STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465119	A. Building B. Wing	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Provo Rehabilitation and Nursing	1001 North 500 West Provo, UT 84604

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33215 Based on observation, interview, and record review, the facility did not ensure that residents had the right to be free from abuse, neglect, misappropriation of property, and exploitation. Specifically, for 7 out of 69 sampled residents, residents were having consensual relationships per their families consent and the residents were not assessed and did not have the capacity to consent and residents were being sexually abused by other residents. Resident identifiers: 50, 70, 208, 209, 310, 311, and 409. Findings included: 1. Resident 70 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, chronic kidney disease stage 2, dementia, essential hypertension, mild protein-calorie malnutrition, dysphonia, history of falling, cognitive communication deficit, major depressive disorder, and fall on same level. Resident 70's medical record was reviewed from 10/7/24 through 10/21/24. A quarterly Minimum Data Set (MDS) assessment dated [DATE], documented that resident 70 had a Brief Interview for Mental Status (BIMS) score of 10. A BIMS score of 8 to 12 indicated moderate cognitive impairment. On 9/1/23 at 12:12 PM, a Nursing progress note documented Note Text : Pt [patient] found by OT [Occupational Therapy] in his room with his pants off and female resident sitting beside him on the bed. OT assisted pt in getting pants on and assisted pt to the dining room. On 9/1/23 at 12:39 PM, a Nursing progress note documented Note Text : CNA [Certified Nursing Assistant] found pt standing behind the curtain with female resident. CNA brought both pt out of the room and to the dining room for lunch. On 9/6/23 at 11:24 AM, a Nursing progress note documented Note Text : Patient is being friendly and having relations with another female resident on the unit. Family is aware and patient is his own power (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0600 Level of Harm - Actual harm Residents Affected - Few	of attorney per nursing management pt is ok to continue relations. Pt was found in his room with pants down and female resident in room. Both parties are in agreement to the situation. Since then both patients have been separate on the unit per their own accord. No concerns at this time, will continue to monitor. A care plan Focus dated 9/18/23, documented RESOLVED: I have a special friend I like to spend time with. We like to hold hands and kiss but sometimes forget that others become uncomfortable when we're in in [sic] public areas displaying affection. - Displaying affection toward resident [resident 208]. He consented with the affection and resident [resident 208] son aware and no concern. - Huddle/Inservice to facility employee in the unit. The Interventions initiated on 9/18/23, included: a. Anticipate and meet needs. b. Approach in a calm manner. c. Assist to develop more appropriate methods of coping and interacting. Encourage to express feelings appropriately. d. Caregivers to provide opportunity for positive interaction, attention. Stop and talk with him/her as passing by. e. If reasonable, discuss behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable. f. Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. g. Provide a program of activities that is of interest and accommodates residents status. h. When displaying affection, staff to talk with parties involved to ensure all are consenting. On 10/10/24 at 4:58 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that the resident associated with resident 70 during the incident on 9/1/23, was resident 208. The DON stated the incident was not reported because the incident was identified as a consensual relationship, between resident 208's family and resident 70 being his own power of attorney at that time. 2. Resident 208 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included, but were not limited to, Alzheimer's disease, essential hypertension, depression, and mild protein-calorie malnutrition. Resident 208's medical record was reviewed from 10/7/24 through 10/21/24. An admission MDS assessment dated [DATE], documented that resident 208 had a BIMS score of 99 which indicated resident 208 was unable to complete the interview. (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 0600 Level of Harm - Actual harm Residents Affected - Few	On 8/29/23 at 4:50 PM, a Nursing progress note documented Late Entry: Note Text: Resident was found in male residents room sitting on bed. Redirected resident and male resident to join day room activities. Despite the redirection, both residents continued to hold hands and have physical contact. Residents were separated during dinner time. (Note: The incident was with resident 70.) On 8/30/23 at 3:49 PM, a Nursing progress note documented Note Text: NO [new order] from provider to initiate Lexapro r/t [related to] hypersexual behavior secondary to Alzheimers [sic], as well as Pepcid 20mg [milligrams] BID [twice a day]. NO in place, representative aware. On 8/30/23 at 4:52 PM, a Nursing progress note documented Note Text: Resident was found by CNA in male residents room. Male resident did not have any pants or brief on, and female resident had her shirt pulled up some. Resident was removed from male residents room. She was then taken to the shower room, her hospice CNA came to do cares on her. DON notified of happenings. CNA staff aware to keep residents separated. (Note: The incident was with resident 70.) On 9/1/23 at 12:11 PM, a Nursing progress note documented Note Text: Pt found in fell ow residents room sitting on the bed. OT found pt this way and brought pt out of the room. (Note: The incident was with resident 70.) On 9/1/23 at 12:35 PM, a Nursing progress note documented Note Text: CNA found pt standing behind the curtain with fell ow resident. CNA brought both patients out of the room for lunch. (Note: The incident was with resident 70.) On 9/6/23 at 1:39 AM, a Nursing progress note documented Note Text: Pt was found in another pt's bed at 0130 [1:30 AM]. She was in the same pt's room that had a res [resident] to res situation on 9/4 [23]. No issues today, the other pt calmly reported to nurse that she was in his bed and asked the nurse to help her to her room. (Note: The incident was with resident 70.) On 9/6/23 at 11:21 AM, Nursing progress note documented Note Text: Patient is being flirtatous [sic] with a male resident on unit. They hold hands and pt is often found in male patients room. Earlier male pt was found on his bed with pants down while [resident name redacted] was in the room with him. Patients family is aware and per nursing management family is ok with patients behavior with this one male patient only, if she is to take a liking to any other resident we must notify her family. After pt was found with the other resident in his room they've been separate on the unit per their own accord. Will continue to monitor. (Note: The incident was with resident 70.) On 9/18/2023 at 7:19 PM, a Nursing progress note documented Note Text : patient found kissing another male resident in the male residents room patient was redirected into an activity 30 min [minute] checks started. (Note: The incident was with resident 50.) A care plan Focus created on 9/18/23 and initiated on 1/8/24, documented I have a special friend I like to spend time with. We like to hold hands and kiss but sometimes forget that others become uncomfortable when we're in in [sic] public areas displaying affection. - Resident displaying affection to resident [resident identifier redacted] and resident [resident identifier redacted]. - Son understand and aware of his mother affection with this resident. - Frequent Visual check and her whereabouts. - Huddle/Inservice staff q [every] change of shift to redirect resident. - Activities that catered to her needs to redirect her behavior. The Interventions created on 9/18/23 and initiated on 1/8/24, included: (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 0600 Level of Harm - Actual harm Residents Affected - Few	a. Anticipate and meet needs. b. Approach in a calm manner. c. Caregivers to provide opportunity for positive interaction, attention. Stop and talk with him/her as passing by. d. If reasonable, discuss behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable. e. Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. f. Minimize potential for resident's disruptive behaviors by offering tasks which divert attention. g. Provide a program of activities that is of interest and accommodates residents status. h. Staff to ensure when I am displaying affection towards others, that all parties are consenting. i. Stop and talk with resident when passing by. On 9/21/23 at 11:24 AM, an Interdisciplinary Team (IDT) progress note documented Note Text : IDT meet today unit managers/social worker and hospice to discuss about the incident that happened last 9/18/23. Resident was found kissing with resident [resident identifier redacted]. She wanders into his room, and both was redirected. Assisted resident back to activities and she stay in activities. Reported the incident to resident son and made aware. Hospice informed and plan to review her medication. Hospice plan to discuss with the son. Resident will be on q 30 mins [minute] checks and check her whereabouts. Plan activities that catered for her needs. Huddle with staff, Inservice about redirecting resident at all times. Continue as plan. Son aware and hospice informed. 3. Resident 50 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, dementia, vascular dementia, pain, essential hypertension, need for assistance with personal care, and cognitive communication deficit. Resident 50's medical record was reviewed from 10/7/24 through 10/21/24. A quarterly MDS assessment dated [DATE], documented that resident 50 did not have a BIMS score due to resident 50 rarely or never understood. On 9/18/23 at 7:21 PM, a Nursing progress note documented Note Text : a female resident found kissing [resident name redacted] in his room the female resident was redirected into an activity 30 min checks started family attempted to call left message DON and MD notified. (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 0600 Level of Harm - Actual harm Residents Affected - Few	A care plan Focus initiated on 9/18/23, documented RESOLVED: I have a special friend I like to spend time with. We like to hold hands and kiss but sometimes forget that others become uncomfortable when we're in in [sic] public areas displaying affection - Displaying affection with resident [resident 208] and he likes the affection, and his family was aware and with no concern. The other resident family also aware with no concern - Huddle/Inservice the staff to Redirect the resident and made aware of the plan. The interventions initiated on 9/18/23 included: a. Administer medications as ordered. Monitor/document for side effects and effectiveness. b. Anticipate and meet needs. c. Approach in a calm manner. d. Assist to develop more appropriate methods of coping and interacting. Encourage to express feelings appropriately. e. Caregivers to provide opportunity for positive interaction, attention. Stop and talk with him/her as passing by. f. Educate family/caregivers on successful coping and interaction strategies. Needs encouragement and active support by family/caregivers. Use these strategies. g. If reasonable, discuss behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable. h. Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. i. Provide a program of activities that is of interest and accommodates residents status. j. When I am displaying affection towards others, ensure staff stop and ensure all parties are consenting. On 9/19/23 at 11:32 AM, a Social Services progress note documented Note Text : Spoke with PT niece today about incident of pt and other female resident kissing. Pt niece was understanding and consents for pt to have relations with another resident as long as he is happy. On 9/21/23 at 12:03 PM, an IDT progress note documented Note Text : IDT meet today. Clinical resource, Unit managers, SSD [Social Services Director] and SSD to discuss the incident that happened last 9/18/23. Resident was found kissing another resident [resident identifier redacted] in his room. Both was redirected. Reported this incident to resident niece and she was laughing because the resident already told her about it. No concern at this time. Will continue to monitor. NP [Nurse Practitioner] made aware of the incident. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 10/16/24 at 11:37 AM, an interview was conducted with the Medical Director (MD). The MD stated that sometimes he was involved with the capacity to consent for residents but it would depend on the situation with the resident. The MD stated that he would get help from psychiatry if the residents were in and out or questionable. The MD stated if there was going to be something legally he would get more opinions. The MD state if the capacity to consent affected anything medical the facility staff would consult with him. The MD stated that he was not consulted on the interaction with resident 70 and resident 208. The MD stated if he was consulted he did not document on either of the residents. The MD stated if the resident had behavioral health services they would usually follow the resident and not him. The MD stated if the residents were on the dementia unit he would expect to be consulted. The MD stated if the resident had no cognitive impairment, diagnoses, disability, or a BIMS score that would have triggered the decision the residents should have the capacity to consent. The MD stated if the residents were on the regular unit and there was a question about capacity he might call in someone else. The MD stated that the residents had a personalized screening for consent. On 10/17/24 at 7:11 AM, an interview was conducted with the Social Worker (SW). The SW stated that he would do different cognitive assessments to determine if the resident had the capacity to consent. The SW stated if the BIMS score was questionable he would do a different more detailed assessment. The SW stated that he would assess if the residents understood and he would look at the residents orientation. The SW stated he would talk with the residents and do they understand what a relationship was and what that meant. The SW stated that residents had rights and they had the right to do what they want as long as it did not cause harm to others. The SW stated if the resident did not understand then he would talk with the family. The SW stated if the residents were both seeking each other he would call the family. The SW stated if the residents were not seeking each other the staff would put in interventions like staff would watch more and intervene. The SW stated if the residents wished to be together and hold hands that was fine but if the residents wanted more we would provide a private space. The SW stated if the other resident was not interested we would follow up with that party to make sure they were okay. The SW stated if the cognition was not there or the resident was on the Memory Care we would contact the family. The SW stated they would take into consideration the families opinion. The SW stated we would allow a companionship and it was all about safety. The SW stated when he met with the the residents he would document in a Social Services note. The SW stated that when the MD's or mental health did their rounds he would discuss the residents wishes with them. On 10/17/24 at 3:32 PM, an interview was conducted with the DON. The DON stated if the resident interactions had the potential to be sexual they would look at cognition and if cognition was not there they would contact the family to see if that was something that would be consensual on their end. The DON stated that until that was identified we would keep the residents separated and make sure the residents were safe and their interactions were done safely. The DON stated for the capacity to consent they would look a the residents BIMS score, diagnoses, involvement with social work, and involve therapy on determining those assessments. The DON stated the capacity to consent would be scanned in the residents medical record. The DON stated that resident 208's son stated that if resident 208 was happy he was happy, but of course the son wanted to keep resident 208 safe. The DON stated that staff were educated that resident 70's and resident 208's relationship was consensual but if it was more sexual to redirect them. The DON stated that snuggling or sitting on the couch was okay and it was more of a companionship. The DON stated that she felt the conversations with the family and redirecting of the residents that there was no need to report because it was not abuse. 48709 (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 0600 Level of Harm - Actual harm Residents Affected - Few	4. Resident 409 was admitted to the facility on [DATE] with diagnoses which included acute respiratory failure with hypoxia, pneumonia, [NAME]-Pick Disease Type C, fracture of neck of left femur, mild cognitive impairment, and acute kidney failure. Resident 409's medical record was reviewed from 10/7/24 through 10/21/24. A quarterly MDS assessment dated [DATE], indicated resident 409 had a BIMS score of 00 which suggested severe cognitive impairment. Per facility documentation, an incident of abuse between resident 409 and resident 209 occurred on 7/31/23. The following was documented: A Nursing Progress note, dated 8/1/23 at 2:02 AM, indicated, Male CNA reported that he went to check resident [409] bc [because] he was told he didn't have a brief. Upon entering the room he noticed that his roommate, resident [209], was looking at resident [409] and was up against resident [409]'s bed. Staff rediretd [sic] resident [209] back to his side of the room, closed the curtain and proceeded to assist resident [409] with his brief. Staff notice that there was a whitish discharge noted arouind [sic] penile area. After assisting resident [sic] [409] with brief he left the room and left the door open. Staff wentback [sic] a few minutes later to check on them and saw that the bedroom door was closed. He opened the door and saw that resident [209] was by resident [409]'s bed, touching him inappropriately with his hand on resident [409]'s genitals. He intervened and redirected resident [209] away from resident [409]. CNA reported incident to nurse and resident [209] was removed from room and placed into another unoccupied room in a different area of the unit. Incident reported to administrator, DON, ADON [Assistant Director of Nursing] and Provider. Review of the Form 358: Reported Incidents, dated 8/1/23 at 12:20 AM, for resident 409 documented, . [Resident 209] was witnessed by CNA [staff name redacted], at approximately 2215 [10:15 PM] near [resident 409's] bed inappropriately touching his genital area. CNA was reported to separate residents immediately and request assistance in residents shared room. The form further documented that resident 209 was moved to a private room with staff supervision and the police department and Adult Protective Services were notified. A Social Services Summary, dated 8/1/23 at 9:39 AM, indicated, Resident has experienced trauma this last week due to a roommate. IDT was held for Resident with daughter to see additional support needed. So far rt [resident] has not shown deference from baseline. Outside support has been offered and denied multiple times from [resident 409]. Referrals were made to [Behavioral Health Service] and NP so that they are available for help. Staff have states that [resident 409] has shown no emotions that are different then from before trauma. A Social Services Progress Note, dated 8/1/23 at 3:58 PM, indicated, PSYCHOSOCIAL ASSESSEMENT [sic]: Pt has limited ability to answer questions. He is able to answer yes and no as long as he is allowed time for response. Pt was asked questions about emotional and mental health. Pt has expressed sadness about the incident from night before. Pt acknowledges he is not angry just sad. Pt has acknowledged that he would like to see someone . (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A Nursing Progress note, dated 8/2/23 at 11:16 AM, indicated, Resident was visited by two [city name redacted] City Detectives regarding incident with previous roommate on night of 7/31 [23]. Resident gave permission to talk to officers but appeared uncomfortable when questioning proceeded to more detailed questions. Nurse asked resident if he wanted to talk to me without them and he said yes. Resident then stated that 'He touched me. He shouldn't have done that.' I asked him if it was without his permission, if it made him uncomfortable, resident responded yes to both questions. I then asked resident if I could tell the officers what he just told me and he responded yes. Officers were informed of conversation. Wctm [will continue to monitor]. Review of the Form 359: Follow-Up Investigation Report, dated 8/7/23 at 9:20 PM, indicated, P't [sic] has limited ability to answer questions. He is able to answer yes and no as long as he is allowed time for response. Pt was asked questions about emotional and mental health. Pt has expressed sadness about the incident from night before. Pt acknowledges he is not angry just sad. Pt has acknowledged that he would like to see someone. Pt will be referred out for mental health services. [Behavioral Health Service] is 2-3 weeks referral. Psych [psychiatric] NP will be in facility next week which both referrals will be made. Follow-up conversation on 8/7/23, resident confirmed this was not a consensual act. The document further indicated, . [Resident 409] also has a history of depression. [Resident 409] capability to meaningfully answer and participate in the BIMS and PHQ9 [Patient Health Questionnaire-9] assessment process depends largely on his status on any given day; his cognitive level fluctuates. Sometimes he is able to answer the basic questions, and other times he does not answer at all. He requires extensive assist with ADL's [activities of daily living] and wheelchair use . The document further indicated, Abuse allegation verified-in follow up interviews with [resident 409], he confirmed that the incident was not consensual. The facility passed this information on to the [city name redacted] Police Department; [Resident 209] has been removed from the Facility in the custody of the police. The document further indicated, [Staff name redacted] worked the adjacent hall on the night of the incident. [Staff name redacted] re-counted the events that [Staff name redacted] reported; specifically, she confirmed that [resident 409] frequently masturbates and that the staff have been instructed to provide him privacy when he experiences that need . The document further indicated, .[resident 409] is known to masturbate often, even when staff are in the room . A Social Services Progress Note, dated 8/8/24 at 3:48 PM, indicated, Follow up with pt evening of 8/7/2023 on incident from previous week. Nursing has continually monitored Pt for change in physical, mental, or emotional health. Pt is documented to be at baseline. Met with pt this last evening to assess psychosocial wellbeing. Pt was able to discuss to verbalize multiple answers tonight. Pt has acknowledged that he is angry, sad, or frustrated over situation with roommate. He is happy that roommate is no longer in facility. Pt answered questions about daughter, birthyear [sic]. Pt laughed over a few jokes agreeing that SW [Social Worker] is able to come back to visit. Pt is selective on who he talks with it is very limited. Pt was offered mental health services which he declined. Pt was offered someone to talk to pt declined. Facility will continue to monitor for change in mental, physical, or emotional health. A Social Services Progress Note, dated 8/22/24 at 8:42 PM, indicated, Pt receive3d [sic] mail today about upcoming court procedures over past roommate. Pt does not want to know about upcoming hearings unless the court needs him. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Resident 409's care plan revealed a focus of, Potential to demonstrate physical behaviors aeb [as evidenced by]: masturbation. Date Initiated: 12/04/2023. It indicated the Goal, Will not harm self or others through the review date. Date Initiated: 12/04/2023. And included the following interventions, Ensure hand hygiene is reminded and carried out frequently throughout the day. Date Initiated: 12/04/2023. Monitor/document/report to MD of danger to self and others. Date Initiated: 12/04/2023. Provide privacy via curtains and blankets/sheets as needed. Date Initiated: 12/04/2023. 5. Resident 209 was admitted to the facility on [DATE] with diagnoses which included [NAME]'s Encephalopathy, frontal lobe and executive function deficit, hypertension, alcohol use unspecified with alcohol-induced persisting amnestic disorder, major depressive disorder, cognitive communication deficit, and personal history of other mental and behavioral disorders. Resident 209's medical record was reviewed from 10/7/24 through 10/21/24. An admission MDS assessment dated [DATE], indicated resident 209 had a BIMS score of 9 which suggested moderate cognitive impairment. The Hospital History and Physical (H & P), dated 5/23/23, indicated: a. A Progress Note Generic, dated 4/24/23 at 10:05 AM, indicated, .4. History of violent behavior Mental status at baseline. He does have a history of violence, including strangling previous RN [Registered Nurse] at his facility, beating up her roommate. He is currently calm and not showing signs of agitation or aggression. Has hand [sic] several ER [emergency room] visits and admissions in last 6 months for violent behavior at care facility. Seen by psychiatry multiple time, neuropsychiatry 10/5/22- these providers/noted indicated that patient has significant impairment, concerns about decision making . b. A Behavioral Health Progress Note, dated 4/24/23 at 1:11 PM, indicated, Based on his history, patient is likely a at chronic risk of harm due to other. Violence seems to have co-occurred with the emergency of his neurocognitive deficit . An Encounter Progress note, dated 5/24/23 at 12:00 AM, indicated, [Resident 209] isa [sic] [AGE] year-old patient who is seen today as a new patient. He was admitted from [facility name redacted] Hospital. He has known cognitive deficits, history of alcohol abuse resulting in Warnicke Korsakoff syndrome. There was mention of a TBI [traumatic brain injury], but [facility name redacted] Hospital could not find in the actual records of this. He was found wandering the streets in the rain and confused. He was taken to the emergency room by police. He had previously been in [facility name redacted] but was discharged to a facility after violent behavior to the staff. He was transferred to [facility name redacted] Hospital for psychiatric consultation if needed. He has been in and out of facilities for many years, he is alert to self only today, is unsure where he is at or the appropriate year. He is currently laying in bed and appears cooperative. He had previously been on estrogen for hypersexuality, this was stopped at the hospital as that is not an appropriate indication, he is on paroxetine which should be helpful. He does have a sister who it appears has been fairly involved in his care. He takes trazodone at night to help him sleep, psych recommended this be used for aggression. He has also been on Eliquis which appears to have been since 2018 for bilateral PEs [pulmonary embolism]. This has been maintained. He is not able or capable of making his own decisions, had previously been at facilities, will be maintained in the secure memory unit, will have low threshold to intervene with behaviors due to his violent history. (continued on next page)

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Provo Rehabilitation and Nursing	1001 North 500 West Provo, UT 84604

