

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465152	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/13/2024
NAME OF PROVIDER OR SUPPLIER Bella Terra St George		STREET ADDRESS, CITY, STATE, ZIP CODE 178 South 1200 East 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38031 Based on observation and interview it was determined, for 2 of 65 sampled residents, that the facility did not treat each resident with respect and dignity and care for each resident in a manner and in an environment that promoted maintenance or enhancement of their quality of life, recognizing each resident's individuality. Specifically, observations were made during multiple meal services of food being served on disposable dishes. Resident identifier: 22 and 27. Findings included: 1. On 11/03/24 at 1:35 PM, an observation was made of the lunch meal service on the 300 hallway. The meal tray for room [ROOM NUMBER] A was observed with the pudding dessert served in a disposable bowl. On 11/05/24 at 11:03 AM, a telephone interview was conducted with the Registered Dietitian (RD). The RD asked why the facility was serving meals with plastic wear and to go containers. The RD stated that they should be served on plates and dishware. The RD stated she did not know if the facility was low on supplies of plates and dishes or if they were doing this to cut down on the time for washing dishes. The RD stated that she was not sure if the facility had enough supply of hot plates. On 11/05/24 at 3:47 PM, an interview was conducted with the Administrator (ADMIN). The ADMIN stated that they procured more supplies for dishes and that they were now in stock. The ADMIN stated that he did not think he had a shortage of dishes but that the challenge was making sure that all the dirty dishes were returned timely to be washed. The ADMIN stated that they had never had an issue with hot plate supplies. The ADMIN was asked why they were using disposable dishes and he responded, That's a good question? The ADMIN stated that as far as he was aware they had enough supplies and were not using disposable dishes. 30563 2. On 11/4/24, an observation was made of the breakfast meal. Resident 22 was observed to have 2 Styrofoam bowls with frosted flakes in them. (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/5/24 at 8:39 AM, an interview was conducted with the Assistant Dietary Manager (ADM). The ADM stated disposable dishware was used because the kitchen ran out of non-disposable. The ADM stated cereal came out in Styrofoam because there were not enough bowls. The ADM stated when the kitchen sent out dishware only about 2/3 of it came back to be washed for the next meal. The ADM stated she had to juggle to dishware. The ADM stated the staff tried not to use Styrofoam because Personally if you live here you don't want to eat off of Styrofoam. The ADM stated the residents were not getting fancy food and it would be nice for them to get real dishes. 50200 3. Resident 27 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which include, but not limited to, aftercare following joint replacement surgery, difficulty in walking, muscle weakness, type 2 diabetes mellitus with hyperglycemia, major depressive disorder, anxiety disorder, essential hypertension, unsteadiness on feet, and history of falling. On 11/4/24 at 8:16 AM, an observation was made of resident 27 eating cereal out of a small disposable cup. On 11/4/24 at 8:16 AM, an interview was conducted with resident 27. Resident 27 stated that she had received her cereal in a disposable container. Resident 27 stated the she would like to eat cereal out of a larger bowl and not a small disposable container. 43212		

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43212 Based on interview and record review, for 1 of 65 sampled residents, the facility failed to provide the residents the right to participate in the development and implementation of a person-centered care plan, the right to attend meetings regarding the person-centered care plan, and the right to request revisions to the person-centered plan of care. Specifically, a resident who wished to participate in her plan of care was not included, and there was no documentation that care plan meetings were being held. Resident identifier: 3. Findings include: Resident 3 was admitted to the facility on [DATE] with diagnoses that included Arnold Chiari Syndrome with spina bifida and hydrocephalus, severe protein-calorie malnutrition, osteomyelitis right ankle and foot, paraplegia, borderline personality disorder, major depressive disorder, morbid obesity, bipolar disorder, and anxiety disorder. On 11/3/24 at 5:16 PM, an interview was conducted with resident 3 who stated the facility was not having care conferences and that she wanted to be included in decisions that were made about her care. Resident 3's medical records were reviewed between 11/3/24 and 11/13/24. According to resident 3's medical records, the last care conference attended was on 12/8/23. Resident 3's MDS (Minimum Data Set) documentation revealed that a quarterly MDS assessment was completed on 2/26/24, an annual MDS assessment was completed on 5/28/2024, and a quarterly MDS assessment was completed on 8/28/2024. On 8/28/24, resident 3's Brief Interview for Mental Status (BIMS) was 15 indicating normal cognition. A review of resident 3's care plan revealed, The resident has expressed a desire to remain in the facility for long term care. Date initiated: 11/30/23. The goal was, The resident will feel safe and comfortable in their home. Date initiated: 11/30/23, Revision on: 12/12/23, Target date: 1/31/25. Interventions included, .Resident will have the opportunity to attend care conferences upon admission and at least quarterly to discuss plan of care, discharge plan/goals, questions/concerns, etc. Discharge plan will be revised as indicated. Date initiated: 11/30/23 . A review of resident 3's medical record revealed care conference documentation for 3/21/23, 6/7/23, and 12/8/23. No care conference documentation was found for 2024. On 11/12/24 at 1:22 PM, an interview was conducted with the Director of Nursing (DON) who stated she attended the resident care conferences if she was invited. The DON stated the Activities Director (AD) had picked up some of the Resident Advocate (RA) duties. The DON also stated that the previous AD was still working part time and could provide training for the services that the RA would provide. (continued on next page)		

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/13/24 at 9:27 AM, an interview was conducted with the DON who stated care conferences were held quarterly or with a significant change in condition. The DON stated if something needed to be changed, it would trigger for a review after the quarterly assessment. The DON stated care conference forms were found in the medical record under the forms care tab and were described as care conference summaries. The DON stated the form should include who attended the conference and what was discussed. The DON stated the AD was planning care conferences and sending out invitations for those conferences.		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38031 Based on observation and interview it was determined, for 2 of 65 sampled residents, that the facility did not ensure the resident right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences. Specifically, the resident call lights were out of reach. Resident identifiers: 1 and 30. Findings included: 1. Resident 1 was admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses which included cerebral infarction, cognitive communication deficit, chronic obstructive pulmonary disease, morbid obesity, type 2 diabetes mellitus, chronic viral hepatitis C, non-pressure chronic ulcer of left lower leg, mood disorder, encephalopathy, atrial fibrillation, pulmonary embolism, hypospadias, retention of urine, chronic kidney disease, major depressive disorder, pyelonephritis, multiple fractures of ribs, bipolar disorder, dysphonia, insomnia, peripheral vascular disease, chronic pain syndrome, opioid dependence, extended spectrum beta lactamase resistance, obstructive and reflux uropathy, anxiety disorder, polyosteoarthritis, hypertension, gout, and methicillin resistant staphylococcus aureus infection classified elsewhere. On 8/2/24, resident 1's Minimum Data Set (MDS) Assessment documented a Brief Interview of Mental Status (BIMS) score of 5 out of 15, which would indicate a severe cognitive impairment. The assessment documented that the resident was a two-person total dependence physical assist for bed mobility, transfer, and toilet use. On 11/03/24 at 4:47 PM, an observation was made of resident 1. Resident 1 was sleeping in bed and his call light was observed on the floor at the foot of the bed, under a trash can, and out of reach. On 11/07/24 at 8:53 AM, an interview was conducted with Certified Nurse Assistant (CNA) 3. CNA 3 stated that resident 1 was fully dependent on staff for assistance with incontinence care and bed baths, and that the resident preferred to stay in bed. 2. Resident 30 was admitted to the facility on [DATE] with diagnoses which consisted of Alzheimer's disease, osteoporosis, bradycardia, hypertension, hyperlipidemia, major depressive disorder, and post-traumatic stress disorder. On 8/28/24, resident 30's MDS Assessment documented a BIMS score of 3 out of 15, which would indicate a severe cognitive impairment. The assessment documented that the resident was a limited one-person physical assist for bed mobility, transfer, and toilet use. On 11/03/24 at 4:43 PM, an observation was made of resident 30. Resident 30 was seated in her recliner towards the foot of the bed. Resident 30's call light was observed on the floor under the bed, at the head of the bed, and out of reach. On 11/12/24 at 1:46 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that resident 1 and resident 30 could utilize their call light if it was within reach.		

