STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465137	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Red Cliffs Health and Rehab	1745 East 280 North St George, UT 84790

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50200 Based on interview and record review, it was determined for 1 of 53 sampled resident, that the facility did not ensure that the interdisciplinary team had determined that the resident's right to self administer medications was clinically appropriate. Specifically, a residents, a resident was not assessed prior to having liquid medication all over her body after the resident sustained an unwitnessed fall. Resident identifier: 368 Findings included: Resident 368 was admitted to the facility on [DATE] with diagnoses which included palliative care, cirrhosis of the liver, hepatic failure, type 2 diabetes with chronic kidney disease, altered mental status, depression, insomnia, and hypothyroidism. Resident 368's medical record was reviewed 6/2/24-6/6/24. Resident 368's incident report dated 10/2/23 was reviewed on 6/4/24. The incident report documented that resident 368 .must have reached for her meds [medications] because she has the lactulose all over her. No documentation could be located in the medical record indicating that resident 368 had been evaluated to safely self administer medications. An admission Brief Interview for Mental Status (BIMS) dated 9/25/23 documented that resident 368 had a score of 9. A BIMS score of 8-12 suggested moderately impaired cognition. On 6/5/24 at 9:55 AM, an interview was completed with the Regional Nurse Consultant (RNC). The RNC stated residents were able to self administer medications after they had the appropriate assessment done by the nursing staff. On 6/5/24 at 12:36 PM, an interview was conducted with the Administrator (ADM). The ADM stated that for this particular investigation it was completed by himself and the former Director of Nursing. The ADM stated the investigation was done on neglect and the resulting fall, but the medication left in the resident's room was not investigated. (continued on next page)

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/6/24 at 7:39 AM, an interview was conducted with the MDS Coordinator. The MDS Coordinator stated that residents required a physician's order and an assessment by a floor nurse before being allowed to self administer medications. The MDS Coordinator stated there was not an order for Lactulose to be self administered. The MDS Coordinator stated there was not an assessment done that allowed resident 368 to self-administer medications.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22992 Based on interview, observation and record review, the facility did not ensure that 3 of 53 sampled residents received services in the facility with reasonable accommodation of resident needs and preferences. Specifically, residents were not provided with transportation for personal needs, and one resident was not provided with incontinence briefs despite developing a rash from the ones that the facility offered. Resident identifiers: 7, 15, and 114. Findings included: 1. Resident 15 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included acute respiratory failure, diabetes mellitus, apraxia following cerebral infarction, hemiplegia, post traumatic stress disorder, irritable bowel syndrome, sacrolitis, pneumonia, and urinary retention. Resident 15 stated that facility staff won't take you to the bank or anything. The van driver . said she will but I have to keep it quiet. I would like to go to the park or the store if I want a treat. I want to see [my kids] at the park but [facility staff] won't take me. On 6/5/24 at 4:30 PM, an interview was conducted with the Resident Advocate (RA). When asked about resident 15 wanting to go to the bank or the park with his children, the RA stated that the resident was able to take himself to the bank because he had a motorized wheelchair. The RA also stated that resident 15 was able to use the bus. The RA then stated, As far as I know, I was always told our facility van is only for medical appointments but I don't know what the guidance is here. If someone can't take themselves I would ask if the family can take them. On 6/6/24 at 9:55 AM, an interview was conducted with the Transportation Driver (TD) and the Administrator (ADM). The TD stated that the van was only supposed to be used for medical appointments, and nothing else. The TD stated that if she took anyone on an errand beside a medical appointment, she would have to obtain approval from the ADM first. The ADM stated that resident 15 had requested to go to the bank, but that the ADM had questioned why the resident needed to go to the bank. When asked if anyone had been denied transportation services, the TD stated that there was a resident who had requested to get cigarettes, but I told her that our policy is that if friends and family are available, then she needed to go through them. On 6/6/24 at approximately 9:45 AM, an interview was conducted with the Regional Nurse Consultant (RNC). The RNC stated that if staff were not busy taking residents to medical appointments, then absolutely staff could take residents to the bank etc. The RNC stated she would just want to make sure the van driver knew about the errands the residents wanted to run, and would not want the driver to have access to resident bank cards. 50200 (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident 114 was admitted to the facility on [DATE] with diagnoses which included acute and chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease, anxiety disorder, paroxysmal atrial fibrillation, severe sepsis with septic shock, cognitive communication deficit, dysphagia, and respiratory syncytial virus. An admission Brief Interview for Mental Status (BIMS) dated 5/16/24 documented that resident 114 had a score of 14. A BIMS score of 13-15 suggested resident 113 was cognitively intact. On 6/2/24 at 3:26 PM, an interview was conducted with resident 114. Resident 114 stated that he had not been able to get money from the ATM since he had been in the facility. Resident 114 stated he had asked staff repeatedly to be taken to an ATM because he would like some cash to buy stuff. Resident 114 stated that he stopped asking because he was told that he could not get a ride. On 6/4/24 at 10:49 AM, an interview was conducted with the RA. The RA stated that if a resident had an outside bank account they could sign themselves out and go with family and/or friends to get the money. The RA stated that the facility policy was to only transport residents for medical appointments. On 6/5/24 at 7:42 AM, an interview was conducted with the [NAME] Office Manager (BOM).The BOM stated residents could choose to open a personal funds account or transport would take the resident to the bank or post office to get what they need. On 6/5/24 at 7:50 AM, an interview was conducted with the Transport Driver (TD). The TD stated residents were transported to and from appointments. The TD stated if there were no friends or family that could take a resident to the bank, then in very rare circumstances they could be taken to the bank, but this must be approved by the administrator first. On 6/5/24 at 8:06 AM, an interview was conducted with the Administrator (ADM). The ADM stated transportation was available to all residents regardless of where they were going. On 6/6/24 at 9:00 AM, an interview was conducted with the TD. The TD stated that resident 114 had mentioned to the hall nurse that he wanted to go to the ATM and the nurse reached out to the TD. The TD stated that when she spoke to resident 114, he wanted to get money for the vending machine from the ATM. The TD stated that resident 114 changed his mind about needing a ride on this particular day and requested an oximeter instead. 30563 3. Resident 7 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included paroxysmal atrial fibrillation, fibromyalgia, type 2 diabetes mellitus, obesity and major depressive disorder. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/3/24 at 9:48 AM, an interview was conducted with resident 7. Resident 7 stated the facility was providing her with briefs that absorbed more, deodorized, and were more comfortable for her extremely sensitive skin. Resident 7 stated she was unable to get those briefs for the last 4 months and had to buy them herself. Resident 7 stated the Administrator came into her room and stated the facility was unable to purchase her briefs because Where does it stop?. Resident 7 stated the Administrator stated to her that other residents would ask for stuff also. Resident 7 stated the briefs cost her about $150 per month. Resident 7 stated when she had to wear the facility provided briefs she got a rash around her waist. Resident 7's medical record was reviewed 6/2/24 through 6/6/24. There were no grievance forms in the grievance binder for resident 7 regarding her briefs. An MDS dated [DATE] revealed a BIMS score of 14 out of 15 which indicated resident 7 was cognitively intact. The MDS further revealed resident 7 was always incontinent of bowel and bladder. A care plan dated 4/15/2020 and updated on 12/19/23 revealed [Resident 7] is at risk for altered skin integrity r/t [related to] Obesity, DM2 [type 2 diabetes mellitus], bed confinement status, incontinence, lymphedema and decreased mobility. The goal was [Resident 7] will maintain clean and intact skin by the review date. The interventions were Apply Barrier Cream after each incontinent episode; Encourage good nutrition and hydration in order to promote healthier skin and; Identify potential causative factors and eliminate/resolve where possible. A care plan dated 11/14/21 revealed [Resident 7] desires to only be changed twice per shift and PRN [as needed]. The goal Chooses to have chucks placed underneath her, which she chooses to provide. The intervention was [Resident 7] choices will be honored; Staff to change [resident 7] twice per shift and PRN, Staff to respect and honor resident choices. Chucks to be placed under resident as she desires. A care plan dated 3/14/23 revealed [Resident 7] is at risk for chronic/recurring MASD [moisture associated skin damage] secondary to incontinence, limited mobility, morbid obesity. The goal was [Resident 7] will have no untreated skin impairment TNR [through next review]. The interventions included Encourage and assist with frequent position changes as able and Medications, treatments, supplements as ordered. On 6/3/24 at 3:58 PM, an interview was conducted with CNA 1. CNA 1 stated that resident 7 used a certain type of brief that had a longer pad. CNA 1 stated resident 7 had to order and pay for the briefs. CNA 1 stated the briefs the facility provided were not very comfortable because of the residents size. CNA 1 stated there was a specific way to put resident 7's brief on. CNA 1 stated the briefs provided by the facility had 2 tabs and the briefs resident 7 bought had 1 large tab. On 6/4/24 at 9:41 AM, an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated the facility had stock briefs available for residents who were incontinent. LPN 1 stated pull up briefs and tab briefs were available in different sizes. LPN 1 stated he was not aware that resident 7 had different briefs than the ones provided by the facility. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/4/24 at 9:48 AM, an interview was conducted with CNA 2. CNA 2 stated each resident had a package in their room of briefs so the CNA's knew what size and kind the resident used. CNA 2 stated pull ups and briefs were offered in all sizes. CNA 2 stated he was not aware of anyone not being able to use briefs the facility provided. On 6/4/24 at 10:00 AM, an interview was conducted with Nursing Aide (NA) 1. NA 1 stated the facility had different brands, types and sizes of briefs available. NA 1 stated all the residents were able to use the facility briefs. NA 1 stated resident 7 used a brief with the tabs. NA 1 stated resident 7 was very sensitive when she was being changed and needed the briefs put on looser. NA 1 stated she was not sure if resident 7 had different briefs or supplied her own. NA 1 stated she used the briefs stored in resident 7's room. On 6/4/24 at 10:06 AM, an interview as conducted with CNA 3. CNA 3 stated the facility had different sizes of briefs. CNA 3 stated resident 7 liked to buy her own briefs because they were more stretchy and absorbed more. On 6/4/24 at 1:11 PM, an interview was conducted with the RA. The RA stated the facility provided briefs or pull ups for the residents. The RA stated she was not aware of any resident that was buying their own briefs. The RA stated if a resident desired different briefs, she would have to get special authorization from the Administrator. The RA stated she thought resident 7 used the facility provided briefs. The RA stated if resident 7 was unable to use the briefs provided then the Administrator would have to provide approval to order the briefs. On 6/4/24 at 1:53 PM, an interview was conducted with the Administrator. The Administrator stated the facility provide everything residents needed. The Administrator stated he talked to resident 7 a while ago regarding her briefs. The Administrator stated the facility had entered a contract with a medical supply company to provide a daily rate for all supplies. The Administrator stated the facility provided briefs for resident 7 but not the kind she liked. The Administrator stated resident 7 bought her own because the facility did not supply the brand she liked. The Administrator stated the briefs provided by the medical supply were on their formulary, so it was easier to manager costs. The Administrator stated resident 7's pull ups were not included in the formulary and was unable to provide the briefs because it was a Cost issue. The Administrator stated he talked to resident 7 about using the facility brief and she stated I understand. The Administrator stated the RA was in the room with him when he talked to resident 7 about using the facility briefs. The Administrator stated it was about 9 months ago and there was no documentation of the conversation. On 6/4/24 at 3:05 PM, a follow up interview was conducted with the Administrator. The Administrator stated that he follow-up with resident 7 about her briefs and resident 7 stated to him she was buying her own briefs because they absorbed better. The Administrator stated that he was unable to remember the other reasons why resident 7 was unable to use the briefs the facility provided because he had walked around the facility and forgot. The Administrator stated that the MDS Coordinator was with him when he talked to resident 7. The Administrator stated the MDS Coordinator was going to do a clinical assessment to determine if the briefs were a want or need. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/4/24 at 3:15 PM, an interview was conducted with the MDS Coordinator. The MDS Coordinator stated resident 7 preferred the feel and the absorption of the briefs she purchased. The MDS Coordinator stated resident 7 mentioned that she was buying her own briefs a couple months ago during Angel Rounds. The MDS Coordinator stated she was not aware of any follow-up after the Angel rounds. The MDS Coordinator stated she had not been asked to complete a clinical assessment on resident 7. The MDS Coordinator stated a clinical assessment would consist of contacting the Wound Nurse, look at the brief to see if it was rubbing and ask the aide so see if there was a difference with the leakage. On 6/4/24 at 3:25 PM, the MDS Coordinator provided a form dated 1/4/24 titled Guardian Angel Rounds: Special Survey Edition revealed Bed A: .Doesn't like paying for her briefs and feels like they are lower quality than the ones she used to get. The MDS Coordinator stated there was no documented follow-up on the form. On 6/6/24 at 8:37 AM, an interview was conducted with the Assistant Director of Nursing (ADON) 1. ADON 1 stated she did not know that resident 7 was buying her own briefs. On 6/6/24 at 8:44 AM, a follow-up interview was conducted with resident 7. Resident 7 stated the Administrator walked in and asked why she liked her briefs. Resident 7 stated she used the facility provided briefs for 30 days to try them out and did not like them. Resident 7 stated she was told by the Administrator that she needed to find another more comparable brand to the facility provided ones. Resident 7 stated she used those briefs for [AGE] years and did not want to try different briefs because the ones she ordered worked for her. On 6/6/24 at 9:04 AM, an interview was conducted with the Regional Nurse Consultant (RNC). The RNC stated if a resident requested different kind of briefs than on the formulary, it would depend on the cost. The RNC stated if there was a reason like for skin or absorption, then the facility should be providing them.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30563 Based on observation, interview and record review it was determined, for 2 out of 53 sampled residents, that the facility did not ensure that the resident had the right to self-determination through support of the resident choice. Specifically, residents were not offered showers according to their preferences. Resident identifiers: 15 and 27. Findings included: 1. Resident 27 was admitted to the facility on [DATE] with diagnoses which included cerebral palsy, cervical root disorders, neuromuscular dysfunction of bladder and major depressive disorder. On 6/33/24 at 9:27 AM, an interview was conducted with resident 27. Resident 27 stated they would like showers every other day but only received showers Mondays and Thursdays. Resident 27 stated it was just how it is. Resident 27 stated they would like more showers but had not been asked. Resident 27 stated he was able to shower independently but there needed to be more staff. Resident 27 was observed to have greasy hair and was observed to be dry shaving his face with a razor. A Minimum Data Set (MDS) dated [DATE] revealed resident had a Brief Interview of Mental Status (BIMS) score of 14 out of 15 which indicated resident 27 was cognitively intact. A care plan dated 10/20/21 and updated 10/19/23 revealed [Resident 27] has an ADL [activities of daily living] self care performance deficit r/t [related to] Cerebral Palsy. The goal was Will be able to participate in part of ADL activity. Will have needs met. Some interventions included Adjust and meet residents needs with ADL assistance per level of need at time of care. Level of assistance may vary depending on time of day and current health conditions and Bathing/Showering: The resident requires up to DEPENDENT assist as needed. Certified Nursing Assistant (CNA) documentation in the tasks section of resident 27's medical record revealed resident 27 required 1 person physical assistance with bathing. Resident 27 was provided showers on 5/13/24, 5/16/24, 5/20/24, 5/23/24, 5/27/24, 5/30/24 and 6/3/24. No documentation could be located to indicate that resident 27 had been asked about how often they would like a shower. 22992 2. Resident 15 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included acute respiratory failure, diabetes mellitus, apraxia following cerebral infarction, hemiplegia, post traumatic stress disorder, irritable bowel syndrome, sacrolitis, and urinary retention. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/3/24 at 7:35 AM, an interview was conducted with resident 15. Resident 15 stated that the facility used to provide him with 3 showers a week, but now they only provided 2. Resident 15 stated he used to be the resident council president, and that this issue had not been discussed at resident council prior to being implemented. Resident 15 stated that he often did not receive the 2 scheduled showers. Resident 15 further stated, and if you said you'd like it (a shower) at a different time, good luck. Resident 15's medical record was reviewed from 6/2/24 through 6/6/24. Resident 15's care plan dated 10/20/21 was reviewed. The care plan indicated that resident 15 has an ADL self care performance deficit r/t Hemiplegia/hemiparesis of Right side, Apraxia. The care plan also indicated that resident 15 required up to substantial or maximal assistance from staff with bathing. Resident 15's shower records were reviewed. Between 5/9/24 and 6/2/24, the records confirmed that resident 15 had only received 2 showers a week. Facility staff completed a document entitled Guardian Angel Rounds: Special Survey Edition. The document was dated October 4, but did not list a year. The document included a question of Are showers given per resident's preference? Staff indicated that they were, however did not document what the resident's preference was. No documentation could be located to indicate that resident 15 had been asked about how often he would like a shower. On 6/5/24 at 9:53 AM, an interview was conducted with the Director of Nursing (DON) and the Regional Nurse Consultant (CRN). The DON stated the CNA Coordinator was in charge of scheduling showers. The DON stated she did not know how showers were scheduled. On 6/5/24 at 10:12 AM, an interview was conducted with the CNA Coordinator. The CNA coordinator stated when she started 3 to 4 months ago showers were not spread out equally among the CNAs. The CNA coordinator stated they went around and asked residents if they had a preferences on the day and the time residents had hours. The CNA Coordinator stated they then created a shower schedule which was located at each nurses station. The CNA Coordinator stated each CNA was to shower no more than 4 resident per shift. The CNA Coordinator stated residents were scheduled at a minimum of 2 showers per week. The CNA Coordinator stated there were only two residents that were provided showers three times per week. The CNA Coordinator stated resident 27 was scheduled twice per week. The CNA Coordinator stated they had not asked resident 27 if they wanted more showers per week. The CNA Coordinator stated if a resident asked for more showers, then staff provided more but the resident needed to ask. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/5/24 at 5:28 PM, an interview was conducted with the Administrator. The Administrator stated he was not aware of the shower process. The Administrator stated residents were showered at least twice per week. The Administrator stated in the last year and a half, there were different methods for shower scheduling implemented. The Administrator stated he did not know if staff asked residents how many showers they wanted per week. The Administrator stated from what he knew, the CNA coordinator scheduled showers. The Administrator stated he delegated shower scheduling to the clinical team. The Administrator stated he was not aware of who determined residents were to be showered twice per week. The Administrator stated as an Administrator, would be most concerns about meeting the regulation. The Administrator stated he did not remember if showers had been discussed in the Quality Assurance meetings.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 22992 Based on interview and record review, the facility did not consider the views of a resident group, nor did they act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. In addition, the facility was not able to demonstrate their response and rationale for such response. Specifically, residents voiced similar concerns over time in the resident council, and the facility did not follow up in a manner that significantly resolved the concerns. Findings included: Resident council notes were reviewed and revealed the following: a. 1/30/24: . The group said they were frustrated with the CNA's (Certified Nursing Assistants) turning off the call lights. I explained that they can put the call light back on if no one comes in 10 minutes. [Names of two residents] were frustrated that they are being woken up at 5:00 AM and dressed. [Names of two residents] said that night shift and early morning they don't answer call lights. [Name of one resident] said they stop answering call lights at 5:00 AM. A Department Response was provided that Education regarding urgency of lights for all shifts .Discuss [with] res (resident) time get up. b. 2/28/24: The Administrator (ADM) . went over that call lights have been an ongoing issue. He shared with the group that the budget has increased so there will be more staff which should help with call light times. [ADM] went over how residents can help by giving positive feedback and encouragement to staff.[Name of resident] brought up that she things its wrong that CNA's turn off the call light. [Name of one resident] - call lights have been bad 20 minutes or more. There was not department response listed for the above mentioned issues. c. March 2024 there were no issues documented regarding staffing or call light response times. d. 4/29/24: One resident stated that they (staff) never come. Two residents stated that call lights have been the same. A Department Response was provided and indicated that staff education was again given regarding call light response times. It should be noted that the facility did not provide this education until 5/22/24, approximately 3 weeks later. e. May 2024 was not provided. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/6/24 at 7:40 AM, an interview was conducted with the facility Administrator (ADM). When asked about the resident council concerns, the ADM stated that after the resident council meeting, he would review the meeting minutes. The ADM stated that its usually food. call lights seem to be the popular thing to talk about. The ADM stated that the minutes were reviewed in the facility Quality Assurance Performance Improvement (QAPI) meetings. The ADM stated that staff have also brainstormed to see if staff were scheduled at the appropriate time. The ADM could not provide any additional information as to what steps had been taken to correct the call light response times.

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F 0580 Level of Harm - Actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22992 Based on interview and record review, it was determined the facility did not immediately consult with the 2 of 53 sample residents' physicians after there was a need to alter treatment significantly. Specifically, one resident had symptoms of a change in condition and the facility physician instructed the facility nurses to contact the surgeon, but no evidence could be located that this occurred. This resulted in the finding of a harm for this resident. In addition, a resident experienced elevated blood glucose levels without timely notification of the physician. Resident identifiers: 53 and 365. Findings included: Resident 365 was admitted to the facility on [DATE] with diagnoses that included spontaneous right patellar tendon rupture, encounter for other orthopedic aftercare, history of falling, and hypertension. Resident 365's entry Minimum Data Set (MDS) assessment indicated that facility staff assessed resident 365 as having a Brief Interview for Mental Status (BIMS) score of 15, which indicates the resident was cognitively in tact. Resident 365's medical record was reviewed from 6/2/24 through 6/6/24 and revealed the following: a. On 9/24/22 a nurses note documented: Pt [patient] arrived to facility via wheelchair from [name of local hospital]. Pt had a right knee repair surgery 9/23. Pt is alert and oriented x4, moves upper extremities equally, is non weightbearing on RLE [right lower extremity], able to move LLE [left lower extremity], sensation intact. Bowel sounds audible all lobes, abdomen soft and nontender, Pt reports that LBM [last bowel movement] was 9/23 in the morning. Pt is incontinent of bowel and bladder, Pt has briefs, wipes, and cream in room for bowel care. Pt is alert, able to verbalize needs . b. On 9/26/22 a nurses note documented: Pt was c/o [complaining of] excruciating bladder spasms. The pt was not seen by his primary, [name of physician], this shift to express his concerns or symptoms. Pt asked RN [Registered Nurse] to ask house MD to do something to give him relief. RN messaged [name of physician] and received orders for a one time dose of 200mg of pyridium. RN administered medication and assessed pt 45 min after and he stated that he feels better and the spasms stopped. pt is alert and able to verbalize needs to staff, tolerated medications whole without complications . : c. An MD [Medical Doctor] Communication form dated 9/26/22, two days after resident 365 was admitted , revealed the following: . Concern: pt admitted Sat [Saturday] - is concerned he is developing infection, wants to see MD and discuss concerns. NEW ORDER 1 - Notify his ortho [orthopedic] Dr [doctor] who operated on him ASAP [as soon as possible] ! 2 - I will see him after clinic today. [Note: No documentation could be located to indicate that the physician saw resident 365 that day, or that facility staff had contacted the orthopedic surgeon during resident 365's stay.] (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	d. On 9/28/22 at 12:26 AM a nurses note documented: . pt had an episode of forgetfulness and confusion this shift. Pt was found sitting on the side of his bed. Staff asked what he was doing, pt stated that he was going to the bathroom. Staff reminded him that he is NWB [non weight bearing] on his R [right] knee and could not walk to the bathroom. Staff got him into bed safely, his R knee is bleeding through the bandage . e. On 9/28/22 at 9:41 AM a nurses note documented: . Pt is alert, able to verbalize needs, takes medications whole, . Night nurse reported that Pt had an episode of confusion last night, Nurse went in this AM [morning] to assess Pt. Pt has diminished lung sounds in the bases, SOBLF (?) and SOBOE [shortness of breath on exertion]. Pt's neuro [neurological] assessment showed minimal left sided facial weakness, moves all extremities equally, denies any numbness or tingling, no changes in sensation, or H/A [headache]. MD has been notified of situation. f. On 9/28/22 at 10:46 AM a nurses note documented: . As ordered by MD, nurse tried to contact surgeon about duration of Bactrim. Unable to reach them, Nurse left a message for the surgeon's office . [Note: This is two days after the physician wrote a note to contact the orthopedic physician for resident 365 as soon as possible regarding the resident's possible infection.] g. On 9/29/22, a nurses note documented: . Resident is alert and verbally responsive, able to make needs known. Resident c/o bladder spasms and not being able to void. Bladder scanned and 85 cc [cubic centimeters] residual noted. MD notified. h. On 9/29/22, the facility physician documented the following in a physician's note: . [Resident 365] . reported pain to his abdomen that started during physical therapy, pain us located to RLQ [right lower quadrant], upon examination no hernia or any other abnormalities were noted. Claims that is able to control bladder and bowels. However, he is experiencing bladder spasms with little urine output post spasms. Denies prior or similar problems prior to this surgery. Reported last PSA [Prostate Specific Antigen] levels were done back in January with normal results. Physician will place patent [sic] on Flomax . i. On 9/29/22 resident 365's blood pressure was 144/81. j. On 9/30/22 at 4:51 PM, resident 365's blood pressure was 143/76. k. On 9/30/22 at 4:52 PM, resident 365's blood pressure was 177/85. l. On 10/1/22 at 12:05 AM, a nurses progress note documented: Resident found on floor next to recliner and walker . When asked resident what happened he said he was not sure.No c/o pain. Resident already has baseline hx [history] of confusion and falls upon admission. Resident has no s/s [signs and symptoms] of injury at this time. No complaints of pain or distress. Resident educated on importance of call light and demonstrated its use. RLE [knee] dressing changed and inspection of surgical site completed. surgical scar well approximated, all staples intact and in place and trace drops of drainage. No swelling, redness, and surgical site is cool to the touch. Clean dressing re applied, wrapped, and ble knee brace secured . Will notify, PCP [primary care physician], family and on call administrator of incident and continue to monitor closely. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	m. On 10/1/22 at 8:30 PM a nurses progress note documented: resident POA [power of attorney] contacted staff and communicated concern regarding residents increased confusion . Family very concerned and request to send to ER [emergency room]. PCP contacted . transfer was completed. Will continue to monitor closely. n. On 10/2/22 at 10:16 AM a nurses progress note documented that the resident had been admitted to the hospital, and was in the intensive care unit. On 6/6/24 at 8:43 AM, an interview was conducted with the Regional Nurse Consultant (RNC). The RNC stated that with regard to the physician note written about resident 365 on 9/26/22, STAT would have been a better word to use than asap. The RNC also stated that the facility nurses should have reached out after the doctor said to get in contact with the orthopedic surgeon. The RNC stated that best practice is to reach out and get a UA with the bladder spasms and excruciating pain. The RNC stated that the facility could still get a culture and sensitivity on a urinalysis even if the resident was on an antibiotic already. The RNC stated that the doctor should have ordered a UA and culture and sensitivity. The RNC did not have any other information regarding the facility's lack of response to the change of condition in resident 365. 30563 2. Resident 53 was admitted to the facility on [DATE] with diagnoses which included type 2 diabetes mellitus, anxiety disorder, adult failure to thrive and diabetic foot ulcer. Resident 53's medical record was reviewed 6/2/24 through 6/6/24. A Other payment assessment MDS dated [DATE] revealed resident 53 had diabetes mellitus. A care plan dated 12/18/23 and updated on 1/2/24 revealed [Resident 53] has Diabetes Mellitus type II. The goal was [Resident 53] will have no complications related to diabetes through the review date. The interventions were Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness; Monitor PRN [as needed] any s/sx [signs and symptoms] of hyperglycemia: increased thirst and appetite, frequent urination, weight loss, fatigue, dry skin, poor wound healing, muscle cramps, abd [abdominal] pain, Kussmaul breathing, acetone breath (smells fruity), stupor, coma; Monitor PRN any s/sx of hypoglycemia: Sweating, Tremor, Increased heart rate (Tachycardia), Pallor, Nervousness, Confusion, slurred speech, lack of coordination, Staggering gait. Physician's orders revealed the following: a. Start date of 2/27/24, Insulin Lispro Injection Solution 100 UNIT/ML [milliliter] (Insulin Lispro) Inject as per sliding scale: if 60 - 80 = 0; 81 - 150 = 2 units (u); 151 - 200 = 4 units; (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	201 - 250 = 6 units; 251 - 300 = 8 units; 301 - 350 = 10 units; 351 - 400 = 14 units, subcutaneously with meals for DM2 Notify Md if pt BS [blood sugar] >60 or <400. b. A start date of 2/27/24 revealed, Insulin Lispro Injection Solution 100 UNIT/ML (Insulin Lispro) Inject as per sliding scale: if 61 - 200 = 0 u; 201 - 250 = 2 u; 251 - 300 = 4 u; 301 - 350 = 5 u; 351 - 400 = 7 u, subcutaneously at bedtime for blood sugars. c. A start date of 12/13/23 and an discontinue date of 3/29/24 revealed, AC [before meals]/HS[at bed time] Blood Sugars before meals and at bedtime for DM Notify MD if pt's BS <60 or >400. d. On 4/24/24 at 7:00 AM, **DO NOT CHANGE THE TIMES** Blood sugar checks prior to meals before meals and at bedtime for DM2 monitoring. The March 2024, April 2024 and May 2024 MARs revealed the following blood sugars: a. On 3/9/24 at 8:00 AM, BS was 404. b. On 3/22/24 at 9:00 PM, BS was 400. c. On 3/28/24 at 9:00 PM, BS was 407. d. On 4/2/24 at 9:00 PM, BS was 400. e. On 4/5/24 at 9:00 PM, BS was 546. f. On 4/7/24 at 5:00 PM, BS was 414. g. On 4/11/24 at 9:00 PM, BS was 400 h. On 4/12/24 at 5:00 PM, BS was 517. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	i. On 4/12/24 at 9:00 PM, BS was 500. j. On 4/16/24 at 9:00 PM, BS was 464. k. On 4/18/24 at 8:00 AM, BS was 1211. l. On 4/26/24 at 8:00 AM, BS was 437. m. On 5/2/24 at 9:00 PM, BS was 404. n. On 5/3/24 at 8:00 AM and 5:00 PM, BS was 404. o. On 5/4/24 at 9:00 PM, BS was 461. p. On 5/6/24 at 9:00 PM, BS was 466. q. On 5/11/24 at 9:00 PM, BS was 404. r. On 5/15/24 at 5:00 PM, BS was 12. s. On 6/3/24 at 7:00 AM, BS was 430. There was no documentation located in resident 53's medical record that the physician was notified of the blood sugars less than 60 and over 400. On 6/6/24 at 7:54 AM, an interview was conducted with Licensed Practical Nurse (LPN) 3. LPN 3 stated when a resident needed a blood sugar obtained a notification came up to alert the nurses in the electronic medical record. LPN 3 stated after obtaining the sample she looked at the physicians order to determine how much insulin needed to be administered. LPN 3 stated if a BS was below 60 or over 400 she would contact the physician to see what the physician wanted her to do. LPN 3 stated high and low blood sugars could cause harm to the resident, so that was why the physician needed to be notified. On 6/6/24 at 8:00 AM, an interview was conducted with Assistant Director of Nursing (ADON) 1. ADON 1 stated if a resident was ordered to have sliding scale insulin, then she would administer the insulin according to the residents blood sugar. ADON 1 stated there was a standing physician's order to contact the physician if the BS is below 60 or above 400. ADON 1 stated she would think the nurse documented the physician notification in the residents progress notes. ADON 1 stated sometimes if the resident refused the insulin, then a progress note popped up in the electronic medical record for the staff to document. ADON 1 stated if a resident's BS was high, the resident could go to Ketoacidosis, and it could be life threatening. ADON 1 stated she was unable to find the physician was notified in resident 53's medical record. On 6/6/24 at 9:16 AM, an interview was conducted with the RNC. The RNC stated residents with sliding scale insulin should have BS parameters and when to notify the physician. The RNC stated generally BS under 60 and BS over 400, the physician should be notified. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	The facility's policy for Change in a Resident's Condition or Status was reviewed. The policy indicated the following: Our facility promptly notified the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.) . 1. The nurse will notify the resident's attending physician or physician on call when there has been a (an): . d. significant change in the resident's physical/emotional/mental condition; e. need to alter the resident's medical treatment significantly; . g. need to transfer the resident to a hospital/treatment center; . i. specific instruction to notify the physician of changes in the resident's condition. 2. A 'significant change' of condition is a major decline or improvement in the resident ' s status that: a. will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions (is not self-limiting); b. impacts more than one area of the resident ' s health status; c. requires interdisciplinary review and/or revision to the care plan; and d. ultimately is based on the judgment of the clinical staff and the guidelines outlined in the Resident Assessment Instrument. 3. Prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider .

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38031 Based on observation, interview and record review it was determined, for 1 of 53 sampled residents, that the facility did not ensure that the resident had the right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and support for daily living safely. Specifically, a resident's bathroom toilet was not secured to the ground and wobbled and the toilet seat was not secured to the base and moved from side to side. Resident identifier: 36. Findings included: Resident 36 was admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses which included chronic obstructive pulmonary disease, polyosteoarthritis, malignant neoplasm of the ovary, chronic fatigue, morbid obesity, anxiety disorder, bipolar disorder, peripheral neuropathy, presence of left and right artificial knee joint, insomnia, and restless leg syndrome. On 6/06/24 at 9:21 AM, an interview was conducted with resident 36. Resident 36 stated that they had put in multiple work orders for the toilet seat to be repaired and it had been replaced and secured multiple times in the past. Resident 36 stated that the seat would break again and again and it was not secure or safe. An observation was made of resident 36's toilet. The base was not secured and the seat was askew and moved from side to side. On 6/06/24 at 9:20 AM, an interview was conducted with Licensed Practical Nurse (LPN) 3. LPN 3 stated that there was a maintenance log at the nurse's station for staff to report any maintenance issues that needed to be looked at. Review of the maintenance log from January 2024 to May 2024 revealed no requests for repair of resident 36's toilet seat. On 6/6/24 at 9:30 AM, an interview was conducted with the Director of Maintenance (DOM). The DOM stated that the flooring in resident 36's bathroom was replaced approximately two months ago and at that time the toilet was completely removed. The DOM stated that since then he had tightened resident 36's toilet seat and the base a few times. The DOM stated that he went into the room regularly to check on the toilet. The DOM stated that he did not have any documentation of the repairs that he made on resident 36's toilet. An observation was made of the DOM moving the base of the toilet from side to side. The DOM stated that he needed to remove the toilet again and replace the metal ring. The DOM stated the staff should inform him verbally or write in the maintenance binder that the toilet needed to be repaired.