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A Nursing Progress note, dated 5/24/23 at 5:19 AM, indicated, ALERT CHARTING: 72 hour admit charting Pt appears to be adjusting well to change. No negative or depressive statements made this shift. Pt has made 2 sexually suggestive comments to CNAs. Will continue to monitor pt for any changes in behavior. A Social Service Summary, dated 6/5/23 at 6:06 AM, indicated, [Resident 209] is admitted to facility for long term care in memory care. [Resident 209] is a [AGE] year-old male that is poor historian with history of frontal lobe/executive function deficit, neurocognitive deficit, TBI, [NAME] Korsakoff syndrome who was brought to the EDultimately [sic] ER after found wandering streets in the rain knocking on his whole childhood home store. He has been in and out of facilities for the last few years with admits to the ER due to violence incidents. His brother is currently seeking guardianship through court order. [Resident 209] has no plans for discharge at this time. A Nursing Progress Note, dated 6/7/23 at 1:14 AM, indicated, Pt flipped off nurse after nurse redirected him to his room. A Nursing Progress Note, dated 6/11/23 at 7:28 PM, indicated, CNA reported to LN [licensed nurse] that fell ow female pt had wandered into pt's room and pt was inappropriate while touching fell ow pt's shoulder and touching her hair. CNA immediately pulled pt out of the room and closed the door told pt he was very inappropriate. A Nursing Progress Note, dated 7/1/23 at 2:15 AM, indicated, Resident to Resident. Patient hit [name redacted] on her hand with his fist. When [name redacted] was trying to reach a pencil of color. After that he insult her with sexual vulgar words and telling her the F and B word. Continue monitoring [resident 209] aggressivity to avoid harmto [sic] another patient. An IDT Progress Note, dated 7/21/23 at 4:28 AM, indicated, IDT team has met to discussed pt. IDT will hold IDT Care plan meeting with family to discuss placement to other facility with the intentions to benefit the resident to help decrease behaviors. A Nursing Progress Note, dated 7/21/23 at 10:54 PM, indicated, Resident used foul language at nurses aides when they refused to get him more ice/water. This nurse asked nicely for resident not to use such language. Resident used more foul language at me and then stood up to try to intimidate me continuing to curse. Resident directed to his room. No further incidents noted. A Nursing Progress Note, dated 7/23/23 at 1:19 AM, indicated, At 2230 [10:30 PM] hrs [hours] patient arrive to the nurse station demanding the phone because he said he needed to call his Father. The nurse kindly mentioned that it was too late to call family. Also, we mention that tomorrow morning will be a better time to try that. He got furious and stated [sic] to using foul language saying the 'F' word and insulting the nurse calling her by the 'B' word. He also flipped the middle finger to her and alluded sexual offences. Then he left back to his room. A Nursing Progress Note, dated 7/23/23 at 1:38 AM, indicated, Resident to resident: Resident continue with sexual insinuations towards female residents. He was also passing in the hall way and many times he stop outside of the female resident's door and look around if someone was watching. Since he noticed that I was keeping my eye on him he did not enter in the room. Continue monitoring. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	An IDT Progress Note, dated 7/25/23 at 3:00 PM, indicated, Per staff and IDT discussion on 07/25/2023, on 07/21/2023 [resident 209] had asked female resident for sexual favors in which she denied and he left her alone regarding any additional sexual acts. Female resident was safe and unharmed and did not appear to be in any emotional distress, and [resident 209] was redirected. [Resident 209] continued to be monitored over the next several shifts, and was noted by LN on shift to be making sexual insinuations towards female residents, per the LN on shift no female resident was directly spoken to or harmed, [resident 209] was using hand and mouth gestures at female residents in the hallway insinuating oral stimulation of the penis. LN was right behind [resident 209] at the time and redirected him imm[TRUNCATED]

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33215 Based on interview and record review, the facility did not ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property were reported immediately, but not later than two hours after the allegation was made to the State Survey Agency (SSA) and Adult Protective Services (APS). Specifically, for 2 out of 69 sampled residents, notification to the SSA and APS was not done when residents with cognitive impairments and without the capacity to consent were found in a resident room and one of the residents was disrobed from the waist down. Resident identifiers: 70 and 208. Findings included: 1. Resident 70 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, chronic kidney disease stage 2, dementia, essential hypertension, mild protein-calorie malnutrition, dysphonia, history of falling, cognitive communication deficit, major depressive disorder, and fall on same level. Resident 70's medical record was reviewed from 10/7/24 through 10/21/24. A quarterly Minimum Data Set (MDS) assessment dated [DATE], documented that resident 70 had a Brief Interview for Mental Status (BIMS) score of 10. A BIMS score of 8 to 12 indicated moderate cognitive impairment. On 9/1/23 at 12:12 PM, a Nursing progress note documented Note Text : Pt [patient] found by OT [Occupational Therapy] in his room with his pants off and female resident sitting beside him on the bed. OT assisted pt in getting pants on and assisted pt to the dining room. On 9/1/23 at 12:39 PM, a Nursing progress note documented Note Text : CNA [Certified Nursing Assistant] found pt standing behind the curtain with female resident. CNA brought both pt out of the room and to the dining room for lunch. On 9/6/23 at 11:24 AM, a Nursing progress note documented Note Text : Patient is being friendly and having relations with another female resident on the unit. Family is aware and patient is his own power of attorney per nursing management pt is ok to continue relations. Pt was found in his room with pants down and female resident in room. Both parties are in agreement to the situation. Since then both patients have been separate on the unit per their own accord. No concerns at this time, will continue to monitor. A care plan Focus dated 9/18/23, documented RESOLVED: I have a special friend I like to spend time with. We like to hold hands and kiss but sometimes forget that others become uncomfortable when we're in in [sic] public areas displaying affection. - Displaying affection toward resident [resident identifier redacted]. He consented with the affection and resident [resident identifier redacted] son aware and no concern. - Huddle/Inservice to facility employee in the unit. The Interventions initiated on 9/18/23, included: (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Anticipate and meet needs. b. Approach in a calm manner. c. Assist to develop more appropriate methods of coping and interacting. Encourage to express feelings appropriately. d. Caregivers to provide opportunity for positive interaction, attention. Stop and talk with him/her as passing by. e. If reasonable, discuss behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable. f. Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. g. Provide a program of activities that is of interest and accommodates residents status. h. When displaying affection, staff to talk with parties involved to ensure all are consenting. On 10/10/24 at 4:58 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that the resident associated with resident 70 during the incident on 9/1/23, was resident 208. The DON stated the incident was not reported because the incident was identified as a consensual relationship, between resident 208's family and resident 70 being his own power of attorney at that time. 2. Resident 208 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included, but were not limited to, Alzheimer's disease, essential hypertension, depression, and mild protein-calorie malnutrition. Resident 208's medical record was reviewed from 10/7/24 through 10/21/24. An admission MDS assessment dated [DATE], documented that resident 208 had a BIMS score of 99 which indicated resident 208 was unable to complete the interview. On 8/29/23 at 4:50 PM, a Nursing progress note documented Late Entry: Note Text: Resident was found in male residents room sitting on bed. Redirected resident and male resident to join day room activities. Despite the redirection, both residents continued to hold hands and have physical contact. Residents were separated during dinner time. On 8/30/23 at 3:49 PM, a Nursing progress note documented Note Text: NO [new order] from provider to initiate Lexapro r/t [related to] hypersexual behavior secondary to Alzheimers [sic], as well as Pepcid 20mg [milligrams] BID [twice a day]. NO in place, representative aware. On 8/30/23 at 4:52 PM, a Nursing progress note documented Note Text: Resident was found by CNA in male residents room. Male resident did not have any pants or brief on, and female resident had her shirt pulled up some. Resident was removed from male residents room. She was then taken to the shower room, her hospice CNA came to do cares on her. DON notified of happenings. CNA staff aware to keep residents separated. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/1/23 at 12:11 PM, a Nursing progress note documented Note Text: Pt found in fell ow residents room sitting on the bed. OT found pt this way and brought pt out of the room. On 9/1/23 at 12:35 PM, a Nursing progress note documented Note Text: CNA found pt standing behind the curtain with fell ow resident. CNA brought both patients out of the room for lunch. On 9/6/23 at 1:39 AM, a Nursing progress note documented Note Text: Pt was found in another pt's bed at 0130 [1:30 AM]. She was in the same pt's room that had a res [resident] to res situation on 9/4 [23]. No issues today, the other pt calmly reported to nurse that she was in his bed and asked the nurse to help her to her room. On 9/6/23 at 11:21 AM, Nursing progress note documented Note Text: Patient is being flirtatous [sic] with a male resident on unit. They hold hands and pt is often found in male patients room. Earlier male pt was found on his bed with pants down while [resident name redacted] was in the room with him. Patients family is aware and per nursing management family is ok with patients behavior with this one male patient only, if she is to take a liking to any other resident we must notify her family. After pt was found with the other resident in his room they've been separate on the unit per their own accord. Will continue to monitor. A care plan Focus created on 9/18/23 and initiated on 1/8/24, documented I have a special friend I like to spend time with. We like to hold hands and kiss but sometimes forget that others become uncomfortable when we're in in [sic] public areas displaying affection. - Resident displaying affection to resident [resident identifier redacted] and resident [resident identifier redacted]. - Son understand and aware of his mother affection with this resident. - Frequent Visual check and her whereabouts. - Huddle/Inservice staff q [every] change of shift to redirect resident. - Activities that catered to her needs to redirect her behavior. The Interventions created on 9/18/23 and initiated on 1/8/24, included: a. Anticipate and meet needs. b. Approach in a calm manner. c. Caregivers to provide opportunity for positive interaction, attention. Stop and talk with him/her as passing by. d. If reasonable, discuss behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable. e. Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. f. Minimize potential for resident's disruptive behaviors by offering tasks which divert attention. g. Provide a program of activities that is of interest and accommodates residents status. h. Staff to ensure when I am displaying affection towards others, that all parties are consenting. i. Stop and talk with resident when passing by. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/16/24 at 11:37 AM, an interview was conducted with the Medical Director (MD). The MD stated that sometimes he was involved with the capacity to consent for residents but it would depend on the situation with the resident. The MD stated that he would get help from psychiatry if the residents were in and out or questionable. The MD stated if there was going to be something legally he would get more opinions. The MD state if the capacity to consent affected anything medical the facility staff would consult with him. The MD stated that he was not consulted on the interaction with resident 70 and resident 208. The MD stated if he was consulted he did not document on either of the residents. The MD stated if the resident had behavioral health services they would usually follow the resident and not him. The MD stated if the residents were on the dementia unit he would expect to be consulted. The MD stated if the resident had no cognitive impairment, diagnoses, disability, or a BIMS score that would have triggered the decision the residents should have the capacity to consent. The MD stated if the residents were on the regular unit and there was a question about capacity he might call in someone else. The MD stated that the residents had a personalized screening for consent. On 10/17/24 at 3:32 PM, an interview was conducted with the DON. The DON stated if the resident interactions had the potential to be sexual they would look at cognition and if cognition was not there they would contact the family to see if that was something that would be consensual on their end. The DON stated that until that was identified we would keep the residents separated and make sure the residents were safe and their interactions were done safely. The DON stated for the capacity to consent they would look a the residents BIMS score, diagnoses, involvement with social work, and involve therapy on determining those assessments. The DON stated the capacity to consent would be scanned in the residents medical record. The DON stated that resident 208's son stated that if resident 208 was happy he was happy, but of course the son wanted to keep resident 208 safe. The DON stated that staff were educated that resident 70's and resident 208's relationship was consensual but if it was more sexual to redirect them. The DON stated that snuggling or sitting on the couch was okay and it was more of a companionship. The DON stated that she felt the conversations with the family and redirecting of the residents that there was no need to report because it was not abuse.

