indicated the following CAA Triggers: 2. Cognitive Loss/ Dementia; 4. Communication; 5. Functional Abilities (Self-Care and Mobility); 6. Urinary Incontinence and Indwelling Catheter; 9. Behavioral Symptoms; 12. Nutritional Status; 16. Pressure Ulcer/ Injury; and 19. Pain. The care plan was reviewed and indicated a Focus of: a. The resident has limited physical mobility r/t hemiplegia, absence of some toes on right foot Date Initiated: 08/05/2021. It indicated the Goals: The resident will demonstrate the appropriate use of motorized wheelchair through the review date. Date Initiated: 08/05/2021 Target Date: 06/05/2024; and The resident will maintain current level of mobility (one person assist limited/extensive) through review date. Date Initiated: 08/05/2021 Target Date: 06/05/2024. It indicated the Interventions/tasks: LOCOMOTION: The resident is able to: operate motorized wheelchair independently Date Initiated: 08/05/2021. b. The resident had a cerebral vascular accident (CVA/Stroke) affecting left side Date Initiated: 08/05/2021. It indicated the Goals: The resident will be free from s/sx [signs/symptoms] of complications of CVA (DVT [deep vein thrombosis], contractures, aspiration pneumonia, dehydration) through review date. Date Initiated: 08/05/2021 Target Date: 06/05/2024. The resident will be able to communicate needs verbally through the review date. Date Initiated 08/05/2021 Target Date: 06/05/2024. It indicated the Interventions/tasks: Monitor/document mobility status. If resident is presenting with problems or paralysis, obtain order for Physical therapy and Occupational therapy to evaluate and treat. Date Initiated: 08/05/2021; Monitor/document/report PRN [as needed] for neurological deficits: level of consciousness, visual function changes, aphasia, dizziness, weakness, restlessness. Date Initiated: 08/05/2021. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. The resident has hemiplegia r/t CVA Date Initiated: 08/05/2021. It indicated the Goals: The resident will remain free of complications or discomfort related to hemiplegia through review date. Date Initiated: 08/05/2021. The resident will maintain optimal status and quality of life within limitations imposed by Hemiplegia through review date. Date Initiated: 08/05/2021 Target Date: 06/05/2024. It indicated the Interventions/tasks: Discuss with resident/resident and family any concerns, fears, issues regarding diagnosis or treatments. Date Initiated: 08/05/2021; Educate resident to anticipate needs for safety to affected hemiplegia side during transfers. Date Initiated: 06/27/2022; Give medications as ordered. Monitor/document for side effects and effectiveness. Date Initiated:08/05/2021; Pain management as needed. See MD [Medical Doctor] orders. Provide alternative comfort measures PRN. Date Initiated: 08/05/2021; PT [physical therapy], OT [occupational therapy], ST [speech therapy] evaluate and treat as ordered. Date Initiated: 08/05/2021. A Clinical Summary dated 6/12/24 at 8:00 AM, indicated resident 35 was seen by an outside orthotic clinic for his ankle foot orthosis (AFO). It further indicated, Device History . posterior leaf spring AFO. Start Date: 2021. End Date: current/present. Comments: This AFO is a generic off the shelf design that of which doesn [sic] not cater to his serve externally rotated ankle foot complex. Increased risk for adverse skin shear with continued use. Custom AFO pursuit necessary in assurance of patient safety/skeletal informational stabilization. It further indicated, Comments: Minor adjustments/repairs pursued as described today. I informed the tending facility staff to pursue daily prolonged stretching of his ankle foot complex in avoiding deformational varus tendency, concern with fixated external rotational deformation at the ankle complex should this not be put in place at his care facility. Written recommendations provided to facility staff present today. All adjustments requested by [Resident name redacted] pursued today were found proper. Follow up as needed. It should be noted that this document was not found in the medical record and was provided after it was requested by the State Survey Agency. The fax server date on this document was 7/30/24 at 4:31 PM from the clinic. The quarterly MDS assessment Section GG Functional Abilities and Goals dated 6/13/24, indicated, Functional Limitation in Range of Motion to the Lower extremity (hip, knee, ankle, foot with Impairment to one side. It further indicated resident 35 used a wheelchair. An Encounter Progress Note dated 7/4//24 at 11:00 PM, indicated, [Resident name redacted] is a [AGE] year-old male who is a long-term resident at [Facility name redacted]. He has a history of a cerebral infarction resulting in left-sided weakness, diabetes, obstructive sleep apnea as well as Charcot's arthropathy. When is at the nurses station today patient came to me to discuss his left foot pain and malformation. Patient states that years ago he hurt his foot and it never healed back to normal position properly. The foot is turned inward and a brace is in place at this time. Patient states that he is able to hold the foot or the toes back and push them down but with very poor range of motion. He stated that he needs to have the foot casted to help him get the foot back into normal position. The brace does not appear to be keeping the footin [sic] a normal anatomical alignment position. I am going to refer the patient to an orthopedic specialist to works on her feet and ankles. I informed patient that I would write the referral and patient was very grateful. Patient was sitting in his wheelchair when I left him by the nurses station. A Progress note dated 7/17/24 at 1:57 PM indicated, Pt [patient] refusing to wear LLE [left lower extremity] brace. Pt educated on importance of wearing brace and verbalized understanding. Pt still refusing to wear brace. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The care plan did not include person-centered or measurable interventions regarding his left-sided weakness and AFO use. On 7/29/24 at 3:51 PM, an interview was conducted with the DON. The DON stated there was no Restorative Nursing Assistant program and that nursing did not do passive range of motion for residents. The DON stated occupational or physical therapy should provide those services if a resident had that ordered. On 7/30/24 at 11:42 AM, an interview was conducted with the ADON. The ADON stated resident 35 had an AFO that he used to wear every day but had been refusing to wear it since his last appointment several weeks ago with the outside orthotic clinic. The ADON stated if that clinic sent any notes back it would be filed in the chart. The ADON stated the resident was not on physical therapy treatments at that time. The ADON stated that she and the DON were responsible for completing the care plans and that the ADON was responsible for completing the quarterly reviews and updates. The ADON stated she and the DON worked on the floor and had to work on the care plans when they had time. On 7/30/24 at 2:01 PM, an interview was conducted with the Occupational Therapist (OT). The OT stated resident 35 was last seen by OT on 8/23/24, for his hand. The OT stated he did know that resident 35 had an AFO for his foot and that the fit rubbed and bothered him. The OT stated he still had trouble with his AFO. 47432 3. Resident 17 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including severe sepsis without septic shock, pneumonitis due to inhalation of food and vomit, malignant neoplasm of esophagus, acute respiratory failure unspecified whether with hypoxia or hypercapnia, asthma uncomplicated, asthma with (acute) exacerbation, gastrointestinal hemorrhage, other acute kidney failure, chronic pulmonary embolism, atherosclerosis of other arteries, schizoaffective disorder depressive type, vascular dementia, type 2 diabetes mellitus without complications, and essential hypertension. Resident 17's medical record was reviewed from 7/28/24 through 8/14/24. Resident 17's care plan was reviewed. A focus area dated 1/17/23, revealed, The resident has oxygen therapy. The goal for this focus area was documented as, The resident will have no s/sx of poor oxygen absorption through the review date. The interventions for this goal were documented as, Monitor of s/sx of respiratory distress and report to MD PRN: Respirations, Pulse oximetry, Increased heart rate (Tachycardia), Restlessness, Diaphoresis, Headaches, Lethargy, Confusion, Atelectasis, Hemoptysis, Cough, Pleuritic pain, Accessory muscle usage, Skin color. There was no guidance in the resident's care plan regarding the changing or cleaning of nasal cannula tubing or oxygen concentrator humidifiers. 4. Resident 26 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including schizoaffective disorder depressive type, dementia, cannabis abuse, nicotine dependence, and asthma. Resident 26's medical record was reviewed from 7/28/24 through 8/14/24. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 26's care plan was reviewed. A focus area dated 8/3/23 revealed, The resident has oxygen therapy r/t respiratory illness. The goal for this focus area was documented as, The resident will have no s/x of poor oxygen absorption through the review date. The interventions for this goal were documented as, Monitor for s/sx of respiratory distress to MD PRN: Respirations, Pulse oximetry, Increased heart rate (Tachycardia), Restlessness, Diaphoresis, Headaches, Lethargy, Confusion, Atelectasis, Hemoptysis, Cough, Pleuritic pain, Accessory muscle usage, Skin color. There was no guidance in the resident's care plan regarding the changing or cleaning of nasal cannula tubing or oxygen concentrator humidifiers. 50200 5. Resident 7 was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses which included unspecified dementia, schizoaffective disorder, paroxysmal atrial fibrillation, obsessive-compulsive disorder, essential hypertension, adult failure to thrive, encephalopathy, and mild cognitive impairment. On 7/28/24 at 12:28 PM, an observation was made of resident 7 in his room. It was noted that the resident was using an oxygen concentrator and was receiving 3 liters per minute of oxygen via a nasal cannula. On 7/28/24, resident 7's medical record was reviewed. The following physician order was noted with an order date of 5/22/23, O2 to keep SPO2 [oxygen saturation] greater than 90%. A review of resident 7's care plan did not document resident 7's oxygen use, goals, or interventions. 6. Resident 24 was admitted to the facility on [DATE] with diagnoses which included, dementia, type 2 diabetes mellitus, chronic viral Hepatitis C, essential hypertension, hyperlipidemia, vertigo, major depressive disorder, osteoarthritis, and inflammatory disease of prostate. On 7/28/24 at 1:32 PM, an observation was made of resident 24 in his room. It was noted that the resident used an oxygen concentrator. The oxygen tubing was not dated. On 7/28/24, resident 24's medical record was reviewed. The following physician order was noted with a start date of 1/17/23, O2 @ [at] 2L [liters] via NC [nasal cannula] @ NOC [nocturnal] to keep sats [saturations] > [greater] than 90% every day and night shift. A care plan Focus addressing oxygen therapy initiated on 1/17/23, documented, The resident has oxygen therapy. Interventions included: a. Encourage or assist with ambulation as indicated. b. Monitor for s/sx of respiratory distress and report to MD PRN: Respirations, Pulse oximetry, Increased heart rate (Tachycardia), Restlessness, Diaphoresis, Headaches, Lethargy, Confusion, Atelectasis, Hemoptysis, Cough, Pleuritic pain, Accessory muscle usage, Skin color. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/31/24 at 3:39 PM, an interview was conducted with the DON. The DON stated that care plans should be revised if there was a change in the resident's condition, a new diagnosis, or quarterly. The DON stated all the nurses should be making care plans and implementing them. The DON stated that sometimes she thought she was a one horse show and could not work on care plans and work on the floor all of the time. The DON stated that she had talked with the Administrator this past month about nursing staff not doing a lot of things that were required of them.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48709 Based on observation, interview, and record review, the facility failed to ensure the interdisciplinary team reviewed and revised the comprehensive care plan after each assessment, including both the comprehensive and quarterly review assessments. Specifically, or 6 out of 30 sampled residents, care plans were not updated after a change in the resident's condition or in response to implemented interventions. Resident identifiers: 3, 17, 26, 32, 35, and 298. Findings included: 1. Resident 32 was admitted to the facility on [DATE] with diagnoses which included acute and chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease (COPD) with acute exacerbation, fluid overload, hypertension, and hyperglycemia. On 7/28/24 at 10:14 AM, an interview was conducted with resident 32. Resident 32 stated he had pain in his legs, feet, and arm. Resident 32 stated he was on pain medication, but they were administered late. Resident 32's medical record was reviewed from 7/28/24 through 8/14/24. A Physician's Telephone Orders dated 5/27/24 at 2:00 PM, indicated, gabapentin 100mg [milligrams] BID [twice a day] for neuropathy. A Physician's Telephone Orders dated 7/11/24 at 12:00 PM, indicated, Increase morphine to 1 ml [milliliter] Q1hr [every 1 hour] PRN [as needed]. A Physician's Telephone Orders dated 7/15/24 at 9:30 AM, indicated, Schedule morphine 1 ml QHS [hour of sleep] with night medication. Keep PRN morphine active. A Physician's Telephone Orders dated 7/15/24 at 12:00 PM, indicated, Lorazepam 2mg / ml 0.50 ml every hours [sic] as needed for anxiety/sob [shortness of breath]/pain x [for] 2 weeks. The Medication Administration Record (MAR) dated May 2024 indicated resident 32 reported his pain level: 12 times at a level 3, nine times at a level 4, 21 times at a level 5, 13 times at a level 6, and two times at a level 7. The MAR dated June 2024 indicated resident 32 reported his pain level: one time at a level 3, two times at a level 4, 36 times at a level 5, one time at a level 6, and three times at a level 7. The MAR dated July 2024 indicated resident 32 reported his pain level: 14 times at a level 3, two times at a level 4, 26 times at a level 5, two times at a level 6, and two times at a level 7. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The admission Minimum Data Set (MDS) Section V: Care Area Assessment (CAA) Summary dated 3/19/24, indicated the following CAA Triggers: 2. Cognitive Loss/ Dementia; 5. Functional Abilities (Self-Care and Mobility); 6. Urinary Incontinence and Indwelling Catheter; 12. Nutritional Status; 15. Dental Care; 16. Pressure Ulcer/ Injury; and 19. Pain. The Initial Care Plan dated 3/19/24, indicated Problems: #3: Visual Function/ Altered Visual Function Impaired; #5 Activities of daily living (ADL) Ability Decrease ADL ability related to (r/t): COPD Assistance needed with: ADLs; #11: Falls Potential for fall r/t: COPD; #14: Dehydration/ Fluid Maintenance; and #15: Dental Care no teeth. The Care Plan indicated a Focus of Terminal care (hospice) Weight loss unavoidable Date Initiated: 04/12/2024 and Resident has the potential for social isolation. He say [sic] his O2 [oxygen] drops when he is to [sic] active. He says he has interest on group activities but has refused all invitations. He prefers in room activities. Date Initiated: 07/20/2024. No care plans were developed or revised for resident 32's pain or hospice care. On 7/30/24 at 11:42 AM, an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated she made sure the quarterly reviews of the care plans were completed. The ADON stated she worked on the floor and would work on the care plans when she had time. On 7/31/24 at 12:16 PM, an interview was conducted with the Director of Nursing (DON). No further documentation was provided. 2. Resident 35 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included artherosclerotic heart disease, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, gout, memory deficit following cerebral infarction, repeated falls, type 2 diabetes mellitus with diabetic polyneuropathy, cerebral infarction, dysphagia, Charcot's Arthropathy, and acquired absence of other right toe. On 7/28/24 at 1:05 PM, an observation and interview were conducted with resident 35. Resident 35 was observed sitting in his wheelchair in the dining room, he wore a white sock on his left foot with no brace. Resident 35's left foot appeared severely impaired and was rotated medially. Resident 35 stated he did wear a brace on his ankle, sometimes. Resident 35 stated that he did not currently receive physical or occupational therapy, nor did anyone do range of motion exercises with him for his left foot. On 7/29/24 at 11:03 AM, an observation of resident 35 was conducted. Resident 35 was in a manual wheelchair and self-propelled himself with the use of his right arm and foot around the nurse's station. Resident 35 wore a white sock on his left foot with no brace and his left hand and wrist had a slight contracture. Resident 35's medical record was reviewed from 7/28/24 through 8/14/24. The admission MDS assessment Section V: CAA Summary with an Assessment Reference Date/Target Date of 3/5/24, indicated the following CAA Triggers: 2. Cognitive Loss/ Dementia; 4. Communication; 5. Functional Abilities (Self-Care and Mobility); 6. Urinary Incontinence and Indwelling Catheter; 9. Behavioral Symptoms; 12. Nutritional Status; 16. Pressure Ulcer/ Injury; and 19. Pain. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The care plan was reviewed and indicated a Focus of: a. The resident has limited physical mobility r/t hemiplegia, absence of some toes on right foot Date Initiated: 08/05/2021. It indicated the Goals: The resident will demonstrate the appropriate use of motorized wheelchair through the review date. Date Initiated: 08/05/2021 Target Date: 06/05/2024; and The resident will maintain current level of mobility (one person assist limited/extensive) through review date. Date Initiated: 08/05/2021 Target Date: 06/05/2024. It indicated the Interventions/tasks: LOCOMOTION: The resident is able to: operate motorized wheelchair independently Date Initiated: 08/05/2021. It should be noted that this focus area had not been revised since it was initiated on 8/5/21. b. The resident had a cerebral vascular accident (CVA/Stroke) affecting left side Date Initiated: 08/05/2021. It indicated the Goals: The resident will be free from s/sx [signs/symptoms] of complications of CVA (DVT [deep vein thrombosis], contractures, aspiration pneumonia, dehydration) through review date. Date Initiated: 08/05/2021 Target Date: 06/05/2024. The resident will be able to communicate needs verbally through the review date. Date Initiated 08/05/2021 Target Date: 06/05/2024. It indicated the Interventions/tasks: Monitor/document mobility status. If resident is presenting with problems or paralysis, obtain order for Physical therapy and Occupational therapy to evaluate and treat. Date Initiated: 08/05/2021; Monitor/document/report PRN for neurological deficits: level of consciousness, visual function changes, aphasia, dizziness, weakness, restlessness. Date Initiated: 08/05/2021. It should be noted that this focus area had not been revised since it was initiated on 8/5/21. c. The resident has hemiplegia r/t CVA Date Initiated: 08/05/2021. It indicated the Goals: The resident will remain free of complications or discomfort related to hemiplegia through review date. Date Initiated: 08/05/2021. The resident will maintain optimal status and quality of life within limitations imposed by Hemiplegia through review date. Date Initiated: 08/05/2021 Target Date: 06/05/2024. It indicated the Interventions/tasks: Discuss with resident/resident and family any concerns, fears, issues regarding diagnosis or treatments. Date Initiated: 08/05/2021; Educate resident to anticipate needs for safety to affected hemiplegia side during transfers. Date Initiated: 06/27/2022; Give medications as ordered. Monitor/document for side effects and effectiveness. Date Initiated:08/05/2021; Pain management as needed. See MD [Medical Doctor] orders. Provide alternative comfort measures PRN. Date Initiated: 08/05/2021; PT [physical therapy], OT [occupational therapy], ST [speech therapy] evaluate and treat as ordered. Date Initiated: 08/05/2021. It should be noted that this focus area had not been revised since 6/27/22. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Clinical Summary dated 6/12/24 at 8:00 AM, indicated resident 35 was seen by an outside orthotic clinic for his ankle foot orthosis (AFO). It further indicated, Device History . Start Date: 2021. End Date: current/present. Comments: This AFO is a generic off the shelf design that of which doesn [sic] not cater to his serve externally rotated ankle foot complex. Increased risk for adverse skin shear with continued use. Custom AFO pursuit necessary in assurance of patient safety/skeletal informational stabilization. It further indicated, Comments: Minor adjustments/repairs pursued as described today. I informed the tending facility staff to pursue daily prolonged stretching of his ankle foot complex in avoiding deformational varus tendency, concern with fixated external rotational deformation at the ankle complex should this not be put in place at his care facility. Written recommendations provided to facility staff present today. All adjustments requested by [Resident name redacted] pursued today were found proper. Follow up as needed. It should be noted that this document was not found in the medical record and was provided after it was requested by the State Survey Agency. The fax server date on this document was 7/30/24 at 4:31 PM from the clinic. The quarterly MDS assessment Section GG Functional Abilities and Goals dated 6/13/24, indicated, Functional Limitation in Range of Motion to the Lower extremity (hip, knee, ankle, foot with Impairment to one side. It further indicated resident 35 used a wheelchair. An Encounter Progress Note dated 7/4//24 at 11:00 PM, indicated, [Resident name redacted] is a [AGE] year-old male who is a long-term resident at [Facility name redacted]. He has a history of a cerebral infarction resulting in left-sided weakness, diabetes, obstructive sleep apnea as well as Charcot's arthropathy. When is at the nurses station today patient came to me to discuss his left foot pain and malformation. Patient states that years ago he hurt his foot and it never healed back to normal position properly. The foot is turned inward and a brace is in place at this time. Patient states that he is able to hold the foot or the toes back and push them down but with very poor range of motion. He stated that he needs to have the foot casted to help him get the foot back into normal position. The brace does not appear to be keeping the footin [sic] a normal anatomical alignment position. I am going to refer the patient to an orthopedic specialist to works on her feet and ankles. I informed patient that I would write the referral and patient was very grateful. Patient was sitting in his wheelchair when I left him by the nurses station. A Progress note dated 7/17/24 at 1:57 PM, indicated, Pt [patient] refusing to wear LLE [left lower extremity] brace. Pt educated on importance of wearing brace and verbalized understanding. Pt still refusing to wear brace. On 7/29/24 at 3:51 PM, an interview was conducted with the DON. The DON stated there was no Restorative Nursing Assistant program and that nursing did not do passive range of motion for residents. The DON stated occupational or physical therapy should provide those services if a resident had that ordered. On 7/30/24 at 11:42 AM, an interview was conducted with the ADON. The ADON stated resident 35 had an AFO that he used to wear every day but had been refusing to wear it since his last appointment several weeks ago with the outside orthotic clinic. The ADON stated if that clinic sent any notes back it would be filed in the chart. The ADON stated the resident was not on physical therapy treatments at that time. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/30/24 at 2:01 PM, an interview was conducted with the Occupational Therapist (OT). The OT stated resident 35 was last seen by OT on 8/23/24, for his hand. The OT stated he did know that resident 35 had an AFO for his foot and that the fit rubbed and bothered him. The OT stated he still had trouble with his AFO. 47432 3. Resident 17 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including severe sepsis without septic shock, pneumonitis due to inhalation of food and vomit, malignant neoplasm of esophagus, acute respiratory failure unspecified whether with hypoxia or hypercapnia, asthma uncomplicated, asthma with (acute) exacerbation, gastrointestinal hemorrhage, other acute kidney failure, chronic pulmonary embolism, atherosclerosis of other arteries, schizoaffective disorder depressive type, vascular dementia, type 2 diabetes mellitus without complications, and essential hypertension. Resident 17's medical record was reviewed from 7/28/24 through 8/14/24. Resident 17's care plan was reviewed. A focus area dated 1/17/23, revealed, The resident has oxygen therapy. The goal for this focus area was documented as, The resident will have no s/sx of poor oxygen absorption through the review date. The interventions for this goal were documented as, Monitor of s/sx of respiratory distress and report to MD PRN: Respirations, Pulse oximetry, Increased heart rate (Tachycardia), Restlessness, Diaphoresis, Headaches, Lethargy, Confusion, Atelectasis, Hemoptysis, Cough, Pleuritic pain, Accessory muscle usage, Skin color. It should be noticed that the last time this focus area was revised was on 1/17/23. 4. Resident 26 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including schizoaffective disorder depressive type, dementia, cannabis abuse, nicotine dependence, and asthma. Resident 26's medical record was reviewed from 7/28/24 through 8/14/24. Resident 26's care plan was reviewed. A focus area dated 8/3/23 revealed, The resident has oxygen therapy r/t respiratory illness. The goal for this focus area was documented as, The resident will have no s/x of poor oxygen absorption through the review date. The interventions for this goal were documented as, Ensure resident is wearing his N/C [nasal cannula] at all times and SPO2 [oxygen saturations] checked QS [every shift] and Monitor for s/sx of respiratory distress to MD PRN: Respirations, Pulse oximetry, Increased heart rate (Tachycardia), Restlessness, Diaphoresis, Headaches, Lethargy, Confusion, Atelectasis, Hemoptysis, Cough, Pleuritic pain, Accessory muscle usage, Skin color. It should be noted that the last time this focus area was revised was on 9/12/22. 50200 5. Resident 3 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which include, paranoid schizophrenia, chronic obstructive pulmonary disease, chronic viral Hepatitis C, major depressive disorder, suicidal ideations, gastro-esophageal reflux disease, essential hypertension, hypothyroidism, chronic pain, type 2 diabetes mellitus, post traumatic stress disorder, low back pain, and hypo-osmolality and hyponatremia. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 3's medical record was reviewed on 7/28/24. A MDS assessment dated [DATE], section GG Functional Abilities, documented: a. Oral hygiene: substantial/maximum assistance b. Toileting hygiene: substantial/maximum assistance c. Shower/bathe self: substantial/maximum assistance d. Upper body dressing: substantial/maximum assistance e. Lower body dressing: substantial/maximum assistance f. Putting on/taking off footwear: substantial/maximum assistance g. Personal hygiene: substantial/maximum assistance h. Chair/bed to chair transfer: dependent i. Toilet transfer: dependent j. Tub/shower transfer: dependent A care plan Focus addressing self-care initiated on 2/23/16, documented, The resident has an ADL self-care performance deficit r/t weakness. The interventions included: a. BATHING/SHOWERING: Check nail length and trim and clean on bath days and as necessary. Report any changes to the nurse. Date initiated 2/25/13. b. ORAL CARE: The resident has upper/lower dentures, The resident requires oral inspection Report changes to the nurse. Date initiated 2/25/13. c. TOILET USE: The resident requires assist of 1 staff for toileting and incontinence care at night, independent during the day. Date initiated 2/10/16. A care plan Focus addressing falls initiated on 8/3/21, documented, The resident has had an actual fall and history of falls r/t difficulty walking, muscle weakness. The interventions included: a. Monitor/document/report PRN x 72 hours to MD for s/sx: Pain, bruises, Change in mental status, New onset: confusion, sleepiness, inability to maintain posture, agitation. Date initiated 8/3/21. b. Staff will assist resident with all transfers. Date initiated 8/3/21. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/29/24 at 8:30 AM, an interview was conducted with resident 3. Resident 3 stated that she could not get out of bed without extensive assistance from facility staff due to a stroke that she had which left her with weakness on the left side of her body. Resident 3 stated that she was unable to walk or use her left hand or arm. Resident 3 stated that she preferred to stay in bed because she was afraid of falling due to her weakness and inability to move her legs well. On 7/29/24 at 8:35 AM, an observation was made of resident 3's left hand which showed a contracture. On 6/14/24, a quarterly MDS assessment revealed that resident 3 had no impairment with range of motion for both upper and lower extremities. On 7/29/24 at 3:09 PM, an interview was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 stated that resident 3 always stayed in bed and had to be hoyer lifted anytime she needed to get out of bed. On 7/29/24 at 3:43 PM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated resident 3 liked to stay in bed. RN 1 stated that resident 3 could not position herself and did not have use of lower legs. RN 1 stated that resident 3 had to be lifted with the hoyer lift. RN 1 stated that resident 3 had bilateral shoulder weakness, and both wrists and hands had arthritis. RN 1 stated that resident 3 had a contracture with her left hand. On 7/31/24 at 7:13 AM, an interview was conducted with the DON. The DON stated that resident 3 had physical therapy for increased strengthening. The DON stated that resident 3 had a contracture in her left hand and this had caused a decrease in range of motion. 6. Resident 298 was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses which included unspecified dementia, essential hypertension, benign prostatic hyperplasia without lower urinary tract symptoms, acute kidney failure, weakness, and unspecified anxiety disorder. Resident 298's medical record was reviewed on 8/7/24. A care plan Focus addressing nutrition initiated on 4/12/24, documented, New resident with a potential nutrition defects r/t: advanced age, dementia. Interventions included: a. Diet order: regular, regular, thins b. Supplements/snacks as ordered A review of resident 298's electronic medical record documented the following weights for resident 298: a. 165.2 pounds on 3/28/24 b. 163.6 pounds on 3/31/24 c. 166.8 pounds on 4/7/24 (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. 199.8 pounds on 4/8/24 e. 168.6 pounds on 5/10/24 f. 167.0 pounds on 5/27/24 g. 156.6 pounds on 6/2/24 h. 140.3 pounds on 7/11/24 From 6/2/24 to 7/11/24, resident 298 had a 10.41% loss of weight. It was to be noted, no revisions to the care plan were made to address the weight loss. On 7/31/24 at 3:39 PM, an interview was conducted with the DON. The DON stated that care plans for residents should be revised if the resident had a change in condition, a new diagnosis, or quarterly MDS assessment. The DON stated she tried to update the care plans as much as she could, but did not have enough time to revise care plans. On 8/7/24 at 1:42 PM, an interview was conducted via text messaging with the Registered Dietitian (RD). The RD texted that resident 298 had a fortified diet ordered and health shakes to help with his weight loss. The RD texted that the facility had weekly weight lists and weekly meetings to discuss residents that had weight loss.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22992 Based on interview and record review, the facility did not ensure that for 2 of 30 sample residents, a discharge summary was included in the residents' medical records. Resident identifiers: 47 and 248. Findings include: 1. Resident 47 was admitted to the facility on [DATE] with diagnoses that included anxiety disorder, edema, hyperlipidemia, major depressive disorder, pain in right hip, spinal stenosis, hypertension, low back pain, history of malignant neoplasm of prostate, and and genetic related intellectual disability. Resident 47's medical record was reviewed on 7/31/24. Resident 47's medical record that the resident discharged from the facility on 5/15/24. No discharge summary or basis for the discharge could be located in resident 47's medical record. On 7/31/24 at 3:25 PM, an interview was conducted with the Director of Nursing. (DON). The DON stated that the Administrator and Social Services Worker worker had a handy [NAME] discharge summary they would provide to the nurse and the nurse would complete the appropriate paperwork. The DON stated that this process has been sporadic since January of 2024. The DON stated that there was a discharge summary that could be completed in the electronic health record that could have been filled out as well. 48709 2. Resident 248 was admitted to the facility on [DATE] with diagnoses which included rheumatoid arthritis, chronic pulmonary edema, cellulitis, sarcopenia, anxiety disorder, opioid use, and repeated falls. Resident 248's medical record was reviewed from 7/28/24 through 8/14/24. An encounter progress note dated 4/18/23 at 11:00 PM indicated, Patient is a [AGE] year-old female who has been admitted to [facility name redacted] for increasing weakness. She has severe arthritis in her extremities making it difficulty for her to even hold things. She has chronic pain, HTN [hypertension], opioid abuse and non compliance with her medications. Today she was seen for her admit visit and she reports that she is discharging to another facility later today. Floor staff stated that she has not been compliant with facility rules since has has been here and wanted to leave the movement she arrived. (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A General Note dated 4/18/24 at 11:12 PM indicated, Late Entry: Note Text: 72 Hour Admit Charting: Res [resident] returned to facility appx [approximately] 16:00 [4:00 PM], pleasant and cooperative with cares, all medications taken as prescribed, res tolerated well. Res asks for assistance as needed, re-directed to use call light as needed for assistance. Call light within res reach. It should be noted that there were no following progress notes or discharge summary in the medical record. On 8/7/24 at 9:49 AM, an interview was conducted with the Administrator (ADM). The ADM stated resident 248 was discharged to another skilled nursing facility (SNF). The ADM stated, It just says discharged to SNF. The ADM stated he did not have any more information