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents have reasonable access to and privacy in their use of communication methods. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48709 Based on observation, interview, and record review, it was determined that for 1 of 65 sampled residents, the facility failed to ensure the resident had reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. Specifically, a resident was not provided access to a phone in her room as requested. Resident identifier: 28. Findings included: On 11/03/24 at 1:42 PM, an interview was conducted with resident 28. Resident 28 stated multiple staff members told her that she cannot get a phone in her room. Resident 28 stated her cell phone did not work. Resident 28 stated she had to use the phone at the nurse's station. On 11/06/24 at 10:16 AM, an observation of Registered Nurse (RN) 2. RN 2 was observed to tell the resident in room [ROOM NUMBER] that the phone had to stay at the nurse's station because it kept getting lost. Resident 28's medical record was reviewed 11/3/24 through 11/13/24. Resident 28 was admitted to the facility on [DATE] with diagnoses which included hypertension, severe persistent asthma with acute exacerbation, and muscle weakness. A Minimum Data Set (MDS) Assessment, dated 9/23/24, indicated resident 28 had a Brief Interview for Mental Status (BIMS) score of 10 which indicated a moderately impaired cognition. On 11/6/24 at 3:11 PM, an interview was conducted with Certified Nurse Assistant (CNA) 4. CNA 4 stated she was not sure if a resident could have a landline phone in their room, but they could have their own cell phones or use the facility phone. On 11/7/24 at 10:26 AM, an interview was conducted with CNA 3. CNA 3 stated that nobody in the facility had a landline phone in their room. CNA 3 stated that if a resident asked to have a landline phone in their room, she would report that to the CNA Coordinator. On 11/13/24 at 8:48 AM, an interview was conducted with the Maintenance Supervisor. The Maintenance Supervisor stated there was a Daily Maintenance Log kept at the nurse's station where staff could notify him of items that needed repair. The Maintenance Supervisor stated he was not sure if the resident's rooms had phone [NAME] in them. A concurrent observation was made of resident 28's room, room [ROOM NUMBER], and 2 phone [NAME] were observed on the wall. The Maintenance Supervisor stated they probably did not work, but he would figure out an option for resident 28 to have a phone in her room. The facility Daily Maintenance binder from the front nursing station was reviewed on 11/13/24 at 8:54 AM. One request was documented from 11/8 for a broken television. No other documentation was provided. (continued on next page)		

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/13/24 at 11:25 AM, an interview was conducted with the Administrator (ADMIN). The ADMIN stated the facility did not have phones in the resident's rooms but had cordless phones at the nurse's stations and some on the nurse's carts that the residents could use. The ADMIN stated the residents needed to be provided a private place to talk on the phone.		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30563 Based on interview and record review, the facility did not ensure that 1 of 65 sampled residents had the right to refuse medical treatment and formulate an advance directive. Specifically, a resident had a signed Provider Order for Life-Sustaining treatment (POLST) form for a Do Not Resuscitate (DNR) but the electronic medical records banner documented that the resident wanted full treatment. Resident identifier: 22. Findings included: Resident 22 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included schizophrenia, cognitive communication deficit and generalized anxiety. Resident 22's medical record was reviewed on [DATE]. A physician's order dated [DATE] revealed FULL CODE; FULL TREATMENT. No directions specified for order. A POLST form dated [DATE] revealed resident 22 desired for no attempt or any continued resuscitation (DNR) and resident wanted comfort measures for medical interventions with no artificial nutrition. According to the banner in resident 22's electronic medical record, resident 22 was a full code with full treatment. On [DATE] at 10:53 AM, an interview was conducted with Licensed Practical Nurse (LPN) 3. LPN 3 stated residents decisions on CPR and medical interventions was documented in the electronic medical record. LPN 3 stated when a resident was admitted the nurse completed a POLST form or Advanced Directives with the resident or family. LPN 3 stated LPN 4 had completed resident 22's POLST form when she was readmitted. LPN 3 stated resident 22 went back and forth between full treatment and being a DNR. LPN 3 stated resident 22 was her own responsible party. LPN 3 stated she did not know why the POLST form and the banner in the electronic medical record were different. LPN 3 stated if resident 22 had coded, she would have looked at the electronic medical record and would have treated resident 22 as a full code and provided CPR. On [DATE] at 11:01 AM, an interview was conducted with LPN 4. LPN 4 stated she completed a POLST form with resident 22 on [DATE]. LPN 4 stated resident 22 changed her mind a lot so maybe she had changed her mind. LPN 4 stated there should be a new physician's order and POLST form if resident 22 changed her mind with her code status. On [DATE] at 10:44 AM, an interview was conducted with the Director of Nursing (DON). The DON stated nurses completed the POLST forms with the resident upon admission. The DON stated the POLST form was then put into the physician's folder for the physician to sign. The DON stated she was not sure how long it took for the POLST form to be put into the residents medical record. The DON stated the nurse, Minimum Data Set (MDS) coordinator or herself updated physician orders which automatically populated the banner in the electronic medical record. (continued on next page)		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 11:03 AM, an interview was conducted with the Director of Nursing (DON). The DON stated if there was a question about the resident's code status, then the resident was a full code. The DON stated she was not sure why there was a physician's order by her on [DATE] that was different from what the POLST form had on it. The DON stated she was not sure if there was a new POLST. The DON stated she would have to investigate why resident 22's POLST and physician's order did not match. The DON stated a nurse can update the physician's order. The DON stated there was a binder at each nurses station with the POLST forms. The DON was observed to check the binder and located the same POLST form dated [DATE]. On [DATE] at 11:10 AM, a follow up interview was conducted with the DON. The DON stated the MDS coordinator just went through and updated all the POLST forms. The DON stated the MDS coordinator and Resident Advocate asked residents in care conferences about updating a POLST form. The DON stated if the POLST and the physician's order were different then she would go with what the banner in the medical record had on it.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50200 Based on observation, interview, and record review it was determined, for 13 out of 65 sampled residents, that the facility did not provide a safe, clean, comfortable, and homelike environment, allowing the residents to use his or her personal belongings to the extent possible. Specifically, residents complained of cold temperatures in their rooms, resident rooms were not cleaned, resident toilets leaked and a toilet seat was loose, a resident sink leaked water, resident showers flooded rooms, holes were found in a residents door, a brown substance was observed on a resident's wall, and resident personal belongings were lost. Resident identifiers: 3, 13, 20, 22, 26, 27, 29, 30, 32, 51, 53, 55, and 120. Findings Included: 1. Resident 53 was admitted to the facility on [DATE] with diagnoses which included, but not limited to, osteomyelitis of vertebra, anxiety disorder, type 1 diabetes mellitus with hyperglycemia, unspecified protein-calorie malnutrition, sepsis, psoas muscle abscess, alcohol abuse, and major depressive disorder. On [DATE] at 2:08 PM, the following observations were made of resident 53's room: a. Towels were wrapped around the base of the toilet and water was leaking out of the bottom of the toilet. b. Toilet seat was loose and covered in brown stains. On [DATE] at 2:08 PM, an interview was conducted with resident 53. Resident 53 stated that her toilet was not getting clean by the facility, the toilet was leaking water on to the floor, and the toilet seat was loose. On [DATE] at 1:26 PM, a follow up interview was conducted with resident 53. Resident 53 stated that the leak for the toilet was fixed, but the toilet lid was still loose and covered in brown stains. 2. Resident 20 was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses which included, but not limited to, displaced intertrochanteric fracture of right femur, mild protein-calorie malnutrition, muscle weakness, rheumatoid arthritis, hypothyroidism, essential hypertension, and unsteadiness on feet. On [DATE] at 4:21 PM, an observation was made of resident 20 in bed covered with multiple blankets around her body and two blankets wrapped around her head. On [DATE] at 4:23 PM, an interview was conducted with resident 20. Resident 20 stated that her room was cold and the air conditioner always felt like it was on. Resident 20 stated that she had asked staff to make her a shawl out of blankets to keep warm. Resident 20 stated that a few months ago the maintenance man placed a plastic device near the vent to divert the cold air, but that did not help her room from being cold. (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Resident 27 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included, but not limited to, aftercare following joint replacement surgery, difficulty in walking, muscle weakness, type 2 diabetes mellitus with hyperglycemia, major depressive disorder, anxiety disorder, essential hypertension, unsteadiness on feet, and history of falling. On [DATE] at 8:14 AM, the following observations were made of resident 27's room: a. There was no screen on the window. b. There were scrapes on the door. c. There were holes in the bathroom door. d. There was a large basin under the sink collecting leaking water. On [DATE] at 8:14 AM, an interview was conducted with resident 27. Resident 27 stated that she could not leave her window open because she did not have a screen on and was worried someone would get in. Resident 27 stated that when she turned on her sink it would leak and there was a container that collected the water. Resident 27 stated that her bathroom door had holes in it. 4. Resident 26 was admitted to the facility on [DATE] with diagnoses which included, but not limited to, facioscapulohumeral muscular dystrophy, unspecified protein-calorie malnutrition, hyperlipidemia, hypomagnesemia, hypo-osmolality and hyponatremia, and weakness. On [DATE] at 3:20 PM, the following observations were made of resident 26' room: a. The shower floor had a black colored stain. b. The ceiling air vent was blowing cold air. c. The bathroom sink would only dispense a small trickle of water. On [DATE] at 3:20 PM, an interview was conducted with resident 26. Resident 26 stated that her bathroom sink would only dispense a trickle of water. On [DATE] at 8:43 AM, a follow up interview was conducted with resident 26. Resident 26 stated that heat was not coming on in her room at all. Resident 26 stated that she told maintenance and Certified Nursing Aides (CNA's) multiple times that her room was cold, there was no heat coming from the vent, and the vent would blow cold air every once in a while. Resident 26 stated that her shower would flood when taking a shower and the CNA's had to put towels around the floor to create a barrier to prevent the water from going into her room. 5. Resident 120 was admitted to the facility on [DATE] with diagnoses which included, but not limited to lymphedema, superficial mycosis, cellulitis of right lower limb, activated protein c resistance, cellulitis of left lower limb, and morbid (severe) obesity due to excess calories. (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 2:18 PM, an interview was conducted with resident 120. Resident 120 stated that her