STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465115	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Terrace at MT Ogden	400 East 5350 South Ogden, UT 84405

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 50200 Based on observation and interview, it was determined for 1 out of 36 sampled residents, the facility did not treat each resident with respect and dignity and care for each resident in a manner in an environment that promoted maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. Specifically, a resident was covered in towels in a shower chair with the sides of her buttocks exposed and being pulled backwards through the hallway. Resident Identifier: 56. Findings included: Resident 56 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included, but were not limited to, hemiplegia and hemiparesis following cerebral infarction, type 2 diabetes mellitus, chronic obstructive pulmonary disease, bipolar disorder, major depressive disorder, adjustment disorder with anxiety, cognitive communication deficit, and muscle weakness. On 8/26/24 at 11:16 AM, an observation was made of resident 56 being pulled backwards in a shower chair by Certified Nursing Assistant (CNA) 3. Resident 56 was observed to be covered in towels with the sides of her buttocks exposed in the 200 hallway. A care plan Focus revealed ADL [activities of daily living] Self Care Performance Deficit r/t [related to] hemiplegia, stroke, weakness, edema, COPD [chronic obstructive pulmonary disease]. An intervention initiated on 7/18/24, included BATHING Requires staff participation with bathing. On 8/26/24 at 11:21 AM, an interview was conducted with resident 56. Resident 56 stated that this was the first time she had been pulled backwards through the hallway. Resident 56 stated that she had always been dressed in a shirt and at least a brief before she exited the shower room. Resident 56 stated she would prefer to be fully dressed after her shower before she was brought back to her room. On 8/26/24 at 11:42 AM, an interview was conducted with CNA 3. CNA 3 stated that it was not unusual for him to bring residents back to their rooms covered in towels to prevent the resident from getting their clothes wet. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/27/24 at 12:10 PM, an interview was conducted with Director of Nursing (DON). DON stated that it was not standard practice for residents to be wheeled backwards through the hallway covered in towels. DON stated that residents should be fully clothed with no sensitive area exposed.

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50200 Based on observation and interview the facility did not provide, 4 of 36 sampled residents, the right to have secured and confidential personal and medical records. Specifically, the computer screen was left open on the medication carts with resident personal information and a nurse report paper was left face up on the medication cart with resident personal information. Resident identifiers: 4, 8, 70, and 76. Findings included: On 8/25/24 at 1:46 PM, an observation was made of Licensed Practical Nurse (LPN) 2. LPN 2 was observed to leave the computer screen open on the medication cart in the 200 hallway and walked away from the computer down the hallway. Residents 8, 70, and 76 were observed to be near the medication cart. On 8/26/24 at 7:23 AM, an observation was made of Registered Nurse (RN) 5. RN 5 was observed to leave the computer screen open on the medication cart in the 200 hallway and walked into resident room [ROOM NUMBER]. Resident 4 was observed to be walking by the medication cart. On 8/27/24 at 7:30 AM, an observation was made of a nurse shift report left on top of a medication cart in the 200 hallway face up with resident personal information and unattended. An observation was made that the medication cart was left unattended for a period of 15 minutes. It was observed that resident 4 was walking the 200 hallway. On 8/29/24 at 11:07 AM, an interview was conducted with Director of Nursing (DON) 1. DON 1 stated that nurses should lock their computer screen any time they leave the medication cart unattended. DON 1 stated that nurse reports with any resident information should never be left out in the open.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 50200 Based on interview and record review, the facility did not develop and implement written policies and procedures that; prohibit and prevent abuse, neglect, and exploitation of residents. Specifically, for 2 out of 5 sampled staff members, the facility did not follow their abuse policy by screening prospective employees licenses prior to employee working with residents. Findings included: A review of employee records revealed the following: Employee 1 was a Nursing Assistant (NA) hired by the facility on 7/31/23, and started working on the floor on 8/10/23. There was no record of Employee 1's license being checked to verify that a previous license had not been obtained. Employee 2 was a Certified Nursing Assistant (CNA) was hired by the facility on 2/2/23, and started working on the floor on 3/6/23. Employee 2's license was verified on 7/28/23. A review of the facility's abuse policy and procedures revealed the following: . a. Screening: Prospective Employees 1. Prior to hire, the Facility will screen potential employees for a history of abuse, neglect, exploitation, or misappropriation of resident property in order to prohibit such abuse, neglect, exploitation, or misappropriation of resident property. This screening will include but not be limited to: Attempting to obtain information from previous employers and/or current employers, whether favorable or unfavorable Documentation of status and any disciplinary actions from licensing or registration boards and other registries. Reviewing the prospective employee's employment history, especially when there is or may be a pattern of inconsistency. 4. All CNAs and licensed employees will have their certificates or licenses verified through the State Board of Nursing. On 8/27/24 at 2:02 PM, an interview was conducted with the Human Resources (HR). The HR stated that a staff member's license or certification verification form was completed upon hire and then the CNA registry was checked. The HR stated that all licenses and certifications were to be checked prior to working with residents. The HR stated that the license check was printed off and then uploaded into the employee file. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/29/24 at 11:34 AM, an interview was conducted with the Administrator (ADM). The ADM stated that HR was the department that verified licenses for employees. The ADM stated that before staff could access the computers their licenses must be checked. The ADM stated that employee license verification must be done prior to the employee working with residents. The ADM stated that when a NA was hired, the process was to always check to see if they had a previous license. The ADM stated that he did not have any proof that the license was checked for Employee 1. The ADM stated he was not sure why it took several months for verification of Employee 2's license.

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 50200 Based on interview and record review, the facility did not ensure that the transfer or discharge was documented in the resident's medical record and appropriate information was communicated to the receiving health care institution or provider. Specifically, for 1 out of 36 sampled residents, a resident did not have any transfer documentation in their medical record when they were transferred to the hospital. Resident identifier: 8. Findings included: Resident 8 was admitted to the facility on [DATE] with diagnoses that include, but were not limited to, hereditary and idiopathic neuropathy, asthma, cognitive communication deficit, weakness, reduced mobility, borderline personality disorder, major depressive disorder, anxiety disorder, chronic obstructive pulmonary disease, malingerer, and panic disorder. Resident 8's medical record was reviewed from 8/25/24 to 8/29/24. Resident 8's progress notes revealed the following: a. On 7/26/24 at 12:12 AM, a nursing note documented, Resident's roommate came out into the hall asking for help and stating that [resident name redacted] was on the floor. When I walked in, she was lying on the floor in front of her TV, lying on her R [right] side. I tried to assess for any injury. [Resident name redacted] was making intelligible comments, and she was unable to help get herself into a sitting position. Her roommate reported that 'she hit her head pretty hard'. She also said that she thinks that 'she may have been knocked out, she wouldn't answer me for several minutes'. EMS [emergency medical services] called and Resident transported via ambulance to [name of hospital redacted]. b. On 7/26/24 at 2:00 AM, a nursing note documented, returned from [name of hospital redacted] ED [emergency department] 7/26/24: Diagnosis from Today's Visit: 1. Altered Mental Status 2. Compression Fracture of L5 [fifth lumbar vertebra] vertebra 3. T12 [twelfth thoracic vertebra compression fracture f/u [follow up] Dr. [doctor] [name redacted] (Neurosurgery). On 8/27/24 at 11:58 AM, an interview was completed with the Corporate Resource Nurse (CRN). The CRN stated that when a resident was discharged or transferred to a hospital a face sheet, a list of resident's medications, and a copy of the bed hold agreement would go with the resident. The CRN stated that there was no information on resident 8's transfer to the hospital.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30563 Based on interview and record review, the facility did not provide written information to the resident or resident representative that specifies the duration of the state bed-hold policy, if any, during which the resident was permitted to return and resume residence in the nursing facility. Specifically, for 2 out of 36 sampled residents, resident's were transported to the hospital and were not informed of the facility bed-hold policy. Resident identifiers: 8 and 56. Findings included: 1. Resident 56 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, type 2 diabetes mellitus with diabetic neuropathy, chronic obstructive pulmonary disease, bipolar disease, and anemia. Resident 56's medical record was reviewed on 8/25/24 through 8/29/24. Resident 56's progress notes revealed on 4/5/24 at 6:20 PM, Called to residents' room by her mother stating her daughter doesn't seem right, I entered the room and noticed residents' right side of mouth drooping, resident slurring her words, very dry mouth, unable to tell me her name, could not tell me what day it was or who the president was, she was able to recognize her mother, extremely drowsy falling asleep while attempting to speak, unable to hold her eyes open but does respond to painful stimuli, all sedating medication have been held all day d/t [due to] lethargy and excessive sleepiness per nursing report, . 911 called resident transported to hospital, mother was here and aware, another nurse called on call provider and on call nursing. There was no information regarding a bed hold agreement in resident 56's medical record. On 8/29/24 at 8:32 AM, an interview was conducted with the Corporate Resource Nurse (CRN). The CRN stated that there was an envelope with paperwork the nurse sent to the hospital with the resident. The CRN stated the bed hold form was given in the envelope that was sent with the resident to the hospital. The CRN stated there was a form on the envelope that had the information provided on it. The CRN stated that form was then scanned into the residents medical record. The CRN stated that there were no bed holds in resident 56's medical record. 50200 2 Resident 8 was admitted to the facility on [DATE] with diagnoses that include, but were not limited to, hereditary and idiopathic neuropathy, asthma, cognitive communication deficit, weakness, reduced mobility, borderline personality disorder, major depressive disorder, anxiety disorder, chronic obstructive pulmonary disease, malingerer, and panic disorder. Resident 8's medical record was reviewed on 8/25/24 to 8/29/24. Resident 8's progress notes revealed the following: (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. On 7/26/24 at 12:12 AM, a nursing note documented, Resident's roommate came out into the hall asking for help and stating that [resident name redacted] was on the floor. When I walked in, she was lying on the floor in front of her TV, lying on her R [right] side. I tried to assess for any injury. [Resident name redacted] was making intelligible comments, and she was unable to help get herself into a sitting position. Her roommate reported that 'she hit her head pretty hard'. She also said that she thinks that 'she may have been knocked out, she wouldn't answer me for several minutes'. EMS [emergency medical services] called and Resident transported via ambulance to [name of hospital redacted]. b. On 7/26/24 at 2:00 AM, a nursing note documented, returned from [name of hospital redacted] ED [emergency department] 7/26/24: Diagnosis from Today's Visit: 1. Altered Mental Status 2. Compression Fracture of L5 [fifth lumbar vertebra] vertebra 3. T12 [twelfth thoracic vertebra compression fracture f/u [follow up] Dr. [doctor] [name redacted] (Neurosurgery). There was no information regarding a bed hold agreement found in resident 8's medical record. On 8/27/24 at 11:58 AM, an interview was conducted with the CRN. The CRN stated that when a resident was discharged or transferred to a hospital a face sheet, a list of the resident's medications, and a copy of the bed hold agreement would go with the resident. The CRN stated the packet with the bed hold agreement was given to EMS, but it never came back with the resident from the hospital.