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22992 Based on interview and record review, the facility did not ensure that 2 of 30 sample residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Specifically, ongoing monitoring for changes in condition were not provided after one resident experienced ongoing emesis and abdmoninal pain, and a second resident had a deep vein thrombosis. The findings for resident 46 were determined to have resulted in immediate jeopardy for resident 46. Resident identifiers: 46 and 298. NOTICE On [DATE] at 3:00 PM, an Immediate Jeopardy was identified when the facility failed to implement Centers for Medicare and Medicaid Services (CMS) recommended practices to provide residents quality of care to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This notice was given verbally and in writing to the facility Administrator (ADM), and the Business Office Manager (BOM) regarding resident 46. On [DATE], the facility ADM provided the following written abatement plan for the removal of the Immediate Jeopardy effective on [DATE] at 11:00 AM: Updated Mountain View Health Services Immediate Jeopardy Removal Plan Date Submitted [DATE] We called and spoke with The Chief Clinical Officer (CCO) of an independent consulting organization as required by UDHHS (Utah Department of Health and Human Services) on [DATE] at approximately 3:05pm regarding the executing an agreement. On [DATE], Mountain View Health Services entered into an agreement with the consulting organization. On [DATE] consultant(s) with the consulting organization will be onsite at the facility. F 684 Quality of Care (Communication) 1. On [DATE] the community management team implemented a morning Standup meeting with Nursing to get report from previous day's activities/concerns. If changes in condition are noted from communication notes DON (Director of Nursing) or ADON (Assistant Director of Nursing) will verify MD (Medical Director) team had been notified and if notification has not been made will do so at that time. When in-person visits are conducted, the consultants will attend morning meetings. In addition, when offsite, the consultants will participate in random morning meetings to review and listen to the process to ensure compliance is achieved. 2. On [DATE] the nursing team implemented a new shift communication form that will be relayed at shift change with oncoming nurse for concerns/follow-up items still pending at shift change. All forms will be left in the drawer at nurse's station so management can review relevant items at the next morning standup meeting and follow up accordingly. In addition, the consultants will provide training on this process [DATE]. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3. On [DATE] a new CNA (Certified Nursing Assistant) communication program/sheets implemented as a way for CNAs to communicate with oncoming shift and report to nurse. Sheets will be collected daily and reviewed during the daily standup meeting with department managers. The consultants will provide education and training on this process [DATE]. 4. On [DATE] nursing implemented a new Communication and Follow-Up book that will remain at the nursing station. The book is a duplicate copy book with highlights and follow-up items from the previous day. The original will be removed and reviewed at daily manager Standup meeting. The consultants will provide education and training on this process [DATE]. 5. On [DATE] communication improvements made between the building and MD team by adding the DON and Administrator have both been added to the secure messaging app between the MD group and Facility. Areas of concern or issues that arise will be addressed in the manager stand-up meeting. 6. On [DATE] representatives from the consulting organization reviewed and assessed the facility's policies and procedures regarding changes in resident condition. The consultants provided the community with a change of condition policy to adopt. The consultants provided education and training on [DATE] [and][DATE] with licensed nursing and nursing assistants. The review with licensed nurses addressed expectations for ongoing assessments of each resident's condition, what constitutes a change in condition, expectations for the communication of changed (sic) in resident condition, and ongoing monitoring of residents experiencing a change in condition. On [DATE] facility in coordination with the consulting organization, the consultants will complete record reviews of all residents for the last 30 days to ensure no resident has experienced a change in condition not previously identified. Any findings of change of condition will be reported to the resident's attending physician and the resident's representative. This information will be communicated with the DON and Administrator at the manager stand-up meeting. The consultants ongoing for the next 30 days will review daily progress notes (M-F) (Monday through Friday) to ensure documented changes of condition are timely identified and action steps are taken with resident changes of condition. Mountain View Health Services has implemented this plan to remove the conditions that constituted immediate jeopardy, and the immediate jeopardy was removed on [DATE]. On [DATE], while completing the recertification survey, surveyors conducted an onsite revisit to verify that the Immediate Jeopardy had been removed. The surveyors determined that the Immediate Jeopardy was removed as alleged on [DATE] at 11:00 AM. Findings include: 1. Resident 46 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included hemiplegia and hemiparesis, chronic obstructive pyelonephritis, severe sepsis without shock, aspiration pneumonitis, acute kidney failure, supraventricular tachycardia, and bipolar disorder. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Although the order for a stat ultrasound for resident 46 was documented to be received at 9:30 PM on [DATE], the facility nurse did not document attempts to have the stat ultrasound performed until 6:15 AM on [DATE]; eight hours and 45 minutes later. Upon receiving notification from the contracted radiology provider that the company did not perform ultrasound tests on the weekend, there were no facility records to document that RN 2 contacted resident 46's physician. [Note: Review of the written telephone order revealed that RN 2 documented she had obtained the order for the Rocpehin and stat ultrasound from NP 1.] d. On [DATE] at 12:50 PM, RN 3 documented that resident 46 . has vomitted (sic) once this shift, it was a light brown color. He has requested more prune juice, but I denied that request and explained that we want to see why his vomit is brown. [Resident 46] had been laying in his vomit all night, we got him up to the shower and changed his bedding. His entire left arm, side of torso, and hip are very red. Cleaned well and put on hydrocortisone cream and barrier cream. Texted pic (picture) to provider of his inflamed skin. RN 3 did not document whether she had informed resident 46's physician of the ongoing brown emesis that resident 46 was experiencing. In addition, RN 3 did not document any indication that she was aware of the stat ultrasound order, or what the status was in obtaining the ultrasound. e. On [DATE] at 10:54 PM, Licensed Practical Nurse (LPN) 3 documented Order noted for ultrasound of Abdomen, [name of contracted radiology provider] notified and is scheduled for Monday [DATE]. No indication was made in the note by LPN 3 that he had contacted resident 46's physician regarding the delay in obtaining the stat ultrasound. f. On [DATE] at 10:10 AM, RN 4 documented that resident 46 had an . Ultrasound scheduled for tomorrow r/t (related to) vomiting and abdominal pain. g. On [DATE] at 4:36 PM, RN 4 documented that resident 46 had a Small amount of dark brown emesis early this morning. No other episodes this shift. h. On [DATE] NP 3 documented that he spoke with resident 46 face to face for approximately 17 minutes, and that they discussed resident 46's medical conditions and his code status. NP 3 also documented that . Patient has cholecystitis and was started on on (sic) Rocephin on [DATE], we will continue to monitor patient closely to determine if antibiotic treatment has been effective. NP 3 documented that resident 46 was experiencing Right upper quadrant/right lower quadrant pain, but did not document any follow up he did with facility staff regarding the ultrasound order. NP 3 did not document any assessment with regard to resident 46's nausea or vomiting. i. On [DATE] at 10:21 PM, RN 5 documented, Res (resident) currently on ABX (antibiotics) IM, (2nd dose) Medication was administered per MD orders. Res tolerated procedure well, there has been no ASE (adverse side effects) observed or reported. Fluids encouraged. RN 5 did not document any assessment with regard to resident 46's abdominal pain, nausea or vomiting. [Note: This note was entered as a late entry on [DATE] at 8:24 AM.] (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 7:17 PM, a telephone interview was conducted with CNA 6. CNA 6 stated that she had worked with resident 46 on [DATE] and [DATE]. CNA 6 stated that resident 46 was complaining about abdominal pain during her shifts. CNA 6 stated that resident 46 had been throwing up and did not get out of bed during her shifts. CNA 6 stated that a bunch of us had to go in and clean him up after the resident had vomited. CNA 6 stated that she observed resident 46's emesis and it wasn't normal throw up . it looked black and like chunky and liquids at the same time. It was black and dark brown. CNA 6 stated that other staff reported to her that resident 46 had been constantly throwing up all day on one of the days she worked with him, I wanna say he threw up both nights but it was worse the next night. They said they wanted to get him an ultrasound and they were waiting but they wanted to get the ultrasound first before they sent him out. On [DATE] at 6:25 PM, a telephone interview was conducted with CNA 4. CNA 4 stated that during the last week of resident 46's life, resident 46 was very sick and he was throwing up for two days. CNA 4 stated that on [DATE], he observed resident 46 while the resident was being weighed. CNA 4 stated that this was the last time he had seen resident 46 and that the resident didn't look really good. He was very pale, and his eyes were sunken in. CNA 4 stated that other staff had reported to him that resident 46 was vomiting a dark liquid and that the resident's health was getting worse and he wasn't feeling well. On [DATE] at 5:39 PM, a telephone interview was conducted with LPN 3. When asked about the note that LPN 3 entered on [DATE], LPN 3 stated that the facility had been having problems with predictability of services with the contracted radiology provider since at least [DATE]. LPN 3 stated the the contracted radiology provider kept putting off coming in to the facility to perform resident 46's ultrasound after it was ordered on [DATE]. LPN 3 stated that he was unsure why there was an order for an ultrasound, or if resident 46 was experiencing a change in condition during the week prior to the resident's death. On [DATE] at 3:55 PM, a telephone interview was conducted with RN 4. RN 4 stated that she worked on Sunday, [DATE], and was aware that resident 46 was supposed to have an abdominal ultrasound completed, but that the contracted radioligy company did not provide ultrasounds on the weekends. RN 4 stated that she did not work on Monday [DATE], and thought that the ultrasound would be completed that day. RN 4 stated that when she returned to work on [DATE], the ultrasound had not been completed so she contacted the contracted radiology company. RN 4 stated that the radiology company told her that they did not have resident 46 on their schedule, and that the earliest they could perform the ultrasound would be on [DATE]. RN 4 stated that she then contacted the on-call provider for further instruction. RN 4 stated that the on-call provider instructed her to schedule the ultrasound at a local hospital. RN 4 stated that the Medical Director was in the facility on [DATE], and she had informed the Medical Director about the delay in getting an ultrasound for resident 46. RN 4 stated that during her shift on [DATE], resident 46 was vomiting at times, although she did not observe the emesis produced. RN 4 stated that staff reported to her that resident 46's emesis was brown or dark brown. RN 4 stated that on [DATE], resident 46 reported he was still experiencing abdominal pain, but did not pinpoint the exact location of the pain. RN 4 reported that on [DATE], resident 46 received a shower, and had consumed at least part of his meals. RN 4 stated that she also worked as the ADON, and that she did not report resident 46's change in condition or delay in obtaining the ultrasound to the DON because we don't have office hours, we just work the floor when we are there. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 12:08 PM, a second interview was conducted with NP 2. NP 2 stated that she was unaware if any previous issues had occurred with the contracted radiology provider. NP 2 stated that other buildings just figure it out how to get the resident in sooner when they received an order to get a stat ultrasound. NP 2 stated she did not think the facility staff accurately communicated resident 46's change of condition to her. When asked if NP 2 was aware that resident 46 had a history of gastrointestinal bleeds, NP 2 stated, No. If I would have known that I would have sent him out to the local hospital. NP 2 stated that the facility was not uploading all of residents' information into the electronic health records, so if she was working from home on a day that the facility staff contacted her, she would not have all of the residents' information available to her. NP 2 stated that other facilities had a 24 hour nursing report to refer to, and a dedicated DON she could speak with, but that at this facility she had to speak with every nurse to obtain information about the residents. On [DATE] at 1:32 PM, a telephone interview was conducted with NP 1. NP 1 stated that she evaluated approximately 150 patients each week and did not recall if she had evaluated resident 46. NP 1 stated that her company did not document anything when an on-call provider was contacted about a specific resident. NP 1 stated that she did not recall if she had written the Rocephin prescription for resident 46 on [DATE]. NP 1 stated that she did not recall why or how she had evaluated resident 46 to diagnose him with cholecystitis. NP 1 stated that typically if she suspected a resident had cholecystitis, she would have the facility start Rocephin injections to control the infection until the ultrasound could be performed. NP 1 stated that if she wrote something as a stat order, she expected it to be done within an hour or two. NP 1 stated that she did not receive any other phone calls from the facility regarding resident 46, nor was she notified that the ultrasound could not be performed on the weekend. NP 1 stated that if the resident did not stabilize or have a reduction in symptoms after receiving the Rocephin injections, then the facility should have sent the resident out to the hospital for further evaluation. NP 1 further stated, I would have expected a phone call back to know that so I could send him out or continue to monitor his symptoms. NP 1 stated that cholecystitis typically responded well to Rocephin. NP 1 stated that had she known about resident 46's ongoing symptoms after receiving the Rocephin, she would have sent him to the hospital no question because his condition has changed. [Cross refer to F776] 50200 2. Resident 298 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included unspecified dementia, essential hypertension, benign prostatic hyperplasia without lower urinary symptoms, acute kidney failure, weakness, and anxiety disorder. Resident 298's medical record was reviewed on [DATE]. An admission Minimum Data Set (MDS) assessment dated [DATE], documented that resident 298 had a Brief Interview for Mental Status (BIMS) score of 13. A BIMS score of 13 to 15 would suggest intact cognition. A review of resident 298's paper medical chart revealed an order dated [DATE], for a right lower extremity ultrasound to rule out a DVT [deep vein thrombosis]. A review of resident 298's progress notes revealed: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	a. On [DATE] at 3:22 PM, a health status noted documented, PT [patient] APPT [appointment] C [with] MDR [medical doctor] WAS CANCELLED PER ADMIN [administration] HIS RLE [right lower extremity] IS QUITE A BIT BIGGER THAN PRIOR TO RECENT HOSPITAL STAY. ,D [sic] WAS INT [sic] TO SEE PT AND HE ORDERED THAT HE SEES HIA [sic] ORTHO ASAP [as soon as possible] AND A U/S [ultrasound] TO RLE TO R/O [rule out] DVT SO THIS RN [registered nurse] CALLED TO SET UP MOBILE EXAM WHEN I DID THE [sic] SAID IT WOULD BE DONE UNTIL [DATE]TH WHICH THAT IS THE [NAME] [sic] DAY THT [sic] HIS APPT WAS RESCHEDULED FOR SO I BUT IT THE MD PHONE THIS INFO MAYBE HE WANTED US TO TAKE PT INTO HOSPITAL FOR EXAM. PT IS ALERT ORIENTED TO TIME AND ABLE TO FEED SELF. ABX [antibiotics] GIVEN AS PER 0RDER [sic] INCISION IS CLEAN DRY ANDEDGES [sic] ARE WELL AOPROXAMATED [sic]. WCTM [will continue to monitor]. b. On [DATE] at 2:54 PM, a health status note documented, Resident had a f/t [sic] appointment with [hospital name redacted] for his r [right] hip. An xray was done. Then he went to see his surgeon [name redacted] for f/u [follow up]. New orders are WBAT [weight bearing as tolerated], PT/OT [physical therapy/occupational therapy] to strength, ambulate and balance. Has anterior hip precautions. Anticoagulated for 2 more weeks from other. COntinue [sic] any chronic meds [medications] otherwise. F/U in 6 weeks with xrays to right hip. (around the [DATE] or 1st week of August) c. On [DATE] at 4:22 PM, a health status note documented, [name redacted] in for US of RLE. Patient was out on an appointment and I told [name redacted] that they made the appoinment [sic] in the afternoon as he had am [sic] appointments. The rep for [name redacted] took the number and said she would call back and come back if he was available. I told her that it had to be done. No calls were returned from [name redacted]. [TRUNCATED]