room had not gotten cleaned and the garbage had not been taken out. Resident 120 stated that this happened on a daily basis. On [DATE] at 8:45 AM, an interview was conducted with the housekeeping supervisor (HS). The HS stated resident rooms got cleaned daily. The HS stated that cleaning a resident room entailed sweeping and mopping the floor, wiping down side tables, nightstands and dressers, and dusting pictures. The HS stated that cleaning the bathroom entailed cleaning the toilet, mirrors and checking the tissue and toilet paper. The HS stated that all garbage should be removed from the resident's rooms. The HS stated that expectations for the housekeeping staff were for the resident rooms to be cleaned daily. On [DATE] at 10:24 AM, an interview was conducted with the Maintenance Supervisor (MS). The MS stated that for all maintenance issues, it should be written down in the maintenance log book unless it was an emergency and then he would expect a text or verbal request. The MS stated that the maintenance logs were checked daily, Monday through Friday. The MS stated that he would write in the log and initial when a request was completed. The MS stated that there were thermostats all over the facility and he was still learning where they were located. The MS stated that in the hallway where residents 20, 26, 27, and 53 were located, he had heard some complaints about the temperature and rooms being cold, but had since remedied the situation. The MS stated that all the windows in the facility should have screens. The MS stated he had not heard about any residents with leaking sinks or toilets. The MS stated that he had not heard about showers in the facility flooding and would assume that it would be reported to him because it might have been ignored in the past. 38031 6. ODORS On [DATE] at 3:44 PM, a strong odor of urine was noted in the memory unit immediately upon entrance past the locked double doors. On [DATE] at 1:44 PM, a strong odor of urine was noted on the memory unit outside of room [ROOM NUMBER]. Resident 30 was pacing the hallway and smelled of urine. On [DATE] at 9:13 AM, a strong odor of urine was noted in the 300 hallway outside of room [ROOM NUMBER]. On [DATE] at 10:25 AM, an observation was made of CNA 5 spraying air freshener multiple times in room [ROOM NUMBER] and 321. 7. On [DATE] at 5:27 PM, an observation was made in the main dining area. A coffee cart was located against the wall towards the main door/corridor. The cart contained a large carafe that was not warm to the touch, a tray of coffee cups, creamer and sweetener. The coffee cart was observed dirty with spilled coffee noted on the shelf. Two empty and used coffee cups were observed in the window sill. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Bella Terra St George		STREET ADDRESS, CITY, STATE, ZIP CODE 178 South 1200 East St George, UT 84790	
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 9:40 AM, an observation was made of the dining room located in the locked memory unit. The floor was observed to be scuffed and dirty. The walls were also scuffed and spackled. The table nearest to the courtyard door had a soiled table cloth on it, and the table near the sink had a soiled table cloth on it. On [DATE] at 9:56 AM, an interview was conducted with Housekeeper (HK) 1. HK 1 stated that she was assigned to the memory unit and the 400 hallway and worked on Wednesday, Thursday, and Saturday. HK 1 stated that she cleaned all the resident rooms and the dining room. HK 1 stated that the resident room cleaning process included cleaning the bathroom sink, toilet, sweeping and mopping the floors, cleaning the bedside tables, wiping off the door handles and light switches, and restocking the toilet paper and paper towels. HK 1 stated that there were usually 4 to 5 housekeeping staff in the building at a time, but lately it had been 4 staff because they were short staffed. HK 1 stated that due to the short staff situation she was helping out in other areas once her area was completed. HK 1 stated that there had been occasions that she was not able to complete her area assigned tasks because resident rooms were extra dirty. HK 1 stated that sometimes she was not able to clean all her assigned rooms and when that happened it would be passed off to the next shift. Review of a housekeeping checklist revealed a line for each resident room. Next to the resident room were columns with sections for check marks in which the housekeeper could document that the following was cleaned: surfaces, sink, toilet, mirror, toilet paper/paper towel, sweep, mop, and trash. There was a column for the housekeeper to document the date and time that the cleaning started and the time finished for that room, and if the resident refused the cleaning. On [DATE] at 2:08 PM, an interview was conducted with the HS. The HS stated that she had just started this week and had begun the scheduling for the housekeeping department. The HS stated that scheduling for housekeepers was to have four staff on the floor, one per hallway, seven days a week during the daytime. The HS stated that she had two laundry staff that were separate from housekeeping staff and one staff was scheduled seven days a week during the daytime. The HS stated that there were new sheets and towels in the laundry room that were ordered last week, and she just ordered 4 dozen towels, 4 dozen flat sheets, and 4 dozen fitted sheets. 8. Resident 29 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included drug induced secondary Parkinsonism, adult failure to thrive, dementia, bipolar disorder, anxiety disorder, drug induced akathisia, suicidal ideation, post-traumatic stress disorder, nephrogenic diabetes insipidus, hyperparathyroidism, chronic kidney disease, schizoaffective disorder, hyperlipidemia, Meniere's disease, non-ST elevation (NSTEMI) myocardial infarction, obstructive sleep apnea, cognitive communication deficit, insomnia, hypertension, and chronic pain. On [DATE] at 2:26 PM, an interview was conducted with resident 29. Resident 29 stated that she had clothes go to laundry that had not been returned. Resident 29 stated that she had two t-shirts and two pairs of shorts go missing in the last 6 months. Resident 29 stated that she informed staff but had never had a resolution to the missing items. Resident 29 stated that she had never had her missing items returned or replaced and had to buy more clothing items herself. Resident 29 stated that her room was cold for about a month now and that she had complained about it to the staff. Resident 29's medical records were reviewed. (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE], resident 29's Quarterly Minimum Data Set (MDS) Assessment documented a Brief Interview for Mental Status (BIMS) score of 10, which would indicate that the resident had a moderate cognitive impairment. On [DATE], resident 29's New Admit Belonging Inventory documented the following: one sweater, one pant, one black iPhone, one charging cord. No documentation could be found of an updated and current resident inventory list. The grievances were reviewed from [DATE] through [DATE] and no documentation could be found for resident 29's missing personal property. On [DATE] at 1:56 PM, an interview was conducted with Licensed Practical Nurse (LPN) 3. LPN 3 stated that resident 29 was alert and oriented times 4 to person, place, time, and situation. LPN 3 stated that resident 29 use to have intermittent confusion but had been more stable in the last 5 months since some medication adjustments. On [DATE] at 1:59 PM, an interview was conducted with CNA 3. CNA 3 stated that resident 29 had not reported any missing property. CNA 3 stated that the process for locating any missing property was to look in the laundry room for any missing clothing and if she could not find it she would report it to the laundry staff to keep an eye out for it. CNA 3 stated that she would then report the missing item to the CNA Coordinator who would then put it on the group chat. On [DATE] at 10:58 AM, an interview was conducted with Laundry Staff (LS) 1. LS 1 stated that the previous process for labeling resident clothing was that the aides were to bag the clothing and tag it so that it could be labeled in the laundry room. LS 1 stated that the aides had not been following that process. LS 1 stated that on Fridays she would take any unlabeled clothing out and ask the residents and staff if they knew who it belonged to. LS 1 stated that if no one claimed the clothing they were previously stored in a big room but does not know where the clothing was located now. LS 1 stated that if a resident was missing clothing the aides would come and look for it in the laundry room. LS 1 stated that she had not had any aides ask about missing clothing for quite some time. 9. Resident 51 was admitted to the facility on [DATE] with diagnoses which included intracerebral hemorrhage, hemiplegia and hemiparesis of left side, neurologic neglect syndrome, chronic kidney disease, hypertension, congestive heart failure, cognitive communication deficit, aphasia, visual loss both eyes, and insomnia. (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 2:34 PM, an interview was conducted with resident 51. Resident 51 stated that she had multiple items of missing clothing. Resident 51 stated that she had informed the Resident Advocate (RA) of the missing items but that he was no longer at the facility. Resident 51 stated she was missing jackets, a pink hamper, pajamas, sweat pants, and t-shirts. Resident 51 was unable to state the quantity of the missing clothing items. Resident 51 stated that she had never had her missing items returned or replaced. Resident 51 also stated that she was missing her bottom dentures and that they had been gone since she changed rooms. Resident 51 stated that her room was cold and that she had informed management but they had not done anything about it. Resident 51 stated that the vents were still blowing cold air into the room and it was worst at night. Resident 51's bathroom was observed with the toilet seat soiled with stool. Resident 51 stated that the remote control for her television did not allow her to select anything and the volume did not work. Resident 51 stated that she could only turn the television on and off. Resident 51 stated that the previous Maintenance Director left last week and no one had fixed her thermostat or television. Resident 51 stated that during incontinence care, CNA 5 threw a soiled chuck pad towards the wall and it smeared stool on the wall. The area pointed out by resident 51 was observed with a dried brown mark consistent with stool. Resident 51's medical records were reviewed. On [DATE], resident 51's MDS Assessment documented a BIMS score of 14, which would indicate that the resident was cognitively intact. The assessment documented that resident 51 did not have any hallucinations or delusions and did not have any physical or verbal behavioral symptoms. On [DATE], resident 51's New Admit Belonging Inventory documented the following: 7 t-shirts, 1 coat, 9 sweats, 1 short, 3 bras, 6 underwear, 6 pairs of socks, a cell phone and a charger. The grievances were reviewed from [DATE] through [DATE] and no documentation could be found for resident 51's missing personal property. On [DATE] at 12:53 PM, an interview was conducted with CNA 6. CNA 6 stated that if a resident reported missing property they would inform the nurse and the nurse would inform the Administrator (ADMIN). CNA 6 stated that they would then attempt to find the missing item. CNA 6 stated that upon admission they obtained an inventory of all the resident's belongings. CNA 6 stated that it was difficult to keep track of any additional personal items that were brought to the facility and he did not know if they updated the resident inventory sheet. CNA 6 stated that resident 51 had reported missing clothing but they had found them. On [DATE] at 9:39 AM, an interview was conducted with LPN 3. LPN 3 stated that resident 51 was alert and oriented times 4 to person, place, time and situation and had no memory deficits. LPN 3 stated that resident 51 did not have any missing personal items. LPN 3 stated that missing money was reported to the ADMIN. LPN 3 stated that if the missing items were clothing she would wait for laundry to check and search in the resident room then if the items could not be located she would notify the ADMIN. LPN 3 stated that sometimes the laundry staff misplaced