STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465112	A. Building B. Wing	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Monument Healthcare Bountiful	460 West 2600 South Bountiful, UT 84010

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 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** 50200 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, were 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, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the State Survey Agency (SSA). Specifically, for 1 out of 18 sampled residents, the facility did not report to the SSA when a resident sustained a fracture during a transportation. Resident identifier: 20 Finding included: Resident 20 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which include, but not limited to, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, atherosclerotic heart disease, type 2 diabetes mellitus, unspecified asthma, fatty liver, anxiety disorder, major depressive disorder, essential hypertension, muscle weakness, and cognitive communication deficit. A review of resident 20's progress notes revealed the following: a. On 11/18/24 at 12:00 AM, a speech therapy note documented, . SLP [speech language pathologist] instructed pt [patient] to recall appointment 3 days prior. Pt unable to recall appointment three days prior indicating decrease short term recall skills. With max [maximum] verbal cues, Patient able to recall going to appointment and falling out of wheelchair. SLP reviewed strategies to prevent falls from wheelchair and from bed in which patient verbalized understanding. b. On 11/19/24 at 3:19 PM, a health states note documented, Note Text: ADON [Assistant Director of Nursing] noted an abrasion that has scabbed over her right knee and asked what happened and patient said 'Oh I fell when I went to the eye doctor.' ADON asked how she fell and she said the wheelchair tipped over and the driver asked strangers for help. She doesn't recall any other information. No other injuries noted. NP [Nurse Practitioner] [name redacted] in the building and informed him. [Name redacted] also assessed the patient and said that she is fine. DON [Director of Nursing] made aware. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465112	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/18/2024
NAME OF PROVIDER OR SUPPLIER: Monument Healthcare Bountiful		STREET ADDRESS, CITY, STATE, ZIP CODE: 460 West 2600 South Bountiful, UT 84010	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. On 11/20/24 at 12:00 AM, a speech therapy note documented, . To increase short term recall skills, SLP instructed pt to recall appointment 3 days prior. Pt unable to recall appointment three days prior indicating decrease short term recall skills. With max verbal cues, Patient able to recall going to appointment and falling out of [sic] wheelchair. d. On 11/26/24 at 1:32 PM, a note documented, Note Text: pt complaining of Bilateral knee and hip pain. pt was assessed by [facility contracted name redacted] provider who ordered bilateral knee and bilateral hip x rays. e. On 11/27/24 at 12:45 AM, a radiology results note documented, Note Text: Requested and received XR [x-ray] results for L [left] knee, pelvis and bilat [bilateral] hips, all findings normal, results to MD [Medical Doctor]. f. On 11/27/24 at 9:33 AM, a progress note documented the following, Note Text: Resident complaining of severe pain to Rt. [right] knee. Bruising present, site warm to touch, abrasion noted to shin. Ice packs applied. recent xrays performed to Lt. [left] knee with no abnormal findings. Resident requesting xrays to be done on Rt. knee. g. On 11/27/24 at 10:11 AM, an alert charting note documented, Change of Condition Summary: Message left for provider to return call regarding Rt knee and if we need to x ray. Nurse manager printed xray report for this nurse, this nurse messaged Provider. Awaiting orders. h. On 11/27/24 at 12:26 PM, an alert charting note documented, Change of Condition Summary: Radiology called this nurse with critical FX [fracture] to Rt Leg/knee. [medical provider name redacted] aware here at facility. i. On 11/27/24 at 12:46 PM, a communication with physician note documented, Note Text: [Medical provider name redacted] here. N.O. [new order] to send pt to ER [emergency room] for TX [treatment] and Eval. [evaluation] Non-ER ambulance called/report given. Copy of Face Sheet and meds [medications] ready for pick up. Message left for stepdaughter, [name redacted] about N.O. results. j. On 11/27/24 at 5:30 PM, a progress note documented, Note Text: [Resident 20] returned from the hospital r/t [related to] pain and fx. She has a knee immobilizer in place. The hospital reports a complicated slightly displaced metaphysis fx of the distal right femur. This is an extensive surgery to repair, d/t [due to] comorbid conditions, there is significant risk to doing a surgery like this. Use the immobilizer, continue Non weightbearing in wheelchair as needed. Please see pt visit notes. On 12/18/24 at 1:03 PM, an interview was conducted with the DON. The DON stated that when she first heard about the allegation with resident 20 falling with the transport company, she notified the previous administrator on 11/19/24. The DON stated on 11/19/24, she did not believe that this was a reportable incident. The DON stated that when the x-ray results came back on 11/26/24, for resident 20 and resident 20 was found to have sustained a fracture due to the fall she notified the previous administrator again and left that up to him to report it. The DON stated that the fracture would be a reportable incident. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Monument Healthcare Bountiful		STREET ADDRESS, CITY, STATE, ZIP CODE 460 West 2600 South Bountiful, UT 84010	

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/18/24 at 1:40 PM, an interview was conducted with the Administrator (ADMIN). The ADMIN stated that there were no reports filed with the SSA in regards to the fall with a fracture for resident 20. The ADMIN stated when the patient had complained of pain and it was identified through x-rays that there was a fracture he would have reported it. The ADMIN stated that something like this should be reported to the SSA within 24 hours. The ADMIN stated that in this situation he would not have any concerns of neglect or harm for resident 20. The ADMIN stated that he would have reported it to the SSA as a fracture.