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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 did not ensure that each resident received adequate supervision to prevent accidents. Specifically, for 2 out of 69 sampled residents, a resident with cognitive impairment eloped from the facility memory care unit. In addition, a resident with cognitive impairment was moved out of the memory care unit and eloped from the facility. Resident identifiers: 50 and 70. Findings included: 1. Resident 70 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, chronic kidney disease stage 2, dementia, essential hypertension, mild protein-calorie malnutrition, dysphonia, history of falling, cognitive communication deficit, major depressive disorder, and fall on same level. Resident 70's medical record was reviewed from 10/7/24 through 10/21/24. On 3/18/23 at 9:35 AM, an Elopement/Wandering Evaluation documented that resident 70 was a Low Risk. On 3/23/23 at 7:54 AM, a Social Service Summary note documented [Resident 70] is admitted to facility for skilled nursing stay at this time. Pt [patient] was living at home with a person that recently moved in with him. Pt has one brother who is not support for him at all. The contact [name redacted] was a senior companion for him and his mother for while and is the only long term he helps. Pt needs 24 hour care due to cognition status. On 3/23/23 at 4:45 PM, a Nursing note documented Note Text : provided assistance with telehealth today with neurologist care taker was present neurologist discussed no concerns that he could see he advised if patient wants to continue to follow up with dementia dx [diagnosis] diagnostic or new dx (example parkinsons) he shouldfollow [sic] up with a general neurologist and he gave recommendations caretaker stated she would schedule and assist patient with the follow up, . On 4/5/23 at 1:28 PM, a Weekly Skilled Review note documented . Cognitive impairment makes discharge concerning, but wants to go home. On 4/13/23 at 9:51 PM, a Nursing note documented Note Text : Resident was observed walking hallway. Resident wandered in room [ROOM NUMBER] and that resident reported he appeared confused, and she called for the CNA [Certified Nursing Assistant] who helped him. Resident currently resting in bed with eyes closed. On 4/15/23 at 9:04 AM, a Nursing note documented Note Text : Alert charting r/t [related to] COC [change of condition]. Resident was recently found wandering into other residents room. Resident has had no recurring behaviors noted during this shift. Resident is alert and oriented per baseline. Vital signs are within normal limits. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/16/23 at 4:22 PM, a Nursing note documented Note Text : Alert charting ongoing to pt for wandered into another pt room. No episode behavior within shift noted. On 4/16/23 at 7:34 PM, a Nursing note documented Note Text : Alert Note: On alert charting d/t [due to] wandering into room [ROOM NUMBER]. Was reported to this writer by the CNA that the family of the resident in room [ROOM NUMBER] told him that the resident had wandered into room [ROOM NUMBER] naked looking for the bathroom. At the time that the CNA was told of this the resident was in his own room. This was reported to management and the Physician. Will pass onto dayshift nurse. WCTM [will continue to monitor] resident for wandering throughout the shift. On 4/17/23 12:00 AM, an Encounter note documented . He has had some issues with wandering and going into peoples rooms, he will likely need the memory care unit for his safety. He reports to be feeling fair, denies any pain, nausea, or other complaints today. Neuro [neurological] - Alert, oriented x2 [person and place]. On 4/18/23 at 11:44 PM, a Nursing note documented Note Text : Resident observed waking in the hall by RT [Respiratory Therapist] and resident stated he just wanted to go sit down in the chairs at the end of the hall. CNA came out of a room observed the resident who told the resident he had been sleeping for three hours and wanted to go fora [sic] walk. When this writer observed resident, he was in his hospital gown which was open in the back had one shoe on and appeared confused he told this writer he was looking for a thing. On 4/19/23 at 12:49 AM, a Daily Skilled Note documented . Resident is Alert, Oriented X 1 [person] No Active Symptoms or Treatments effecting Level of Consciousness, Cognition, Sleep, Mood, or Behavior. Cognitive symptoms described as Alert with confusion. On 4/19/23 at 11:14 AM, a Nursing note documented Note Text : Pt moved from room [ROOM NUMBER] to room [ROOM NUMBER]. No problems with transfer. Provider and management aware. Social work aware. WCTM. (Note: Resident 70 was moved to the memory care unit that was locked.) On 6/18/23 at 9:35 AM, an Elopement/Wandering Evaluation documented that resident 70 was a Low Risk. A quarterly Minimum Data Set (MDS) assessment dated [DATE], documented that resident 70 had a Brief Interview for Mental Status (BIMS) score of 10. A BIMS score of 8 to 12 indicated moderate cognitive impairment. On 6/29/23 at 6:20 AM, a Social Service Summary note documented Social Service Summary : [resident 70] was moved into memory care due to wandering and disrobing after his skilled stay at facility. Pt has had an increased BIMS score since admission. Pt also had a diagnosis of UNSPECIFIED DEMENTIA, UNSPECIFIED SEVERITY, WITHOUT BEHAVIORAL DISTURBANCE, PSYCHOTIC DISTURBANCE, MOOD DISTURBANCE, AND ANXIETY with a history of strokes. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/20/23 at 3:28 PM, a Nursing note documented Note Text : At approximately 1435 [2:35 PM] the pt's brother asked the nurse where the pt is. The nurse asked the brother if he had already checked the pt's room/bathroom as he can usually be found in there and the brother said he was not in there. At this point the nurse and the pt's brother set out to find the pt. Pt was not found in the main dining hall where church was being held. The nurse asked the CNAs if they had seen the pt, one said she thought he might be at church and another one said he had been let out to spend some time outside in front of the building, which others had apparently seen him do on previous occassions [sic]. One cna took her car out driving around the facility searching for the pt. The nurse and pt's brother continued to walk around inside and outside the facility looking for the pt. While looking outside one of the facility's transport staff told the nurse that he had received a call about the pt being found and was on his way to get him. Once returned to the facility, the nurse assessed the pt before the pt's brother took the pt out for their dinner appointment. Neuros [neurological] started since the fall was unwitnessed. On 8/20/23 at 9:25 PM, a Nursing note documented Note Text : On monitoring for elopement, frequent checks done. safety precautions in place. all needs anticipated and met. call light within reach for assistance. will cont [continue] to monitor. On 8/25/23 at 7:45 PM, a Fall Committee Interdisciplinary Team (IDT) note documented LATE ENTRY Note Text : DON [Director of Nursing] and PT [Physical Therapy] present during review on 08/25/2023. Most recent fall risk assessment conducted 08/20/2023, with a score of 9, indicating resident is a medium fall risk. Most recent fall recorded 08/20/2023, fall was unwitnessed and did not result in any injuries. New interventions include; re-assess elopement risk and education to staff on memory care unit policy and procedure. Exhibit Form 359 submitted to the State Survey Agency documented on 8/21/23 at 12:00 PM, The resident was friendly and simply stated he was bored and wanted to go outside. The resident stated that he also was trying to go see his brother in Springville. I asked him if he was happy here, he said yes. The resident said he feels safe and liked living here. On 8/21/23 at 11:00 AM, CNA 2 was interviewed by a staff member [CNA 2] was the staff member that opened the door and let [resident 70] leave. While speaking with her, she said that he simply asked to go outside, and she let him out. She claims that she has seen him outside of the memory care unit before, as well as the courtyard outside. So she didn't think it was an issue letting him out. After some education, she expressed remorse in allowing him outside unsupervised, and stated that she should have checked with the floor nurse. On 10/10/24 at 11:00 AM, an interview was conducted with CNA 1. CNA 1 stated that she was not aware of any residents that were able to go outside unattended and she had never seen any resident go outside unattended. CNA 1 stated she had worked at the facility since September 2024. CNA 1 stated if a resident wanted to go outside she would ask the nurse or tell the nurse to let them know who she was taking outside. CNA 1 stated that she would stay outside with the resident. CNA 1 stated the smoking area was secured and if a resident was left out in the smoking area they would not be able to get out. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/17/24 at 3:36 PM, an interview was conducted with the DON. The DON stated that resident 70's brother had come to the facility to take resident 70 out and that was not uncommon. The DON stated that resident 70's brother came in looking for resident 70 and the nurse was unsure where resident 70 was and starting looking for him. The DON stated as staff were outside the transportation called to tell them they found resident 70 and they were on the way to get him. The DON stated they would determine if a resident needed to be on the unit by looking at their previous elopement history, reports from the hospital, wandering or exit seeking in the facility, and they would discuss with the family proper placement. The DON stated the elopement assessment contained resident cognition, elopement history, and statements wanting to go home. The DON stated that resident 70 was noticed missing at 2:35 PM. The DON stated a bystander called that resident 70 had fallen in the grass a couple blocks away. The DON stated CNA 2 reported she had seen resident 70 up front outside before and thought it was okay to let him out. The DON stated that education was provided to CNA 2 to clarify if a resident on the secured unit could go out. The DON stated CNA 2 was a newer employee. The DON stated when resident 70 had been outside in the past it had been with recreation therapy. The DON stated they were using consistent staff on the unit and a therapist had a desk on the unit and was on the unit daily. 2. Resident 50 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, dementia, vascular dementia, pain, essential hypertension, need for assistance with personal care, and cognitive communication deficit. Resident 50's medical record was reviewed from 10/7/24 through 10/21/24. A quarterly MDS assessment dated [DATE], documented that resident 50 did not have a BIMS score due to resident 50 rarely or never understood. On 11/7/23, the Elopement Wandering Evaluation documented that resident 50 was a high risk for elopements. On 12/12/23 at 1:47 PM, a Nursing note documented Note Text : IDT discussion on moving resident off of unit d/t todays incident, as well as lack of exit seeking behavior. Resident is observed to wander aimlessly at times but is not exit seeking. Discussed plan to move resident today to room [ROOM NUMBER]A with IDT and resident Niece [name redacted]- Niece approves of room change and will be coming to see him at the facility today. On 12/12/23, resident 50 was to room [ROOM NUMBER]-A. (Note: Resident 50 was moved to room that was not on the secured unit.) (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/24/23 at 3:42 PM, a Nursing note documented Note Text: Resident was seen at apx [approximately] 1245 [12:45 PM] after lunch today walking with walker towards 400 hall. Nurse could not locate resident about 10 minutes later and began looking. Staff and management notified when resident could not be found. Staff looked in all rooms, outside around building and neighborhood. Nurse attemped [sic] multiple times to contact family but unable to reach anyone. Nurse called police to report resident missing. Dispatch stated that a call was made about a man outside near our building. [Name redacted] fire dept [department], ambulance, and police were seen near [name redacted] underground parking. Nurse ran over to [name redacted] with dispatch on the phone. Resident was found with police and EMTs [Emergency Medical Technicians]. EMTs reported that he may have fallen, bystanders helped him to the side of the parking garage and called police. EMTs reported that all VS [vital signs] were wnl [within normal limits], resident appeared unharmed upon assessment. A small scrape to right knee is the only skin alteration nurse noted. Nurse and EMTs brought resident back to facility in ambulance. Resident was immediately returned to 100 Hall locked unit. Will have new placement in rm [room] 103. Neuro's started on resident on 100 Hall. VSS [vital signs stable], resident happy to be back. On 12/28/23 at 4:41 PM, a Nursing note documented Note Text : patient has been wandering hallways on memory care unit. He has entered rooms that are not his. He got upset at a cna for redirecting him out of a female residents room. He is currently in a room that is not his but is unoccupied. He does not want to go to his own room and doesn't show any reason to dislike his current room. He just seems to be confused and wandering. Otherwise no issues noted. Will continue to monitor On 2/21/24 at 11:25 PM, a Nursing note documented Note Text : Alert charting. Patient is struggling with the room move and is not happy with it. He was seeking to elope and asked staff to unlock the door. He is adamant that he is leaving and is complaining about his roommate not sleeping. On 2/25/23 at 11:57 AM, a Nursing note documented Note Text : resident and family notified of room change and was agreeable to room change today resident moved with all belongings room updated in chart. On 10/17/24 at 3:49 PM, an interview was conducted with the DON. The DON stated that resident 50 had admitted to the unit initially due to cognition and elopement risk. The DON stated that resident 50 was no longer exit seeking so staff thought it was appropriate to move resident 50 off the unit. The DON stated at 12:45 PM, after lunch resident 50 was walking the back side of the hall and 10 minutes later the nurse could not locate resident 50. The DON stated that staff did a search of the building, contacted the family, called the police department, and dispatch reported they might have located resident 50.