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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** 46232 Based on interview and record review it was determined, for 5 out of 53 sampled residents, that the facility did not ensure that residents were free from abuse, neglect, misappropriation of resident property, and exploitation. Specifically, a staff member recorded a video in the shower room while a resident was in the bathtub naked, a cognitively impaired resident kissed two different cognitively impaired residents on two different occasions and another resident who was cognitively impaired was involved in a sexual relationship. Resident Identifiers: 5, 12, 17, 36, 42, and 374. Findings Included: 1. Resident 42 was admitted to the facility on [DATE] with the following diagnoses of delirium, unspecified dementia with psychotic disturbance, anxiety disorders, cognitive communication deficit, and major depressive disorder. Resident 42's medical records were reviewed on 6/5/24 through 6/6/24. A facility admission agreement signed and dated 9/2/20, section G subsection f documented the following authorization to pictures, Authorization to Photograph. Resident authorizes Facility and its affiliates to photograph client and/or portions of client's body for documentation of physical conditions, and/or to follow medical progress. Photos will be protected and the Client's right to privacy will be observed. On 3/1/24, a Quarterly and Annual Review documented resident 42 was confused at baseline line, struggled to answer questions and was a poor historian. It also documented resident 42 had not reported any history of trauma. On 5/23/24, a Montreal Cognitive Assessment (MoCA) assessment documented resident 42 had scored a 3 out of 30 which indicated severe cognitive impairment. On 5/31/24, a Quarterly Brief Interview for Mental Status (BIMS) assessment was done and documented resident 42 had severe cognitive impairment. On 5/31/24, a Quarterly and Annual Review documented resident 42 was confused at baseline and had not reported any history of trauma. On 2/2/24 at 4:07 PM, a facility incident report documented that an incident had occurred with resident 42 in the shower room. The incident description stated, it had been discovered due to a video clip that had been sent and resident 42 was unaware of what had occurred. It stated that resident 42 was in the bath tub being bathed by staff who took a recording of themselves with the resident 42 clearly visible in the background. The incident report documented the video had been sent via social media application to unknown sources and once the video had been discovered by the Certified Nursing Assistant (CNA) coordinator, it was reported to the abuse coordinator. No other information was located in the incident report. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A form titled exhibit 358 was submitted to the State Survey Agency (SSA) on 2/3/24 at 11:15 AM. The form revealed that an allegation of mental/verbal abuse had occurred. The incident documented that a CNA had posted a video on a social media application of themselves dancing while showering a resident. Resident 42 was seen in the background of the video without their consent. This had been anonymously reported to human resources. It documented the incident had occurred on 2/2/24 at 11:30 PM and staff had become aware the following day at 10:00 AM. The form documented there had been no change to resident 42's mental status and no physical injury had occurred to them. The measure taken to protect residents' safety by the facility stated, the CNA no longer worked at the facility. Adult Protective Services and the Ombudsman had been notified of the incident. The form documented the incident had not been reported to a law enforcement agency. A form titled exhibit 359 was submitted to the SSA on 2/9/24 at 12:40 PM. The form 359 documented resident 42 had severe dementia and did not have any recollection of the incident. A summary of the interviews with witnesses confirmed resident 42 was exposed in a social media application video without their consent. The perpetrator no longer worked at the facility during the time of the investigation, and it documented the NA (Nursing Assistant] shortly sent in their resignation after the incident via text message. It documented the picture disappeared on the social media application. The investigation verified that the allegation had occurred and documented that several witnesses had confirmed that resident 42's back was seen while in the bathtub. The form documented that resident 42 was unable to understand the situation or recall the incident. It concluded that abuse had occurred because the NA had sent the video to a social media application where resident 42 was exposed and without their consent. Corrective actions taken by the facility included in-service education to staff regarding the facility's digital images policy and the relation to abuse. On 6/5/24 at 9:54 AM, an interview was conducted with CNA 6. CNA 6 stated resident 42 was a one person assist with showers and needed to have staff in the shower room with them. CNA 6 stated resident 42 was able to follow showering instructions and was able to help bathe themselves. CNA 6 stated staff were not allowed to have personal cellphones in resident areas because they need to respect residents personal home. On 6/5/24 at 3:51 PM, an interview was conducted with CNA 13. CNA 13 stated they had a shower schedule which notified the CNA's what rooms they were assigned to shower for the shift. CNA 13 stated resident 42 had showers scheduled for the evening shift. CNA 13 stated resident 42 was able to help with their showers if they were talked through it. CNA 13 stated there was a video taken of the shower room with resident 42 in it. CNA 13 stated resident 42 was tilted forward in the bathtub and their stomach and whole chest were visible in the video. CNA 13 stated they were not supposed to have their own person phones near resident care areas. CNA 13 stated resident 42 was unaware of the video taken of them. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 6/5/24 at 4:11 PM, a telephone interview was conducted with CNA 14. CNA 14 stated them and a few other CNA's were together outside of work hours when they viewed a video that showed a resident in the background. CNA 14 stated CNA 16 had filed a report stating they were injured and had been put on light duty. CNA 14 stated for safety purposes CNA 16 should not have been allowed to shower resident 42. CNA 14 stated CNA 16 had been taking pictures of themselves and resident 42 and then CNA 16 posted a video about being on light duty. CNA 14 stated resident 42 was in the background of the video. CNA 14 stated resident 42 was naked in the bathtub and they were seen playing with the water. CNA 14 stated resident 42's exposed chest made it visible they did not have breasts. CNA 14 stated resident 42's privacy was violated. CNA 14 stated staff were not allowed to have phones while they provided resident care and they were not allowed to take picture or videos of residents due to privacy violations. On 6/5/24 at 4:44 PM, an interview was conducted with the Administrator (ADMIN). The Admin stated the CNA coordinator had been notified by another CNA of a social media video where a resident was visible in the background. The Admin stated the CNA coordinator had informed them the video was taken around midnight the night before or around when the shower was done. The Admin stated the platform the video was taken on was temporary and the video disappeared a short time later. The Admin stated CNA 16 had taken a short video in the shower room where resident 42 appeared to be in the bathtub. The Admin stated they viewed the video and resident 42's bare back, shoulders and face were seen in the video. The Admin stated the video consisted of CNA 16 doing a dance and stating they loved light duty and then phone was turn and resident 42 was seen in the video. The Admin stated they notified Adult Protective Services (APS) and APS had not referred them to law enforcement. The Admin stated they had not notified the police. The Admin stated the police should have been notified so they could make the determination if the incident was considered a crime. The Admin stated CNA 16 resigned shortly after the incident and they had been unable to interview resident 42 since they were unable to recall what happened. The Admin stated they notified resident 42's son about the video and the son became upset. The Admin stated the investigation included asking anyone that viewed the video to delete it. The Admin stated they were unsure if they had individually asked all the CNAs about deleting the video. The Admin stated they wanted it deleted so it would not be viewed anymore. The Admin stated the staff should already know the digital media policy which was staff did not take pictures or video of a resident without their consent and they were not allowed to be distributed. On 6/5/24 at 5:05 PM, an interview was conducted with CNA 15. CNA 15 stated resident 42's CNA was supposed to be on light duty. CNA 15 stated CNA 16 posted a video to their private story on a social media application which showed CNA saying they were on light duty and could not wait to get off. CNA 15 stated CNA 16 was seen dancing and resident 42 was seen in the background of the video naked in the bathtub. CNA 15 stated resident 42 was observed to be naked from their head down to the their stomach due to the camera's angle. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 6/5/24 at 5:15 PM, an interview was conducted with the Resident Advocate (RA). The RA stated they were made aware of resident 42's incident after the Admin had submitted the 358 and notified APS. The RA stated the CNA coordinator had shown the Admin the social media video. The RA stated they were notified what had occurred in the video by the Admin. The RA stated it had been described that resident 42 was in a bathtub naked and they could be seen from the belly up while a CNA had been doing a dance. The RA stated they were the main contact for APS. The RA stated the APS investigator had asked for the CNA's contact information to let them know the incident had been reported. The RA stated the APS investigator had spoken to resident 42. The RA stated the APS investigator stated resident 42 did not remember what had happened and they had been talking gibberish during the interview. The RA stated the APS investigator notified them the case was going to be referred to the Attorney General's Office. The RA stated the APS investigator later told them, the attorney general was going to talk to resident 42. The RA stated they were unsure if the attorney general had come in and talked to resident 42. On 6/5/24 at 12:30 PM, an attempt was made to contact CNA 16 by phone. On 6/7/24 at 6:06 PM, CNA 16 responded by text message and stated the following, if you have any further questions can contact my attorney [name removed] at [phone number removed]. please do not contact me any further thank you. 2. Resident 5 was initially admitted to the facility on [DATE] and readmitted on [DATE] with the diagnoses of encounter for palliative care, type 2 diabetes mellitus with diabetic neuropathy, venous insufficiency, hypertensive heart disease with heart failure, chronic respiratory failure with hypoxia, unspecified dementia and Alzheimer's disease. Resident 5's medical record was reviewed on 6/3/24 through 6/6/24. On 4/4/24, a Quarterly Minimum Data Set (MDS) documented resident 5 had a BIMS score of 1 which indicated severe cognitive impairment. A care plan focus area initiated on 3/7/23 documented resident 5 had a potential communication problem related to difficulty understanding secondary to Dementia. Documented interventions included to ensure/provide a safe environment. On 3/29/24 at 10:24 AM, a facility incident report documented a resident-to-resident interaction had occurred in the activity room. The nursing description documented, Victim was in activity room with perpetrator. Victim lifted up her chin when she saw and then he kissed her on or near the lips. Victims did not appear disturbed, though has cognitive impairment. Resident 5 was unable to give a description of the incident. Immediate actions taken included the immediate separation of both resident. It documented the perpetrator was monitored and the victim was under the supervision of staff since they had been assisted to the day room. The incident report documented resident 5 to be wheelchair bound. The mental status section documented both the perpetrator and the victim had severe dementia. The incident report revealed the APS, the Ombudsman, the responsible party and the state had been notified of the incident. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 4/4/24 at 10:37 AM, a nurse note documented, Staff witnessed incident and immediately separated residents and began directly monitoring and supervising. Victim was then placed in day room. Staff immediately administrator [sic] who began process of investigation with staff and RA. Proper authorities and responsible parties were notified and safety of residents ensured by verifying supervision, monitoring, and placement of victim in separate location. Care plan updated. Victim assessed for any signs and symptoms of distress. None identified to this point. Care plan and medications reviewed for both residents. Psychotropics medication to be reviewed with physician and pharmacy. A physician order with a start date of 4/12/24 documented as followed: [Resident 5] to be monitored in the dayroom as able and as she tolerates for safety. every shift A form titled exhibit 358 was submitted to the State Survey Agency (SSA) on 3/29/24 at 3:30 PM. The form noted that the incident was an allegation of sexual abuse. The victim identified was resident 5 and the alleged perpetrator was resident 374 who was noted as a resident with dementia. Staff had become aware of the incident on 3/29/24 at 2:45 PM. A detailed account of the incident stated, Victim was in the activity room with perpetrator. Victim was kissed, on or close to the lips by the perpetrator. It is unknown if this was welcome because the victim was dementia. The immediate steps taken to ensure the resident's safety included the separation of the resident 5 from the perpetrator and kept safe from resident 374. The resident's family had been notified of the incident. The Agencies notified included the Ombudsman and APS. The exhibit 358 documented that the incident had not been reported to a law enforcement agency. A form titled 359 was submitted to the SSA on 4/5/24. The facility's investigation included 3 staff interviews and 5 resident interviews. The perpetrator statement documented resident 374 had dementia and was unable to be interviewed but he stated that resident 5 was his women. A staff interview documented resident 374 was observed to kiss resident 5 during an activity. Resident 5 put her hand out and he held it and went in and kissed her. No additional outcomes were documented to had occurred to either resident post incident. A summary of the witnesses interview documented, Residents were in the activity room, [resident 374] walked over to [resident 5]. She looked up at him and he leaned down and kissed her. Staff redirected [resident 374]. [Resident 5] did not react or respond in a manner to suggest that it was unwelcome; however, she doesn't have the cognitive capacity to consent. An interview summary with resident 374 documented he had dementia and stated resident 5 was his lady. An interview summary with other resident revealed other resident noted resident 374 was very friendly and had seen resident 374 attempt to kiss other women before. The relevant summary information provided documented, Perpetrator is a pleasant [AGE] year old male with vascular dementia. He is independently mobile, and takes a medication that has a potential side affect of increased libido (asking Dr. to review) His BIMS score is a 4. Victims is a [AGE] year old female with Alzheimer's dementia and multiple comorbitites. Her BIMS score is 1. The investigation verified the allegation type had occurred and stated, Multiple witnesses saw [resident 374] kiss [resident 5] near the mouth. Although it did not appear unwelcome, the victim does not have decision making capacity. The corrective actions taken from the investigation of the allegation included separating both residents and resident 374 was put on frequent checks. The systemic action documented was, Perpetrator's medication that has a side effect of increased libido was discontinued by his physician. No counseling needs or other interventions were documented to assist resident 5 with the sexual abuse that had been verified. The form documented, Victim has a BIMS score of 1 and cannot recall the incident. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 6/5/24 at 9:41 AM, an interview was conducted with CNA 5. CNA 5 stated resident 5 was not mentally with it. CNA 5 stated resident 5 was not able to consent kissing other residents. CNA 5 stated they were not aware of any incident that involved resident 5 being kissed. On 6/6/24 at 7:49 AM, an interview was conducted with CNA 12. CNA 12 stated resident 5 was confused. CNA 12 stated depending on how resident 5 was feeling during the day, they needed to have a second staff member with them during resident cares. CNA 12 stated they usually rounded on resident's every two hours. CNA 12 stated resident 5 was unable to consent to anything due to them being confused and being unable to recall events. CNA 12 stated resident 374 had a history of behaviors such as wandering and exit seeking. CNA 12 stated resident 374 attempted to link up with other residents and one time they had grabbed on to resident 374. CNA 12 stated resident 5 was unable to give consent for a kiss. On 6/6/24 at 8:12 AM, an interview was conducted with CNA 18. CNA 18 stated resident 5 required two-person physical assistance with a Hoyer lift with transfers. CNA 18 stated resident 5's dementia was so severe they were unable to recall the date. CNA 18 stated resident 5 was unable to express their needs. CNA 18 stated they were unaware of any interactions between resident 374 and resident 5. CNA 18 stated resident 374 believed they were a ladies man and they liked to show affection in the form of kisses. On 6/6/24 at 8:32 AM, an interview was conducted with Licensed Practical Nurse (LPN) 3. LPN 3 stated resident 5 was confused and when resident 5 was in the day room they needed to monitor them. LPN 3 stated they were aware a resident had kissed another resident and stated maybe resident 374 had kissed resident 5. LPN 3 stated resident 5 was not able to consent to being kissed. On 6/6/24 at 10:31 AM, an interview was conducted with Assistant Director of Nursing (ADON) 1. ADON 1 stated resident 5 was kind of able to make their needs known. ADON 1 stated resident 5 did not like being left on their own and liked human interaction. ADON 1 stated they did not believe resident 5 was able to consent to being kissed by another resident. ADON 1 stated there had been a resident that had been making advances towards other residents. ADON 1 stated they were unsure who those residents had been. On 6/6/24 at 10:50 AM, an interview was conducted with the Admin. The Admin stated they tried to interview both residents involved. The Admin stated they had been notified by the nurse, that two CNA's who stated they saw resident 374 kiss resident 5. The Admin stated they interviewed the CNAs and they stated resident 374 brought their face close to resident 5 and resident 5 was kissed when they looked and saw resident 374. The Admin stated they had been informed by staff that an activity at the time this happened. The Admin stated resident 374 had a prior history but they were unsure of what had occurred the first time. The Admin stated the doctor changed some of resident 374's medications due to the incident. The Admin stated resident 5 had a diagnosis of dementia with a BIMS score of 1 and it was unlikely that resident 5 remembered the incident. 22992 3. Resident 17 was admitted to the facility on [DATE] with diagnoses that included amnesia, pulmonary heart disease, generalized osteoarthritis, pulmonary hypertension, severe protein-calorie malnutrition, anxiety disorder, and chronic pain syndrome. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Resident 17's medical record was reviewed from 6/2/24 through 6/6/24. On 9/8/23, a Saint [NAME] University Mental Status (SLUMS) examination was completed for resident 17. The resident was assessed as having a score of 13 out of 30, indicating that the resident's cognitive status was in the dementia category. On 12/23/23, a care conference was held with resident 17. Staff documented that the resident . had increasing behaviors and has been more confused than normal. Care concerns PT [patient] increased confusion. On 2/1/24, a MOCA was completed for resident 17. The resident was assessed as having a score of 13 out of 30, indicating moderate cognitive impairment. Progress notes for resident 17 revealed the following: a. On 1/25/24, Resident has appeared to be very confused, she is reporting that her room mate is threatening to kill her, punch her, find her and kill her. Resident states that her roommate is calling her uglyface. Resident is very upset, crying and scared, she doesn't feel safe. It is noted very clearly that Resident's roommate was not in room when Resident states these threats where (sic) made. b. On 4/12/24 . PTs BIMS score showed that she is Moderately impaired with a score of 11. PTs cognition has declined recently and she is having a harder time remembering where her friends rooms are located. c. On 5/23/24, . pt started a shared companionship with a male resident. BIMS ranges from 11-15 historically. Reviewed resident mental status. IDT [Interdisciplinary Team] spoke with resident and discussed her relationship and if resident is capable of communicating her thoughts of the relationship. She does enjoy the relationship with male resident and is having sexual relations. Interviewed staff concerning this residents relationship with male resident. Staff agree it is consensual and conducted in privacy. IDT created and implemented a care plan. Contacted PCP [primary care physician] for capacity to consent to the relationship. The progress note did not indicate how the resident's capacity to consent was assessed or determined, nor did it address her BIMS, SLUMS, or MOCA evaluations. On 6/5/24 at 4:30 PM, an interview was conducted with the RA. When asked about resident 17 being involved in a sexual relationship with another resident, the RA stated she was unaware of the issue, and did not know who the other resident involved in the relationship was. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 6/6/24 at 7:40 AM, an interview was conducted with the facility Administrator (ADM). The ADM stated that he was unsure about how long resident 17 had been in a sexual relationship with another resident. The ADM stated that it had come to his attention approximately 4 to 6 weeks prior when a corporate team member identified it. When asked how he had determined if the residents were capable of giving consent for a sexual relationship, the ADM stated that he had reviewed it with the IDT team, and they (the residents) seemed ok. The ADM stated that the residents had been interviewed and were able to state that they understood what a relationship means and about sexual contact. The ADM stated that he was aware resident 17 had a diagnosis of amnesia but that he had looked it up and it meant that the resident was forgetful . so I didn't feel like that related to the determination of consent. The ADM further stated that I didn't see that as a diagnosis that would impair her. The ADM stated that he was unaware of resident 17's MOCA and SLUMS scores, or her increased confusion in previous assessments. The ADM also stated that they had reached out to the physicians for both residents to also help determine if the residents were able to give consent, but the physician had not yet responded. On 6/6/24 at 8:43 AM, an interview was conducted with the Regional Nurse Consultant (RNC). The RNC stated that there was a corporate pathway of determining if residents had the capacity to consent to a sexual relationship, and that the physician was supposed to be contacted. The RNC confirmed that neither resident had been evaluated by their physician to determine capacity to consent, even though multiple attempts have been made . The doctor needs to be first and until the doctor clears it, we should have stopped it. After the survey team completed the recertification survey, The facility provided a letter dated 6/7/24 that had been written and signed by resident 17's physician. The letter stated, . I have been asked to provide a letter or note regarding her (resident 17) capacity to consent. Patient does not have any history of dementia. She is not on any dementia medication at this time as well. She is free of any communicable diseases that I know of. The patient manages her own checkbook and other affairs. The patient does have osteoarthritis and does not drive a vehicle. However she is able to leave the facility whenever she desires. If she would like to be in any intimate relationship I do not see any reason to stop her at this point legally. I would caution her to only become romantically involved in relationship (sic) and not financially at this stage in life. 38031 4. A. Resident 12 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which consisted of encounter for palliative care, rheumatoid arthritis, type II diabetes mellitus, vascular dementia, polyneuropathy, pulmonary hypertension, hypertension, hyperlipidemia, aphasia, cerebral infarction, thrombophilia, hemiplegia and hemiparesis, anxiety disorder, and major depressive disorder. On 6/2/24, resident 12's medical records were reviewed. On 9/8/23, resident 12's MDS assessment documented a BIMS score of 4/15, which would indicate that the resident was severely cognitively impaired. Resident 12's progress notes revealed the following: (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	a. On 11/8/23 at 4:51 PM, the nurse note documented, Pt has been increaslingly (sic) tearful this shift. She is unable to verbalize why she is upset. POA [Power of Attorney] was called and visited. POA is concerned the behaviors may be caused by a UTI [urinary tract infection] or that the pt may need an increase in her antidepressant medication. PCC [sic] notified. b. On 11/9/23 at 10:34 PM, the nurse note documented, Pt had resident [374] who was in her room. She felt uncomfortable and asked me to get him out of her room. Pt's roommate claimed he had been in there earlier that day as well. c. On 1/18/24 at 4:45 PM, the nurse note documented, Resident has an episode of sadness and crying and requested for her daughter to call her up. Had Tylenol for headache and requested to put her to bed. She is on antibiotic for UTI without adverse reaction noted. Resident has runny nose and cough and informed [provider name removed]. Will continue to monitor resident. On 4/28/21, a care plan for impaired cognitive function/dementia or impaired thought process was initiated. Interventions included: use the resident preferred name; identify yourself at each interaction; face the resident when speaking and make eye contact; reduce any distractions; provide necessary cues; reorient and supervise as needed; and monitor for any changes in cognitive function. Resident 12's Kardex documented, DO NOT ALLOW PT TO BE IN PRESENCE OF [RESIDENT 374] UNATTENDED. PT IS NOT TO BE LEFT ALONE WITH [RESIDENT 374] D/T [due to] INAPPROPRIATE BEHAVIOR. The facility abuse investigation, form 358, documented that on 11/13/23 at 3:30 PM, resident 12's Power of Attorney (POA) informed the ADM that resident 374 took resident 12 back to her room and the roommate [resident 36] heard kissing noises. The form documented that the date of the alleged incident was 7/13/23. The report documented that the residents were separated. On 11/13/23, the ADM interview with resident 374 documented Resident has BIMS of 4-5. Could not describe situation but denies kissing. On 11/13/23, the interview with resident 12 documented, Asked if she's been kissing perpetrator, she says 'yes'. Asked why she's kissing him, replied 'because it feels good'. Resident has BIMS of 4-5. Roommate says 'She wants to but she doesn't want to.' The facility final investigation, form 359, documented the steps to investigate the allegation was, Asked the victim if [resident 374] has been kissing her; replied 'Yes'. Asked why, she responded, 'because it feels good' and 'it tasted good'. The summary of interviews documented, Resident's roommate says that perpetrator has been coming back into the room with her after dinner. Then they go on the other side of the room and she hears kissing sounds. Says victim wants to do it, but also doesn't want to do it. The report documented that the perpetrator was mobile which made it difficult to monitor his location and staff observed resident 374 wheeling resident 12 around. The conclusion of the facility investigation documented, Evidence does not verify that abuse occurred. Victim says they've been kissing because it feels good. Both residents have dementia. The corrective action taken documented that the residents were separated and staff were notified to intervene if resident 374 tried to wheel resident 12 around or enter her room. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The investigation included a form for Tips on Assessing Consent to Sexual Intimacy in Older Adults and documented questions to ask residents with impaired cognition to determine capacity to consent to physical/sexual intimacy. The form documented that the IDT should meet and review the residents most recent BIMS scores, any documentation of behaviors, change in condition, responsible party input when applicable, responses to questions and any input from a therapist regarding decision making abilities. The form stated that a summary note of findings that included a determination of whether residents could knowingly consent to physical/sexual intimacy should be documented and care planned. The form documented that after the assessment was completed and determined that one or both residents were unable to consent that the staff should ensure that residents were protected from sexual abuse or exploitation. It should be noted that no documentation could be found to demonstrate that the facility evaluated resident 12 or resident 374 for the capacity to consent to sexual activity. On 6/3/24 at 2:26 PM, an interview was conducted with resident 36 who was resident 12's roommate. Resident 36 stated that there was a male resident that kissed resident 12 and would not let go. Resident 36 stated that she could hear the kissing, but did not see it because resident 12 and resident 374 were behind the privacy curtain. Resident 36 stated that she could hear resident 12 whining like a whimper during this time. Resident 36 stated that resident 12 did not say anything during the kissing noises. Resident 36 stated that she only witnessed the one incident and she informed resident 12's POA about it. Resident 36 stated that the male resident [resident 374] tried to enter resident 12's room afterwards but the facility put a sign up that kept him out. Resident 36 stated that after the incident resident 12 was more quiet than usual. On 6/3/24 at 2:38 PM, an interview was conducted with resident 12. Resident 12 replied yes when asked if she had a relationship with a male resident at the facility in the past. Resident 12 was unable to say who the individual was, to recall their name, or to describe what the relationship was like. On 6/3/24 at 3:21 PM, an interview was conducted with CNA 10. CNA 10 stated that resident 12 was a two-person assist for transfers utilizing the sit to stand lift. CNA 10 stated that resident 12 could propel herself in a manual wheelchair. CNA 10 stated that resident 12 had occasional confusion and sometimes could not answer questions properly. CNA 10 stated that sometimes resident 12 could not identify the people in the pictures in her room. CNA 10 stated that a few months ago resident 374 wanted to talk to resident 12 and be close to he [TRUNCATED]

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46232 Based on observation, interview, and record review, the facility did not prevent misappropriation of resident's medications for 3 of 53 sample residents. Specifically, cognitively impaired residents had missing fentanyl patches on numerous occasions. Resident identifiers: 5, 42, and 43. Findings Included: 1. Resident 5 was initially admitted to the facility on [DATE] and readmitted on [DATE] with the diagnoses of encounter for palliative care, type 2 diabetes mellitus with diabetic neuropathy, venous insufficiency, hypertensive heart disease with heart failure, chronic respiratory failure with hypoxia, unspecified dementia and Alzheimer's disease. On 6/5/24 at 11:44 AM, an observation was made of resident 5 in their room. Resident 5 was brought back to their room by the licensed practical nurse (LPN) 4 and regional nurse consultant (RNC). The RNC and LPN 4 informed resident 5 they needed to look at their back. The RNC and LPN 4 helped lean resident 5 in the chair and pulled their shirt up. Resident 5's back was observed, and no fentanyl patch was located on their back. Resident 5's medical record was reviewed on 6/3/24 to 6/6/24. On 4/4/24, a Quarterly Minimum Data Set (MDS) documented resident 5 had a Brief Interview for Mental Status (BIMS) score of 1 which indicated severe cognitive impairment. Resident 5's physician orders were reviewed and documented the following fentanyl patch orders: a. An order with a start date of 4/22/24 documented, Fentanyl- Remove Fentanyl Patch - Co-signature With Another Nurse Upon Narcotic Destruction (q [every] 3days). every 72 hours. b. An order with a start date of 4/23/24 documented, Check fentanyl patch placement. every shift for pain. c. A physician order with a start date of 5/16/24 documented, FentaNYL Patch 72 Hour 75 microgram (MCG)/hour (HR.) Apply 1 patch transdermally every 72 hours for pain and remove per schedule. Resident 5's progress notes were reviewed from April 2024 to June of 2024 and documented the following notes for resident 5's fentanyl patch: a. On 4/21/24 at 10:57 PM, a nurse note documented, [name and hospice name removed] will be coming 04/22/24 at the facility to give a written order from MD [medical doctor] per RN [registered nurse] [name removed]. She reported having a new order for Fentanyl Will clarify the orders resident had before before [sic] giving a new orders. b. On 4/22/24 at 2:58 PM, an orders administration note documented, Fentanyl- Remove Fentanyl Patch - Co-signature With Another Nurse Upon Narcotic Destruction (q3days). every 72 hours. first patch placed today 4/22. (continued on next page)

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Red Cliffs Health and Rehab	1745 East 280 North St George, UT 84790