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F 0689 Level of Harm - Minimal harm or potential for 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 interview and record review, the facility failed to ensure that each resident received adequate supervision to prevent accidents. Specifically, for 2 out of 36 sampled residents, a resident that was considered an elopement risk with a wandergaurd left the facility unattended and the resident was a smoker without a smoking assessment. In addition, another resident that had an unwitnessed fall and did not have neurological checks completed. Resident identifiers: 59 and 185. Findings included: 1. Resident 185 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, acute on chronic systolic congestive heart failure, moderate protein-calorie malnutrition, chronic obstructive pulmonary disease, mild intellectual disabilities, cognitive communication deficit, urinary tract infection, dementia, alcohol abuse, and essential hypertension. Resident 185's medical record was reviewed on 8/25/24. On 7/8/23 at 6:22 PM, the Elopement/Wandering Evaluation documented that resident 185 was a High Risk for wandering with a score of 11. A resident with a score of 10 to 55 was considered a High Risk. On 7/9/23 at 10:29 AM, a Nursing progress note documented Note Text: Pt. [patient] attempt to check out stating that he want [sic] to go home and get his money and shoes. Pt. was assist back to his room and friend on his contact was called. Pt. exhibit confusion. A care plan Focus initiated on 7/10/23, documented Elopement risk/wanderer r/t [relate to] History of attempts to leave facility unattended. The intervention initiated on 7/10/23, documented Document wandering behavior and attempted diversional interventions. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/10/23 at 3:22 PM, a Nursing progress note documented Note Text: Verbal Consent for Wander Guard and Patient Education This progress note documents an important discussion and intervention with the patient regarding their desire to leave the facility and concerns about their safety. The patient expressed a willingness to leave, even mentioning the possibility of exiting through a window if necessary. The nurse . [name redacted] and I obtained verbal consent from the patient to implement a wander guard system, and we also provided education on the importance of following the medical team's orders and ensuring a safe departure if and when it becomes appropriate. During a conversation with the patient, they expressed a strong desire to leave the facility, stating that they were ready to leave by any means necessary, including through a window. Recognizing the potential risk to their safety, the nurse . director and I engaged in a discussion with the patient to address their concerns and explore alternative solutions. We explained the concept of a wander guard system, which is designed to enhance patient safety by preventing unauthorized exits from the facility. After providing a clear explanation of the purpose and functionality of the wander guard, we obtained verbal consent from the patient to implement this measure. The patient demonstrated understanding of the purpose of the system and agreed to its implementation. Additionally, we took the opportunity to educate the patient on the importance of following the medical team's orders and completing the full course of antibiotics as prescribed. We emphasized that staying in the facility and receiving proper treatment would enhance their overall well-being and increase the chances of a successful recovery. We addressed any concerns or questions the patient had, ensuring they were well-informed and involved in their care decisions. A physician's order dated 7/10/23 at 3:41 PM, documented Check Wandergaurd Placement at the beginning of every Shift every shift for wander guard. Discontinued on 9/23/23. On 7/13/23, a St. Louis University Mental Status (SLUMS) Examination documented that resident 185 had dementia with a score of 1 to 20. An admission Minimum Data Set assessment dated [DATE], documented that resident 185 had a Brief Interview for Mental Status (BIMS) score of 11. A BIMS score of 8 to 12 indicated moderate impairment. On 7/25/23, a SLUMS Examination documented that resident 185 had dementia with a score of 1 to 20. On 7/26/23 at 4:01 PM, a Nursing progress note documented Note Text: Resident removed wander guard on NOC [night] shift, wander guard was found on bed table, Wander guard reapplied to right wrist. On 8/26/23 at 1:47 PM, a Nursing progress note documented Note Text: Resident removed wander guard this afternoon and returned it to his nurse stating that 'it slows him down.' New straps are pending delivery so there is no wander guard on at this time. Resident is currently lying down in his bed. Provider notified. Staff notified. Will reapply wander guard as soon as able to. On 8/26/23 at 8:10 PM, a Nursing progress note documented Note Text: Resident cut his wandergaurd off today. It was placed in the top drawer of the nurses cart, we are awaiting a delivery of new bands. Resident has been compliant with staying in the facility today. Will continue to monitor closely. On 9/16/23 at 2:55 PM, a Nursing progress note documented Note Text: Resident asked if he could go out this morning. When asked who he was going with he said no one. He was told that he couldn't leave the building by himself. He said he thought so, but he wanted to try. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/22/23 at 3:48 PM, a Nursing progress note documented Note Text: Resident called a friend this morning and she came to the facility and signed him out. They have not returned yet. He did take all medicaiton [sic] this morning. He has the wander guard on the right ankle. He has his belongings packed in boxes and sitting in front of his bed. On 9/23/23 at 2:42 PM, a Nursing progress note documented Note Text: resident went out to smoke with other residents. CNA [Certified Nursing Assistant] called saying resident was down by [name redacted] gas station refusing to come back to facility. Resident stated to CNA that Resident was 'going to get on the bus and go were the homeless people are.' ON callnursing [sic] manger [sic] reported above. On call nursing manager to call back with plan. (Note: Resident 185 did not have a smoking evaluation completed and a care plan that addressed smoking had not been developed.) On 9/23/23 at 2:52 PM, a Nursing progress note documented Note Text: on call nursing manger said to go over to [name redacted] store and try to get resident back. If resident will not come then call the police. on my way to store another floor nurse will watch my patients. On 9/23/23 at 3:19 PM, a Nursing progress note documented Note Text: Returned from [name redacted] store. On Call nursing supervisor called and reported that there was no sign of CNA or resident at [name redacted] and on my way back to facility. There [sic] The CNA who saw the resident at [name redacted] store was on his way home from work. 911 called reported protected patient missing last seen at [name redacted] store to catch a bus to where the homeless people are. Police officer to come to the facility. On 9/23/23 at 3:53 PM, a Nursing progress note documented Note Text: Police Officer [name redacted] came and got the information needed, looked at chart picture we have of resident. Policer [sic] is going to look for resident and bring him back if he can. On 9/23/23 at 10:35 PM, a Nursing progress note documented Note Text: R [resident] returned to facility tonight. R was alert and oriented X3 [person, place, and time]. Head to toe assessment done. No apparent signs of injuries noted. Skin looked intact. Vitals taken BP [blood pressure]: 131/76, Pulse 94, Resp [respirations] 18, Temp [temperature] 98. R was compliant and pleasant. Wander guard noted to hisL [sic] [left] foot. On 9/23/23 at 10:42 PM, a Skin Evaluation documented no apparent signs of injuries noted. Skin looked dry, warm and intact. No edema noted. A care plan Focus initiated on 7/10/23, documented Elopement risk/wanderer r/t History of attempts to leave facility unattended. The interventions initiated on 9/23/23, documented Q15 [every fifteen] minute checks, Supervision when outside of building and Wander Guard to left ankle. A physician's order dated 9/24/23 at 6:00 AM, documented Wander Guard placement and function every shift for wander guard. On 9/24/23 at 2:46 PM, the Elopement/Wandering Evaluation documented that resident 185 was a low risk for elopement with a score of 6. A resident with a score of 0 to 9 was considered a Low Risk. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/24/23 at 6:29 PM, an Alert Note progress note documented Note Text: Resident is alert, ox4 [oriented times four to person, place, time, and event], follows all commands, answers questions appropriately. Resident has not tried to leave facility grounds this shift. Resident was placed on Q [every] 15min [fifteen minute] watch while in building, 1:1 [one on one] while out smoking at approximately 15:00 [3:00 PM]. Reported to on coming nurse the above restrictions and gave her the q 15min monitor sheet. On 9/25/23 at 9:00 AM, an Interdisciplinary Team (IDT) Note progress note documented Text: IDT reviewed incident that occurred 9/23/2023. At approximately 2:30 pm, it was identified that resident had left the facility alone. Resident reported to a staff member that he 'wanted to live with the homeless people'. Facility was thoroughly searched, as well as, surrounding areas. Emergency response was issued to locate the resident (Police, UTA [Utah Transit Authority], emergency room s, Homeless Shelters convenience stores) were all notified. Emergency contact and primary physician were notified as well. Employees searched the streets of [NAME] for 6 hours until dark. At approximately 2122 [9:22 PM], resident returned to facility. Head to toe assessment completed, no injury noted. Wander guard placement/functionality assessed and found to be in working order. Provider notified. Police were also notified of residents return. Intervention: Resident was placed on Q15 minute visual checks and supervision when resident is outside of the building. On 9/25/23 at 6:36 PM, a Nursing progress note documented Note Text: Resident has had 15 minute checks and has been present for them. He walked past the nurse on