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47431 Based on observation, interview, and record review, the facility did not ensure that a resident who needs respiratory care was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the resident's goals and preferences. Specifically, for 1 out of 69 sampled residents, a resident that required oxygen (O2) therapy did not have physician's orders indicating the type of oxygen delivery system, when to administer the oxygen, and the equipment settings for the prescribed flow rates. Resident identifier: 103. Findings included: Resident 103 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included metabolic encephalopathy, pneumonia, acute posthemorrhagic anemia, hypovolemic shock, and chronic obstructive pulmonary disease. On 10/8/24 at 9:35 AM, an observation was made of Licensed Practical Nurse 5 placing resident 103's O2 tubing and positioning the nasal cannula (NC) on resident 103's face. On 10/10/24 at 10:32 AM, an observation was made of resident 103 with a NC on his face and the O2 concentrator set at 2 Liters (L). A review of resident 103's medical record was conducted on 10/7/24 through 10/21/24. On 9/6/24, a physician's order for Resident 103 documented, O2 per NC at 2L per minute to keep saturations (sats) greater than 90% every shift. The physician's order was discontinued on 9/10/24 at 9:39 AM, due to discharged to the hospital. On 9/10/24 at 2:10 AM, a Nursing Progress Note revealed the following. Resident 103 transferred to the hospital at approximately 10:00 PM on 9/9/24. Provider notified of situation and gave orders for transfer to emergency department (ED). The resident transported to the hospital via ambulance service. Nurse to nurse report was given to ED charge nurse. On 9/13/24 at 8:20 PM, a Nursing Progress Note revealed the following. Resident 103 arrived back at the facility at approximately 3:30 PM, via facility's transport from the hospital. Patient was at the hospital for a Gastrointestinal (GI) bleed and GI ulcer. On 9/13/24, a physician's order for resident 103 documented, O2 per NC at 2 Liters per minute to keep sats greater than 90% every shift. The physician's order was discontinued on 9/19/24 at 9:34 AM. On 9/18/24 at 8:08 PM, a Nursing Progress Note revealed the following. Resident 103 was sent to the hospital via ambulance service at 7:30 PM, due to low O2 sats at 79%. On 9/18/24 at 11:25 PM, a Nursing Progress Note revealed the following. Resident 103 has been admitted to the hospital with hypoxia, hypotensive, and mental status. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/18/24, a Care Plan was initiated and created for resident 103. The focus revealed resident 103 had O2 therapy related to ineffective gas exchange and chronic obstructive pulmonary disease (COPD). The goal being that resident 103 would have no signs and symptoms (s/sx) of poor O2 absorption through the review date of 1/1/25. With an intervention of, if the resident was allowed to eat, oxygen still must be given to the resident but in a different manner (e.g., change from mask to a nasal cannula). Return resident to the usual oxygen delivery method after the meal. On 9/25/24 at 5:45 PM, a Nursing Progress Note revealed the following. Resident 103 arrived with the facility's transport team from the hospital at around 2:00 PM. Patient was stable. On 9/25/24, a hospital discharging order revealed the following. Discharge oxygen instructions, wear 1L of oxygen for comfort and to keep saturations above 90%. A review of physician's orders revealed no active order for oxygen therapy upon return from hospital on 9/25/24. On 9/27/24, a Care Plan was initiated and created for resident 103. The focus revealed resident 103 had COPD. The goal would to be free of s/sx of respiratory infections through review date. With the intervention, give oxygen therapy as ordered by physician. On 10/16/24 at 2:20 PM, an interview was conducted with Registered Nurse (RN) 3. RN 3 stated every time when entering a room, she would do a quick assessment of the resident looking for s/sx of shortness of breath, check what the O2 level was set at, and using her nursing judgement she would adjust the level as needed. RN 3 stated that there were standing orders, which was to keep the resident O2 levels maintained. RN 3 stated if O2 levels dip to low she would call the physician for additional orders. RN 3 stated resident 103 should have an active order to be on oxygen. On 10/17/24 at 3:15 PM, an interview was conducted with the Director of Nursing (DON). The DON stated oxygen should have an order, even if there were standing order, there still needed to be an order that was entered into the resident's medical record.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33215 Based on interview and record review, the facility did not ensure that pain management was provided to residents who required such services. Specifically, for 1 out of 69 sampled residents, a resident that complained about mouth pain for approximately ten months was not provided interventions timely. Resident identifier: 64. Findings included: Resident 64 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, anoxic brain damage, antisocial personality disorder, delusional disorders, dysphagia, anxiety disorder, psychotic disorder with delusions, mood affective disorder, major depressive disorder, mild protein-calorie malnutrition, essential hypertension, and mental disorder. Resident 64's medical record was reviewed on 10/9/24 through 10/21/24. A care plan Focus initiated on 6/7/23 and revised on 9/16/24, documented PAIN [resident 64] has acute/chronic pain r/t [related to] Cervicalgia, Polyneuropathy, GERD [gastroesophageal reflux disease], mouth pain and low back pain. The Goal included Will verbalize adequate relief of pain or ability to cope with incompletely relieved pain through the review date. and Will voice a level of comfort of [sic] through the review date. The interventions included: a. Anticipate need for pain relief and respond immediately to any complaint of pain. Initiated on 6/7/23. b. Monitor/record/report to Nurse any signs and symptoms (s/sx) of non-verbal pain: Changes in breathing (noisy, deep/shallow, labored, fast/slow); Vocalizations (grunting, moans, yelling out, silence); Mood/behavior (changes, more irritable, restless, aggressive, squirmy, constant motion); Eyes (wide open/narrow slits/shut, glazed, tearing, no focus); Face (sad, crying, worried, scared, clenched teeth, grimacing) Body (tense, rigid, rocking, curled up, thrashing). Initiated on 6/19/23. c. Pain assessment every shift. Initiated on 6/19/23, d. Report to Nurse any change in usual activity attendance patterns or refusal to attend activities related to s/sx or complaints of (c/o) pain or discomfort. Initiated on 6/7/23. e. Reposition for comfort as tolerated. Initiated on 6/19/23. f. Use non pharmalogical interventions to aid in treating pain. Initiated on 6/19/23. An additional care plan Focus initiated on 6/19/23 and revised on 9/16/24, documented DENTAL [resident 64] is Edentulous. The Goal included Will be free of infection, pain or bleeding in the oral cavity by/through review date. The interventions initiated on 6/19/23, included: a. RESOLVED: Administer medications as ordered. Monitor/document for side effects and effectiveness. Resolved date 9/26/14. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Coordinate arrangements for dental care, transportation as needed/as ordered. c. Monitor/document/report to Medical Doctor (MD) as needed (PRN) signs and symptoms of oral/dental problems needing attention: Pain (gums & palate), Abscess, Debris in mouth, Lips cracked or bleeding, Tongue (black, coated, inflamed, white, smooth), Ulcers in mouth, Lesions. d. Requires Mechanical Soft texture. Consult with dietitian and change if chewing/swallowing problems are noted. The Order Summary was reviewed. The following medications were started for pain management on 6/6/23, a. Acetaminophen oral tablet, give 650 milligrams (mg) by mouth every six hours PRN for pain. b. Benzocaine mouth/throat Gel 10 % dental, give one application by mouth before meals and at bedtime for gum pain. c. Celecoxib oral capsule, give 100 mg by mouth every 12 hours PRN for pain. d. Gabapentin oral tablet, give 100 mg by mouth three times a day for neuropathy. e. Lidocaine external patch 4 %, apply to affected area topically two times a day for pain. f. Tylenol oral tablet, give 650 mg by mouth three times a day for pain. On 12/11/23 at 12:22 PM, a Minimum Data Set (MDS) Notes documented LATE ENTRY Note Text : resident c/o difficulty chewing and swallowing r/t mouth pain and has active mar [Medication Administration Record] for mouth numbing gel. On 12/23/23 at 10:56 AM, a Nursing note documented Note Text : Pt [patient] asking to go to the hospital because he is sick and that his mouth is burning. Pt given his med [medication] for his mouth, pt went to his room. On 1/19/24 at 9:42 AM, Nursing note documented Pt c/o that he does not feel good, he feels really sick and needs to go to the hospital. Pt states his whole face is swollen and the right side of his face hurts more. States he feels dizzy and these symptoms started about 5 days ago. States he is dying. No swelling to face noted. Pt was able to eat most of his breakfast. Pt resp [respirations] even and unlabored. Breath sounds clear all quadrants, moving air well. Heart with reg [regular] rate. Abd [abdomen] soft non tender. Bowel sounds present all quadrants. Pt mouth checked with tongue blade and flashlight. No redness, no swelling no drainage noted. Pt has Benzocaine topical scheduled before meals and at hs [at bedtime]. Pt has started smoking again. not sure when he started again. MD made aware. On 1/20/24 at 9:41 AM, a Nursing note documented Note Text : Pt reports his head hurts really bad. Pt took his medications. Pt is sitting by the nurses station and took hold of his head and began to shake and kick he feet. incident last approx [approximately] 12 seconds. Pt states he needs to see a doctor because its happening too much. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/21/24 at 9:07 AM, an electronic Medication Administration Record (eMAR) -Medication Administration Note documented Note Text : MONITOR LEVEL OF PAIN every shift Pt states he is in pain rubbing the right side of his face, cannot rate pain. given scheduled Tylenol already. On 1/25/24 at 10:33 AM, an eMAR-Medication Administration Note documented Note Text : Celecoxib Oral Capsule 100 MG Give 100 mg by mouth every 12 hours as needed for pain PRN Administration was: Ineffective. On 1/30/24 at 9:23 AM, a Social Services note documented Note Text : Patient is stating that they need to see the dentist. Dentist has been notified for visit with patient. On 1/30/24 at 2:09 PM, a Nursing note documented Note Text : Dentist came to facility to see resident due to the pain in his gums/jaw. After assessment by dentist, recommendation to start diflucan 100mg PO [by mouth] BID [twice a day] for the first day, then once daily for 13 days for a total of 15 tablets. Family notified of treatment. On 2/2/24 at 6:52 AM, an eMAR-Medication Administration Note documented Note Text : MONITOR LEVEL OF PAIN every shift pt reports he gets really bad pain in his brain causing his brain to wobble. Pt grabbed his head with both hands and head began to shake and groaning for several seconds. MD notified. On 2/4/24 at 10:17 PM, a Nursing note documented Note Text : Alert Charting: Resident continues on fluconazole for gum infection, no adverse side effects noted at this time. Resident with c/o gum pain this eve [evening], pain relief gel administered as ordered. On 2/5/24 at 12:48 PM, a Nursing note documented Note Text : Alert Charting: Resident continues on fluconazole for gum infection, no adverse side effects noted at this time. Resident complained of normal mouth pain and pain relief gel administered as ordered. On 2/7/24 at 11:19 AM, a Nursing note documented Note Text : Pt continues on Fluconazole 100 mg BID daily. Pt still complains that his gum hurts and asks for more soon after it has been applied. No side effects noted. On 2/8/24 at 1:25 PM, a Nursing note documented Note Text : patient continues fluconazole to treat oral fungal infection patient reported mouth pain but no other concerns noted. On 2/8/24 at 11:18 PM, a Nursing note documented Note Text : ABX [antibiotic] Fluconazole Patient continues fluconazole to treat oral fungal infection. Patient reported mouth pain and said the topical cream helped during this shift. On 2/9/24 at 1:57 PM, a Nursing note documented Note Text : alert charting patient continues fluconazole for fungal infection in mouth pain still reports some pain. On 2/10/24 at 12:25 AM, an eMar - Shift Level Administration Note documented Note Text : Pt c/o gum pain for which he received orajel for comfort. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/15/24 at 11:24 AM, a Nursing note documented Note Text : ALERT CHARTING: Pt has finsihed [sic] course of Fluconazole. No neg [negative] side effects noted. Pt toleratied [sic] course of medication well. c/o gum pain this morning. On 3/2/24 at 12:17 PM, an eMAR-Medication Administration Note documented Note Text : MONITOR LEVEL OF PAIN every shift Pt complained of having gum pain. On 3/4/24 at 8:32 AM, an eMAR-Medication Administration Note documented Note Text : MONITOR LEVEL OF PAIN every shift Resident c/o pain 8/10 in gums. Benzocaine cream applied per orders. On 3/6/24 at 9:29 AM, an eMAR-Medication Administration Note documented Note Text : MONITOR LEVEL OF PAIN every shift my mouth hurts. On 4/2/24, a dental visit note documented a periodic oral evaluation. 4.2.24 - Exam complete. Patient was prescribed an antifungal mouthwash at our previous visit, which appeared to be successful. Patient has a severely dry mouth, encouraged drinking plenty of fluids. On 4/8/24 at 12:43 PM, a Change in Condition note documented Change in Condition : Symptoms or signs noted of Condition change: Pain (uncontrolled) . Notifications : Reported to primary care clinician: [name of Nurse Practitioner redacted] Date and time of clinician notification: 04/08/2024 7:00 AM . On 4/8/24 at 12:50 PM, a Nursing note documented Note Text : patient reported intense gum pain given tylenol and celebrex scheduled oragel [sic] with some relief md [Medical Director] don [Director of Nursing] and [name redacted] notified. On 4/8/24 at 3:45 PM, a Condition Follow-up note documented Condition follow-up note from start of : 4/8/2024 Resident is being monitored for : pain in gums . Pnl [pain level] 3 - 4/8/2024 14:33 [2:33 PM] Pain scale: Numerical Current Conditions : pain tylenol celebrex and orajel given therapy applied heat . On 4/8/24 at 11:30 PM, a Condition Follow-up note documented Condition follow-up note from start of : 4/8/2024 Resident is being monitored for : pain in gums . Pnl 2 - 4/8/2024 19:08 [7:08 PM] Pain scale: Numerical Current Conditions : pain tylenol celebrex and orajel given therapy applied heat . On 4/9/24 at 1:00 AM, an Encounter note documented . Chief Complaint / Nature of Presenting Problem: Mouth Pain History Of Present Illness: Patient is a [AGE] year-old male with a history of anoxic brain injury and antisocial personality disorder who has been complaining of mouth and gum pain. Nursing reports that he has been complaining of mouth and gum pain for a while. He has had all of his teeth already removed. On exam it was not the patient's teeth or mouth that was hurting him, it was the patient's jaw and face on the right side.He [sic] had no evidence of rash, induration, swelling, or cellulitis. He had no signs concerning for shingles. Diagnosis, Assessment and Plan . Mouth pain Right upper jaw/gum pain. No obvious abnormality or trauma. Increase gabapentin to 300 mg by mouth 3 times a day Consider increasing Celebrex if gabapentin increased does not improve pain. Patient has all of his teeth removed. Refer to ENT [Ear, Nose, and Throat] for evaluation. The note was signed by the Nurse Practitioner (NP). (Note: On 6/18/24, the Celebrex (celecoxib) was scheduled BID but the dose was never increased.) (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/9/24, the Order Summary Report documented ENT referral r/t right upper jaw pain. On 4/9/24 at 2:49 PM, a Nursing note documented Note Text : N/O [new order] [name redacted] NP to increase Gabapentin to 300mg for neuropathy and refer pt to ent for right upper jaw pain. orders updated. Family and management aware. On 4/9/24 at 3:33 PM, a Condition Follow-up documented Condition follow-up note from start of : 4/8/2024 Resident is being monitored for : increased gum pain . Pnl 1 - 4/9/2024 09:39 [9:39 AM] Pain scale: Numerical Current Conditions : patient continues to complain of mouth pain given prn medications with scheduled encouraged rest pain has improved but he is still very uncomfortable . On 4/9/24 at 11:25 PM, a Condition Follow-up documented Condition follow-up note from start of : 4/8/2024 Resident is being monitored for : increased gum pain . Pnl 6 - 4/9/2024 20:16 [8:16 PM] Pain scale: Numerical Current Conditions : Patient continues to complain of increased gum pain. Patient was able to sleep after administration of PRN pain medication. Patient stated not drinking a lot of water at this time because the cold ice hurts his mouth. Room temperature water was provided. On 4/10/24 at 1:25 AM, a Nursing note documented Note Text : alert charting r/t COC [change of condition]: Resident continues to complain of gum pain. Patient was able to sleep this shift after administration of PRN pain medication. On 4/10/24 at 3:55 PM, a Condition Follow-up documented Condition follow-up note from start of : 4/8/2024 Resident is being monitored for : Increased gum pain . Pnl 4 - 4/10/2024 08:26 [8:26 AM] Pain scale: PAINAD [Pain Assessment in Advanced Dementia] Current Conditions : Res [resident]Gabapentin was increased to 300mg and it has helped but res is still complaining of some pain relieved with prn Tylenol and [NAME] [sic]. On 4/11/24 at 12:01 AM, a Condition Follow-up documented Condition follow-up note from start of : 4/8/2024 Resident is being monitored for : Increased gum pain . Pnl 5 - 4/10/2024 21:34 [9:34 PM] Pain scale: Numerical Current Conditions : Res Gabapentin was increased to 300mg resident is still complaining of pain, somewhat relieved with prn [NAME] [sic]. On 4/11/24 at 2:36 AM, a Condition Follow-up documented Condition follow-up note from start of : 4/8/2024 Resident is being monitored for : Increased gum pain . Pnl 6 - 4/11/2024 01:18 [1:18 AM] Pain scale: Numerical Current Conditions : Resident up to nurses' station with C/O 'bad' pain in gums. Given PRN Tylenol with some relief. On 4/11/24 at 5:29 AM, a Nursing note documented Note Text : Alert Charting - Med Change: Resident continues on increased Gabapentin without S/S [signs and symptoms] of adverse effects. Resident up at 0118 and again at 0500 [5:00 AM] with continued C/O gum pain. Given Tylenol at 0118, and instructed resident that I could only give Tylenol againafter [sic] 0718 [7:18 AM]. On 4/11/24 at 1:14 PM, a Nursing note documented Note Text : Gum pain charting. patient has [sic]requesting an appointment for his gums. patient was notified there has been a referral put in for that. been reporting pain continuously. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/12/24 at 1:25 AM, a Nursing note documented Note Text : Alert charting r/t med change: Gabapentin increased to 300mg. Patient was compliant [sic] with medication this shift and tolerated well. Patient continues to complain of intense pain to gums. On 4/12/24 at 1:26 AM, a Nursing note documented Note Text : alert charting r/t COC: Patient continues to complain of intense pain to gums. Patient was able to sleep after administration of PRN pain medication. On 4/12/24 at 5:00 AM, a Nursing note documented Note Text : Patient continues to complain of increase pain. Patient was administered PRN Tylenol at 0200 [2:00 AM]. At 0500 patient requested an additional dose of Tylenol. Nurse informed patient that no more doses or pain medication were available at the moment and that the provider would be made aware of the current orders not being sufficient to alleviate pain. Patient became very distressed and aggressive, and started kicking the door to the nurses station. Management & provider notified. On 4/13/24 at 2:43 AM, a Nursing note documented Note Text : Resident C/O pain/pressure to head and extreme gum pain. Tylenol ineffective. Given Celecoxib Oral Capsule 100 MG (Celecoxib). On 4/13/24 at 8:13 AM, an eMAR-Medication Administration Note documented Note Text : Celecoxib Oral Capsule 100 MG Give 100 mg by mouth every 12 hours as needed for pain PRN Administration was: Ineffective. On 4/15/24 at 1:00 AM, an Encounter note documented . Chief Complaint / Nature of Presenting Problem: Dental Pain History Of Present Illness: Patient is seen today complaining of dental pain. Patient is not able to identify the specific tooth. Patient already has an appointment with a dentist but unknown how soon that will be. Patient will likely need some breakthrough pain management until his appointment. Diagnosis, Assessment and Plan . Mouth pain Appointment with dentist is being established. Will offer patient some low-dose oxycodone as needed until his appointment. Will also consider prophylactic antimicrobial coverage. Follow-up Plan: Oxycodone 5 mg every 6as [sic] needed x 7 days or until his dentist appointment which ever comes first. The note was signed by the NP. (Note: The prophylactic antimicrobial coverage was not started.) On 4/15/24 at 10:59 AM, a Nursing note documented Note Text : Resident was started on oxycodone 5mg Q6 [every six] hours for 7 days to assist with gum pain until he is able to go to the dentist/ ENT appointment. On 4/15/24 at 12:18 PM, an eMAR-Medication Administration Note documented Note Text : Celecoxib Oral Capsule 100 MG Give 100 mg by mouth every 12 hours as needed for pain Given for severe oral pain. On 4/16/24 at 12:00 AM, an eMAR-Medication Administration Note documented Note Text : Acetaminophen Oral Tablet Give 650 mg by mouth every 6 hours as needed for pain PRN Administration was: Ineffective Follow-up Pain Scale was: 6. On 4/16/24 at 5:48 AM, a Nursing note documented Note Text : Alert Charting: Resident started on Oxycodone 5mg prn for pain. Resident C/O pain at 0059 [12:59 AM] 15 Apr [April]. with some relief after 1 hour. Resident with no S/S of adverse effects. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/16/24 at 7:02 AM, an eMAR-Medication Administration Note documented Note Text : MONITOR LEVEL OF PAIN every shift pt reports his neck pain is 9/10 and 10/10 for his mouth. On 4/17/24 at 12:51 PM, a Condition Follow-up note documented Condition follow-up note from start of : 4/8/2024 Resident is being monitored for : Increased gum pain . Pnl 4 - 4/17/2024 08:58 [8:58 AM] Pain scale: Numerical Current Conditions : Pt c/o gum pain today. Asked for more after he had received a recent dose. at one point pt was getting very anxious and grimacing and calmed down after medication was given to him. Pt does not like cold water, LN [Licensed Nurse] gave warm tap water which pt drank without difficulty. On 4/17/24 at 8:50 PM, a Condition Follow-up note documented Condition follow-up note from start of : 4/8/2024 Resident is being monitored for : Increased gum pain . Pnl 0 - 4/17/2024 19:43 [7:43 PM] Pain scale: Numerical Current Conditions : Patient complained of intense gum pain this shift. Pain was well controlled with PRN medication. Patient has been able to sleep this shift. No new concerns at this time. On 4/18/24 at 2:07 AM, an eMAR-Medication Administration Note documented Note Text : oxyCODONE HCl Oral Tablet 5 MG Give 1 tablet by mouth every 6 hours as needed for pain for 7 Days PRN Administration was: Ineffective Patient continues to complain of intense pain. Follow-up Pain Scale was: 6. On 4/19/24 at 4:07 AM, an eMAR-Medication Administration Note documented Note Text : Acetaminophen Oral Tablet Give 650 mg by mouth every 6 hours as needed for pain PRN Administration was: Ineffective Follow-up Pain Scale was: 6. On 4/20/24 at 12:17 AM, an eMAR-Medication Administration Note documented Note Text : Celecoxib Oral Capsule 100 MG Give 100 mg by mouth every 12 hours as needed for pain PRN Administration was: Ineffective. On 4/22/24 at 3:36 PM, a Nursing note documented Note Text : ENT clinic referred patient to a clinic specializing in TMJ [temporomandibular joint]. On 4/27/24 at 7:42 AM, an eMAR-Medication Administration Note documented Note Text : MONITOR LEVEL OF PAIN every shift about a 9, my gums hurt real bad. On 4/29/24 at 7:15 AM, an eMAR-Medication Administration Note documented Note Text : Acetaminophen Oral Tablet Give 650 mg by mouth every 6 hours as needed for pain Oral pain 7/10. On 6/4/24 at 3:57 PM, an eMAR-Medication Administration Note documented Note Text : CP [compound] -Magic Mouthwash 1:1:1 [ratio of viscous lidocaine, Maalox, and diphenhydramine] Give 10 ml [milliliters] by mouth four times a day for Mouth pain for 14 Days Swish and spit medication still pending from pharmacy, MD aware. (Note: The physician's order was discontinued on 6/18/24.) On 6/4/24, a dental visit note documented that a limited oral exam was completed and a cancer screening. Resident 64's pain was not addressed. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/18/24 at 1:00 AM, an Encounter note documented . Chief Complaint / Nature of Presenting Problem: Jaw pain History Of Present Illness: Patient is seen today for follow-up of his jaw pain which has been consistent and persistent since his admission last year. Patient is edentulous and has had workups with dentistry in the past. Patient has been taking numbing gels to his gums but there are concerns for TMJ. Patient is confused and requires memory care secure unit for safety and wandering risk. Patient does have as needed orders for Celebrexbut [sic] has not been taking them as often as he could. Follow-up Plan: Increase celebrex to 100 mg BID. The note was signed by the NP. On 6/18/24 at 9:34 AM, a Nursing note documented Note Text : new order: schedule Celebrex to BID for jaw pain. On 6/21/24 at 7:05 AM, an eMAR-Medication Administration Note documented Note Text : MONITOR LEVEL OF PAIN every shift states my gums are killing me. On 6/21/24 at 7:05 AM, an eMAR-Medication Administration Note documented Note Text : Celecoxib Oral Capsule 100 MG Give 100 mg by mouth two times a day for pain pt states his gums are killing me. On 6/21/24 at 2:03 PM, an eMAR-Medication Administration Note documented Note Text : (AA [antianxiety]- MONITOR EPISODES Q [every] SHIFT OF ANXIETY AEB [as evidenced by]: anxious statements every shift for monitoring c/o pain to gums and neck. On 6/21/24 at 7:16 PM, a Nursing note documented Note Text : ALERT CHARTING: No adverse reaction noted to Celebrex. Pt complains of having more pain to gums and neck today. Pt gets some relief after meds [medications] given. Pt has been OOB [out of bed] all day watching TV then falls asleep on the couch. Enc [encourage] to go to his bed but wants to stay in the day room to watch tv. On 6/22/24 at 3:25 AM, a Nursing note documented Note Text : Alert Charting: Resident continues on Celebrex. No adverse reactions noted. Resident does C/O more breakthrough pain than before medication change. On 6/23/24 at 12:48 PM, an eMAR-Medication Administration Note documented Note Text : Acetaminophen Oral Tablet Give 650 mg by mouth every 6 hours as needed for pain Follow-up Pain Scale was: 8 PRN Administration was: Ineffective md don aware. On 6/23/24 at 12:53 PM, a Nursing note documented Note Text : Pt asking for [NAME] [sic] before he eats lunch. Pt rates gum pain at 8/10. No relief from earlier dose. Pt slept for approx 2 hours and when he woke up for lunch he began c/o gum pain. MD, don aware. On 6/25/24 at 10:01 AM, an eMAR-Medication Administration Note documented Note Text : (AA)- MONITOR EPISODES Q SHIFT OF ANXIETY AEB: anxious statements every shift for monitoring pain to gums, pt gets very anxious and demands medication. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/2/24 at 1:00 AM, an Encounter note documented . Chief Complaint / Nature of Presenting Problem: Mouth and neck pain History Of Present Illness: Patient is a [AGE] year-old male who is a long-term resident of our memory care unit. He is complaining of chronic mouth and neck pain. Nursing reports that he complains of mouth and neck pain specially after he smokes. He refuses to wear his dentures. They feel like his pain has been much improved since starting Celebrex. Patient denies any other acute issues or concerns. Diagnosis, Assessment and Plan . Mouth pain Nurse reports that he is complaining of his mouth and neck pain less since starting the Celebrex. I encouraged the patient to stop smoking which he stated he would not. He appears to be comfortable. He states that he is not having mouth pain currently. Continue Celebrex 100 mg twice a day . The note was signed by the NP. On 7/5/24 at 7:49 AM, an eMAR-Medication Administration Note documented Note Text : Celecoxib Oral Capsule 100 MG Give 100 mg by mouth two times a day for pain Pt took his meds with water and began shaking his head and moaning and groaning om [sic] pain. calmed down after putting oral gel on his gums. On 7/8/24 at 12:02 PM, a Nursing note documented Note Text : patient refused tums this am stated it [NAME] [sic] his gums to chew. On 7/9/24 at 7:54 AM, an eMAR-Medication Administration Note documented Note Text : MONITOR LEVEL OF PAIN every shift 'whew' my gums hurts real bad. On 7/11/24 at 7:49 AM, an eMAR-Medication Administration Note documented Note Text : Calcium Carbonate Oral Wafer Give 500 mg by mouth one time a day for supplement refused stated it hurts his gums to chew md notified. On 7/21/24 at 7:47 AM, an eMAR-Medication Administration Note documented Note Text : Celecoxib Oral Capsule 100 MG Give 100 mg by mouth two times a day for pain pt states my whole mouth hurts really bad. On 8/5/24 at 11:51 AM, a Social Services note documented Note Text : Referred out to be seen by dentist. On 8/13/24 at 8:05 AM, a Social Services note documented LATE ENTRY Note Text : Resident was seen by dental today. Dentist advise using magic mouthwash regularly. On 8/13/24, a dental visit note documented 8.13.24 - Spoke to patient about using Magic Mouthwash regularly with indefinite refills. 8/5/24 - Per SW [Social Worker], [name redacted], pt is having tooth pain. (Note: The Magic Mouthwash was initiated on 8/21/24.) On 8/15/24 at 1:21 PM, an eMAR-Medication Administration Note documented Note Text : (AA)- MONITOR EPISODES Q SHIFT OF ANXIETY AEB: anxious statements every shift for monitoring Pt came out of his room this morning stating he was tripping bad, shaking his head and c/o gum pain. LN talked to pt for a few minutes and asked pt to describewhat [sic] he meant. Pt couldn't. meds given, with tylenol. On 8/15/24 at 3:50 PM, an eMAR-Medication Administration Note documented Note Text : Acetaminophen Oral Tablet Give 650 mg by mouth every 6 hours as needed for pain just as high as you can go on the scale. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/15/24 at 4:39 PM, an eMAR-Medication Administration Note documented Note Text : Acetaminophen Oral Tablet Give 650 mg by mouth every 6 hours as needed for pain Follow-up Pain Scale was: 10 PRN Administration was: Ineffective md and don aware. On 8/15/24 at 4:44 PM, a Nursing note documented Note Text : poor pain control to gums today. asking for oral gel more often, tylenol given x2. pt asking if someone can go buy some oral gel for him. If not, pt states he is going to break a window and climb out. On 8/16/24 at 10:57 AM, a Nursing note documented Note Text : Pt back from smoke break. Asking for oral Gel for his gums. Pt threatening to kick the door so he can get out or to have someone open the door for him so he can leave. Wants to break a window so he can get out. Redirecting not helpful. On 8/17/24 at 11:52 AM, an eMAR-Medication Administration Note documented Note Text : Acetaminophen Oral Tablet Give 650 mg by mouth every 6 hours as needed for pain Follow-up Pain Scale was: 2 PRN Administration was: Ineffective pt states it is hard to tell. On 8/18/24 at 6:26 AM, an eMAR-Medication Administration Note documented Note Text : Celecoxib Oral Capsule 100 MG Give 100 mg by mouth two times a day for pain It hurts real bad per pt. On 8/18/24 at 7:05 AM, an eMAR-Medication Administration Note documented Note Text : Acetaminophen Oral Tablet Give 650 mg by mouth every 6 hours as needed for pain Follow-up Pain Scale was: 5 PRN Administration was: Ineffective provider on call made aware. On 8/18/24 at 8:20 AM, a Nursing note documented Note Text : asking for oral gel for his gums nonstop. States well can I just go, like leave? Pt redirected with no results. Threatens to kick the door open or break a window and go out. States his gums are very painful. NP notified. Tylenol order changed to Q4prn 650 mg. NP will see pt today. On 8/19/24 at 1:00 AM, an Encounter note documented . Chief Complaint / Nature of Presenting Problem: Mouth Pain History Of Present Illness: Patient is seen today for acute complaints of mouth pain. Appears to be related to patient's gums, primarily on his right side. Patient is edentulous and had dentures at 1 point but they have since been misplaced. Patient has also been on a pureed diet in the past due to the lack of teeth but patient continues to refuse this diet and would prefer regular meals which has been difficult for him to consume due to the lack of teeth. Patient has also recently started smoking again but unknown correlation between smoking and gum pain. Gums on the right side do appear to be slightly irritated and red. Patient is asking for more Orajel. Diagnosis, Assessment and Plan . Mouth pain Unsure if this is related to patient starting smoking again. Concerns for possible abscess given the mildly irritated nature of his right lower gums. Patient has had dental workups in the past which have been unremarkable. Will order CBC [complete blood count], CMP [comprehensive metabolic panel] for concerns of possible abscess. The note was signed by the NP. On 8/19/24 at 1:59 AM, an eMAR-Medication Administration Note documented Note Text : Acetaminophen Oral Tablet Give 650 mg by mouth every 4 hours as needed for pain c/o gum hurting.Has [sic] had multiple doses of oral gel with no efffective [sic] relief. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/20/24 at 1:00 AM, an Encounter note documented . Chief Complaint / Nature of Presenting Problem: Lab Follow up/Agitation History Of Present Illness: Patient is seen today for follow-up of his mouth pain, agitation, and valproic acid level which was obtained yesterday. Valproic acid level of 30.1 which is subtherapeutic. Patient likely to benefit from an increase in his Depakote. Could be related to patient's agitation but unknown correlation with patient's mouth pain. Other workup has been unremarkable for signs of infection or possible abscess. Diagnosis, Assessment and Plan . Mouth pain Unsure if this is related to patient starting smoking again. Concerns for possible abscess given the mildly irritated nature of his right lower gums, however, yesterday's CBC was unremarkable for signs of infection. Patient has had dental workups in the past which have been unremarkable. Follow-up Plan: Increase Depakote to 500 mg 3 times daily, recheck Valproic acid level 8/26. The note was signed by the NP. On 8/20/24 at 7:55 AM, an eMAR-Medication Administration Note documented Note Text : Acetaminophen Oral Tablet Give 650 mg by mouth every 4 hours as needed for pain PRN Administration was: Ineffective Follow-up Pain Scale was: 5 swearing at nurse as pt stated he needed more oralgel [sic] for his gum pain. On 8/20/24 at 8:03 AM, a Nursing note documented Note Text : Pt received all of his am meds. shortly thereafter pt asking for more [NAME] [sic] and neck rub. Pt informed that he received his meds already. Asked pt to lie down for a little while and allow the meds to work. calling LN a liar and inappropriate language toward LN. ADON [Assistant Director of Nursing] notified as to what other option to use to help pt understand that his meds have been given already. On 8/20/24 at 1:37 PM, a Nursing note documented Note Text : Noon meds given with increase dose of Depakote plus tylenol. Pt sat in his room until lunch time. Pt now asking for more [NAME] [sic]. LN informed pt that he had already had his meds plus the[TRUNCATED]