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. On 5/1/24 at 5:44 PM, an orders administration note documented, fentaNYL Transdermal Patch 72 Hour 50 MCG /HR. Apply 1 patch transdermally every 72 hours for pain and remove per schedule. unable to find; confirmed with second nurse. d. On 5/4/24 at 5:46 PM, an orders administration note documented, Check fentanyl patch placement every shift for pain. old patch not located e. On 5/5/24 at 12:24 PM, an orders administration note documented, Check fentanyl patch placement every shift for pain. no patch on resident. f. On 5/7/24 at 2:51 PM, an orders administration note documented, fentaNYL Transdermal Patch 72 Hour 50 MCG/HR. Apply 1 patch transdermally every 72 hours for pain and remove per schedule. Old patch not present. g. On 5/7/24 at 3:56 PM, an orders administration note documented, Fentanyl- Remove Fentanyl Patch - Co-signature With Another Nurse Upon Narcotic Destruction (q3days). every 72 hours. No patch present. h. On 5/18/24 at 3:04 PM, an orders administration note documented, Check fentanyl patch placement. every shift for pain. no patch noted. i. On 5/19/24 at 2:12 PM, an orders administration note documented, Fentanyl- Remove Fentanyl Patch - Co-signature With Another Nurse Upon Narcotic Destruction (q3days). every 72 hours. not on resident j. On 5/19/24 at 4:13 PM, an orders administration note documented, FentaNYL Patch 72 Hour 75 MCG/HR. Apply 1 patch transdermally every 72 hours for pain and remove per schedule. not on resident. k. On 5/25/24 at 1:16 PM, an orders administration note documented, Fentanyl- Remove Fentanyl Patch - Co-signature With Another Nurse Upon Narcotic Destruction (q3days). every 72 hours. old patch was not found. l. On 5/29/24 at 6:05 PM, an orders administration note documented, Check fentanyl patch placement every shift for pain. fentanyl patch not found. m. On 6/1/24 at 2:59 PM, an order administration note documented, Check fentanyl patch placement every shift for pain. not on resident On 6/5/24 at 11:09 AM, an interview was conducted with certified nursing assistant (CNA) 7. CNA 7 stated resident 5's patch came off when they had cleaned her. CNA 7 stated they had it aside and put it in the trash can. CNA 7 stated they had informed the nurse, but they didn't have a chance to notify other staff. CNA 7 stated the trash had just been thrown away. CNA 7 stated they were unsure how medications were disposed of since they did not deal with medications. On 6/5/24 at 11:32 AM, an interview was conducted with the Regional Nurse Consultant (RNC). The RNC stated the Minimum Data Set Coordinator (MDSC) had just thrown resident 5's trash away and they were not aware a medication patch had been discarded in there. The RNC stated they were going to inform the MDSC to look for the trash bag in the dumpster and to have them locate the patch. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	d. On 5/1/24 at 1:24 PM, an orders-administration note documented, Fentanyl- Check Placement Of Fentanyl Patch Every Shift. every shift. not on pt [patient]. e. On 5/1/24 at 2:53 PM, an orders- administration note documented, Fentanyl- Remove Fentanyl Patch & Provide To DON/RN Designee For Narcotic Destruction (q3days) one time a day every 3 day(s). no fentanyl patch present; placing new one. f. On 5/19/24 at 2:11 PM, an orders- administration note documented, Fentanyl- Remove Fentanyl Patch & Provide To DON/RN Designee For Narcotic Destruction (q3days) one time a day every 3 day(s). not on resident. g. On 5/19/24 at 2:11 PM, an orders- administration note documented, Fentanyl- Check Placement Of Fentanyl Patch Every Shift every shift. not on resident. h. On 5/28/24 at 4:06 PM, an orders- administration note documented, Fentanyl- Remove Fentanyl Patch & Provide To DON [director of nursing]/RN [Registered Nurse] Designee For Narcotic Destruction (q3days). one time a day every 3 day(s). Fentanyl patch not found. i. On 6/3/24 at 4:47 PM, a Nurse Practitioner note documented, .She has been having a hard time getting pain relief. She tears of her pain patches, so they are not working. We went back to pill for to try and help her . j. On 6/4/24 at 1:47 PM, an orders- administration note documented, fentaNYL Transdermal Patch 72 Hour 12MCG/HR**DAW** Apply 2 patch transdermally in the evening every 3 day(s) for Pain. Dr. [doctor] discontinued these patches due to resident continually removing them. 3. Resident 43 was admitted to the facility on [DATE] with diagnoses that included dementia, chronic obstructive pulmonary disease, hypothyroidism, muscle wasting, adult failure to thrive, nicotine dependence, and osteoarthritis. Resident 43's medical records were reviewed. On 4/11/24, a Quarterly BIMS assessment documented resident 43 had a score of 0 which indicated severe cognitive impairment. Resident 43's physician orders were reviewed and documented the following fentanyl patch orders: a. An order with a start date of 8/25/23 and end date of 6/6/24 documented, FentaNYL Patch 72 Hour 75 MCG/HR. Apply 1 patch transdermally every 72 hours for pain and remove per schedule. b. An order with a start date of 9/13/23 and end date of 6/6/24 documented, Fentanyl- Check Placement Of Fentanyl Patch Every Shift. c. An order with a start date of 9/15/23 and end date of 6/6/24 documented, Fentanyl- Remove Fentanyl Patch - Co-signature With Another Nurse Upon Narcotic Destruction (q3days) one time a day every 3 day(s). (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 43's progress notes were reviewed from April 2024 to June 2024 and documented the following notes for resident 42's fentanyl patch: a. On 4/27/24 at 6:04 PM, an Administration Note documented, Fentanyl- Remove Fentanyl Patch - Co-signature With Another Nurse Upon Narcotic Destruction (q3days). one time a day every 3 day(s). CNA and I both searched her back and found no prior fentanyl patch. b. On 4/29/24 at 7:49 PM, an Administration Note documented, Fentanyl- Check Placement Of Fentanyl Patch Every Shift. every shift. Patch is not on Resident. c. On 4/30/24 at 12:07 PM, an Administration Note documented, FentaNYL Patch 72 Hour 12 MCG/HR. Apply 1 patch transdermally every 72 hours for pain and remove per schedule. fentanyl patch not found on pt. another one was placed. d. On 5/2/24 at 7:53 PM, an Administration Note documented, Fentanyl- Check Placement Of Fentanyl Patch Every Shift. every shift. Patch is not in place. e. On 5/5/24 at 1:56 PM, an Administration Note documented, Fentanyl- Check Placement Of Fentanyl Patch Every Shift. every shift. unable to find patch. f. On 5/6/24 at 8:56 AM, an Administration Note documented, Fentanyl- Remove Fentanyl Patch - Co-signature With Another Nurse Upon Narcotic Destruction (q3days). one time a day every 3 day(s). No patch located on patient. g. On 5/11/24 at 7:12 PM, an Administration Note documented, FentaNYL Patch 72 Hour 12 MCG/HR Apply 1 patch transdermally every 72 hours for pain and remove per schedule .could not find patch anywhere on residents body. h. On 5/12/24 at 9:14 AM, an Administration Note documented, Fentanyl- Remove Fentanyl Patch & Provide To DON/RN Designee For Narcotic Destruction (q3days) one time a day every 3 day(s). Patch was not on resident and was not found. i. On 5/1/7/24 at 9:20 PM, an Administration Note documented, Fentanyl- Check Placement Of Fentanyl Patch Every Shift .Fentanyl patch is missing. j. On 5/18/24 at 4:08 PM, an Administration Note documented, Fentanyl- Remove Fentanyl Patch & Provide To DON/RN Designee For Narcotic Destruction (q3days). one time a day every 3 day(s). no patch noted. Verified by 2 nurses. k. On 5/21/24 at 3:58 PM, an Administration Note documented, Fentanyl- Remove Fentanyl Patch & Provide To DON/RN Designee For Narcotic Destruction (q3days) one time a day every 3 day(s). Fentanyl patch was not found on Resident or anywhere in her room. l. On 5/23/24 at 6:53 PM, an Administration Note documented, .We were not able to find if her Fentanyl patch was still in place. The oncoming evening nurse acknowledged this and will attempt to check for it. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50200 Based on record review and interview, it was determined, the facility did not ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source, were reported immediately, but not later than 2 hours after the allegation was made to the State Survey Agency (SSA). In addition, report the results of all investigations to the SSA within 5 working days of the incident. Specifically, for 4 out of 53 sampled residents, exhibit 358 entity reports of neglect and abuse allegations were not submitted to the SSA in a timely manner. In addition, exhibit 359 follow-up investigation report of one resident was submitted to the SSA seven working days after the neglect incident was reported. Resident identifiers: 364, 367, 370 and 374. Findings included: 1. Resident 367 was admitted to the facility on [DATE] with diagnoses which included end stage renal disease, dependence on renal dialysis, type 2 diabetes, hypertensive chronic kidney disease stage 5, chronic atrial fibrillation, and cognitive communication deficit. Resident 367's medical record was reviewed 6/2/24 through 6/6/24. On 9/20/23 at 11:04 AM, the facility exhibit 358 entity report documented on 9/19/23 at 8:00 PM, it was reported the resident was transported to the hospital ER [emergency room] and when returning to the facility he had tipped his wheelchair back and fell . This fall resulted in the resident hitting his head. Per the Administrator, the resident told the transporter he felt fine. However, the transporter returned the resident to the ER where the resident was found to have a non-displaced cervical fracture. Per the Administrator, the course of treatment is a soft collar for about four weeks. As for the manner in which the resident was secured in the vehicle and what, if any, precautions were taken relative to his potential neck injury. APS [Adult Protective Services] and Ombudsman were notified. Review of the exhibit 358 entity report documented the incident occurred on 9/19/23 at 8:00 PM, and it was reported to the SSA on 9/20/23 at 11:04 AM. 2. Resident 370 was admitted to the facility on [DATE] and readmitted [DATE] with diagnoses which included palliative care, paroxysmal atrial fibrillation, moderate protein-calorie deficiency, unspecified dementia, heart failure, chronic kidney disease stage 3, peripheral vascular disease, and pulmonary hypertension. Resident 370's medical record was reviewed 6/2/24 through 6/6/24. On 11/15/23 at 5:19 PM, the facility exhibit 358 entity report was documented on 11/14/23 at 11:30 PM, resident's roommate reported to floor Nurse that the resident had fallen in their room. Resident was assessed and sent to the ER for further evaluation, it was found that the resident sustained a left femur fracture. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the exhibit 358 entity report documented the incident occurred 11/14/23 at 11:30 PM, and it was reported to the SSA on 11/15/23 at 5:19 PM. On 6/5/24 at 11:55 AM, an interview was conducted with the Administrator (ADM). The ADM stated a major injury was a fracture, loss of limb, something that would cause permanent damage, a major head injury, and probably sutures. The ADM stated the timeline for reporting major injuries to the ADM was immediately from staff, and then he would report to the state within two hours. 38031 3. Resident 374 was admitted to the facility on [DATE] with a diagnosis of vascular dementia. On 6/3/24, resident 374's medical records were reviewed. Resident 374's progress notes and facility reported incidents revealed the following: a. On 4/3/24 at 2:48 PM, the nurse note documented, Pt did exit the facility and got out to the parking lot area. He was followed out to the parking lot by multiple staff members, to which he was verbally aggressive towards. The facility initial notification to the State Survey Agency (SSA), form 358, documented that the staff were first informed of resident 374's elopement on 4/3/24 at 10:00 AM. No documentation could be found to demonstrate that APS was informed of the elopement. b. On 4/4/24 at 11:06 AM, the nurse note documented, Upon being notified of resident exiting facility, staff immediately went to ensure safety and found him a short distance off of property, and across the street. Resident redirected and calming communication initiated, and safe escort back into facility. Frequent checks and monitors initiated, per protocol. Family notified. Cause of resident being able to exit was sought after and identified that he was able to get out of door with no alert system due to the door being propped open. This was fixed and staff was educated on not propping door open, and re-edcuated [sic] on the door alarm system function. Future placement for resident in another facility with designated memory care unit has been initiated. No documentation could be located to demonstrate that the facility notified the SSA or APS of resident 374's elopement. c. On 4/13/24 at 5:28 PM, the alert note documented, Resident attempted to exit out of the front of the building before being stopped by the CNA's [Certified Nurse Assistant]. He then snuck out the back and made it out to the road. We wee (sic) able to redirect him back to the building. No documentation could be found to demonstrate that the facility notified the SSA or APS of resident 374's elopement. On 6/5/24 at 2:10 PM, an interview was conducted with the facility Administrator (ADM). The ADM stated resident 374 eloped several times. The ADM stated that an actual elopement should be reported to him by staff and should be relayed in the morning stand up meeting. The ADM stated that elopements should then be reported to the SSA. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[Cross-refer F689] 30563 4. Resident 364 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included encounter for change or removal of surgical wound dressing, major depressive disorder, Alzheimer's disease, and Fall of superior rim of left pubis, subsequent encounter for fracture with routine healing (6/2/23). Resident 364's medical record was reviewed 6/2/24 through 6/6/24. A nursing progress note dated 5/29/23 9:40 PM revealed, Resident was in bathroom and fell to floor and hit head and had goose egg, and L [left] hip edema, pain and not able to put pressure on it. [Physician's name removed] and patient dtr [daughter] [name removed] notified. Dtr came to facility and stated she wants mom seen at ER to rule out hip fx [fracture]. [Physician's name removed] agreed, and patient sent out via [local ambulance company]. A nursing progress note dated 5/29/23 at 11:59 PM, Spoke with [local hospital] nurse and resident was admitted to [NAME] 4, in room [ROOM NUMBER] for left femur fracture. An incident report dated 5/29/23 at 7:40 PM revealed Resident was in bathroom and fell to floor and hit head and had red slightly raised area, and L hip redness, pain, and not able to put pressure on it. [Physician's name removed] and patient dtr [name removed] notified. Dtr came to facility and stated she wants mom seen at ER to rule out hip fx. [Physician's name removed] agreed, and patient sent out via [local ambulance service] . The exhibit 358 that the facility submitted to the SSA revealed that the staff became aware of the incident on 5/29/23 at 7:40 PM. The form further revealed the Administration became aware on 5/30/23 at 9:30 AM during morning meeting. An email dated 6/1/23 at 6:17 PM revealed the SSA was notified that resident 364 sustained a hip fracture. On 6/5/24 at 5:23 PM, an interview was conducted with the Administrator. The Administrator stated after there was an allegation of abuse or neglect, the incident needed to be reported to the SSA within 2 hours. The Administrator stated if a resident sustained a fracture, that would need to be reported within 2 hours because that was a significant injury. The Administrator stated he did not know why the allegation was reported on 6/1/23 when the facility was aware of the fracture on 5/29/24 at 11:59 PM. The Administrator stated he did not recall the allegation and investigation. On 6/6/24 at 7:38 AM, an interview was conducted with the Administrator. The Administrator stated when he looked back on the investigation the previous DON reported the allegation. The Administrator stated the DON failed to meet the reporting within 2 hours.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46232 Based on interview and record review it was determined, 7 of 53 sampled residents, that in response to allegations of abuse, neglect, exploitation, or mistreatment, the facility failed to thoroughly investigate and report the results of all investigations to the State Survey Agency (SSA) within 5 days of the incident. Specifically, medication was left in a resident room and the resident had not been evaluated for safe self-administration, missing fentanyl patches for multiple residents, hot coffee was thrown on a resident and resulted in skin redness, an allegation of sexual abuse in which a resident had been kissed and a resident eloped from the facility. Resident identifiers: 5, 12, 31, 42, 43, 368, and 374. Findings Included: 1. Resident 5 was initially admitted to the facility on [DATE] and readmitted on [DATE] with the diagnoses of encounter for palliative care, type 2 diabetes mellitus with diabetic neuropathy, venous insufficiency, hypertensive heart disease with heart failure, chronic respiratory failure with hypoxia, unspecified dementia and Alzheimer's disease. On 6/5/24 at 11:44 AM, an observation was made of resident 5 in their room. Resident 5 was brought back to their room by the licensed practical nurse (LPN) 4 and regional nurse consultant (RNC). The RNC and LPN 4 informed resident 5 they needed to look at their back. The RNC and LPN 4 helped lean resident 5 in the chair and pulled their shirt up. Resident 5's back was observed, and no fentanyl patch was located on their back. Resident 5's medical record was reviewed on 6/3/24 to 6/6/24. On 4/4/24, a Quarterly Minimum Data Set (MDS) documented resident 5 had a Brief Interview for Mental Status (BIMS) score of 1 which indicated severe cognitive impairment. Resident 5's physician orders were reviewed and documented the following fentanyl patch orders: a. An order with a start date of 4/22/24 documented, Fentanyl- Remove Fentanyl Patch - Co-signature With Another Nurse Upon Narcotic Destruction (q [every] 3days). every 72 hours. b. An order with a start date of 4/23/24 documented, Check fentanyl patch placement. every shift for pain. c. A physician order with a start date of 5/16/24 documented, FentaNYL Patch 72 Hour 75 micrograms (MCG)/hour (HR.) Apply 1 patch transdermally every 72 hours for pain and remove per schedule. Resident 5's progress notes were reviewed from April 2024 to June of 2024 and documented the following notes for resident 5's fentanyl patch: (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. On 4/21/24 at 10:57 PM, a nurse note documented, [name and hospice name removed] will be coming 04/22/24 at the facility to give a written order from MD [medical doctor] per RN [registered nurse] [name removed]. She reported having a new order for Fentanyl Will clarify the orders resident had before before [sic] giving a new orders. b. On 4/22/24 at 2:58 PM, an orders administration note documented, Fentanyl- Remove Fentanyl Patch - Co-signature With Another Nurse Upon Narcotic Destruction (q3days). every 72 hours. first patch placed today 4/22. c. On 5/1/24 at 5:44 PM, an orders administration note documented, fentaNYL Transdermal Patch 72 Hour 50 MCG [micrograms]/HR [hour]. Apply 1 patch transdermally every 72 hours for pain and remove per schedule. unable to find; confirmed with second nurse. d. On 5/4/24 at 5:46 PM, an orders administration note documented, Check fentanyl patch placement every shift for pain. old patch not located. e. On 5/5/24 at 12:24 PM, an orders administration note documented, Check fentanyl patch placement every shift for pain. no patch on resident. f. On 5/7/24 at 2:51 PM, an orders administration note documented, fentaNYL Transdermal Patch 72 Hour 50 MCG/HR. Apply 1 patch transdermally every 72 hours for pain and remove per schedule. Old patch not present. g. On 5/7/24 at 3:56 PM, an orders administration note documented, Fentanyl- Remove Fentanyl Patch - Co-signature With Another Nurse Upon Narcotic Destruction (q3days). every 72 hours. No patch present. h. On 5/18/24 at 3:04 PM, an orders administration note documented, Check fentanyl patch placement. every shift for pain. no patch noted. i. On 5/19/24 at 2:12 PM, an orders administration note documented, Fentanyl- Remove Fentanyl Patch - Co-signature With Another Nurse Upon Narcotic Destruction (q3days). every 72 hours. not on resident. j. On 5/19/24 at 4:13 PM, an orders administration note documented, FentaNYL Patch 72 Hour 75 MCG/HR. Apply 1 patch transdermally every 72 hours for pain and remove per schedule. not on resident. k. On 5/25/24 at 1:16 PM, an orders administration note documented, Fentanyl- Remove Fentanyl Patch - Co-signature With Another Nurse Upon Narcotic Destruction (q3days). every 72 hours. old patch was not found. l. On 5/29/24 at 6:05 PM, an orders administration note documented, Check fentanyl patch placement every shift for pain. fentanyl patch not found. m. On 6/1/24 at 2:59 PM, an order administration note documented, Check fentanyl patch placement every shift for pain. not on resident. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	It should be noted there was no documentation located to indicate an investigation had been done on resident 5's fentanyl patches. On 6/5/24 at 11:09 AM, an interview was conducted with certified nursing assistant (CNA) 7. CNA 7 stated resident 5's patch came off when they had cleaned her. CNA 7 stated they had it aside and put it in the trash can. CNA 7 stated they had informed the nurse, but they didn't have a chance to notify other staff. CNA 7 stated the trash had just been thrown away. CNA 7 stated they were unsure how medications were disposed of since they did not deal with medications. On 6/5/24 at 11:32 AM, an interview was conducted with the Regional Nurse Consultant (RNC). The RNC stated the Minimum Data Set Coordinator (MDSC) had just thrown resident 5's trash away and they were not aware a medication patch had been discard of in there. The RNC stated they were going to inform the MDSC to look for the trash bag in the dumpster and to have them locate the patch. 2. Resident 42 was admitted to the facility on [DATE] with the following diagnoses of Delirium, unspecified dementia, moderate, with psychotic disturbance, anxiety disorders, cognitive communication deficit, and major depressive disorder. Resident 42's medical records were reviewed on 6/5/24 to 6/6/24. On 5/31/24, a Quarterly BIMS assessment was done and documented resident 42 had severe cognitive impairment. Resident 5's physician orders were reviewed and documented the following fentanyl patch orders: a. An order with a start date of 4/8/24 and end date of 6/3/24 documented, Fentanyl- Check Placement Of Fentanyl Patch Every Shift. every shift. b. An order with a start date of 4/10/24 and end date of 5/1/24 documented the following, Fentanyl- Remove Fentanyl Patch & Provide To DON [Director of Nursing] /RN [Registered Nurse] Designee For Narcotic Destruction (q3days) one time a day every 3 day(s). c. An order with a start date of 4/22/24 and end date of 5/1/24 documented, fentanyl Transdermal Patch 72 Hour 12 MCG/HR. **DAW [Dispense as written]** Apply 1 patch transdermally in the evening every 3 day(s) for Pain. d. An order with a start date of 5/1/24 and end date of 5/5/24 documented, fentanyl Transdermal Patch 72 Hour 12 MCG/HR. **DAW** Apply 2 patch transdermally in the evening every 3 day(s) for Pain. e. An order with a start date of 5/1/24 and end date of 6/3/24 documented, Fentanyl- Remove Fentanyl Patch & Provide To DON/RN Designee For Narcotic Destruction (q3days) one time a day every 3 day(s). f. An order with a start date of 5/5/24 and end date of 6/4/24, documented, fentanyl Transdermal Patch 72 Hour 12 MCG/HR. **DAW** Apply 2 patch transdermally in the evening every 3 day(s) for Pain. Resident 42's progress notes were reviewed from March 2024 to June 2024 and documented the following notes for resident 42's fentanyl patch: (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. On 3/22/24 at 8:42 PM, a late entry nurse note stated, SN [skilled/staff nurse] had been looking through out the day to see if a Fentanyl patch had been placed, could not find one, and placed a new one. It may be that behaviors could be from pain as we do not know how long she has been with out this pain medication. b. On 4/21/24 at 10:54 AM, an orders- administration note documented, Fentanyl- Check Placement Of Fentanyl Patch Every Shift.every shift. unable to find; verified by 2 nurses. c. On 4/24/24 at 6:31 PM, an orders- administration note documented, Fentanyl- Check Placement Of Fentanyl Patch Every Shift. every shift. fentanyl patch not noted on patient since 04/20. No new one placed. d. On 5/1/24 at 1:24 PM, an orders-administration note documented, Fentanyl- Check Placement Of Fentanyl Patch Every Shift. every shift. not on pt [patient]. e. On 5/1/24 at 2:53 PM, an orders- administration note documented, Fentanyl- Remove Fentanyl Patch & Provide To DON/RN Designee For Narcotic Destruction (q3days) one time a day every 3 day(s). no fentanyl patch present; placing new one f. On 5/19/24 at 2:11 PM, an orders- administration note documented, Fentanyl- Remove Fentanyl Patch & Provide To DON/RN Designee For Narcotic Destruction (q3days) one time a day every 3 day(s). not on resident. g. On 5/19/24 at 2:11 PM, an orders- administration note documented, Fentanyl- Check Placement Of Fentanyl Patch Every Shift every shift. not on resident. h. On 5/28/24 at 4:06 PM, an orders- administration note documented, Fentanyl- Remove Fentanyl Patch & Provide To DON/RN Designee For Narcotic Destruction (q3days). one time a day every 3 day(s). Fentanyl patch not found. i. On 6/3/24 at 4:47 PM, a Nurse Practitioner note documented, .She has been having a hard time getting pain relief. She tears of her pain patches, so they are not working. We went back to pill for to try and help her . j. On 6/4/24 at 1:47 PM, an orders- administration note documented, fentaNYL Transdermal Patch 72 Hour 12MCG/HR**DAW** Apply 2 patch transdermally in the eveningevery 3 day(s) for Pain. Dr. [doctor] discontinued these patches due to resident continually removing them. It should be noted there was no documentation located to indicate an investigation had been done on resident 42's fentanyl patches. 3. Resident 43 was admitted to the facility on [DATE] with diagnoses that included dementia, chronic obstructive pulmonary disease, hypothyroidism, muscle wasting, adult failure to thrive, nicotine dependence, and osteoarthritis. Resident 43's medical records were reviewed. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/11/24, a Quarterly BIMS assessment documented resident 43 had a score of 0 which indicated severe cognitive impairment. Resident 43's physician orders were reviewed and documented the following fentanyl patch orders: a. An order with a start date of 8/25/23 and end date of 6/6/24 documented, FentaNYL Patch 72 Hour 75 MCG/HR. Apply 1 patch transdermally every 72 hours for pain and remove per schedule. b. An order with a start date of 9/13/23 and end date of 6/6/24 documented, Fentanyl- Check Placement Of Fentanyl Patch Every Shift. c. An order with a start date of 9/15/23 and end date of 6/6/24 documented, Fentanyl- Remove Fentanyl Patch - Co-signature With Another Nurse Upon Narcotic Destruction (q3days) one time a day every 3 day(s). Resident 43's progress notes were reviewed from April 2024 to June 2024 and documented the following notes for resident 42's fentanyl patch: a. On 4/27/24 at 6:04 PM, an Administration Note documented, Fentanyl- Remove Fentanyl Patch - Co-signature With Another Nurse Upon Narcotic Destruction (q3days). one time a day every 3 day(s). CNA and I both searched her back and found no prior fentanyl patch. b. On 4/29/24 at 7:49 PM, an Administration Note documented, Fentanyl- Check Placement Of Fentanyl Patch Every Shift. every shift. Patch is not on Resident. c. On 4/30/24 at 12:07 PM, an Administration Note documented, FentaNYL Patch 72 Hour 12 MCG/HR. Apply 1 patch transdermally every 72 hours for pain and remove per schedule. fentanyl patch not found on pt. another one was placed. d. On 5/2/24 at 7:53 PM, an Administration Note documented, Fentanyl- Check Placement Of Fentanyl Patch Every Shift. every shift. Patch is not in place. e. On 5/5/24 at 1:56 PM, an Administration Note documented, Fentanyl- Check Placement Of Fentanyl Patch Every Shift. every shift. unable to find patch. f. On 5/6/24 at 8:56 AM, an Administration Note documented, Fentanyl- Remove Fentanyl Patch - Co-signature With Another Nurse Upon Narcotic Destruction (q3days). one time a day every 3 day(s). No patch located on patient. g. On 5/11/24 at 7:12 PM, an Administration Note documented, FentaNYL Patch 72 Hour 12 MCG/HR Apply 1 patch transdermally every 72 hours for pain and remove per schedule .could not find patch anywhere on residents body. h. On 5/12/24 at 9:14 AM, an Administration Note documented, Fentanyl- Remove Fentanyl Patch & Provide To DON/RN Designee For Narcotic Destruction (q3days) one time a day every 3 day(s). Patch was not on resident and was not found. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	i. On 5/1/7/24 at 9:20 PM, an Administration Note documented, Fentanyl- Check Placement Of Fentanyl Patch Every Shift .Fentanyl patch is missing. j. On 5/18/24 at 4:08 PM, an Administration Note documented, Fentanyl- Remove Fentanyl Patch & Provide To DON/RN Designee For Narcotic Destruction (q3days). one time a day every 3 day(s). no patch noted. Verified by 2 nurses. k. On 5/21/24 at 3:58 PM, an Administration Note documented, Fentanyl- Remove Fentanyl Patch & Provide To DON/RN Designee For Narcotic Destruction (q3days) one time a day every 3 day(s). Fentanyl patch was not found on Resident or anywhere in her room. l. On 5/23/24 at 6:53 PM, an Administration Note documented, .We were not able to find if her Fentanyl patch was still in place. The oncoming evening nurse acknowledged this and will attempt to check for it. m. On 5/27/24 at 12:04 PM, an Administration Note documented, FentaNYL Patch 72 Hour 12 MCG/HR. Apply 1 patch transdermally every 72 hours for pain and remove per schedule. no patch on pt. n. On 6/1/24 at 10:48 PM, an Administration Note documented, Fentanyl- Check Placement Of Fentanyl Patch Every Shift. every shift. not present on resident. o. On 6/2/24 at 2:26 PM, an Administration Note documented, FentaNYL Patch 72 Hour 12 MCG/HR. Apply 1 patch transdermally every 72 hours for pain and remove per schedule. not on resident. p. On 6/5/24 at 2:01 PM, an Administration Note documented, FentaNYL Patch 72 Hour 12 MCG/HR Apply 1 patch transdermally every 72 hours for pain and remove per schedule. No patch found. Nurse manager notified. It should be noted there was no documentation located to indicate an investigation had been done on resident 43's fentanyl patches. On 6/5/24 at 10:24 AM, an interview was conducted with Registered Nurse (RN) 2. RN 2 stated they had three different types of narcotics which included pills, patches, and liquid medications. RN 2 stated they followed the physician orders with all medications. RN 2 stated with narcotics, nurses needed to sign them out to make sure they had been given correctly and following the protocol. RN 2 stated a fentanyl patch was considered a narcotic and it needed to be monitored daily if it was placed. RN 2 stated the fentanyl patch needed to be replaced every 3 days. RN 2 stated two nurses were needed to waste the old fentanyl patch. RN 2 stated the other nurse needed to co-sign and served as a witness that the old patch had been removed. RN 2 stated they notified the physician if it was noticed the fentanyl patch had been missing. RN 2 stated they asked the physician if they needed to replace the patch and adjust the timing of the order. RN 2 stated fentanyl patches were placed on a residents upper body if they were alert and oriented. RN 2 stated if a resident was confused, the fentanyl patch was placed in an area where they were unable to reach such as their back. RN 2 stated they documented where the fentanyl patch was placed so other nurses knew where it was located. RN 2 stated when they were unable to find the fentanyl patch, a progress note was written. RN 2 stated the DON became aware of the missing fentanyl patch by reading the progress note. RN 2 stated resident 43 was known to remove their own fentanyl patch since staff were unable to the previous patch. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/5/24 at 10:49 AM, an interview was conducted with Licensed Practical Nurse (LPN) 4. LPN 4 stated nursed documented where the fentanyl patch had been placed. LPN 4 stated when the fentanyl patch was removed, two nurses were needed to sign off and waste it to ensure it had been disposed of properly and it had not been stolen. LPN 4 stated the fentanyl patches were placed on a spot the resident was not able to reach super well but there were some residents that took their patches off. LPN 4 stated resident 42 fentanyl patches had been discontinued due to them taking their patches off frequently. On 6/5/24 at 11:32 AM an interview was conducted with the Regional Nurse Consultant (RNC). The RNC stated fentanyl patches were signed out before they were applied on the resident. The RNC stated nurses handled narcotics. The RNC stated two nurse signatures were required when the fentanyl patches were wasted. The RNC stated the two signatures served as a verification purpose to ensure the patches were not used inappropriately. On 6/5/24 at 11:47 AM, an interview was conducted with Assistant Director of Nursing (ADON) 2. The ADON 2 stated once a fentanyl patch had been administered, two nurses needed to sign off on it. The ADON 2 stated two nurses were needed to verify placement of the new fentanyl patch and the removal of the old fentanyl patch. The ADON 2 stated they needed to have two sets of eyes since it was a controlled substance and they needed to make sure the patch was recovered and placed correctly. The ADON 2 stated the old fentanyl patches needed to be discarded in the lock to assure they were not able to be used again. The ADON 2 stated the fentanyl patches needed to be placed out of reach on confused residents and a tegaderm needed to placed as well. The ADON 2 stated that it was unacceptable for nurses to documented they were unable to locate the patch. The ADON 2 stated if a fentanyl patch was not located, the nurse should notify nursing management immediately, so they were able to follow up on it. The ADON 2 stated if a fentanyl patch was missing, they conducted their own investigation in tracking the patch. The ADON 2 stated they were unaware of any fentanyl patch investigations for the month of may. On 6/5/24 at 12:58 PM, a phone interview was conducted with Registered Nurse (RN) 5. RN 5 described the process for fentanyl patches. RN 5 stated they first pulled the fentanyl patch out, then it was marked out in the medication administration record and lastly it was placed on the resident. RN 5 stated they looked for the old patch and removed it. RN 5 stated the old patch needed to be wasted with another nurse since the patch was a narcotic. RN 5 stated sometimes it was previously noted in the progress notes the fentanyl patch was not located. RN 5 stated when that occurred they found another RN to confirm it was not located and then they sign off the fentanyl had been wasted without it being located. RN 5 stated they had issues with the fentanyl patch not being placed. RN 5 stated they tried to notify the nurse administration when this happened and would try to do a note but it was forgotten when it got busy. RN 5 stated for resident ([NAME]) and resident 5, a tegaderm patch was placed on top of the fentanyl patch to secure it to the skin. RN 5 stated the fentanyl patch was placed on their back and out of reach. RN 5 stated they recently had an issue locating a resident's fentanyl patch and assumed the previous fentanyl patch had been removed but an new one had not been applied. 38031 (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/03/24 at 2:26 PM, an interview was conducted with resident 36 who was resident 12's roommate. Resident 36 stated that there was a male resident that kissed resident 12 and would not let go. Resident 36 stated that she could hear the kissing, but did not see it because resident 12 and resident 374 were behind the privacy curtain. Resident 36 stated that she could hear resident 12 whining like a whimper during this time. Resident 36 stated that resident 12 did not say anything during the kissing noises. Resident 36 stated that she only witnessed the one incident and she informed resident 12's POA about it. Resident 36 stated that the male resident [resident 374] tried to enter resident 12's room afterwards but the facility put a sign up that kept him out. Resident 36 stated that after the incident resident 12 was more quiet than usual. On 6/04/24 at 11:51 AM, a telephone interview was conducted with resident 12's POA. The POA stated that another male resident was kissing resident 12. The POA stated that the male resident was going into resident 12's room and pushed her to dinner and lunch. The POA stated that as far as she knew everyone put a stop to it. The POA stated that her mother did not tell her about the incident, but she was crying hysterically when she arrived. The POA stated that resident 12's roommate told her about the incident with another male resident. The POA stated that resident 12 had short term memory deficits. The POA stated that the family would come to visit and by the next day resident 12 had no recollection of it. The POA stated that she did not want resident 12 to have the relationship with the other male resident. The POA stated that the facility placed a sign on resident 12's door that stated not to allow any other resident to enter the room. The POA stated that she made everyone aware to keep resident 12 and the other male resident separated. On 6/04/24 at 12:35 PM, an interview was conducted with the Resident Advocate (RA). The RA stated that resident 12's roommate, resident 36, said she heard kissing noises. The RA stated that if a resident could consent to the sexual contact the physician would evaluate for that capacity to consent. The RA stated that she recalled that resident 12 said she liked resident 374, she was not traumatized and did not need a counselor. The RA stated that she did not speak with resident 12's roommate about the incident. The RA stated that resident 12 was confused, she could answer yes/no questions, and had memory deficits. The RA stated that she did not recall if she referred resident 12 to a social worker for an evaluation. The RA stated that normally she would discuss any incidents with the ADM and nurse management, and they would refer to the corporate team before submitting it to the State Survey Agency (SSA). The RA stated that she could not determine if resident 12 was capable to consent. The RA stated that she knew the incident was discussed in an IDT meeting, but she did not recall what was determined. The RA stated that the incident was discussed with the corporate team but does not recall what was determined or what guidance was provided. The RA stated that they were to make sure that the residents had no sexual contact. It should be noted that no documentation could be found to demonstrate that an IDT meeting was conducted to evaluate the incident between resident 12 and resident 374. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/04/24 at 3:47 PM, a follow-up interview was conducted with resident 12's POA. The POA stated that she was informed of the incident between resident 12 and the male resident a couple of days later. The POA stated that when she came to visit resident 12 she was wearing a bra. The POA stated that this was unusual because resident 12 never wore a bra, and she speculated on who had put it on the resident. The POA stated that she never found out who had placed the bra on resident 12 and she wondered if it was resident 374. The POA stated that there were issues with resident 374 being in resident 12's room, he would come and get her for breakfast, lunch and dinner. The POA stated that she was aware of it for approximately 4 days before she put a stop to it. The POA stated that when she found out about the kissing incident, she talked to resident 12. The POA stated that resident 12 started crying and said she did not know what to do. The POA stated she asked resident 12 how the kissing made her feel and she said good. The POA stated that she did not want resident 374 touching resident 12 and she told the facility staff to keep them separated. The POA stated that the facility put a sign on resident 12's door that said staff only. The POA stated that she spoke with the RA and made it very clear to keep the residents separated. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/05/24 at 1:29 PM, an interview was conducted with the facility Administrator (ADM) and the RA. The ADM stated that the RA informed him of the incident between resident 12 and resident 374. The ADM stated he was rounding and resident 36, the roommate, said she heard kissing noises. The ADM stated that he interviewed resident 36 and she was somewhat reliable. The ADM stated that he reported the incident to the State Survey Agency (SSA) and then started an investigation. The ADM then stated that resident 12's POA notified him of the incident. The ADM stated that resident 12's POA initially obtained resident 12's statement regarding the incident. The ADM verified that the facility interview documentation had the POA listed as the interviewer for resident 12's statement. The ADM then stated that resident 36 reported hearing kissing noises to resident 12's POA and initially the POA obtained resident 36's statement. The ADM stated that the facility final investigation report did not document who interviewed resident 12 and obtained the statement that she liked kissing resident 374. The ADM stated that it was possible that they interviewed resident 12 but that it was not documented. The RA stated that the ADM was the individual who interviewed resident 12 and resident 36. The ADM stated that resident 36 had reported hearing kissing sounds but did not see anything. The ADM stated that he did not have the interview documented but likely would have asked how resident 12 had responded to the touch. The RA stated that resident 12 had said that she liked resident 374 and that he was nice to her. The RA stated that she did not dig into it to get the basic information. The RA stated that she asked resident 12 was he inappropriate to you? The RA stated that resident 12 responded no and she liked resident 374 that he was nice to her. The RA stated that she started the investigation and then the ADM went and spoke to resident 12. The ADM stated, that must have been when she said it tasted good. The ADM stated that resident 12 had difficulty with her memory and gets confused. The ADM stated that the physician had to determine if the resident had the capacity to consent to sexual activity. The RA stated that resident 12 did not have the capacity to consent. The ADM stated that they did not have the physician assess resident 12 for capacity to consent. The ADM stated that based on resident 12's statement that she like to be with resident 374, they determined that the allegation of sexual abuse was unsubstantiated. The ADM stated that resident 12's POA requested that the residents were separated. The ADM stated that he did not have any documentation of resident 36's reports of resident 12's responses to the kissing, and he does not recall the roommates reports of whimpering and whining during the incident. The RA stated that she determined that resident 12 was at her normal baseline after the kissing incident but does not recall if the resident was assessed. The RA stated that she made the determination that resident 12 was at baseline based on asking the floor nurse how the resident was doing. At this point in the interview the Corporate Social Service Worker (CSSW) joined the conversation. The CSSW stated that usually they would put monitoring for any sexual behaviors and would document in the progress notes. The CSSW stated that with allegations of sexual abuse with residents with diminished capacity there should be a physician assessment to determine the resident's capacity to consent. The CSSW stated that it would then be reviewed by the IDT, care planned, and staff education should be provided. [Cross-refer F600] 5. Resident 374 was admitted to the facility on [DATE] with a diagnosis of vascular dementia. On 6/3/24, resident 374's [NAME] [TRUNCATED]

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38031 Based on interview and record review it was determined, for 2 of 53 residents sampled, that the facility did not coordinate assessments with the pre-admission screening and resident review (PASARR) program. Specifically, residents with a serious mental illness (SMI) were not referred for a Level II PASARR assessment with a newly evident SMI or upon a significant change in status. Resident identifier: 36 and 44. Findings included: 1. Resident 36 was admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses which included, but were not limited to, anxiety disorder and bipolar disorder. On 6/02/24, resident 36's electronic medical records were reviewed. On 1/20/22, resident 36's PASARR Level I documented a serious mental illness of Bipolar Disorder, and Generalized Anxiety Disorder. The Level I indicated that a referral for Level II evaluation was needed. On 2/7/22, the PASARR office screened resident 36 out due to No signs of symptoms, not impaired. The PASARR Level II referral documented that resident 36 was prescribed Seroquel and Trazodone for their SMI. On 5/13/24, the physician ordered for resident 36 Lithium Carbonate Capsule 150 milligram (mg), give 150 mg by mouth one time a day for Bipolar Disorder. On 5/13/24, the physician ordered for resident 36 Lithium Carbonate Capsule 300 mg, give 300 mg by mouth in the evening for Bipolar Disorder. On 6/05/24 at 12:32 PM, an interview was conducted with the Corporate Social Service Worker (CSSW). The CSSW stated that a Level II referral would be re-evaluated if the resident had a new serious mental illness diagnosis, a new medication, or new high PHQ-9 (depression assessment) score. On 6/05/24 at 2:29 PM, the CSSW stated that resident 36 was initially screened out for a Level II, but that a new Level II PASARR referral would be sent out again today. 2. Resident 44 was admitted to the facility on [DATE] with a diagnosis which included, but was not limited to, psychotic disorder with delusions. On 6/03/24, resident 44's electronic medical records were reviewed. On 4/14/21, the PASARR Level I did not contain the diagnosis of psychotic disorder with delusion. The Level I screen indicated that a referral for a Level II was not needed. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/05/24 at 12:19 PM, an interview was conducted with the Social Service Worker (SSW). The SSW stated that when a resident was first admitted and was expected to stay longer than 30 days she would screen the resident for any SMI diagnoses. The SSW stated she would talk to the nursing staff to determine if the resident was having any signs and symptoms of the diagnosis and then she would send a Level II referral to the PASARR office for evaluation. The SSW stated that if a resident was diagnosed with a SMI any time while residing in the facility they would be referred for a Level II evaluation. The SSW stated that resident 44 was not able to communicate, and the nurses should have notified her of the SMI diagnosis. The SSW stated that she would also be informed of a SMI diagnosis from the provider order or any psychotropic medication orders. The SSW stated that nothing was passed on to her to screen resident 44 for Level II. The SSW stated that a diagnosis of psychotic disorder would be something that she would screen a PASARR Level II for. On 6/05/24 at 2:31 PM, an interview was conducted with the CSSW. The CSSW stated that resident 44 was missed and would be referred today for a PASARR Level II evaluation.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38031 Based on interview and record review it was determined, for 1 of 53 sampled residents, that the facility did not develop and implement a baseline care plan for the resident within 48 hours of the resident's admission and must include at a minimum the initial goals based on admission orders, physician orders, dietary orders, therapy services, social services, and any pre-admission screening and resident review PASARR recommendations if applicable. Specifically, the resident did not have a baseline care plan initiated within 48 hours of admission. Resident identifier 36. Findings included: Resident 36 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which consisted of chronic obstructive pulmonary disease, polyosteoarthritis, malignant neoplasm of ovary, hyperlipidemia, chronic fatigue, morbid obesity, anxiety disorder, bipolar disorder, idiopathic peripheral autonomic neuropathy, presence of left and right artificial knee joint, insomnia, opioid dependence, and restless leg syndrome. On 6/2/24, resident 36's medical records were reviewed. On 9/5/23, resident 36 had a baseline care plan initiated and nursing services selected were for oxygen therapy, pain management, activities of daily living (ADL) assistance, skilled nursing assessment, and fall prevention. The care plan also included a Level I PASARR, dietary orders, and preferences. It should be noted that the baseline care plan was initiated 4 days after resident 36 was readmitted to the facility. Resident 36's comprehensive care plan was reviewed. The following care areas were identified as initiated after resident 36's initial admission to the facility on [DATE]: at risk for falls was initiated on 2/1/22; uses psychotropic medication was initiated on 2/4/22; has nutritional problems was initiated on 1/28/22; at risk for pain was initiated on 2/1/22; has malignant neoplasm was initiated on 2/9/22; altered respiratory status was initiated on 2/9/22; at risk for constipation was initiated on 2/1/22; impaired activity was initiated on 2/1/22; and ADL self performance deficit was initiated on 2/1/22. It should be noted that none of the care areas were initiated within 48 hours of resident 36's initial admission. On 6/04/24 at 10:52 AM, an interview was conducted with the Minimum Data Set (MDS) Coordinator (MDSC). The MDSC stated that on the day of admission they care planned all the basics and put the information into the Kardex. The MDSC stated that the baseline care plan was completed on the day of admission or within the first 48 hours and she was responsible for completing it. The MDSC stated that all residents were care planned for falls.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50200 Based on interviews and record review, the facility did not develop and implement a comprehensive person-centered care plan consistent with the resident's rights that included measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs that were identified in the comprehensive assessment. Specifically, for 1 out of 53 sampled residents, the residents care plan did not identify tasks related to the proper changing and monitoring of the resident's PureWick urinary system device and the resident received a urinary tract infection while using this device. Resident Identifier: 54. Findings Included: Resident 54 was admitted to the facility on [DATE] with diagnoses which included cervical disc disorder, primary osteoarthritis, type 2 diabetes with neuropathy, hypothyroidism, morbid obesity, weakness, muscle weakness, anxiety, obstructive sleep apnea, hypertension, and a history of falling. Resident 54's medical record was reviewed 6/2/24-6/6/24. An admission Minimum Data Set (MDS) assessment dated [DATE], documented that resident 54 had a Brief Interview for Mental Status (BIMS) score of 15. A BIMS score of 13 to 15 would suggest intact cognition. A care plan Focus addressing toileting cares initiated on 2/8/24, documented [Resident 54] has a risk for bladder incontinence and requires assistance with toileting cares r/t [related to] activity intolerance. The interventions included: a. Clean peri-area after each incontinent episode b. [Resident 54] uses a PureWick system for her incontinence c. Monitor and document intake and output per facility policy d. Monitor/document for signs and symptoms of a urinary tract infection: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. On 6/2/24 at 2:38 PM, an interview was conducted with resident 54. Resident 54 stated she personally purchased the PureWicks that were used. Resident 54 stated she had a urinary tract infection a few months ago and was given an antibiotic. Resident 54 stated that she trained the staff regarding the care of the PureWick. Resident 54 stated the PureWick was getting changed once daily. On 6/4/24 at 9:27 AM, an interview was conducted with Licensed Practical Nurse (LPN) 2. LPN 2 stated resident 54's orders are to monitor PureWick while she was in bed. LPN 2 stated she does not know when the PureWick gets changed or how often. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/4/24 at 9:44 AM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated there was no directive order for the PureWick and he was unaware how often it got changed. On 6/4/24 at 9:56 AM, an interview was conducted with Certified Nurse Assistant (CNA) 4. CNA 4 stated there was not a place to chart that the PureWick was changed. CNA 4 stated she was not sure that changing the PureWick was a CNA task. On 6/4/24 at 10:52 AM, an interview was conducted with the MDS Coordinator. The MDS Coordinator stated one of the Assistant Directors of Nursing completed the comprehensive care plan and then she added the orders and tasks to the chart. The MDS Coordinator stated the PureWick was added to the care plan on 2/8/24. The MDS Coordinator stated that there were no orders on how often to change the PureWick and no place to document that the PureWick had been changed.