a clothing item and she would inform them first in an attempt to locate the missing item. LPN 3 stated that resident 5 wore dentures and to her knowledge she did not have any missing dentures. LPN 3 stated that approximately 4 months ago resident 51 resided in a different room. LPN 3 stated that if a resident was missing dentures she would notify the kitchen in case they were left on a meal tray. LPN 3 stated that no one brought missing teeth to her attention and those were expensive so they needed to follow up on that. (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 1:59 PM, an interview was conducted with CNA 3. CNA 3 stated that resident 51 had not reported any missing property. CNA 3 stated that resident 51 had reported she could not find an article of clothing but it was located inside the room. On [DATE] at 2:58 PM, an interview was conducted with the HS. The HS stated that for missing property they would leave a rack with unlabeled clothing in the activity room for residents to claim. The HS stated that they asked the residents to come down hall by hall to see if any of the items were theirs. The HS stated that when they were notified of missing items they kept track of them on a sheet of paper. A resident roster with room numbers was observed on the wall. The HS stated that she would write any missing items next to the resident's name. The HS stated that she was not aware of any missing items for resident 29 or resident 51. The HS stated that as the supervisor the missing item log was supposed to go to her, but she had not received any of those logs yet. The HS stated that there were no clothes in laundry that were not labeled and unaccounted for. On [DATE] at 3:26 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that the grievance form was located on the Resident Advocate (RA) door. The DON stated that staff were to fill out the form, place it under the RA's door and he would determine which department would investigate the grievance. The DON stated that the resident, ADMIN and RA signs the form. The DON stated that missing personal property would go to the ADMIN and RA and the RA would determine if a grievance needed to be filled out for the missing property. The DON stated that if a grievance was escalated to her it would be investigated. The DON stated that when she investigated a grievance she would ask the resident when was the last time they saw the item, the timeframe of it being missed, ask staff if they noticed the item was missing, review camera footage, and then replace the property as needed. The DON stated that staff should report missing property to the RA or ADMIN. The DON stated that if a missing item was located in the resident room then they would not fill out a grievance form. The DON stated that staff should just know to inform the DON, ADMIN or RA of any missing property. On [DATE] at 9:08 PM, an interview was conducted with the RA. The RA stated he was in charge of the grievances. The RA stated the process was that when a complaint came in, the facility had 5 days to investigate the complaint. The RA stated there was a form that was filled out by the resident, staff or family members. The RA stated that staff looked for missing items and if they were unable to find the item then they would talk to the resident about what they wanted to happen. The RA stated they replaced clothing items. The RA stated that when the investigation was completed he went over it with the resident and the ADMIN signed the form. (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 9:40 AM, a follow-up interview was conducted with the RA. The RA stated that resident 29 had not informed him of any missing personal property. The RA stated that typically, if something was missing, they would take the resident to the lost and found to locate the item. The RA stated if the resident was still unable to locate the missing item they would let the ADMIN know so that the item could be replaced. The RA stated that if a resident was missing dentures, they would first look to see if they were thrown away by mistake. The RA stated that if the dentures could not be located, he would make an appointment with the dental provider to obtain a replacement. The RA stated that resident 51 would state that clothing items were missing but it was determined that those items were never brought into the facility. The RA stated that the resident's inventory sheet did not contain the extensive list of items that resident 51 had said was missing. The RA stated that the resident inventory list should be updated anytime they brought new items into the facility. The residents should notify the CNA's so they could update the inventory. The RA stated that if a CNA noticed that the resident had new items they should inventory those new items right away. The RA stated that items came and went from the facility and if something was delivered to the facility for a resident and staff was aware then it should be added to the inventory list. The RA stated that resident 51 never mentioned to him that she was missing her dentures. The RA stated that resident 51 had a habit of leaving her dentures out. The RA stated that if resident 51 was stating that her dentures were missing then they needed to locate them or obtain new ones. On [DATE] at 9:55 AM, an observation was made of the facility thermostats. The ,d+[DATE] hallway had two thermostats, one with a #4 written in sharpie on it and a second unlabeled one next to it. The #4 thermostat read 64 degrees and was set at 74 degrees Fahrenheit. The second unlabeled thermostat read 66 degrees and was set to 74 degrees. The 300 hallway across from the nurse's station read 70 degrees and was set at 72 degrees. The memory unit thermostat located at the nurse's station read 69 degrees and was set to 82 degrees. The door to the outside patio was observed propped open in the dining room. On [DATE] at 1:46 PM, a follow-up interview was conducted with the DON. The DON stated that dental appointments were now being scheduled by her, but previously it was the RA's responsibility. The DON stated that missing personal property was investigated through the grievance process by the ADMIN and DON now. The DON stated that the staff should help the resident fill out the form. The DON stated that for missing items, such as clothing, staff should contact the HS and see if the item could be located in laundry, then they should look in the resident room. The DON stated that if the item was not found they would replace the item as needed. The DON stated that the CNA's should update the resident inventory list and fill out a new sheet every time there are new items brought into the facility. The DON stated that the grievance notice needed to be updated. The DON stated that new dentures would be obtained for resident 51 and she would make the appointment now. (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 10:24 AM, an interview was conducted with the MS. The MS stated that he started at the facility approximately 2 weeks ago. The MS stated that the process for maintenance requests or repairs was that staff would text him in an emergency situation and if it was not an emergency, staff would write it in the daily maintenance log. The MS stated that he checked the log daily, Monday through Friday. The MS stated that he documented in the log any issues that were resolved or passed off to another department. The MS stated that the facility temperature was regulated by ambient air by the thermostats. The MS stated that a few rooms on the 100 and 200 hallway had the thermostat located inside the room and another thermostat in the hallway. The MS stated the when he was hired he had no training and nothing was passed off to him. The MS stated that the previous supervisor was gone when he started. The MS stated that he had complaints of residents being cold and resident 51 was one of those residents to complain. The MS stated that he had taken care of the cold temperature complaints. The MS stated that one of the rooms was on a different thermostat and he changed it from cold to heat. The MS stated that the thermostat in the ,d+[DATE] hallway was turned off. The MS stated that if the thermostat was reading a lower temperature than it was set to, it was set to cool. The MS stated that when he arrived the thermostats had not been set to heat yet. The MS stated that he was not sure of any records prior to his start date. The MS stated that the televisions not in working condition would be replaced. The MS stated that he had provided resident 51 with a new television remote when he first started. 43212 10. Resident 3 was admitted to the facility on [DATE] with diagnoses that included Arnold Chiari Syndrome with spina bifida and hydrocephalus, severe protein-calorie malnutrition, osteomyelitis right ankle and foot, paraplegia, borderline personality disorder, major depressive disorder, morbid obesity, bipolar disorder, and anxiety disorder. On [DATE] at 4:40 PM, an interview was conducted with resident 3 who stated one of her blankets had gone missing and was never found. Resident 3 stated that she notified one of the laundry staff members, but they were unable to find the blanket. Resident 3's medical records were reviewed between [DATE] and [DATE]. Resident 3's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 15, which indicated a normal cognition. On [DATE] at 3:30 PM, medical records revealed there was no documentation of resident 3's belongings when she was admitted to the facility. 11. Resident 13 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included Hereditary and idiopathic neuropathy, chronic respiratory failure, symptomatic epilepsy and epileptic syndromes with simple partial seizures, morbid obesity, hypertensive heart and chronic kidney disease with heart failure, muscle weakness, major depressive disorder, and chronic pain. On [DATE] at 4:04 PM, an interview was conducted with resident 13 who stated she had several items of clothing that were missing. Resident 13 stated tops, bottoms, and some of her temple garments were missing. Resident 13 stated a new bag of garments had been thrown away. Resident 13 stated when clothing items went missing the staff would search for them. Resident 13 stated staff have been able to find most, but not all of her clothing. (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 13's medical records were reviewed between [DATE] and [DATE]. On [DATE], an admission MDS assessment dated [DATE] revealed resident 13 had a BIMS score of 13, which indicated a normal cognition. On [DATE] at 3:34 PM, a review of resident 13's medical records revealed an inventory sheet from [DATE]. The inventory form included 4 t-shirts, 1 sweater, 4 pairs of pants, 2 pajama tops, 2 pajama bottoms, 6 garment tops, 6 garment bottoms, 1 pair shoes, 1 pair sandals, 4 pairs socks, 6 rings, 20 pairs earrings, 2 pair glasses, 1 black cell phone, 1 cell phone charger, 2 headphone sets, 1 black radio with CD player and cassette player, 1 gray HP laptop, 1 black water filter pitcher, DVD rack with DVDs, CDs and videos, 1 power chair, 1 power amp, craft supplies, 3 book cases with books, 1 nebulizer, 1 CPAP. No updated inventory sheets were found. Grievances were reviewed between [DATE] and [DATE]. No documentation was found regarding resident 3's missing blanket or resident 13's missing clothing items. On [DATE] at 4:06 PM, an interview was conducted with CNA 4 and CNA 5 who stated if a resident's clothing went missing, they would first go to the laundry to see if the item was there. CNA 4 stated she would report the missing item to the nurse and to the Human Resource (HR) manager. CNA 4 stated the nurse would document missing items. CNA 5 stated mostly the CNA's looked in the resident's room, but would also look in the activities room or the kitchen. On [DATE] at 10:58 AM, an interview was conducted with LS 1 who stated the process for missing clothing was that the CNA's were supposed to put new resident's clothing in a bag and put a tag on the bag so the clothing and other items could be labeled. LS 1 stated that process had not been happening for 3 to 4 years. LS 1 stated she had been taking unlabeled laundry out every Friday and asking residents to identify items that belonged to them. LS 1 stated if clothing items were not claimed, they used to be taken to a room where they were stored, but she did not know if that was being done now. LS 1 stated there was a label machine in the laundry room, but had not labeled the laundry for quite some time since resident clothing was being brought to the laundry room in large laundry barrels with clothing of several residents inside. LS 1 stated laundry was done every day so there should not be a long wait for laundry to return to the resident. LS 1 stated CNA's had not come to look for laundry in quite some time. LS 1 stated she was aware of resident 3's missing blanket, but was unable to find it. On [DATE] at 3:15 PM, an interview was conducted with the DON who stated the RA was taking care of grievances, and was responsible for missing personal property. The DON stated she and the ADMIN would follow up on those grievances. The DON stated residents could use a grievance form to let staff know about missing personal items, or could tell them directly. The DON stated all residents should know how to fill out a grievance form. The DON stated she was not sure if there was a posting to let residents know who they could contact for a grievance form. The DON stated depending on the type of clothing that was missing, the HS would be contacted. The DON stated staff could help the resident look through their room to locate the missing item. The DON stated there were mesh bags that were sent to the laundry with resident clothing when the resident was admitted so clothing could be labeled. The DON stated that CNA's should fill out a new inventory sheet upon admission and when new clothing items came to the facility. 