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48709 Based on observation, interview, and record review, the facility failed to ensure a resident with limited range of motion received appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Specifically, for 2 out of 30 sampled residents, recommended treatments of daily prolonged stretching were not followed up on, occupational therapy orders were not implemented, and splints were not being provided. Resident identifiers: 1 and 35. Findings included: 1. Resident 35 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included artherosclerotic heart disease, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, gout, memory deficit following cerebral infarction, repeated falls, type 2 diabetes mellitus with diabetic polyneuropathy, cerebral infarction, dysphagia, Charcot's Arthropathy, and acquired absence of other right toe. On 7/28/24 at 1:05 PM, an observation and interview were conducted with resident 35. Resident 35 was observed sitting in his wheelchair in the dining room, he wore a white sock on his left foot with no brace. Resident 35's left foot appeared severely impaired and was rotated medially. Resident 35 stated he did wear a brace on his ankle, sometimes. Resident 35 stated that he did not currently receive physical or occupational therapy, nor did anyone do range of motion exercises with him for his left foot. On 7/29/24 at 11:03 AM, an observation of resident 35 was conducted. Resident 35 was in a manual wheelchair and self-propelled himself with the use of his right arm and foot around the nurse's station. Resident 35 wore a white sock on his left foot with no brace and his left hand and wrist had a contracture. Resident 35's medical record was reviewed from 7/28/24 through 8/14/24. A Clinical Summary dated 6/12/24 at 8:00 AM, indicated resident 35 was seen by an outside orthotic clinic for his ankle foot orthosis (AFO). It further indicated, Device History . Start Date: 2021. End Date: current/present. Comments: This AFO is a generic off the shelf design that of which doesn [sic] not cater to his serve externally rotated ankle foot complex. Increased risk for adverse skin shear with continued use. Custom AFO pursuit necessary in assurance of patient safety/skeletal informational stabilization. It further indicated, Comments: Minor adjustments/repairs pursued as described today. I informed the tending facility staff to pursue daily prolonged stretching of his ankle foot complex in avoiding deformational varus tendency, concern with fixated external rotational deformation at the ankle complex should this not be put in place at his care facility. Written recommendations provided to facility staff present today. All adjustments requested by [resident name redacted] pursued today were found proper. Follow up as needed. It should be noted that this document was not found in the medical record and was provided after it was requested by the State Survey Agency. The fax server date on this document was 7/30/24 at 4:31 PM from the clinic. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The quarterly Minimum Data Set assessment Section GG Functional Abilities and Goals dated 6/13/24, indicated, Functional Limitation in Range of Motion to the Lower extremity (hip, knee, ankle, foot with Impairment to one side. It further indicated resident 35 used a wheelchair. An Encounter Progress Note dated 7/4//24 at 11:00 PM, indicated, [Resident name redacted] is a [AGE] year-old male who is a long-term resident at [Facility name redacted]. He has a history of a cerebral infarction resulting in left-sided weakness, diabetes, obstructive sleep apnea as well as Charcot's arthropathy. When is at the nurses station today patient came to me to discuss his left foot pain and malformation. Patient states that years ago he hurt his foot and it never healed back to normal position properly. The foot is turned inward and a brace is in place at this time. Patient states that he is able to hold the foot or the toes back and push them down but with very poor range of motion. He stated that he needs to have the foot casted to help him get the foot back into normal position. The brace does not appear to be keeping the footin [sic] a normal anatomical alignment position. I am going to refer the patient to an orthopedic specialist to works on her feet and ankles. I informed patient that I would write the referral and patient was very grateful. Patient was sitting in his wheelchair when I left him by the nurses station. The care plan focus, The resident had a cerebral vascular accident (CVA/Stroke) affecting the left side was initiated on 8/5/21. It indicated the goal of, The resident will be free from s/sx [signs and symptoms] of complications of CVA (DVT [deep vein thrombosis], contractures, aspiration pneumonia, dehydration) through review date. It further indicated Interventions/Tasks of, Monitor/document mobility status. If resident is presenting with problems or paralysis, obtain order for Physical therapy and Occupational therapy to evaluate and treat. The care plan focus, The resident has hemiplegia r/t [related to] CVA was initiated on 8/5/21, with a Target Date of 6/5/24. It indicated the goals, The resident will remain free of complications or discomfort related to hemiplegia through review date and The resident will maintain optimal status and quality of life within limitations imposed by Hemiplegia through review date. It indicated the Interventions/Tasks, Discuss with resident/resident and family any concerns, fears, issues regarding diagnosis or treatments and PT [physical therapy], OT [occupational therapy], ST [speech therapy] evaluate and treat as ordered. On 7/29/24 at 3:51 PM, an interview was conducted with the Director of Nursing (DON). The DON stated there was no Restorative Nursing Assistant (RNA) program and that nursing did not do passive range of motion for residents. The DON stated occupational or physical therapy should provide those services if a resident had that ordered. On 7/30/24 at 11:42 AM, an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated resident 35 had an AFO that he used to wear every day but had been refusing to wear it since his last appointment several weeks ago with the outside orthotic clinic. The ADON stated if that clinic sent any notes back it would be filed in the chart. The ADON stated the resident was not on physical therapy treatments at that time. On 7/30/24 at 12:38 PM, an interview was conducted with the Physical Therapy Assistant (PTA). The PTA stated she had worked with resident 35 in the past but not in the last six months or so. The PTA was reviewing the medical chart and stated resident 35 was last seen by physical therapy April 2023. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/30/24 at 2:01 PM, an interview was conducted with the Occupational Therapist (OT). The OT stated resident 35 was last seen by OT on 8/23/24, for his hand. The OT stated he did know that resident 35 had an AFO for his foot and that the fit rubbed and bothered him. The OT stated he still had trouble with his AFO. On 7/31/24 at 11:18 PM, a follow up interview was conducted with the DON. The DON stated she had not seen the outside orthotic clinic summary from 6/12/24. The DON stated she needed to look at it and notify the physician. The DON stated his assigned nurse should have put that order in. 33215 2. Resident 1 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included, but were not limited to, acute myocardial infarction, acute respiratory failure with hypoxia, age-related cognitive decline, type 2 diabetes mellitus, non-pressure chronic ulcer of foot, rheumatoid arthritis, acquired deformity of lower leg, muscle wasting and atrophy, dysphagia, and difficulty in walking. On 7/28/24 at 11:59 AM, an observation was conducted of resident 1. Resident 1 was laying in bed and appeared to have contractures to her hands and fingers bilateral. There were no splints or rolled hand towels observed in resident 1's room and resident 1 did not have splints or rolled hand towels in or on her hands. On 7/28/24 at 12:17 AM, an observation was conducted of resident 1. Resident 1 was observed eating lunch in her room. Resident 1 was observed with contractures to her hands bilateral. Resident 1's medical record was reviewed on 7/29/24. A care plan Focus initiated on 6/19/13, documented The resident has limited physical mobility r/t Neurological deficits, osteoporosis, Weakness, contractures which can lead to falls. The interventions included, but were not limited to, prom [passive range of motion] to bilateral hands, splint to hands as tolerated. The intervention was initiated on 5/31/14. On 1/26/22, a physician's order documented OT Clarification: OT to tx [treat] 3-5 x/wk [times per week] x [times] 8 weeks for self cares, x-fers [transfers], ROM [range of motion], contracture mgnt [management], pt [patient]/caregiver ed [education], their [sic] [therapeutic] ex [exercise], there [therapeutic] act [activity]. An OT Discharge Summary with services dates from 10/17/23 to 3/12/24, documented that resident 1 had contractures of the right and left hand. The reason for discharge was due to resident 1 meeting maximum potential at that time. The discharge disposition was Nursing. A short term goal included, but was not limited to, 5. [Met]: Pt will tolerate air splint in R [right] hand x 2 hrs [hours]/day to [sic] for contracture management and prevent skin breakdown. The start status documented not tolerating splint currently. The concluding status documented Towel roll placement - not tolerating air splint. It should be noted that the OT Discharge Summary did not address resident 1's left hand contracture. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/29/24 at 8:45 AM, an observation was conducted of resident 1. Resident 1 was observed at the medication cart and her right foot was observed to be turned inward. Resident 1 did not have a brace or splint on the foot. On 7/29/24 at 11:59 AM, an interview was conducted with resident 1. Resident 1 stated that therapy or staff did not do exercises with her hands. Resident 1 stated that she did not have braces or splints for her hands and could not remember if she ever had them. On 7/29/24 at 1:08 PM, an interview was conducted with Certified Nursing Assistant (CNA) 3. CNA 3 stated that she was not aware of any exercises or a split that resident 1 was to be wearing. CNA 3 stated that resident 1's hands did not really open and resident 1 would use her wrist to grab things. CNA 3 stated that resident 1's fingers were always in the down direction towards the palm of the hand and resident 1 was unable to move her fingers. CNA 3 stated that she was not sure if therapy was working with resident 1 or if the CNAs were to be doing that. CNA 3 stated that she was not aware of any exercises. On 7/29/24 at 1:37 PM, an interview was conducted with the DON. The DON stated that resident 1 had arthritis that was causing the contractures. The DON stated the staff had tried to use rolled towels in resident 1's hands and resident 1 had refused them. The DON stated that resident 1 wanted to do as much as possible for herself. The DON stated that resident 1 used special spoons to eat. The DON stated that resident 1 could not grasp and did not have that fine motor movement. The DON stated that PT and OT did not work with resident 1 that she knew of. The DON stated that resident 1 used splints in the past and resident 1 would use the splints every once in awhile when resident 1 had pain but resident 1 would refuse the splints. The DON stated that resident 1 used to have a splint on her foot but resident 1 did not like to wear the splint and resident 1 had a wound on her foot currently. An observation was conducted of resident 1's room with the DON. The DON removed a foot splint from resident 1's closet. Resident 1 stated the foot brace belonged to her roommate and the brace was not hers. There were no hand splints in resident 1's closet or the dresser drawers. Resident 1 stated that she did not have a hand splint and the hand splints were from a long time ago. The DON stated there were no exercises like PROM for resident 1's hands. The DON stated there was nothing that she was aware of that staff were doing to ensure that resident 1's contractures did not get worse. The DON stated the staff would make sure that resident 1's finger nails were clipped and clean. Documentation was unable to be located regarding resident 1's refusals of the splints and hand towels. On 7/29/24 at 3:51 PM, a follow up interview was conducted with the DON. The DON stated the facility did not have a RNA program. The DON stated if the referral from PT or OT was to Nursing then by all means we should be doing that. The DON stated the staff just watch the resident and if the resident were to fall we would make the referral to PT and OT. The DON stated they had a meeting every Friday and would talk about the residents, if the residents were falling, and if the residents needed PT or OT. The DON stated that OT would do the ROM exercises with the residents.

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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** 33215 Based on observation, interview, and record review, the facility did not ensure that each resident received adequate supervision and assistance devices to prevent accidents and the resident environment did not remain as free of accident hazards as was possible. Specifically, for 1 out of 30 sampled residents, a resident was not provided adequate supervision and interventions to reduce hazards and risks that resulted in an acute complete femoral neck fracture with partial displacement. Resident identifiers: 298. Findings included: 1. Resident 298 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included, but were not limited to, dementia, essential hypertension, acute kidney failure, and anxiety disorder. Resident 298's medical record was reviewed on 8/7/24. A Baseline Care Plan signed by the Director of Nursing (DON) on 3/28/24, documented that resident 298 did not have a history of falls and a Fall Management Care Plan was not implemented. On 3/29/24, a Morse Fall Scale documented that resident 298 was a High Risk for Falling with a score of 50. A resident was considered a High Risk with a score of 45 and higher. An admission Minimum Data Set (MDS) assessment dated [DATE], documented that resident 298 had a Brief Interview for Mental Status (BIMS) score of 13. A BIMS score of 13 to 15 would indicate intact cognition. The Care Area Assessment Summary of the MDS documented that falls had triggered to be care planned. On 4/11/24 at 8:29 AM, a Fall Incident Report documented Staff radio nurse, to report resident fell . Nurse knocked and entered res [resident] room. Staff reported fall was witnessed. Res was assessed, res cognitive to baseline, A&O [alert and oriented] x2, name and situation. PERRLA [pupils are equal, round, and reactive to light and accommodation] WNL [within normal limits], ROM [range of motion] completed without difficulty, res assisted into bed. Res was painful r/t [related to] skin tear to R [right] elbow., res had a reddened area R lateral side just below hair line. Staff reported that redness to forehead was there earlier before the fall. Res had a large skin tear to R elbow, wound Tx [treatment] provided, affected area was cleansed with wound cleaner, pat dry. using steri strips tear was close and approximated well. Bacitracin applied, covered with non-adherent dressing, and wrapped. Neuro's [neurological's] started per protocol. MD [Medical Director], family notified via voicemail, and DON 04/12/2023. Res stated his feet fell out from under him and he fell to the ground. Res stated he hit head and touched over red area to R side of forehead. [Note: Neuro's were unable to be located.] A care plan Focus initiated on 4/12/24, documented The resident has had an actual fall with minor injury d/t [due to] Hypotension and Unsteady gait. The interventions included: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	a. Anticipate patients needs and monitor for unsteady balance. Date Initiated 4/11/24. b. Continue interventions on the at-risk plan. Date initiated 4/12/24. [Note: The at-risk plan was unable to be located.] On 5/18/24 at 3:59 AM, a Health Status Note documented Note Text: Resident fell in his room about 1900 [7:00 PM]. It was an unwitnessed fall lost his balance and went down on his left side. Able to move all his extremities without pain. A small red mark was found on his left back shoulder. He was too weak to get up on his own. Three maximum assist to left [sic] him onto his lounge chair. Vital signs taken and T [temperature] 98.0, P [pulse] 64, R [respirations] 28 B/P [blood pressure] 96/56 and 02 [oxygen] sats [saturations] 92% on room air. MD notified of low B/P and fall at 2238 [10:38 PM]. Administrator and DON notified at 0345 [3:45 AM] and 0348 [3:48 AM] this morning. Morning nurse to be notified in am and family. Neuro checks and VS [vital signs] doing well no changes. [Note: No new interventions were implemented to prevent falls after the fall 5/18/24.] On 5/19/24 at 9:00 AM, an Incident Follow up documented Date of Incident: 5/19/2024 Type of Incident: Fall Root Cause: Unsteady gait Treatment Required: None Interventions put into place: Neuros, call light given to resident, rounds every 15 minutes Referrals Made: None. [Note: No new interventions were implemented to prevent falls after the fall on 5/19/24. An assessment after the fall was unable to be located.] On 5/19/24 at 11:00 PM, an encounter documented Date of Service: 05/20/2024 Visit Type: Acute Transition of Care: No transition occurred. Progress Note . Chief Complaint / Nature of Presenting Problem: Fall History Of Present Illness: Patient is a [AGE] year-old male with a past medical history significant for Alzheimer's dementia. He was previously a resident at the [name redacted] and was admitted here one month ago. He has tried to escape multiple times and constantly packs his things to leave. He often waits by the locked door of the unit to leave. Today CNA [Certified Nursing Assistant] reported that patient had 2 falls over the weekend. Denied hitting his head. Patient reports that he is fine. He denied any uncontrolled pain. He denied any issues or concerns. The Nurse Practitioner (NP) signed the note on 5/20/24 at 8:39 AM. On 5/19/24 at 4:45 PM, a Fall Incident Report documented . Client had an unobserved fall out of dining room chair. Client pulled tablecloth halfway off. When CNA walked into dining room to check on clients, other residents were helping client off of floor. Client stated 'I feel. I am okay.' Client was put on neuros and observed every 15 minutes. [Note: No new interventions were implemented to prevent falls after the second fall on 5/19/24.] On 5/20/24 at 2:50 PM, an Orders - General Note from electronic record (eRecord) documented Note Text: CNA comes to nurse and stated resident had an assisted fall and was lowered to ground after being toileted. He lost his balance and she grabbed him and lowered him. Both South and North nurse in to assist resident and transfer him to his w/c [wheel chair]. He did not appear to be in pain but rather confused. He sustained a small r elbow tear to his arm from the w/c during transfer. Cleaned and dressed. He then rested quietly throughout the rest of the shift. [Note: No new interventions were implemented to prevent falls after the fall on 5/20/24.] (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 5/20/24 at 11:00 PM, an encounter documented Date of Service: 05/21/2024 Visit Type: Acute Transition of Care: No transition occurred. Progress Note . Chief Complaint / Nature of Presenting Problem: Right hip pain History Of Present Illness: [Resident 298] is a [AGE] year-old long-term care resident here at [name redacted]. Per the nurses report he has had a couple of falls over the weekend. He was evaluated yesterday but denied any significant pain. It is unclear if he had another fall since yesterday's evaluation but currently he has complaints of right hip pain. He has been unable to stand. Most of his pain is localized to the anterior and lateral right hip. General: Elderly male in mild distress. Does appear confused which is his baseline Musculoskeletal: Patient does have tenderness to palpation over the right hip laterally anteriorly. He does have pain with internal and external rotation of the right hip. This localizes anteriorly. Acute right hip pain Patient's right hip pain appears to be acute and it is unclear whether this is related to a fall over the weekend or a new fall today. Given his acute right hip pain and evaluation today I do recommend x-rays of the right hip stat [immediately]. These were ordered today. Plan to follow-up after x-rays. Fall On fall precautions. The MD signed the note on 5/21/24 at 11:17 AM. On 5/21/24 at 11:40 AM, a Health Status Note documented Note Text: NEW ORDER: Pt [patient] is not bearing any wt [weight] on rt [right] leg has a lg [large] skin tear on rt elbow. md notified ordered a xray it has been ordered and they stated it wil [sic[be done today. pt had a shr [shower] today. On 5/21/24, the Diagnostics report documented . Right hip, 2 views Comparison: None. Findings: There is an acute complete femoral neck fracture with partial displacement compatible with a Garden Classification III fracture. IMPRESSION: 1. Garden classification III acute femoral neck fracture. The diagnostics report was signed by the diagnostics radiologist on 5/21/24 at 6:23 PM. On 5/22/24 at 2:51 AM, a Health Status Note documented Note Text: Follow up on res x-ray: Impressions noted; There is an acute complete femoral neck Fx [fracture] with partial displacement compatible with a Garden class III. Mild degree of osteopenia. Moderate osteoarthritis. X-ray results sent to MD, response pending. WCTM [will continue to monitor]. On 5/22/24 at 5:30 AM, a Health Status Note documented Note Text: Staff reported res, has been up all night did not sleep a [NAME], trying to wiggle his way out of bed. Staff has continuously throughout shift had to re center res into bed and remind resident that he, could not walk d/t broken femur. will pass on to upcoming shift nurse for monitoring and follow-up. On 5/22/24 at 6:54 AM, an Orders - General Note from eRecord documented Note Text: MD notified of results of Xray and new order for resident to be sent to ER [emergency room] for eval/tx [evaluation and treatment]. Preparing paperwork. On 5/22/24 at 3:01 PM, a Health Status Note documented Note Text: Received call from [hospital name redacted]. They will do surgergy [sic] this afternoon and resident to be admitted to med [medical] surg [surgical] floor. On 8/7/24 at 12:23 PM, an interview was conducted with NP 2. NP 2 stated she saw resident 298 because he had a fall. NP 2 stated that resident 298 was walking around pushing his recliner around and had no pain. NP 2 stated the MD came in the next day and said that resident 298 had a broken femur. NP 2 stated that she did not do a full hip exam because resident 298 was moving fine. NP 2 stated that she did not expect a break. NP 2 stated that the MD sent resident 298 out and resident 298 did have a break. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 8/8/24 at 11:50 AM, an interview was conducted with the DON. The DON stated that resident 298 had an unwitnessed fall on 5/18/24 at about 3:00 AM. The DON stated that resident 298 had another fall on 5/19/24 at 9:00 AM. The DON stated the fall on 5/20/24, was an assisted fall at 3:00 PM. The DON stated at that time herself and the CNA lowered resident 298 to the floor and the DON stated that she did not notice anything. The DON stated that the NP saw resident 298 the morning of 5/21/24, and noted we need an xray. The DON stated that resident 298 somehow had a shower during that time on 5/21/24. The DON stated the facility called the x-ray company at 11:34 AM, and they arrived at the facility at 5:41 PM, to do the x-ray on 5/21/24. The DON stated at 6:23 PM, the x-ray company either faxed the results or notified the facility of the results. The DON stated that the nurse on 5/22/24, made a progress note that results were pending from the doctor. The DON stated at the end of the shift the nurse made a note that resident 298 was up all night and passed the information to the oncoming nurse which was the DON. The DON stated at 6:55 AM, she notified the doctor and resident 298 was sent out to the hospital. On 8/14/24 at 7:29 AM, an interview was conducted with CNA 3. CNA 3 stated that if a resident was a fall risk the resident would have something on there door like a color indicating if they were a fall risk or a runaway risk. CNA 3 stated that she started at the facility in May or June 2024. CNA 3 stated that she met resident 298 after her second day and resident 298 had fallen and broken his femur. CNA 3 stated resident 298 would try and roll out of bed or get up. CNA 3 stated there were interventions after the fracture to keep resident 298 in bed and resident 298 had a wedge pillow. CNA 3 stated that resident 298 would try and get up even though he had a broken femur. CNA 3 stated that she would get in report if a resident was a fall risk. CNA 3 stated that she did not know if there was a kardex for residents or where to see interventions. CNA 3 stated that 15 minute checks were done with neuros. CNA 3 stated that 15 minute checks we done for the first hour, then 30 minute checks, then 45 minute checks, and then every hour for three days. CNA 3 stated the nurse had a form at the nurses station that the CNAs would document the neuro checks. CNA 3 stated that neuros were done after every fall. CNA 3 stated if a resident had an intervention to anticipate needs she would observe what the resident was like and what the resident needed. CNA 3 stated if the resident was cold then she would get them a blanket, if the resident was dirty she would give them a shower regardless if it was the residents shower day. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 8/14/24 at 7:39 AM, an interview was conducted with the DON. The State Survey Agency (SSA) Lead Licensor asked the DON what an At Risk Plan was and how was that a fall care plan intervention. The DON stated why was that there and that should not be there. The DON stated that was assuming that the nurses knew what the at risk plan was for the resident. The DON stated that she had no idea why that was on the care plan. The DON stated to her an at risk plan was why the resident fell . The DON stated the at risk plan did not tell her anything if that was on the care plan as an intervention. The DON stated where did they get that. The DON stated the facility used to have a form that was stapled to the incident form and would document why the resident was falling and would go more in depth. The DON stated that she would not recommend the at risk plan as an intervention because you need to fix the problem. The DON stated the at risk told the staff nothing. The SSA Lead Licensor asked the DON what the intervention 15 minute checks meant. The DON stated that 15 minute checks meant neuros and vital signs every 15 minutes. The DON stated that neuros were conducted with an unwitnessed fall. The DON stated that 15 minute checks were done in four sets. The DON stated that anticipate needs meant that the resident was a high fall risk and the staff need to have eyes more on the resident. The DON stated to have eyes more on the resident meant to make sure staff were watching the resident and a little bit more eyes on the resident. The DON stated it was impossible to do a one on one in the facility. The DON stated that all the nurses should be doing the care plans. The DON stated that interventions could be customized. The DON stated that staff needed to find out why the fall happened and if the fall fell into any of the categories on the computer then great if not the intervention could be customized. On 8/14/24 at 8:42 AM, a follow up interview was conducted with the DON. The SSA Lead Licensor asked the DON if she had details regarding resident 298's fracture. The DON stated that resident 298 was not in any pain that day and had no signs of a fracture. The DON stated the CNA was getting resident 298 ready to toilet and the DON went in to assist and resident 298 was lowered to the ground. The DON stated that she had been told if the fall was assisted she did not have to do a fall. The DON stated there may have been a fall the next day also but she was not sure. The DON stated that neuro checks were only done if the resident hit their head. The DON stated that she usually kept the neuro checks and she had record of them.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50200 Based on interview and record review, the facility did not ensure that a resident who enters the facility with an indwelling catheter or subsequently received one was assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrated that catheterization was necessary. Specifically, for 1 out of 30 sampled residents, a resident continued to have an indwelling catheter without having a diagnosis for keeping it in place. Resident identifiers: 298. Findings included: Resident 298 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included dementia, essential hypertension, benign prostatic hyperplasia without lower urinary symptoms, acute kidney failure, weakness, and anxiety disorder. Resident 298's medical record was reviewed on 8/7/24. An admission Minimum Data Set assessment date 4/10/24, documented that resident 298 had a Brief Interview for Mental Status (BIMS) score of 13. A BIMS score of 13 to 15 would suggest intact cognition. On 5/25/24 at 3:38 PM, a health status note documented, Spoke with [name redacted] RN [registered nurse] at [name of hospital redacted] regarding discharge from hospital back to facility prior to 1700 [5:00 PM]. Resident admitted to hospital on 5/22/24. res [resident] underwent R [right] hemiarthroplasty, silver long dressing placed over incision. Res is a 1-2 person assist ambulating with walker and transfers. Res was straight Cath [urinary catheter] this morning, there was trauma that caused bleeding, res is returning with a indwelling catheter d/t [due to] retention. Res VS [vital signs] BP [blood pressure] 114/62, HR [heart rate] **, Temp [temperature] 36.6, RR [respiratory rate] 18, O2 [oxygen] 94% RA [room air]. Res has dentures with self, Abductor pillow, res not tolerating well, HS/NOC [bedtime/nighttime] use. Res has been on a reg [regular] diet, has tolerated well. On 6/3/24 at 8:49 PM, a health status note documented, Staff reported resident scrotum and testicles were red. This nurse assessed, affected area was observed, scrotum and testicles very red. This nurse provided and educated staff present, of proper perineal care, wiping front to back of both bowel and urine. Barrier cream applied. Resident has an indwelling catheter. On 6/9/24 at 1:46 PM, a health status note documented, Resident tolerating oral ABX [antibiotics] d/t sepsis, no ASE [adverse side effects] noted. Foley intact and was placed during resident's stay in Hospital. 200ml [milliliters] in down drain bag and fluids encouraged . (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/23/24 at 1:15 PM, a health status note documented, Resident slipped from wheelchair to floor, CNA [Certified Nursing Assistant] was able to prevent resident from hitting the floor hard. Did not hit head, no injuries, but Foley catheter was pulled out. Resident denies pain, Removed wheelchair cushion to prevent sliding again, No bleeding from Foley being pulled out, however resident has been having hematuria since at least yesterday. 10ml balloon intact but appears to have deflated some. Medical directorship and family notified. Resident is incontinent without the Foley, will assess through the shift if resident is urinating and straight cath for retention. On 6/23/24 at 5:12 PM, a health note documented. Resident had barely any urine in brief. Cathed using sterile technique, only a few drops of urine output. No longer hematuria like yesterday and earlier this morning. Due to resident having little output, unable to determine if resident is retaining or not. Foley catheter in, resident tolerated procedure well. Medical directorship notified. On 6/24/24 at 8:08 PM, a physician note documented, . during pt [patient] fall his foley catheter was pulled out. He was not able to void due to urinary retention so a foley catheter was place [sic] again .Pt was having dark, cloudy, and foul smelling urine over the weekend. He was started on Macrobid 100mg [milligrams] PO [by mouth] BID [two times daily] X [times] 7 days to treat UTI [urinary tract infection] .Pt had a ground level fall over the weekend. No injuries were noted during my assessment. His foley catheter was pulled out during the fall. We are leaving the catheterout [sic] due to pt not having a dx [diagnosis] for keeping it in place. On 8/8/24 at 8:31 AM, an interview was conducted with Licensed Nurse (LN) 5. LN 5 stated that an order was required for a resident to have a urinary catheter. LN 5 stated that she was unsure if the facility had a policy regarding residents and urinary catheters. On 8/8/24 at 1:57 PM, an interview was conducted with the Director of Nursing (DON). The DON stated there was not a policy or procedure regarding residents with urinary catheters. The DON stated she could not recall why resident 298 had a urinary catheter or if he ever saw a urologist regarding the continued use of a urinary catheter.