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30563 Based on interview and record review it was determined, for 1 of 53 sampled residents, that the facility did not ensure that the discharge needs of the resident was identified and resulted in the development of a discharge plan for the resident; that regular re-evaluation to identify changes that required modification to the discharge plan was completed; and referrals to local agencies for the purpose of returning to the community were documented. Specifically, the resident desired to transfer to another long term care facility closer to family and the facility did not follow-up with the resident or family for the transfer. Resident identifier: 7. Findings included: Resident 7 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included paroxysmal atrial fib, fibromyalgia, type 2 diabetes mellitus, obesity and major depressive disorder. On 6/3/24 at 10:08 AM, an interview was conducted with resident 7. Resident 7 stated she would like to move to another facility to be closer to family. Resident 7 stated she would like to move near her son and daughter. Resident 7 stated that she had asked the Resident Advocate (RA) about discharging but had not gotten the name of a facility from her family. Resident 7's medical record was reviewed 6/2/24 through 6/6/24. A quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 14 our of 15 which indicated resident was cognitively intact. The MDS further revealed the resident participated in assessment and goal setting. The MDS revealed there was no active discharge planning that occurred for the resident to return to the community and the resident did not want to talk to someone about the possibility of leaving the facility and returning to live and receive services in the community. An assessment titled Social Services: Discharge Planning Review dated 1/24/24 revealed Resident would like to transfer to a facility in northern Utah to be closer to family. However she would like to remain here until her wound has healed before transferring. A skin assessment dated [DATE] revealed that resident 7's skin was clean, dry and intact. A skin assessment dated [DATE] revealed, Excoriation n [sic] the buttocks with ongoing treatment. A skin assessment dated [DATE] revealed, excoriation in the buttocks with ongoing treatment. no redness or skin breakdown noted in upper and lower extremities. applied moisturizer in upper and lower extremities. continuous monitoring. A skin assessment dated [DATE] revealed, skin is intact. A skin assessment dated [DATE] revealed Skin is intact. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no discharge care plan located in resident 7's medical record. On 6/4/24 at 12:35 PM, an interview was conducted with the Resident Advocate (RA). The RA stated when a resident desired to discharge, then staff notified her. The RA stated when a resident was admitted , she asked the resident about home health preferences. The RA stated if a resident did not have a home health agency, then she provided a list to the resident and allowed the resident to make the decision. The RA stated a physician's order was obtained, asked therapy about equipment needed and set-up equipment needed to discharge home. The RA stated the facility had weekly meetings to discuss residents who were receiving skilled services and discussed how long till the resident was expected to discharge. The RA stated if the discharge was resident initiated to another facility, then she typically contacted the family and resident. The RA stated she then sent resident information to the facility. The RA stated a lot of times when a resident asked to discharge, it was not a right now but in the future. The RA stated she asked the resident when they thought they wanted to discharge and asked the timeframe. The RA stated she set-up reminders on her email for the future discharge. The RA stated she knew at one point resident 7 wanted to transfer to a facility by family. The RA sated she asked resident 7 what facility she wanted to go to but the resident did not know. The RA stated resident 7 was her own responsible party and resident 7 wanted to talk to her son. The RA stated she followed-up with resident 7 a few weeks ago. The RA stated resident 7's son recently got another job so resident 7 wanted to transfer near him. The RA stated she did not ask resident 7 if she could contact resident 7's family member. The RA stated if she followed-up with a resident it was typically documented in the progress notes. The RA stated she was off for a few weeks and was planning to follow-up with resident 7 in the next couple of weeks. The RA stated she wanted to make sure she had the time to help resident 7. The RA stated when she followed-up with resident 7 in April she said it was right when her son changed jobs and she wanted to find out where he was. The RA stated it was not documented in her follow-ups. On 6/6/24 at 8:58 AM, a follow-up interview was conducted with resident 7. Resident 7 stated she was waiting to call her son and ask where she should transfer to be near him. Resident 7 stated the RA had not asked her if she could contact her family to determine where she could be transferred to be near them.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38031 Based on interview and record review it was determined, for 1 of 53 residents sampled, that the facility did not ensure that the resident was given the appropriate treatment and services to maintain or improve their ability to carry out the activities of daily living. Specifically, a resident was not provided bathing/shower assistance in a timely manner. Resident identifier: 36. Findings included: Resident 36 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which consisted of chronic obstructive pulmonary disease, polyosteoarthritis, malignant neoplasm of ovary, hyperlipidemia, chronic fatigue, morbid obesity, anxiety disorder, bipolar disorder, idiopathic peripheral autonomic neuropathy, presence of left and right artificial knee joint, insomnia, opioid dependence, and restless leg syndrome. On 6/2/24 at 2:09 PM, an interview was conducted with resident 36. Resident 36 stated that her shower schedule was supposed to be Tuesdays and Fridays, but the facility was short staffed. Resident 36 stated that she received a shower yesterday, but she had to insist on the shower yesterday. On 6/2/24, resident 36's medical records were reviewed. On 3/1/24, resident 36's Minimum Data Set (MDS) assessment documented a Brief Interview for Mental Status score of 14/15, which indicated the resident was cognitively intact. The assessment documented that resident 36 required a one-person physical assistance with supervision for bed mobility, transfers, and toilet use. Resident 36's Kardex for bathing/showering documented that resident 36 required setup to partial/moderate assist as needed. Resident 36's bathing task for the last 30 days documented that the resident received one-person assistance for bathing on 5/7/24, 5/10/24, 5/14/24, 5/17/24, 5/21/24, 5/24/24, and 6/1/24. It should be noted that resident 36 went 7 days without a shower from 5/24/24 to 6/1/24. On 6/4/24 at 9:38 AM, an interview was conducted with Certified Nurse Assistant (CNA) 5. CNA 5 stated that resident 36 required limited assistance with supervision for cares. CNA 5 stated that resident 36 occasionally needed assistance with toileting and cleaning afterwards. On 6/5/24 at 9:52 AM, an interview was conducted with CNA 6. CNA 6 stated that resident 36's scheduled shower days were Tuesday and Friday. CNA 6 stated that when a shower was provided, they filled out a shower sheet. Resident 36's shower sheets documented that a shower was provided on 5/21/24, 5/24/24, and 6/4/24. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/5/24 at 1:31 PM, an interview was conducted with the Director of Nursing (DON). The DON stated the staff completed the showers according to the schedule and accommodated the resident's preference. The DON stated that resident 36 should be provided the shower per the schedule unless she refused.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45470 Based on interview and record review, it was determined that, for 1 of 53 sampled residents, that the facility failed to provide the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for residents who were unable to carry out activities of daily living. Specifically, a resident was not provided showers for weeks at a time. Resident identifier: 41. Findings Included: 1. Resident 41 was admitted to the facility on [DATE] and again on 4/9/24 with diagnoses which include chronic respiratory failure with hypoxia, functional quadriplegia, obstructive pulmonary disease, neuromuscular dysfunction of bladder, protein-calorie malnutrition, protein-calorie malnutrition, contracture of muscle, rheumatoid arthritis, bed confinement status, urinary tract infection, pyelonephritis, resistance to multiple antibiotics, dependence of supplemental oxygen, acute respiratory failure, anemia in chronic kidney disease, heart failure, major depressive disorder, obstructive sleep apnea, anxiety disorder, insomnia, muscle weakness, and presence of automatic cardiac defibrillator. On 6/4/24 at 12:30 PM an interview with resident 41. Resident 41 stated that her showers were frequently missed. Resident 41 stated that it was not uncommon for her to go weeks without a bath. Resident 41 stated that sometimes on her shower days staff would offer a shower at 2:00 AM or 3:00 AM, and she would deny the shower because she wanted to be asleep at that time. Resident 41 stated that she believed her showers were missed due to low staffing at the facility. Resident 41's electronic medical records were reviewed 6/2/24 through 6/6/24. Resident 41 had a care plan dated 5/17/22 and revised on 3/29/24 that documented, [Resident 41] has an ADL [Activities of Daily Living] self care performance deficit r/t [related to] impaired mobility secondary to RA [rheumatoid arthritis], functional quadriplegia, chronic pain, multiple contractures present on admission. The goal, revised on 11/8/23, documented, [Resident 41] will be able to participate in part of ADL activity and will have needs met throughout review date. An intervention on the care plan with an initiation date of 9/6/23 and revision date of 4/19/24 documented, Bathing/Showering: the resident requires up to DEPENDENT assist as needed. The POC [Point of Care] Response History of the Tasks: ADL - Bathing section revealed resident 41 was provided a shower on 5/11/24 during the last 30 days. Documentation revealed resident 41 received 1 shower over 30 days. On 6/5/24 at 10:17 AM, an interview with Certified Nursing Assistant (CNA) 9 was conducted. CNA 9 stated that he was aware of residents who had multiple missed shower days in a row. CNA 9 stated that the facility did not have enough staff to complete all the showers on top of the other daily tasks. CNA 9 stated that resident 41's showers were often missed because she required two CNAs, and resident 41's showers took longer than the average time to complete. CNA 9 stated that when a resident's shower was missed, the task was passed off to the next shift. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/5/24 at 4:07 PM, an interview with CNA 8 was conducted. CNA 8 stated that each time a resident required a shower, a shower sheet was filled out and turned into the nurse. CNA 8 stated that resident showers were recorded in the resident electronic medical record. CNA 8 stated that if the resident refused a shower, the resident was required to sign the shower sheet. CNA 8 stated that there was not enough time for staff to complete all of the required resident showers. CNA 8 stated that it would be helpful if the facility staffed one or two extra aides who helped with completing resident showers. CNA 8 stated that if the staff did not have enough time to get to a resident's shower or bed bath, the task would be handed over to the next shift. On 6/5/24 at 4:25 PM, an interview with Registered Nurse (RN) 2 was conducted. RN 2 stated that resident 41 was completely dependent on staff for showers. RN 2 stated that resident 41 was completely dependent on staff for almost every task.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22992 Based on interview and record review, the facility did not ensure that 3 of 53 sample residents received treatment and care in accordance with professional standards of practice. Specifically, one resident experienced a change in condition, and the facility did not act in a timely manner to treat the condition. This resulted in a finding of harm for this resident. In addition, one resident was not monitored for a change in condition after a dental procedure, and a resident who was incontinent developed Moisture Associated Skin Damage (MASD). Resident identifiers: 5, 7, and 365. Findings include: 1. Resident 365 was admitted to the facility on [DATE] with diagnoses that included spontaneous right patellar tendon rupture, encounter for other orthopedic aftercare, history of falling, and hypertension. Resident 365's entry Minimum Data Set (MDS) assessment indicated that facility staff assessed resident 365 as having a Brief Interview for Mental Status score of 15, which indicated the resident was cognitively intact. Resident 365's medical record was reviewed from 6/2/24 through 6/6/24 and revealed the following: a. On 9/24/22 a nurses note documented: Pt (patient) arrived to facility via wheelchair from [name of local hospital]. Pt had a right knee repair surgery 9/23. Pt is alert and oriented x4, moves upper extremities equally, is non weightbearing [sic] on RLE (right lower extremity), able to move LLE (left lower extremity), sensation intact. Bowel sounds audible all lobes, abdomen soft and nontender, Pt reports that LBM (last bowel movement) was 9/23 in the morning. Pt is incontinent of bowel and bladder, Pt has briefs, wipes, and cream in room for bowel care. Pt is alert, able to verbalize needs . b. On 9/26/22 a nurses note documented: Pt was c/o (complaining of) excruciating bladder spasms. The pt was not seen by his primary, [name of physician], this shift to express his concerns or symptoms. Pt asked RN (Registered Nurse) to ask house MD [medical doctor] to do something to give him relief. RN messaged [name of physician] and received orders for a one time dose of 200mg [milligrams] of pyridium. RN administered medication and assessed pt 45 min after and he stated that he feels better and the spasms stopped. pt is alert and able to verbalize needs to staff, tolerated medications whole without complications . c. An MD Communication form dated 9/26/22, two days after resident 365 was admitted , revealed the following: . Concern: pt (patient) admitted Sat (Saturday) - is concerned he is developing infection, wants to see MD and discuss concerns. NEW ORDER 1 - Notify his ortho (orthopedic) Dr (doctor) who operated on him ASAP [As Soon As Possible]! 2 - I will see him after clinic today. [Note: No documentation could be located to indicate that the physician saw resident 365 that day, or that facility staff had contacted the orthopedic surgeon during resident 365's stay.] (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	d. On 9/28/22 at 12:26 AM a nurses note documented: . pt had an episode of forgetfulness and confusion this shift. Pt was found sitting on the side of his bed. Staff asked what he was doing, pt stated that he was going to the bathroom. Staff reminded him that he is NWB (non weight bearing) on his R (right) knee and could not walk to the bathroom. Staff got him into bed safely, his R knee is bleeding through the bandage . e. On 9/28/22 at 9:41 AM a nurses note documented: . Pt is alert, able to verbalize needs, takes medications whole, . Night nurse reported that Pt had an episode of confusion last night, Nurse went in this AM (morning) to assess Pt. Pt has diminished lung sounds in the bases, SOBLF (?) and SOBOE (shortness of breath on exertion). Pt's neuro (neurological) assessment showed minimal left sided facial weakness, moves all extremities equally, denies any numbness or tingling, no changes in sensation, or H/A (headache). MD has been notified of situation. f. On 9/28/22 at 10:46 AM a nurses note documented: . As ordered by MD, nurse tried to contact surgeon about duration of Bactrim. Unable to reach them, Nurse left a message for the surgeon's office . [Note: This is two days after the physician wrote a note to contact the orthopedic physician for resident 365 as soon as possible regarding the resident's possible infection.] g. On 9/29/22, a nurses note documented: . Resident is alert and verbally responsive, able to make needs known. Resident c/o bladder spasms and not being able to void. Bladder scanned and 85 cc (cubic centimeters) residual noted. MD notified. h. On 9/29/22, the facility physician documented the following in a physician's note: . [Resident 365] . reported pain to his abdomen that started during physical therapy, pain us located to RLQ (right lower quadrant), upon examination no hernia or any other abnormalities were noted. Claims that is able to control bladder and bowels. However, he is experiencing bladder spasms with little urine output post spasms. Denies prior or similar problems prior to this surgery. Reported last PSA (Prostate Specific Antigen) levels were done back in January with normal results. Physician will place patent (sic) on Flomax . i. On 9/29/22 resident 365's blood pressure was 144/81. j. On 9/30/22 at 4:51 PM, resident 365's blood pressure was 143/76. k. On 9/30/22 at 4:52 PM, resident 365's blood pressure was 177/85. l. On 10/1/22 at 12:05 AM, a nurses progress note documented: Resident found on floor next to recliner and walker . When asked resident what happened he said he was not sure.No c/o pain. Resident already has baseline hx (history) of confusion and falls upon admission. Resident has no s/s (signs and symptoms) of injury at this time. No complaints of pain or distress. Resident educated on importance of call light and demonstrated its use. RLE (knee) dressing changed and inspection of surgical site completed. surgical scar well approximated, all staples intact and in place and trace drops of drainage. No swelling, redness, and surgical site is cool to the touch. Clean dressing re applied, wrapped, and ble [bilateral lower extremity] knee brace secured . Will notify, PCP (primary care physician), family and on call administrator of incident and continue to monitor closely. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	m. On 10/1/22 at 8:30 PM a nurses progress note documented: resident POA (power of attorney) contacted staff and communicated concern regarding residents increased confusion. Family very concerned and request to send to ER (emergency room). PCP contacted . transfer was completed. Will continue to monitor closely. n. On 10/2/22 at 10:16 AM a nurses progress note documented that the resident had been admitted to the hospital, and was in the intensive care unit. On 6/6/24 at 8:43 AM, an interview was conducted with the Regional Nurse Consultant (RNC). The RNC stated that with regard to the physician note written about resident 365 on 9/26/22, STAT would have been a better word to use than asap. The RNC also stated that the facility nurses should have reached out after the doctor said to get in contact with the orthopedic surgeon. The RNC stated that best practice was to reach out and get a urinalysis (UA) with the bladder spasms and excruciating pain. The RNC stated that the facility could still get a culture and sensitivity on a urinalysis even if the resident was on an antibiotic already. The RNC stated that the doctor should have ordered a UA and culture and sensitivity. The RNC did not have any other information regarding the facility's lack of response to the change of condition in resident 365. The facility's policy for Change in a Resident's Condition or Status was reviewed. The policy indicated the following: Our facility promptly notified the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.) . 1. The nurse will notify the resident's attending physician or physician on call when there has been a (an): . d. significant change in the resident's physical/emotional/mental condition; e. need to alter the resident's medical treatment significantly; . g. need to transfer the resident to a hospital/treatment center; . i. specific instruction to notify the physician of changes in the resident's condition. 2. A 'significant change' of condition is a major decline or improvement in the resident's status that: a. will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions (is not self-limiting); b. impacts more than one area of the resident's health status; c. requires interdisciplinary review and/or revision to the care plan; and d. ultimately is based on the judgment of the clinical staff and the guidelines outlined in the Resident Assessment Instrument. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	3. Prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider . 30563 2. Resident 7 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included paroxysmal atrial fibrillation, fibromyalgia, type 2 diabetes mellitus, obesity and major depressive disorder. On 6/3/24 at 9:56 AM, an interview was conducted with resident 7. Resident 7 stated she had her teeth were extracted. Resident 7 stated she was wondering when she was getting dentures. Resident 7 stated she had not been to a follow-up appointment after having her teeth extracted. Resident 7's medical record was reviewed on 6/2/24 through 6/6/24. A nursing progress note dated 3/26/24 at 3:50 PM, Spoke with [name removed] surgical regarding PT [patient] surgery in the morning. PT to be NPO [nothing by mouth] after 0045 [12:45 PM]; may take BP [blood pressure] medication in morning if necessary. Faxed over health history. The next progress note was 4/1/24 at 2:02 PM from the Nutrition/Dietary note. The note revealed .RDN [Registered Dietitian Nutritionist] spoke with resident about mouth pain. Resident had all teeth pulled and needs altered texure (sic). There were no notes regarding monitoring of resident 7 after having dental surgery. On 6/6/24 at 8:30 AM, an interview was conducted with Assistant Director of Nursing (ADON) 1. ADON 1 stated she was aware that resident 7 had a dental procedure. ADON 1 stated when a resident returned to the facility after a surgical procedure, the physicians sent guidance and orders to care for the resident. ADON 1 stated the nurse needed to complete a progress note regarding the surgical procedure, what the physician ordered, what to monitor and when there was a follow-up appointment. ADON 1 stated after a dental procedure, nursing staff should monitor for pain and bleeding. ADON 1 confirmed there was no monitoring of resident 7 after the dental procedure. ADON 1 was unable to find orders from the dentist or information regarding the dental procedure. On 6/6/24 at 8:58 AM, a follow-up interview was conducted with resident 7. Resident 7 stated she had not heard anything about getting dentures. Resident 7 stated she had asked staff about her follow-up appointment for dentures but staff did not know anything. On 6/5/24 at 9:13 AM, an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated they were not aware that resident 7 had teeth extracted and needed dentures. LPN 1 stated there was a transport director that scheduled appointments. LPN 1 was observed to review nursing progress notes. LPN 1 stated there was a note from resident 7's physician on 6/4/24 that resident 7 needed to be fitted for dentures. On 6/5/24 at 3:48 PM, an interview was conducted with the Transport Driver. The Transport Driver stated she scheduled appointments. The Transportation Driver stated resident 7 did not have a follow up dental appointment scheduled. The Transport Driver stated she transported resident 7 to a dental appointment a couple of months ago. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 6/6/24 at 9:01 AM, an interview was conducted with the RNC. The RNC stated after a resident had teeth extracted, nurses should monitor for bleeding, fever, and sign and symptoms of infection. The RNC stated usually a resident received prophylactic antibiotics after having teeth extracted and there would be alert charting by nurses. The RNC stated resident 7 was provided a follow-up dental appointment on 5/6/24 but there was no information regarding dentures on the form. The RNC stated there was no follow-up or monitoring of resident 7 after having her teeth extracted. 3. Resident 5 was initially admitted to the facility on [DATE] and readmitted on [DATE] with the diagnoses of encounter for palliative care, type 2 diabetes mellitus with diabetic neuropathy, venous insufficiency, hypertensive heart disease with heart failure, chronic respiratory failure with hypoxia, unspecified dementia and Alzheimer's disease. Resident 5's medical record was reviewed on 6/3/24 through 6/6/24. On 4/4/24, a Quarterly Minimum Data Set [MDS] documented resident 5 had a Brief Interview for Mental Status [BIMS] score of 1 which indicated severe cognitive impairment. There was no information located under the mobility section for functional abilities. The skin section of the MDS documented resident 5 was at risk from developing pressure ulcers/injuries and it documented at the time of the assessment resident 5's only skin problem were skin tears. Resident 5 was not noted to have MASD (Moisture Associated Skin Damage). On 5/2/24, a stated optional MDS documented resident 5 was a two-person extensive assist with transfers, toileting and bed mobility. On 12/19/23, a weekly skin review/assessment documented, Blanchable redness to buttocks rest of skin is dry and intact. On 1/3/24, a professional wound specialist note documented resident 5 had dermatitis associated with moisture. The examination section documented the age of the coccyx wound to be 1 week and it noted the wound type to be MASD. The stage of the wound documented it was limited to breakdown of skin and the wound bed had erythema and was blanchable. It noted the coccyx wound was shallow and stated the wound was likely to heal well but may be slowed down due to resident 5's inability to reposition herself and lying in bed all the time. On 1/6/24 at 7:34 AM, a skin/wound note documented, MASD TO COCCYX Wound bed is 100% [percent] pink, red, healthy, erythema, blanchable. Wound edges are attached to base. Periwound tissues are macerated. No drainage, no odor. A physician order with a start date of 1/7/24 documented as followed: BUTTOCKS EXCORIATION: Cleanse with NS [normal saline] and apply chamosyn with brief changes. every shift for buttocks excoriation. On 1/10/24 at 12:11 PM, a nutrition/dietary note documented, Moisture Associated Skin Damage [MASD] to coccyx noted to be new .will continue to monitor. On 1/10/24, a professional wound specialist note documented resident 5's MASD to coccyx was progressing well and had nice improvement. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 1/12/24 at 1:10 AM, an orders administration note documented, .She has 2 stage II [two] sacral area which were cleansed, skin prepped, covered with a pink silicone bordered bandage. She tolerated the care well. She verbalized being in pain, hydrocodone was effective. On 1/13/24 at 6:29 AM, a skin/wound note documented, MASD to coccyx: PROXIMAL: . Wound bed is 100% pink, red, healthy, erythema, blanchable. Wound edges are attached to base. Periwound tissues are macerated. No drainage, no odor. On 1/17/24, a professional wound specialist note documented resident 5's MASD to coccyx had resolved within 4 weeks and it documented a treatment order of chamosyn to coccyx area every day for 14 days. On 1/17/24 at 5:46 PM, a skin/wound note documented, Wound care to coccyx: Remove old dressing, cleanse with NS. Apply skin prep to periwound. Apply Medihoney wound gel to wound bed. Secure with bordered absorbent dressing. To be completed three times a week. one time a day every Mon [Monday], Wed [Wednesday], Fri [Friday]. wound resolved, no dressing required On 1/20/24 at 1:15 PM, a skin/wound note documented, MASD TO COCCYX: Resolved. On 2/13/24 at 5:22 PM, an orders administration note documented, Weekly skin checks every Tues [Tuesday] Day shift. Please complete the WEEKLY SKIN ASSESSMENT after you do skin check. These are to be completed by the end of your shift. one time a day every Tue On 3/3/24 and 3/11/24, a weekly skin review/assessment documented, .redness noted to coccyx. On 3/13/24, a nurse note documented, Resident with blanchable redness to sacrum. Silicone dressing placed. On 3/17/24, a weekly skin review/assessment documented, redness noted to coccyx. On 3/25/24 and 3/31/24, a weekly skin review/assessment documented, redness noted to coccyx. ointment applied. reposition every 2 hours or PRN [as needed]. no other skin issues noted. On 3/28/24 at 8:17 PM, a physician progress note documented, Nursing report no skin lesions to sacrum or coccyx. She is not ambulatory and is confined to wheeled recliner. On 4/14/24, a weekly skin review/assessment documented, excoriation on the buttocks. On 4/30/24, a hospice visit note documented the hospice nurse had assisted a facility certified nursing assistant (CNA) in providing a brief change for resident 5 and noted resident 5's skin to be intact at the time. On 5/1/24, a hospice visit note documented resident 5 had healing skin tears to bilateral arms and there was no other evidence of skin break down. On 5/12/24, a weekly skin review/assessment documented, Excoriation on the buttocks . (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 5/13/24, a hospice visit note documented an integumentary assessment was conducted and assessed resident 5's skin was pale and had poor turgor. A Braden risk assessment scale was done and revealed resident 5's skin was occasionally moist and required an extra linen change once a day. The assessment documented resident 5 had a potential problem with friction and shear due to their skin probably sliding down sheets and chairs. On 5/23/24, a weekly skin review/assessment documented, Excoriation on the buttocks. Hospice nurse is bringing skin barrier for this. On 5/23/24 at 3:54 PM, an alert note documented, Skin Check: 1. Moisture Associated Skin Damage [MASD] Excoriation on the buttocks. Hospice nurses is bringing skin barrier for this. Bowel prep meds [medication] are changed from scheduled to prn [as needed]. On 5/23/24, a hospice visit note documented, Redness present to coccyx area, no open sores, Advised staff to apply barrier cream with all brief changes and reposition frequently. An integumentary assessment was conducted and documented a Braden risk assessment scale. It stated resident 5's skin is often but not always moist and linens needed to be changed as often as 3 times in 24 hours. It stated resident 5 was completely immobile and did not make even slight changes in body without assistance. It stated resident 5 had a problem with friction and shear due constant friction from sliding down in bed, sliding against the sheet with transfers, and frequent repositioning. On 5/28/24, a weekly skin review/assessment documented, Multiple small skin tears noted during brief change in sacral area. Red, no odor. It documented there was a new skin integrity problem on resident 5's sacrum and documented the new skin problem as a skin tear. On 5/29/24 at 9:47 AM, a nurse note documented, New pressure sores found on resident's R [right] buttocks and coccyx. Other areas on L [left] buttocks becoming red. Hospice notified; no new orders at this time. Silicone dressings and zinc cream placed where appropriate. Pillows placed for pressure relief. On 5/29/24, a weekly skin review/assessment documented, New pressure sores to R buttock and coccyx, other areas on L buttocks becoming red. Hospice notified. The skin review documented resident 5 had altered skin integrity to their right buttocks and coccyx and documented the skin problem as a pressure. On 6/2/24, a weekly skin review/assessment documented, Current pressure sores to R buttock and coccyx, other areas on L buttocks becoming red. Hospice notified. On 6/2/24 at 6:35 PM an alert note documented, New Skin Issue found on Weekly Skin Check. Skin treatment in progress. On 6/3/24 at 2:20 PM, a nutrition/dietary note documented, Continues hospice cares. Recent notes of pressure sores. Will await upcoming wound note to complete full assessment. Resident 5's Medication Administration Records (MAR) and Treatment Administration Records (TAR) were reviewed for the past 5 months for the buttocks excoriation treatment which was scheduled for twice a day. The following documentation revealed: (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 0684 Level of Harm - Actual harm Residents Affected - Few	a. January: Resident 5 had 10 missed treatments out of 49 total treatments. b. February: Resident 5 had 13 missed treatments out 58 total treatments. [Note: There were 3 days where resident 5 had not receive treatments twice a day.] c. March: Resident 5 had 12 missed treatments out of 62 total treatments. [Note: There was 1 day where resident 5 had not received treatments twice a day.] d. April: Resident 5 had 11 missed treatments out of 60 total treatments. [Note: There were 2 days where resident 5 had not received treatments twice a day.] e. May: Resident 5 had 10 missed treatments out of 62 total treatments. [Note: There was 1 day where resident 5 had not received treatments twice a day.] On 6/5/24 at 10:37 AM, an interview was conducted with Licensed Practical Nurse (LPN) 4. LPN 4 stated resident 5 needed assistance with rolling in bed and was incontinent of bowel and bladder. LPN 4 stated incontinence care was provided to resident 5 and they checked on them frequently to see if they needed to be clean and if they needed barrier cream. LPN 4 stated if a resident's brief was not changed often enough, then it caused skin break. LPN 4 stated a type of skin break down that was developed was excoriation which was redness and inflammation of the skin. LPN 4 stated the wound nurse was notified as soon as they noticed any kind of skin breakdown on a resident. LPN 4 stated resident 5 had some pressure ulcer on their coccyx and sacrum area. LPN 5 stated resident 5 was on an air mattress which helped prevent ulcers by distributing the pressure to different areas and helped with circulation. LPN 5 stated they just barely received new orders for repositioning resident 5 every two hours. On 6/6/24 at 10:01 AM, an interview was conducted with the Assistant Director of Nursing (ADON) 2. ADON 2 they were the wound care nurse. ADON 2 stated if a resident had a new wound or skin injury, staff filled out a form and turned it in to them and they notified the house doctor if needed. ADON 2 stated they put the orders in for wounds which informed the nurses of the specific wound care instructions. ADON 2 stated they monitored the skin breakdown and treatments ordered for all the residents. ADON 2 stated a pressure sore was a cause of Moisture Associated Skin Damage (MASD). ADON 2 stated the skin irritation occurred when a resident was in a wet brief. ADON 2 stated MASD had many stages and it started with an abrasion. ADON 2 stated MASD created friction on the skin and caused the skin to break down. ADON 2 stated the skin breakdown led to an abrasion from the brief pulling on the skin. ADON 2 stated if MASD was not cared for or taken care of regularly, then it became a pressure sore. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 6/6/24 at 10:15 AM, an interview was conducted with the Assistant Director of Nursing (ADON) 1. ADON 1 stated they had previously been the wound care nurse at the facility. ADON 1 stated any time they had been notified of a wound, they examined and determined if the wound needed to be seen by the wound care provider. ADON 1 stated if a resident had MASD, the facility doctor followed up with the resident and wound care did not see them. ADON 1 stated MASD was moisture associated skin dermatitis and it was found under the breast and groin. ADON 1 stated MASD was an avoidable rash. ADON 1 stated a resident could have had moisture associated skin problems if they were in a wet brief for prolonged periods of time. ADON 1 stated frequent rounding and brief changes were done to prevent skin problems. ADON 1 stated resident 5 had MASD to their bottoms in January. ADON 1 stated the moisture weakened the skin and if not taken care of, turned into a greater issue. ADON 1 stated they were notified that resident 5 had pressure sores by the hospice nurse. ADON 1 stated resident 5's bottom had been blanchable last week but now it had opened and was no longer blanchable.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50200 Based on observation, interviews and record review it was determined, the facility did not ensure that each resident with limited range of motion received appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Specifically, for 2 out of 53 sampled residents, residents with limited range of motion were not given restorative nursing services to prevent a further decrease in range of motion in upper and lower extremities. Resident Identifiers: 7, 54. Findings Included: 1. Resident 54 was admitted to the facility on [DATE] with diagnoses which included cervical disc disorder, primary osteoarthritis, type 2 diabetes with neuropathy, hypothyroidism, morbid obesity, weakness, muscle weakness, anxiety, obstructive sleep apnea, hypertension, and a history of falling. Resident 54's medical record was reviewed 6/2/24-6/6/24. On 6/2/24 at 2:39 PM, an interview was conducted with resident 54. Resident 54 stated that she could wiggle her feet a bit, but was unable to move or feel her lower extremities. Resident 54 stated she was unable to get out of bed or walk. Resident 54 stated she required an electric wheelchair to be mobile. Resident 54 stated that she had a decrease in range of motion in her upper extremities and had to do exercises by herself. On 6/2/24 at 2:40 PM, an observation was made of resident 54's lower extremities. Resident 54's feet and toes were observed to have contractures. Review of resident 54's progress notes revealed the following: a. On 1/24/24 at 7:39 PM, the note documented, Pt [patient] has recently been hospitalized for a GLF [ground level fall] and weakness, likely r/t [related to] progressing cervical spine disease. Pt has weakness in legs, impaired mobility, and poor dexterity. Difficulty using controls or using a writing utensil. b. On 1/24/24 at 9:16 PM, the note documented, upper extremity ROM [range of motion] limited with minimal use r.t. [related to] weakness from DJD [degenerative joint disease] .Adjustment to admission: Pt adjusting well in good spirits, looking forward to therapy and getting up for activities. Anticipates need for hoyer with 2-3 person assist .Pt cannot move own legs, requests adjustments routinely which causes pain. Review of resident 54's provider notes revealed the following: (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. On 1/31/24 at 8:26 PM, an admission note documented upon examination of upper extremities diffuse arthritic changes are noted bilaterally. Upon examination of lower extremities sensation is not present upon light touch. Physical and Occupational therapy will evaluate patient for transfers, strengthening, mobility, and ADL's [activities of daily living] .Musculoskeletal: Mild arthritic change, contractures of feet and toes, decrease ROM BLE [bilateral lower extremities] . Assessment/plan: Cervical disc disorder, unsp [unspecified], unspecified cervical region: PT [physical therapy] and OT [occupational therapy] fore [sic] rehab. On 6/5/24 at 9:56 AM, an interview was conducted with the Regional Nurse Consultant (RNC). The RNC stated the restorative nursing program was not run as a traditional program at the facility. A CNA [certified nursing assistant] assisted with lifting weights, walking, and transferring with the residents. The RNC stated an order was not needed for restorative nursing services. The RNC stated that residents with contractures should get ROM exercises. On 6/5/24 at 1:44 PM, an interview was conducted with the Minimum Data Set [MDS] Coordinator. The MDS Coordinator stated restorative nursing was not care planned and had not been for the last 2 or 3 years. The MDS Coordinator stated when floor nurses received an admit they could populate all interventions and this triggered the need for restorative nursing. The MDS Coordinator stated there was not a straightforward RNA program at the facility. 30563 2. Resident 7 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included paroxysmal atrial fibrillation, fibromyalgia, type 2 diabetes mellitus, obesity and major depressive disorder. On 6/3/24 at 10:04 AM, an interview was conducted with resident 7. Resident 7 stated she had limited range of motion (ROM) in her legs. Resident 7 stated she would like to have therapy to keep the same level of functioning. Resident 7 stated she would like to be able to get to the side of the bed and into her wheelchair. Resident 7 stated she should be getting restorative therapy but there were no staff that provided that. Resident 7 stated she did her own therapy in bed because she did not receive therapy. Resident 7 stated after going to hospital, she came back and received 30 days of therapy. Resident 7 stated after the 30 day therapy, she was discharged from therapy and then her level of function decreased. Resident 7's medical record was reviewed 6/2/24 through 6/6/24. A quarterly Minimum Data Set (MDS) dated [DATE] revealed resident had limited ROM to both sides. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A care plan dated 10/20/21 and updated on 9/20/23 revealed [Resident 7] has an ADL [activities of daily living] self care performance deficit r/t [related to] Morbid Obesity. The goal was Will be able to participate in part of ADL activity. Will have needs met. Interventions included Adjust and meet residents needs with ADL assistance per level of need at time of care. Level of assistance may vary depending on time of day and current health conditions; Bed Mobility: The resident requires up to SUBSTANTIAL/MAXIMAL assist as needed. She uses a Trapeze on her bed Transfers: The resident requires up to DEPENDENT assist as needed. She uses a Hoyer lift. [Resident 7] prefers to stay in her bed Locomotion: The resident uses motorized wheelchair, she does not use it often. Dressing: The resident requires up to DEPENDENT assist as needed. Eating: The resident requires up to SET UP OR CLEAN UP assist as needed; and PT/OT [Physical Therapy/Occupational Therapy] evaluation and treatment as per MD [Medical Doctor] orders. Certified Nursing Assistant (CNA) documentation in the Tasks section of the medical record revealed ROM (Active) should be done everyday. There was no documentation that ROM was completed for the previous 30 days. A list of residents who were provided RNA services was provided by the Administrator. Resident 7 was not on the list. On 6/4/24 at 1:45 PM, an interview was conducted with Physical Therapist (PT) 1. PT 1 stated she had worked with resident 7 in the past. PT 1 stated in the past resident 7 wanted to learn how to be transferred in the Hoyer lift or a slide board. PT 1 stated resident 7 did not feel safe on the slide bard and there was not enough bend in resident 7's knee to use the Hoyer lift. PT 1 stated she provided resident 7 a lot of exercises in bed to try so resident 7 would be able to sit on the side of the bed. PT 1 stated resident 7 was able to get to the side of the bed with the help of 2 staff members. PT 1 stated resident 7 would have to lay right back down after sitting at the side of the bed. PT 1 stated resident 7's insurance had a co-pay for therapy and resident 7 did not want to pay the co-pay. PT 1 stated the last time resident 7 received therapy services was in 2021. PT 1 stated the Director of Rehab had tried to work with a Restorative Nursing Aide program. PT 1 stated there was a form that the therapist filled out regarding how many times per week and how often RNA services should be provided. PT 1 stated there was usually a CNA in charge of the RNA program. PT 1 stated she was not sure if there was an RNA program at the facility. PT 1 stated it had been a while since she filled out one of the sheets. PT 1 stated the RNA staff member had been pulled to provide CNA cares when someone did not show up. PT 1 stated resident 7 would benefit from RNA services. On 6/4/24 at 2:12 PM, an interview was conducted with the Director of Rehab (DOR). The DOR stated stated the RNA program was frustrating. The DOR stated resident care needs came first before exercise and maintaining their level of function. The DOR stated the RNA helped as a CNA when the facility was short staffed. The DOR stated recently the facility was working on getting the RNA program going. The DOR stated she wanted residents to get more exercises. The DOR stated resident 7's insurance required she pay a co-pay which was about $30 and resident 7 stated she did not want to pay for therapy. The DOR stated resident 7 was not on RNA services. The DOR stated anyone would benefit from RNA services. The DOR stated that resident 7 would have benefited from RNA services. The DOR stated resident 7 had unrealistic expectations and was very weak. The DOR stated resident 7's transferring was not safe and discussed with her about how to be safe and she always wanted things in an unsafe way. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/6/24 at 8:37 AM, an interview was conducted with Assistant Director of Nursing (ADON) 1. ADON 1 stated she was not aware that resident 7 had limited ROM. ADON 1 stated restorative nursing services were a work in progress. ADON 1 stated a list of people who were receiving services was reviewed and resident 7 was not on the list. ADON 1 stated resident 7 was very particular with who she was willing to work with. ADON 1 stated RNA services would be beneficial for someone to come in and assist resident 7 with exercises. On 6/5/24 at 9:57 AM, an interview was conducted with the Regional Nurse Consultant (RNC). The RNC stated the RNA program was not a typical RNA program. The RNC stated the RNA completed resident weights, walking, ROM, transferring and assisted with dining. The RNC stated the RNA did not document exercises done in the resident's electronic medical record.