30563 (continued on next page)		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50200 Based on observation, interview, and record review it was determined, for 2 out of 65 sampled residents, that the facility did not make prompt efforts to resolve grievances. Specifically, residents expressed grievances about missing personal property to staff and there was no resolution to the grievances. Resident identifiers: 29, 51. Findings included: 38031 1. Resident 29 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included drug induced secondary Parkinsonism, adult failure to thrive, dementia, bipolar disorder, anxiety disorder, drug induced akathisia, suicidal ideation, post-traumatic stress disorder, nephrogenic diabetes insipidus, hyperparathyroidism, chronic kidney disease, schizoaffective disorder, hyperlipidemia, Meniere's disease, non-ST elevation (NSTEMI) myocardial infarction, obstructive sleep apnea, cognitive communication deficit, insomnia, hypertension, and chronic pain. On 11/03/24 at 2:26 PM, an interview was conducted with resident 29. Resident 29 stated that she had clothes go to laundry that had not been returned. Resident 29 stated that she had two t-shirts and two pairs of shorts go missing in the last 6 months. Resident 29 stated that she informed staff but had never had a resolution to the missing items. Resident 29 stated that she had never had her missing items returned or replaced and had to buy more clothing items herself. Resident 29's medical records were reviewed. On 9/29/24, resident 29's Quarterly Minimum Data Set (MDS) Assessment documented a Brief Interview for Mental Status (BIMS) score of 10, which would indicate that the resident had a moderate cognitive impairment. On 12/13/21, resident 29's New Admit Belonging Inventory documented the following: one sweater, one pant, one black iPhone, one charging cord. No documentation could be found of an updated and current resident inventory list. The grievances were reviewed from January 2024 through October 2024 and no documentation could be found for resident 29's missing personal property. On 11/06/24 at 1:56 PM, an interview was conducted with Licensed Practical Nurse (LPN) 3. LPN 3 stated that resident 29 was alert and oriented times 4 to person, place, time, and situation. LPN 3 stated that resident 29 use to have intermittent confusion but had been more stable in the last 5 months since some medication adjustments. (continued on next page)		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/06/24 at 1:59 PM, an interview was conducted with Certified Nurse Assistant (CNA) 3. CNA 3 stated that resident 29 had not reported any missing property. CNA 3 stated that the process for locating any missing property was to look in the laundry room for any missing clothing and if she could not find it she would report it to the laundry staff to keep an eye out for it. CNA 3 stated that she would then report the missing item to the CNA Coordinator who would then put it on the group chat. 2. Resident 51 was admitted to the facility on [DATE] with diagnoses which included intracerebral hemorrhage, hemiplegia and hemiparesis of left side, neurologic neglect syndrome, chronic kidney disease, hypertension, congestive heart failure, cognitive communication deficit, aphasia, visual loss both eyes, and insomnia. On 11/03/24 at 2:34 PM, an interview was conducted with resident 51. Resident 51 stated that she had multiple items of missing clothing. Resident 51 stated that she had informed the Resident Advocate (RA) of the missing items but that he was no longer at the facility. Resident 51 stated she was missing jackets, a pink hamper, pajamas, sweat pants, and t-shirts. Resident 51 was unable to state the quantity of the missing clothing items. Resident 51 stated that she had never had her missing items returned or replaced. Resident 51 also stated that she was missing her bottom dentures and that they had been gone since she changed rooms. Resident 51's medical records were reviewed. On 10/9/24, resident 51's MDS Assessment documented a BIMS score of 14, which would indicate that the resident was cognitively intact. The assessment documented that resident 51 did not have any hallucinations or delusions and did not have any physical or verbal behavioral symptoms. On 1/11/24, resident 51's New Admit Belonging Inventory documented the following: 7 t-shirts, 1 coat, 9 sweats, 1 short, 3 bras, 6 underwear, 6 pairs of socks, a cell phone and a charger. The grievances were reviewed from January 2024 through October 2024 and no documentation could be found for resident 51's missing personal property. On 11/05/24 at 12:53 PM, an interview was conducted with CNA 6. CNA 6 stated that if a resident reported missing property they would inform the nurse and the nurse would inform the Administrator (ADMIN). CNA 6 stated that they would then attempt to find the missing item. CNA 6 stated that upon admission they obtained an inventory of all the resident's belongings. CNA 6 stated that it was difficult to keep track of any additional personal items that were brought to the facility and he did not know if they updated the resident inventory sheet. CNA 6 stated that resident 51 had reported missing clothing but they had found them. (continued on next page)		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/06/24 at 9:39 AM, an interview was conducted with LPN 3. LPN 3 stated that resident 51 was alert and oriented times 4 to person, place, time and situation and had no memory deficits. LPN 3 stated that resident 51 did not have any missing personal items. LPN 3 stated that missing money was reported to the ADMIN. LPN 3 stated that if the missing items were clothing she would wait for laundry to check and search in the resident room, then if the items could not be located she would notify the ADMIN. LPN 3 stated that sometimes the laundry staff misplaced a clothing item and she would inform them first in an attempt to locate the missing item. LPN 3 stated that resident 5 wore dentures and to her knowledge she did not have any missing dentures. LPN 3 stated that approximately 4 months ago, resident 51 resided in a different room. LPN 3 stated that if a resident was missing dentures, she would notify the kitchen in case they were left on a meal tray. LPN 3 stated that no one brought missing teeth to her attention and those were expensive so they needed to follow up on that. On 11/06/24 at 3:26 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that the grievance form was located on the RA door. The DON stated that staff were to fill out the form, place it under the RA's door and he would determine which department would investigate the grievance. The DON stated that the resident, ADMIN and RA signs the form. The DON stated that missing personal property would go to the ADMIN and RA and the RA would determine if a grievance needed to be filled out for the missing property. The DON stated that if a grievance was escalated to her it would be investigated. The DON stated that when she investigated a grievance she would ask the resident when was the last time they saw the item, the timeframe of it being missed, ask staff if they noticed the item was missing, review camera footage, and then replace the property as needed. The DON stated that staff should report missing property to the RA or ADMIN. The DON stated that if a missing item was located in the resident room then they would not fill out a grievance form. The DON stated that staff should just know to inform the DON, ADMIN or RA of any missing property. On 11/6/24 at 9:08 PM, an interview was conducted with the RA. The RA stated he was in charge of the grievances. The RA stated the process was that when a complaint came in, the facility had 5 days to investigate the complaint. The RA stated there was a form that was filled out by the resident, staff or family members. The RA stated that staff looked for missing items and if they were unable to find the item then they would talk to the resident about what they wanted to happen. The RA stated they replaced clothing items. The RA stated that when the investigation was completed he went over it with the resident and the ADMIN signed the form. (continued on next page)		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/07/24 at 9:40 AM, a follow-up interview was conducted with the RA. The RA stated that resident 29 had not informed him of any missing personal property. The RA stated that typically if something was missing they would take the resident to the lost and found to locate the item. The RA stated if the resident was still unable to locate the missing item they would let the ADMIN know so that the item could be replaced. The RA stated that if a resident was missing dentures, they would first look to see if they were thrown away by mistake. The RA stated that if the dentures could not be located he would make an appointment with the dental provider to obtain a replacement. The RA stated that resident 51 would state that clothing items were missing but it was determined that those items were never brought into the facility. The RA stated that the resident's inventory sheet did not contain the extensive list of items that resident 51 had said was missing. The RA stated that the resident inventory list should be updated anytime they brought new items into the facility. The residents should notify the CNA's so they could update the inventory. The RA stated that if a CNA were to notice that the resident had new items they should inventory those new items right away. The RA stated that items came and went from the facility and if something was delivered to the facility for a resident and staff was aware then it should be added to the inventory list. The RA stated that resident 51 never mentioned to him that she was missing her dentures. The RA stated that resident 51 had a habit of leaving her dentures out. The RA stated that if resident 51 was stating that her dentures were missing, they needed to locate them or obtain new ones. On 11/12/24 at 1:46 PM, a follow-up interview was conducted with the DON. The DON stated that dental appointments were now being scheduled by her, but previously it was the RA's responsibility. The DON stated that missing personal property was investigated through the grievance process by the ADMIN and DON now. The DON stated that the staff should help the resident fill out the form. The DON stated that for missing items such as clothing staff should contact the HS and see if the item could be located in laundry, then they should look in the resident room. The DON stated that if the item was not found they would replace the item as needed. The DON stated that the CNA's should update the resident inventory list and fill out a new sheet every time there are new items brought into the facility. The DON stated that the grievance notice needed to be updated. The DON stated that new dentures would be obtained for resident 51 and she would make the appointment now. 3. A review