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50200 Based on interview and record review, the facility did not ensure that residents maintained acceptable parameters of nutritional status, such as usual body weight or desirable body weight range. Specifically, for 1 out of 30 sampled residents, a resident was not provided their ordered nutritional supplement shake and the resident had weight loss. Resident identifier: 298. Findings included: Resident 298 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included dementia, essential hypertension, benign prostatic hyperplasia without lower urinary symptoms, acute kidney failure, weakness, and anxiety disorder. Resident 298's medical record was reviewed on 8/7/24. An admission Minimum Data Set assessment date 4/10/24, documented that resident 298 had a Brief Interview for Mental Status (BIMS) score of 13. A BIMS score of 13 to 15 would suggest intact cognition. A care plan Focus addressing nutrition initiated on 4/12/24, documented New resident with potential nutrition defects r/t [related to] : advanced age, dementia. The interventions included: a. Diet order: Regular, regular, thins b. Supplements/snacks as ordered A review of resident 298's electronic medical record documented the following weights for resident 298: a. 165.2 pounds on 3/28/24. b. 163.6 pounds on 3/31/24. c. 166.8 pounds on 4/7/24. d. 199.8 pounds on 4/8/24. e. 168.6 pounds on 5/10/24. f. 167.0 pounds on 5/27/24. g. 156.6 pounds on 6/2/24. h. 140.3 pounds on 7/11/24. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	From 6/2/24 to 7/11/24, resident 298 had a 10.41% loss of weight. It was to be noted, no revisions to the care plan were made to address the weight loss. A review of resident 298's paper medical chart revealed the following dietary orders: a. Mighty shakes three times a day (TID) with]meals. Order date 5/31/24. b. Fortify diet. Order date 6/14/24. c. Fortify diet. Add mighty shakes TID with meals. Order date 6/28/24. A review of resident 298's electronic medical record revealed the following orders: a. REGULAR diet MECHANICAL SOFT texture, Regular consistency, Mechanical Soft Fortified. Start date 6/15/24. b. REGULAR diet MECHANICAL SOFT texture, Regular consistency, Add mighty shakes TID with meals for Fortified diet related to post hip surgery replacement. Start date 6/29/24. On 6/28/24, a physician progress note documented, Malnutrition, unspecified type. Patient has had a decrease in weight by 9.1% of entire body weight. He weighed 156.6 pounds on 6/16/24 and his most recent weight on 6/23/24 was 143.2 pounds. I am concerned about patient's rapid weight loss and believe that he is experiencing malnutrition. Dietitian in to eval [evaluate] and treat. Push for increase if daily nutritional PO [oral] intake. On 8/7/24 at 1:42 PM, an interview was conducted via text messaging with the Registered Dietitian (RD). The RD texted that resident 298 had a fortified diet ordered and health shakes to help with his weight loss. The RD texted that the facility had a weekly weight list and weekly meetings to discuss residents that had weight loss. On 8/8/24 at 10:45 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that the residents received the mighty shakes with the medication pass three times a day. The DON stated that the order for mighty shakes was located on the Medication Administration Record (MAR). The DON stated that it was checked off in the MAR when the resident received their mighty shake. The DON stated that the facility did not record the amount of mighty shake consumed by the residents. A review of resident 298's MAR revealed that resident 298 did not receive mighty shakes from 6/1/24 to 7/12/24.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47432 Based on observation, interview, and record review, the facility did not ensure that a resident who needed respiratory care was provided such care care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Specifically, for 5 out of 30 sampled residents, the facility did not have orders for multiple residents' nasal cannulas, oxygen concentrator humidifier or oxygen concentrator to be changed nor was there any documentation that they were being changed, and a resident with an order for a mustache cannula instead received a standard nasal cannula. Resident identifiers: 7, 17, 24, 26, and 32. Findings Included: 1. Resident 17 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including severe sepsis without septic shock, pneumonitis due to inhalation of food and vomit, malignant neoplasm of esophagus, acute respiratory failure unspecified whether with hypoxia or hypercapnia, asthma uncomplicated, asthma with (acute) exacerbation, gastrointestinal hemorrhage, other acute kidney failure, chronic pulmonary embolism, atherosclerosis of other arteries, schizoaffective disorder depressive type, vascular dementia, type 2 diabetes mellitus without complications, and essential hypertension. On 7/28/24 at 1:24 PM, an initial observation was made of resident 17. Resident 17 was laying in bed and noted to be using an oxygen concentrator. There were no dates on the nasal cannula tubing or the humidifier. Upon interview, resident 17 was unable to tell me when or how often staff change the tubing or the humidifier for the concentrator. Resident 17's medical record was reviewed from 7/28/24 through 8/14/24. Resident 17's physician orders were reviewed. There were no orders for resident 17's oxygen concentrator tubing or oxygen concentrator humidifier to be changed. The only oxygen related order was an order dated 8/18/23, that stated, O2 [oxygen] @ [at] 3L [liters] via nc [nasal cannula] @ NOC [night shift] to keep sats [saturations] > [greater than] 90% every day and night shift. Resident 17's Medication Administration Record (MAR) and Treatment Administration Record (TAR) were reviewed for the month of July 2024. There was no documentation on the MAR or TAR showing that resident 17's oxygen concentrator tubing or oxygen concentrator humidifier had been changed. Resident 17's care plan was reviewed. A focus area dated 1/17/23, revealed, The resident has oxygen therapy. The goal for this focus area was documented as, The resident will have no s/sx [signs and symptoms] of poor oxygen absorption through the review date. The interventions for this goal were documented as, Monitor of s/sx of respiratory distress and report to MD [Medical Doctor] PRN [as needed]: Respirations, Pulse oximetry, Increased heart rate (Tachycardia), Restlessness, Diaphoresis, Headaches, Lethargy, Confusion, Atelectasis, Hemoptysis, Cough, Pleuritic pain, Accessory muscle usage, Skin color. There was no guidance in the resident's care plan regarding the changing or cleaning of nasal cannula tubing or oxygen concentrator humidifiers. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident 26 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including schizoaffective disorder depressive type, dementia, cannabis abuse, nicotine dependence, and asthma. On 7/28/24 at 11:02 AM, an initial observation was made of resident 26. Resident 26 was noted to have an oxygen concentrator in his room. There were no dates on the nasal cannula tubing or the humidifier. Upon interview, resident 26 stated that he did not know how often staff changed the tubing or the humidifier. Resident 26 stated that staff change the tubing and humidifier as needed. It should be noted that while the oxygen concentrator was running, resident 26 was not wearing his nasal cannula. Resident 26's medical record was reviewed from 7/28/24 through 8/14/24. Resident 26's physician orders were reviewed. There were no orders for resident 26's oxygen concentrator tubing or oxygen concentrator humidifier to be changed. The only oxygen related order was an order dated 1/17/23, that stated, O2 @ 2L via nc @ NOC to keep sats > 90% every day and night shift for hypoxia. Wean as tolerated. Resident 26's MAR and TAR were reviewed for the months of March 2024 through August 2024. There was no documentation on the MAR or TAR showing that resident 26's oxygen concentrator tubing or oxygen concentrator humidifier had been changed. Resident 26's care plan was reviewed. A focus area dated 8/3/23, revealed, The resident has oxygen therapy r/t [related to] respiratory illness. The goal for this focus area was documented as, The resident will have no s/sx of poor oxygen absorption through the review date. The interventions for this goal were documented as, Ensure resident is wearing his N/C at all times and SPO2 [oxygen saturations] checked QS [every shift] and Monitor for s/sx of respiratory distress to MD PRN: Respirations, Pulse oximetry, Increased heart rate (Tachycardia), Restlessness, Diaphoresis, Headaches, Lethargy, Confusion, Atelectasis, Hemoptysis, Cough, Pleuritic pain, Accessory muscle usage, Skin color. There was no guidance in the resident's care plan regarding the changing or cleaning of nasal cannula tubing or oxygen concentrator humidifiers. 48709 3. Resident 32 was admitted to the facility on [DATE] with diagnoses which included acute and chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease with acute exacerbation, fluid overload, hypertension, and hyperglycemia. On 7/28/24 at 10:18 AM, an observation was made of resident 32 in his room. Resident 32 was awake, in bed, and wore a nasal cannula connected to an oxygen concentrator running at 8 liters per minute. On 7/29/24 at 10:18 AM, an observation was made of resident 32. Resident 32 was in his bed and wore a nasal cannula that was connected to an oxygen concentrator. Resident 32's medical record was reviewed from 7/28/24 through 8/14/24. A physician's order dated 3/19/24 at 6:00 PM, indicated, Continuous oxygen per moustache cannula at 6-8L every day and night shift. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	It should be noted that resident 32's care plan did not address oxygen therapy. On 7/29/24 at 11:57 AM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated resident 32 wore a nasal cannula and received 6 to 15 liters of oxygen. RN 1 stated she did not know what a moustache cannula was and looked it up online during the interview. RN 1 stated a moustache cannula was for high concentration oxygen. On 7/29/24 at 12:12 PM, an interview was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 stated resident 32 wore a nasal cannula. On 7/30/24 at 1:53 PM, an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated resident 32 wore a nasal cannula and a moustache cannula at times. The ADON stated the moustache cannula was from a hospital order and that the order should have been clarified with hospice. On 7/31/24 at 12:16 PM, an interview was conducted with the Director of Nursing (DON). The DON stated if resident 32 wore a moustache cannula he could get more oxygen and it would be more effective than a nasal cannula. The DON stated he wore a nasal cannula by error or that it could have been because his insurance would not pay for it, but the nurse should have notified the physician and got an order for it. The DON stated resident 32's oxygen therapy should have been in his care plan. 50200 4. Resident 7 was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses which included dementia, schizoaffective disorder, paroxysmal atrial fibrillation, obsessive-compulsive disorder, essential hypertension, adult failure to thrive, encephalopathy, and mild cognitive impairment. On 7/28/24 at 12:28 PM, an observation was made of resident 7 in his room. It was noted that the resident was using an oxygen concentrator and was receiving 3 liters per minute of oxygen via a nasal cannula. The oxygen tubing was not dated. On 7/28/24, resident 7's medical record was reviewed. The following physician order was noted with an order date of 5/22/23, O2 to keep SPO2 greater than 90%. There were no orders for resident 7's oxygen tubing and nasal cannula to be changed. On 7/29/24, resident 7's TAR was reviewed for the months of May 2023 through July 2024. There was no documentation of oxygen tubing or nasal cannula changes recorded. 5. Resident 24 was admitted to the facility on [DATE] with diagnoses which included, dementia, type 2 diabetes mellitus, chronic viral Hepatitis C, essential hypertension, hyperlipidemia, vertigo, major depressive disorder, osteoarthritis, and inflammatory disease of prostate. On 7/28/24 at 1:32 PM, an observation was made of resident 24 in his room. It was noted that the resident used an oxygen concentrator. The oxygen tubing was not dated. (continued on next page)

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	465086	A. Building B. Wing	08/14/2024

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/28/24, resident 24's medical record was reviewed. The following physician order was noted with a start date of 1/17/23, O2 @ 2L via NC @ NOC to keep sats > than 90% every day and night shift. There were no orders for resident 24's oxygen tubing and nasal cannula to be changed. On 7/29/24, resident 24's TAR was reviewed for the months of January 2023 to July 2024. There was no documentation of oxygen tubing or nasal cannula changes recorded. On 7/29/24 at 11:52 AM, an interview was conducted with CNA 2. CNA 2 stated that CNAs reported to the floor nurse about oxygen supplies. CNA 2 stated she was unsure how often the nasal cannulas and oxygen tubing were changed. On 7/30/24 at 8:01 AM, an interview was conducted with RN 1. RN 1 stated that the graveyard shift usually changed out the oxygen supplies. RN 1 stated that the nasal cannulas and oxygen tubing should be changed at least monthly. RN 1 stated that there should be an order in the MAR that showed when it needed to be changed. On 7/31/24 at 7:21 AM, an interview was conducted with the DON. The DON stated that the night nurses changed the oxygen supplies once a month on Sundays. The DON stated that it should be charted in the MAR. The DON stated that she had asked the nurses to place tape with the date on it so people knew that it had been changed. The DON was unable to locate in the medical records of residents 7 and 24 where the order for the oxygen supplies to be changed was located or where this was documented that it had been changed.