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F 0689 Level of Harm - Actual harm Residents Affected - Some	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** 46232 Based on interview and record review it was determined, for 4 of 53 sampled residents, that the facility did not ensure that the resident environment remained as free of accident hazards as was possible and that each resident received adequate supervision and assistance devices to prevent accidents. Specifically, a resident sustained multiple falls with one resulting in a fracture, a resident transported in the facility vehicle was not properly secured and sustained a fall with injury. These findings were cited at a harm. In addition, a resident with wandering behaviors, eloped from the facility and a resident was not secured in their wheelchair and sustained a fall. Resident identifiers: 5, 18, 367, and 374. Findings Included: 1. Resident 5 was initially admitted to the facility on [DATE] and readmitted on [DATE] with the diagnoses of encounter for palliative care, type 2 diabetes mellitus with diabetic neuropathy, venous insufficiency, hypertensive heart disease with heart failure, chronic respiratory failure with hypoxia, unspecified dementia and Alzheimer's disease. Resident 5's medical record was reviewed on 6/3/24 thru 6/6/24. On 5/2/24, a State Optional Minimum Data Set (MDS) documented resident 5 was a two-person extensive assist with transfers, toileting and bed mobility. On 4/4/24, a Quarterly MDS documented resident 5 had a Brief Interview for Mental Status [BIMS] score of 1 which indicated severe cognitive impairment. There was no information located under the mobility section for functional abilities. A care plan focus area initiated on 8/11/23 documented resident 5 was at risk for falls related to impaired mobility and confusion secondary to Dementia/Alzheimer's. The listed interventions included: 1. Fall mattress in place. This was initiated on 8/25/23. 2. Bed in the lowest position and locked in place whenever resident 5 was in bed. This was initiated on 12/27/23. A care plan focus area initiated on 8/28/23 and resolved on 10/19/23 documented resident 5 had an unwitnessed fall on 8/25/23 resulting in bruising/swelling to right lower leg. Resolved interventions included: 1. Educated CNA's (certified nursing assistant) about safety protocols related to falls. 2. Fall mattress in place. On 10/15/23, a post fall Morse Fall Scale documented resident 5 had scored 75 which indicated they were a high fall risk. The document stated resident 5 had an impaired gait and overestimated/forgot limitations. Resident 5's progress notes and facility incident reports were reviewed and documented the following falls: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	a. On 8/25/23 at 12:25 PM, a late entry fall note documented, Per floor nurse: Resident found by CNA [certified nursing assistant] on floor. Bruising noted to right lower leg, under her shin. Resident unable to explain what happened. Fall assessment completed. Hospice notified regarding fall, waiting for further orders. b. On 8/25/23 at 3:50 PM, a facility incident report documented resident 5 had an unwitnessed fall in their room. The nursing description of the incident report documented, Pt [patient] was found by the CNA's on the floor next to the bed with her right leg tucked under her left leg. She was not crying out in pain. Pt reported no injury. CNA placed pt back in bed with assessment completed after movement to bed: she has a large bruise to the right lower leg under her shin. The Immediate actions taken included education on fall safety protocol and hospice had been notified of the fall. It documented the facility was waiting for an update from hospice on how to proceed post fall. A Pain Assessment in Advance Dementia (PAINAD) was done and documented resident 5's pain post fall was a 2 which indicated mild pain. The predisposing physiological factors listed included impaired memory, opioid therapy, antianxiety therapy and hospice patient. Confusion. The Predisposing situation factors listed included inadequate communication and side rails up. Resident 5's mental status was documented as oriented to person. c. On 12/26/23 at 8:53 AM, a nurse note documented, Pt [patient] was found on the floor next to her bed sitting on her bottom. Pt was in bed being combative hitting out at staff 15 minutes prior to this incident when staff was trying to change pt brief. EMT [emergency medical technician] was contacted and pt was transported to the ER [emergency room] where it wasdetermined [sic] pt has a fractured femur and tibia. Hospital is going to monitor pt overnight to determine surgery needs. Dr [doctor] notified at 12pm. Voice mail left for POA [power of attorney]. POA was determined to be deployed in saudi [NAME] and wife [name removed] POA at the moment. [name removed] spoke with hospital and the Dr will be in touch with her tomorrow. d. On 12/26/23 at 11:35 AM, a facility incident report documented resident 5 had an un-witnessed fall in their room. The incident report description stated resident 5 had been unable to give a description of their fall. The nursing description documented resident 5 had been found on the floor next to their bed on their bottom. It documented resident 5 had been combative with staff during a brief change, 15 minutes before the fall. Resident 5 was taken to the hospital and was required to stay overnight due to having a fractured femur and tibia and needing possible surgery. Resident 5's power of attorney was notified of the fall. The incident report documented no injuries had been observed post incident. The predisposing physiological factors listed included confusion and impaired memory. The predisposing situational factors listed included physical aggression and refusing 1 on 1 help. Resident 5 was documented to be a total assist with transfer. A Pain Assessment in Advance Dementia (PAINAD) was done and documented resident 5's pain post fall was a 10 which indicated severe pain. e. On 12/28/24 at 5:33 PM, a nurse note documented, Resident is admitted from [local hospital] around 1424pm [2:24 PM] via [name removed] ambulance on gurney. She is alert but weak and pale looking .Has R [right] lateral thigh surgical site with steri strips and covered with clear dressing. She has 2 little site with dressing. No bleeding noted. She is going to be on [name removed] hospice care and confirmed by daughter in law on the phone . (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Some	On 12/26/23 at 11:35 AM, a facility incident report documented resident 5 had an un-witnessed fall in their room. The incident report description stated resident 5 had been unable to give a description of their fall. The nursing description documented resident 5 had been found on the floor next to their bed on their bottom. It documented resident 5 had been combative with staff during a brief change, 15 minutes before the fall. Resident 5 was taken to the hospital and was required to stay overnight due to having a fractured femur and tibia and needing possible surgery. Resident 5's power of attorney was notified of the fall. The incident report documented no injuries had been observed post incident. The predisposing physiological factors listed included confusion and impaired memory. The predisposing situational factors listed included physical aggression and refusing 1 on 1 help. Resident 5 was documented to be a total assist with transfer. A Pain Assessment in Advance Dementia (PAINAD) was done and documented resident 5's pain post fall was a 10 which indicated severe pain. An exhibit form 358 was submitted to the State Survey Agency (SSA) on 12/26/23 at 11:30 AM. The exhibit documented resident 5 had a fall with injury and staff had become aware of the incident on 12/26/23 at 11 AM. The exhibit documented resident 5 had fallen in their room and the suspected injury had either been a hip fracture or dislocation. Resident 5 was sent to the emergency for evaluation and treatment due to the injury obtained. On 12/26/23 at 1:51 PM, a hospital history and physical report documented resident 5 had arrived to the emergency room with right hip pain after being found down bedside their bed. It documented, Upon arrival, EMS [emergency medical services] reported an obvious deformity of her right hip/pelvis and possible deformity of her right knee. An exhibit form 359 was submitted to the SSA on 1/2/24 at 1:15 PM. The additional information section of the exhibit form documented a hip fracture had been confirmed. The X-ray report showed that resident 5 had sustained a closed fracture proximal end of femur. The witness interview summary documented the fall had not been witnessed. It documented the certified nursing assistant (CNA) had gone in to change resident 5's brief minutes earlier and resident 5 was being combative. The CNA stopped the brief change and went to find additional help. When the CNA returned with a nurse, resident 5 was found sitting on the floor. A staff interview documented resident 5 had been very confused and restless and must have either rolled off the bed or tried to stand up. Resident 5's CNA for the shift stated the bed was in the low position and the fall mat had been in place when they arrived on shift. It documented when the CNA returned to resident 5's room at 11 AM, the fall mat was not in place, but the bed was still in the low position. The CNA raised the bed to change resident 5's brief but resident 5 became combative. The interview documented the CNA had lowered resident 5's bed to close to the lowest position and stepped into the hall to get assistance. It documented the CNA heard resident 5 fall and entered the room to find resident 5 on the floor. The investigation documented there was no perpetrator identified for the incident. The investigation concluded the allegation of a fall with an injury had been verified and documented, resident 5's care plan stated that here should be a floor mat. Even through (sic) the CNA only left the room quickly to get assistance and did lower the bed, the floor mat was not in place. Corrective actions implemented after the investigation included a point of care task for CNAs to ensure the floor mat was in place and one on one CNA education/training regarding fall mats and other interventions. On 6/5/24 at 9:41 AM, an interview was conducted with Certified Nursing Assistant (CNA) 5. CNA 5 stated resident 5 was dependent on all cares. CNA 5 stated resident 5 was bedbound and was unable to walk. CNA 5 stated resident 5 was a fall risk but they were unsure if resident 5 had any falls. CNA 5 stated resident 5's bed was put in the lowest position and they had a fall mat next to their bed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	On 6/5/24 at 11:09 PM, an interview was conducted with CNA 7. CNA 7 stated resident 5 was a total care resident. CNA 7 stated resident 5 was able to make their needs known occasionally. CNA 7 stated resident 5 had a fall mat because they climbed out of bed. CNA 7 stated resident 5 was a fall risk and they had interventions in place such as a fall mat, bed in the lowest position, frequent checks and having resident 5 in the day room with staff. CNA 7 stated they were sure resident 5 had been injured due to previous falls. On 6/6/24 at 7:57 AM, an interview was conducted with CNA 17. CNA 17 stated resident 5 was mentally out of it. CNA 17 stated resident 5 frequently rolled themselves out of bed. CNA 17 stated the resident was placed in the day room during the day so staff was able to observe them often. On 6/6/24 at 7:49 AM, an interview was conducted with CNA 12. CNA 12 stated resident 5 was confused. CNA 12 stated depending on how resident 5 was feeling during the day, they needed to have a second staff member with them during resident cares. CNA 12 stated they usually rounded on resident's every two hours. CNA 12 stated resident 5 was a fall risk and needed a hoyer lift for transfers. CNA 12 stated resident 5 was a fall risk and had interventions in place such as a fall mat, bed in the lowest position, and frequent checks. CNA 12 stated they were aware resident 5 had falls in the past but they were unsure of the severity of the falls. On 6/6/24 at 8:12 AM, an interview was conducted with CNA 18. CNA 18 stated resident 5 was a total assist and was a two-person hoyer lift with transfers. CNA 18 stated resident 5's dementia was so severe they were unable to recall the date. CNA 18 stated resident 5 was unable to express their needs. CNA 18 stated resident 5 was a fall risk because they forgot they were unable to bear weight and tried to stand. CNA 18 stated if resident 5 was in bed, staff made sure resident 5's bed was in the lowest position with the fall mat in place. CNA 18 stated resident 5 was put in high traffic areas near staff so staff always had eyes on resident 5. CNA 18 stated resident 5 had a fall about 5 months ago where they messed their leg up. CNA 18 stated they had heard details about the fall and stated whoever resident 5's aid was at the time, left the resident's room to find help. CNA 18 stated resident 5 fell and landed on her hip in the short time the aid had left to find help. On 6/6/24 at 8:32 AM, an interview was conducted with Licensed Practical Nurse (LPN) 3. LPN 3 stated they looked in the care plan to see what interventions were put in place to prevent a resident from falling. LPN 3 stated resident 5 had a fall where something was fractured. LPN 3 stated interventions for resident 5 were frequent two-hour checks, bed in the low position and the floor mat. LPN 3 stated resident 5 was confused and when resident 5 was in the day room they needed to monitor them. On 6/6/24 at 9:38 AM, an interview was conducted with the Resident Advocate (RA). The RA stated resident 5 required a bit of help from staff and was dependent for most of their cares. The RA stated resident 5 was wheelchair bound. The RA stated they believed resident 5 was a high fall risk. The RA stated fall interventions included the bed in the lowest position and fall mats if the residents crawled out of bed. The RA stated they were unsure if resident 5 had any falls with injury. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	On 6/6/24 at 10:31 AM, an interview was conducted with the Assistant Director of Nursing (ADON) 1. The ADON 1 stated resident 5 was able to reposition themselves while in bed and they were able to roll out of bed. The ADON 1 stated resident 5 was unable to get out of bed safely. The ADON 1 stated resident 5 had fall interventions that included the bed in the lowest position and the fall mat on the floor when resident 5 was in bed. The ADON 1 stated resident 5 had rolled out of bed and broken their hip. The ADON 1 stated they were unsure of the specific details of the fall. The ADON 1 stated they assisted resident 5's nurse after the resident had fallen. The ADON 1 stated they remembered seeing resident 5 on the floor and the fall mat was stood up against the wall. The ADON 1 stated they were unsure if the emergency medical technicians had moved it out of the way to assist resident 5. 38031 2. Resident 374 was admitted to the facility on [DATE] with a diagnosis of vascular dementia. On 6/3/24, resident 374's medical records were reviewed. On 11/6/23, resident 374's Admission Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 5/15, which would indicate a severe cognitive impairment. On 11/16/23, resident 374's Montreal Cognitive Assessment (MOCA) score was 8/30. A score of less than 10 indicated a severe cognitive impairment. Resident 374's progress notes documented the following: a. On 11/1/23 at 3:17 PM, the admission note documented that resident 374 wandered at times and required redirection. The mental status documented that the resident was alert and confused at baseline. b. On 11/8/23 at 11:57 AM, the social service note documented that resident 374 .BIMS score shows he is severely impaired with a score of 5. PTs [patients] goal is to maintain his quality of life while being care for in a safe environment. c. On 2/21/24 at 4:30 AM, the nurse note documented, PT [patient] assisted another resident in an elopement attempt (1900) last night. PT was redirected and instructed to ask us for help when a resident wants to know the location of the exits. PT was monitored by staff, no further incidents noted. d. On 2/25/24 at 10:30 AM, the nurse note documented, Resident became aggressive with staff when staff attempted to guide him out of other residents's (sic) rooms. e. On 2/28/24 at 7:04 AM, the nurse note documented, Resident appears to be more confused, wandering into other Residents rooms. f. On 3/16/24 at 7:24 PM, the alert note documented, Elopement: Resident remains on elopement precautions. He has been in the hallway, in his room, at the nurse station and in the activity room. Resident has not demonstrated seeking to leave. Doorbell checks on going all day continue for safety and elopement prevention. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	g. On 3/22/24 at 5:59 AM, the nurse note documented, Resident is with ongoing monitoring for elopement. He is wandering around the facility. He is alert but with episodes of confusion. He is forgetful and always loose (sic) his cellphone. He is able to ambulate. Will continue monitor resident. h. On 3/23/24 at 6:40 AM, the nurse note documented, Resident is on continues (sic) 15 minutes monitoring due to elopement. He is ambulatory and with confusion. Resident eats in the dining area with supervision, is continent of bowel and bladder. Will continue monitor resident. i. On 4/3/24 at 3:50 AM, the nurse note documented, resident remains on elopement precautions per facility protocol. resident currently resting in bed with eyes closed. re orientation provided regarding residents (sic) room and facility. frequent reminders provided by staff. will continue to monitor closely. j. On 4/3/24 at 2:48 PM, the nurse note documented, Pt [patient] did exit the facility and got out to the parking lot area. He was followed out to the parking lot by multiple staff members, to which he was verbally aggressive towards. He then proceeded to go across the street when this nurse went inside to get pt sisters' number. The nurse he was with was shoved by pt as she was attempting to redirect him back into the building. Pt was not being cautious of traffic as he was crossing the street and was ignoring the nurse he was with as she was trying to keep him safe from traffic. Pt was attempting to go into the building across the street and the other nurse was blocking the door to the building to which he was forcefully trying to open and move nurse. A male staff member came over and was able to redirect pt back into the building. Sister aware as well as dr [doctor]. k. On 4/4/24 at 11:06 AM, the nurse note documented, Upon being notified of resident exiting facility, staff immediately went to ensure safety and found him a short distance off of property, and across the street. Resident redirected and calming communication initiated, and safe escort back into facility. Frequent checks and monitors initiated, per protocol. Family notified. Cause of resident being able to exit was sought after and identified that he was able to get out of door with no alert system due to the door being propped open. This was fixed and staff was educated on not propping door open, and re-edcuated (sic) on the door alarm system function. Future placement for resident in another facility with designated memory care unit has been initiated. l. On 4/13/24 at 5:28 PM, the alert note documented, Resident attempted to exit out of the front of the building before being stopped by the CNA's [Certified Nurse Assistant]. He then snuck out the back and made it out to the road. We wee (sic) able to redirect him back to the building. m. On 4/19/24 at 3:44 PM, the alert note documented, New behavior observed. Resident is forgetful and confused. Leaving valuable belongings such as wallet and cellphone and will approach staff to help him. He roams around the facility Monitors his whereabouts and redirect resident if needed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	n. On 4/24/24 at 11:02 AM, the nurse note documented, PT had an episode of elopement. PT walked out of facility to the main road and up to the stores. An aide asked for assistance so I left the facility and ran towards the road where I met her. I saw the resident up the road about 1/4 mile. I continued to run where I was in earshot so I could try and get his attention. I asked him where we were going and he said to go away, go back, and don't touch me. I continued to keep my distance as we walked into the store where he wandered and looked for a restroom. At this time I contacted the ADON's [Assistant Director of Nursing] to let them know where I was. I showed him the bathroom; he went in and used the bathroom. After he used the bathroom he started to walk out of the facility, again I followed at a distance when the ADON showed up. She told me to head back to the facility. o. On 4/25/24 at 1:17 AM, the alert note documented, Due to recent elopement and physical attack on a CNA, resident is on a 1 to 1. Resident wondered [sic] around the facility with a 1 to 1 then went to bed where he has been asleep without any issues. p. On 4/25/24 at 8:41 PM, the alert note documented, Elopement: Resident was on a 1 to 1 observation for several hours today where he wondered [sic] around the facility with a 1 to 1. However, there were short periods of time when he disappeared into other pt rooms. I found him inside the door of 414 sitting in a chair eating a small chocolate bar she gave him. She was not alarmed. He went into rm [room] 403 and scared resident A there, as she reported this to me, and that no contact was made. [Resident 374] was compliant with his med [medication] regimen today. He ate adequate amounts at meals. He remained calm and pleasant. He did not leave the building. On 10/30/23, the Additional Admission Assessment documented under Wander Risk Scale that the resident was a low risk for wandering. On 11/16/24, resident 374's care conference documented, nursing stated that PT has had no recent falls but that he does wander so the concern would be if he got out. On 11/30/23, the physician communication form documented a concern was Pt has exited the facility multiple times while exit seeking. Exit seeking is daily occurrence now. New order documented, tell family he needs lock down memory care. On 3/12/24, the wander risk scale documented a score of 19, which indicated a high risk to wander. The assessment documented the resident was ambulatory, could not follow instructions, had a history of wandering, had a medical diagnosis of dementia, had wandered within the home without leaving the grounds, and had wandered in the past month. The community risk assessment documented that resident 374 did not know the address or phone number, was not aware of basic traffic/pedestrian laws, was not aware of surroundings and safety, was not able to make his own medical decisions, and was not able to remember to sign out. The elopement assessment documented that resident 374 was not safe independently in the community, but the care plan was not updated. On 4/3/24, resident 374's incident report documented that the Staff was notified by separate resident of another resident who exited building and was seen heading away from the facility. Staff immediately left to locate resident and found him of premise a short distance from facility. Resident began aggressive verbal behavior and staff called from [sic] additional staff assistance. Multiple staff then escorted resident back into facility to ensure safety. The incident report documented that resident 374 was confused, had an impaired memory, and was an active exit seeker. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	On 11/6/23, resident 374 had a care plan initiated for at risk for impaired safety related to wandering, vascular dementia, and confusion. Interventions identified included to anticipate the needs of the resident as much as possible; resident 374 enjoyed walking up and down the halls, sitting in the lobby looking out the window and working out in the therapy room; calmly redirect and cue as needed related to wandering; and monitor for significant changes in behavior. On 3/8/24, resident 374 had a care plan initiated for elopement risk/wanderer related to dementia. Interventions identified included assess for a fall risk; distract from wandering by offering pleasant diversions, structured activities, food, conversation, television and books; door bell/sensor installed on main doors to alert staff when opened; and monitor for fatigue and weight loss. On 3/6/24, the 24 hour every 15 minute safety checks were initiated for resident 374. The safety sheet revealed incomplete documentation for the 15 minute checks from midnight through 11:45 AM, from 4:45 PM through 5:15 PM, and at 6:45 PM. On 3/7/24, the 24 hour every 15 minute safety check sheet for resident 374 revealed incomplete documentation from midnight through 5:45 AM. On 3/13/24, the 24 hour every 15 minute safety check sheet for resident 374 revealed incomplete documentation from 6:15 AM through 5:45 PM. On 3/14/24, the 24 hour every 15 minute safety check sheet for resident 374 revealed incomplete documentation from midnight through 5:45 AM, and from 2:00 PM through 11:45 PM. On 3/16/24 and 3/17/24, the 24 hour every 15 minute safety check sheet had both dates documented on the form. The safety sheet had incomplete documentation from 6:15 AM through 5:30 PM. On 3/21/24, the 24 hour every 15 minute safety check sheet for resident 374 revealed incomplete documentation from midnight through 5:45 AM, and from 5:00 PM through 11:45 PM. On 3/25/24, the 24 hour every 15 minute safety check sheet for resident 374 revealed incomplete documentation from 10:00 AM through 11:45 PM. It should be noted that no documentation could be found of the 24 hour every 15 minute safety checks for 3/9/24, 3/10/24, 3/11/24, 3/15/24, 3/18/24, 3/19/24, 3/20/24, 3/22/24, 3/23/24, and 3/24/24. Additionally, no documentation could be found of the 24 hour safety checks for resident 374 after 3/25/24 until his discharge on 4/26/24. On 6/04/24 at 9:46 AM, an interview was conducted with CNA 11. CNA 11 stated that resident 374 was confused and had dementia. CNA 11 stated he would hear resident 374 ramble and say stuff that would not make sense. CNA 11 stated that resident 374 had sudden outbursts of aggression with staff. CNA 11 stated that resident 374 had exit seeking behaviors and some of the nurses would report that he exited the building. CNA 11 stated that resident 374 was found outside the building a few times. CNA 11 stated that when they would try to bring resident 374 inside he would become aggressive. CNA 11 stated that if a resident was high risk for elopement they checked their location every 15 minutes and charted it to make sure they were in a safe area. CNA 11 stated that the facility did not have a wander guard system. CNA 11 stated that the side door chimed when opened they were supposed to check it. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	On 6/04/24 at 9:58 AM, an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated that an elopement was when a resident had left the facility grounds or when they go outside intending to leave. LPN 1 stated that a resident was determined to be high risk for elopement based on assessing multiple incidents of exit seeking behavior or actual elopements from the facility. LPN 1 stated that staff precautions for exit seeking behaviors were to move the resident closer to the nurse's station, conduct hourly rounding by the Certified Nurse Assistant (CNA) and nurses, training on re-direction or activities to distract, de-escalation techniques, and administering ordered medications to help with agitation and anxiety. If you see them walking around with their bag it's a good indication that they are trying to exit seek. LPN 1 stated that if a resident was placed on 1:1 monitoring the staff would need to have eyes on the resident at all times, and they would have a dedicated and assigned staff. LPN 1 stated that if the resident was on every 15 minute safety checks the staff would frequently check on the resident's location. LPN 1 stated that they had pictures of the residents that had exit seeking behaviors posted in the staff break room to alert the staff of who needed monitoring. LPN 1 stated that they also relayed this information during shift report and it was located in the resident's chart. LPN 1 stated that they had received training on de-escalating techniques upon hire and during all staff meetings. On 6/04/24 at 10:07 AM, an interview was conducted with CNA 12. CNA 12 stated that resident 374 was exit seeking and usually was trying to find a bathroom or to find his way home. CNA 12 stated that they would re-direct resident 374 or offer a snack or drink. CNA 12 stated they would walk with resident 374 and take him outside for fresh air. CNA 12 stated that resident 374 would respond to having a cup of coffee, but did not like to be told what to do. CNA 12 stated that resident 374 could get aggressive and responded better to male staff. CNA 12 stated that resident 374 had exited the building 2-3 times. CNA 12 stated that safety monitoring included having a staff member with resident 374 at all times. CNA 12 stated that they mostly checked on resident 374 every 15 minutes and would ask over the radio if anyone had eyes on him. CNA 12 stated that the nurse documented resident 374's wandering, but the CNAs did not document for the 15 minute checks. CNA 12 stated that resident 374 was alert and confused with short-term and long-term memory deficits. On 6/04/24 at 12:35 PM, an interview was conducted with the Resident Advocate (RA). The RA stated that an elopement was when a resident was off the property without a staff member or someone having eyes on them. The RA stated that those residents who were at risk for elopement were posted in the room behind the nurse's station, and they had visual checks completed hourly. The RA stated that resident 374 was a known elopement risk and would try to exit the facility. The RA stated that she was not sure when resident 374's exit seeking behaviors started, but he had been a known risk for awhile before he was discharged . The RA stated that she spoke to resident 374's family member and was informed that he was not safe at home and had previously gone to the grocery store and could not find his way home. The RA stated that resident 374 had cognitive deficits that made him not safe in the community without supervision. The RA stated that she was aware of resident 374 exiting the facility off property only once. The RA stated that staff found him and by the time they got to him he was across the road. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	On 6/04/24 at 2:10 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that an elopement was when a resident left the facility unsupervised and they did not have the capacity to do that. The DON stated that a wander risk assessment should be completed upon admission and quarterly for every resident, and based upon the assessment they would care plan it and put alerts in place. The DON stated that they had photos on the elopement risk wall in the medication room, and the nurse or aide had to round on that patient every hour or more frequently if needed. The DON stated that the room was accessible by all staff. The DON stated that if a resident was on a 1:1 safety check they had a dedicated staff with eyes on the resident at all times. The DON stated that if a resident was on every 15 minutes safety checks staff had to see where the resident was located every 15 minutes, and the check needed to be signed by the staff on the form. The DON stated that the purpose of the form was to have accountability to ensure the resident was safe. The DON stated that the facility did not have a wander guard system. The DON stated they had a doorbell that chimed when the door was opened. The DON stated that they had set the chime to alert during the evening hours after the day shift staff had left the building. The DON stated when the door was opened it would chime at the nurse's station. The DON stated that the door bell was implemented as an intervention around the first part of March 2024 and this was a [TRUNCATED]