of the facility's resident council meeting minutes revealed: a. April 2024: .resident concerned that his non-labeled clothes are disappearing. Another resident commented that she had the same issue with a pair of pants that were not labeled not coming back through laundry .lost & found 'laundry day' for residents to search through unmarked clothing to find their missing property .proposed system changes for noting missing clothes, labeling clothes properly, or repairing/replacing damaged clothing .asked for grievances for all damaged/missing clothing, to be followed-up on, after the lost-&-found event, if still missing . b. July 2024: .Various interventions being taken, including process being implemented for labeling and bagging new clothing, a large clothing reclamation event being held, a weekly unlabeled laundry lost and found rack, a staff meeting in-service on process, and regular training for implementing consistent labeling procedure . c. August 2024: .Laundry Missing PIP [performance improvement plan] in process, to address . d. September 2024: .Laundry Missing Incidents were individually investigated and resolved . (continued on next page)		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/6/24 at 3:00 PM, the facility's resident council meeting was attended. Multiple residents stated that they did not know how to file a grievance and to whom the grievance should be filed with. On 11/7/24 at 10:07 AM, an observation was made of the facility's posted grievance procedure with an outdated resident advocate's name listed as the grievance official. On 11/7/24 at 12:04 PM, an interview was conducted with the ADMIN. The ADMIN stated that he had attended the resident council meeting on 11/6/24. The ADMIN stated that he did not know that some residents did not how to fill out a grievance form and that he learned that in the resident council meeting. The ADMIN stated that he would discuss grievances with the management staff and how to notify residents about the grievance process. [Cross-refer F584]		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety 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** 50200 Based on interview and record review, it was determined for 7 out of 65 sampled residents that the facility did not ensure that each resident had the right to be free from abuse and neglect. Specifically, residents were not assessed for the capacity to consent to a sexual relationship. This was cited at an immediate jeopardy level. Another resident experienced unwanted sexual contact from another resident. In addition, a resident without capacity was able to leave the facility against medical advice and was charged with trespassing. The last 2 examples were cited at a harm level. Resident identifiers: 6, 49, 54, 67, 121, 319, 419. Findings included: Notice: On 11/7/24 at 7:15 PM, Immediate Jeopardy (IJ) was identified when the facility failed to implement Centers for Medicare and Medicaid Services recommended practices to prevent various forms of abuse. Notice of the IJ was given verbally and in writing to the facility Administrator, Director of Nursing, Regional [NAME] President, [NAME] President of Clinicals, Director of Acquisitions and Risk Management, President of the Operations and the Owners. On 11/8/24 at 7:10 PM, the Director of Acquisitions and Risk Management provided the following abatement plan for the removal of the IJ effective on 11/8/24 at 8:00 PM. Immediate Actions Taken to Correct Deficient Practices Director of Nursing (DON) has implemented a one-to-one staff member assigned to ensure that resident 54 is prevented from perpetuating further sexual abuse of resident 121 or other residents. This will ensure that resident 121 is protected from resident 54. DON will inservice the one-to-one staff member regarding their job responsibilities to verify understanding of their one- to-one assignment. DON or designee will complete a Sexual Activity Capacity for Consent (SACC) assessment for residents 54 and 121 with appropriate revisions made to the plan of care as indicated based on the outcome of those assessments. Regional [NAME] President of Operations (RVPO) or designee will complete a Sexual Activity Survey of all current residents to identify any residents who express or exhibit a desire to engage in sexual activity with others, to identify any residents who have experienced sexual activity with another person while admitted in the facility, and to ensure a Sexual Activity Capacity for Consent assessment is completed as indicated for those individuals with appropriate care plan development or revision as indicated. RVPO will ensure that any resident who reports experiencing sexual activity with another person while admitted to the facility will be evaluated using the Trigger Event program for the need to report and investigate that sexual encounter as an allegation of abuse. (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Measures to Ensure the Deficient Practice Does Not Recur Director of Risk Management (DRM) completed education with DON and Minimum Data Set (MDS) Coordinator on the Sexual Activity Capacity for Consent (SACC) assessment for residents, including definition of capacity, definition of sexual activity and how to appropriately complete the assessment with residents, including assessment schedule. President of Operations completed education regarding the facility's abuse policy with the facility abuse coordinator and other interdisciplinary team members. This included education on the definitions of different types of abuse and reporting requirements, with an emphasis on sexual abuse. RVPO will complete education regarding the facility's abuse policy with all staff of the facility currently on shift. RVPO will complete education with all staff not currently working on or before their next shift. This will include education on the definitions of different types of abuse and reporting requirements, with an emphasis on sexual abuse. President of Operations has initiated a Trigger Event program to provide oversight of the facility's abuse program, wherein the abuse coordinator or designee is required to notify RVPO, Regional Nurse Consultant and assigned corporate staff member of any resident situations that have potential to be an allegation of abuse or other reportable incident as immediately as possible for group review and decision making. President of Operations has completed training with Nursing Home Administrator, DON, RVPO and RNC on the Trigger Event program. Beginning 11/8/24, RVPO or designee will complete the Risk Management audit daily Monday-Friday x 2 weeks then 3 times weekly x 2 months to ensure allegations of abuse are identified and reported timely. Beginning 11/8/24, DON or designee will complete a progress note audit daily Monday-Friday x 2 weeks then 3 times weekly x 2 months to ensure all allegations of abuse are recognized from the information entered into the medical records of residents and reported timely. Beginning 11/9/24, RVPO or designee will perform a Sexual Activity Survey audit daily Monday-Friday x 2 weeks then weekly x 2 months to ensure residents who wish to engage in sexual activity have been identified and appropriately assessed with a plan of care implemented and residents who have experienced sexual activity with another person while admitted in the facility are identified and evaluated appropriately using the Trigger Event program to ensure appropriate reporting and investigation of allegations of abuse. Measures to Monitor and Ensure Corrective Action is Achieved and Sustained (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	QAA committee under the direction of the RVPO or RNC will review the findings from the risk management audit, progress note audit and sexual activity survey audit monthly until a lesser frequency is determined to be appropriate. Any ongoing problems with residents of the facility regarding abuse allegations, including appropriate reporting and investigation of abuse allegations, will be addressed with modifications to the plan of correction implemented at the direction of the QAA committee. The facility alleges removal of immediate jeopardy on 11/8/24 at 20:00. On 11/11/24 at 2:00 PM, while completing a recertification survey an onsite revisit to verify the removal of the Immediate Jeopardy was completed. The surveyors determined that the Immediate Jeopardy was removed as alleged on 11/8/24 at 8:00 PM. Immediate Jeopardy: The facility's Abuse Policy revised on 6/11/24, was reviewed and revealed the following: Definitions .3. Sexual abuse: Non-consensual sexual contact of any type with a resident . Abuse Prevention .4. This facility honors a resident's right to engage in consensual sexual relationships. a. A licensed nurse or social worker shall complete the facility's designated assessment in the resident's medical record to determine whether the resident has the capacity to consent upon becoming aware that a resident wishes to engage in a consensual sexual relationship with another individual. b. The facility will re-evaluate a resident's capacity to consent as needed based on changes in the individual resident's physical, mental and psychosocial needs. c. If a resident has a legal or other designated representative to make decisions on his or her behalf, it is important for the resident, resident representative and facility staff to understand the types and scope of decision-making authority of the representative . 1. Resident 54 was admitted to the facility on [DATE] with diagnoses which included, but not limited to, diffuse traumatic brain injury (TBI) with loss of consciousness, unspecified ataxia, adjustment disorder with mixed disturbance of emotions and conduct, unspecified depression, and cognitive communication deficit. On 4/23/24 a Brief Interview for Mental Status (BIMS) assessment was conducted on resident 54. Resident 54 scored a 12. A score of 8-12 indicated moderately impaired cognition. A review of resident 54's care plan revealed, Focus: Resident has mental health diagnoses of TBI [traumatic brain injury] and adjustment disorder with aggression and depression as well as impulsive sexual behaviors. He uses of [sic] anti-depressant, anti-anxiety, anti-psychotic medications. Date initiated: 3/28/24 Revision on 5/16/24 Interventions included the following: (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	a. Administer medication per physician order. Monitor for side effects and notify MD [medical doctor] of any adverse or consistent side effects that occur r/t [related to] psychotropic drug use. Date initiated: 3/28/24 b. Document target symptoms Q [every] shift. Notify MD of any new/worsened symptoms of mental illness that are not effectively managed with current pharmacological and non-pharmacological interventions. Date initiated: 3/28/24 c. If resident's mental health symptoms become unmanageable in-house or a mental health crisis occurs, call the crisis line or notify the MD to obtain transfer orders for a psychiatric evaluation in the hospital setting. Date initiated: 3/28/24 d. MD will perform a medication review and make adjustments to medication regimen as indicated to target impulsive sexual behaviors that have not responded to non-pharmacological approaches. Date initiated: 5/15/24 e. Obtain informed consent for use of psychotropic medication. Medication regimen including black box warnings will be reviewed in each care conference meeting. Date initiated: 3/28/24 f. Psychotropic committee will review the medication regimen, target symptoms and side effects at least quarterly and make recommendations as indicated. Date initiated: 3/28/24 g. Staff should use the following non-pharmacological interventions to help manage resident's behavioral symptoms: 1) Provide opportunities for socialization 2) Provide encouragement, support and active listening 3) Provide reminders about appropriate interactions with others. Set boundaries and reminder [sic] resident about boundaries for interactions with others as needed. 4) Due to religious beliefs, resident's RP [responsible party] prefers that resident not have materials provided to him to be able to self-express sexual needs. 