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33215 Based on interview and record review, the facility did not ensure that pain management was provided to residents who required such services. Specifically, for 1 out of 30 sampled residents, a resident with an acute complete femoral neck fracture was not provided pain management prior to being discharged to the hospital. Resident identifiers: 298. Findings included: Resident 298 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included, but were not limited to, dementia, essential hypertension, acute kidney failure, and anxiety disorder. Resident 298's medical record was reviewed on 8/7/24. A care plan Focus initiate on 3/29/24, documented Resident has pain related to general body aches. The Goal included Resident will suffer no unrelieved episodes of pain during facility stay. The interventions initiated on 3/29/24, included: a. Assess intensity of pain using pain scale. b. Assess type, duration, and frequency of pain. c. Discuss with resident effective and ineffective measures. d. Encourage verbalization of feelings about the pain. e. Medications as ordered. An admission Minimum Data Set assessment dated [DATE], documented that resident 298 had a Brief Interview for Mental Status (BIMS) score of 13. A BIMS score of 13 to 15 would indicate intact cognition. On 4/11/24 at 8:29 AM, a Fall Incident Report documented Staff radio nurse, to report resident fell . Nurse knocked and entered res [resident] room. Staff reported fall was witnessed. Res was assessed, res cognitive to baseline, A&O [alert and oriented] x2, name and situation. PERRLA [pupils are equal, round, and reactive to light and accommodation] WNL [within normal limits], ROM [range of motion] completed without difficulty, res assisted into bed. Res was painful r/t [related to] skin tear to R [right] elbow., res had a reddened area R lateral side just below hair line. Staff reported that redness to forehead was there earlier before the fall. Res had a large skin tear to R elbow, wound Tx [treatment] provided, affected area was cleansed with wound cleaner, pat dry. using steri strips tear was close and approximated well. Bacitracin applied, covered with non-adherent dressing, and wrapped. Neuro's [neurological's] started per protocol. MD [Medical Director], family notified via voicemail, and DON [Director of Nursing] 04/12/2023. Res stated his feet fell out from under him and he fell to the ground. Res stated he hit head and touched over red area to R side of forehead. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	On 5/18/24 at 3:59 AM, a Health Status Note documented Note Text: Resident fell in his room about 1900 [7:00 PM]. It was an unwitnessed fall lost his balance and went down on his left side. Able to move all his extremities without pain. A small red mark was found on his left back shoulder. He was too weak to get up on his own. Three maximum assist to left [sic] him onto his lounge chair. Vital signs taken and T [temperature] 98.0, P [pulse] 64, R [respirations] 28 B/P [blood pressure] 96/56 and 02 [oxygen] sats [saturations] 92% on room air. MD notified of low B/P and fall at 2238 [10:38 PM]. Administrator and DON notified at 0345 [3:45 AM] and 0348 [3:48 AM] this morning. Morning nurse to be notified in am and family. Neuro checks and VS [vital signs] doing well no changes. On 5/19/24 at 9:00 AM, an Incident Follow up documented Date of Incident: 5/19/2024 Type of Incident: Fall Root Cause: Unsteady gait Treatment Required: None Interventions put into place: Neuros, call light given to resident, rounds every 15 minutes Referrals Made: None. On 5/19/24 at 11:00 PM, an encounter documented Date of Service: 05/20/2024 Visit Type: Acute Transition of Care: No transition occurred. Progress Note . Chief Complaint / Nature of Presenting Problem: Fall History Of Present Illness: Patient is a [AGE] year-old male with a past medical history significant for Alzheimer's dementia. He was previously a resident at the [name redacted] and was admitted here one month ago. He has tried to escape multiple times and constantly packs his things to leave. He often waits by the locked door of the unit to leave. Today CNA [Certified Nursing Assistant] reported that patient had 2 falls over the weekend. Denied hitting his head. Patient reports that he is fine. He denied any uncontrolled pain. He denied any issues or concerns. The Nurse Practitioner (NP) signed the note on 5/20/24 at 8:39 AM. On 5/19/24 at 4:45 PM, a Fall Incident Report documented . Client had an unobserved fall out of dining room chair. Client pulled tablecloth halfway off. When CNA walked into dining room to check on clients, other residents were helping client off of floor. Client stated 'I feel. I am okay.' Client was put on neuros and observed every 15 minutes. On 5/20/24 at 2:50 PM, an Orders - General Note from electronic record (eRecord) documented Note Text: CNA comes to nurse and stated resident had an assisted fall and was lowered to ground after being toileted. He lost his balance and she grabbed him and lowered him. Both South and North nurse in to assist resident and transfer him to his w/c [wheel chair]. He did not appear to be in pain but rather confused. He sustained a small r elbow tear to his arm from the w/c during transfer. Cleaned and dressed. He then rested quietly throughout the rest of the shift. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	On 5/20/24 at 11:00 PM, an encounter documented Date of Service: 05/21/2024 Visit Type: Acute Transition of Care: No transition occurred. Progress Note . Chief Complaint / Nature of Presenting Problem: Right hip pain History Of Present Illness: [Resident 298] is a [AGE] year-old long-term care resident here at [name redacted]. Per the nurses report he has had a couple of falls over the weekend. He was evaluated yesterday but denied any significant pain. It is unclear if he had another fall since yesterday's evaluation but currently he has complaints of right hip pain. He has been unable to stand. Most of his pain is localized to the anterior and lateral right hip. General: Elderly male in mild distress. Does appear confused which is his baseline Musculoskeletal: Patient does have tenderness to palpation over the right hip laterally anteriorly. He does have pain with internal and external rotation of the right hip. This localizes anteriorly. Acute right hip pain Patient's right hip pain appears to be acute and it is unclear whether this is related to a fall over the weekend or a new fall today. Given his acute right hip pain and evaluation today I do recommend x-rays of the right hip stat [immediately]. These were ordered today. Plan to follow-up after x-rays. Fall On fall precautions. The MD signed the note on 5/21/24 at 11:17 AM. On 5/21/24 at 11:40 AM, a Health Status Note documented Note Text: NEW ORDER: Pt [patient] is not bearing any wt [weight] on rt [right] leg has a lg [large] skin tear on rt elbow. md notified ordered a xray it has been ordered and they stated it wil [sic[be done today. pt had a shr [shower] today. On 5/21/24, the Diagnostics report documented . Right hip, 2 views Comparison: None. Findings: There is an acute complete femoral neck fracture with partial displacement compatible with a Garden Classification III fracture. IMPRESSION: 1. Garden classification III acute femoral neck fracture. The diagnostics report was signed by the diagnostics radiologist on 5/21/24 at 6:23 PM. On 5/22/24 at 2:51 AM, a Health Status Note documented Note Text: Follow up on res x-ray: Impressions noted; There is an acute complete femoral neck Fx [fracture] with partial displacement compatible with a Garden class III. Mild degree of osteopenia. Moderate osteoarthritis. X-ray results sent to MD, response pending. WCTM [will continue to monitor]. On 5/22/24 at 5:30 AM, a Health Status Note documented Note Text: Staff reported res, has been up all night did not sleep a [NAME], trying to wiggle his way out of bed. Staff has continuously throughout shift had to re center res into bed and remind resident that he, could not walk d/t broken femur. will pass on to upcoming shift nurse for monitoring and follow-up. On 5/22/24 at 6:54 AM, an Orders - General Note from eRecord documented Note Text: MD notified of results of Xray and new order for resident to be sent to ER [emergency room] for eval/tx [evaluation and treatment]. Preparing paperwork. On 5/22/24 at 3:01 PM, a Health Status Note documented Note Text: Received call from [hospital name redacted]. They will do surgergy [sic] this afternoon and resident to be admitted to med [medical] surg [surgical] floor. The May 2024 Medication Administration Record was reviewed. A physician's order dated 3/28/24, documented PAIN SCALE ASSESS PAIN BID [twice daily] USING VERBAL SCALE (0-10) every day and night shift. Resident 298 had no reported pain until 5/20/24. a. On 5/20/24 at 6:00 PM, verbal scale 5. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	b. On 5/21/24 at 6:00 AM, verbal scale 5. c. On 5/21/24 at 6:00 PM, Face, Legs, Activity, Cry, and Consolability (FLACC) scale 7. d. On 5/22/24 at 6:00 AM, FLACC scale 7. (Note: The Order Summary Report was reviewed and resident 298 did not have any pain management medications available prior to being discharged to the hospital on 5/22/24.) On 8/5/24 at 2:10 PM, a telephone interview was conducted with Registered Nurse (RN) 5. RN 5 stated that she had identified that resident 298 was not receiving any pain medication, and that other staff did not identify the issue sooner. RN 5 stated that after she brought this to the physician's attention, the resident was prescribed Tramadol. RN 5 stated, I don't think anybody should be in pain. On 8/7/24 at 12:23 PM, an interview was conducted with NP 2. NP 2 stated she saw resident 298 because he had a fall. NP 2 stated that resident 298 was walking around pushing his recliner around and had no pain. NP 2 stated the MD came in the next day and said that resident 298 had a broken femur. NP 2 stated that she did not do a full hip exam because resident 298 was moving fine. NP 2 stated that she did not expect a break. NP 2 stated that the MD sent resident 298 out and resident 298 did have a break. On 8/8/24 at 11:50 AM, an interview was conducted with the DON. The DON stated that resident 298 had an unwitnessed fall on 5/18/24 at about 3:00 AM. The DON stated that resident 298 had another fall on 5/19/24 at 9:00 AM. The DON stated the fall on 5/20/24, was an assisted fall at 3:00 PM. The DON stated that herself and the CNA lowered resident 298 to the floor and the DON stated that she did not notice anything. The DON stated that the NP saw resident 298 the morning of 5/21/24, and noted we need an xray. The DON stated that resident 298 somehow had a shower during that time on 5/21/24. The DON stated the facility called the x-ray company at 11:34 AM, and they arrived at the facility at 5:41 PM, to do the x-ray on 5/21/24. The DON stated at 6:23 PM, the x-ray company either faxed the results or notified the facility of the results. The DON stated that the nurse on 5/22/24, made a progress note that results were pending from the doctor. The DON stated at the end of the shift the nurse made a note that resident 298 was up all night and passed the information to the oncoming nurse which was the DON. The DON stated at 6:55 AM, she notified the doctor and resident 298 was sent out to the hospital. On 8/14/24 at 8:42 AM, an interview was conducted with the DON. The State Survey Agency Lead Licensor asked the DON if she had details regarding resident 298's fracture. The DON stated that resident 298 was not in any pain that day and had no signs of a fracture. The DON stated the CNA was getting resident 298 ready to toilet and the DON went in to assist and resident 298 was lowered to the ground. The DON stated that she had been told if the fall was assisted she did not have to record it as a fall. The DON stated there may have been a fall the next day also but she was not sure. The DON stated that neuro checks were only done if the resident hit their head. The DON stated that she usually kept the neuro checks and she had record of them.

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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** 50200 Based on interview and record review, the facility did not ensure that 5 of ^^ sample residents were seen by the physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. Resident identifiers: 7, 24, 28, 29, and 44. Findings include: 1. Resident 7 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included unspecified dementia, schizoaffective disorder, paroxysmal atrial fibrillation, obsessive-compulsive disorder, essential hypertension, mild cognitive impairment of uncertain or unknown etiology, adult failure to thrive, and encephalopathy. A review of resident 7's medical record of physician visits revealed that the last facility MD [medical doctor] visit was 2/27/24, indicating that the resident had not been seen by the physician in approximately 5.5 months. 2. Resident 24 was admitted to the facility on [DATE] with diagnoses which included unspecified dementia, type 2 diabetes mellitus, chronic viral Hepatitis C, essential hypertension, hyperlipidemia, major depressive disorder, and inflammatory disease of the prostate. A review of resident 24's medical record of physician visits revealed that the last facility MD visit was 2/27/24, indicating that the resident had not been seen by the physician in approximately 5.5 months. 3. Resident 28 was admitted to the facility on [DATE] with diagnoses which included, unspecified dementia, generalized anxiety disorder, schizoaffective disorder, and unspecified severe protein-calorie malnutrition. A review of resident 28's medical record of physician visits revealed the last facility MD visit was 9/9/23, indicating that the resident had not been seen by the physician in approximately 11 months. 4. Resident 29 was admitted to the facility on [DATE] with diagnoses which included, dysarthria and anarthria, gastro-esophageal reflux disease without esophagitis, dysphagia, unruptured cerebral aneurysm, major depressive disorder, chronic kidney disease, anemia in chronic kidney disease, type 1 diabetes mellitus, cognitive communication deficit, generalize muscle weakness, and history of falling. A review of resident 29's medical record of physician visits revealed that she had not been seen by the facility MD since being admitted to the facility. 5. Resident 44 was admitted to the facility on [DATE] with diagnoses which included Alzheimer's disease, type 2 diabetes mellitus, unspecified dementia, anxiety disorder, benign prostatic hyperplasia without lower urinary tract symptoms, dysphagia, hyperlipidemia, major depressive disorder, unstable angina, and unspecified anemia. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of resident 44's medical record of physician visits revealed the only facility MD visit was 6/5/24. On 8/12/24 at 12:09 PM, an interview was conducted with the Director of Nursing [DON]. The DON stated that facility providers discussed with the nursing staff in regards to what residents needed to be seen or were in need of recertification visits. The DON stated that the facility MD needed to see residents every 60 days.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 48709 Based on interview and record review, the facility failed to designate a registered nurse to serve as the Director of Nursing (DON) on a full-time basis. Specifically, the DON did not work 40 hours a week. Findings included: On 7/31/24 at 7:20 AM, an interview was conducted with the DON. The DON stated she worked 12 hours on Mondays, Wednesdays, and Fridays. The DON stated she was assigned to resident care on her shifts. On 7/31/24 at 2:54 PM, an interview was conducted with the Administrator (ADM). The ADM stated the DON worked a 12 hour shift on Mondays, Tuesdays, and Wednesdays. The Nurse's July 2024 schedule indicated, DON Registered Nurse (RN) was scheduled as follows: D [day shift] Monday, July 1; D Wednesday, July 3; N [night shift] Sunday, July 7; D Monday, July 8; 0.5 [half shift] Tuesday, July 9; D Thursday, July 11; * [not available] Friday, July 12; * Saturday, July 13; * Sunday, July 14; D Monday, July 15; D Tuesday, July 16; D Wednesday, July 17; D Friday, July 19; D Monday, July 22; D Wednesday, July 24; D Friday, July 26; D Monday, July 29; and D Wednesday, July 31. On 8/5/24 at 2:10 PM, a telephone interview was conducted with RN 5. RN 5 stated that she would like to see the DON work full time. RN 5 stated that the DON was always scheduled to work the floor when she was on shift, and that a DON and a shift nurse are two different things. RN 5 stated that she did not communicate with the current DON unless it was the DON who had worked with a specific resident. On 8/7/24 at 9:55 AM, an interview was conducted with the DON. The DON stated that a D on the nurse's schedule indicated the staff member worked the day shift, an N indicated the staff member worked the night shift, a 0.5 on the nurse's schedule indicated the staff was available for part of a shift to pass medications or work half of the day, and an asterisk on the nurse's schedule meant the staff member was not available to work.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33215 Based on interview and record review, the facility did not provide pharmaceutical services that included the accurate acquiring, receiving, dispensing, and administering of all drugs and biological's to meet the needs of each resident. Specifically, for 4 out of 30 sampled residents, licensed nursing staff were not signing out controlled substances and reconciling at the time of administration. Resident identifiers: 1, 3, 4, and 38. Findings included: 1. Resident 38 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, dementia with agitation, essential hypertension, and neurocognitive disorder with Lewy bodies. Resident 38's medical record was reviewed on 8/12/24. The August 2024 Medication Administration Record (MAR) was reviewed on 8/12/24 at 12:21 PM. Resident 38's ARISE medications had not been administered. (Note: According to the medication pass times provided by the facility the ARISE medications were to be administered between 7:00 AM to 11:00 AM.) The ARISE medications included the following: a. amlodipine besylate 5 milligram (mg) tablet one time a day related to essential hypertension. b. citalopram hydrobromide 20 mg tablet one time a day for depression. c. lisinopril 40 mg tablet one time a day related to essential hypertension. d. olanzapine 5 mg tablet one time a day for anxiety. e. spironolactone 25 mg tablet one time a day for blood pressure. f. Senna 8.6 mg tablet two times a day for bowel care. g. hydrocodone-acetaminophen 5-325 mg tablet three times a day for pain. h. lorazepam 1 mg tablet three times a day for agitation give after meal. The August 2024 Electronic MAR Administration Details was reviewed. On 8/12/24 at 12:32 PM, resident 38 had received the ARISE and NOON dose of hydrocodone-acetaminophen and lorazepam. (Note: According to the medication pass times provided by the facility the NOON medications were to be administered between 11:00 AM and 2:00 PM.) The Controlled Drug Record was reviewed. The hydrocodone-acetaminophen and lorazepam had not been signed out as being administered to resident 38. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/12/24 at 2:09 PM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated that the Business Officer Manager spoke with her and told her to come tell the State Survey Agency (SSA) Lead Licensor that she had documented the hydrocodone-acetaminophen and lorazepam at the same time on the MAR. RN 1 stated that she had given resident 38 her morning medications but did not document them until 12:31 PM. On 8/12/24 at 2:24 PM, a follow up interview was conducted with RN 1. RN 1 stated that she was not sure why she did not sign out resident 38's medications at the time of administration. RN 1 stated that she thought she was just wound up with everything going on. RN 1 stated there were other residents that received their medications and she had not signed them out that morning. The SSA Lead Licensor asked RN 1 what the process was for administering medications. RN 1 stated she knew that she was to chart as she went but sometimes she did not. RN 1 stated she thought it was faster and cutting corners. RN 1 stated she was not sure what do you want me to say. 2. Resident 3 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included, but were not limited to, paranoid schizophrenia, chronic viral hepatitis C, major depressive disorder, type 2 diabetes mellitus without complications, psychoactive substance dependence, psychosis, post-traumatic stress disorder, attention-deficit hyperactivity disorder, chronic pain, essential hypertension, suicidal ideations, and low back pain. Resident 3's medical record was reviewed on 8/12/24. The August 2024 MAR was reviewed. The ARISE dose of clonazepam 0.5 mg tablet, the ARISE and NOON dose of gabapentin 600 mg tablet, and the ARISE and NOON dose of Oxycodone 10 mg tablet had been signed out as being administered to resident 3. The Controlled Drug Record was reviewed. The medications had not been signed out as being administered to resident 3. 3. Resident 1 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included, but were not limited to, acute myocardial infarction, acute respiratory failure with hypoxia, age-related cognitive decline, type 2 diabetes mellitus, non-pressure chronic ulcer of foot, rheumatoid arthritis, acquired deformity of lower leg, muscle wasting and atrophy, dysphagia, and difficulty in walking. Resident 1's medical record was reviewed on 8/12/24. The August 2024 MAR was reviewed. The ARISE dose of lorazepam 0.5 mg tablet had been signed out as being administered to resident 1. The Controlled Drug Record was reviewed. The medication had not been signed out as being administered to resident 1. 4. Resident 4 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, Huntington's disease, psychotic disorder with delusions, mood disorder due to known physiological condition, bipolar II disorder, conversion disorder with seizures or convulsions, migraine, chronic pain, essential hypertension, and gastro-esophageal reflux disease. (continued on next page)

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	465086	A. Building B. Wing	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Health Services	5865 South Wasatch Drive Ogden, UT 84403