the 200 hall way and the nurse followed behind. He went out the 200 side door and the door did not alarm. He had taken his wander guard off. He was followed inthem [sic] parking lot and the nurse was talking with him and asking him to stop and talk with her. He did go with a staff member and back into the building. He then became one on one in nurse management office. He has been watched closely. A new wander guard was put on his left ankle. On 9/25/23 at 8:49 PM, a Therapy progress note documented Note Text: The patient is experiencing difficulties remembering how to check himself out of the SNF [Skilled Nursing Facility] and has presented with increased memory loss that adversely impacts his safety, independence and well-being. He could benefit from ST [Speech Therapy] sessions implementing compensatory strategies so that he can return to his PLOF [prior level of functioning] successfully. On 9/26/23 at 7:38 PM, an Alert Note progress note documented Note Text: Resident remain on Q 15 minute checks, 1:1 when he goes out to smoke. Resident has stayed all day in his room. Resident is withdrawn, not interacting with staff or residents as before. On 9/28/23 at 2:21 PM, an Alert Note progress note documented Note Text: Resident continues to be Q15 minute checks. Resident has remained mostly in room except to smoke. Resident stated today that he wants to get on a bus and go to [NAME], Utah. Resident 1:1 when he is out smoking. On 9/29/23 at 4:51 PM, an Alert Note progress note documented Note Text: Resident remains on Q 15 minute check. Resident caught smoking in his restroom by night shift staff. Resident has tried to use the back door exit at end of hall to go smoke. Resident is 1:1 when he smokes. Resident expresses desire to 'leave this place'. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/5/23 at 5:00 PM, a Nursing progress note documented Note Text: Resident transferred to [Long Term Care Facility name redacted] with all belongings, medications (controlled and scheduled)via [name redacted] transportation. The exhibit 358 form submitted to the State Survey Agency (SSA) was reviewed. On 9/23/23 at 2:30 PM, it was identified that resident 185 had left the facility alone with mild cognitive impairment. He had last been heard to say that he wanted to live with the homeless people. Emergency response was issued to locate the resident were all notified. Resident 185 did not have any emergency need for medications and the weather was favorable. Emergency contact and primary physician were notified as well. Eight individuals employed by the facility searched the streets of [NAME] for six hours until dark to find resident 185. The facility pulled the eight individuals off of the search for the day around 8:30 PM, when it was no longer light outside. The facility anticipated continuing the search on Sunday morning. All the while, the plan was to have Police, UTA, emergency room s, etc. keep an eye out for resident 185 through the night. On 9/23/23 at 9:22 PM, resident 185 showed back up to the facility stating that he was cold so he came back. Resident 185's evaluation will be performed to make sure there were no injuries as well as to determine careplan adjustments going forward. The exhibit 359 form submitted to the SSA was reviewed. The Summary of interviews with witnesses documented that there were no witnesses to the incident. It was identified that resident 185 had gotten out of the facility when a CNA left the building to go home at 2:40 PM, and resident 185 was walking down the sidewalk behind the gas station in close proximity to the facility. The CNA attempted to get resident 185 to go back to the building but resident 185 refused. The CNA alerted staff at the facility that resident 185 had gotten out of the building. The CNA was off the clock and did not feel like he needed to stay with resident 185 so he left. From that time forward the facility was not able to locate resident 185. The Unit Manager had noted that resident 185 in the past had expressed desires to leave the facility, but had never acted on that desire. Resident 185 had times when he had been more lucid than others. Resident 185 was a supervised smoker and had a wandergaurd anklet on. As much as the facility could ascertain, resident 185 slipped away while out on supervised smoking when the staff member was taking another resident back. On 8/26/24 at 11:41 AM, an interview was conducted with CNA 4. CNA 4 stated that he was off shift driving home when he saw resident 185 at the bus stop by the local convenient store. CNA 4 stated that he called the facility to let them know. CNA 4 stated that he asked resident 185 to get in the vehicle so he could take him back to the facility but resident 185 would not get in the vehicle. CNA 4 stated that resident 185 was a supervised smoker and resident 185 had a wander guard on his ankle. CNA 4 stated that resident 185 liked to cut off the wandergaurd and would use a butter knife. CNA 4 stated if a resident was a supervised smoker he would put a smoking apron on the resident, make sure the resident was ashing their cigarette appropriately, watch the resident for safety, and dispose of their cigarette. CNA 4 stated that he was unsure if resident 185 had the wandergaurd on or not the day of the elopement. CNA 4 stated that resident 185 liked to hang around the exit door of the facility and staff would try to keep resident 185 occupied in the activities room. CNA 4 stated that the distraction would work sometimes to keep resident 185 away from the doors. CNA 4 stated that he should have stayed with resident 185 at the bus stop and it had been a learning experience. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/26/24 at 11:43 AM, an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated that she was on call the night that resident 185 had eloped and she got the call from the floor nurse. LPN 1 stated that resident 185 was always trying to get to the bank or had a destination in mind. LPN 1 stated that resident 185 was a supervised smoker the day he eloped and she believed that resident 185 had snuck away. LPN 1 stated that resident 185 had been homeless before and thought he might be headed back there. LPN 1 stated that she spent the day looking for resident 185, like six hours. LPN 1 stated that the floor nurses did the elopement assessments. LPN 1 stated there were things to consider if the resident was a high risk. LPN 1 stated if the resident could actively leave the facility then yes they would put in a process. LPN 1 stated the high risk would depend on the resident's cognition and history. LPN 1 stated that she could not remember what interventions were in place for resident 185. On 8/26/24 at 2:18 PM, an interview was conducted with CNA 5. CNA 5 stated if a resident was a supervised smoker she would get the residents ready by the door. CNA 5 stated that some CNAs would let the residents get their cigarettes prior to going out or the CNA would take the box out with them. CNA 5 stated that two staff would take the residents all out and we would make sure the residents got their smokes. CNA 5 stated that she would watch the residents all smoke and when the resident were finished the staff would take the residents back in the facility. CNA 5 stated if the resident was a wander risk the resident usually would have a wandergaurd on and the alarm would go off if the resident went out the door. CNA 5 stated the wandergaurd was an extra check. CNA 5 stated that usually their was someone outside during the smoke break while the other staff member was bringing the residents in. CNA 5 stated if there was only one staff member during the smoke break it was usually at night when there was less staff. CNA 5 stated she would monitor the smoke break the entire time until the residents were all finished. CNA 5 stated that there were also smoke aprons for the residents. On 8/26/24 at 3:01 PM, an interview was conducted with the Administrator (ADM). The ADM stated that CNA 4 was driving down the road and saw resident 185 and CNA 4 thought he would check it out. The ADM stated that CNA 4 stopped to check on resident 185 to see if he was okay. The ADM stated that CNA 4 asked resident 185 if he wanted to get in his van and go back to the facility and resident 185 replied no. The ADM stated that CNA 4 stated that the situation felt weird but CNA 4 thought it was okay for resident 185 to be out there. The ADM stated that CNA 4 left and called the nurse. The ADM stated that resident 185 had said that he was going to the ghetto so the ADM called resident 185's family to see where that might be. The ADM stated that resident 185 walked into the building on his own right as they called off the search. The ADM stated the staff increased monitoring and needed to get resident 185 to a better environment. The ADM stated that resident 185 had the wandergaurd on and 15 min checks. The ADM stated the wandergaurd system for the facility would alarm but it would not lock the doors. The ADM stated that resident 185 continued to try and leave the facility. The ADM stated that education with the staff members was provided. The ADM stated when resident 185 admitted to the facility he was not a wander risk and there were no notes that indicated he was a wander risk. The ADM stated that resident 185 was not exit seeking but anxious and staff would walk the building with resident 185. The ADM stated that staff met as a team after resident 185 had eloped and decided that resident 185 was able to leave the building and get himself back was he really a risk. The ADM stated that resident 185 was reassessed as a low elopement risk. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/26/24 at 4:35 PM, an interview was conducted with CNA 6. CNA 6 stated that she could not remember any circumstances regarding resident 185. CNA 6 stated that she thought she worked on a hall that resident 185 was not on so she did not have much interaction with resident 185. CNA 6 stated any resident who was deemed unsafe to smoke for any reason would be a supervised smoker. CNA 6 stated there was a list of residents that were smokers so the staff did not miss anyone. CNA 6 stated the staff did not have time to take the smokers out extra if their smoke time was missed. CNA 6 stated whom ever was assigned to the smoke break and that resident would ensure the resident got their smoke break. CNA 6 stated that the residents were gathered by the door by the nurses station on the 200 hall. CNA 6 stated the staff would make sure the resident was wearing a smoking apron and would get the residents ready to go outside. CNA 6 stated there was a coded lock box due to residents complaining of missing smokes. CNA 6 stated another staff member would assist to get everyone outside. CNA 6 stated that staff would control the lighter for the residents depending on the circumstances. CNA 6 stated that sometimes the extra staff member would stay outside if the staff member was able. CNA 6 stated if there were two staff one would push the residents into the facility and the other staff member would stay outside while the residents finished smoking. CNA 6 stated if there was one staff member then technically yes there might be a moment when the residents were unsupervised outside but she would push the residents just inside the door so she could watch the residents that were still outside. CNA 6 stated if there was a resident with a wandergaurd or the resident was an elopement risk she would push them into the facility first so she knew that they were safe. The facility policy and procedure Elopement/Unsafe Wandering was reviewed. The policy and procedure had a revision/review date of 1/2022. Policy It is the policy of this facility to provide a safe environment for all residents through appropriate assessment and interventions to prevent accidents related to unsafe wandering or elopement. Purpose This facility is committed to promoting resident autonomy by providing an environment that remains as free of accident hazards as possible. Each resident is assisted in attaining or maintaining their highest practicable level of function through providing the resident adequate supervision and diversional programs to prevent unsafe wandering while maintaining the least restrictive environment for those at risk for elopement. Procedure 1. Residents with capabilities of ambulation and/or mobility in wheelchair will have an Elopement/Wandering Evaluation completed to determine risks for elopement and unsafe wandering on admission and with observed behaviors of wandering or attempting to elope. 2. Residents with high risk factors will be identified as At Risk and will have an individualized care plan developed that includes measurable objectives and timeframes. a. Care plan interventions will consider the elements of the evaluation or behavior observations that identified the resident at risk. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No lighting materials (e.g. matches, lighters), tobacco products, or smoking devices will be allowed to be kept in the possession of the residents, either on their person or in the facility. 2. Upon admission (7-10 days), residents who desire to smoke will be assessed as well as their ability to do so safely. All new admissions will be on supervised smoking until assessment is reviewed by the interdisciplinary team. The Interdisciplinary Team will accomplish this using the Smoking Assessment form and a review of the resident's clinical record. At the end of this period it will be determined if the resident will be allowed to smoke either under supervision or independently with or without protective devices. In either case, no lighting materials (e.g., matches, lighters), tobacco products, or smoking devices will be allowed to be kept in the possession of the resident, either on their person or in the facility 3. The results of the evaluation will be placed in the resident's chart and the IDT recommendations will be care planned. 4. Upon quarterly review by the IDT, or at any time a significant change of condition occurs, smoking residents will be re-assessed as to their ability to smoke safely, either independently or under supervision, and their ability to understand and comply with facility non-smoking policy using the Smoking Assessment form. 5. If a resident decides to begin smoking after initially being assessed as a non-smoker, the facility will follow the above procedures. 6. The frequency of smoking for residents that are determined not safe will be the following times with staff supervision 06:30 [6:30 AM] 11:30 [AM] 15:30 [3:30 PM] 20:30 [8:30 PM] 09:30 [9:30 AM] 13:30 [1:30 PM] 18:30 [6:30 PM] 22:30 [10:30 PM] These times will be no more than twenty (20) minute increments or 2 cigarettes 7. If it is determined that a resident is a safe smoker, smoking materials will still be retained by nursing staff and they may come and request 1 or 2 cigarettes at the time they desire to go out to smoke unsupervised There will be no smoking between the hours of 23:00 [11:00 PM] and 6:30 [AM] by any resident even if they are deemed safe 8. The facility reserves the right to immediately confiscate smoking materials as well as to rescind the individual smoking privileges if failing to take such measures would jeopardize resident safety. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/29/24 at 8:40 AM, an interview was conducted with Director of Nursing (DON) 1 and Corporate Resource Nurse (CRN). The CRN stated if the fall was unwitnessed, then neurological assessments were completed. The CRN stated if a resident was found on the floor, the nurse should conduct a full body assessment. The CRN stated after a fall the nursing staff notified the Medical Doctor and the resident's representative. The CRN stated alert charting was implemented for 72 hours. The CRN stated within 24 business hours the Interdisciplinary Team reviewed the fall and looked for a more permanent intervention. The CRN stated there were no neurological assessments completed after the fall on 1/5/24.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30563 Based on interview, observation and record review it was determined, for 12 of 36 sampled residents, that the facility did not have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment. Specifically, there were observations of resident's call lights alarming up to 30 minutes before assistance was provided, residents complained of long call light wait time and resident council minutes revealed resident concerns with staffing. Resident identifiers: 10, 12, 14, 20, 29, 34, 38, 56, 58, 70, 133 and 383. Findings include: 1. Observations of Call lights: a. On 8/25/24 at 8:26 AM, an observation was made of a call light on in room [ROOM NUMBER]. The call light was answered by staff at 8:54 AM. b. On 8/25/24 at 8:27 AM, an observation was made of a call light on in room [ROOM NUMBER]. The call light was answered by staff at 8:57 AM. c. On 8/25/24 at 11:04 AM, an observation was made of a call light on in room [ROOM NUMBER]. The call light was answered by the Administrator at 11:36 AM. d. On 8/25/24 at 8:27 AM, an observation was made of a call light on in room [ROOM NUMBER]. The call light was answered by staff at 8/25/24 at 8:35 AM. e. On 8/25/24 at 11:06 AM, an observation was made of resident 56's call light alarming. Resident 56's call light was answered at 11:21 AM. 2. Resident interviews: a. On 8/25/24 at 11:26 AM, an interview was conducted with resident 56. Resident 56 stated she did not feel like there was enough staff. Resident 56 stated at night time it took a long time for her call light to be answered. Resident 56 stated her call light was on for about 20 minutes before the surveyor entered the residents room. Resident 56 stated that morning before breakfast she waited an hour and a half for her call light to be answered. Resident 56 stated she needed a liner in her brief changed because it was wet. Resident 56 stated staff were unable to change her before breakfast. Resident 56 stated she had to eat breakfast with a wet liner in her brief. Resident 56 stated half of the time, staff told her that she needed to wait till after the meal trays were picked up to be changed. Resident 56 stated some staff were doing a really good job and others were not good. Resident 56 stated she reported staffing concerns to a nurse manager who was no longer employed at the facility. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. On 8/25/24 at 10:04 AM, an interview was conducted with resident 70. Resident 70 stated that he did not like using the call light because staff did not respond all the time or it took over 30 minutes for staff to come and help him. c. On 8/25/24 at 11:20 AM, an interview was conducted with resident 58. Resident 58 stated he felt like there was a long wait for the call lights to be answered. d. On 8/25/24 at 11:24 AM, an interview was conducted with resident 38. Resident 38 stated staff did not get to her roommate as quickly as they should. Resident 38 stated her roommate called for a nurse last night and it took staff a long time to respond. e. On 8/25/24 at 11:38 AM, an interview was conducted with resident 14. Resident 14 stated sometimes she felt there needed to be more staff. Resident 14 stated sometimes it took a while depending on the situations that were going on with other residents. Resident 14 stated she needed assistance getting out of bed first thing in the morning and pushed her call light. Resident 14 stated staff tried to get there as quickly as they could but she had an incontinent episode a could weeks ago. Resident 14 stated she wanted to make sure she was getting the same attention as other residents. f. On 8/25/24 at 11:55 AM, an interview was conducted with resident 383. Resident 383 stated the facility needed more Certified Nursing Assistants (CNA) because they were overworked and unable to answer call lights in a timely manor. Resident 383 stated a staff member could only do what they could do. g. On 8/25/24 at 11:57 AM, an interview was conducted with resident 133. Resident 133 stated staff were over worked. Resident 133 stated on Friday he turned on the call light, then had to get the phone in his room and call the front desk for assistance. Resident 133 stated he needed to use the urinal and was unable to get up by himself. Resident 133 stated he was going to have a shower and get his face shaved on 8/24/24 but he did not get the shower or his face shaved because there were not enough staff. h. On 8/25/24 12:21 PM, an interview was conducted with resident 20. Resident 20 stated her call light was on for a long time and staff did not come answer the call light. Resident 20 stated staff were on their phones a lot. i. On 8/25/24 at 12:58 PM, an interview was conducted with resident 34. Resident 34 stated there was not enough staff. Resident 34 stated the weekends seemed to be the worse and for the most part the CNA's were doing the work of two people. Resident 34 stated one time he had to wait over four hours to get changed. j. On 8/25/24 at 1:50 PM, an interview was conducted with resident 12. Resident 12 stated that the call lights were never answered and he had to wait a long time before staff would come in. Resident 12 stated that it was worse on the weekends. k. On 8/25/24 at 2:06 PM, an interview was conducted with resident 10. Resident 10 stated that the night staff did not answer call lights. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	l. On 8/25/24 at 2:30 PM, an interview was conducted with resident 29. Resident 29 stated on the weekends there were longer response times to call lights. Resident 29 stated sometimes he had to wait up to an hour for the call light to be answered. 3. Staff Interviews: a. On 8/27/24 at 3:11 PM, an interview was conducted with CNA 6. CNA 6 stated staffing was usually pretty good. CNA 6 stated if staff were looking at what they needed to do during shift and planned their day, then staff were able to get everything done. CNA 6 stated answering call lights were hard during meal times. CNA 6 stated residents call lights alarmed at the same time and it was hard to answer all the call lights. b. On 8/28/24 at 10:42 AM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated that she had been asked to pick up an open shift at the facility weekly do to staff shortages. RN 1 stated that she knew that residents had complained about long call light wait times. RN 1 stated she tried to help out with answering the call lights, but she had her own job to complete. RN 1 stated she did not believe there was enough staff to work the halls. c. On 8/28/24 at 10:52 AM, an interview was conducted with RN 2. RN 2 stated that she did not feel like she was able to complete all of her duties in the facility due to staffing shortages. RN 2 stated she had been asked to stay late, come in early, or work overtime the last few months. d. On 8/28/24 at 10:55 AM, an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated that she had been asked to come in early, stay late after her shift, and to pick up overtime. LPN 1 stated that weekend staffing was poor as management was not in the building to help answer call lights and assist residents. LPN 1 stated residents complain about the long call light wait times. e. On 8/29/24 at 9:35 AM, an interview was conducted with Nursing Assistant (NA) 1. NA 1 stated resident's were frustrated because there were a lot of call lights on at one time. NA 1 stated residents will think they have been waiting a long time when it had only been a couple of minutes. NA 1 stated weekend staffing was different. NA 1 stated management was not in the facility on the weekends, so staff were not as on top of things as they needed to be. NA 1 stated it was harder to work on the weekends. NA 1 stated sometimes it was hard to get all the residents changed because there were back to back call lights and no one else was able to help. NA 1 stated she was left in the dining room by herself over the weekend because another CNA needed to use the bathroom. f. On 8/29/24 at 9:47 AM, an interview was conducted with CNA 7. CNA 7 stated staffing was good and the nurses were helpful to CNA's. CNA 7 stated there might be a day that the floor was short a CNA but there was a nurse on call that called another CNA into work. CNA 7 stated the the nurse on call had helped fill in at times. CNA 7 stated there were some residents that complained of long call light times. CNA 7 stated usually during meals when staff were passing meal trays in the hallway and staff answered call lights when they were done passing meal trays. 47431 4. Resident Council Minutes: (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. A review of the facility's resident council notes for March 2024 revealed complaints that nurses were good, but residents felt they were overwhelmed. Medication delivery was rushed. b. A review of the facility's resident council notes for April 2024 revealed complaints about call lights during night shift were struggling again. Complaints of new CNAs, residents saying they did not seem to understand what to do and ongoing complaints of evening shift. c. A review of the facility's resident council notes for May 2024 revealed complaints that call lights were sometimes good and sometimes not good on night shift. They have seen an improvement on evening shifts call light responds. d. A review of the facility's resident council notes for July 2024 revealed night shifts call lights were getting better but sometimes still long. There was still room for improvement, issues with CNAs and night shift but were getting better. On 8/28/24 at 11:16 AM, an interview was conducted with the Administrator (ADM). The ADM that the facility was always hiring new staff, even when it was not needed. The ADM stated that the nursing staff numbers remained the same on the weekdays and the weekends, but the difference is that the leadership staff were not in the building to help with the overflow of resident requests. The ADM stated that the facility did utilize agency nursing staff for approximately 3 to 4 shifts a week. The ADM stated that he was aware that some residents have complained about the long call light wait times. 47432 50200

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 30563 Based on interview and record review, the facility did not provide pharmaceutical services which included procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident. Specifically, for 1 out of 36 sampled residents, the resident did not have gabapentin available. Resident identifier: 14. Findings included: Resident 14 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included acute on chronic combined systolic and diastolic heart failure, type 2 diabetes mellitus, morbid obesity, reduced mobility, and muscle weakness. On 8/25/24 at 11:36 AM, an interview was conducted with resident 14. Resident 14 stated she had a sciatica problem and it flared up in the morning. Resident 14 stated she had requested to see the physician regarding changing times of her muscle relaxer. Resident 14 stated her pain was 10 out of 10 every morning and the pain woke her up at night. Resident 14's medical record was reviewed on 8/25/24 through 8/28/24. Resident 14 had physician's orders for gabapentin 400 milligrams (mg) three times a day for neuropathy. According to the nursing progress notes on 8/25/24 at 8:35 AM, gabapentin was not administered because Resident out. According to nursing progress notes on 8/25/24 at 1:20 PM, gabapentin was not administered because Needs RX [prescription] from pharmacy. The August 2024 Mediation Administration Record revealed resident 14 was not administered gabapentin on 8/25/24 at 8:00 AM and 2:00 PM. Resident 14 was administered cyclobenzaprine 10 mg every eight hours as needed for spasms on 8/25/24 at 6:43 AM. In addition, a Lidocaine External Patch 5% was applied at 7:30 AM on 8/25/24, to resident 14's lower back. A care plan dated 5/8/24, revealed Has chronic pain r/t [related to] DM [diabetes mellitus], CHF [congestive heart failure], morbid obesity. The goal was Will not have an interruption in normal activities due to pain through the review date. Interventions included Will verbalize adequate relief of pain or ability to cope with incompletely relieved pain through the review date; Will voice a level of comfort through the review date; Follow pain scale to medicate as ordered; and Pain assessment every shift. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/29/24 at 9:35 AM, an interview was conducted with Nursing Assistant (NA) 1. NA 1 stated resident 14 did not ask for a lot of assistance. NA 1 stated she had complained of pain and NA 1 reported the pain to the nurse. NA 1 stated resident 14 was waiting for the medication to kick in. NA 1 stated resident 14 had neuropathy in her feet. NA 1 stated resident 14 was able to verbalize her needs. On 8/27/24 at 3:19 PM, an interview was conducted with Certified Nursing Assistant (CNA) 6. CNA 6 stated that resident 14 walked to the nurses cart and asked the nurse for pain medications if she was in pain. CNA 6 stated resident 14 was alert and oriented to be able to verbalize her pain. On 8/27/24 at 1:13 PM, an interview was conducted with Director of Nursing (DON) 2. DON 2 stated that gabapentin needed a prescription from the physician. DON 2 stated that was why resident 14 did not have the gabapentin available. DON 2 stated other interventions were used for pain on 8/25/24.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30563 Based on interview and record review it was determined, for 2 of 36 sampled resident, that the facility did not ensure that each resident's drug regimen was free from unnecessary drugs. An unnecessary drug was any drug when used in excessive dose; or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Specifically, blood pressure medication was administered when a residents blood pressure was outside of the physician ordered parameters. In addition, another resident missed his antipsychotic and diuretic medication because he was scheduled for dialysis during the scheduled administration time. The same resident was not administered insulin according to physician's orders. Resident identifiers: 22 and 34. Findings included: 1. Resident 22 was admitted to the facility on [DATE] with diagnoses which included spastic hemiplegia affecting right dominate side, intracranial injury without loss of consciousness, muscle weakness, hypothyroidism, hypertension, pressure hydrocephalus, epilepsy, schizophrenia and major depressive disorder. Resident 22's medical record was reviewed 8/25/24 through 8/28/24. Resident 22 had a physician's order dated 7/3/2020 for Propranolol 20 MG (milligrams) once daily. The parameters were to Give 20 mg by mouth one time a day . Hold if BP [blood pressure] < [less than] 120/70 or HR [heart rate] <60 related to essential hypertension. *HOLD IF BP <120/60, OR HR<60. According to the August 2024 Medication Administration Record (MAR) the Propranolol 20 MG was administered to resident 22 when blood pressure was outside of parameters: a. On 8/3/24, 111/80 b. On 8/21/24, 117/75 c. On 8/22/24, 117/75 According to the August 2024 MAR the