5) Involve resident's family in care. Family to take resident out of facility on outings as able. Resident's dad identified that working out is a helpful outlet for sexual frustration. Date initiated: 5/16/24 Revision on 5/16/24 A review of resident 54's progress notes revealed the following: a. On 4/24/24 at 4:46 PM, a social service note documented, Note Text: RA [resident advocate] met with RT [resident] and RT father to discuss RT being physical with one of facilities NA [nursing aides]. RT apologized for this and promised to not do it again. RT would like to apologize to NA and RA will facilitate this meeting. RT father explained to RT in office that this is not allowed and also apologized to facility for this happening. RA spoke with RT about sexual health and keeping it private. Father said that he is going to start taking RT to the gym more to help provide an outlet for RT. Pend [sic] b. On 5/6/24 at 9:49 AM, a social service note documented, Late Entry: Note Text: RA interviewed [resident 54] separately and asked what happened? [resident 54] stated he hugged [resident 319] and then grabbed her breast. RA asked resident why he would grab a woman's breast without consent? [resident 54] replied 'because I am a guy.' RA explained that just because he is a guy he cannot grab another woman's body without consent. [resident 54] stated 'I see a tit I grab one.' RA explained that the victim of this could press charges and call the police for assault, [resident 54] then reminded RA that his father is a retired police man. Resident then told RA that he was sorry. (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	c. On 5/22/24 at 11:23 AM, an alert charting note documented, Note Text: Helped get resident some water and medications for the morning. Ensured that call light was in reach and asked if there was anything else I could get him. He asked 'can I see your tits?' I told him no and that it was not an appropriate thing to ask. d. On 5/23/24 at 5: 27 PM, an alert charting note documented, Note Text: Resident asked CNA [Certified Nurses Aide] who was helping him to shower 'it is not fair that I have to be naked' and you are not. 'You should also get naked'. Also tried to spray CNA with the shower hose. When to talked to Resident and explained that it is not appropriate this type of comments and that it is also not appropriate to try to get CNA wet with the shower hose . It is becoming hard for female CNA to provide care for this resident who continue to be have inappropriate behavior. e. On 5/23/24 at 11:45 PM, a general progress note documented, Note Text: Resident continuously tried to convince aide to go out on a date with him. Aide continued to tell him no. Educated resident that this behavior is inappropriate. Resident apologized and went to his room. f. On 5/24/24 at 1:00 AM, a provider encounter note documented, .Patient seen today for behaviors. Nurses report patient has been having low moods and inappropriate sexual behaviors . g. On 5/31/24 at 6:02 PM, an alert charting note documented, Note Text: Resident is fixated on a female CNA. She reported that he is following her in the Facility. When confronted by CNA to stop this behavior, resident just continue [sic] following her. Resident has to be re- directed several times according to CNA by managementsand [sic] nurses but resident continue to pursed [sic] her unwanted attention. h. On 6/1/24 at 1:15 AM, a general progress note documented, Note Text: Aide reported to nurse that she and other aides have previously experienced inappropriate behaviors from resident while assisting with showers. Aide stated that when giving the resident a shower, resident began to inappropriately touch himself, aide told resident that it was inappropriate and resident stated 'he was almost finished', aide said she would return when he was ready to get out of shower. Aide did not report this until hearing of his continued behavior because she was scared she would get in trouble for leaving resident alone. i. On 6/1/24 at 6:13 PM, an alert charting note documented, Note Text: During lunch in Dinning [sic] room A CNA dropped something on the floor. When she bend down to pick it up resident make [sic] a comment 'Nice ass'. This unsolicited comment made the female CNA very uncomfortable. CNA told resident that those type of comments are very inappropriate. I also when to talk to resident privately about this comment and explain again that his actions and comments are very inappropriate towards females. j. On 6/1/24 at 11:07 PM, an alert charting note documented, .Pt [patient] kept staring at a female cna this evening. Pt kept asking female cna about her boyfriend. Made female cna feel uncomfortable . (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	k. On 6/3/24 at 1:00 AM, a provider encounter documented, .Today I was also informed by the staff that patient has been displaying inappropriate sexual behaviors toward female staff at the facility, such as groping an underage CNA. When speaking to patient about this she [sic] denies doing anything wrong. At this point after discussion with the facility management we will arrange a care coordination meeting with the patient's power of attorney to help decide on the best course of action. This could possibly include additional medications to help suppress his behavior, or a possible referral to the behavioral health unit . l. On 6/4/24 at 5:32 PM, an alert charting note documented, Note Text: Resident is to be male only when preforming [sic] cares due to hypersexual behaviors. Must have 2 females present if female staff is preforming [sic] cares. m. On 6/28/24 at 9:00 PM, an alert charting note documented, Note Text: Resident had call light on. When CNA entered room and asked what he wanted he said 'your number.'CNA asked if he actually needed anything and resident started to use his urinal in front of her. CNA told resident to call when he was done and left the room. n. On 11/7/24 at 10:40 AM, a communication with resident note documented, Resident [resident 54] was observed kissing resident [resident 121] in his room. Administration met separately with [resident 54] to discuss his relationship with [resident 121]. [Resident 54] stated that they are just friends and confirmed that that both she and [resident 54] consented to the kiss. A review of resident 54's Monitoring Record revealed the following number of episodes of inappropriate sexual comments every shift: a. On 5/23/24 PM shift- 2 b. On 5/25/24 PM shift- 2 c. On 5/26/24 AM shift- 2 d. On 6/14/24 AM shift- 1 e. On 6/21/24 AM shift- 4 f. On 6/28/24 PM shift- 1 g. On 9/1/24 AM shift- 2 h. On 9/1/24 PM shift- 2 i. On 9/7/24 PM shift- 1 j. On 9/9/24 AM shift- 1 k. On 9/10/24 AM shift- 2 l. On 9/16/24 AM shift- 2 (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465152	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/13/2024
NAME OF PROVIDER OR SUPPLIER Bella Terra St George		STREET ADDRESS, CITY, STATE, ZIP CODE 178 South 1200 East St George, UT 84790	
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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	m. On 9/16/24 PM shift- 2 n. On 9/17/24 AM shift- 1 o. On 9/22/24 AM shift- 2 p. On 9/23/24 AM shift- 2 q. On 9/24/24 AM shift- 1 r. On 9/29/24 AM shift- 2 s. On 9/30/24 AM shift- 1 t. On 10/1/24 AM shift- 1 u. On 10/1/24 PM shift- 1 v. On 10/5/24 AM shift- 2 w. On 10/6/24 AM shift- 2 x. On 10/7/24 AM shift- 2 y. On 10/13/24 AM shift- 1 z. On 10/14/24 AM shift- 1 aa. On 10/15/24 AM shift- 1 bb. On 10/20/24 AM shift- 2 cc. On 10/21/24 AM shift- 2 dd. On 10/22/24 AM shift- 2 ee. On 10/26/24 AM shift- 2 ff. On 10/27/24 AM shift- 2 gg. On10/28/24 AM shift- 1 hh. On 11/3/24 AM shift- 2 ii. On 11/4/24 AM shift- 2 jj. On 11/4/24 PM shift- 2 (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	kk. On 11/5/24 AM shift- 2 2. Resident 121 was admitted to the facility on [DATE] with diagnoses which included, but not limited to, metabolic encephalopathy, type 2 diabetes mellitus with hypoglycemia, acute respiratory failure with hypoxia, iron deficiency anemia, other seizures, unspecified dementia, restlessness and agitation, and mild neurocognitive disorder due to known physiological condition with behavioral symptoms. Resident 121's medical record was reviewed. On 9/30/24 a BIMS assessment was conducted on resident 121. Resident 121 scored a 10. A score of 8-12 would indicate moderately impaired cognition. A review of resident 121's care plan revealed, Focus: The resident has a behavior problem of angry outburst, wandering, hallucinations and delusions at times Date initiated: 10/25/24 Revision on: 11/5/24 Interventions included teh following: a. Anticipate and meet The resident's needs. Date initiated: 10/25/24 b. Caregivers to provide opportunity for positive interaction, attention. Stop and talk with him/her as passing by. Date initiated: 10/25/24 c. If reasonable, discuss The resident's behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable to the resident. Date initiated: 10/25/24 d. Praise any indication of The resident's progress/improvement in behavior. Date initiated: 10/25/24 e. Provide a program of activities that is of interest and accommodates residents status. Date initiated: 10/25/24 Another care plan revealed, Focus: The resident has an alteration in neurological status r/t disease process MILD NEUROCOGNITIVE DISORDER DUE TO KNOWN PHYSIOLOGICAL CONDITION WITH BEHAVIORAL DISTURBANCE Date initiated: 11/4/24 Revision on 11/4/24 Interventions included the following: a. Allow the resident a rest period when she is upset. Date initiated: 11/4/24 b. Cueing, reorientation as needed. Date initiated: 11/4/24 c. Discuss with resident/resident and family any concerns, fears, issues regarding diagnosis or treatments. Date initiated: 11/4/24 d. Give medications as ordered. Monitor/document for side effects and effectiveness. Date initiated: 11/4/24 e. Provide emotional support when the resident appears agitated. Date initiated: 11/4/24 (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	f. Special attention provided when the resident has contact with her mother. Date initiated: 11/4/24 A review of resident 121's progress notes revealed the following: a. On 9/25/24 at 3:35 AM, an admission progress note documented, 9/25/2024 03:35 (3:35 AM) Admission Progress Note admitted /Time:: 9/24/2024 1930 (7:30 PM) admitted from/Transported by:: [Hospital Name] transported by mother Primary diagnosis for admission:: Pneumonitis Secondary diagnoses:: DM2 [diabetes mellitus type 2], Acute Respiratory Failure with hypoxia Hx [history] of methamphetamine abuse Vital signs upon admission:: 150/93 bp [blood pressure] 96 pulse 24 rr [respiratory rate] 97.5 t [temperature] 96 o2 [oxygen] 61 inches tall 148.5 lbs Pain level/interventions administered as applicable:: na [not applicable] Mental status upon admission:: Resident was very anxious and hysterically crying. Resident stated she was angry her mom left her here. Mother brought a few belongings in, and told the staff good luck and left facility. Pt very stressed and pacing in the halls. CNA showered resident andpt [sic] calmed down. During assessment patient was oriented and answered questions appropriately, but gets distracted and confused easily. Mobility status/mobility devices:: patient ambulates independently. States she used a walker in the hospital and is requesting a walker to use.Special devices used:: na Oriented to facility. b. On 9/25/24 at 11:45 AM, a skilled charting note documented, Late Entry: Note Text: Resident is A/A/O [sic] [alert and oriented] x 2 with intermittent confusion with auditory and visual hallucinations noted. c. On 9/26/24 at 12:28 AM, an alert charting note documented, Note Text: Pt very anxious at beginning of shift. Returned from an outing with her mother and was very upset and crying. pt stated her mom doesn't care about her and only wants to visit her so she can lecture her about using drugs. Nurse took pt to her room and talked to her for a few minutes while giving her, her medications. Pt took medications and stated she needed to go walk the halls because she continued to be so upset with her mom. After pacing the halls for 20 minutes patient returned to room to watch tv [television]. d. On 9/30/24 at 11:15 PM, a skilled charting note documented, Note Text: Resident alert and oriented to self. no resp [respiratory] distress noted, lungs clear. Denies pain at this time. Requires frequent redirection. talks to self and wanders up and down the hallways, yelling at self and staff and other residents. Neighbor reports she was kicking at the walls in the middle of the night last night. pt skin turgor supple, intact. continent of bowel and bladder. good appetite, eats rapidly. takes fluids well. e. On 10/1/24 at 8:00 AM, a