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident's medical record was reviewed on 8/12/24. The August 2024 MAR was reviewed. The ARISE dose of pregabalin 200 mg capsule, the NOON dose of pregabalin 100 mg capsule, the ARISE dose of Morphine Sulfate extended release 15 mg tablet, the ARISE dose of modafinil 200 mg tablet, the ARISE dose of Oxycodone 10 mg tablet, and the NOON dose of clonazepam 1 mg tablet had been signed out as being administered to resident 4. The Controlled Drug Record was reviewed. The medications had not been signed out as being administered to resident 4. On 8/12/24 at 2:47 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that the nursing staff should be signing out medications at the time they were administered. The DON stated that sometimes they may be signed out within the hour.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48709 Based on observation, interview, and record review, the facility did not ensure that residents were free of any significant medication errors. Specifically, for 4 out of 30 sampled residents, one resident had multiple missed doses of two medications, a second resident was not administered pregabalin a time sensitive medication at the scheduled times as ordered by the physician, a third resident received a double dose of their pain and anxiety medications, and a fourth resident received a double dose of warfarin. Resident identifiers: 4, 32, 38, and 298. Findings include: 1. Resident 32 was admitted to the facility on [DATE] with diagnoses which included acute and chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease (COPD) with acute exacerbation, fluid overload, hypertension, and hyperglycemia. On 7/29/24 at 10:11 AM, an observation and interview were conducted with resident 32. Resident 32 was awake, in bed, and wore a nasal cannula connected to an oxygen concentrator running at 8 liters per minute. Resident 32 stated one of his respiratory medications, air duo had been empty and he had not received that medication since Friday. Resident 32's medical record was reviewed from 7/28/24 through 8/14/24. A physician's order dated 3/19/24 at 7:00 PM, indicated, Fluticasone-Salmeterol Inhalation Aerosol Powder Breath Activated 232-14 MCG/ACT [micrograms/actuation] (Fluticasone-Salmeterol) 2 puff inhale orally two times a day for COPD. The July 2024 Medication Administration Record (MAR) indicated a 9 for the hour of sleep (HS) doses on 7/27/24, 7/28/24, and the Arise dose on 7/29/24, for the medication, Fluticasone-Salmeterol Inhalation Aerosol Powder Breath Activated 232-14 MCG/ACT (Fluticasone-Salmeterol) 2 puff inhale orally two times a day for COPD. On 7/29/24 at 11:57 AM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated resident 32 was on hospice and they were in charge of his medications. RN 1 stated, All of his breathing stuff is on them. RN 1 held a medication box which was labeled, Fluticasone Propionate and Salmeterol HFA [hydrofluoroalkane] Inhalation 115 mcg/21 mcg. RN 1 stated hospice sent the wrong dose and that even when they have the correct medication, it only lasted 15 days. RN 1 stated she called the hospice nurse today because resident 32 was very mad that the medication was not available. RN 1 stated, He can't breathe. RN 1 stated that the hospice company was available on the weekends and had a backup on-call person if nobody answered. RN 1 reviewed resident 32's MAR and stated when there was a 9 on the document, that indicated the medication was not given. A physician's order dated 5/27/24, indicated, Gabapentin 100mg [milligrams] PO (by mouth) BID (twice a day) for neuropathy. The MAR dated May 2024 was reviewed. There was no Gabapentin order listed or administration documented. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The MAR dated June 2024 indicated, Gabapentin Oral Tablet (Gabapentin) Give 100 mg orally two times a day for neuropathy -Start Date- 06/08/2024 1600 [4:00 PM]. It further indicated the medication was administered for the first time on 6/9/24, PM. On 7/30/24 at 1:53 PM, an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated a telephone order should be put in immediately and then faxed to the pharmacy. The ADON stated the pharmacy could deliver it late at night. The ADON reviewed the order in the chart and stated that it was written by the hospice Family Nurse Practitioner. The ADON stated she was not sure why the order did not get put in sooner. 33215 2. Resident 38 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, dementia with agitation, essential hypertension, and neurocognitive disorder with Lewy bodies. On 8/12/14 at 11:45 AM, an observation was conducted. The Administrator was observed pushing resident 38 in the wheel chair into the assisted dining room for the lunch meal service. Resident 38 was observed yelling no repeatedly. Certified Nursing Assistant (CNA) 1 was observed to assist resident 38 with dining. Resident 38 was observed to be agitated, mumbling, crying, and spit out her dentures. The Business Office Manager (BOM) was observed to walk to the nurses station and asked RN 1 if resident 38 had any anxiety medication. The BOM told RN 1 that she better medicate resident 38 or resident 38 would not eat and would be back in her room. Resident 38's medical record was reviewed on 8/12/24. The August 2024 MAR was reviewed on 8/12/24 at 12:21 PM. Resident 38's ARISE medications had not been administered. (Note: According to the medication pass times provided by the facility the ARISE medications were to be administered between 7:00 AM to 11:00 AM.) The ARISE medications included the following: a. amlodipine besylate 5 mg tablet one time a day related to essential hypertension. b. citalopram hydrobromide 20 mg tablet one time a day for depression. c. lisinopril 40 mg tablet one time a day related to essential hypertension. d. olanzapine 5 mg tablet one time a day for anxiety. e. spironolactone 25 mg tablet one time a day for blood pressure. f. Senna 8.6 mg tablet two times a day for bowel care. g. hydrocodone-acetaminophen 5-325 mg tablet three times a day for pain. h. lorazepam 1 mg tablet three times a day for agitation give after meal. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The August 2024 Electronic MAR Administration Details was reviewed. On 8/12/24 at 12:32 PM, resident 38 had received the ARISE and NOON dose of hydrocodone-acetaminophen and lorazepam. The Controlled Drug Record was reviewed. The hydrocodone-acetaminophen and lorazepam had not been signed out as being administered to resident 38. On 8/12/24 at 1:26 PM, an interview was conducted with RN 1. RN 1 stated that resident 38 had a lot of anxiety. RN 1 stated that resident 38's anxiety was usually after the husband left the facility. RN 1 stated that resident 38's husband was not in the facility today and she was not sure what started resident 38's agitation. RN 1 stated that resident 38 wanted to go home. RN 1 stated if resident 38 was agitated she would not eat well. RN 1 stated that resident 38's medications yes and no helped resident 38's agitation. RN 1 stated that some days were better then others. RN 1 stated that she was not aware if the Medical Director had reassessed resident 38's medications for effectiveness. On 8/12/24 at 1:37 PM, an interview was conducted with CNA 1. CNA 1 stated that resident 38 was not normally like that. CNA 1 stated that someone gave resident 38 a Pepsi earlier today and resident 38 wanted her Pepsi and did not want to eat. CNA 1 stated that resident 38 might not have gotten her medications on time. CNA 1 stated that resident 38 was usually fussy but not like she was today. CNA 1 stated that resident 38 kept stating she wanted the Pepsi. CNA 1 stated that resident 38 usually struggled with eating lunch but she would eat breakfast. CNA 1 stated that after she got resident 38's Pepsi resident 38 did eat her lunch better. CNA 1 stated that resident 38's husband would bring in Pepsi. On 8/12/24 at 2:09 PM, an interview was conducted with RN 1. RN 1 stated that the BOM spoke with her and told her to come tell the State Survey Agency (SSA) Lead Licensor that she had documented the hydrocodone-acetaminophen and lorazepam medications at the same time. RN 1 stated that she had given resident 38 her morning medications but did not document them until 12:31 PM. On 8/12/24 at 2:24 PM, a follow up interview was conducted with RN 1. RN 1 stated that she was not sure why she did not sign out resident 38's medications at the time of administration. RN 1 stated that she thought she was just wound up with everything going on. RN 1 stated there were other residents that received their medications and she did not sign them out this morning. The SSA Lead Licensor asked RN 1 what the process was for administering medications. RN 1 stated she knew that she was to chart as she went but sometimes she did not. RN stated she thought it was faster and cutting corners. RN 1 stated she was not sure what do you want me to say. On 8/12/24 at 2:47 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that the nursing staff should be signing out medications at the time they were administered. The DON stated that sometimes they may be signed within the hour. 3. Resident 4 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, Huntington's disease, psychotic disorder with delusions, mood disorder due to known physiological condition, bipolar II disorder, conversion disorder with seizures or convulsions, migraine, chronic pain, essential hypertension, and gastro-esophageal reflux disease. On 7/29/24 at 7:51 AM, RN 1 was observed to prepare and administer medications to resident 4. RN 1 administered a pregabalin capsule 200 mg with the other morning medications that were prepared. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 4's medical record was reviewed on 7/29/24. A physician's order dated 5/7/20, documented Pregabalin Capsule 200 MG Give 1 capsule by mouth one time a day for GIVE AT 0600 [6:00 AM] am ONLY (time sensitive). A physician's order dated 5/9/20, documented Pregabalin Capsule 100 MG Give 1 capsule by mouth one time a day for TIME SENSITIVE NARCOTIC (Give at 1400 [2:00 PM]). A physician's order dated 5/9/20, documented Pregabalin Capsule 100 MG Give 1 capsule by mouth one time a day for TIME SENSITIVE NARCOTIC (GIVE AT 2100 [9:00 PM] ONLY). The July 2024 Electronic MAR Administration Details was reviewed. The following administration times were documented for the pregabalin: a. On 7/1/24 at 7:21 AM, 1:32 PM, and 7/2/24 at 12:57 AM. b. On 7/2/24 at 6:28 AM, 12:04 PM, and 10:60 PM. c. On 7/3/24 at 7:38 AM, 12:07 PM, and 7:40 PM. d. On 7/4/24 at 6:06 AM, 1:17 PM, and 7:33 PM. e. On 7/5/24 at 8:25 AM, 12:55 PM, and 7:43 PM. f. On 7/6/24 at 6:30 AM, 12:57 PM, and 7:24 PM. g. On 7/7/24 at 6:11 AM, 1:00 PM, and 7:39 PM. h. On 7/8/24 at 9:30 AM, 12:30 PM, and 7:28 PM. i. On 7/9/24 at 6:39 AM, 1:18 PM, and 7:28 PM. j. On 7/10/24 at 7:35 AM, 12:02 PM, and 8:32 PM. k. On 7/11/24 at 6:22 AM, 1:00 PM, and 7:36 PM. l. On 7/12/24 at 8:17 AM, 12:39 PM, and 9:05 PM. m. On 7/13/24 at 8:01 AM, 12:02 PM, and 6:31 PM. n. On 7/14/24 at 6:18 AM, 1:29 PM, and 6:33 PM. o. On 7/15/24 at 6:08 AM, 1:04 PM, and 7:40 PM. p. On 7/16/24 at 9:15 AM, 12:15 PM, and 8:16 PM. q. On 7/17/24 at 7:31 AM, 2:05 PM, and 7:54 PM. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	r. On 7/18/24 at 7:39 AM, 1:43 PM, and 7:50 PM. s. On 7/19/24 at 10:01 AM, 12:37 PM, and 7:30 PM. t. On 7/20/24 at 6:17 AM, 1:18 PM, and 7:10 PM. u. On 7/21/24 at 6:39 AM, 1:05 PM, and 7:51 PM. v. On 7/22/24 at 10:35 AM, 12:15 PM, and 11:13 PM. w. On 7/23/24 at 6:06 AM, 1:08 PM, and 9:36 PM. x. On 7/24/24 at 10:50 AM, 2:02 PM, and 9:10 PM. y. On 7/25/24 at 6:11 AM, 1:22 PM, and 7:17 PM. z. On 7/26/24 at 9:07 AM, 4:19 PM, and 7:03 PM. aa. On 7/27/24 at 6:31 AM, 12:57 PM, and 6:17 PM. bb. On 7/28/24 at 7:06 AM, 1:00 PM, and 7:31 PM. cc. On 7/29/24 at 8:00 AM and 12:21 PM. On 7/29/24 at 10:30 AM, an interview was conducted with RN 1. RN 1 stated that resident 4's pregabalin on the MAR documented to administer at ARISE. RN 1 stated that ARISE was a flex time for medication administration but the physician's order documented to give the pregabalin at 6:00 AM. RN 1 stated the physician's order indicated 6:00 AM, because resident 4 received a noon dose of the pregabalin. RN 1 stated that the noon dose of the pregabalin was on a flex time also. RN 1 stated that resident 4 received three doses of pregabalin a day. RN 1 stated the morning dose of pregabalin was 200 mg and the other doses were 100 mg. RN 1 stated the facility had the noon dose of pregabalin coded to give at 1:00 PM, but the physician's order documented to give the pregabalin at 2:00 PM. RN 1 stated that she would give the noon dose of pregabalin closer to 2:00 PM. On 7/29/24 at 11:13 AM, an interview was conducted with the DON. The DON stated the facility had flex times to administer the medications but the nurse should have given the pregabalin between 6:00 AM and 7:00 AM. The DON stated that pregabalin was a narcotic and the staff liked to watch resident 4 because resident 4 took a lot of narcotics. The DON stated that resident 4 would have another dose of the pregabalin at 2:00 PM, so the staff needed to be conscious about the medication timing. A facility Memorandum dated 1/22/2013, documented the following Medication Pass Times. To allow the residents here at [facility name redacted] more autonomy and flexibility we are changing medication pass times. The new times are as follows: Early AM (5am to 9am) Arise (7am to 11am) (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Noon (11 am to 2 pm) PM (4pm to 7 pm) HS (7pm to 10pm) BID = arise & pm TID [three times a day] = arise, noon, & pm QID [four times a day] = arise, noon, pm, & hs. 50200 4. Resident 298 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included unspecified dementia, essential hypertension, benign prostatic hyperplasia without lower urinary symptoms, acute kidney failure, weakness, and unspecified anxiety disorder. Resident 298's medical record was reviewed 8/7/24. A review of resident 298's physician orders in the electronic medical record revealed the following orders: a. Warfarin Sodium Oral Tablet 2 mg, Give 2 mg by mouth one time a day for Anticoagulation Deep Vein Thrombosis (DVT). Start date 6/22/24. b. Warfarin Sodium Oral Tablet 2 mg, Give 1.5 tablet by mouth one time a day for Anticoagulation DVT until 7/1/24 at 11:59 PM. Start date 6/26/24. End date 7/1/24. c. Coumadin Oral Tablet (Warfarin Sodium), Give 3 mg by mouth one time a day for DVT. Start date 6/27/24. d. Coumadin Oral Tablet 1 mg, Give 1 tablet by mouth one time a day for DVT give with 2 mg to equal 3 mg. Start date 6/27/24. e. Coumadin Oral Tablet 4 mg, Give 4 mg by mouth one time a day for DVT. Start date: 7/2/24. f. Coumadin Oral Tablet 4 mg, Give 3 mg by mouth by one time a day every Tuesday (Tues), Wednesday (Wed), Friday (Fri), Saturday (Sat), and Sunday (Sun) for DVT until 7/7/24 at 11:59 PM. Start date 7/2/24. g. Coumadin Oral Tablet, Give 3 mg by mouth one time a day every Tuesday, Wednesday, Friday, Saturday, and Sunday for DVT until 7/8/24 at 11:59 PM. Recheck prothrombin time (PT)/ international normalized ratio (INR) on 7/8/24. Start date 7/3/24. h. Coumadin Oral Tablet 4 mg, Give 1 tablet by mouth one time a day for DVT until 7/8/24 at 11:59 PM. Start date 7/3/24. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	i. Coumadin Oral Tablet 4 mg, Give 1 tablet by mouth one time a day every Monday and Thursday for DVT until 7/8/24 at 11:59 PM. Start date 7/4/24. j. Coumadin Oral Tablet 4 mg, Give 1 tablet by mouth one time a day every Monday and Thursday for DVT until 7/4/24 at 11:59 PM. Start date 7/4/24. On 7/1/24 at 11:48 PM, a health status note documented, PT 18.9 INR 1.63 MD [Medical Doctor] notified: New Order received: Give 4mg on Monday 07/01/24; give 4mg on Thursday 07/04/24. Give 3mg all other days (Tues 07/02, Wed 07/03, Fri 07/05, Sat 07/06, and Sun 07/07/2024 Re-check PT/INR on 07/08/2024. All orders completed under orders and labs; PT/INR tracker completed; order sent to pharmacy. On 7/3/24 at 12:56 AM, a health status note documented, Res [resident] received 4mg coumadin x2 [sic] this shift. MD was notified on what if anything to monitor for and hold on tomorrow evenings PM dose? (07/03/24) Response from MD is pending. WCTM [will continue to monitor] Med [medication] error completed and placed on DON desk. On 8/8/24 at 1:58 PM, an interview was conducted with the DON. The DON stated that staff always had access to the DON, ADON, the Administrator, and the doctors if an error had been made. The DON stated there was always a way to get a hold of them by calling or text message. The DON stated that text messaging was better because she did not always see that she had missed a call. The DON stated that a change of condition due to an error the staff were to text message first and then call if no response. The DON stated that staff were to use their judgement and send the resident out if necessary. The DON stated she would say if it was a dire emergency the staff should call the MD if they had not heard back from text message in 15 to 30 minutes. The DON stated there were some nurses who thought that they had to get an order before they could do anything. The DON stated there were forms that were filled out and brought back to DON office.

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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 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48709 Based on observation, interview, and record review, the facility did not obtain laboratory (lab) services to meet the needs of the residents. Specifically, for 3 out of 30 sampled residents, residents that had a urinalysis (UA) collected did not have the UA completed in a timely manner. Resident identifiers: 8, 18, and 44. Findings included: 1. Resident 18 was admitted to the facility on [DATE] with diagnoses which included schizophrenia, other stimulant abuse with stimulant-induced psychotic disorder, and unspecified mycosis. On 8/10/24 at 2:17 PM, an observation was made of the physician's phone. There was a text message at 2:03 PM, from Licensed Nurse (LN) 3 to the physician which revealed resident 18 had redness to his groin area and had urgency and burning upon urination. LN 3 text messaged resident 18's urine was positive for leukocytes and nitrates. LN 3 asked the Medical Director (MD) if it was okay to have a UA with Culture and Sensitivity (C&S) completed. On 8/10/24 at 2:52 PM, an interview was conducted with LN 3. LN 3 stated resident 18 had some redness in his groin area. LN 3 stated resident 18 was on Diflucan not long ago. LN 3 stated he asked the MD if resident 18 needed a UA completed. LN 3 stated resident 18 had provided a urine sample and it was ready to be picked up from the laboratory. Resident 18's medical record was reviewed from 7/28/24 through 8/14/24. A Health Status Note dated 8/10/24 at 6:01 PM, indicated, Resident completed the oral Diflucan ABX [antibiotics] on 8/9/24. Resident's groin not so red this shift, resident does c/o [complain of] burning upon urination. Order noted to obtain UA-C&S if indicated. I notified [company name redacted] lab for pickup on specimen, I was informed later that [NAME] [sic] will not be able to pickup later in the day, I informed the lab rep [representative] that UA needs picked up today and rep sent reply they will do there [sic] best to pick up the specimen in the med [medication] room specimen fridge. A physician's order dated 8/10/24, indicated, UA- obtain C&S if indicated. On 8/12/24 at 1:34 PM, an interview was conducted with Licensed Practical Nurse (LPN) 2. LPN 2 stated he was not sure where urine dip results were supposed to be located. LPN 2 stated if he did a urine dip, he would document the results in the medical chart and notify the physician. On 8/12/24 at 2:47 PM, an interview was conducted with the Director of Nursing (DON). The DON stated she could not find urine dip results and did not have the results from the urine analysis that was supposed to have been sent out on 8/10/24. 50200 (continued on next page)

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	465086	A. Building B. Wing	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Health Services	5865 South Wasatch Drive Ogden, UT 84403

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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 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident 44 was admitted to the facility on [DATE] with diagnoses which included Alzheimer's disease, type 2 diabetes mellitus, dementia, anxiety disorder, benign prostatic hyperplasia without lower urinary tract symptoms, dysphagia, hyperlipidemia, major depressive disorder, unstable angina, and anemia. Resident 44's medical record was reviewed on 8/9/24 through 8/13/24. On 8/9/24 at 4:36 PM, a physician progress note documented, .Pt [patient] is more confused and has increased general weakness, because patient's white blood cell count is elevated I am going to have a urine analysis and a culture and sensitivityperformed [sic] to determine if patient has a urinary tract infection which could be causing the elevated white blood cell count and confusion. On 8/10/24 at 12:47 PM, a health status note documented, Order noted to obtain UA and C&S if indicated. UA collected this shift6 [sic] at 1115. [11:15 AM] [Lab name redacted] notified for UA pick up. On 8/10/24 at 2:17 PM, an interview was conducted with LN 5. LN 5 stated that labs were collected by the nurses and then the lab needed to be called to pick up the samples. LN 5 stated that once she placed an order in the computer she would print off a lab slip to accompany the samples. On 8/10/24 at 2:51 PM, an interview was conducted with LN 3. LN 3 stated that resident 44 had an increase in aggression and this was why a urinalysis was ordered. LN 3 stated that resident 44 had complained of the inability to urinate on 8/9/24, and the doctor wanted a urinalysis done. LN 3 stated he had been able to get a urine sample from resident 44 on 8/10/24. LN 3 stated that if he was unable to get the lab company to come to the facility then the Administrator would drop off the sample when he left for the day. On 8/13/24 at 9:30 AM , an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated that no results for the urinalyses had come back. The ADON stated that since the lab company was used, it took longer for the results to be faxed to the facility. The ADON stated that results would be faxed from the hospital to the fax machine located in the nurse's office. 33215 3. Resident 8 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, schizoaffective disorder, chronic kidney disease stage 3, cannabis abuse, essential hypertension, polycystic kidney, type 2 diabetes mellitus without complications, mental disorders, stimulant dependence, and urinary tract infection. On 8/10/24 at 2:17 PM, an observation was made of the physician's phone. There was a text message at 2:03 PM, from LN 3 to the physician which revealed resident 8 had signs and symptoms of a urinary tract infection (UTI). Resident 8 had urgency and burning upon urination. LN 3 dipped resident 8's urine and was positive for leukocytes and nitrates. LN 3 asked the MD if it was okay to have a UA and C&S completed. LN 3 text messaged that resident 8 had redness in groin and asked if it was okay to start Nystatin powder. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/10/24 at 2:52 PM, an interview was conducted with LN 3. LN 3 stated resident 8 was being monitored for a UTI and was waiting for the physician to respond to the text message. LN 3 stated resident 8's urine was dipped two hours ago and was positive so there was a sample waiting for the laboratory to pick up. Resident 8's medical record was reviewed on 8/11/24. On 8/10/24 at 2:16 PM, a Health Status Note documented Note Text: Resident assisted with her shower before lunch. I obtained a UA sample from resident d/t [due to] complaints of burning upon urinations [sic]. Resident has redness in groin area, will see about order for Nystatin powder. Notified NP [Nurse Practitioner]. On 8/10/24 at 6:10 PM, a Health Status Note documented Note Text: Order noted to obtain UA-C&S if indicated. I collected the UA from resident and specimen is in med room specimen fridge. [Name of lab redacted] informed. Will continue to monitor. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/11/24 at 9:11 AM, an interview was conducted with the DON and LN 3. LN 3 stated there had not been any residents with a change of condition in the last 24 hours. The DON stated there had not been any residents with a change of condition in the last 24 hours but three urinalyses were collected. The DON stated the staff could not send the urinalyses out because the staff did not have a printer. The DON stated she was waiting for the Business Officer Manager (BOM) to come to the facility so she could print the orders. The DON stated that staff did not have access to the printer on the weekends. The DON stated that Administration needed to provide staff with a printer so they could print orders. The DON stated that when the NP was getting ready to leave the facility LN 3 needed to see if there were any orders. The DON stated if you know your patient needed a UA and has had a change of condition you need to take care of it and change the change of condition. The DON stated that LN 3 needed to get the labs out. LN 3 stated that he needed the paperwork. The DON stated there was only one order for the urinalyses that were collected. The DON stated when the UA was collected staff were to put in the order, get a copy of the order, and send the order with the UA. The DON stated she was waiting for the BOM to come to the facility so she could print the order and complete the process. The DON stated that the BOM would have to come in every time if Administration did not want staff to have access to the printer. LN 3 stated that he needed to get a hold of the lab company to see what they were doing. LN 3 stated that the lab company messaged the night nurse last night and stated they needed to reschedule the pick up to Monday for the urinalyses. LN 3 and the DON stated that a UA was good in the fridge for 24 hours. The DON stated that staff had been trained on the lab company. The DON stated that she thought the training was in April 2024. LN 3 stated that resident 44's UA was ordered Friday evening and was collected Saturday morning. LN 3 stated that mid Saturday he sent a message to the lab company, dated and time stamped the UA. LN 3 stated that when the UA was time stamped the 24 hour time frame for results started. LN 3 stated that resident 8 and resident 18 fell under the change of condition. LN 3 stated he notified the MD and dipped the urine. LN 3 stated the urine had signs of nitrates and the MD wanted to collect a UA. LN 3 stated the urinalyses were collected on Saturday. LN 3 stated he contacted the lab company and was told the lab company would be to the facility to pick up the urinalyses. LN 3 stated he stayed last night and let the night shift nurse know. LN 3 stated he could run the urinalyses over to the local hospital and the Administrator was going to do that yesterday but the lab company said that they would pick up the urinalyses and the lab company never showed up. LN 3 stated that he could still run the urinalyses over to the local hospital today but he was waiting to print the information. LN 3 stated on the weekends it could be difficult because staff had to clarify things. LN 3 stated the MD came in late on Friday at 3:30 PM, and was at the facility until at least 6:00 PM. LN 3 stated it was hard when you get all these orders and then the weekend was coming. LN 3 stated that he decided to get a UA on resident 8 and resident 18 because they were having the same symptoms as resident 44. On 8/11/24 at 9:54 AM, the DON asked the Certified Nursing Assistant to take the three urinalyses to the lab at the local hospital. On 8/11/24 at 10:03 AM, an interview was conducted with LN 3. LN 3 stated that he needed to follow up regarding resident 8's Nystatin powder. LN 3 stated that he sent a message to the MD regarding the urinalyses and the Nystatin powder. LN 3 stated that the night nurse told him that the MD responded but did not say anything about the Nystatin powder. LN 3 stated that the urinalyses were not ordered urgent. On 8/11/24 at 10:10 AM, the BOM asked LN 3 if the labs from yesterday came back. LN 3 stated that he called the lab company twice and they never came to the facility. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/11/24 at 10:37 AM, an interview was conducted with the BOM. The BOM stated if staff needed access to the printer there was a whole process. The BOM stated when staff need something the staff were to call the Administrator and the Administrator would tell the staff where the keys were located. The BOM stated that staff could just make a copy on the fax machine in the medication room and the resident face sheets were in the paper medical record. The BOM stated that staff had access to the front office. The BOM stated if the staff had an emergent need they were to call the Administrator and the Administrator had a code for a lock box that had the keys to everything. The BOM stated the lock box also had spare keys to the medication cart. The BOM stated if the key box was accessed the Administrator would come in the next time and change the code. The BOM stated when the staff do an order the lab company would come in on Wednesdays. The BOM stated that staff were to write a telephone order which was there official order. The BOM stated that results would come to the fax machine in the medication room or the labs could be accessed through the lab portal on the computer. On 8/11/24 at 10:42 AM, an interview was conducted with the DON. The DON stated that was the first time she had ever heard about a lock box with keys. The DON stated there was a fax machine in the medication room but it did not print. The DON stated if staff had to send a resident out with a Medication Administration Record the staff could not print one and that was frustrating. On 8/12/24 at 11:40 AM, an interview was conducted with the DON. The DON stated the urinalyses had not come back yet. The DON stated the lab company told staff to take the labs to the local hospital if the lab company was unable to come pick them up. The DON stated that the local hospital would call the lab company with the results. The DON stated if the lab was critical the local hospital would call the facility, if the lab was not critical the local hospital would fax the lab to the facility. The DON checked the lab portal for the lab company and stated that the urinalyses were not back yet. The State Survey Agency (SSA) Lead Licensor asked the DON if the local hospital lab used the lab company to process their urinalyses because the three urinalyses were taken to the local hospital yesterday. The DON stated that the facility used the lab company for the three urinalyses. The SSA Lead Licensor asked the DON if the three urinalyses were taken to the local hospital yesterday. The DON stated Oh ya I will have to call them. On 8/12/24 at 2:43 PM, an interview was conducted with the DON. The DON stated that the local hospital had an outside lab company process the three urinalyses which was separate from the lab company that the facility used. The DON stated the urinalyses were in process right now and in the hands of the outside lab company. On 8/13/24 at 11:52 AM, an interview was conducted with resident 8. Resident 8 stated she was not having burning with urination and the facility had done some tests. Resident 8 was unable to complete the interview. Resident 8 stated she was having a hard time communicating with me. On 8/14/24 at 7:33 AM, an interview was conducted with the DON. The DON stated that the three urinalyses did not come back yesterday so she would need to follow up with those today. The three urinalyses results were never provided to the SSA.