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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** 33215 Based on interview and record review, the facility assessment did not accurately reflect the resident's status. Specifically, for 2 out of 18 sampled residents, a resident who was receiving hospice services was not coded on two quarterly Minimum Data Set (MDS) assessments and an annual MDS assessment as receiving hospice services. In addition, a resident that had a Preadmission Screening and Resident Review (PASRR) Level II was not coded on the MDS as having one. Resident identifiers: 22 and 27. Findings included: 1. Resident 22 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, acute kidney disease, hypertensive heart disease with heart failure, atrial fibrillation, protein-calorie malnutrition, dementia, anxiety disorder, urticaria, and pain. On 12/16/24 at 9:41 AM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated that resident 22 was receiving hospice services. Resident 22's medical record was reviewed on 12/16/24 through 12/18/24. A hospice Clinical Summary note documented a hospice start of care date of 10/13/23. The quarterly MDS assessment dated [DATE], documented that resident 22 was not on hospice while a resident. The annual MDS assessment dated [DATE], documented that resident 22 was not on hospice while a resident. The quarterly MDS assessment dated [DATE], documented that resident 22 was not on hospice while a 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 12/17/24 at 1:41 PM, an interview was conducted with the MDS Coordinator. The MDS Coordinator stated that she made a schedule and the whole building ran on that schedule for completing the MDS assessments. The MDS Coordinator stated that she would give the schedule to the department heads. The MDS Coordinator stated that she did not want the nurses over loaded with to many assessments so she would spread the assessments out. The MDS Coordinator stated that Social Services would do the Brief Interview for Mental Status score and the Patient Health Questionnaire-9. The MDS Coordinator stated that she would go over all the other questions with the residents that no one else asked. The MDS Coordinator stated that Social Services, Activities, and the Director of Nursing would do their annual MDS assessment off of the schedule she provided them. The MDS Coordinator stated that Social Services completed sections C, D, E, and Q on the MDS assessment. The MDS Coordinator stated that Activities completed section F on the admission MDS assessment and the annual MDS assessment for Skilled Nursing Facility residents. The MDS Coordinator stated that she completed all other sections on the MDS assessment. The MDS Coordinator stated an Interdisciplinary Team meeting would be held to discuss section GG and they would use the nursing assessments. The MDS Coordinator stated that section O on the MDS assessment was gathered from the many assessments. The MDS Coordinator stated the first place she would look to see if a resident was on hospice services would be the printed daily census but resident 22 was listed as private. The MDS Coordinator stated that she would also look in the census section of the residents medical record but resident 22 was listed as private pay there also. The MDS Coordinator further stated that on the Special Instructions section of resident 22's medical record the hospice company was listed. 38031 2. Resident 27 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which consisted of, but were not limited to, arthrogryposis multiplex, functional quadriplegia, chronic kidney disease, schizotypal disorder, major depressive disorder, and generalized anxiety disorder. Resident 27's medical record was reviewed on 12/16/24 through 12/18/24. On 6/17/22, the PASRR Level II was completed for resident 27. The assessment documented resident 27's diagnoses under Section 7 were schizotypal personality disorder, generalized anxiety disorder, and major depressive disorder. On 6/23/22, the PASRR Letter of Determination documented that resident 27 had been approved for Nursing Facility Services and Recommendations for specialized services were available on the PASRR evaluation. On 11/1/24, resident 27's significant change MDS assessment documented under section A1500 PASRR a No response to the question was the resident currently considered by the state level II PASRR process to have a serious mental illness. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/18/24 at 11:30 AM, an interview was conducted with the MDS Coordinator. The MDS Coordinator stated that Section A on the admission or annual MDS Assessment was where the question on PASRR was located. The MDS Coordinator confirmed that the 11/1/24, significant change assessment documented a No response to the question was the resident currently considered by the state Level II PASRR process to have a serious mental illness. The MDS Coordinator stated that she would look for the information to that question in the resident electronic medical record under documents for a Level II PASRR. The MDS Coordinator stated that the PASRR Letter of Determination said that resident 27 was approved for medical services but it did not say that resident 27 had a Serious Mental Illness (SMI) or an Intellectual Disability. The MDS Coordinator stated that she only reviewed the letter of determination when answering the PASRR question in section A of the MDS assessment because the letter of determination summarized the PASRR Level II evaluation. The MDS Coordinator reviewed the PASRR Level II assessment from 6/17/22, and stated that section 4 of the assessment documented that resident 27 had a SMI. The MDS Coordinator stated that she did not verify with the PASRR level II evaluation before she made the determination to answer question A1500 to the negative. The MDS Coordinator stated that she made the determination to answer No to the question based on the information contained within the letter of determination. The MDS Coordinator stated that it was her responsibility to read the entire PASRR Level II evaluation and based on the evaluation question A1500 should have been marked Yes.