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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** 33215 Based on interview and record review, the facility did not provide routine and emergency drugs to its residents. Specifically, for 1 out of 69 residents, a resident that was experiencing pain, agitation, and depression did not have their medications available for administration. Resident identifier: 64. Findings included: Resident 64 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, anoxic brain damage, antisocial personality disorder, delusional disorders, dysphagia, anxiety disorder, psychotic disorder with delusions, mood affective disorder, major depressive disorder, mild protein-calorie malnutrition, essential hypertension, and mental disorder. Resident 64's medical record was reviewed on 10/9/24 through 10/21/24. On 1/18/24 at 4:51 PM, an electronic Medication Administration Record (eMAR) -Medication Administration Note documented Note Text : Zoloft Oral Tablet Give 200 mg [milligrams] by mouth in the evening for depression refill request sent. The January 2024 Medication Administration Record (MAR) was reviewed. Resident 64 did not receive Zoloft on 1/18/24. On 2/18/24 at 3:54 PM, an eMAR-Medication Administration Note documented Note Text : Zoloft Oral Tablet Give 200 mg by mouth in the evening for depression refill request sent. On 2/20/24 at 5:14 PM, an eMAR-Medication Administration Note documented Note Text : Zoloft Oral Tablet Give 200 mg by mouth in the evening for depression Pharm [pharmacy] notified of need of refill of this medication, they will deliver medication this evening. On 2/21/24 at 4:27 PM, an eMAR-Medication Administration Note documented Note Text : Zoloft Oral Tablet Give 200 mg by mouth in the evening for depression [pharmacy name redacted] notified, medication to be sent out this evening. The February 2024 MAR was reviewed. Resident 64 did not receive Zoloft on 2/18/24, 2/20/24, and 2/21/24. On 5/30/24 at 8:14 PM, an eMAR-Medication Administration Note documented Note Text : busPIRone HCl [hydrochloride] Oral Tablet 5 MG Give 10 mg by mouth three times a day for anxiety Medication not available. Ordered from pharmacy. MD [Medical Director] Staff and Nurse MGMT [management] notified. On 9/16/24 at 9:56 AM, an eMAR-Medication Administration Note documented Note Text : traMADol HCl Oral Tablet 25 MG Give 1 tablet by mouth three times a day for pain related to TMJ [temporomandibular joint] unavailable pharmacy will send md [Medical Director] notified ok to give at next scheduled dose. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/16/24 at 2:07 PM, an eMAR-Medication Administration Note documented Note Text : traMADol HCl Oral Tablet 25 MG Give 1 tablet by mouth three times a day for pain related to TMJ unavailable pharmacy will send md notified ok to give at next scheduled dose. The September 2024 MAR was reviewed. Resident 64 did not receive two doses of Tramadol on 9/16/24. On 10/14/24 at 9:29 AM, a physician's order documented TEGretol-XR [extended release] Tablet Extended Release 12 Hour 100 MG (CarBAMazepine ER) Give 1 tablet by mouth two times a day for nerve pain. On 10/14/24 at 8:06 PM, an eMAR-Medication Administration Note documented Note Text : TEGretol-XR Tablet Extended Release 12 Hour 100 MG Give 1 tablet by mouth two times a day for nerve pain waiting for pharmacy. On 10/14/24 at 11:32 PM, a Nursing note documented Note Text : *ALERT MED [medication] CHANGE TERGATOL [sic] - PT [patient] was not administered tergatol [sic] this shift d/t [due to] waiting for pharmacy. Pt was slightly agitated earlier and his biggest complaint was receiving more benzocaine gel for his gums. On 10/16/24 at 12:59 PM, an eMAR-Medication Administration Note documented Note Text : Depakote Oral Tablet Delayed Release 250 MG Give 500 mg by mouth three times a day for unspecified mood [affective] disorder med not available, pharm notified, they will fill today and send. On 10/15/24 at 10:36 AM, an interview was conducted with resident 64. Resident 64 stated that he had really bad mouth pain. Resident 64 stated he was supposed to see the dentist and he had not seen them yet. Resident 24 stated his gums were hurting bad right now, 24 hours a day. Resident 64 stated that he could ask for oral gel but he was tired of asking for it and the staff always ran out of the oral gel. Resident 24 stated at one time he had used a mouth wash but they took me off of it. Resident 64 stated that he was not sure if the mouth wash worked because he was not on it long enough. Resident 64 ended the conversation, stood up from the couch grimacing in pain, grabbed the right side of his face, and stated that he was in pain right now and was going to ask for his oral gel. On 10/17/24 at 10:44 AM, an interview was conducted with Licensed Practical Nurse (LPN) 4. LPN 4 stated that she did not have issues with the pharmacy and refilling medications. LPN 4 stated if she called the pharmacy for a refill the pharmacy would tell her the refill would be to the facility by the end of shift. LPN 4 stated the facility had an emergency medication system. LPN 4 stated the system had a stock of narcotics and antibiotics. LPN 4 stated if the pill card was in the blue line of medications she could push the reorder button in the eMAR system. LPN 4 stated if it was the last pill she would call the pharmacy. LPN 4 stated the eMAR system showed when the medication was last ordered and if the refill was in progress. On 10/17/24 at 3:18 PM, an interview was conducted with the Director of Nursing (DON). The DON stated the facility had changed pharmacies approximately six to eight months ago. The DON stated the emergency medication system contained narcotics and antibiotics. The DON stated the staff had to fax a signed order to the pharmacy in order to access the narcotics in the emergency medication system. The DON stated that staff were able to now reorder medications through the eMAR system.

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	465119	A. Building B. Wing	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Provo Rehabilitation and Nursing	1001 North 500 West Provo, UT 84604

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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 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, 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, for 1 out of 69 sampled residents, a resident administered his own blood pressure medication, diabetes medication, and blood thinner that his family member brought from home. There was no documentation from the nurse regarding the incident, dosage of the medications, and why medications were listed as administered by the nurse. Resident identifier: 160. Findings included: Resident 160 was admitted to the facility on [DATE] and readmitted after surgery on 9/28/24 with diagnoses which included fracture of shaft of right fibula, diabetes mellitus (DM), mild protein calorie malnutrition, hypertension (HTN), atrial fibrillation, and alcohol dependence. On 10/7/24 at 11:30 AM, an interview was conducted with resident 160 and his family member. Resident 160 stated he had asked for his medications at 6:00 AM. Resident 160 stated Physical Therapy came to get him at about 10:30 AM, and he asked for his medications again. Resident 160 stated the nurse told him, his medications had been administered. Resident 160 stated his family member brought in his Metformin, blood pressure medication, and blood thinner. Resident 160 stated he had to chase down the nurses to get his medications administered. Resident 160's family member confirmed she brought medications to resident 160 that morning. Resident 160's medical record was reviewed on 10/7/24 through 10/21/24. A physician's order dated 9/28/24, revealed Apixaban Oral tablet 5 MG [milligrams]. Give 1 tablet by mouth two times a day for blood thinner. A physician's order dated 9/28/24, revealed Metformin HCl [hydrochloride] oral Tablet 1000 MG. Give 1 tablet by mouth two times a day for DM. A physician's order dated 9/28/24, revealed Metoprolol Tartrate Oral Tablet 50 MG. Give 1 tablet by mouth two times a day for HTN. The October 2024 Medication Administration Record (MAR) revealed resident 160 was administered medications on 10/7/24 at 8:25 AM. Resident 160's progress notes were reviewed and there were no notes regarding resident 160 administering their own medications. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/15/24 at 11:47 AM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated there was a flex time for medication administration. RN 1 stated nurses could administer medications an hour before and an hour after the flex time, so the nurse was able to administer morning medications as early as 6:00 AM. RN 1 stated if family members administered medications to a resident she would report it, unless there was an order in place for residents to take medications from home. RN 1 stated she would report it to the Director of Nursing (DON). RN 1 stated she would want to know which medications and how much the resident took. RN 1 stated Metformin, blood thinner, and blood pressure medications would be concerning to have the resident administer instead of being administered the medications at the facility. On 10/15/24 at 12:25 PM, a phone interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated she did not administer resident 160's medication. LPN 1 stated a manger was helping her with medication pass that day and that nurse was the one who administered the medications. LPN 1 was informed that her initials were on the MAR for the morning of 10/7/24. LPN 1 stated that she did administer the medications. LPN 1 stated resident 160 had told her that he took medications from home and she was not sure how resident 160 obtained the medications. LPN 1 stated resident 160 refused the medications she offered him. LPN 1 stated she wasted the medications and thought she documented that the medications had been wasted. LPN 1 stated she should have documented the medications as refused. LPN 1 stated the process for administering medication was that she pulled up the residents medical record on the computer and went through each medication, then popped out the medication and clicked on the medication. LPN 1 stated after the medication was administered, then she went back into the medical record and documented that medications were administered. LPN 1 stated she did not go back into resident 160's medical record to click that the medication was refused. LPN 1 stated she remembered that resident 160's family member brought him the medications and did not see any medication bottles or verify dosages. LPN 1 stated that resident 160 stated he took three medications. LPN 1 stated she was not sure what time the medications were taken. LPN 1 stated resident 160 was really mad he had not received his medication but then was fine with her the rest of the day. On 10/16/24 at 10:40 AM, an interview was conducted with Assistant Director of Nursing (ADON). The ADON stated the nurse did not strike out the medications and note that resident 160's family member had brought in medications. The ADON stated if medications were wasted, the medications were put into a drug buster container. On 10/17/24 at 3:23 PM, an interview was conducted with the DON. The DON stated medications should not be provided to residents from family members. The DON stated the physician should be notified immediately so that staff can identify why the resident was needing family to bring in the medications. The DON stated she was not notified until the next day. The DON stated she notified the physician and the physician discussed the concerns with the resident. On 10/17/24 at 3:25 PM, an interview was conducted with the Regional Nurse Consultant (RNC). The RNC stated the DON would need to ask the family why they were bringing medications into the resident. The RNC stated staff also needed to complete an Interdisciplinary Team Meeting to determine if medications needed to be entered into the medical record with a specific time.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 30563 Based on observation, interview, and record review, the facility did not store, prepare, distribute and serve food in accordance with professional standards for food service safety. Specifically, steam table was soiled, hood vents were dusty, the wall behind the dish machine was soiled, tile missing grout, and a fan had dust build up. Findings included: 1. On 10/7/24 at 10:36 AM, an initial tour of the kitchen was conducted. The following was observed: a. Under the steam table shelf which was above the food, the steam table was observed to be soiled. b. The hood vents were observed to have dust in it. The hood vents were above the stove, tilt stove, and oven. According to a sticker the last time the hood vents were inspected was April 6th, 2024. It revealed that hood vents were due to be cleaned 10/6/24. c. There was a wall behind the dish machine that was soiled with a yellow/brown substance with a hole in the wall. d. There was missing grout in the tile in the dish machine room. 2. On 10/21/24 at 10:32 AM, a follow-up kitchen tour was conducted. The following was observed: a. The hood vents were observed to have dust on them. The hood vents were above the stove, tilt stove, and oven. b. There was a fan observed on the floor pointed toward the food preparation area that had dust build up on it. c. There was a wall behind the dish machine that was soiled with a yellow/brown substance with a hole in the wall. d. There was missing grout in the tile in the dish machine room. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/21/24 at 10:39 AM, an interview was conducted with the Dietary Manager (DM). The DM stated stated staff took down vents and cleaned them. The DM stated that every quarter a company came to clean everything in the kitchen. The DM stated the fan was from an employee personal fan and she was not sure how often it was cleaned. The DM stated the shelf above the steam table was cleaned daily when the steam table was wiped down. The DM stated the shelf was stained and not soiled. The DM provided a cleaning list for the cooks and the steam table was on the list twice daily. The DM stated the shelf probably needed to be replaced because it was stained. The DM stated she had not noticed the grout was missing in the dish machine room. The DM stated the wall behind the dish machine was dirty with a hole in it and she was sending a work order to the Maintenance department.