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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 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33215 Based on interview and record review, the facility did not obtain laboratory (lab) services only when ordered by a physician; physician assistant; nurse practitioner (NP), or clinical nurse specialist. Specifically, for 2 out of 30 sampled residents, a resident had a urinalysis (UA) collected without a physician's order and a resident had a Complete Blood Count (CBC) blood lab collected without a physician's order. Resident identifiers: 8 and 18. Findings included: 1. Resident 8 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, schizoaffective disorder, chronic kidney disease stage 3, cannabis abuse, essential hypertension, polycystic kidney, type 2 diabetes mellitus without complications, mental disorders, stimulant dependence, and urinary tract infection. Resident 8's medical record was reviewed on 8/11/24. On 8/10/24 at 2:16 PM, a Health Status Note documented Note Text: Resident assisted with her shower before lunch. I obtained a UA sample from resident d/t [due to] complaints of burning upon urinations [sic]. Resident has redness in groin area, will see about order for Nystatin powder. Notified NP. On 8/10/24 at 6:10 PM, a Health Status Note documented Note Text: Order noted to obtain UA-C&S [culture and sensitivity] if indicated. I collected the UA from resident and specimen is in med [medication] room specimen fridge. [Name of lab redacted] informed. Will continue to monitor. A physician's order for the UA collected on 8/10/24, was unable to be located. (continued on next page)

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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 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/11/24 at 9:11 AM, an interview was conducted with the Director of Nursing (DON) and Licensed Nurse (LN) 3. LN 3 stated there had not been any residents with a change of condition in the last 24 hours. The DON stated there had not been any residents with a change of condition in the last 24 hours but three urinalyses were collected. The DON stated the staff could not send the urinalyses out because the staff did not have a printer. The DON stated she was waiting for the Business Officer Manager (BOM) to come to the facility so she could print the orders. The DON stated that staff did not have access to the printer on the weekends. The DON stated that Administration needed to provide staff with a printer so they could print orders. The DON stated that when the NP was getting ready to leave the facility LN 3 needed to see if there were any orders. The DON stated if you know your patient needed a UA and has had a change of condition you need to take care of it and change the change of condition. The DON stated that LN 3 needed to get the labs out. LN 3 stated that he needed the paperwork. The DON stated there was only one order for the urinalyses that were collected. The DON stated when the UA was collected staff were to put in the order, get a copy of the order, and send the order with the UA. The DON stated she was waiting for the BOM to come to the facility so she could print the order and complete the process. The DON stated that the BOM would have to come in every time if Administration did not want staff to have access to the printer. LN 3 stated that he needed to get a hold of the lab company to see what they were doing. LN 3 stated that the lab company messaged the night nurse last night and stated they needed to reschedule the pick up to Monday for the urinalyses. LN 3 and the DON stated that a UA was good in the fridge for 24 hours. The DON stated that staff had been trained on the lab company. The DON stated that she thought the training was in April 2024. LN 3 stated that mid Saturday he sent a message to the lab company, dated and time stamped the UA. LN 3 stated that when the UA was time stamped the 24 hour time frame for results started. LN 3 stated that resident 8 fell under the change of condition. LN 3 stated he notified the Medical Director (MD) and dipped the urine. LN 3 stated the urine had signs of nitrates and the MD wanted to collect a UA. LN 3 stated the urinalyses were collected on Saturday. LN 3 stated he contacted the lab company and was told the lab company would be to the facility to pick up the urinalyses. LN 3 stated he stayed last night and let the night shift nurse know. LN 3 stated he could run the urinalyses over to the local hospital and the Administrator was going to do that yesterday but the lab company said that they would pick up the urinalyses and the lab company never showed up. LN 3 stated that he could still run the urinalyses over to the local hospital today but he was waiting to print the information. LN 3 stated on the weekends it could be difficult because staff had to clarify things. LN 3 stated the MD came in late on Friday at 3:30 PM, and was at the facility until at least 6:00 PM. LN 3 stated it was hard when you get all these orders and then the weekend was coming. LN 3 stated that he decided to get a UA on resident 8 because the resident was having the same symptoms as another resident. 48709 2. Resident 18 was admitted to the facility on [DATE] with diagnoses which included schizophrenia, other stimulant abuse with stimulant-induced psychotic disorder, and mycosis. Resident 18's medical record was reviewed from 7/28/24 through 8/14/24. (continued on next page)

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An Encounter progress note dated 8/8/24 at 11:00 PM, indicated, Patient is a [AGE] year-old male who was homeless and is now admitted to [Facility name redacted] and is in the memory unit. Today patient was seen to review his recent lab work. Patient had a CBC with auto differential performed on 8/7/2024. Patient's platelet level is slightly decreased at 147.8, normal level is above 150.50. I am going to encourage patient to eat a well-balanced diet and stay well-hydrated. I educated our nursing staff to continue to push nutrition and hydration to help in patient's rehabilitation/recovery. Will recheck patient's CBC with auto differential again and 1 month. It should be noted that there was no physician order for a CBC around the date of 8/7/24, or lab results in the medical record. On 8/12/24 at 2:47 PM, an interview was conducted with the DON. The DON stated she had no idea where the order or results of the CBC blood test referred to in the Encounter progress note dated 8/8/24 at 11:00 PM, was.

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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 0777 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain x-rays/tests when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33215 Based on interview and record review, the facility did not promptly notify the ordering physician, physician assistant, nurse practitioner (NP), or clinical nurse specialist of results that fell outside of clinical reference ranges. Specifically, for 1 out of 30 sampled residents, the Medical Director (MD) was not notified timely when the x-ray results documented that the resident had an acute complete femoral neck fracture with partial displacement. Resident identifier: 298. Findings included: Resident 298 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included, but were not limited to, dementia, essential hypertension, acute kidney failure, and anxiety disorder. Resident 298's medical record was reviewed on 8/7/24. On 5/20/24 at 11:00 PM, an encounter documented Date of Service: 05/21/2024 Visit Type: Acute Transition of Care: No transition occurred. Progress Note . Chief Complaint / Nature of Presenting Problem: Right hip pain History Of Present Illness: [Resident 298] is a [AGE] year-old long-term care resident here at [name redacted]. Per the nurses report he has had a couple of falls over the weekend. He was evaluated yesterday but denied any significant pain. It is unclear if he had another fall since yesterday's evaluation but currently he has complaints of right hip pain. He has been unable to stand. Most of his pain is localized to the anterior and lateral right hip. General: Elderly male in mild distress. Does appear confused which is his baseline Musculoskeletal: Patient does have tenderness to palpation over the right hip laterally anteriorly. He does have pain with internal and external rotation of the right hip. This localizes anteriorly. Acute right hip pain Patient's right hip pain appears to be acute and it is unclear whether this is related to a fall over the weekend or a new fall today. Given his acute right hip pain and evaluation today I do recommend x-rays of the right hip stat [immediately]. These were ordered today. Plan to follow-up after x-rays. Fall On fall precautions. The MD signed the note on 5/21/24 at 11:17 AM. On 5/21/24 at 11:40 AM, a Health Status Note documented Note Text: NEW ORDER: Pt [patient] is not bearing any wt [weight] on rt [right] leg has a lg [large] skin tear on rt elbow. md notified ordered a xray it has been ordered and they stated it wil [sic] be done today. pt had a shr [shower] today. On 5/21/24, the Diagnostics report documented . Right hip, 2 views Comparison: None. Findings: There is an acute complete femoral neck fracture with partial displacement compatible with a Garden Classification III fracture. IMPRESSION: 1. Garden classification III acute femoral neck fracture. The diagnostics report was signed by the diagnostics radiologist on 5/21/24 at 6:23 PM. On 5/22/24 at 2:51 AM, a Health Status Note documented Note Text: Follow up on res [resident] x-ray: Impressions noted; There is an acute complete femoral neck Fx [fracture] with partial displacement compatible with a Garden class III. Mild degree of osteopenia. Moderate osteoarthritis. X-ray results sent to MD, response pending. WCTM [will continue to monitor]. (continued on next page)

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F 0777 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/22/24 at 5:30 AM, a Health Status Note documented Note Text: Staff reported res, has been up all night did not sleep a [NAME], trying to wiggle his way out of bed. Staff has continuously throughout shift had to re center res into bed and remind resident that he, could not walk d/t [due to] broken femur. will pass on to upcoming shift nurse for monitoring and follow-up. On 5/22/24 at 6:54 AM, an Orders - General Note from electronic Record documented Note Text: MD notified of results of Xray and new order for resident to be sent to ER [emergency room] for eval/tx [evaluation and treatment]. Preparing paperwork. On 8/8/24 at 9:46 AM, an interview was conducted with the Director of Nursing (DON). The DON stated when staff received an order for an x-ray they were to call the mobile x-ray company. The DON stated the mobile x-ray company would tell the staff when they could be out to do the x-ray because the staff would want to know how long it would take. The DON stated that she was thinking that STAT would mean four to eight hours. The DON stated that she believed that was what the mobile x-ray company had told her. The DON stated that once the order was in and she had a time the mobile x-ray company would be at the facility the staff would fax a face sheet and the order to the mobile x-ray company. The DON stated it was up to the nurse at that time to see how important the x-ray was and the nurse would decide to send the resident out or wait for the mobile x-ray company. The DON stated that once the mobile x-ray company was at the facility the staff would let the MD know. The DON stated that once the x-ray report was back the staff were to document the MD was notified, date and time, and put the results in the computer. The DON stated that once the MD called back the staff were to go back into the computer and document what the MD wanted done and put the x-ray results in the DON office. The DON stated she would look into the computer to see if the steps had been done and the DON would make sure the MD signed the x-ray results. The DON stated with a STAT order the staff could sometimes take the resident over to the local hospital. The DON stated the process was not as secure as she would like it to be. The DON stated as a nurse STAT would mean the dire situation of the person. The DON stated that she might go four hours with a fracture. The DON stated that it would be a nurse call and if she had to call the MD to get additional orders she would. On 8/8/24 at 11:50 AM, an interview was conducted with the DON. The DON stated that resident 298 had an unwitnessed fall on 5/18/24 at about 3:00 AM. The DON stated that resident 298 had another fall on 5/19/24 at 9:00 AM. The DON stated the fall on 5/20/24, was an assisted fall at 3:00 PM. The DON stated at that time herself and the Certified Nursing Assistant lowered resident 298 to the floor and the DON stated that she did not notice anything. The DON stated that the NP saw resident 298 the morning of 5/21/24, and noted we need an x-ray. The DON stated that resident 298 somehow had a shower during that time on 5/21/24. The DON stated the facility called the x-ray company at 11:34 AM, and the x-ray company arrived at the facility at 5:41 PM, to do the x-ray on 5/21/24. The DON stated at 6:23 PM, the x-ray company either faxed the results or notified the facility of the results. The DON stated that the nurse on 5/22/24, made a progress note that results were pending from the doctor. The DON stated at the end of the shift the nurse made a note that resident 298 was up all night and passed the information to the oncoming nurse which was the DON. The DON stated at 6:55 AM, she notified the doctor and resident 298 was sent out to the hospital.

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	465086	A. Building B. Wing	08/14/2024

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F 0779 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep signed and dated reports of x-rays and other diagnostic services in the residents record. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50200 Based on interview and record review, the facility did not file in the resident's clinical record the signed and dated reports of radiological and other diagnostic services. Specifically, for 1 out of 30 sampled residents, a resident's ultrasound and x-ray reports were not filed in the medical record. Resident identifier: 298 Findings included: Resident 298 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included, but were not limited to, dementia, essential hypertension, acute kidney failure, and anxiety disorder. Resident 298's medical record was reviewed on 8/7/24. A. On 6/20/24 at 11:08 AM, a health status note documented, [Name redacted] came in to do an US [ultrasound] to residents RLE [right lower extremity]. RESULTS: Thrombus in common femoral. Femoral vein pros and dist, popliteal and posterior tibial veins with minimal flow. Veins non compressible. IMPRESSION: RLE DVT [deep vein thrombosis] MD [Medical Doctor] notified immediately. A review of the medical record revealed no ultrasound report in resident 298's medical record. On 8/7/24 at 1:57 PM, an interview was conducted with the Director of Nursing [DON]. The DON stated that if the nursing staff received an order for an ultrasound to rule out a DVT the timeframe for the ultrasound to be done would be immediate and if that was not possible then the resident needed to be sent to the hospital. The DON stated that all radiology reports came to her and she would have the physician review, sign, and the paper copy would be filed in the resident's paper medical record. The DON stated that the nursing staff did not have great critical thinking skills and that caused them to miss important things. The DON stated that the facility did not have a policy regarding residents who had a suspected DVT or required an urgent (STAT) ultrasound. The DON stated that the facility could do better. The DON stated that resident 298 did not have any anticoagulation therapy after hip surgery. The DON stated that she had spoken with Nurse Practitioner 2 and was informed that the resident should have been on anticoagulant therapy after surgery to prevent blood clots. 33215 (continued on next page)

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F 0779 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B. On 5/20/24 at 11:00 PM, an encounter documented Date of Service: 05/21/2024 Visit Type: Acute Transition of Care: No transition occurred. Progress Note . Chief Complaint / Nature of Presenting Problem: Right hip pain History Of Present Illness: [Resident 298] is a [AGE] year-old long-term care resident here at [name redacted]. Per the nurses report he has had a couple of falls over the weekend. He was evaluated yesterday but denied any significant pain. It is unclear if he had another fall since yesterday's evaluation but currently he has complaints of right hip pain. He has been unable to stand. Most of his pain is localized to the anterior and lateral right hip. General: Elderly male in mild distress. Does appear confused which is his baseline Musculoskeletal: Patient does have tenderness to palpation over the right hip laterally anteriorly. He does have pain with internal and external rotation of the right hip. This localizes anteriorly. Acute right hip pain Patient's right hip pain appears to be acute and it is unclear whether this is related to a fall over the weekend or a new fall today. Given his acute right hip pain and evaluation today I do recommend x-rays of the right hip stat. These were ordered today. Plan to follow-up after x-rays. Fall On fall precautions. The MD signed the note on 5/21/24 at 11:17 AM. On 5/21/24 at 11:40 AM, a Health Status Note documented Note Text: NEW ORDER: Pt [patient] is not bearing any wt [weight] on rt [right] leg has a lg [large] skin tear on rt elbow. md notified ordered a xray it has been ordered and they stated it wil [sic[be done today. pt had a shr [shower] today. On 5/21/24, the Diagnostics report documented . Right hip, 2 views Comparison: None. Findings: There is an acute complete femoral neck fracture with partial displacement compatible with a Garden Classification III fracture. IMPRESSION: 1. Garden classification III acute femoral neck fracture. The diagnostics report was signed by the diagnostics radiologist on 5/21/24 at 6:23 PM. (Note: The x-ray results were requested from the Administrator. The x-ray results were faxed to the facility on [DATE] at 3:16 PM. The x-ray results were not in resident 298's medical record and the x-ray results were not signed or dated.) On 5/22/24 at 2:51 AM, a Health Status Note documented Note Text: Follow up on res [resident] x-ray: Impressions noted; There is an acute complete femoral neck Fx [fracture] with partial displacement compatible with a Garden class III. Mild degree of osteopenia. Moderate osteoarthritis. X-ray results sent to MD, response pending. WCTM [will continue to monitor]. (continued on next page)