Propranolol 20 MG was held and not administered when the blood pressures were: a. On 8/1/24, 11/86 b. On 8/6/24, 112/73 c. On 8/8/24, 109/71 d. On 8/10/24, 119/91 (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	e. On 8/14/24, 108/78 f. On 8/28/24, 98/60 According to the July 2024 MAR the Propranolol 20 MG was administered with the following blood pressures: a. On 7/3/24, 117/89 b. On 7/11/24, 118/70 c. On 7/17/24, 101/67 d. On 7/19/24, 101/67 e. On 7/20/24, 101/67 According to the July 2024 MAR the Propranolol 20 MG was held and not administered with the following blood pressures: a. On 7/1/24, 116/66 b. On 7/6/24, 110/81 c. On 7/8/24, 106/71 d. On 7/18/24, 101/67 e. On 7/21/24, 102/83 f. On 7/29/24, 107/71 On 8/28/24 at 8:27 AM, an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated blood pressure medications were administered according to the physician ordered parameters. LPN 1 stated usually the physician's parameters were to hold if the diastolic number was less than a certain number. LPN 1 stated she did not understand the parameters for resident 22's blood pressures and would need to clarify with the physician before administering the Propranolol. On 8/28/24 at 8:38 AM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated when a resident had blood pressure medications, parameters were checked prior to administering the medications. RN 1 stated if the blood pressure was within parameters then she would administer the medication. RN 1 stated she would hold the medication if the blood pressure was outside parameters. RN 1 stated with resident 22's parameter orders she would hold the medication if either systolic or diastolic were under the parameters. RN 1 stated she would hold if the heart rate was less than 60. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/28/24 at 8:41 AM, an interview was conducted with LPN 3. LPN 3 stated if a resident had blood pressure medications with parameters, she would check the blood pressure and heart rate. LPN 3 stated then she would administer or hold the medication according to parameters. LPN 3 stated she would document why medications were not administered. LPN 3 stated she administered resident 22's medications on 8/28/24. LPN 3 stated resident 22's blood pressure was 98/60 so she held the Propranolol. LPN 3 stated typically physician ordered parameters would say to hold if the systolic was under a certain number. LPN 3 stated according to resident 22's parameters she would hold the Propranolol if either systolic was under 120 or diastolic was below 60. LPN 3 stated she did not understand the parameters for resident 22 and should have clarified the physician ordered parameters. On 8/28/24 at 8:44 AM, an interview was conducted with Director of Nursing (DON) 1. DON 1 stated for blood pressure medications with physician ordered parameters, the nurses should take the residents blood pressure and heart rate then compare those to the parameters. DON 1 stated the nurse would then administer or hold the medication. DON 1 stated with resident 22's medication should be held if any of the numbers were low. DON 1 stated she would have to verify the parameters for resident 22 because there were 2 different blood pressure parameters. DON 1 stated the physician was to be notified if the blood pressure or heart rate were below the parameters. DON 1 stated that the parameters should have been to hold the medication if blood pressure was less than 120/60. DON 1 stated there was a free text area in the physician's order and the nurse must have accidentally wrote 120/70 and it should have been 120/60. 47432 2. Resident 34 was admitted to the facility on [DATE] and readmitted [DATE] with diagnoses including primary osteoarthritis left shoulder, type 1 diabetes mellitus with diabetic neuropathy, type 1 diabetes mellitus with diabetic chronic kidney disease, hypothyroidism, Alzheimer's disease, dementia, end stage renal disease, and mood disorder due to known physiological condition with depressive features. Resident 34's medical record was reviewed from 8/25/24 through 8/29/24. Resident 34's Medication MAR and Treatment Administration Record (TAR) were reviewed for the months of June, July, and August 2024. The following orders were noted to have irregularities: a. Abilify Oral Tablet 2 milligram Give 1 tablet by mouth one time a day for anxirty [sic] /depression. This order was placed on 6/20/24 with a start date of 6/21/24. It should be noted that the order was listed as being scheduled for 7:00 AM, administration. For the month of July 2024, resident 34's MAR showed that resident 34 missed 12 doses of Abilify. The dates that resident 34 missed doses were 7/1/24, 7/3/24, 7/5/24, 7/9/24, 7/10/24, 7/12/24, 7/15/24, 7/19/24, 7/23/24, 7/24/24, 7/26/24, and 7/29/24. The reason documented on the MAR for the 12 missed doses was, Absent from facility. For the month of August 2024, resident 34's MAR showed that resident 34 missed ten doses of Abilify. The dates that resident 34 missed the doses were 8/2/24, 8/7/24, 8/9/24, 8/12/24, 8/14/24, 8/16/24, 8/19/14, 8/21/24, 8/22/24, and 8/26/24. The reason documented for the missed doses on the MAR was, Absent from facility. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The reason documented for the missed doses on 8/7/24 and 8/12/24, was as other/see nurse notes. Resident 34's progress notes were reviewed. There were no nursing progress notes that documented a reason for the missed doses of the medication. It should be noted that resident 34 had orders to attend hemodialysis Mondays, Wednesdays, and Fridays at an offsite location. Resident 34's listed pickup and transport time was 6:00 AM. b. Torsemide Tablet Give 80 milligram by mouth one time a day for edema. This order was placed on 6/11/22. It should be noted that the order was listed as being scheduled for 7:00 AM, administration. For the month of July 2024, resident 34's MAR showed that resident 34 missed 12 doses of Torsemide. The dates that resident 34 missed the doses were 7/1/24, 7/3/24, 7/5/24, 7/9/24, 7/10/24, 7/12/24, 7/15/24, 7/19/24, 7/23/24, 7/24/24,7/26/24, and 7/29/24. The reason documented on the MAR for the 12 missed doses was, Absent from facility. For the month of August 2024, resident 34's MAR showed that resident 34 missed nine doses of Torsemide. The dates that resident 34 missed the doses were 8/2/24, 8/8/24, 8/12/24, 8/14/24, 8/16/24, 8/19/24, 8/21/24, 8/22/24, and 8/26/24. The reason documented for the missed dotes on the MAR was, Absent from facility. The reason documented for the missed dose on the 8/12/24 was, other/see nurse notes. Resident 34's progress notes were reviewed. There were no nursing progress notes documented for 8/12/24. It should be noted that resident 34 had orders to attend hemodialysis Mondays, Wednesdays, and Fridays at an offsite location. Resident 34's listed pickup and transport time was 6:00 AM. c. Novolog Injection Solution 100 Unit/milliliters (Insulin Aspart) Inject as per sliding scale: if 180-230 = 2; 231-280 =4; 281-330 = 6; 331-380 = 8; 381-430 = 10 below 60 or above 400, notify provider, subcutaneously at bedtime for DM II [type 2 diabetes mellitus].This order was placed on 6/11/24. For the month of June 2024, resident 34's MAR showed that resident 34 received 2 units of insulin on 6/30/24. Resident 34's blood glucose had been reported as 156, which was outside the listed parameters of 180-230 that would indicate a need for 2 units of insulin to be administered. On 8/28/24 at 3:50 PM, an interview was conducted with the Corporate Resource Nurse (CRN). The CRN stated that resident 34 should not have missed his Abilify or Torsemide. The CRN stated that the facility should have communicated with the facility physician to determine if the scheduled medication times could be adjusted on the days that resident 34 went to dialysis. The CRN stated that the facility did not follow resident 34's insulin parameters for the dose given on 6/30/24. The CRN stated that the facility was on a four step action plan for this reason.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 50200 Based on observation and interview, the facility did not ensure safe and secure storage of drugs and biologicals in accordance with accepted professional principles; or include the appropriate accessory and cautionary instructions, and the expiration date on the medication. Specifically, an opened multi-dose vial in the medication cart had exceeded the 28 day expiration date, an insulin pen was not dated with the date it was opened, and bubble packs had medication taped back in. Resident identifiers: 28. Findings included: 1. On 8/27/24 at 7:00 AM, the medication cart at the top of the 100 hallway was inspected. An observation was made that the medication cart contained a Lispro insulin vial with an open date of 7/21/24, and a used glargine insulin pen with no open or expiration date on it. An interview was conducted with Registered Nurse (RN) 3. RN 3 stated that opened insulin was good for 28 days and then it must be discarded. RN 3 stated she was unsure when the insulin pen was opened and the vial of insulin needed to be removed from the cart. 2. On 8/27/24 at 7:44 AM, an observation was made of RN 4 during medication pass. RN 4 was observed to untape the back of a medication bubble pack and administered the medication to resident 28. On 8/27/24 at 7:50 AM, an interview was conducted with RN 4. RN 4 stated that she would not tape medications back into the bubble pack. RN 4 stated she would discard the medication and should not have given the medication to the resident. On 8/27/24 at 8:57 AM, an interview was conducted with Director of Nursing (DON) 1. DON 1 stated she personally did not know that the nurses taped medications back into the bubble packs. DON 1 stated that the nurses should not be taping medications back into the bubble packs and the medications should be discarded. DON 1 stated that all undated open medications needed to be discarded. DON 1 stated that insulin needed to be replaced after 28 days of it being opened. 30563 3. On 8/25/24 at 8:15 AM, an observation was made of the medication cart in the 100 hallway. There was a ball with intravenous antibiotic on top of the medication cart. The antibiotic was observed to be unattended on the medication cart. On 8/29/24 at 11:05 AM, an interview was conducted with DON 1. DON 1 stated medications should not be left unattended at anytime.