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50200 Based on interview and record review it was determined that for 2 out 53 sampled residents, that the facility did not ensure that the resident who was incontinent of bladder received the appropriate treatment and services to prevent urinary tract infections (UTI) and to restore continence to extent possible. Specifically, a resident developed a UTI after facility staff were not instructed and trained on the proper changing, frequency, and monitoring of the resident's PureWick urinary system device and a resident had a delay in starting antibiotic therapy for a UTI. Resident identifiers: 36, 54. Findings Included: 1. Resident 54 was admitted to the facility on [DATE] with diagnoses which included cervical disc disorder, primary osteoarthritis, type 2 diabetes with neuropathy, hypothyroidism, morbid obesity, weakness, muscle weakness, anxiety, obstructive sleep apnea, hypertension, and a history of falling. Resident 54's medical record was reviewed 6/2/24-6/6/24. An admission Minimum Data Set (MDS) assessment dated [DATE], documented that resident 54 had a Brief Interview for Mental Status (BIMS) score of 15. A BIMS score of 13 to 15 would suggest intact cognition. A care plan Focus addressing toileting cares initiated on 2/8/24, documented [Resident 54] has a risk for bladder incontinence and requires assistance with toileting cares r/t [related to] activity intolerance. The interventions included: a. Clean peri-area after each incontinent episode b. [Resident 54] uses a PureWick system for her incontinence c. Monitor and document intake and output per facility policy d. Monitor/document for s/sx [signs and symptoms] UTI [urinary tract infection]: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp [temperature], urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns Review of Resident 54's physician orders revealed the following: a. Urinalysis (UA) for dysuria one time only. This order was initiated on 3/1/24. (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 0690 Level of Harm - Actual harm Residents Affected - Few	b. Macrobid Oral Capsule 100 milligrams (mg) (Nitrofurantoin Monohyd Macro), Give 1 capsule by mouth two times a day for UTI for 7 days. The order was initiated on 3/6/24 and discontinued on 3/14/24. The medication was documented as administered on 3/6/24 through 3/13/24. Review of resident 54's progress notes revealed the following: a. On 3/1/24 at 1:34 PM, the note documented, .ordered UA for dysuria. b. On 3/1/24 at 3:33 PM, the noted documented, obtained UA. c. On 3/2/24 at 3:35 PM, the note documented, Received UA results, no Bacteria noted. Sent copy to PCP [primary care physician]. d. On 3/6/24 at 10:49 AM, the note documented, UA sensitivity results received from lab. <100,000 CFU/ml E. Coli. [Escherichia coli] MD [medical doctor] notified. New orders from Macrobid 100mg BID [twice a day] x 7 days. Ordered from .Pharmacy, NP [nurse practitioner] gave ok to start first dose HS [hour of sleep]. On 6/2/24 at 2:38 PM, an interview was conducted with resident 54. Resident 54 stated she personally purchased the PureWicks that were used. Resident 54 stated she had a urinary tract infection a few months ago and was given an antibiotic. On 6/4/24 at 9:27 AM, a follow-up interview was conducted with resident 54. Resident 54 stated that CNAs changed the PureWick once daily. Resident 54 stated she trained the CNA's on how to change the PureWick. Resident 54 stated 32 PureWicks come in a box and she purchased them monthly as she used one box a month. Resident 54 stated she informed staff when to change the PureWick. On 6/4/24 at 9:33 AM, an interview was conducted with Licensed Practical Nurse (LPN) 2. LPN 2 stated resident 54's orders are to monitor PureWick while she is in bed. LPN 2 stated she did not know when the PureWick got changed or how often. On 6/4/24 at 9:44 AM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated there was not a directive order for the PureWick and he was unaware how often it got changed. On 6/4/24 at 9:56 AM, an interview was conducted with Certified Nurse Assistant (CNA) 4. CNA 4 stated there was not a place to chart that the PureWick was changed. CNA 4 stated she was not sure that changing the PureWick was a CNA task. On 6/4/24 at 1:10 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that she was unaware that any residents in the facility used a PureWick. On 6/4/24 at 1:35 PM, an interview was conducted with the DON and Minimum Data Set (MDS) Coordinator. The DON stated that CNAs did not document in the medical record with regards to the PureWick. The MDS Coordinator stated that CNAs were to change the PureWick at 4:00 AM and 4:00 PM. On 6/6/24 at 9:20 AM, an interview was conducted with the Regional Nurse Consultant (RNC). The RNC stated that facility staff had not received training on the PureWick urinary device. (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 0690 Level of Harm - Actual harm Residents Affected - Few	38031 2. Resident 36 was admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses which included chronic obstructive pulmonary disease, polyosteoarthritis, malignant neoplasm of the ovary, chronic fatigue, morbid obesity, anxiety disorder, bipolar disorder, peripheral neuropathy, presence of left and right artificial knee joint, insomnia, and restless leg syndrome. On 6/02/24 at 2:18 PM, an interview was conducted with resident 36. Resident 36 stated she had frequent urinary tract infections (UTI) and may have a one now. Resident 36 stated that she had pain in her pelvis/abdomen area and burning with urination. Resident 36 stated that she gave a urine sample but she does not know the results of the urinalysis. On 6/05/24, resident 36's medical records were reviewed. On 3/1/24, resident 36's Minimum Data Set (MDS) assessment documented a Brief Interview for Mental Status score of 14/15, which indicated the resident was cognitively intact. The assessment documented that resident 36 required a one-person physical assistance with supervision for bed mobility, transfers, and toilet use. On 1/9/24, the provider progress note documented that the resident had a history of UTI. UTI: Patient still feels that she has a bladder infection. She is generally not feeling well and has dysuria. She stopped her antibiotics about 4 days ago. The physician's assessment and plan documented, Patient with a UTI, will continue to monitor for now and follow up. We will check a UA and follow up with results. On 1/9/24, resident 36's provider ordered a UA with a culture and sensitivity (C & S). On 1/12/24, resident 36's urinalysis results documented the appearance of the specimen as slightly cloudy, with 1+ bacteria and 1+ mucus in the sample. On 1/12/24, resident 36's urine culture revealed Klebsiella pneumoniae as the infectious organism and it was susceptible to Nitrofurantoin or Macrobid. On 1/15/24 at 8:00 PM, a physician order for Macrobid Oral Capsule 100 milligrams (mg) two times a day for UTI for 5 days was entered for resident 36. Resident 36's Medication Administration Record (MAR) documented the Macrobid 100 mg by mouth two times a day was administered on 1/16/24 through 1/21/24 for a total of 9 doses administered. It should be noted that the medication order was for a total of 10 doses to be administered. On 1/15/24, the evening dose documented to see the progress note. On 1/16/24 at 11:19 PM, the MAR documented that Ceftriaxone Reconstituted 1 gram intramuscular injection, one time only for UTI was administered. Resident 36's progress notes revealed the following: a. On 1/1/24 at 8:06 PM, the note documented, Resident finished last dose of Macrobid for UTI, no ADR [adverse drug reaction] observed or reported. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	b. On 1/9/24 at 2:24 PM, the note documented, Received orders from [name of provider omitted] to do a repeat UA on this pt. [patient] received UA via straight cath per pt request. c. On 1/15/24 at 5:09 PM, the note documented, received orders from [name of provider omitted] to start this pt on macrbid (sic) 100 mg tab [tablet] BID [two times a day] for 5 days. d. On 1/15/24 at 7:43 PM, the progress note documented that the Macrobid had not arrived from the pharmacy. e. On 1/17/24 at 4:43 PM, the note documented, Pt on abx [antibiotic] for UTI. No adverse reactions noted. Pt is more unsteady on feet than at baseline. [NAME] in reach. Pt encouraged to wait for assistance before toileting or ambulating. f. On 1/21/24 at 3:08 PM, the note documented, Resident finished course of Macrobid for UTI. No ADR observed or reported. Fluids encouraged. On 6/04/24 at 2:39 PM, an interview was conducted with Licensed Practical Nurse (LPN) 4. The LPN stated they could get lab results back within a day or two, depending on if it was ordered immediately. The LPN stated that they documented a progress note to show that the lab order was completed, and it could be passed on in report for the next shift to follow up with the results. The LPN stated that the results were faxed to them. The LPN stated that once they reviewed the results they placed the results in the medical records basket to be scanned into the resident chart and notified the provider by the communication app or by telephone. The LPN stated that they would then document that the provider was notified in a progress note. On 6/04/24 at 2:46 PM, an interview was conducted with LPN 1. LPN 1 stated that it usually took 1-2 days to get lab results back. LPN 1 stated that they obtained the lab specimens and entered a progress note that it was completed. LPN 1 stated that it was passed off in report to the next shift. LPN 1 stated that if there were questions about labs they had documentation of when it was sent in the progress notes. LPN 1 stated that they could also call the lab and follow-up on the results. On 6/05/24 at 8:02 AM, an interview was conducted with the Regional Nurse Consultant (RNC). The RNC stated that the nurses should manage all of their patient's lab orders. The RNC stated that when the nurse sent a specimen they should follow-up with the lab for results by the end of the day and if it was ordered stat they should follow-up within a couple of hours. The RNC stated that the nurse should notify the provider immediately if the results were critical, otherwise the result was placed in the provider binder for review. The RNC stated that resident 36 had a lot of UTIs that were escherichia-coli associated. The RNC stated that they provided education with the aides on proper wiping from front to back. The RNC stated that resident 36's UA with C & S was ordered on 1/9/24 and results were obtained on 1/12/24. The RNC stated that the culture showed the organism as Klebsiella. The RNC stated that resident 36 was treated with Macrobid on 1/15/24 and Ceftriaxone on 1/16/24, and that the culture showed it was susceptible to both antibiotics. The RNC stated that it was not an appropriate timeframe for the treatment of the UTI. The RNC stated that treatment was dependent on the results of the culture and sensitivity report. The RNC stated that they had a difficult time getting this provider to respond. The RNC stated that if the nurses were not able to reach resident 36's provider they should call the facility medical director within 24 hours and then notify the Director of Nursing. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	46232

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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 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** 45470 Based on observation, interview, and record review, it was determined, for 2 of 53 sampled residents, the facility failed to ensure that residents who needed respiratory care, including tracheostomy care and tracheal suctioning, was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Specifically, a resident was not provided the necessary equipment to prevent water buildup in their nasal cannula, and a resident's oxygen tubing was not changed weekly. Resident identifiers 36 and 41. Findings Included: 1. Resident 41 was admitted to the facility on [DATE] and again on 4/9/24 with diagnoses which include chronic respiratory failure with hypoxia, functional quadriplegia, obstructive pulmonary disease, neuromuscular dysfunction of bladder, protein-calorie malnutrition, protein-calorie malnutrition, contracture of muscle, rheumatoid arthritis, bed confinement status, urinary tract infection, pyelonephritis, resistance to multiple antibiotics, dependence of supplemental oxygen, acute respiratory failure, anemia in chronic kidney disease, heart failure, major depressive disorder, obstructive sleep apnea, anxiety disorder, insomnia, muscle weakness, and presence of automatic cardiac defibrillator. On 6/4/24 at 12:30 PM, an interview with resident 41 was conducted. Resident 41 stated that she required a water trap for her nasal cannula. Resident 41 stated that the water trap helped to collect excess water so the water would not come out of the nasal cannula and drip down her face or into her nose. Resident 41 stated that sometimes water would drip into her nose and down her throat and caused her to choke. An observation of resident 41's nasal cannula was made. Resident 41 was wearing the nasal cannula and water was observed dripping out of the tubing around resident 41's nostrils. The oxygen tubing did not have a water trap. Resident 41's face appeared wet from the water. On 6/4/24 at 12:33 PM, an interview with resident 41's family member was conducted. Resident 41's family member stated that the family had ordered water traps for resident 41's nasal cannula and the water traps had been delivered to the facility. Resident 41's family member stated that the facility had lost the water traps. Resident 41's family member stated that they had reported the issue to the facility and nothing was done to amend the issue. A form titled Grievance/Complaint Report dated 2/26/24 documented, Lincare brought in a bag of oxygen + [and] CPAP [continuous positive airway pressure] supplies for [resident 41] and gave them to Nurse [name redacted]. 2 days later those items had not made it to [resident 41] and the Nurse said they could not find them anywhere . [Resident 41's family member] would like [Nurse's name redacted] written up for loosing supplies the patient has to pay for. The form was filled out by resident 41's family member and was signed by the administrator on 2/26/24. On 6/5/24 at 3:23 PM, an interview with the Administrator was conducted. The Administrator stated that he believed the facility had the water supplies and was unaware that resident 41 did not currently have the water traps. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/5/24 at 3:45 PM, an interview with the Director of Nursing (DON) was conducted in resident 41's room. The DON stated she was unaware of where the water trap was for resident 41's oxygen tubing. The DON told resident 41 she would work on a solution to the problem. On 6/5/24 at 4:05 PM, an interview with the Assistant Director of Nursing (ADON) 1 was conducted. The ADON 1 stated that she had found the water traps in the supply closet and staff were able to attach a water trap to resident 41's oxygen tubing. 38031 2. Resident 36 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which consisted of chronic obstructive pulmonary disease, polyosteoarthritis, malignant neoplasm of ovary, hyperlipidemia, chronic fatigue, morbid obesity, anxiety disorder, bipolar disorder, idiopathic peripheral autonomic neuropathy, presence of left and right artificial knee joint, insomnia, opioid dependence, and restless leg syndrome. On 6/02/24 at 2:27 PM, an interview was conducted with resident 36. Resident 36's had oxygen running at 2. 5 liters via a nasal cannula (NC). The NC tubing was labeled 5/12. Resident 36 stated that they were supposed to change the oxygen tubing every Sunday, but they did not always do that. On 6/2/24, resident 36's medical records were reviewed. On 3/1/24, resident 36's Minimum Data Set (MDS) assessment documented a Brief Interview for Mental Status score of 14/15, which indicated the resident was cognitively intact. The assessment documented under respiratory treatment that resident 36 required oxygen therapy. On 2/12/24, resident 36 had an order for oxygen per nasal cannula at 1 to 5 liters per minute as needed to maintain oxygen saturations greater than 90%. The order further stated that every Sunday the nasal cannula and oxygen filters on the concentrators were to be changed. The order summary documented the order as discontinued. The order summary revealed that resident 36 did not have any active orders for oxygen therapy. Review of the May 2024 Treatment Administration Record revealed that the oxygen order was not active, and resident 36 did not have any other current oxygen orders. Resident 36's Kardex documented, OXYGEN SETTINGS as ordered. [Resident 36] uses oxygen at night. On 2/9/22, resident 36's care plan for altered respiratory status and difficulty breathing related to chronic obstructive pulmonary disease was initiated. An intervention identified was OXYGEN SETTINGS as ordered. [Resident 36] uses oxygen at night. The intervention was last revised on 12/19/23. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Departmental (Respiratory Therapy) - Prevention of Infection policy documented to obtain the appropriate equipment or supplies necessary for the ordered therapy. The policy further stated that the oxygen cannula and tubing was to be changed every seven days or as needed. The policy stated that the following information should be recorded in the resident's medical record: date and time the respiratory therapy was performed, type of respiratory therapy performed, name and title of individual who performed the respiratory therapy, all assessment data obtained during the treatment, refusal of treatment and reason why, and signature and title of person recording the information. The policy was last updated in January 2024. On 6/05/24 at 10:12 AM, an interview was conducted with Certified Nurse Assistant (CNA) 5. CNA 5 stated on Sunday the CNAs changed the oxygen tubing and the urinals. CNA 5 stated that there was not a specific person responsible for this task and he was not sure if it was documented anywhere. On 6/05/24 at 10:25 AM, an interview was conducted with CNA 6. CNA 6 observed resident 36's oxygen tubing and stated that it was changed on 6/2/24. CNA 6 stated that if the tubing was previously labeled with the date of 5/12 then it was a long time and should have been changed.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38031 Based on interview and record review it was determined, for 1 out of 53 sampled residents, that the facility did not ensure that pain management was provided to residents who required such services, consistent with professional standards of practice, the comprehensive care plan, and the residents' goals and preferences. Specifically, the resident's pain medication was not administered per the physician orders and the resident had complaints of uncontrolled pain. Resident identifier: 50. Findings included: Resident 50 was admitted to the facility on [DATE] with diagnoses which included palliative care, chronic obstructive pulmonary disease, anxiety disorder, viral hepatitis, epilepsy, low back pain, hypertensive heart disease, neuromuscular dysfunction of the bladder, hemiplegia, insomnia, chronic pulmonary embolism, and osteoarthritis. On 6/02/24 at 2:41 PM, an interview was conducted with resident 50. Resident 50 stated that he had pain in his back and he had to wait for his pain medication. Resident 50 stated that when it was given on time the pain was managed and controlled. Resident 50 stated that he had an order for Oxycodone 10 milligrams (mg) that was scheduled every 4 hours and as needed. Resident 50 stated that sometimes the 4:00 AM dose was delayed to 6:00 AM or 7:00 AM. On 6/3/24, resident 50's medical records were reviewed. On 11/1/22, resident 50 had Oxycodone 10 mg every 4 hours for chronic pain ordered. Resident 50's administration time for the Oxycodone 10 mg in May 2024 revealed the following: a. On 5/1/24, the medication was documented as administered at 4:19 AM and 7:26 PM. b. On 5/2/24, the medication was documented as administered at 1:45 AM, 5:06 AM, and 8:01 PM. c. On 5/3/24, the medication was documented as administered at 12:06 AM, 5:07 AM, and 7:27 PM. d. On 5/4/24, the medication was documented as administered at 12:12 AM, 3:52 AM, and 7:39 PM. e. On 5/5/25, the medication was documented as administered at 3:01 AM, 5:04 AM, 8:04 AM, 11:21 AM, 4:01 PM, 7:49 PM, and 11:16 PM. f. On 5/6/24, the medication was documented as administered at 5:06 AM, 7:06 AM, 11:42 AM, 3:23 PM, 7:51 PM and 11:16 PM. g. On 5/7/24, the medication was documented as administered at 4:16 AM, 7:15 AM, 2:25 PM, 4:53 PM, and 7:18 PM. h. On 5/8/24, the medication was documented as administered at 12:08 AM, 4:50 AM, 7:37 AM, 11:37 AM, 4:58 PM and 7:43 PM. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	i. On 5/9/24, the medication was documented as administered at 12:16 AM, 5:34 AM, 7:57 AM, 11:44 AM, 4:16 PM, and 7:23 PM. j. On 5/10/24, the medication was documented as administered at 1:50 AM, 6:04 AM, 8:26 AM, 12:27 PM, and 5:20 PM. Resident 50's May 2024 Medication Administration Record (MAR) documented that the Oxycodone 10 mg was scheduled to be administered at 12:00 AM, 4:00 AM, 8:00 AM, 12:00 PM, 4:00 PM, and 8:00 PM. Resident 50's pain scores on a scale of 0 to 10, with 0 being no pain and 10 being the worst pain possible, were documented as follows: a. On 5/1/24, the pain score was a 6/10 at 10:01 AM, a 4/10 at 11:29 AM, a 5/10 at 7:25 PM, and a 0/10 at 11:44 PM. b. On 5/2/24, the pain score was a 4 at 5:06 AM, a 2/10 at 7:15 AM, and a 4/10 at 7:58 PM. c. On 5/3/24, the pain score was a 4/10 at 5:07 AM, a 1/10 at 4:38 PM, and a 4/10 at 7:26 PM. d. On 5/4/24, the pain score was a 6/10 at 12:11 AM, a 1/10 at 1:45 AM, a 4/10 at 5:49 AM, a 7/10 at 5:45 PM, and a 4/10 at 7:42 PM. e. On 5/5/24, the pain score was a 5/10 at 5:04 AM, a 3/10 at 11:02 AM, and a 3/10 at 7:49 PM. f. On 5/6/24, the pain score was a 8/10 at 9:31 AM, a 4/10 at 11:45 AM, a 3/10 at 7:51 PM, and a 1/10 at 11:54 PM. g. On 5/7/24, the pain score was a 7/10 at 1:53 PM and a 4/10 at 7:19 PM. h. On 5/8/24, the pain score was a 6/10 at 12:11 AM, a 1/10 at 12:51 AM, a 2/10 at 11:20 AM, a 5/10 at 7:41 PM, and a 0/10 at 11:09 PM. i. On 5/9/24, the pain score was a 4/10 at 5:34 AM, a 8/10 at 11:45 AM, a 0/10 at 12:39 PM, a 7/10 at 1:49 PM, a 0/10 at 2:16 PM, and a 4/10 at 7:25 PM. j. On 5/10/24, the pain score was a 4/10 at 6:04 AM, a 3/10 at 7:05 AM, and a 5/10 at 11:38 PM. Resident 50 had a care plan for at risk for pain related to chronic immobility secondary to hemiplegia, back pain, osteoarthritis, and end of life initiated on 11/8/22. The care plan documented an intervention of Anticipate the resident's need for pain relief and respond immediately to any complaints of pain. This intervention was last revised on 11/15/23. Review of the facility policy on Administering Pain Medications defined pain management as the process of alleviating the resident's pain based on his or her clinical condition and established treatment goals. The policy documented Administer pain medications as ordered. If there are signs or symptoms of serious adverse consequences related to narcotic (opioid) analgesics (including somnolence, delirium, respiratory depression), notify the practitioner prior to administering. The policy was last revised in March 2024. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	On 6/06/24 at 8:00 AM, an interview was conducted with Licensed Practical Nurse (LPN) 3. LPN 3 stated that resident 50 had Oxycodone scheduled for administration every 4 hours at 12:00 AM, 4:00 AM, 8:00 AM, 12:00 PM, 4:00 PM, and 8:00 PM. LPN 3 stated that the resident should receive 6 doses of Oxycodone a day. LPN 3 stated that narcotic pain medication should not be administered early and a complication of early administration was overdose. LPN 3 stated that resident 50 also received morphine scheduled and as needed for pain. LPN 3 stated that they monitored the resident for orientation, pain, effectiveness and how alert they were. LPN 3 stated that if the pain medication was scheduled they should be waking the resident to administer it if he was sleeping unless he refused. LPN 3 stated that if the resident refused they would document it in the Medication Administration Record and in a progress notes. On 6/06/24 at 8:29 AM, an interview was conducted with the Regional Nurse Consultant (RNC). The RNC stated that licensed nurses should monitor adverse side effects, and non-pharmacological interventions to pain relief for any as needed (PRN) pain medications. The RNC stated that the licensed nurse should monitor pain scores and side effects of any scheduled pain medications. The RNC stated that for medications that were ordered to be administered every 4 hours the resident should be receiving 6 doses a day. The RNC stated that for narcotic pain medication a potential complication of administering doses too close together was overdose. The RNC stated that PRN narcotics should be administered at least 2 hours apart.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22992 Based on interview, observation and record review it was determined, for 10 out of 53 sampled residents, that the facility did not have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment. Specifically, residents voiced concerns with call light wait times and not receiving assistance with bathing and pain management. In addition, concerns with regard to staffing issues were raised during resident council on repeated occasions. Resident identifiers: 7, 10, 15, 36, 41, 50, 54, 55, 116 and 376. Findings included: 1. Resident council notes were reviewed and revealed the following: a. 1/30/24: . The group said they were frustrated with the CNA's (Certified Nursing Assistants) turning off the call lights. I explained that they can put the call light back on if no one comes in 10 minutes. [Names of two residents] were frustrated that they are being woken up at 5:00 AM and dressed. [Names of two residents] said that night shift and early morning they don't answer call lights. [Name of one resident] said they stop answering call lights at 5:00 AM. A Department Response was provided that Education regarding urgency of lights for all shifts .Discuss [with] res (resident) time get up. b. 2/28/24: The Administrator (ADM) . went over that call lights have been an ongoing issue. He shared with the group that the budget has increased so there will be more staff which should help with call light times. [ADM] went over how residents can help by giving positive feedback and encouragement to staff.[Name of resident] brought up that she things (sic) its wrong that CNA's turn off the call light. [Name of one resident] - call lights have been bad 20 minutes or more. There was no department response listed for the above mentioned issues. c. March 2024 there were no issues documented regarding staffing or call light response times. d. 4/29/24: One resident stated that they (staff) never come. Two residents stated that call lights have been the same. A Department Response was provided and indicated that staff education was again given regarding call light response times. It should be noted that the facility did not provide this education until 5/22/24, approximately 3 weeks later. e. May 2024 was not provided. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/6/24 at 7:40 AM, an interview was conducted with the facility Administrator (ADM). When asked about the resident council concerns, the ADM stated that after the resident council meeting, he would review the meeting minutes. The ADM stated that its usually food. call lights seem to be the popular thing to talk about. The ADM stated that the minutes were reviewed in the facility Quality Assurance Performance Improvement (QAPI) meetings. The ADM stated that staff have also brainstormed to see if staff were scheduled at the appropriate time. The ADM could not provide any additional information as to what steps had been taken to correct the call light response times. 2. On 6/3/24 at 7:35 AM, an interview was conducted with resident 15. Resident 15 stated that he typically waited for 40 minutes for his call light to be answered. Resident 15 stated that even when staff answered his call light, they would come in and ask what he needed, leave, and not return. 30563 3. On 6/3/24 at 9:42 AM, an interview was conducted with resident 7. Resident 7 stated there was not enough CNAs. Resident 7 stated that the facility hired 2 CNAs and then 2 CNAs would would quit. Resident 7 stated it seamed like it was hard for the facility to get enough staff. 4. On 6/2/24 at 3:14 PM, an interview was conducted with resident 376. Resident 376 stated the CNAs were Swamped. Resident 376 stated she would like to move around her room more often but CNAs were too busy to have time to be with her. Resident 376 stated when she pushed her call light it took 20 to 25 minutes for a staff member to answer it and if she was having a heart attack, she would not be able to get anyone into her room. The form titled Facility Assessment Tool dated 12/13/22 revealed the following: Requirement Nursing facilities will conduct, document, and annually review a facility-wide assessment, which includes both their resident population and the resources the facility needs to care for their resident (S483.70(e)). Purpose The purpose of the assessment is to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. Use this assessment to make decisions about your direct care staff needs, as well as your capabilities to provide services to the residents in your facility, at least annually, per the above requirement. Using a competency-based approach focuses on ensuring that each resident is provided care that allows the resident to maintain or attain their highest practicable physical, mental, and psychosocial well-being. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The form titled Facility Assessment Tool revealed it was reviewed by the Administrator, Director of Nursing (DON), Governing Body Representative, Medical Director, and Assistant Director of Nursing and was updated on 6/26/23. The form revealed the facility was licensed to provide care for 124 residents and the average daily census was 70-80. The Admission process including common diagnoses the facility was able to care for was documented. The acuity section revealed the average number of residents with special treatments included 30 for oxygen, 3 for bilevel positive airway pressure (BIPAP)/continuous positive airway pressure (CPAP), 1 for behavioral health needs, 1 for Intravenous (IV) medications, 1 for injections, 1 for dialysis, 1 for ostomy care, 12 for hospice care, and 1 for respite care. The Staffing plan revealed the facility needed 4 licensed nurses to provide direct care, 6-7 Nurses Aides, 1 other nursing personnel, 1 Speech therapist, 1 Activity Manager, 1 Resident Advocate, 1 Registered Dietitian, 1 Dietary Manager, 1 Cook, 2 Dietary Aides, 1 Physical Therapist, 1 Occupational Therapist, and 1 Speech Therapist. The Individual staff assignment section revealed 3.3 Describe how you determine and review individual staff assignments for coordination and continuity of care for residents within and across these staff assignments. Input from direct caregivers, residents, families, IDT [Interdisciplinary Team] and others (surveys, resident council meetings, satisfaction surveys, physicians, and other clinician input). Adverse events (incident reports, medication error reports, laboratory and radiology reports, and consultant reports) performance indicators (QAPI [Quality Assessment and Performance Improvement], Star rating, clinical dashboard) survey findings (2567 and FYI's [for your information]). Complaints/Grievances. (Input by PCP [Primary Care Physician], surveys, council meetings, written comments, feedback from staff and residents.) Staff training was listed on the form. 38031 5. Resident 50 was admitted to the facility on [DATE] with diagnoses which included palliative care, chronic obstructive pulmonary disease, anxiety disorder, viral hepatitis, epilepsy, low back pain, hypertensive heart disease, neuromuscular dysfunction of the bladder, hemiplegia, insomnia, chronic pulmonary embolism, and osteoarthritis. On 6/02/24 at 2:41 PM, an interview was conducted with resident 50. Resident 50 stated that he had pain in his back and he had to wait for his pain medication. Resident 50 stated that when it was given on time the pain was managed and controlled. Resident 50 stated that he had an order for Oxycodone 10 milligrams (mg) that was scheduled every 4 hours and as needed. Resident 50 stated that sometimes the 4:00 AM dose was delayed to 6:00 AM or 7:00 AM. [Cross-refer F697] 6. Resident 36 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which consisted of chronic obstructive pulmonary disease, polyosteoarthritis, malignant neoplasm of ovary, hyperlipidemia, chronic fatigue, morbid obesity, anxiety disorder, bipolar disorder, idiopathic peripheral autonomic neuropathy, presence of left and right artificial knee joint, insomnia, opioid dependence, and restless leg syndrome. On 6/2/24 at 2:09 PM, an interview was conducted with resident 36. Resident 36 stated that her shower schedule was supposed to be Tuesdays and Fridays, but the facility was short staffed. Resident 36 stated that she received a shower yesterday, but she had to insist on the shower yesterday. [Cross-refer F676] (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	43212 7. On 6/3/24 at 8:31 AM, an interview was conducted with resident 55 who stated she has had to wait 30 minutes for staff to answer her call light. Resident 55 stated the daytime hours were when additional staff were needed. 8. On 6/3/24 at 9:08 AM, an interview was conducted with resident 10 who stated the day shift did not have enough staff. Resident 10 stated she had to wait 20 minutes or longer to receive help. 45470 9. On 6/5/24 at 10:17 AM an interview with Certified Nursing Assistant (CNA) 9 was conducted. CNA 9 stated that he was aware of residents who had multiple missed shower days in a row. CNA 9 stated that the facility did not have enough staff to complete all the showers on top of the other daily tasks. CNA 9 stated that resident 41's showers were often missed because she required two CNAs, and resident 41's showers took longer than the average time to complete. CNA 9 stated that when a resident's shower was missed, the task was passed off to the next shift. 10. On 6/5/24 at 4:07 PM an interview with CNA 8 was conducted. CNA 8 stated that each time a resident required a shower, a shower sheet was filled out and turned into the nurse. CNA 8 stated that resident showers were recorded on the resident electronic medical record. CNA 8 stated that if the resident refused a shower, the resident was required to sign the shower sheet. CNA 8 stated that there was not enough time for staff to complete all of the required resident showers. CNA 8 stated that it would be helpful if the facility staffed one or two extra aides who helped with completing resident showers. CNA 8 stated that if the staff did not have enough time to get to a resident's shower or bed bath, the task would be handed over to the next shift. 50200 11. Resident 54 was admitted to the facility on [DATE] with diagnoses which included cervical disc disorder, primary osteoarthritis, type 2 diabetes with neuropathy, hypothyroidism, morbid obesity, weakness, muscle weakness, anxiety, obstructive sleep apnea, hypertension, and a history of falling. On 6/2/24 at 2:33 PM, an interview was conducted with resident 54. Resident 54 stated she did not feel there was enough staff in the facility to care for her. Resident 54 stated that she was incontinent and used a PureWick urinary device because it was easier than waiting for staff to respond to the call light to change her brief. Resident 54 stated it could take over 20 minutes for staff to respond. On 6/4/24 at 3:10 PM, an observation was made with resident 54. Resident 54's call light was on and the green light flashing. It was observed that no staff were in the room with resident 54. On 6/4/24 at 3:16 PM, an observation was made of resident 54 who pushed the call light again. No staff responded to the call light and it was shut off. On 6/4/24 at 3:38 PM, an observation was made of resident 54 who pushed the call light again. Staff responded to the resident's call light at 3:40 PM. Resident 54 had been waiting for staff assistance from 3:10 PM until 3:40 PM. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12. Resident 116 was admitted to the facility on [DATE] with diagnoses which included aftercare following joint replacement therapy, hypertensive chronic kidney disease, type 2 diabetes mellitus, post-polio syndrome, atrial fibrillation, major depressive disorder, obstructive sleep apnea, and cognitive communication deficit. On 6/2/24 at 2:08 PM, an interview was conducted with resident 116. Resident 116 stated that she was often in pain and when she pressed her call light the response time could be in excess of 15 minutes. Resident 116 stated that most of the time she would go out in the hallway to get staff attention because the call light was never answered.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45470 Based on interview and record review it was determined, for 1 out of 53 sampled residents, that the facility did not ensure each resident's drug regimen remained 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 would indicate the dose should be reduced or discontinued. Specifically, a resident's medication was not being monitored and this resulted in the resident being hospitalized . Resident identifier: 41. Findings Included: 1. Resident 41 was admitted to the facility on [DATE] and again on [DATE] with diagnoses which include chronic respiratory failure with hypoxia, functional quadriplegia, obstructive pulmonary disease, neuromuscular dysfunction of bladder, protein-calorie malnutrition, protein-calorie malnutrition, contracture of muscle, rheumatoid arthritis, bed confinement status, urinary tract infection, pyelonephritis, resistance to multiple antibiotics, dependence of supplemental oxygen, acute respiratory failure, anemia in chronic kidney disease, heart failure, major depressive disorder, obstructive sleep apnea, anxiety disorder, insomnia, muscle weakness, and presence of automatic cardiac defibrillator. On [DATE] at 3:40 PM, an interview with resident 41's family member was conducted. Resident 41's family member stated that when resident 41 returned from the hospital on [DATE], resident 41 was taking a medication called linezolid. Resident 41's family member stated that resident 41 was supposed to have blood work done while taking the medication to monitor for acute blood loss. The family member stated that the facility never completed any blood work and resident 41 had to be re-hospitalized due to acute blood loss. The family member stated that resident 41 nearly died in the hospital due to the facilities negligence. The family member stated that resident 41 had to have blood transfusions at the hospital. On [DATE] at 3:45 PM, an interview with resident 41 was conducted. Resident 41 stated that she had to go to the hospital on [DATE] because she had acute blood loss. Resident 41 stated that prior to her hospitalization while taking Linezolid, she had felt fatigued, confused, and had dark stools. Resident 41's electronic medical record was reviewed. Hospital records dated [DATE] documented that resident 41 was admitted to the hospital on [DATE] with a primary diagnosis of sepsis secondary to a urinary tract infection (UTI). The hospital records revealed that resident 41 was discharged from the hospital on [DATE]. Hospital discharge orders from [DATE] were reviewed. Linezolid 600 milligrams (mg) oral tablet was ordered with instructions that stated, 1 tabs (600 mg) Oral BID [twice a day] for 14 days. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A document from the Food and Drug Administration from [DATE] was reviewed. The document included the following, WARNINGS Myelosuppression (including anemia, leukopenia, pancytopenia, and thrombocytopenia) has been reported in patients receiving linezolid. In cases where the outcome is known, when linezolid was discontinued, the affected hematologic parameters have risen toward pretreatment levels. Complete blood counts should be monitored weekly in patients who receive linezolid, particularly in those who receive linezolid for longer than two weeks, those with pre-existing myelosuppression, those receiving concomitant drugs that produce bone marrow suppression, or those with a chronic infection who have received previous or concomitant antibiotic therapy. Discontinuation of therapy with linezolid should be considered in patients who develop or have worsening myelosuppression. A review of resident 41's Medication Administration Records (MAR) revealed that resident 41 was given Linezolid Oral Tablet 600 MG twice a day from [DATE] to [DATE]. It should be noted that the hospital orders for linezolid had instructions that stated, Oral BID for 14 days and resident 41 received the medication for 23 days. Resident 41 received 17 extra doses of linezolid that was not ordered from the hospital discharge orders. A review of resident 41's medical records revealed that there was no documentation of a complete blood count being completed while resident 41 was taking linezolid from [DATE] to [DATE]. A Pharmacy Consultation Report from [DATE] was reviewed. The report documented, CONSIDER HAVING A STOP DATE FOR LINEZOLID. The rationale for the recommendation was documented as, Risk of serious hematologic and neurologic toxicity increases after >2 weeks and >4 weeks of therapy. The physician's response of the Pharmacy Consultation Report was documented as, I accept the recommendations above . Should have 2 weeks total. The physician signed the document on [DATE]. A Nurses Note from [DATE] at 8:40 PM documented, resident co [complains of] feeling dehydrated. bp [blood pressure] ,d+[DATE] hr [heart rate] 97 o2 [oxygen] sat [saturation] 94%. Temp [temperature] wnl [within normal limits]. Primary care physician notified 500ml [milliliter] bolus of normal saline given over one hour as per md [medical director] order instructions. resident tolerated well. will continue to monitor closely. A Nurses Note from [DATE] at 10:35 PM documented, resident continues to c/o [complain of] upset stomach and generalized malaise. bp no ,d+[DATE] hr 117 md notified and resident request to go to ER [emergency room]. MD notified. EMT [emergency medical technician] transferred resident to ER at this time. will continue to monitor closely for updates on condition. family is on phone and aware of transfer. Hospital records from [DATE] documented, .In the emergency room : [NAME] blood cell count was 2.9 with ANC [absolute neutrophil count] at 1200. Platelet count was 18. Hemoglobin was 4.7 . In the emergency room , 2 units of packed red blood cells were ordered and 1 unit of platelets .She was admitted to the hospitalist service for medical management .She presents with 2 days of dark stool in conjunction with low hemoglobin, platelets, and neutrophils. She recently completed a 2-week course of treatment with linezolid. I suspect she has myelosuppression from linezolid leading to thrombocytopenia/anemia and subsequent gastrointestinal bleeding .She will be admitted to the intermediate care unit for careful evaluation . (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 12:01 PM, an interview with the Director of Nursing (DON) was conducted. The DON stated that typically when a resident discharged from the hospital on a medication that required specific monitoring, the hospital would include the monitoring orders in the discharge orders. On [DATE] at 12:11 PM, an interview with the Regional Nurse Consultant (RNC) was conducted. The RNC stated she believed that it was not mandatory to monitor linezolid. The RNC stated that it looked like whoever entered in the order for the medication did not put an end date, and the medication was given until [DATE]. On [DATE] at 4:38 PM, an interview with Assistant Director of Nursing (ADON) 2 was conducted. ADON 2 stated that the physician did not give any orders to monitor resident 41's complete blood count. ADON 2 stated that in the physician's progress notes, the physician wrote, monitor labs, but did not include any orders. ADON 2 stated that the nursing staff would not pull labs without an order. ADON 2 stated that the facility should not have allowed this to happen to resident 41. ADON 2 stated that she was now monitoring every antibiotic in the building and personally reaching out to the physician for orders.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38031 Based on interview and record review it was determined, for 2 of 53 sampled residents, the facility did not ensure that residents who used psychotropic drugs received a gradual dose reduction (GDR) unless clinically contraindicated. Specifically, residents prescribed psychotropic medications did not have a gradual dose reduction attempted nor a clinical contraindication form with a physician rationale. Resident identifiers: 36 and 47. Findings included: 1. Resident 36 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which consisted of chronic obstructive pulmonary disease, polyosteoarthritis, malignant neoplasm of ovary, hyperlipidemia, chronic fatigue, morbid obesity, anxiety disorder, bipolar disorder, idiopathic peripheral autonomic neuropathy, presence of left and right artificial knee joint, insomnia, opioid dependence, and restless leg syndrome. On 6/2/24, resident 36's medical records were reviewed. Resident 36's physician orders revealed the following: a. On 9/13/23, an order for Lithium Carbonate Oral Tablet 300 milligrams (mg), give 300 mg by mouth in the evening for Bipolar disorder was initiated. The order was discontinued. b. On 10/29/23, an order for Lithium Carbonate Oral Tablet 300 milligrams (mg), give 300 mg by mouth one time a day for Bipolar disorder at bedtime was initiated. The order was discontinued. c. On 11/23/23, an order for Lithium Carbonate Oral Tablet 300 milligrams (mg), give 300 mg by mouth one time a day for Bipolar disorder at bedtime was initiated. The order was discontinued. d. On 5/13/24, an order for Lithium Carbonate Oral Tablet 300 milligrams (mg), give 300 mg by mouth one time a day for Bipolar disorder at bedtime was initiated. The order was active. e. On 5/14/24, an order for Lithium Carbonate Oral Capsule 150 mg, give 150 mg by mouth one time a day for Bipolar disorder was initiated. The order was active. f. On 4/16/23, an order for Seroquel Tablet 25 mg, give 25 mg by mouth two times a day for Bipolar was initiated. The order was discontinued. g. On 10/29/23, an order for Seroquel Tablet 25 mg, give 25 mg by mouth two times a day for Bipolar was initiated. The order was discontinued. h. On 11/23/23, an order for Seroquel Tablet 25 mg, give 25 mg by mouth two times a day for Bipolar was initiated. The order was discontinued. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	i. On 5/13/24, an order for Seroquel Tablet 25 mg, give 25 mg by mouth two times a day for Bipolar was initiated. The order was active. j. On 2/13/23, an order for Seroquel Tablet 200 mg, give one tablet by mouth one time a day for Bipolar at bedtime was initiated. The order was discontinued. k. On 5/21/23, an order for Seroquel Tablet 200 mg, give one tablet by mouth one time a day for Bipolar at bedtime was initiated. The order was discontinued. l. On 11/23/23, an order for Seroquel Tablet 200 mg, give one tablet by mouth one time a day for Bipolar at bedtime was initiated. The order was discontinued. m. On 5/13/24, an order for Seroquel Tablet 200 mg, give one tablet by mouth one time a day for Bipolar at bedtime was initiated. The order was active. Resident 36's Psychotropic Medication Monthly Review revealed the following: a. On 5/21/24, resident 36's Psychotropic Medication Monthly Review documented that the Lithium 300 mg GDR was clinically contraindicated and supportive documentation by the physician was on 4/22/24. On 4/17/24, resident 36's Psychotropic Medication Monthly Review documented that a GDR was due with 0 episodes of depression in April 2024 and the Interdisciplinary Team (IDT) determined that the resident continue with the current treatment. No documentation of a GDR attempt or a clinically contraindication for a GDR was found. On 4/22/24, resident 36's Clinically Contraindicated GDR and Duplicative Medication form had check marks next to GDR contraindicated and duplicative therapy necessary. No documentation was provided for a rationale for the clinical contraindication for the GDR or the duplicative therapy. b. On 5/21/24, resident 36's Psychotropic Medication Monthly Review documented that the Lithium 150 mg GDR was clinically contraindicated and supportive documentation was on 4/22/24. On 4/17/24, resident 36's Psychotropic Medication Monthly Review documented that a GDR was due with 0 episodes of depression in April 2024 and the IDT determined that the resident continue with current treatment. No documentation of a GDR attempt or a clinically contraindication for a GDR was found. On 4/22/24, resident 36's Clinically Contraindicated GDR and Duplicative Medication form had check marks next to GDR contraindicated and duplicative therapy necessary. No documentation was provided for a rationale for the clinical contraindication for the GDR or the duplicative therapy. On 5/30/24, resident 36's Clinically Contraindicated GDR and Duplicative Medication form had check marks next to duplicative therapy necessary for the Lithium and Seroquel. No documentation was provided for a rationale for the clinical contraindication for the GDR or the duplicative therapy. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/05/24 at 8:02 AM, an interview was conducted with the Regional Nurse Consultant (RNC). The RNC stated that she obtained the Medication Monthly Review from the previous Director of Nursing's email and she would look for the physician response. The RNC confirmed that the GDR for the Lithium was not completed by the provider and did not contain a rationale for contraindication and duplicate therapy. 43212 2. Resident 47 was admitted to the facility initially on 4/2/23, and was readmitted on [DATE] with diagnoses that included hemiplegia and hemiparesis, dementia without behavioral, psychotic, mood and anxiety disturbance, type 2 diabetes, bipolar disorder, panic disorder, major depressive disorder, and history of falling. Resident 47's medical records were reviewed between 6/2/24 and 6/6/24. A annual Minimum Data Set (MDS) dated [DATE] revealed that resident 47 had a Brief Interview for Mental Status (BIMS) of 13, indicating resident 47 was cognitively intact. The MDS also revealed that resident 47 did not exhibit any negative behaviors. Additionally, the MDS revealed there had been no Gradual Dose Reductions (GDR) attempted and the physician had not documented that a GDR was clinically contraindicated. On 4/2/23, a physician order documented, Risperidone Oral Tablet 0.25 MG [milligram]; Give 1 tablet by mouth two times a day for irritability. On 4/10/23, a physician order documented, Risperidone Oral Tablet 0.25 MG; Give 1 tablet by mouth two times a day related to bipolar II disorder. On 4/26/23, a physician order documented, Risperidone Oral Tablet 0.25 MG; Give 1 tablet by mouth two times a day related to bipolar II disorder. On 7/5/23, a physician order documented, Risperidone Oral Tablet 0.25 MG; Give 1 tablet by mouth two times a day related to bipolar II disorder. On 5/13/24, a physician order documented, Risperidone Oral Tablet 0.25 MG; Give 1 tablet by mouth two times a day related to bipolar II disorder. On 4/2/23, a physician order documented, Escitalopram Oxalate Oral Tablet 10 MG; Give 1 tablet by mouth one time a day for depression. On 4/26/23, a physician order documented, Escitalopram Oxalate Oral Tablet 10 MG; Give 1 tablet by mouth one time a day for depression. On 7/5/23, a physician order documented, Escitalopram Oxalate Oral Tablet 10 MG; Give 1 tablet by mouth one time a day for depression. On 5/13/24, a physician order documented, Escitalopram Oxalate Oral Tablet 10 MG; Give 1 tablet by mouth one time a day for depression. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A care plan care area initiated on 4/5/23 revealed, [Resident's name removed] uses psychotropic medications r/t [related to] bipolar II, panic disorder, depression. The goal was, [Resident's name removed] will be/remain free of psychotropic drug related complications, including movement disorder, discomfort, hypotension, gait disturbance, constipation/impaction or cognitive/behavioral impairment through review date. Interventions included, Administer psychotropic medications as ordered by physician. Monitor for side effects and effectiveness Q [every]-shift; Consult with pharmacy, MD [medical doctor] to consider dosage reduction when clinically appropriate at least quarterly; Monitor PRN [as needed] any adverse reactions of psychotropic medications: unsteady gait, tardive dyskinesia, EPS [extrapyramidal side effects](shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps, nausea, vomiting, behavior symptoms not usual to the person. On 2/21/24 at 9:56 AM, a psychotropic progress note revealed, Reviewed pts [patients] Escitalopram, Risperidone, and Trazodone. IDT recommendation for CC [clinically contraindicated] form or dose reduction for Escitalopram, Risperidone, no changes recommended for Trazodone. Pt to be reviewed in 30 days. On 4/19/24 at 1:29 PM, a psychotropic progress note revealed, Psychotropic IDT meeting: request sent via fax to [physician's name removed] for GDR or election of clinically contraindicated forms for Escitalopram, Risperidone, trazodone and melatonin doses. Previously sent fax requests have not returned. Will continue to contact that office for response. Review in 30 days. On 5/22/24 at 4:36 PM, a psychotropic progress note revealed, Psychotropic IDT meeting: request sent via fax to [physician's name removed] for GDR or election of clinically contraindicated form for duplicative therapy of sedative/hypnotic medications. Review in 90 days. An MD communication form dated 4/19/24 revealed, CONCERN; Psychotropic IDT [interdisciplinary Team] review meeting for the above name pt was held on 4/17/24. Attached forms are forms requiring your review. Facility Medical Director and Pharmacist recommended a GDR or Clinically Contraindicated forms. In staying in compliance with CMS [Centers for Medicare and Medicaid Services] please review, sign and return forms within 72 hrs [hours] of receipt. Thank you. Also attached are forms from 12/23, 1/24, 2/24, 3/24, & 4/24. Included on the form was medication information for Trazodone 100 mg QD [every day], Risperidone 0.25 mg, Escitalopram 10 MG QD .Notifications of review with responsible party .Gradual Dose Reduction, Tracking with behavior symptoms, IDT determination, Next review date, and physician review section and signature. It should be noted that the physicians signature for the dates reviewed was not obtained until 5/2/24. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/6/24 at 8:46 AM, an interview was conducted with the Assistant Director of Nursing (ADON) 1 who stated she had sent the psychotropic forms over for physician to sign and he thought there was too much paperwork to sign. The ADON 1 stated the physician had asked the facility to stop sending over the requests for signatures. The ADON 1 stated the facility medical director, medical assistant, pharmacist, resident advocate and ADON 1 participated in the psychotropic medication meetings. The ADON 1 stated the corporate staff asked her to talk with the resident's family and see if resident 47 could change primary care physicians, however, the family did not want to make that change. The ADON 1 stated the Director of Nursing (DON) went to the physicians office and obtained the requested signatures on 5/2/24.