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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** 50200 Based on interview and record review, the facility did not ensure that residents received adequate supervision and assistance devices to prevent accidents. Specifically, for 1 out of 18 sampled residents, a resident slid out of her wheelchair during a transport and sustained a femur fracture. Resident identifier: 20 Finding included: Resident 20 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which include, but not limited to, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, atherosclerotic heart disease, type 2 diabetes mellitus, unspecified asthma, fatty liver, anxiety disorder, major depressive disorder, essential hypertension, muscle weakness, and cognitive communication deficit. A quarterly Minimum Data Set assessment dated [DATE], documented that resident 20 had a Brief Interview of Mental Status (BIMS) score of 11. A BIMS score of 8 to 12 would suggest moderate cognitive impairment. In addition, section GG functional range of motion revealed that resident 20 had impairment on both sides in the lower extremities. A review of resident 20's progress notes revealed the following: a. On 11/18/24 at 12:00 AM, a speech therapy note documented, . SLP [speech language pathologist] instructed pt [patient] to recall appointment 3 days prior. Pt unable to recall appointment three days prior indicating decrease short term recall skills. With max [maximum] verbal cues, Patient able to recall going to appointment and falling out of wheelchair. SLP reviewed strategies to prevent falls from wheelchair and from bed in which patient verbalized understanding. SLP and patient discussed possible electric wheelchair for patient in which SLP provided wheelchair company with patient's information. SLP reviewed strategies to prevent falls and prevent cognitive communication decline. b. On 11/19/24 at 3:19 PM, a health status note documented, Note Text: ADON [Assistant Director of Nursing] noted an abrasion that has scabbed over her right knee and asked what happened and patient said 'Oh I fell when I went to the eye doctor.' ADON asked how she fell and she said the wheelchair tipped over and the driver asked strangers for help. She doesn't recall any other information. No other injuries noted. NP [Nurse Practitioner] [name redacted] in the building and informed him. [Name redacted] also assessed the patient and said that she is fine. DON [Director of Nursing] made aware. c. On 11/20/24 at 12:00 AM, a speech therapy note documented, . To increase short term recall skills, SLP instructed pt to recall appointment 3 days prior. Pt unable to recall appointment three days prior indicating decrease short term recall skills. With max verbal cues, Patient able to recall going to appointment and falling out of [sic] wheelchair. d. On 11/26/24 at 1:32 PM, a note documented, Note Text: pt complaining of Bilateral knee and hip pain. pt was assessed by [facility contracted name redacted] provider who ordered bilateral knee and bilateral hip x rays. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	e. On 11/27/24 at 12:45 AM, a radiology results note documented, Note Text: Requested and received XR [x-ray] results for L [left] knee, pelvis and bilat [bilateral] hips, all findings normal, results to MD [Medical Doctor]. f. On 11/27/24 at 9:33 AM, a progress note documented the following, Note Text: Resident complaining of severe pain to Rt. [right] knee. Bruising present, site warm to touch, abrasion noted to shin. Ice packs applied. recent xrays [sic] performed to Lt. [left] knee with no abnormal findings. Resident requesting xrays [sic] to be done on Rt. knee. g. On 11/27/24 at 10:11 AM, an alert charting note documented, Change of Condition Summary: Message left for provider to return call regarding Rt knee and if we need to x ray. [sic] Nurse manager printed xray [sic] report for this nurse, this nurse messaged Provider. Awaiting orders. h. On 11/27/24 at 12:26 PM, an alert charting note documented, Change of Condition Summary: Radiology called this nurse with critical FX [fracture] to Rt Leg/knee. [medical provider name redacted] aware here at facility. i. On 11/27/24 at 12:46 PM, a communication with physician note documented, Note Text: [Medical provider name redacted] here. N.O. [new order]to send pt to ER [emergency room] for TX [treatment] and Eval. [evaluation] Non-ER ambulance called/report given. Copy of Face Sheet and meds [medications] ready for pick up. Message left for stepdaughter, [name redacted] about N.O. results. j. On 11/27/24 at 5:30 PM, a progress note documented, Note Text: [Resident 20] returned from the hospital r/t [related to] pain and fx. She has a knee immobilizer in place. The hospital reports a complicated slightly displaced metaphysis fx of the distal right femur. This is an extensive surgery to repair, d/t [due to] comorbid conditions, there is significant risk to doing a surgery like this. Use the immobilizer, continue Non weightbearing [sic] in wheelchair as needed. Please see pt visit notes. A review of resident 20's physician's orders revealed: a. On 11/26/24 at 1:14 PM, obtain 3 View x ray [sic] of R [right] knee and R hip one time only for r hip and r knee pain for 1 Day. b. On 11/26/24 at 1:20 PM, obtain 3 view L knee and L hip x ray one time only for L hip and L knee pain for 1 Day. A review of resident 20's hospital emergency room history and physical dated 11/27/24, documented . Patient is complaining of significant pain primarily in the right hip she does report having a fall where she slid out of her wheelchair 1 week ago, she has had ongoing pain with pain in the right knee, pain primarily in the right hip. A review of resident 20's November 2024 Medication Administration Record revealed: a. On 11/20/24, an as needed (PRN) Percocet Tablet 5-325 milligram (mg) was administered for a pain score of 6. b. On 11/25/24, a PRN Percocet Tablet 5-325 mg was administered for a pain score of 9. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	c. On 11/26/24, a PRN Percocet Tablet 5-325 mg was administered for a pain score of 6. It should be noted that resident 20 did not receive PRN Percocet for pain on any other days in November 2024. On 12/17/24 at 10:55 AM, an interview was conducted with the DON. The DON stated that the van driver from the contracted company did not inform the facility that resident 20 had fallen out of her wheelchair during transport to an appointment. The DON stated that resident 20 started complaining of pain on 11/26/24. The DON stated that orders for x-rays were obtained and x-rays were completed. On 12/18/24 at 9:17 AM, an interview was conducted with the ADON. The ADON stated that she noticed an abrasion on resident 20's right knee and asked resident 20 what happened. The ADON stated that resident 20 informed her that she fell during transportation and the driver had to get help from strangers. The ADON stated the NP went in and assessed resident 20 the same day. The ADON stated that resident 20 denied any other injuries and there was no swelling to her right knee. On 12/18/24 at 10:11 AM, an interview was conducted with the Administrator (ADMIN). The ADMIN stated that he was not the Administrator at the time the incident occurred. The ADMIN stated that the only information he had about the fall with resident 20 was a statement given by the van driver from the contracted transport company. The ADMIN stated that he reviewed the contract the facility had with transport company and the company had been used by the facility since February 2024. The ADMIN stated that his expectations were that if an incident occurred with a resident during transport the facility should be notified. On 12/18/24 at 10:36 AM, an interview was conducted with the ADMIN and the DON. The ADMIN stated that the transport driver did notify the Admissions Coordinator that resident 20 slid out of her wheelchair and he had to stop to get help to boost her up. The ADMIN stated that the Admissions Coordinator asked the transport driver to notify resident 20's nurse. The DON stated that her expectations of staff were to assess the resident and document in the progress notes the findings. The DON stated that she became aware of the incident on 11/19/24, when the ADON noticed that resident 20 had a scabbed over abrasion on her knee. The DON stated that was when resident 20 informed the ADON that she fell out of her wheelchair during transport. The DON stated that she requested a written statement by the transport driver about what occurred with resident 20. On 12/18/24 at 10:45 AM, an interview was conducted with the SLP. The SLP stated that resident 20 had informed her on 11/18/24, that resident 20 had slid out of the wheelchair during transport. The SLP stated that resident 20 informed her that her knee was painful. The SLP stated that she informed the DON on 11/18/24. The SLP stated that she did not make a progress note that she alerted staff and she should have. On 12/18/24 at 10: 58 AM, an interview was conducted with Registered Nurse (RN) 2. RN 2 stated that the van driver did report to her that resident 20 slid out of her wheelchair and hit her knee. RN 2 stated that it was close to shift change and she put resident 20 back into bed. RN 2 stated that she did not ask resident 20 anything about what happened, if she was injured, or in any pain. RN 2 stated she did not assess resident 20. RN 2 stated that she did not chart anything in resident 20's medical record about what had occurred. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 12/18/24 at 11:12 AM, a phone interview was conducted with the contracted transportation company van driver. The van driver stated that on 11/15/24, he was taking resident 20 to a doctors appointment. The van driver stated that as he was driving resident 20, she informed him that she was sliding out of her wheelchair. The van driver stated that he stopped in the parking lot of a local school. The van driver stated that resident 20 had slid down in her wheel chair and the seatbelt was wrapped around resident 20's chest and resident 20's lower half was dangling in the air. The van driver stated that he was unable to pull resident 20 back up in her chair. The van driver stated he flagged down a mail man to call for help from security inside the school. The van driver stated that after a bit of time, someone from the school came out to assist him. The van driver stated that he instructed the security personnel to lift resident 20 under the arms and he would pick resident 20 up from her legs and lift her back up into the wheelchair. The van driver stated that it was company policy that if they were transporting someone and they fell on to the floor then he would have to call 911. The van driver stated that resident 20 was held in her chair by the seatbelt and was not fully onto the ground and that was why he continued taking her to the appointment. The van driver stated that resident 20 stated she was okay and wanted the van driver to put her fluffy socks back onto her feet because they fell off while she slid down. The van driver stated that he contacted his boss and requested the mini van to transport resident 20 back to the facility because the resident's wheelchair would be facing a different direction and she would be more secure. The van driver stated that he followed the mini van back to the facility and did not transport resident 20 back to the facility. The van driver stated that he took resident 20 back inside the facility and informed the Admissions Coordinator about what happened. The van driver stated that he spoke with the nurse who was caring for resident 20 and informed her of what happened because he was worried that resident 20 was injured. The van driver stated that he spoke with the nurse in charge about what happened, but could not recall her name. The van driver stated that resident 20 told him that she slid down in her wheelchair often. On 12/18/24 at 1:12 PM, a phone interview was conducted with the Admissions Coordinator (AC). The AC stated that resident 20 had gone to an appointment and upon return, the van driver informed her that resident 20 had slipped out of her wheelchair. The AC stated the van driver informed her that he was able to pull resident 20 back up and into her wheel chair. The AC stated that she informed the van driver to report it to the charge nurse. The AC stated that she could not recall who the charge nurse was that day. The AC stated that she did not think that slipping out of a wheel chair was a problem and she did not report it to anyone.