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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** 47431 Based on interview and record review, the facility did not obtain laboratory services to meet the needs of its residents. Specifically, for 3 of 36 sampled residents, a resident did not have a Valproic acid level, thyroid-stimulating hormone (TSH), complete blood count (CBC), and a comprehensive metabolic panel (CMP) completed as ordered by the physician. Another resident did not have a TSH redrawn six weeks after the June levels were drawn. In addition, another resident did not have a urinalysis (UA) with culture and sensitivity (C&S) obtained that was orded by the physician. Resident identifiers: 22, 34, and 58. Findings included: 1. Resident 58 was admitted to the facility on [DATE] with diagnoses which included bipolar disorder, disorder of urea cycle metabolism, disorientation, unspecified psychosis not due to a substance or known physiological condition, and personal history of urinary tract infections. Review of records was completed on 8/25/24 through 8/29/24. An admission Minimum Data Set assessment dated [DATE], revealed that resident 58 had a Brief Interview of Mental Status score of 9 which indicated moderately impaired cognition. A review of physician's orders revealed an order started on 8/7/24, for a UA C&S one time only related to disorientation, unspecified until 8/7/24 at 11:59 PM, to obtain urine was marked completed on 8/7/24. On 8/7/24 at 2:14 PM, a Nursing Progress Notes revealed the following. Nurse went in the resident's room for morning medication pass and the resident was lying on the side of his bed. His emergency contact was notified, and the provider was notified. Resident had a new order for a UA due to some confusion. On 8/8/24 at 5:56 PM, a Fall Committee Interdisciplinary Team progress note revealed the following, Resident was currently resting in bed. Resident denied pain or discomfort related to fall. His emergency contact was notified, and the provider was notified. Resident has a new order for a UA C&S due to some confusion. The UA C&S results were unable to be located. On 8/27/24 at 3:30 PM, an interview with Director of Nursing (DON) 2 was conducted. DON 2 stated she was unable to locate the lab results for the UA C&S or any progress notes from 8/7/24. 30563 2. Resident 22 was admitted to the facility on [DATE] with diagnoses which included spastic hemiplegia affecting right dominate side, intracranial injury without loss of consciousness, muscle weakness, hypothyroidism, hypertension, pressure hydrocephalus, epilepsy, schizophrenia, and major depressive disorder. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 22's medical record was reviewed on 8/25/24 through 8/28/24. On 10/23/23, resident 22's TSH level was 0.079 which was low. It was written on the laboratory results Reduce Levothyroxine to 125 mcg [micrograms] recheck in 6 weeks. Signed with a date of 10/26/23. A physician's order dated 10/26/23, revealed TSH one time a day for lab. On 12/7/23, there was a laboratory results that revealed Test not performed. Insufficient specimen to perform or complete. A physician's order dated 2/4/24, revealed CBC and CMP urgently for lethargy. On 2/5/24, there was a laboratory results form that revealed Test not performed. The required specimen for the test ordered was not received . Comp. [comprehensive] Metabolic Panel . The CBC revealed Test not performed. Whole blood specimen partially or completely clotted. A common cause is insufficient mixing upon collection. A physician's order dated 3/29/24, revealed TSH 4/1/24 one time only for 2 days only signs off if obtained. A physician's order dated 4/3/24, revealed T3 [Triiodothyronine] and T4 [Thyroxine] one time only for lab for 1 day. A physician's order dated 7/12/24, revealed Valproic Acid one time only related to epilepsy. On 7/15/24, there was a laboratory results form that revealed A lavender top tube was received with no test indicated. On 7/22/24 at 2:30 PM, Valproic Acid 105 microgram per milliliter which was high. There was a signature dated 7/26/24, and revealed to recheck in two weeks. A physician's order dated 7/24/24, revealed Valproic Acid one time only related to epilepsy. A physician's order dated 7/27/24, revealed Valproic Acid one time only related to epilepsy. On 7/28/24, Valproic Acid was . not performed. No serum received. A physician's order dated 8/9/24, revealed Valproic Acid one time only related to epilepsy. A nursing progress note dated 8/9/24 at 7:31 AM, revealed Date for Valproic acid draw changed to 8/12 as phlebotomist will be here that day, provider notified and is ok with having lab drawn on Monday On 8/15/24, Valproic Acid was not performed. Gel barrier tube was unsuitable for test orders. On 8/22/24, Valproic acid was not performed. No serum received. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/27/24 at approximately 2:00 PM, an interview was conducted with DON 1. DON 1 stated from 7/28/24, the wrong tube was sent to the laboratory and there was a physician's order to redraw in two weeks. DON 1 stated there was a note that the Valproic acid was not performed in two weeks and the provider was notified. DON 1 stated the nursing note revealed no new orders. DON 1 stated the laboratory note from the 8/22/24, that Valproic was not done and provider was notified. DON 1 stated that since they notified the physician that the Valproic acid was not done, there were no new orders, so there was no need to follow-up on the Valproic Acid after 7/22/24, even though it had been attempted twice. On 8/28/24 at 12:19 PM, a follow-up interview was conducted with DON 1. DON 1 stated the laboratory process started with nursing staff communicating with the physician for an order. DON 1 stated all physician's orders were entered into the medical record. DON 1 stated there was a phlebotomists who worked at the facility and drew the residents specimen. DON 1 stated then the laboratory was called to pick up the specimen. DON 1 stated the results were in the residents medical record. On 8/28/24 at 12:48 PM, an interview was conducted with the Corporate Resource Nurse (CRN). The CRN stated there was a four step action plan for the laboratory process. The CRN stated the action plan was started on 8/8/24. The CRN stated the policy was reviewed. The CRN stated there was now an in house phlebotomist and staff were auditing five random charts per week for laboratory orders and results. The CRN stated the TSH was not done 12/7/23, because the specimen was insufficient and the TSH was not rechecked. 47432 3. Resident 34 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including primary osteoarthritis left shoulder, type 1 diabetes mellitus with diabetic neuropathy, type 1 diabetes mellitus with diabetic chronic kidney disease, hypothyroidism, Alzheimer's disease, dementia, and mood disorder due to known physiological condition with depressive features. Resident 34's medical record was reviewed from 8/25/24 through 8/29/24. Resident 34's Medication Administration Record (MAR) and Treatment Administration Record were reviewed for the months of June, July, and August 2024. Resident 34 had an order placed on 6/3/24, that revealed, TSH and Lipid Panel on 6/5/24 (send to dialysis with pt [patient]) one time only for spin and call for lab p/u [pick up] when he returns for 1 day. Resident 34's June 2024 MAR documented that this order was never completed. This order was discontinued on 6/5/24. Resident 34 had an order placed on 6/5/24, that revealed, TSH and Lipid Panel on 6/7/24 (send to dialysis with pt) one time only for spin and call for lab p/u when he returns for 1 Day. Resident 34's June 2024 MAR documented that this order was never completed. This order was discontinued on 6/7/24. Resident 34 had an order placed on 6/7/24 that revealed, TSH and Lipid Panel on 6/7/24 (send to dialysis with pt) one time only for spin and call for lab p/u when he turns for 1 Day. Resident 34's June 2024 MAR documented that this order was not not completed until 6/10/24 at 9:41 AM. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The lab report for the labs drawn on 6/10/24, was reviewed. According to the lab report, the sample was not collected until 6/14/24, was received by the laboratory on 6/15/24, and the results were reported to the facility on [DATE]. On 6/19/24 at 4:27 PM, a nursing progress note revealed, Provider reviewed the labs for 6/14/24 and the [sic] let the following new orders: Draw a T3 and T4. The lab report for the labs ordered on 6/19/24, was reviewed. According to the lab report, the sample was collected on 6/20/24, was received by the laboratory on 6/22/24, and the results were reported to the facility on [DATE]. On 6/24/24 at 10:15 AM, a nursing progress note revealed, NP [nurse practitioner] looked over t4 and t3 labs that came back. she gave new order to increases [sic] Synthroid from 125 mcg to 150 mcg q [every] daily. she also has a [sic] order for TSH to be recheck [sic] in 6 weeks resident notified of new orders. There were no orders for Resident 34's TSH to be rechecked in six weeks located in the in the medical record. On 8/28/24 at 12:48 PM, an interview was conducted with the CRN. The CRN stated that the facility had a four step action plan for labs as of 8/8/24. The CRN stated that Resident 34's TSH should have been rechecked six weeks after the t3 and t4 labs were drawn. The facility Laboratory Testing Policy/Procedure revised 11/2016 revealed, POLICY: It is the policy of this facility to obtain laboratory and radiology services when ordered by a physician, PA [Physician's Assistant], NP or clinical nurse specialist and to promptly notify the ordering entity of test results. PROCEDURES: 1. Laboratory and radiology services will be arranged as ordered. 2. Results of laboratory, radiological, and diagnostic tests outside the clinical reference ranges shall be reported to the resident's attending physician, PA NP or clinical nurse specialist promptly or as specified in the order. 3. Notification of test results will be documented in the resident's clinical record. 4. Results of all diagnostic services shall be made a part of the resident's medical record.