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45470 Based on interview and record review, the facility did not ensure, for 3 of 53 sampled residents, were free of significant medication errors. Specifically, a resident was given linezolid for more days than what was ordered by the hospital, narcotics were given outside of physician ordered parameters, and lorazepam was given more often than what was ordered. Resident identifiers: 41, 50, and 372. Findings Included: 1. Resident 41 was admitted to the facility on [DATE] and again on 4/9/24 with diagnoses which include chronic respiratory failure with hypoxia, functional quadriplegia, obstructive pulmonary disease, neuromuscular dysfunction of bladder, protein-calorie malnutrition, protein-calorie malnutrition, contracture of muscle, rheumatoid arthritis, bed confinement status, urinary tract infection, pyelonephritis, resistance to multiple antibiotics, dependence of supplemental oxygen, acute respiratory failure, anemia in chronic kidney disease, heart failure, major depressive disorder, obstructive sleep apnea, anxiety disorder, insomnia, muscle weakness, and presence of automatic cardiac defibrillator. On 6/2/24 at 3:45 PM, an interview with resident 41 was conducted. Resident 41 stated that she had to go to the hospital on 4/1/24 because she had acute blood loss. Resident 41 stated that prior to her hospitalization while taking Linezolid, she had felt fatigued, confused, and had dark stools. Resident 41 stated that her hair had fallen out due to the acute blood loss. Resident 41's electronic medical record was reviewed. Hospital records dated 3/1/24 documented that resident 41 was admitted to the hospital on 3/1/24 with a primary diagnosis of sepsis secondary to a urinary tract infection (UTI). The hospital records revealed that resident 41 was discharged from the hospital on 3/9/24. Hospital discharge orders from 3/9/24 were reviewed. Linezolid 600 milligrams (mg) oral tablet was ordered with instructions that stated, 1 tabs (600 mg) Oral BID [twice a day] for 14 days. A review of resident 41's Medication Administration Records (MAR) revealed that resident 41 was given Linezolid Oral Tablet 600 MG twice a day from 3/9/24 to 4/1/24. It should be noted that the hospital orders for linezolid had instructions that stated, Oral BID for 14 days and the resident 41 received the medication for 23 days. Resident 41 received 17 extra doses of linezolid that were not ordered from the hospital discharge orders. A Nurses Note from 4/1/24 at 8:40 PM documented, resident co [complains of] feeling dehydrated. bp [blood pressure] 95/57 hr [heart rate] 97 o2 [oxygen] sat [saturation] 94%. Temp [temperature] wnl [within normal limits]. Primary care physician notified 500ml [milliliter] bolus of normal saline given over one hour as per md [medical director] order instructions. resident tolerated well. will continue to monitor closely. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	A Nurses Note from 4/1/24 at 10:35 PM documented, resident continues to c/o upset stomach and generalized malaise. bp no 85/45 hr 117 md notified and resident request to go to ER [emergency room]. MD notified. EMT [emergency medical technician] transferred resident to ER at this time. will continue to monitor closely for updates on condition. family is on phone and aware of transfer. Hospital records from 4/2/24 documented, .In the emergency room : [NAME] blood cell count was 2.9 with ANC [absolute neutrophil count] at 1200. Platelet count was 18. Hemoglobin was 4.7 . In the emergency room , 2 units of packed red blood cells were ordered and 1 unit of platelets .She was admitted to the hospitalist service for medical management .She presents with 2 days of dark stool in conjunction with low hemoglobin, platelets, and neutrophils. She recently completed a 2-week course of treatment with linezolid. I suspect she has myelosuppression from linezolid leading to thrombocytopenia/anemia and subsequent gastrointestinal bleeding .She will be admitted to the intermediate care unit for careful evaluation . On 6/5/24 at 12:11 PM, an interview with the Regional Nurse Consultant (RNC) was conducted. The RNC stated that it looked like whoever entered the order for the medication did not put an end date, and the medication was given until 4/1/23. 30563 2. Resident 372 was admitted to the facility on [DATE] and readmitted on [DATE] and discharged on [DATE] with diagnoses which included palliative care, chronic respiratory failure, diastolic heart failure, obesity, and respiratory failure. Resident 372's medical record was reviewed 6/2/24 through 6/6/24. A Physician's Visit for follow up after a hospitalization dated 5/5/23 revealed no orders for Lorazepam. A hospice History and Physical dated 6/7/23 revealed no orders for Lorazepam. A hospice physician's order dated 6/12/23 revealed emergency kit as directed Lorazepam 2 mg/milliliters (ml) 0.5 ml by mouth (PO)/sublingual (SL) every 4 hours for anxiety as needed (PRN). A nursing progress note dated 9/20/23 at 9:09 AM revealed, Pt [patient] is requesting Lorazepam be scheduled. Called an (sic) notified hospice about patient's request. They stated to go ahead and have it scheduled. Scheduled for 6 times a day 4hrs [hours] apart and PRN q [every] 4 if needed during hours of sleep. Pt has been notified of change and state that she was happy cause she doesn't have to remember to ask the nurse to bring it in. A physician's order dated 9/21/23 and discontinued on 9/26/23 revealed Lorazepam Oral Concentrate 2 MG/ML (Lorazepam) Give 0.5 ml by mouth every 4 hours for anxiety, nausea, hold for sedition Do not wake up to give medication. A nursing progress note dated 9/26/23 at 12:31 PM revealed, Hospice nurse [name removed] came in to see patient today, gave verbal orders to update medication. Lorazepam TID [three times a day] and Bisacodyl 5mg BID [twice daily]. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	A Hospice physician's order dated 9/20/23 and signed by a facility nurse on 9/26/23 revealed Lorazepam 2 MG/ml give 0.5ml TID for anxiety. Hold for excessive sedation. A physician's order dated 9/26/23 and discontinued on 10/4/23 revealed, Lorazepam Oral Concentrate 2 MG/ML (Lorazepam) Give 0.5 ml by mouth three times a day for anxiety, nausea, hold for sedition Do not wake up to give medication. A hospice order dated 10/4/23 revealed resident was to have Lorazepam scheduled TID discontinued and schedule Lorazepam 2MG/ml concentrate take 0.5 ml by mouth at bedtime. A physician's order dated 10/4/23 and discontinued 10/17/23 revealed Lorazepam Oral Concentrate 2 MG/ML (Lorazepam) Give 0.5 ml by mouth every 4 hours as needed for anxiety, nausea, hold for sedation. On 6/5/24 at 9:21 AM, an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated staff coordinated with a hospice nurse and team by contacting the hospice agency or nurse directly. LPN 1 stated the hospice nurse evaluated residents weekly and brought signed orders by the hospice physician. LPN 1 stated hospice provided all the supplies, medications, and refills if needed. LPN 1 stated if there was a narcotic, the order was sent to the pharmacy directly. LPN 1 stated the hospice nurse provided a paper copy of the physician's order to the nurse or was faxed to the facility. On 6/5/24 at 9:40 AM, an interview was conducted with the Director of Nursing (DON) and Regional Nurse Consultant (RNC). The RNC stated the hospice nurse faxed physician's orders or provided a verbal physician's orders to nurses. The RNC stated the physician orders were faxed to the pharmacy to get the medication filled. The RNC stated Lorazepam medication would require a written physician order. On 6/6/24 at 9:11 AM, a follow-up interview was conducted with the RNC. The RNC stated the orders were entered into the electronic medical record wrong. The RNC stated physician's orders should have been for three times a day from 9/20/23 through 9/26/23. The RNC stated the Lorazepam order should not have been scheduled for every 4 hours. 38031 3. Resident 50 was admitted to the facility on [DATE] with diagnoses which included palliative care, chronic obstructive pulmonary disease, anxiety disorder, viral hepatitis, epilepsy, low back pain, hypertensive heart disease, neuromuscular dysfunction of the bladder, hemiplegia, insomnia, chronic pulmonary embolism, and osteoarthritis. On 6/02/24 at 2:41 PM, an interview was conducted with resident 50. Resident 50 stated that he had pain in his back and he had to wait for his pain medication. Resident 50 stated that when it was given on time the pain was managed and controlled. Resident 50 stated that he had an order for Oxycodone 10 milligrams (mg) that was scheduled every 4 hours and as needed. Resident 50 stated that sometimes the 4:00 AM dose was delayed to 6:00 AM or 7:00 AM. On 6/3/24, resident 50's medical records were reviewed. On 11/1/22, resident 50 had Oxycodone 10 mg every 4 hours for chronic pain ordered. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Resident 50's administration time for the Oxycodone 10 mg in May 2024 revealed the following: a. On 5/5/25, the medication was documented as administered at 3:01 AM, 5:04 AM, 8:04 AM, and 11:21 AM. It should be noted that the medication was administered early and not at the every four hour interval as ordered by the physician. b. On 5/6/24, the medication was documented as administered at 5:06 AM and 7:06 AM. It should be noted that the medication was administered early and not at the every four hour interval as ordered by the physician. c. On 5/7/24, the medication was documented as administered at 4:16 AM, 7:15 AM, 2:25 PM, 4:53 PM, and 7:18 PM. It should be noted that the medication was administered early and not at the every four hour interval as ordered by the physician. d. On 5/8/24, the medication was documented as administered at 4:50 AM, 7:37 AM, 4:58 PM and 7:43 PM. It should be noted that the medication was administered early and not at the every four hour interval as ordered by the physician. e. On 5/9/24, the medication was documented as administered at 5:34 AM, 7:57 AM, 11:44 AM, 4:16 PM, and 7:23 PM. It should be noted that the medication was administered early and not at the every four hour interval as ordered by the physician. d. On 5/10/24, the medication was documented as administered at 6:04 AM and 8:26 AM. It should be noted that the medication was administered early and not at the every four hour interval as ordered by the physician. Resident 50's May 2024 Medication Administration Record (MAR) documented that the Oxycodone 10 mg was scheduled to be administered at 12:00 AM, 4:00 AM, 8:00 AM, 12:00 PM, 4:00 PM, and 8:00 PM. Review of the facility policy on Administering Pain Medications defined pain management as the process of alleviating the resident's pain based on his or her clinical condition and established treatment goals. The policy documented Administer pain medications as ordered. If there are signs or symptoms of serious adverse consequences related to narcotic (opioid) analgesics (including somnolence, delirium, respiratory depression), notify the practitioner prior to administering. The policy was last revised in March 2024. On 6/06/24 at 8:00 AM, an interview was conducted with Licensed Practical Nurse (LPN) 3. LPN 3 stated that resident 50 had Oxycodone scheduled for administration every 4 hours at 12:00 AM, 4:00 AM, 8:00 AM, 12:00 PM, 4:00 PM, and 8:00 PM. LPN 3 stated that the resident should receive 6 doses of Oxycodone a day. LPN 3 stated that narcotic pain medication should not be administered early and a complication of early administration was overdose. LPN 3 stated that resident 50 also received morphine scheduled and as needed for pain. LPN 3 stated that they monitored the resident for orientation, pain, effectiveness and how alert they were. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	On 6/06/24 at 8:29 AM, an interview was conducted with the Regional Nurse Consultant (RNC). The RNC stated that for medications that were ordered to be administered every 4 hours the resident should be receiving 6 doses a day. The RNC stated that for narcotic pain medication a potential complication of administering doses too close together was overdose. The RNC stated that PRN narcotics should be administered at least 2 hours apart. [Cross-refer F697]

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46232 Based on observation, interview and record review it was determined that the facility did not ensure that all drugs and biological's were labeled in accordance with currently accepted professional principles, were stored under proper temperature controls, and included the expiration date when applicable. Specifically, fentanyl patches were not disposed of properly and discontinued eye drops were available for use in a resident room. Resident identifiers: 5, 41, 42, and 43. Finding Included: 1. Resident 5 was initially admitted to the facility on [DATE] and readmitted on [DATE] with the diagnoses of encounter for palliative care, type 2 diabetes mellitus with diabetic neuropathy, venous insufficiency, hypertensive heart disease with heart failure, chronic respiratory failure with hypoxia, unspecified dementia and Alzheimer's disease. On [DATE] at 11:44 AM, an observation was made of resident 5 in their room. Resident 5 was brought back to their room by the Licensed Practical Nurse (LPN) 4 and Regional Nurse Consultant (RNC). The RNC and LPN 4 informed resident 5 they needed to look at their back. The RNC and LPN 4 helped lean resident 5 in the chair and pulled their shirt up. Resident 5's back was observed, and no fentanyl patch was located on their back. Resident 5's medical record was reviewed on [DATE] to [DATE]. On [DATE], a Quarterly Minimum Data Set (MDS) documented resident 5 had a Brief Interview for Mental Status (BIMS) score of 1 which indicated severe cognitive impairment. Resident 5's physician orders were reviewed and documented the following fentanyl patch orders: a. An order with a start date of [DATE] documented, Fentanyl- Remove Fentanyl Patch - Co-signature With Another Nurse Upon Narcotic Destruction (q [every] 3days). every 72 hours. b. An order with a start date of [DATE] documented, Check fentanyl patch placement. every shift for pain. c. A physician order with a start date of [DATE] documented, FentaNYL Patch 72 Hour 75 MCG [micrograms]/HR. [hour] Apply 1 patch transdermally every 72 hours for pain and remove per schedule. Resident 5's progress notes were reviewed from [DATE] to June of 2024 and documented the following notes for resident 5's fentanyl patch: a. On [DATE] at 10:57 PM, a nurse note documented, [name and hospice name removed] will be coming [DATE] at the facility to give a written order from MD [medical doctor] per RN [registered nurse] [name removed]. She reported having a new order for Fentanyl Will clarify the orders resident had before before [sic] giving a new orders. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. On [DATE] at 2:58 PM, an orders administration note documented, Fentanyl- Remove Fentanyl Patch - Co-signature With Another Nurse Upon Narcotic Destruction (q3days). every 72 hours. first patch placed today ,d+[DATE]. c. On [DATE] at 5:44 PM, an orders administration note documented, fentaNYL Transdermal Patch 72 Hour 50 MCG/HR. Apply 1 patch transdermally every 72 hours for pain and remove per schedule. unable to find; confirmed with second nurse. d. On [DATE] at 5:46 PM, an orders administration note documented, Check fentanyl patch placement every shift for pain. old patch not located. e. On [DATE] at 12:24 PM, an orders administration note documented, Check fentanyl patch placement every shift for pain. no patch on resident. f. On [DATE] at 2:51 PM, an orders administration note documented, fentaNYL Transdermal Patch 72 Hour 50 MCG/HR. Apply 1 patch transdermally every 72 hours for pain and remove per schedule. Old patch not present. g. On [DATE] at 3:56 PM, an orders administration note documented, Fentanyl- Remove Fentanyl Patch - Co-signature With Another Nurse Upon Narcotic Destruction (q3days). every 72 hours. No patch present. h. On [DATE] at 3:04 PM, an orders administration note documented, Check fentanyl patch placement. every shift for pain. no patch noted. i. On [DATE] at 2:12 PM, an orders administration note documented, Fentanyl- Remove Fentanyl Patch - Co-signature With Another Nurse Upon Narcotic Destruction (q3days). every 72 hours. not on resident. j. On [DATE] at 4:13 PM, an orders administration note documented, FentaNYL Patch 72 Hour 75 MCG/HR. Apply 1 patch transdermally every 72 hours for pain and remove per schedule. not on resident. k. On [DATE] at 1:16 PM, an orders administration note documented, Fentanyl- Remove Fentanyl Patch - Co-signature With Another Nurse Upon Narcotic Destruction (q3days). every 72 hours. old patch was not found. l. On [DATE] at 6:05 PM, an orders administration note documented, Check fentanyl patch placement every shift for pain. fentanyl patch not found. m. On [DATE] at 2:59 PM, an order administration note documented, Check fentanyl patch placement every shift for pain. not on resident. It should be noted there was no documentation located to indicate the missing fentanyl patches had been recovered and disposed of. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 11:09 AM, an interview was conducted with Certified Nurse Assistant (CNA) 7. CNA 7 stated resident 5's patch came off when they had cleaned her. CNA 7 stated they had it aside and put it in the trash can. CNA 7 stated they had informed the nurse, but they didn't have a chance to notify other staff. CNA 7 stated the trash had just been thrown away. CNA 7 stated they were unsure how medications were disposed of since they did not deal with medications. On [DATE] at 11:32 AM, an interview was conducted with the RNC. The RNC stated the Minimum Data Set Coordinator (MDSC) had just thrown resident 5's trash away and they were not aware a medication patch had been discard of in there. The RNC stated they were going to inform the MDSC to look for the trash bag in the dumpster and to have them locate the patch. 2. Resident 42 was admitted to the facility on [DATE] with the following diagnoses of Delirium, unspecified dementia, moderate, with psychotic disturbance, anxiety disorders, cognitive communication deficit, and major depressive disorder. Resident 42's medical records were reviewed on [DATE] to [DATE]. On [DATE], a Quarterly BIMS assessment was done and documented resident 42 had severe cognitive impairment. Resident 5's physician orders were reviewed and documented the following fentanyl patch orders: a. An order with a start date of [DATE] and end date of [DATE] documented, Fentanyl- Check Placement Of Fentanyl Patch Every Shift. every shift. b. An order with a start date of [DATE] and end date of [DATE] documented the following, Fentanyl- Remove Fentanyl Patch & Provide To DON [Director of Nursing]/RN Designee For Narcotic Destruction (q3days) one time a day every 3 day(s). c. An order with a start date of [DATE] and end date of [DATE] documented, fentanyl Transdermal Patch 72 Hour 12 MCG/HR. **DAW [Dispense as written]** Apply 1 patch transdermally in the evening every 3 day(s) for Pain. d. An order with a start date of [DATE] and end date of [DATE] documented, fentanyl Transdermal Patch 72 Hour 12 MCG/HR. **DAW** Apply 2 patch transdermally in the evening every 3 day(s) for Pain. e. An order with a start date of [DATE] and end date of [DATE] documented, Fentanyl- Remove Fentanyl Patch & Provide To DON/RN Designee For Narcotic Destruction (q3days) one time a day every 3 day(s). f. An order with a start date of [DATE] and end date of [DATE], documented, fentanyl Transdermal Patch 72 Hour 12 MCG/HR. **DAW** Apply 2 patch transdermally in the evening every 3 day(s) for Pain. Resident 42's progress notes were reviewed from [DATE] to [DATE] and documented the following notes for resident 42's fentanyl patch: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. On [DATE] at 8:42 PM, a late entry nurse note stated, SN [skilled/staff nurse] had been looking through out the day to see if a Fentanyl patch had been placed, could not find one, and placed a new one. It may be that behaviors could be from pain as we do not know how long she has been with out this pain medication. b. On [DATE] at 10:54 AM, an orders- administration note documented, Fentanyl- Check Placement Of Fentanyl Patch Every Shift.every shift. unable to find; verified by 2 nurses. c. On [DATE] at 6:31 PM, an orders- administration note documented, Fentanyl- Check Placement Of Fentanyl Patch Every Shift. every shift. fentanyl patch not noted on patient since ,d+[DATE]. No new one placed. d. On [DATE] at 1:24 PM, an orders-administration note documented, Fentanyl- Check Placement Of Fentanyl Patch Every Shift. every shift. not on pt. e. On [DATE] at 2:53 PM, an orders- administration note documented, Fentanyl- Remove Fentanyl Patch & Provide To DON/RN Designee For Narcotic Destruction (q3days) one time a day every 3 day(s). no fentanyl patch present; placing new one. f. On [DATE] at 2:11 PM, an orders- administration note documented, Fentanyl- Remove Fentanyl Patch & Provide To DON/RN Designee For Narcotic Destruction (q3days) one time a day every 3 day(s). not on resident. g. On [DATE] at 2:11 PM, an orders- administration note documented, Fentanyl- Check Placement Of Fentanyl Patch Every Shift every shift. not on resident. h. On [DATE] at 4:06 PM, an orders- administration note documented, Fentanyl- Remove Fentanyl Patch & Provide To DON [Director of Nursing]/RN [Registered Nurse] Designee For Narcotic Destruction (q3days). one time a day every 3 day(s). Fentanyl patch not found. i. On [DATE] at 4:47 PM, a Nurse Practitioner note documented, .She has been having a hard time getting pain relief. She tears of her pain patches, so they are not working. We went back to pill for to try and help her . j. On [DATE] at 1:47 PM, an orders- administration note documented, fentaNYL Transdermal Patch 72 Hour 12MCG/HR**DAW** Apply 2 patch transdermally in the evening every 3 day(s) for Pain. Dr. [doctor] discontinued these patches due to resident continually removing them. It should be noted there was no documentation located to indicate the missing fentanyl patches had been recovered and disposed of. 3. Resident 43 was admitted to the facility on [DATE] with diagnoses that included dementia, chronic obstructive pulmonary disease, hypothyroidism, muscle wasting, adult failure to thrive, nicotine dependence, and osteoarthritis. Resident 43's medical records were reviewed. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE], a Quarterly BIMS assessment documented resident 43 had a score of 0 which indicated severe cognitive impairment. Resident 43's physician orders were reviewed and documented the following fentanyl patch orders: a. An order with a start date of [DATE] and end date of [DATE] documented, FentaNYL Patch 72 Hour 75 MCG/HR. Apply 1 patch transdermally every 72 hours for pain and remove per schedule. b. An order with a start date of [DATE] and end date of [DATE] documented, Fentanyl- Check Placement Of Fentanyl Patch Every Shift. c. An order with a start date of [DATE] and end date of [DATE] documented, Fentanyl- Remove Fentanyl Patch - Co-signature With Another Nurse Upon Narcotic Destruction (q3days) one time a day every 3 day(s). Resident 43's progress notes were reviewed from [DATE] to [DATE] and documented the following notes for resident 42's fentanyl patch: a. On [DATE] at 6:04 PM, an Administration Note documented, Fentanyl- Remove Fentanyl Patch - Co-signature With Another Nurse Upon Narcotic Destruction (q3days). one time a day every 3 day(s). CNA and I both searched her back and found no prior fentanyl patch. b. On [DATE] at 7:49 PM, an Administration Note documented, Fentanyl- Check Placement Of Fentanyl Patch Every Shift. every shift. Patch is not on Resident. c. On [DATE] at 12:07 PM, an Administration Note documented, FentaNYL Patch 72 Hour 12 MCG/HR. Apply 1 patch transdermally every 72 hours for pain and remove per schedule. fentanyl patch not found on pt. another one was placed. d. On [DATE] at 7:53 PM, an Administration Note documented, Fentanyl- Check Placement Of Fentanyl Patch Every Shift. every shift. Patch is not in place. e. On [DATE] at 1:56 PM, an Administration Note documented, Fentanyl- Check Placement Of Fentanyl Patch Every Shift. every shift. unable to find patch. f. On [DATE] at 8:56 AM, an Administration Note documented, Fentanyl- Remove Fentanyl Patch - Co-signature With Another Nurse Upon Narcotic Destruction (q3days). one time a day every 3 day(s). No patch located on patient. g. On [DATE] at 7:12 PM, an Administration Note documented, FentaNYL Patch 72 Hour 12 MCG/HR Apply 1 patch transdermally every 72 hours for pain and remove per schedule .could not find patch anywhere on residents body. h. On [DATE] at 9:14 AM, an Administration Note documented, Fentanyl- Remove Fentanyl Patch & Provide To DON/RN Designee For Narcotic Destruction (q3days) one time a day every 3 day(s). Patch was not on resident and was not found. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	i. On [DATE]/24 at 9:20 PM, an Administration Note documented, Fentanyl- Check Placement Of Fentanyl Patch Every Shift .Fentanyl patch is missing. j. On [DATE] at 4:08 PM, an Administration Note documented, Fentanyl- Remove Fentanyl Patch & Provide To DON/RN Designee For Narcotic Destruction (q3days). one time a day every 3 day(s). no patch noted. Verified by 2 nurses. k. On [DATE] at 3:58 PM, an Administration Note documented, Fentanyl- Remove Fentanyl Patch & Provide To DON/RN Designee For Narcotic Destruction (q3days) one time a day every 3 day(s). Fentanyl patch was not found on Resident or anywhere in her room. l. On [DATE] at 6:53 PM, an Administration Note documented, .We were not able to find if her Fentanyl patch was still in place. The oncoming evening nurse acknowledged this and will attempt to check for it. m. On [DATE] at 12:04 PM, an Administration Note documented, FentaNYL Patch 72 Hour 12 MCG/HR. Apply 1 patch transdermally every 72 hours for pain and remove per schedule. no patch on pt. n. On [DATE] at 10:48 PM, an Administration Note documented, Fentanyl- Check Placement Of Fentanyl Patch Every Shift. every shift. not present on resident. o. On [DATE] at 2:26 PM, an Administration Note documented, FentaNYL Patch 72 Hour 12 MCG/HR. Apply 1 patch transdermally every 72 hours for pain and remove per schedule. not on resident. p. On [DATE] at 2:01 PM, an Administration Note documented, FentaNYL Patch 72 Hour 12 MCG/HR Apply 1 patch transdermally every 72 hours for pain and remove per schedule. No patch found. Nurse manager notified. It should be noted there was no documentation located to indicate the missing fentanyl patches had been recovered and disposed of. On [DATE] at 10:24 AM, an interview was conducted with Registered Nurse (RN) 2. RN 2 stated they had three different types of narcotics which included pills, patches, and liquid medications. RN 2 stated they followed the physician's orders with all medications. RN 2 stated with narcotics, nurses needed to sign them out to make sure they had been given correctly and following the protocol. RN 2 stated a fentanyl patch was considered a narcotic and it needed to be monitored daily if it was placed. RN 2 stated the fentanyl patch needed to be replaced every 3 days. RN 2 stated two nurses were needed to waste the old fentanyl patch. RN 2 stated the other nurse needed to co-sign and served as a witness that the old patch had been removed. RN 2 stated they notified the physician if it was noticed the fentanyl patch had been missing. RN 2 stated they asked the physician if they needed to replace the patch and adjust the timing of the order. RN 2 stated fentanyl patches were placed on a residents upper body if they were alert and oriented. RN 2 stated if a resident was confused, the fentanyl patch was placed in an area where they were unable to reach such as their back. RN 2 stated they documented where the fentanyl patch was placed so other nurses knew where it was located. RN 2 stated when they were unable to find the fentanyl patch, a progress note was written. RN 2 stated the DON became aware of the missing fentanyl patch by reading the progress note. RN 2 stated resident 43 was known to remove their own fentanyl patch since staff were unable to the previous patch. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 10:49 AM, an interview was conducted with Licensed Practical Nurse (LPN) 4. LPN 4 stated nurses documented where the fentanyl patch had been placed. LPN 4 stated when the fentanyl patch was removed, two nurses were needed to sign off and waste it to ensure it had been disposed of properly and it had not been stolen. LPN 4 stated the fentanyl patches were placed on a spot the resident was not able to reach super well but there were some residents that took their patches off. LPN 4 stated resident 42 fentanyl patches had been discontinued due to them taking their patches off frequently. On [DATE] at 11:32 AM, an interview was conducted with the Regional Nurse Consultant (RNC). The RNC stated fentanyl patches were signed out before they were applied on the resident. The RNC stated nurses handled narcotics. The RNC stated two nurse signatures were required when the fentanyl patches were wasted. The RNC stated the two signatures served as a verification purpose to ensure the patches were not used inappropriately. On [DATE] at 11:47 AM, an interview was conducted with Assistant Director of Nursing (ADON) 2. The ADON 2 stated once a fentanyl patch had been administered, two nurses needed to sign off on it. The ADON 2 stated two nurses were needed to verify placement of the new fentanyl patch and the removal of the old fentanyl patch. The ADON 2 stated they needed to have two sets of eyes since it was a controlled substance and they needed to make sure the patch was recovered and placed correctly. The ADON 2 stated the old fentanyl patches needed to be discarded in the lock to assure they were not able to be used again. The ADON 2 stated the fentanyl patches needed to be placed out of reach on confused residents and a tegaderm needed to placed as well. The ADON 2 stated that it was unacceptable for nurses to documented they were unable to locate the patch. The ADON 2 stated if a fentanyl patch was not located, the nurse should notify nursing management immediately, so they were able to follow up on it. The ADON 2 stated if a fentanyl patch was missing, they conducted their own investigation in tracking the patch. The ADON 2 stated they were unaware of any fentanyl patch investigations for the month of May. On [DATE] at 12:58 PM, a phone interview was conducted with Registered Nurse (RN) 5. RN 5 described the process for fentanyl patches. RN 5 stated they first pulled the fentanyl patch out, then it was marked out in the medication administration record and lastly it was placed on the resident. RN 5 stated they looked for the old patch and removed it. RN 5 stated the old patch needed to be wasted with another nurse since the patch was a narcotic. RN 5 stated sometimes it was previously noted in the progress notes the fentanyl patch was not located. RN 5 stated when that occurred they found another RN to confirm it was not located and then they sign off the fentanyl had been wasted without it being located. RN 5 stated they had issues with the fentanyl patch not being placed. RN 5 stated they tried to notify the nurse administration when this happened and would try to do a note but it was forgotten when it got busy. RN 5 stated for resident 43 and resident 5, a tegaderm patch was placed on top of the fentanyl patch to secure it to the skin. RN 5 stated the fentanyl patch was placed on their back and out of reach. RN 5 stated they recently had an issue locating a resident's fentanyl patch and assumed the previous fentanyl patch had been removed but an new one had not been applied. On [DATE], the facility provided the policy for discarding and destroying medications. The policy stated, Any controlled substance that is considered hazardous waste is managed in accordance with federal, state and local hazardous waste regulations, as well as the Controlled Substance Act and DEA regulations. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Resident 41 was initially admitted to the facility on [DATE] and readmitted on [DATE] with the diagnoses of chronic respiratory failure with hypoxia, functional quadriplegia, chronic obstructive pulmonary disease, contracture of muscle, muscle weakness and patient's noncompliance with other medical treatment and regimen due to unspecified reason. Resident 41's medical record was reviewed on [DATE] thru [DATE]. On [DATE] at 8:36 AM, Licensed Practical Nurse (LPN) 1 was observed preparing resident 41's medications at the nurse cart. LPN 1 stated the ordered eye drops were in the room. LPN 1 was observed to gown up before entering resident 41's room. Three eye drop medications were observed on resident 41's media console which included Refresh eye drops, Systane lubricating eye drops and Polymyxin B sulfate eye drops. LPN 1 was observed to grab the Polymyxin B sulfate/trimeth eye drops and administered one drop in each eye. On [DATE] at 11:37 AM, an interview was conducted with resident 41. Resident 41 stated they notified the nurse of the eye drops they wanted for the day. Resident 41 stated they chose between the Refresh tears or the Systane eye drops. A discontinued physician order with a start date of [DATE] and end date of [DATE] documented as followed: Refresh Tears Ophthalmic Solution (Carboxymethylcellulose Sodium Ophth). Instill 2 drop in both eyes every 6 hours as needed for dry eyes. An active physician order with a start date of [DATE] documented as followed: Systane Ophthalmic Solution 0XXX,d+[DATE].3 % [percent] (Polyethylene Glycol-Propylene Glycol (Ophth). Instill 2 drop in in both eyes three times a day for dry eyes. A discontinued physician order with a start date of [DATE] and end date of [DATE] documented as followed: Polytrim Ophthalmic Solution ,d+[DATE].1 Unit/ML [mililiter] % (polymyxin B- Trimethoprim). Instill 1 drop in both eyes every 3 hours for Conjunctivitis for 7 days. It should be noted resident 41 was administered eye drops that had been discontinued and were still available for use in resident 41 room. On [DATE] at 12:23 PM, an interview was conducted with LPN 1. LPN 1 stated the resident needed a doctors order saying it was okay to have medications in the room. LPN 1 stated they looked in a resident's physician orders to see if they had an order for medication at bedside. LPN 1 stated if a medication was located at bedside, they still needed to double check the order. LPN 1 stated they verified what the order was on the computer and compared it to the medication on hand to make sure they were the same. LPN 1 stated if a medication was kept in the room, they looked at the expiration date as well to make sure it had not expired. LPN 1 stated the process was different with resident 41 since they needed to gown up. LPN 1 stated resident 41 was not able to get out of bed and use the eye drops themselves. LPN 1 stated they had not removed the eye drops from the room and gave her the poly because they thought it was the same thing. LPN 1 stated they should have verified the medication with what had been ordered. LPN 1 stated a medication was removed from the cart once it had been discontinued. LPN 1 stated resident 41 had only one active order for eye drops which was the Systane. LPN 1 stated the eye drops needed to be kept in the medication cart until they had the okay from the provider to have them at bedside. LPN 1 stated there was no physician order for the refresh eye drops and there needed to be a current order to have those eye drops administered. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 3:01 PM, an interview was conducted with the Director of Nursing (DON). The DON stated medications were stored in the medication cart, medication room and a fridge. The DON stated medications were stored in those locations for the safety of the patient. The DON stated they expected their nurses to follow the five rules of medication administration. On [DATE] at 3:20 PM, an interview was conducted with the Assistant Director of Nursing (ADON) 1. The ADON 1 stated medication were located in the medication fridge or the medication cart. The ADON 1 stated medications were in those places to assure the nurses were double checking the orders to make sure resident received the right medication. The ADON 1 stated for a resident to have medication in their room, the doctor had to evaluate them and deem them safe to keep medications at bedside. The ADON 1 stated after they had been evaluated, an order was put in documenting the resident was okay to have medications and their care plan was updated. The ADON 1 stated medication were discarded into a bin once they had been discontinued. The ADON 1 stated they expected the nurses to take the discontinued medication out of the medication cart and dispose of it properly. The ADON 1 stated resident 41 had asked to keep medication in their room about two years ago but the provider at the time declined their request. 45470