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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** 38031 Based on observation, interview, and record review, the facility did not ensure that pain management was provided to residents who required services consistent with professional standards of practice and the comprehensive person-centered care plan and the resident's goals and preferences. Specifically, for 1 out of 18 sampled residents, a resident was not provided pain medications prior to wound care treatments nor afterwards and the resident had complaints of pain throughout the treatment. Resident identifier: 42. Findings included: Resident 42 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included, but were not limited to, orthostatic hypotension, anemia, chronic kidney disease, dementia, pain, abrasion right foot, anxiety disorder, pressure ulcer right and left heel unstageable, restless leg syndrome, presence right knee joint, peptic ulcer, depression, and anorexia. On 12/16/24 at 9:06 AM, an interview was conducted with resident 42. Resident 42 stated that he had pain in the right knee and right toes. A healed surgical scar was observed on resident 42's right knee. Resident 42 stated that his current pain was an 8 out of 10 on a pain scale with 10 being the worse pain possible. Resident 42 stated that the staff had not given him anything for his pain and he had not requested anything for it yet. Resident 42's medical record was reviewed on 12/16/24 through 12/18/24. On 11/19/24, resident 42's Minimum Data Set (MDS) assessment documented a Brief Interview for Mental Status score of 8 out of 15 which would indicate a moderate cognitive impairment. The MDS assessment documented that resident 42 was dependent on staff for toileting hygiene, lower body dressing, and putting on and taking off footwear; and was a substantial/maximal staff assist for showers, rolling left to right, sitting to lying, sit to stand, and transfers. Resident 42's physician's orders revealed the following: a. On 10/13/24, an order was initiated for Acetaminophen Oral Tablet 500 milligram (mg), give two tablets by mouth every eight hours as needed for pain. b. On 10/13/24, an order was initiated for a pain evaluation to be conducted every shift. c. On 12/6/24, an order was initiated for Morphine Sulfate (Concentrate) Oral Solution 20 mg/milliliter (ml), give 0.25 ml by mouth every hour as needed for pain. (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 0697 Level of Harm - Actual harm Residents Affected - Few	Resident 42's December 2024 Medication Administration Record (MAR) documented pain scores of 1 to 4 with the majority of scores being a 0. The MAR documented on 12/6/24, a pain score of 8 out of 10. The MAR documented that Tylenol was administered 10 times for pain scores of 1 to 8 and all administrations were documented as effective. On 12/6/24, Morphine was ordered and no documentation of administration was noted. On 12/16/24, the MAR documented that the resident was last given Tylenol at 4:19 PM, and the medication was documented as effective. On 12/17/24 for the morning shift the licensed nurse documented a pain score of 0 out of 10. On 12/11/24, the Pressure Injury and Wound evaluation documented a right and left heel pressure ulcer. The right heel measured 3.7 centimeter (cm) length x (by) 6.8 cm width x 0.3 cm depth. The wound was documented as unstageable with obscured full-thickness skin and tissue loss. The left heel measured 3.5 cm x 3.5 cm x 0.3 cm. The wound was documented as unstageable with obscured full-thickness skin and tissue loss. On 8/28/24, resident 42 had a care plan initiated for at risk for pain related to inflammation of prosthetic devices, restless leg syndrome, pressure ulcers and Peptic ulcer. Interventions identified on the care plan included: Administer analgesia medication as per orders; Anticipate need for pain relief and respond as soon as possible to any complaint of pain; Monitor/document for side effects of pain medication; Monitor/record/report to nurse resident complaints of pain or requests for pain treatment; and Notify physician if interventions were unsuccessful or if current complaint was a significant change from residents past experience of pain. On 12/17/24 at 8:40 AM, an interview was conducted with Certified Nurse Assistant (CNA) 1. CNA 1 stated that resident 42 was dependent on staff for cares and mostly stayed in bed. CNA 1 stated that resident 42 had pain in his right knee from a previous surgery and he did not like to straighten that leg. CNA 1 stated that the knee stayed bent and they propped a pillow underneath it for comfort and support. CNA 1 stated that resident 42 complained of pain with any movement of that knee and leg and would become agitated with cares. CNA 1 stated that resident 42 had wounds on both feet and the podus boots were to be worn while the resident was in bed. On 12/17/24 at 10:46 AM, an interview was conducted with Registered Nurse (RN) 3. RN 3 stated that resident 42 was alert and oriented to self only. RN 3 stated that resident 42 had dementia with occasional confusion, and had both short and long term memory deficits. RN 3 stated that resident 42 complained of pain in the bilateral heels and the right knee. RN 3 stated that resident 42 had pressure ulcers on both heels and his right knee was contracted due to a previous surgery. RN 3 stated that she evaluated resident 42's pain using the Pain Assessment in Advanced Dementia scale. RN 3 stated that resident 42 would vocalize pain with any wound care and dressing changes and would start to yell. RN 3 stated that resident 42 had both Tylenol and Morphine ordered for pain management. RN 3 stated that the Morphine was a new order and had not been administered yet. RN 3 stated that she evaluated resident 42's pain during the scheduled