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 47432 Based on observation, interview, and record review it was determined, for 10 of 36 sampled residents, that the facility did not provide food prepared by methods that conserve flavor and appearance or provide food and drink that was palatable, attractive, and at an appetizing temperature. Specifically, there were multiple complaints from residents about the quality of the food, there were multiple resident council complaints about the flavor of the food, and a test tray was bland to the taste with overcooked foods. Resident identifiers: 10, 12, 14, 20, 28, 34, 38, 56, 59, and 68. Findings Include: On 8/25/24 at 12:51 PM, an interview was conducted with resident 10. Resident 10 stated that the food served at the facility was not good. Resident 10 stated that the food served gave her diarrhea. Resident 10 stated that the eggs and oatmeal served were not good and caused her to have constipation. At 2:02 PM, an additional interview was conducted with Resident 10. Resident 10 stated that the food served was so bad that she had called her son to bring her food from fast food for lunch. On 8/25/24 at 1:53 PM, an interview was conducted with resident 12. Resident 12 stated that the food served at the facility did not taste good. Resident 12 stated that sometimes the food was served hot. On 8/25/24 at 11:35 AM, an interview was conducted with resident 14. Resident 14 stated that the food served at the facility was bland. On 8/25/24 at 12:16 PM, an interview was conducted with resident 20. Resident 20 stated that the food served at the facility was not good and causes her to have diarrhea. On 8/25/24 at 10:21 AM, an interview was conducted with resident 28. Resident 28 stated that the food served at the facility did not always taste good and that the food served was not always served hot. On 8/25/24 at 12:06 PM, an interview was conducted with resident 34. Resident 34 stated that the kitchen staff had a tendency to be lazy and served the same foods frequently. On 8/25/24 at 11:24 AM, an interview was conducted with resident 38. Resident 38 stated that the food served was not good. Resident 38 stated that the food served was too spicy. On 8/25/24 at 11:24 AM, an interview was conducted with resident 56. Resident 56 stated that the food served at the facility was bland to the taste. On 8/25/24 at 12:25 PM, an interview was conducted with resident 59. Resident 59 stated that he did not like the food served at the facility. Resident 59 stated that he had friends bring food into the facility for him and his wife. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/25/24 at 2:51 PM, an interview was conducted with resident 68. Resident 68 stated that the food served at the facility was terrible. Resident 68 stated that anything served that required preparation tended to not be good. On 8/28/24 at 8:21 AM until 8:50 AM, an observation was made of the 200 hallway. Trays were observed to be served to residents. Plates were observed without the heating pellet system. The pellet heating system was used to keep meals warm while they were delivered to residents. On 8/28/24, a test tray was obtained from the kitchen. The last try plated was at 12:44 PM. According to the menu posted at the facility, the entree should have been breaded chicken. The entree received was not breaded and had a slight purple color when cut into. The meat was try and chewy. The carrots were overcooked and mushy. A review of the facility's resident council notes for the month of March 2024 revealed complaints about cold food being served at the facility. A review of the facility's resident council notes for the month of April 2024 revealed complaints about cold food being served at the facility. A review of the facility's resident council notes for the month of May 2024 revealed complaints about cold food being served at the facility. A review of the facility's resident council notes for the month of July 2024 revealed complaints about cold food being served at the facility. A review of the facility's resident council notes for the month of August 2024 revealed complaints about the salads served at the facility. The resident council notes had complaints of items being out of stock in the kitchen. On 8/29/24 at 9:21 AM, an interview was conducted with the Dietary Manager (DM). The DM stated that the facility used a pellet system to keep meal trays warm for residents who ate in their rooms. The DM stated that the pellet system should always be used to keep meals warm. On 8/29/24 at 10:27 AM, an interview was conducted with the facility administrator (ADM). The ADM stated that meals should be served within a 5-10 minute window. The ADM stated that the pellet system was recently purchased to help keep meals warm prior to being served to address resident and resident council complaints of cold food. The ADM stated that the only reason the pellet system would not be used was if the kitchen ran out of pellets before they finished serving meals or if residents did not return their trays timely prior to the next meal service. The ADM stated that the facility purchased 110 pellets for a facility census of 80. The ADM stated that his expectation for kitchen staff was that the food starts improving and gets better. The ADM stated that he had seen food quality improve with new kitchen staff.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50200 Based on observation and interview, the facility did not establish and 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 36 sampled residents, a medication was touched by bare hands and administered to a resident and hallway meal trays were not delivered in a sanitary manner. Resident identifier: 28. Findings Included: 1. On 8/27/24 at 7:44 AM, an observation was made of Registered Nurse (RN) 4 during medication pass. RN 4 removed a pill that was taped back into a bubble pack. RN 4 was unable to remove the pill from the tape and pulled the pill off the tape and dropped the pill into the medication cup. RN 4 administered the pill to resident 28. On 8/27/24 at 7:50 AM, an interview was conducted with RN 4. RN 4 stated that she would not tape medications back into the bubble pack. RN 4 stated she would discard the medication and should not have given the medication to the resident. On 8/27/24 at 8:57 AM, an interview was conducted with Director of Nursing (DON) 1. DON 1 stated she personally did not know that the nurses taped medications back into the bubble packs. DON 1 stated that the nurses should not be taping medications back into the bubble packs and the medications should be discarded. 2. During the lunch meal service on 8/25/24, the following observations were conducted. a. At 12:23 PM, Certified Nursing Assistant (CNA) 6 was observed to place the lid of the chocolate milk in the palm of their hand to pour a resident a cup of the chocolate milk. CNA 6 was observed to place the lid back on the jug of chocolate milk. b. At 12:26 PM, CNA 5 was observed to serve a meal tray to resident room [ROOM NUMBER] bed B. CNA 5 did not perform hand hygiene upon exiting room [ROOM NUMBER] and obtained another meal tray from the meal cart. c. At 12:30 PM, a staff member was observed to serve a meal tray to resident room [ROOM NUMBER]. The staff member did not perform hand hygiene upon exiting room [ROOM NUMBER] and obtained another meal try from the meal cart from resident room [ROOM NUMBER]. d. At 12:34 PM, a staff member was observed to serve a meal tray to resident room [ROOM NUMBER]. The resident in room [ROOM NUMBER] was on enhanced barrier precautions. The staff member did not perform hand hygiene upon exiting room [ROOM NUMBER]. e. At 12:42 PM, an observation was made of CNA 1. CNA 1 delivered a food tray into a resident room, handed the resident their utensils and did not perform hand hygiene after exiting the room and picking up another tray. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	f. At 12:43 PM, an observation was made of CNA 2. CNA 2 delivered a food tray to a resident and then picked up a different tray and served the tray without hand hygiene being performed. g. At 12:44 PM, an observation was made of CNA 1. CNA 1 delivered a food tray and did not perform hand hygiene before delivering a food tray to a resident. h. At 12:45 PM, an observation was made of CNA 1. CNA 1 delivered a food tray and did not perform hand hygiene after exiting the room. i. At 12:47 PM, an observation was made of CNA 1. CNA 1 delivered a food tray and did not perform hand hygiene after exiting the room. j. At 1:02 PM, an observation was made of CNA 1. CNA 1 delivered a food tray and did not perform hand hygiene after exiting the room. k. At 1:04 PM, an observation was made of CNA 1. CNA 1 delivered a food tray and did not perform hand hygiene after exiting the room. l. At 1:05 PM, an observation was made of CNA 1. CNA 1 touched their face, picked up a food tray, delivered the food tray to a resident and did not perform hand hygiene. 3. During the breakfast meal service on 8/28/24, the following observations were conducted. a. At 8:24 AM, an observation was made of CNA 3. CNA 3 did not perform hand hygiene after he delivered a tray to a resident. b. At 8:30 AM, an observation was made CNA 3. CNA 3 did not perform hand hygiene after he delivered a tray to a resident and assisted the resident to sit up in bed. On 8/28/24 at 8:27 AM, an interview was conducted with CNA 4. CNA 4 stated that the received training on how to pass food trays to residents in the halls. CNA 4 stated that after a tray was given to a resident hand hygiene should be performed. CNA 4 stated that if at any time you assisted the resident or came into contact with the resident then hand hygiene should be performed. On 8/28/24 at 8:55 AM, an interview was conducted with CNA 3. CNA 3 stated that before meal service hand hygiene should be performed. CNA 3 stated that hand hygiene should be performed before and after entering a residents room. CNA 3 stated that hand hygiene should be performed after delivering a meal tray to a resident. 47431 33215

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30563 Based on interview and record review, the facility did not establish an antibiotic stewardship program that included antibiotic use protocols and a system to monitor antibiotic use. Specifically, for 1 out of 36 sampled resident, staff were not aware of who and why a resident was ordered prophylaxis antibiotics. Resident identifier: 56. Findings included: Resident 56 was admitted to the facility on [DATE] with diagnoses which included hemiplegia and hemiparesis, type 2 diabetes mellitus, chronic obstructive pulmonary disease, bipolar disorder, major depressive disorder, and anxiety. Resident 56's medical record was reviewed on 8/25/24 through 8/29/24. A care plan dated 3/3/24, revealed Is on Antibiotic Therapy r/t [related to] UTI. The goal was Will be free of any discomfort or adverse side effects of antibiotic therapy through the review date. The interventions included Administer medication as ordered and Observe for possible side effects every shift. On 6/2/24 at 1:48 PM, a Nurse Practitioner / Physician's Assistant Progress Note revealed, She has had recurrent UTI. She wants prophylaxis abx [antibiotic] to help prevent recurrence. ASSESSMENT AND PLAN: Recurrent UTI: Start Florastor 1 by mouth every morning. Start Keflex 500 mg [milligrams] by mouth every morning no intake, vitamin C at thousand milligrams by mouth every morning as prophylaxis to help prevent recurrence of UTI. A nursing progress note dated 6/2/24 at 3:09 PM, revealed Resident c/o [complained of] UTI like s/s [signs and symptoms]. Per provider request resident to have 1000mg q [every] AM, Florastor q AM and Keflex 500mg q AM. A physician's order dated 6/3/24, revealed Keflex Oral Capsule 500 MG (Cephalexin) Give 1 capsule by mouth in the morning for Prophylaxis. On 8/27/24 at 12:59 PM, an interview was conducted with Director of Nursing (DON) 2. DON 2 stated resident 56 had history of reoccurring UTI's. DON 2 stated her last UTI was on 2/27/24. On 8/28/24 at 3:44 PM, an interview was conducted with the Corporate Resource Nurse (CRN). The CRN stated she was unsure which provider started the Keflex. The CRN stated that there was no information from a urologist regarding the Keflex.