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22992 Based on record review and interview, the facility did not ensure that laboratory services were provided to meet the needs of 2 of 53 sample residents. Specifically, labs were not obtained per the physician order. Resident identifiers: 36 and 42. Findings included: 1. Resident 42 was admitted to the facility on [DATE] with diagnoses that included dementia with psychotic disturbance, restless leg syndrome, anxiety, osteoarthritis, diabetes mellitus, protein calorie malnutrition, hypertension, cognitive communication deficit and delirium. Resident 42's medical record was reviewed from 6/2/24 through 6/6/24. Resident 42 had a physician order dated 12/2/22 that indicated resident 42 was to have a serum creatinine level drawn every 6 months. On 6/4/24, a nursing progress note indicated that the resident had her blood drawn to check the serum creatinine. No lab results for serum creatinine since the lab was ordered were located in resident 42's medical record. On 6/6/24, the Regional Nurse Consultant was asked to provide the missing lab results, but did not provide any additional documentation. 38031 2. Resident 36 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which consisted of chronic obstructive pulmonary disease, polyosteoarthritis, malignant neoplasm of ovary, hyperlipidemia, chronic fatigue, morbid obesity, anxiety disorder, bipolar disorder, idiopathic peripheral autonomic neuropathy, presence of left and right artificial knee joint, insomnia, opioid dependence, and restless leg syndrome. On 6/02/24 at 2:18 PM, an interview was conducted with resident 36. Resident 36 stated she may have a urinary tract infection (UTI) now. Resident 36 stated that she had pain in her pelvis/abdomen area and burning with urination. Resident 36 reported a history of frequent UTIs. On 6/2/24, resident 36's medical records were reviewed. On 3/1/24, resident 36's Minimum Data Set (MDS) assessment documented a Brief Interview for Mental Status score of 14/15, which indicated the resident was cognitively intact. The assessment documented that resident 36 required a one-person physical assistance with supervision for bed mobility, transfers, and toilet use. Resident 36's physician orders revealed the following: (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. On 2/20/24, a Urinalysis (UA) was ordered. No documentation could be found of the laboratory results. b. On 3/6/24, a Complete Blood Count (CBC) was ordered. No documentation could be found of the laboratory results. On 6/04/24 at 2:39 PM, an interview was conducted with Licensed Practical Nurse (LPN) 4. LPN 4 stated they could get lab results back within a day or two, depending on if it was ordered immediately. LPN 4 stated that they documented a progress note to show that the lab order was completed, and it could be passed on in report for the next shift to follow up with the results. LPN 4 stated that the results were faxed to them. LPN 4 stated that once they reviewed the results they placed the results in the medical records basket to be scanned into the resident chart and notified the provider by the communication app or by telephone. LPN 4 stated that they would then document that the provider was notified in a progress note. On 6/04/24 at 2:46 PM, an interview was conducted with LPN 1. LPN 1 stated that it usually took 1-2 days to get lab results back. LPN 1 stated that they obtained the lab specimens and entered a progress note that it was completed, then passed off in report to the next shift. LPN 1 stated that if there was a question of a lab they had documentation of when it was sent. On 6/05/24 at 8:02 AM, an interview was conducted with the Regional Nurse Consultant (RNC). The RNC stated that the nurses should manage all of their patient's lab orders. The RNC stated that when the nurse sent a specimen they should follow-up with the lab for results by the end of the day and if it was ordered stat they should follow-up within a couple of hours. The RNC stated that the nurse should notify the provider immediately if the results were critical, otherwise the result was placed in the provider binder for review. The RNC stated that there were times when they were not able to obtain a lab specimen due to dehydration. The RNC stated that the order had an end date of the day it was entered so it would need to be entered again if the sample was not obtained on that day. The RNC stated that there should be a progress note that stated why it was not obtained and it would be located in the Treatment Administration Record. The RNC confirmed that the lab orders for the UA on 2/20/24 and the CBC on 3/6/24 were not obtained.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38031 Based on interview and record review it was determined, for 1 of 53 sampled residents, that the facility did not promptly notify the ordering physician or provider of the laboratory results that fall outside of clinical ranges. Specifically, a resident's lithium levels and urinalysis results were not reported to the physician. Resident identifier: 36. Findings included: Resident 36 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which consisted of chronic obstructive pulmonary disease, polyosteoarthritis, malignant neoplasm of ovary, hyperlipidemia, chronic fatigue, morbid obesity, anxiety disorder, bipolar disorder, idiopathic peripheral autonomic neuropathy, presence of left and right artificial knee joint, insomnia, opioid dependence, and restless leg syndrome. On 6/2/24, resident 36's medical records were reviewed. Resident 36's physician orders revealed the following: a. On 9/8/23, a order for a Lithium level was initiated. b. On 9/13/23, a order for a Urinalysis was initiated. c. On 1/12/24, a order for a Urinalysis was initiated. d. On 5/23/24, a order for a Lithium level was initiated. Review of the laboratory reports and progress notes revealed no documentation that would indicate that the provider had been notified of the laboratory results. On 6/04/24 at 2:39 PM, an interview was conducted with Licensed Practical Nurse (LPN) 4. LPN 4 stated that could get lab results back within a day or two, depending on if it was ordered immediately. LPN 4 stated that once they reviewed the results they placed the results in the medical records basket to be scanned into the resident chart and notified the provider by the communication app or by telephone. LPN 4 stated that they would then document that the provider was notified in a progress note. On 6/05/24 at 8:02 AM, an interview was conducted with the Regional Nurse Consultant (RNC). The RNC stated that the nurses should manage all of their patients lab orders. The RNC stated that when the nurse sent a specimen they should follow-up with the lab for results by the end of the day and if it was ordered stat they should follow-up within a couple of hours. The RNC stated that the nurse should notify the provider immediately if the results were critical, otherwise the result was placed in the provider binder for review. The RNC stated that they implemented a stamp for the lab results in March 2024. The stamp had a spot for the nurse to document the date, time, provider notified, and the licensed nurse's signature.

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F 0775 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep complete, dated laboratory records in the resident's record. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38031 Based on interview and record review it was determined, for 1 of 53 sampled residents, that the facility did not file in the resident's clinical record laboratory reports that were dated and contained the name and address of the testing laboratory. Specifically, a resident's laboratory results were not located in the electronic medical records. Resident identifier: 36. Findings included: Resident 36 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which consisted of chronic obstructive pulmonary disease, polyosteoarthritis, malignant neoplasm of ovary, hyperlipidemia, chronic fatigue, morbid obesity, anxiety disorder, bipolar disorder, idiopathic peripheral autonomic neuropathy, presence of left and right artificial knee joint, insomnia, opioid dependence, and restless leg syndrome. On 6/2/24, resident 36's medical records were reviewed. Resident 36's physician orders revealed the following: a. On 9/8/23, a order for a Lithium level was initiated. b. On 9/13/23, a order for a Urinalysis was initiated. c. On 1/12/24, a order for a Urinalysis was initiated. d. On 5/23/24, a order for a Lithium level was initiated. No documentation could be found in resident 36's electronic medical records of the laboratory results for the above noted laboratory orders. On 6/04/24 at 2:39 PM, an interview was conducted with Licensed Practical Nurse (LPN) 4. LPN 4 stated that could get lab results back within a day or two, depending on if it was ordered immediately. LPN 4 stated that once they reviewed the results they placed the results in the medical records basket to be scanned into the resident chart and notified the provider by the communication app or by telephone. LPN 4 stated that they would then document that the provider was notified in a progress note. On 6/05/24 at 8:02 AM, an interview was conducted with the Regional Nurse Consultant (RNC). The RNC stated that some of the laboratory results were obtained from the lab portal and were not located in the facility medical records. The RNC stated that the process was that once the lab results were received they were placed in the lab binder at each nurse's station. The RNC stated that the nurse should notify the provider immediately if the results were critical, otherwise the result was placed in the provider binder for review. The RNC stated that once the physician viewed the results they signed them and then they were sent to medical records to be scanned into each resident's electronic medical record.

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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 0790 Level of Harm - Actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30563 Based on observation, interview and record review it was determined, for 1 of 53 sampled residents, that the facility must assist a resident in making appointments and arranging for transpiration to and from the dental services location. Specifically, a resident had teeth extracted and there was no follow-up appointment for dentures scheduled. Resident identifier: 53. Findings included: Resident 7 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included paroxysmal atrial fibrillation, fibromyalgia, type 2 diabetes mellitus, obesity and major depressive disorder. On 6/3/24 at 9:56 AM, an interview was conducted with resident 7. Resident 7 stated she had her teeth extracted. Resident 7 stated she was wondering when she was getting dentures. Resident 7 stated she had not been to a follow-up appointment after having her teeth extracted. Resident 7's medical record was reviewed on 6/2/24 through 6/6/24. A nursing progress note dated 3/26/24 at 3:50 PM, Spoke with [name removed] surgical regarding PT [patient] surgery in the morning. PT to be NPO [nothing by mouth] after 0045 [12:45 PM]; may take BP [blood pressure] medication in morning if necessary. Faxed over health history. The next progress note was 4/1/24 at 2:02 PM from the Nutrition/Dietary note. The note revealed .RDN [Registered Dietitian Nutritionist] spoke with resident about mouth pain. Resident had all teeth pulled and needs altered texture. There were no notes regarding monitoring of resident 7 after having dental surgery. On 6/4/24 at 1:16 PM, an interview was conducted with the Resident Advocate (RA). The RA stated there was a dental service that came to the facility and saw residents. The RA stated she put together a list of residents to be seen. The RA stated if the resident was not able to see the dental service company that came to the facility, then the transportation driver scheduled the appointments. The RA stated resident 7 had dental work done outside the facility. The RA stated she did not know about dental appointments outside of the facility and the Transportation Driver knew about it. On 6/6/24 at 8:30 AM, an interview was conducted with Assistant Director of Nursing (ADON) 1. ADON 1 stated she was aware that resident 7 had a dental procedure. ADON 1 stated when a resident returned to the facility after a surgical procedure, the physicians sent guidance and orders to care for the resident. ADON 1 stated the nurse needed to complete a progress note regarding the surgical procedure, what the physician ordered, what to monitor and when there was a follow-up appointment. ADON 1 stated after a dental procedure, nursing staff should monitor for pain and bleeding. ADON 1 confirmed there was no monitoring of resident 7 after the dental procedure. ADON 1 was unable to find orders from the dentist or information regarding the dental procedure. The ADON stated she did not know about dentures or an appointment for resident 7. (continued on next page)

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F 0790 Level of Harm - Actual harm Residents Affected - Few	On 6/6/24 at 8:58 AM, a follow-up interview was conducted with resident 7. Resident 7 stated she had not heard anything about getting dentures. Resident 7 stated she had asked staff about her follow-up appointment for dentures but staff did not know anything. On 6/5/24 at 9:13 AM, an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated they were not aware that resident 7 had teeth extracted and needed dentures. LPN 1 stated there was a transport director that scheduled appointments. LPN 1 was observed to review nursing progress notes. LPN 1 stated there was a note from resident 7's physician on 6/4/24 that resident 7 needed to be fitted for dentures. On 6/5/24 at 3:48 PM, an interview was conducted with the Transport Driver. The Transport Driver stated she scheduled appointments. The Transportation Driver stated resident 7 did not have a follow-up dental appointment scheduled. The Transport Driver stated she transported resident 7 to a dental appointment a couple of months ago. On 6/6/24 at 9:01 AM, an interview was conducted with the Regional Nurse Consultant (RNC). The RNC stated after a resident had teeth extracted, nurses should monitor for bleeding, fever, and sign and symptoms of infection. The RNC stated usually a resident received prophylactic antibiotics after having teeth extracted and there would be alert charting by nurses. The RNC stated resident 7 was provided a follow-up dental appointment on 5/6/24 but there was no information regarding dentures on the form. The RNC stated there was no follow-up or monitoring of resident 7 after having her teeth extracted. The RNC stated she did not know about dentures for resident 7. Additional information provided by the facility on 6/10/24 revealed an email from an outside dental service dated 6/6/24 at 12:26 PM. The email revealed [Name of company] referred [resident 7] to [name removed] Oral surgery for 28 teeth to be extracted on March 27th. This was a near full mouth extraction which can cause lots of swelling. We try to allow 6-8 weeks for the mouth to heal before we do an impression. We have [name of doctor removed] scheduled at another facility Saturday and asked if he could swing by [name of facility] after to get impressions for dentures. If [resident 7] isn't seen Saturday 6/8, she will be seen the following week. I will contact you with the date if needed. It should be noted that it was 10 weeks since resident 7's extractions.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50200 Based on observation, interviews and record review it was determined, the facility did not provide for 1 out of 53 sampled residents, specialized rehabilitative services such as physical therapy and occupational therapy that were required in the resident's comprehensive plan of care. Specifically, a resident was not provided specialized rehabilitation services that were documented as being needed by the facility medical doctor upon admission. Resident Identifier: 54. Findings Included: Resident 54 was admitted to the facility on [DATE] with diagnoses which included cervical disc disorder, primary osteoarthritis, type 2 diabetes with neuropathy, hypothyroidism, morbid obesity, weakness, muscle weakness, anxiety, obstructive sleep apnea, hypertension, and a history of falling. Resident 54's medical record was reviewed 6/2/24-6/6/24. On 6/2/24 at 2:39 PM, an interview was conducted with resident 54. Resident 54 stated that she could wiggle her feet a bit, but was unable to move or feel her lower extremities. Resident 54 stated she was unable to get out of bed or walk. Resident 54 stated she required an electric wheelchair to be mobile. Resident 54 stated that she had a decrease in range of motion in her upper extremities and had to do exercises by herself. On 6/2/24 at 2:40 PM, an observation was made of resident 54's lower extremities. Resident 54's feet and toes were observed to have contractures. Review of resident 54's progress notes revealed the following: a. On 1/24/24 at 7:39 PM, the note documented Pt [patient] has recently been hospitalized for a GLF [ground level fall] and weakness, likely r/t [related to] progressing cervical spine disease. Pt has weakness in legs, impaired mobility, and poor dexterity. Difficulty using controls or using a writing utensil. b. On 1/24/24 at 9:16 PM, the note documented upper extremity ROM [range of motion] limited with minimal use r.t. [related to] weakness from DJD [degenerative joint disease] .Adjustment to Admission: Pt adjusting well in good spirits, looking forward to therapy and getting up for activities. Anticipates need for hoyer with 2-3 person assist .Pt cannot move own legs, requests adjustments routinely, which causes pain. Review of resident 54's provider notes revealed the following: a. On 1/31/24 at 8:26 PM, an admission note documented, upon examination of upper extremities diffuse arthritic changes are noted bilaterally. Upon examination of lower (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	extremities sensation is not present upon light touch. Physical and Occupational therapy will evaluate patient for transfers, strengthening, mobility, and ADL's [activities of daily living] .Musculoskeletal: Mild arthritic change, contractures of feet and toes, decrease ROM BLE [bilateral lower extremities] .Assessments/plan: Cervical disc disorder, unsp [unspecified], unspecified cervical region: PT [physical therapy] and OT [occupational therapy] fore [sic] rehab. b. On 2/7/24 at 3:19 PM, the provider note documented, .is able to move her feet, but not her legs. She has her electric wheelchair that allows her to get out of her room, and around the facility. c. On 2/20/24 at 2:14 PM, the provider note documented, Neurological: decreased sensation of BLEs Cranial nerves II-XII intact No tremors Not ambulatory BLE near complete paralysis. d. On 2/21/24 at 8:18 AM, the provider note documented, .notes a loss of strength in her bilateral upper extremities (BUE) and reports stiffness. She also describes a sensation of numbness from her knees down, accompanied by feelings of heat and pressure. Test/Orders: Dr. Orders Fatigue: Labs to be drawn. Assure she is using CPAP [continuous positive pressure]. Weakness: We will draw labs with CBC [compete blood count], CMP [comprehensive metabolic panel], and thyroid studies. PT and OT. On 6/4/24 at 12:20 PM, an interview was conducted with the Director of Rehabilitation [DOR]. The DOR stated that due to resident 54's insurance coverage the facility did not perform rehabilitation services with residents who had this insurance company. The DOR stated resident 54's insurance was difficult to get reimbursed financially after performing therapy. On 6/4/24 at 2:52 PM, a phone interview was conducted with the Nurse Practitioner [NP]. The NP stated that the facility medical director performed the initial evaluation on all newly admitted residents to the facility and then would recommend the resident for PT/OT. The NP stated resident 54 needed to do PT/OT in order to care for herself. The NP stated they did not know why resident 54 was not doing therapy or why an order was not placed, but would find out. On 6/5/24 at 7:44 AM, an interview was conducted with the [NAME] Manager. The [NAME] Manager stated that in the past there were issues with the insurance company that the resident had and the facility had to refund money back to the insurance company after claims had been paid for. The [NAME] Manager stated the facility had started sending claims to the insurance company in the past year and had not had any issues. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/5/24 at 8:09 AM, an interview was conducted with the Administrator [ADM]. The ADM stated that there were not any issues in the past 18 months with the insurance company making payments for services rendered. On 6/6/24 at 10:11 AM, a text message from the NP stated that the facility doctor had ordered PT/OT and it was being reordered as of yesterday.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45470 Based on interview and record review it was determined, for 3 of 53 sampled residents, that the facility did not keep confidential all information contained in the resident's records, regardless of the form or storage method of the records. Additionally, the facility did not maintain the medical records on each resident that were complete, accurately documented, and readily accessible. Specifically, a resident's name was included in a different residents medical record, and a resident's medical records from the hospital were not included in the residents electronic medical records at the facility. Resident identifiers: 18, 42, and 43. Findings Included: 1. Resident 43 was admitted to the facility on [DATE] with diagnoses that included dementia, chronic obstructive pulmonary disease, hypothyroidism, muscle wasting, adult failure to thrive, nicotine dependence, and osteoarthritis. Resident 42 was admitted to the facility on [DATE] with diagnoses that included dementia, restless legs syndrome, anxiety disorders, generalized osteoarthritis, type 2 diabetes mellitus, protein-calorie malnutrition, hyperlipidemia, hypertension, cognitive communication deficit, delirium, insomnia, and major depressive disorder. Resident 43's Nurses Note from 12/17/22 at 10:39 PM documented, Resident yelling out of control .Hit and kicked and slapped resident, [name of Resident 42 redacted], and staff nurses who separated the two residents to avoid further injury. Physician and Administrator notified. On 6/5/24 at 11:17 AM, an interview with Registered Nurse (RN) 2 was conducted. RN 2 stated that in the past she had used resident names in other residents' electronic medical charts for identification purposes. RN 2 stated that nobody in the facility had told her she was not allowed to do so. On 6/5/24 at 11:22 AM, an interview with Licensed Practical Nurse (LPN) 1 was conducted. LPN 1 stated that staff should never include a resident's name in a different resident's electronic medical record. LPN 1 stated that it was a HIPAA (Health Insurance Portability and Accountability Act) violation. On 6/5/24 at 12:15 PM, an interview with the Regional Nurse Consultant was conducted. The Regional Nurse Consultant stated that resident's names should never be used in other resident's medical records. The Regional Nurse Consultant stated that it would be a HIPAA violation. 43212 2. Resident 18 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included Parkinsonism, type 2 diabetes, morbid obesity, chronic kidney disease, acquired absence of left leg above knee, chronic obstructive pulmonary disease, and major depressive disorder. Resident 18's medical records were reviewed between 6/2/24 and 6/6/24. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/17/23 at 11:49 PM an Alert progress note revealed, Resident had a fall earlier during the day and hit her head hard. Tonight resident developed severe headache and visual changes. Resident sent to ER [emergency room] for evaluation. [Physician's name removed] and family notified. It should be noted that hospital notes from resident 18's ER visit could not be found in the medical record. On 5/17/23 at 9:14 PM, a physician progress note revealed, .Patient presented to [hospital name removed] on 2/17/23 via EMS [emergency medical services] from [facility name removed] after suffering a fall; she was transferring to her wheelchair, when the wheelchair moved causing her to hit her head on a wall. She states that since the head injury she has been suffering from a headache, and neck pain which has progressively worsened in nature. She notes that it is exacerbated with bright lights and loud noises. She denies any history of migraines. She denies being on any blood thinners at this time. Denies any numbness, weakness, nausea, vomiting, or any other associated symptoms. ED [emergency department] course: Lab work and imaging obtained .CT [computer tomography] head and cervical spine shows no acute injury but does show moderate degenerative changes . On 6/5/24 at 8:31 AM, hospital records were requested for the ER visit on 2/17/23. On 6/5/24 at 10:05 AM, an email was received from the facility administrator (ADM) with the requested hospital records attached. The email stated, I have attached the hospital records you requested. The incident was investigated and reported as potential abuse (no incident report). The resident was sent out, so there isn't a record of neuro checks at that time. We don't have a fall risk assessment that was completed on that date. The requested hospital records were reviewed. It should be noted the records were printed on 6/5/24 at 9:18 AM.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 22992 Based on interview, record review, and observation, the facility did not establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. In addition, the facility did not develop and implement appropriate plans of action to correct identified quality deficiencies. Resident identifiers: 5, 7, 12, 17, 18, 31, 36, 41, 42, 43, 50, 53, 54, 365, 367, 372, and 374. Findings included: 1. Based on interview and record review it was determined, for 5 out of 53 sampled residents, that the facility did not ensure that residents were free from abuse, neglect, misappropriation of resident property, and exploitation. Specifically, a staff member recorded a video in the shower room while a resident was in the bathtub naked, a cognitively impaired resident kissed two different cognitively impaired residents on two different occasions and another resident who was cognitively impaired was involved in a sexual relationship. Resident Identifiers: 5, 12, 17, 36, 42, and 374. [Cross refer to F600] 2. Based on interview and record review, the facility did not ensure that 4 of 53 sample residents received treatment and care in accordance with professional standards of practice. Specifically, one resident experienced a change in condition, and the facility did not act in a timely manner to treat the condition. This resulted in a finding of harm for this resident. In addition, one resident was not monitored for a change in condition after experiencing chest pain, another resident was not monitored for a change in condition after a dental procedure, and a resident who was incontinent developed Moisture Associated Skin Damage (MASD). Resident identifiers: 5, 7, 53, and 365. [Cross refer to F684] 3. Based on interview and record review it was determined, for 6 of 53 sampled residents, that the facility did not ensure that the resident environment remained as free of accident hazards as was possible and that each resident received adequate supervision and assistance devices to prevent accidents. Specifically, a resident sustained multiple falls with one resulting in a fracture, a resident transported in the facility vehicle was not properly secured and sustained a fall with injury, and a resident had hot coffee thrown on them by another resident. These findings were cited at harm. In addition, a resident with wandering behaviors, eloped from the facility and a resident was not secured in their wheelchair and sustained a fall. Resident identifiers: 5,18, 31, 43, 367, and 374. [Cross refer to F689] (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Based on interview and record review it was determined that for 2 out 53 sampled residents, that the facility did not ensure that the resident who was incontinent of bladder received the appropriate treatment and services to prevent urinary tract infections (UTI) and to restore continence to extent possible. Specifically, a resident developed a UTI after facility staff were not instructed and trained on the proper changing, frequency, and monitoring of the resident's PureWick urinary system device and a resident had a delay in starting antibiotic therapy for a UTI. Resident identifiers: 36, 54. [Cross refer to F690] 5. Based on interview and record review it was determined, for 1 out of 53 sampled residents, that the facility did not ensure that pain management was provided to residents who required such services, consistent with professional standards of practice, the comprehensive care plan, and the residents' goals and preferences. Specifically, the resident's pain medication was not administered per the physician orders and the resident had complaints of uncontrolled pain. Resident identifier: 50. [Cross refer to F 697] 6. Based on interview and record review it was determined, for 1 out of 53 sampled residents, that the facility did not ensure each resident's drug regimen remained 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 would indicate the dose should be reduced or discontinued. Specifically, a resident's medication was not being monitored and this resulted in the resident being hospitalized . Resident identifier: 41. [Cross refer to F757] 7. Based on interview and record review, the facility did not ensure, for 3 of 53 sampled residents, were free of significant medication errors. Specifically, a resident was given linezolid for more days than what was ordered by the hospital, narcotics were given outside of physician ordered parameters, and lorazepam was given more often than what was ordered. Resident identifiers: 41, 50, and 372. [Cross refer to F 760] 8. On 7/22/22, an annual recertification survey was completed at the facility. The deficiencies cited during the survey included 580, 600, 610, 684 (at a harm level), 757, 758, 761, and 842. All of these deficiencies were re-cited during the June 2024 recertification survey. 9. On 3/2/23, an abbreviated complaint survey was completed at the facility. The deficiencies cited during the survey included 600, 609, 676, 677, and 690. All of these deficiencies were re-cited during the June 2024 recertification survey. (continued on next page)

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Red Cliffs Health and Rehab	1745 East 280 North St George, UT 84790

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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/6/24 at 7:40 AM, an interview was conducted with the facility Administrator (ADM). The ADM stated that the Quality Assurance and Performance Improvement (QAPI) committee met every month. The ADM stated that part of their QAPI process was to review prior deficiencies that were cited. The ADM stated that the facility had been working on correcting previous deficiencies, and had done a lot with abuse. The ADM stated I don't know why showers is still an issue. I give the shower issue over to the DON (Director of Nursing) and she can delegate that out. I don't know what to implement in that, because its more clinical. It's outside of what I've had my hands on. I try to give ideas in QAPI but other people have better ideas than I do.

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 43212 Based on observation and interview, the facility did not establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Specifically, the facility did not demonstrate having an assessment to identify Legionella and other opportunistic waterborne pathogens, control measures to prevent the growth of opportunistic waterborne pathogens, and how to monitor them. Additionally, a resident was observed helping another resident during dining and was touching the other resident's food with bare hands. Resident identifier: 24 and 46. Findings included: 1. On 6/6/24 at 9:38 AM, an interview was conducted with Assistant Director of Nursing (ADON) 2, who was the facilities designated infection preventionist. ADON 2 stated the Director of Maintenance (DOM) was the person in charge of water management. On 6/6/24 at 10:12 AM, an interview was conducted with the DOM who stated all of the facility domestic water goes through the water softener. The DOM stated he had not tested for Legionella and was unaware if it had to be done. 30563 2. On 6/5/24 at 12:43 PM, an observation was made of resident 46 and resident 24. Resident 46 was observed to be touching resident 24's sandwich with her bare hands. Resident 46 was observed to cut resident 24's sandwich into 4 pieces and slid the plate back to resident 24. Resident 24 was observed to pick up the sandwich and eat it. Resident 46 was observed to lick her fingers and then grabbed a tomato out of resident 24's sandwich. Resident 46 was observed to use her fingers and a knife to cut resident 24's tomato and then place it back onto the plate for resident 24. On 6/6/24 at 10:06 AM, an interview was conducted with Registered Nurse (RN) 4. RN 4 stated that staff should not touch residents food with their bare hands. RN 4 stated resident's should not be touching or cutting up other residents food. On 6/6/24 at 10:08 AM, an interview was conducted with Certified Nurse Assistant (CNA) 6. CNA 6 stated all staff should be washing hands prior to serving residents food. CNA 6 stated gloves or the resident silverware should be used to cut food. CNA 6 stated other residents should not be touching other residents food for them. CNA 6 stated staff needed to pay better attention to residents in the dining room to provide assistance when needed. On 6/6/24 at 10:12 AM, an interview was conducted with Assistant Director of Nursing (ADON) 1. ADON 1 stated residents should not touch each others food and staff should not be touching residents food with barehands.