medication administration times and with any wound care. RN 3 stated that the Tylenol was effective if it was given in the morning and evening and she thought it controlled resident 42's pain. RN 3 stated that she liked to administer Tylenol before or after wound care because the wound care was uncomfortable for him. (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 0697 Level of Harm - Actual harm Residents Affected - Few	On 12/17/24 at 11:58 AM, an observation was made of RN 3 performing wound care on resident 42's bilateral heel pressure ulcers. RN 3 gathered her wound care supplies and donned a gown and gloves for wound care. RN 3 asked resident 42 prior to wound care what his level of pain was and the resident stated it was a 2 out of 10 and the right foot was worse than the left. RN 3 attempted to reposition resident 42 and attempted to straighten the right leg. Resident 42 was observed moaning during the repositioning of the legs. RN 3 removed the podus boot and sock from resident 42's right foot. Resident 42 stated Owe, watch that heel. RN 3 removed the podus boot and sock from left foot and resident 42 moaned in pain. RN 3 removed the old dressing from the right heel and resident 42 moaned. RN 3 placed a 2 x 2 gauze that was soaked in wound cleanser on the wound bed. Resident 42 moaned and stated owe. RN 3 wiped the wound bed in a circular motion with the gauze and resident 42 moaned in pain throughout the wound care that was provided to the right heel. RN 3 asked resident 42 if he wanted some Tylenol and resident 42 replied no. RN 3 again asked if she could bring him some Tylenol and resident 42 replied okay. RN 3 doffed her Personal Protective Equipment and exited the room to obtain more wound care supplies. RN 3 returned with more wound care supplies and donned a gown and gloves. RN 3 did not administer any Tylenol to resident 42. RN 3 removed the old dressing from the left heel and stated that slough came off with the dressing. The dressing was observed to stick to the wound bed during removal. RN 3 stated that the left heel wound was open to the bone. RN 3 applied a 2 x 2 gauze dressing soaked in wound cleanser to the wound bed and the wound was cleaned using a circular motion. Resident 42 was observed to moan throughout the dressing change to the left foot. Upon completion of the wound care RN 3 told resident 42 that she would bring him some Tylenol along with a protein drink. RN 3 exited the resident room. On 12/17/24 at 3:17 PM, a follow-up interview was conducted with RN 3 RN 3 stated that she did not attempt to premedicate resident 42 with pain medication prior to wound care today. RN 3 stated that premedicating with pain medication helped resident 42 and she should have done that. RN 3 stated that she still had not administered any pain medication to resident 42. On 12/18/24 at 8:08 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that for any pain associated with wound care the licensed nurse should administer pain medication 30 to 40 minutes prior to wound care. The DON was informed of the wound care observation with resident 42 and the observations of pain. The DON stated, he has a morphine order too. The DON was informed that the resident had not been administered pain medication prior to wound care nor afterwards up until 3:17 PM, no further comment was provided.

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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 signed and dated reports of radiological services. Specifically, for 1 out of 18 sampled residents, a resident's x-ray report was not located in the medical record. Resident identifier: 20 Findings included: Resident 20 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which include, but not limited to, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, atherosclerotic heart disease, type 2 diabetes mellitus, unspecified asthma, fatty liver, anxiety disorder, major depressive disorder, essential hypertension, muscle weakness, and cognitive communication deficit. Resident 20's medical record was reviewed on 12/16/24 through 12/18/24. A review of resident 20's progress notes revealed the following: a. On 11/26/24 at 1:32 PM, a progress note documented, Note Text: pt [patient] complaining of Bilateral knee and hip pain. pt was assessed by [facility contracted name redacted] provider who ordered bilateral knee and bilateral hip x rays [sic]. b. On 11/27/24 at 12:45 AM, a radiology results note documented, Note Text: Requested and received XR [x-ray] results for L [left] knee, pelvis and bilat [bilateral] hips, all findings normal, results to MD [Medical Doctor]. c. On 11/27/24 at 9:33 AM, a progress note documented the following, Note Text: Resident complaining of severe pain to Rt. [right] knee. Bruising present, site warm to touch, abrasion noted to shin. Ice packs applied. recent xrays [sic] performed to Lt. [left] knee with no abnormal findings. Resident requesting xrays [sic] to be done on Rt. knee. d. On 11/27/24 at 10:11 AM, an alert charting note documented, Change of Condition Summary: Message left for provider to return call regarding Rt knee and if we need to x ray [sic]. Nurse manager printed xray [sic] report for this nurse, this nurse messaged Provider. Awaiting orders. e. On 11/27/24 at 12:26 PM, an alert charting note documented, Change of Condition Summary: Radiology called this nurse with critical FX [fracture] to Rt Leg/knee. [medical provider name redacted] aware here at facility. An x-ray report for resident 20's right knee was not found in the medical record. On 12/17/24 at 10:55 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that resident 20 had x-rays performed on her bilateral knees and hips. The DON stated that the facility had received printed reports for resident 20's left knee and bilateral hips, but did not receive a printed report for the right knee. The DON stated that she would provide me a copy of the report once she obtained it. (continued on next page)