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F 0779 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/8/24 at 9:46 AM, an interview was conducted with the DON. The DON stated when staff received an order for an x-ray they were to call the mobile x-ray company. The DON stated the mobile x-ray company would tell the staff when they could be out to do the x-ray because the staff would want to know how long it would take. The DON stated that she was thinking that STAT would mean four to eight hours. The DON stated that she believed that was what the mobile x-ray company had told her. The DON stated that once the order was in and she had a time the mobile x-ray company would be at the facility the staff would fax a face sheet and the order to the mobile x-ray company. The DON stated it was up to the nurse at that time to see how important the x-ray was and the nurse would decide to send the resident out or wait for the mobile x-ray company. The DON stated that once the mobile x-ray company was at the facility the staff would let the MD know. The DON stated that once the x-ray report was back the staff were to document the MD was notified, date and time, and put the results in the computer. The DON stated that once the MD called back the staff were to go back into the computer and document what the MD wanted done and put the x-ray results in the DON office. The DON stated she would look into the computer to see if the steps had been done and the DON would make sure the MD signed the x-ray results. The DON stated with a STAT order the staff could sometimes take the resident over to the local hospital. The DON stated the process was not as secure as she would like it to be. The DON stated as a nurse STAT would mean the dire situation of the person. The DON stated that she might go four hours with a fracture. The DON stated that it would be a nurse call and if she had to call the MD to get additional orders she would. On 8/8/24 at 11:50 AM, an interview was conducted with the DON. The DON stated the facility called the x-ray company at 11:34 AM, and the x-ray company arrived at the facility at 5:41 PM, to do the x-ray on 5/21/24. The DON stated at 6:23 PM, the x-ray company either faxed the results or notified the facility of the results. The DON stated that the nurse on 5/22/24, made a progress note that results were pending from the doctor. The DON stated at the end of the shift the nurse made a note that resident 298 was up all night and passed the information to the oncoming nurse which was the DON. The DON stated at 6:55 AM, she notified the doctor and resident 298 was sent out to the hospital.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47432 Based on observation, interview, and record review, the facility did not store, prepare, distribute and serve food in accordance with professional standards for food service safety. Specifically, the low temperature dish washing machine did not reach a minimum temperature of 120 degrees Fahrenheit, a whole ham was stored above premade peanut butter and jelly sandwiches, bagged fruit, and strawberry dessert cups in the walk in refrigerator, there were onions stored on the floor of the walk in refrigerator, yogurt cups were not stored on ice on a snack cart located in a hallway, and meals were stored uncovered at the central nurse's station. Findings included: On 7/28/24 at 8:52 AM, an initial observation was made of the facility kitchen. The dish machine was noted to be a low temperature dish machine. The dish machine temperature log for the month of July 2024 was reviewed. It was noted that none of the logged temperatures were at or above 120 degrees Fahrenheit. On 7/30/24 at 11:49 AM, an observation was made of the kitchen walk in refrigerator. There was noted to be a box of Buffetmaster ham and water product stored on the top shelf of the walk in refrigerator. The Buffetmaster was stored above pre-made peanut butter and jelly sandwiches, strawberry dessert cups, and bagged fruit. There was also noted to be a bag of onions stored on the floor of the walk in refrigerator. On 7/30/24 at 2:02 PM, the Dietary Manager (DM) ran the dish machine for a cycle while the surveyor was present. The dish machine did not reach higher than 100 degrees Fahrenheit during the wash or rinse cycle. It should be noted that the dish machine had been running for several cycles prior to being observed. On 8/7/24 at 8:17 AM, an observation was made of the central nurse's station. There were noted to be three uncovered breakfast meal trays sitting on the counter of the station. On 7/30/24 at 1:52 PM, an interview was conducted with the DM. The DM stated that the dish machine should reach 140 degrees Fahrenheit. The DM stated that meat should not be stored above other foods in the walk-in refrigerator. 43212 On 8/9/24 at 8:00 PM, an observation was made of a service cart in the hallway across from the dining area. The cart had pre-made sandwiches, two yogurt cups, snacks, and a pitcher of ice water on the top shelf. The second shelf of the cart had a cooler that contained ice. The yogurt cups were not stored on ice to keep them cool. The sandwiches appeared to be mostly peanut butter and jelly. Some sandwiches had resident names on them. A Mighty Shake was observed to be in a container on the nurses medication cart. There was no ice to keep the shake cool. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 8/9/24 at 9:25 PM, an observation was made of Certified Nursing Assistant (CNA) 4 who exited the secure unit to obtain snacks for some of the residents on the unit. He obtained several sandwiches and snack items and returned to the secure unit. On 8/10/24 at 2:15 AM, an observation was made of the service cart in the hallway across from the dining area. The two yogurts were still sitting on the cart and had not been chilled, and the Mighty Shake remained on the nurse cart in the container with no ice to chill the shake.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. 47432 Based on observation and interview, the facility did not dispose of garbage and refuse properly. Specifically, the facility was found to have stored uncovered, used aluminum soda cans outdoors directly outside of the kitchen. Findings included: On 7/30/24 at 11:49 AM, an observation was made of the facility kitchen. There was a large black plastic garbage bag stored outdoors directly outside the entrance to the kitchen. The garbage bag was torn open and empty aluminum soda cans were spilling out of the bag and onto the concrete ground. On 7/30/24 at 1:52 PM, an interview was conducted with the Dietary Manager (DM). The DM stated that she was aware of the empty soda cans being stored outside the kitchen. The DM stated that a resident of the facility was collecting the cans to be recycled. The DM stated that the bags of soda cans had been torn open by a recent windstorm.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 33215 Based on interview, observation and record review, the facility did not ensure that the facility was administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Specifically, multiple areas of immediate jeopardy and harm were identified. In addition, multiple areas of non compliance were cited on the previous survey and again during the current recertification survey. Resident identifiers: 46 and 298. Findings include: 1. Based on interview and record review, the facility did not ensure that 2 of 30 sample residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Specifically, ongoing monitoring for changes in condition were not provided after one resident experienced ongoing emesis and abdominal pain, and a second resident had a deep vein thrombosis. The findings for resident 46 were determined to have resulted in immediate jeopardy for resident 46. Resident identifiers: 46 and 298. [Cross refer to F684] 2. Based on observation, interview, and record review, the facility did not ensure that each resident received adequate supervision and assistance devices to prevent accidents and the resident environment did not remain as free of accident hazards as was possible. Specifically, for 1 out of 30 sampled residents, a resident was not provided adequate supervision and interventions to reduce hazards and risks that resulted in an acute complete femoral neck fracture with partial displacement. Resident identifiers: 298. [Cross refer to F689] 3. Based on interview and record review, the facility did not ensure for 2 of 30 sample residents that radiology and other diagnostic services were provided to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. Specifically, residents were not provided with ultrasounds as ordered by the physician. This resulted in a finding of Immediate Jeopardy for resident 46. Resident identifiers: 46 and 298. [Cross refer to F776] 4. Based on interview and record review, the facility did not ensure that pain management was provided to residents who required such services. Specifically, for 1 out of 30 sampled residents, a resident with an acute complete femoral neck fracture was not provided pain management prior to being discharged to the hospital. Resident identifiers: 298. [Cross refer to F697] (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. In addition, during the October 2022 recertification survey, the facility was cited F550, F580, F584, F609, F610, F641, F656, F684, F689, F692, F697, F755, F760, F761, F773, F812, F835, F840, F842, F867, F880, F882, and F923 among other areas of non-compliance. These same areas were again identified during the current recertificaiton survey.

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48709 Based on interview and record review, the facility did not arrange services with an outside agency. Specifically, for 2 out of 30 sampled residents, residents had physician's orders to follow up with a specialist and the facility staff had not made the appointments. Resident identifiers: 25 and 35. Findings included: 1. Resident 35 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included artherosclerotic heart disease, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, gout, memory deficit following cerebral infarction, repeated falls, type 2 diabetes mellitus with diabetic polyneuropathy, cerebral infarction, dysphagia, Charcot's Arthropathy, and acquired absence of other right toe. Resident 35's medical record was reviewed from 7/28/24 through 8/14/24. A Minimum Data Sheet assessment Section GG Functional Abilities and Goals dated 6/13/24, indicated, Functional Limitation in Range of Motion to the Lower extremity (hip, knee, ankle, foot with Impairment to one side. It further indicated resident 35 used a wheelchair. An Encounter Progress Note dated 7/4//24 at 11:00 PM, indicated, [Resident name redacted] is a [AGE] year-old male who is a long-term resident at [Facility name redacted]. He has a history of a cerebral infarction resulting in left-sided weakness, diabetes, obstructive sleep apnea as well as Charcot's arthropathy. When is at the nurses station today patient came to me to discuss his left foot pain and malformation. Patient states that years ago he hurt his foot and it never healed back to normal position properly. The foot is turned inward and a brace is in place at this time. Patient states that he is able to hold the foot or the toes back and push them down but with very poor range of motion. He stated that he needs to have the foot casted to help him get the foot back into normal position. The brace does not appear to be keeping the footin [sic] a normal anatomical alignment position. I am going to refer the patient to an orthopedic specialist to works on her feet and ankles. I informed patient that I would write the referral and patient was very grateful. Patient was sitting in his wheelchair when I left him by the nurses station. A Physician's Order dated 7/5/24, indicated, Please refer pt [patient] to an orthopedic foot + [and] ankle surgeon (specialist) for pt's L [left] foot. On 7/30/24 at 2:48 PM, an interview was conducted with the Receptionist. The Receptionist stated she scheduled the referral appointments for residents and that she did not have an appointment scheduled for an orthopedic specialist for resident 35. On 7/31/24 at 11:18 AM, an interview was conducted with the Director of Nursing (DON). The DON stated when a physician orders a consult, verbally or however, the nurse should put it in the appointment book, and then the receptionist will make the appointment. (continued on next page)

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/7/24 at 1:39 PM, a follow-up interview was conducted with the Receptionist. The Receptionist reviewed the appointment book that was located at the nurse's station and stated she reviewed it daily. The Receptionist stated the nurses were responsible for putting any referrals or orders in the appointment book. 2. Resident 25 was admitted to the facility on [DATE], and readmitted on [DATE] with diagnoses which included sepsis, acute respiratory failure, type 2 diabetes mellitus, vascular dementia, pneumonia, pressure ulcer of left heal, metabolic encephalopathy, hypertension, and atrial fibrillation. Resident 25's medical record was reviewed from 7/28/24 through 8/14/24. A physician's order dated 6/4/24, indicated, Pulmonary function test [PFT]- eval [evaluate] COPD [chronic obstructive pulmonary disease]. On 8/7/24 at 1:39 PM, an interview was conducted with the Receptionist. The Receptionist stated that she would have been the person to make the PFT appointment. The Receptionist stated the order was not in the appointment book, so she did not make the appointment for resident 25's PFT. On 8/7/24 at 1:44 PM, an interview was conducted with the DON. The DON stated she did not know if resident 25 had his PFT appointment yet. The DON stated resident 25 had previously had Covid and had issues with his COPD. The DON stated, he was so sick and was not getting better. The DON stated the appointment should have been made as soon as possible.

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F 0841 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Designate a physician to serve as medical director responsible for implementation of resident care policies and coordination of medical care in the facility. 22992 Based on interview, observation and record review, the facility did not ensure the the medical director was effective in their role of implementing resident care policies and coordinating medical care in the facility. Specifically, multiple areas of immediate jeopardy and harm were identified. In addition, multiple areas of non compliance were cited on the previous survey and again during the current recertification survey. Resident identifiers: 46 and 298. Findings include: 1. Based on interview and record review, the facility did not ensure that 2 of 30 sample residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Specifically, ongoing monitoring for changes in condition were not provided after one resident experienced ongoing emesis and abdominal pain, and a second resident had a deep vein thrombosis. The findings for resident 46 were determined to have resulted in immediate jeopardy for resident 46. Resident identifiers: 46 and 298. [Cross refer to F684] 2. Based on observation, interview, and record review, the facility did not ensure that each resident received adequate supervision and assistance devices to prevent accidents and the resident environment did not remain as free of accident hazards as was possible. Specifically, for 1 out of 30 sampled residents, a resident was not provided adequate supervision and interventions to reduce hazards and risks that resulted in an acute complete femoral neck fracture with partial displacement. Resident identifiers: 298. [Cross refer to F689] 3. Based on interview and record review, the facility did not ensure for 2 of 30 sample residents that radiology and other diagnostic services were provided to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. Specifically, residents were not provided with ultrasounds as ordered by the physician. This resulted in a finding of Immediate Jeopardy for resident 46. Resident identifiers: 46 and 298. [Cross refer to F776] 4. Based on interview and record review, the facility did not ensure that pain management was provided to residents who required such services. Specifically, for 1 out of 30 sampled residents, a resident with an acute complete femoral neck fracture was not provided pain management prior to being discharged to the hospital. Resident identifiers: 298. [Cross refer to F697] (continued on next page)

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	465086	A. Building B. Wing	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Health Services	5865 South Wasatch Drive Ogden, UT 84403

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

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F 0841 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. In addition, during the October 2022 recertification survey, the facility was cited F550, F580, F584, F609, F610, F641, F656, F684, F689, F692, F697, F755, F760, F761, F773, F812, F835, F840, F842, F867, F880, F882, and F923 among other areas of non-compliance. These same areas were again identified during the current recertificaiton survey.

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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** 33215 Based on observation, interview, and record review, the facility did not maintain records on each resident that were complete, accurately documented, and readily accessible. Specifically, for 6 out of 30 sampled residents, progress notes, an appointment referral, and Occupational Therapy orders were located in the wrong resident medical records. In addition, resident medical records were unsecured in the Director of Nursing (DON) office. Resident identifiers: 1, 3, 7, 24, 35, and 148. Findings included: 1. Resident 1 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included, but were not limited to, acute myocardial infarction, acute respiratory failure with hypoxia, age-related cognitive decline, type 2 diabetes mellitus, non-pressure chronic ulcer of foot, rheumatoid arthritis, acquired deformity of lower leg, muscle wasting and atrophy, dysphagia, and difficulty in walking. On 7/29/24, resident 1's paper medical record was reviewed. Progress Notes for resident 3 and resident 148 were located in resident 1's paper medical record. 50200 2. Resident 7 was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses which include unspecified dementia, schizoaffective disorder, paroxysmal atrial fibrillation, obsessive-compulsive disorder, essential hypertension, adult failure to thrive, encephalopathy, and mild cognitive impairment. Resident 7's medical record was reviewed 7/28/24 An appointment referral note for resident 35 was located in resident 7's paper medical chart. 3. Resident 24 was admitted to the facility on [DATE] with diagnoses which included, unspecified dementia, type 2 diabetes mellitus, chronic viral Hepatitis C, essential hypertension, hyperlipidemia, vertigo, major depressive disorder, osteoarthritis, and inflammatory disease of prostate. Resident 24's medical record was reviewed on 7/28/24. An order for occupational therapy for a different resident dated 11/21/22, was located inside resident 24's paper medical chart. On 7/29/24 at 11:01 AM, an interview was conducted with the Business Office Manager (BOM). The BOM stated that the facility did not really have a person for medical records. The BOM stated the Receptionist or any extra Certified Nursing Assistant would help file medical records in the resident paper medical record if they had time. The BOM stated that once the paperwork went through the signature process the DON would get the paperwork together, bring the paperwork to the Receptionist, and the Receptionist would file the paperwork in the resident paper medical record when there was time. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	43212 4. On 8/9/24 at 11:02 PM, an observation was made in the office of the DON of three stacks of papers approximately 12 to 15 inches each and bound by rubber bands and stacked on top of boxed items in the corner of the room. The papers were observed to have resident protected heath information and personally identifiable information. The DON office door was open and was not being occupied or monitored.

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F 0843 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have an agreement with at least one or more hospitals certified by Medicare or Medicaid to make sure residents can be moved quickly to the hospital when they need medical care. 33215 Based on interview, the facility did not have in effect a written transfer agreement with one or more hospitals approved for participation under the Medicare and Medicaid programs. Specifically, the facility never provided the State Survey Agency (SSA) their hospital transfer agreement. Findings included: On 8/7/24 at 1:03 PM, the hospital transfer agreement was requested from the Administrator. On 8/7/24 at 1:25 PM, an interview was conducted with the Administrator. The Administrator stated that he was having trouble finding the hospital transfer agreement. On 8/12/24 at 9:53 AM, an interview was conducted with the Administrator. The Administrator stated that the hospital transfer agreement that he had was outdated. The Administrator stated that he reached out to the two local hospitals to get the hospital transfer agreement updated. The Administrator stated that one of the hospitals he contacted was by email only. The Administrator stated that he would provide the SSA the hospital transfer agreement when he received it. A hospital transfer agreement was never provided to the SSA.

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F 0867 Level of Harm - 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, observation and record review, the facility did not ensure that policies were established and implemented to ensure that identified quality deficiencies were corrected. Specifically, multiple areas of immediate jeopardy and harm were identified. In addition, multiple areas of non compliance were cited on the previous survey and again during the current recertification survey. Resident identifiers: 46 and 298. Findings include: 1. Based on interview and record review, the facility did not ensure that 2 of 30 sample residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Specifically, ongoing monitoring for changes in condition were not provided after one resident experienced ongoing emesis and abdominal pain, and a second resident had a deep vein thrombosis. The findings for resident 46 were determined to have resulted in immediate jeopardy for resident 46. Resident identifiers: 46 and 298. [Cross refer to F684] 2. Based on observation, interview, and record review, the facility did not ensure that each resident received adequate supervision and assistance devices to prevent accidents and the resident environment did not remain as free of accident hazards as was possible. Specifically, for 1 out of 30 sampled residents, a resident was not provided adequate supervision and interventions to reduce hazards and risks that resulted in an acute complete femoral neck fracture with partial displacement. Resident identifiers: 298. [Cross refer to F689] 3. Based on interview and record review, the facility did not ensure for 2 of 30 sample residents that radiology and other diagnostic services were provided to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. Specifically, residents were not provided with ultrasounds as ordered by the physician. This resulted in a finding of Immediate Jeopardy for resident 46. Resident identifiers: 46 and 298. [Cross refer to F776] 4. Based on interview and record review, the facility did not ensure that pain management was provided to residents who required such services. Specifically, for 1 out of 30 sampled residents, a resident with an acute complete femoral neck fracture was not provided pain management prior to being discharged to the hospital. Resident identifiers: 298. [Cross refer to F697] (continued on next page)

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F 0867 Level of Harm - Actual harm Residents Affected - Some	5. In addition, during the October 2022 recertification survey, the facility was cited F550, F580, F584, F609, F610, F641, F656, F684, F689, F692, F697, F755, F760, F761, F773, F812, F835, F840, F842, F867, F880, F882, and F923 among other areas of non-compliance. These same areas were again identified during the current recertificaiton survey.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. 33215 Based on interview, the facility did not establish an infection prevention and control program (IPCP) that included, at a minimum, an antibiotic stewardship program that included antibiotic use protocols and a system to monitor the antibiotic use. Specifically, the facility infection control tracking and trending was not done and the facility had not established an antibiotic stewardship program. Findings included: On 7/31/24 at 7:23 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that she could not locate her infection control binder, but would look for the binder and bring it to the State surveyor. The DON stated that she was not currently tracking or trending infections in the facility. The DON stated that she did not have the policy for antibiotic stewardship. The DON stated to prevent infections from being spread, all staff should be hand sanitizing in between contact with residents and then washing their hands after they entered a resident's room. On 8/14/24 at 12:00 PM, it should be noted that the infection control binder was never brought to the State surveyor.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 33215 Based on interview, the facility did not ensure that the designated Infection Preventionist (IP) who was responsible for the facility's infection prevention and control program had completed specialized training in infection prevention and control. Specifically, the Director of Nursing (DON) who was the designated IP had not completed the specialized training in infection prevention and control. Findings included: On 7/29/24 at 10:47 AM, an interview was conducted with the DON. The DON stated that she was the designated IP for the facility and she had completed the specialized training for the IP certification. The DON stated she took the training and was supposed to take the test. The DON stated she had until November 2024 to take the test. The DON stated she thought she did the training in May 2024. The DON stated regarding infection control she had been so busy. The DON stated she learned about the enhanced barrier precautions, multidrug resistant organisms, and how she could do charts. The DON stated she was still working on those things to get them in place. The DON stated they sent her a form to see where she was at with the infection control and to see what strategies she was using. The DON stated she thought they was the State. The DON stated she did not have the programs in place in the computer for infection control. The DON stated she did not have it all in order to function as a health care facility. The DON was unable to provide documentation that she had attended or completed specialized training in infection prevention and control. On 7/31/24 at 3:15 PM, a follow up interview was conducted with the DON. The DON stated that she had been informed during the previous survey in October 2022 that she needed to obtain her IP certification. The DON stated that she did not start the training until January of 2024, but had since completed the training. The DON stated she had not yet taken the test to become a certified IP. When asked why the DON waited from October 2022 until January 2024 to start her IP certification training, the DON stated, probably because I had other things going on. 22992

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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, the facility did not have adequate outside ventilation. Specifically, the facility was found to have numerous odors throughout the survey. Findings included: On 7/28/24 at 10:05 AM, an observation was made of the 100 hall locked unit. There was a strong urine odor near rooms [ROOM NUMBERS]. On 7/28/24 at 10:22 AM, an observation was made of the 300 hall at the facility. There was noted to be a strong urine odor through out the hallway. On 7/28/24 at 10:43 AM, an observation was made of the 200 hall at the facility. there was noted to be a strong urine odor around rooms [ROOM NUMBERS]. On 7/28/24 at 12:18 PM, an observation was made of the 300 hall at the facility. There was noted to be a strong urine odor near the entrance to room [ROOM NUMBER]. On 7/28/24 at 12:28 PM, an observation was made of the 100 hall locked unit. There was a strong urine odor near room [ROOM NUMBER]. On 7/29/24 at 7:36 AM, an observation was made of the 100 hall locked unit. There was a strong urine odor when entering the hallway. On 7/29/24 at 10:40 AM, an observation was made of the 200 hall at the facility. There was noted to be a strong odor of urine near the entrances to rooms 204, 205, 212, and 213. On 7/29/24 at 10:46 AM, an observation was made of the 200 hall at the facility. There was noted to be a strong urine odor with the strongest smell around rooms [ROOM NUMBERS]. On 7/29/24 at 11:50 AM, an observation was made of the solarium room on the 400 hall of the facility. There were noted to be odors of urine and moisture. It should be noted that there was a koi fish pond located in this room. On 7/29/24 at 1:11 PM, an observation was made of the 100 hall locked unit. There was a strong urine odor near room [ROOM NUMBER]. On 7/29/24 at 1:40 PM, an observation was made of the 200 hall at the facility. There was noted to be a strong urine odor with the strongest odors around rooms 204 through 207. On 7/29/24 at 3:34 PM, an observation was made of the 100 hall locked unit. There was a strong urine odor near room [ROOM NUMBER]. On 7/30/24 at 7:36 AM, an observation was made of the 100 hall locked unit. There was a strong urine odor near room [ROOM NUMBER]. (continued on next page)

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F 0923 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/30/24 at 8:00 AM, an observation was made of the 200 hall at the facility. There was a strong urine odor on the 200 hallway near rooms [ROOM NUMBERS]. On 7/30/24 at 9:16 AM, an additional observation was made of the 200 hall at the facility. There was noted to be a strong odor of urine near rooms [ROOM NUMBERS]. On 7/30/24 at 9:29 AM, an interview was conducted with Housekeeper (HK) 1. HK 1 stated that the residents' rooms were cleaned everyday at the facility. HK 1 stated that room [ROOM NUMBER] was dirty and smelled really bad. On 7/30/24 at 10:15 AM, an interview was conducted with HK 2. HK 2 stated that housekeeping used cleaning supplies to clean the rooms and remove odors. On 7/30/24 at 10:42 AM, an observation was made of the 100 hall locked unit. There was a strong urine odor near room [ROOM NUMBER]. On 7/30/24 at 2:34 PM, an interview was conducted with Certified Nursing Assistant (CNA) 2. CNA 2 stated that she sprayed herself with perfume after changing a resident's soiled brief because the smell overwhelmed her. On 8/10/24 at 1:30 PM until 2:51 PM, an observation was made of the 200 hall at the facility. There was noted to be a strong urine odor throughout the hallway. On 8/10/24 at 1:43 PM, an observation was made of the 100 hall locked unit. There was a strong urine odor near room [ROOM NUMBER]. On 8/10/24 at 2:00 PM, an observation was made of the 300 hall at the facility. There was a strong urine odor in the 300 hallway near room [ROOM NUMBER]. On 8/11/24 at 8:55 AM, an observation was made of the central nurses station at the facility. There was noted to be a strong urine odor. On 8/11/24 at 10:04 AM, an observation was made of the 200 hall at the facility. There was noted to be a strong urine odor in the hallway near the entrance to room [ROOM NUMBER]. On 8/12/24 at 10:22 AM, an observation was made of the 300 hall at the facility. There was noted to be a strong urine odor throughout the hallway. On 8/13/24 at 8:10 AM, an observation was made of the main lobby. There was noted to be a strong odor of urine. On 8/13/24 at 11:35 AM, an observation was made of a strong urine odor in the solarium. On 8/14/24 at 7:36 AM, an observation was made of the 200 hall at the facility. There was noted to be a strong urine odor throughout the hallway. On 8/14/24 at 11:30 AM, an observation was made of the 100 hall locked unit. There was a strong urine odor when entering the 100 hallway. (continued on next page)

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F 0923 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	33215 30563 48709 50200