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F 0779 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/18/24 at 9:25 AM, the Regional Clinical Operations Director provided a copy of the x-ray report of resident 20's right knee.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38031 Based on observation, interview, and record review, the facility did not maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Specifically, for 1 out of 18 sampled residents, hand hygiene and donning and doffing of Personal Protective Equipment (PPE) was not performed appropriately during a wound care treatment observation. Resident identifier: 42. Findings included: Resident 42 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included, but were not limited to, orthostatic hypotension, anemia, chronic kidney disease, dementia, pain, abrasion right foot, anxiety disorder, pressure ulcer right and left heel unstageable, restless leg syndrome, presence right knee joint, peptic ulcer, depression, and anorexia. On 12/16/24 at 9:06 AM, an interview was conducted with resident 42. Resident 42 stated that he had pain in the right knee and right toes. A healed surgical scar was observed on resident 42's right knee. Resident 42 was observed wearing bilateral podus boots on his feet. Resident 42 stated that he had wounds on the heels of both feet and he stated that the dressings were changed every three days. Resident 42 was observed lying on an air mattress with a pillow positioned under his right knee. Resident 42's medical record was reviewed on 12/16/24 through 12/18/24. On 11/19/24, resident 42's Minimum Data Set (MDS) assessment documented a Brief Interview for Mental Status score of 8 out of 15 which would indicate a moderate cognitive impairment. The MDS assessment documented that resident 42 was dependent on staff for toileting hygiene, lower body dressing, and putting on and taking off footwear; and was a substantial/maximal staff assist for showers, rolling left to right, sitting to lying, sit to stand, and transfers. Resident 42's physician's orders revealed the following: a. On 11/1/24, an order was initiated for Enhanced Barrier Precautions for wound every shift. b. On 12/16/24, an order was initiated for Wound care left heel: Cleanse with wound cleanser, apply skin prep to surrounding wound and then apply Medi-Honey and cover with border foam dressing. Change daily and PRN [as needed] one time a day for wound management AND as needed. c. On 12/16/24, an order was initiated for Right heel wound: Clean with wound cleanser, apply Medi-Honey, skin prep to surrounding skin then cover with foam dressing. Change daily and PRN. every day shift AND as needed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/11/24, the Pressure Injury and Wound evaluation documented a right and left heel pressure ulcer. The right heel measured 3.7 centimeter (cm) length x (by) 6.8 cm width x 0.3 cm depth. The wound was documented as unstageable with obscured full-thickness skin and tissue loss. The left heel measured 3.5 cm x 3.5 cm x 0.3 cm. The wound was documented as unstageable with obscured full-thickness skin and tissue loss. On 8/28/24, resident 42 had a care plan initiated for Enhanced Barrier Precautions. Interventions identified on the care plan included: [NAME] and Doff gown and glove as per facility protocol for high contact care activities; patient identifier placed on door frame; and perform hand hygiene per facility policy. On 10/17/24, resident 42 had a care plan initiated for impairment to skin integrity related to unstageable pressure injuries. Interventions identified on the care plan included: avoid scratching and keep hands and body parts from excessive moisture; keep fingernails short; encourage good nutrition and hydration in order to promote healthier skin; follow facility protocols for treatment of injury; monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, signs and symptoms of infection, maceration etc. to provider; and skin maintenance to prevent and treat bruises, injuries, pressure sores, and infection. On 12/17/24 at 8:40 AM, an interview was conducted with Certified Nurse Assistant (CNA) 1. CNA 1 stated that resident 42 was dependent on staff for cares and mostly stayed in bed. CNA 1 stated that resident 42 had pain in his right knee form a previous surgery and he did not like to straighten that leg. CNA 1 stated that the knee stayed bent and they propped a pillow underneath it for comfort and support. CNA 1 stated that resident 42 complained of pain with any movement of that knee and leg and would become agitated with cares. CNA 1 stated that resident 42 had wounds on both feet and the podus boots were to be worn while the resident was in bed. On 12/17/24 at 10:46 AM, an interview was conducted with Registered Nurse (RN) 3. RN 3 stated that resident 42 was alert and oriented to self only. RN 3 stated that resident 42 had dementia with occasional confusion, and had both short and long term memory deficits. RN 3 stated that resident 42 complained of pain in the bilateral heels and the right knee. RN 3 stated that resident 42 had pressure ulcers on both heels and his right knee was contracted due to a previous surgery. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/17/24 at 11:58 AM, an observation was made of RN 3 performing wound care on resident 42's bilateral heel pressure ulcers. RN 3 stated that the wound orders for the right and left heel were to cleanse the wound bed with wound cleaner, apply Medihoney to the wound bed, apply skin prep to the surrounding wound skin and to cover the wound with a foam dressing. RN 3 was observed to gather the wound care supplies. RN 3 squeezed approximately a tablespoon amount of Medihoney into a medication cup. RN 3 performed hand hygiene with Alcohol-based Hand Rub (ABHR). RN 3 was observed to open the wound cart drawer and take out multiple packages of 2 x 2 sterile gauze dressings. RN 3 tore open the package and pulled the sterile gauze out with her bare hands and placed them into a water cup and sprayed them with wound cleanser. RN 3 obtained two foam dressings and a package of sterile cotton tipped applicators. RN 3 sated that she had to donn a gown and gloves for wound care because resident 42 had an infection but she was not sure what the organism was. RN 3 donned a gown, performed hand hygiene with ABHR, and donned gloves just inside resident 42's room. RN 3 adjusted resident 42's bed height using the bed remote. RN 3 asked resident 42 prior to wound care what his level of pain was and the resident stated it was a 2 out of 10 and the right foot was worse than the left. RN 3 attempted to reposition resident 42 and attempted to straighten the right leg. Resident 42 was observed moaning during the repositioning of the legs. RN 3 removed the podus boot and sock from resident 42's right foot. Resident 42 stated Owe, watch that heel. RN 3 removed the podus boot and sock from left foot and resident 42 moaned in pain. RN 3 removed the old dressing from the right heel and resident 42 moaned. RN 3 stated that the wound had purulent drainage on the old dressing that was yellow and green in color. RN 3 placed a 2 x 2 gauze that was soaked in wound cleanser on the wound bed. Resident 42 moaned and stated owe. RN 3 wiped the wound bed in a circular motion with the gauze and resident 42 moaned in pain. RN 3 then removed her gloves and donned new gloves. RN 3 did not perform hand hygiene. RN 3 applied Medihoney to the wound bed with a sterile cotton tipped applicator. No measurements were obtained. RN 3 stated that the wound was improving, that it no longer bled with dressing changes, and the skin was starting to look more even. RN 3 then applied a foam dressing to cover the wound. RN 3 placed the sock and podus boot back on resident 42's right foot. RN 3 asked resident 42 if he wanted some Tylenol and resident 42 replied no. RN 3 again asked if she could bring him some Tylenol and resident 42 replied okay. RN 3 doffed her PPE and exited the room to obtain more wound care supplies. RN 3 was observed to place more 2 x 2 sterile gauze into the water cup with her bare hands and then sprayed them with wound cleanser. RN 3 returned to the resident room with the wound care supplies and donned a gown. RN 3 performed hand hygiene with ABHR and then donned a new pair of gloves. RN 3 removed the old dressing from the left heel and stated that slough came off with the dressing. RN 3 stated that the purulent drainage was less and there was a mild odor noted today. The dressing was observed to stick to the wound bed during removal. RN 3 stated that the left heel wound was open to the bone. RN 3 applied a 2 x 2 gauze dressing soaked in wound cleanser to the wound bed and the wound was cleaned using a circular motion. RN 3 then doffed her dirty gloves and donned new gloves. RN 3 did not perform hand hygiene. RN 3 applied Medihoney to the wound bed using a sterile cotton tipped applicator and then a bordered adhesive dressing was applied to the wound. RN 3 applied resident 42's left sock and podus boot. Resident 42 was observed to moan throughout the dressing change to the left foot. Upon completion of the wound care RN 3 told resident 42 that she would bring him some Tylenol along with a protein drink. RN 3 doffed her gown and gloves, performed hand hygiene with ABHR, and exited the resident room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/17/24 at 3:17 PM, a follow-up interview was conducted with RN 3. RN 3 stated that gloves should be changed after going from a dirty area to a clean area. RN 3 stated that she removed the old dirty dressing, cleaned the wound bed, and then changed her gloves. RN 3 stated that she performed hand hygiene upon entrance to the room and prior to donning gloves. RN 3 stated that hand hygiene should be performed between glove changes as well. RN 3 stated she should have changed her gloves and performed hand hygiene prior to cleaning the wound bed and applying the new treatment. On 12/18/24 at 8:08 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that her expectation for staff during wound care was that hand hygiene should be performed prior to donning any gloves. The DON stated that gloves needed to be changed when moving between a dirty to clean area. The DON stated that staff should doff dirty gloves, perform hand hygiene, and then donn clean gloves for each wound that was provided treatment and after removing an old bandage and before the new treatment was applied. The DON was informed of the wound care observation with resident 42 and no further comment was provided. Review of the facility policy and procedure for Handwashing/Hand Hygiene documented, 7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: a. Before and after coming on duty; b. Before and after direct contact with residents; c. Before preparing or handling medications; d. Before performing any non-surgical invasive procedures; e. Before and after handling an invasive device (e.g., urinary catheters, IV [intravenous] access sites); f. Before donning sterile gloves; g. Before handling clean or soiled dressings, gauze pads, etc.; h. Before moving from a contaminated body site to a clean body site during resident care; i. After contact with a resident's intact skin' j. After contact with blood or bodily fluids; k. After handling used dressings, contaminated equipment, etc.; l. After contact with objects (e.g. medical equipments) in the immediate vicinity of the resident; m. After removing gloves; The policy was last revised on February 1, 2024.