psychological provider note documented, [resident 121] exhibits poor cognition throughout interview including poor attention, distractibility, poor memory, poor social understanding or decreased complex attention. She is unable to explain how she became homeless or how she took care of herself prior to or during homelessness. She is unable to verbalize a plan after discharge. [Resident 121] has persistent abnormal movements including rubbing at her face, neck and arms. She is unable to remain still. Subjective interview and objective assessment of MOCA [Montreal Cognitive Assessment] scoring 14 indicate Major Neurocognitive Disorder, most likely drug induced from many years of alcohol and methamphetamine abuse . (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	f. On 10/1/24 at 9:19 AM, a skilled charting note documented, Note Text: pt had overdose on meth [methamphetamine] use. pt currently on augmentin for s/s [signs and symptoms] of resp [respiratory] infection. no resp distress noted. lungs clear. room air sats [saturation] at 97. Denies pain this am. needs redirected often. talks to self and wanders up and down the hallways, yelling at self and other staff and residents. pt educated to stop slamming doors and raising her voice at others. pt skin turgor supple, intact. continent of bowel and bladder. good appetite, eats rapidly. takes fluids well. Today pt reported by management that pt is going to be staying long term. g. On 10/6/24 at 9:27 AM, a skilled charting note documented, Note Text: pt wandering up and down hallways, talking loudly to self and arguing with staff and other residents. unable to redirect pt. h. On 10/7/24 at 1:34 AM, a skilled charting note documented, Late Entry: Note Text: Pt returned to facility from outing with mom and granddaughter. Pt very agitated and crying stating her mother makes her super upset. Pt states she does not want mother or granddaughter into the facility. Pt very upset and pacing the halls yelling at her self for 30 min [minutes]. i. On 10/18/24 at 11:21 PM, a skilled charting note documented, Note Text: Resident is alert and oriented x 2-3. Often confused, not oriented to situation. Pleasant with staff. Wanders hallways often. Good appetite. Compliant with BS [blood sugar] checks and insulin administration. Takes pills whole. Denies pain. Has not slept well the past two nights. j. On 10/27/24 at 3:36 PM, an alert charting note documented, Note Text: Corporate nurse found pt walking by street in front of facility this afternoon, nurse was able to direct pt back into the facility. notified DON [Director of Nursing] k. On 10/29/24 at 1:57 PM, a skilled charting note documented, Note Text: Resident is alert and oriented x 2 self, situation. Resident has episodes of confusion. Resident shows signs of anxiety and sadness. Resident is found often pacing the hallways and talking to self. Resident was redirected and invited to multiple activities during the day. Resident has redness under pannus. Resident is a limited assistance with dressing ADL [activities of daily living] and toileting. WCTM [will continue to monitor]. l. On 10/31/24 at 4:00 PM, a skilled nursing note documented, Late Entry: Note Text: No changes in LOC [level of consciousness]. Resident did have multiple verbal outburst. Resident was upset because mother would not take her trick or treating. Resident was given time to calm down and verbalize why she was upset. Resident calmed and went to socialize with other residents in the activity [sic] room. WCTM. m. On 11/8/24 at 8:49 AM a COMMUNICATION - with Resident note documented, Note Text: Resident [121] was observed kissing resident [54] in his room. Administration met separately with [resident 121] to discuss her relationship with [resident 54]. [Resident 121] stated that they are just friends and confirmed that both she and [resident 54] consented to the kiss. 3. Resident 319 was admitted to the facility on [DATE] and readmitted on [DATE] and discharged on [DATE] with diagnoses which included metabolic encephalopathy, hypothyroidism, bipolar II disorder, anxiety, disease of blood and blood-forming organs, hypertension, and traumatic brain injury. Resident 319's medical record was reviewed 11/3/24 through 11/13/24. (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A quarterly MDS dated [DATE] revealed resident 319's BIMS score was 13 which indicated cognitively intact. A social services note dated 5/6/24 at 9:45 AM revealed a late entry RA met with [resident 121] to inquire about report that [resident 54] grabbed her breast. [Resident 121] stated that she was coming down 200 hall towards the gym area and stopped to give [resident 54] a hug and as he hugged her he moved his hand down her body and grabbed her breast, [resident 121] stated that she immediately told [resident 54] no and he said he was sorry and continued moving away from her towards 300 hall and she went outside. That was the end of it. A social services note dated 5/6/24 at 9:47 AM was a late entry created on 5/14/24. The note revealed, RA met with RT again and asked if RT would like to press charges against RT for what she reported? RT stated 'No, I don't want to cause trouble for anyone.' RA asked RT if she was sure, and maybe wanted to think about it longer? RT replied 'I am sure, I don't want to press charges, period.' Potential for Harm 4. Resident 6 was admitted to the facility on [DATE] with diagnoses which include hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting right dominant side, other abnormalities of gait and mobility, aphasia, dysphagia following cerebral infarction, epilepsy, cognitive communication deficit, and major depressive disorder. On 11/3/24 at 6:14 PM, an observation was made of resident 49 pushing resident 6 in her wheelchair in the 100 hallway. On 11/3/24 at 6:45 PM, an interview was conducted with resident 49. Resident 49 was sitting in the dining room when resident 6 entered the dining room in a wheelchair. Resident 6 was observed to sit at resident 49's table. Resident 49 pointed to resident 6 and stated that was his girlfriend. Resident 6 was observed to move her head in a yes motion and smiled. On 11/6/24 at 3:37 PM, an observation was made of resident 49 and resident 6 in the activity room. Resident 6 and resident 49 were sitting on a sofa. Resident 6 was observed to have her head on resident 49's chest and resident 49 had his arm around resident 6. Both residents were observed with their eyes closed. Resident 6's medical record was reviewed. On 2/6/24 a BIMS assessment was completed on resident 6. Resident 6 scored a 9. A score of 8-12 would indicate moderately impaired cognition. A review of resident 6's sexual activity capacity for consent dated 2/21/24 revealed: a. Describe resident's stated choice: She stated, 'I love him' she said and likes to cuddle with him, but does not want a sexual relationship. She does not want any sexual touching. (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of resident 6's care plan revealed Focus: MOOD & BEHAVIOR: [Resident 6] has potential for mood and coping issues due to desire to have a romantic relationship with another resident. [Resident 6's] outside medical provider [name redacted] has been consulted and confirmed [resident 6] has capacity to make her own decisions and provide consent. Date initiated: 5/29/24 Revision on 6/26/24 Interventions included the following: a. Assess [resident 6's] capacity to give consent for romantic relations with another resident. Date initiated: 5/29/24 Revision on: 5/29/24 b. If any other resident requests romantic encounter with [resident 6], staff will verify if [resident 6] also wants encounter and if she doesn't, staff will make sure her rights are protected. Staff will make sure other resident respects [resident 6's] wishes. Date initiated: 5/29/24 c. Offer psychosocial support as needed Date initiated: 5/29/24 Revision on: 5/29/24 d. Whenever [resident 6] elects to spend time with other resident, staff will ask and verify that spending time is what she wants and that there is no coercion involved. Reinforce that any kind of romantic and/or sexual expression is her choice. Date initiated: 5/29/24 Revision on: 5/29/24 Another care plan revealed Focus: [Resident 6] has an on again off again relationship with another consenting resident. Date initiated: 6/26/24 An intervention included [Resident 6] will only have romantic companionship with other consenting residents. Staff will verify that 321B is interested in a romantic encounter with [resident 6] PRN [as needed]. [Resident 6] and 321B will confine their romantic relations to a location that is appropriate and separate from other residents. [Resident 6] and 321B will be respectful of other resident's and their rights. Date initiated: 6/26/24 A review of resident 6's progress notes revealed the following: a. On 3/4/24 at 11:22 AM, a social service note documented, RA met with resident and confirmed resident no longer wants to associate with [resident 49] after the incident at church yesterday. RA asked if resident has attempted to talk with resident since, and resident stated no. RA asked resident to notify staff if she feels unsafe. RA will meet with [resident 49] and talk with him about no contact with [resident 6]. b. On 3/4/24 at 1:27 PM, a social service note documented, [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** 43212 Based on interview and record review, for 1 of 65 sampled residents, the facility did not take all the necessary steps to prevent the exploitation of a resident for personal gain. Specifically, when the facility became aware of possible exploitation of a resident, the police were not notified, and no follow-up occurred to protect the resident. Resident identifier: 13. Findings include: Resident 13 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included hereditary and idiopathic neuropathy, chronic respiratory failure, symptomatic epilepsy and epileptic syndromes with simple partial seizures, morbid obesity, hypertensive heart and chronic kidney disease with heart failure, muscle weakness, major depressive disorder, and chronic pain. Resident 13's medical record was reviewed between 11/3/24 and 11/13/24. On 6/11/24, an admission Minimum Data Set (MDS) assessment revealed resident 13 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated a normal cognition. On 8/6/24 at 7:53 AM, a progress note revealed, RA [resident advocate] met with RT [resident] to discuss help with setting up crypto account. RA quickly determined RT is a victim of scam. Perpetrator is stating they are [celebrity] the singer and they are going to marry RT. RT is excited about this relationship and [celebrity] coming to [city] while touring in Las Vegas to meet RT. RA made it very clear that any requests for money, or crypto, loans is a scam and RT could fall victim to identity and financial theft. RA contacted [bank] after learning RT has provided log in information for her online banking. [Bank] closed down the accounts and froze a fraudulent deposit. RA facilitated RT visiting the DLD [drivers license division] to renew her license, this was first step for RT to visit the branch in person and have new accounts created. RA offered support to RT and explained feelings of grief are normal and expected when any relationship ends. RA made it clear that RT should no longer speak with this person and block any further communication. On 8/13/24 at 7:45 AM, a psychological progress note revealed, .Her bank account was shut down when [celebrity] tried to deposit some money into her account so that she could buy a house. SW [social work] and bank worked with her to close accounts and protect her assets. She continues to speak to [celebrity and his son] on the internet. She does not believe it to be a scam .The patient has had increased sadness and loneliness since changes in her relationship with [celebrity]. (continued on next page)		

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/13/24 at 7:58 AM, a social service progress note revealed, RA has communicated with RT therapist [name], [Behavioral Health Provider]. Therapist confirmed RT has continued online relationship, and is having difficulty accepting that relationship was a scam. RA has learned that RT was upset about account being closed, and was not happy RA intervened to help RT not fall victim to scam. RT has communicated with nursing staff that she is attempting to repair online relationship and that [celebrity-son] is not speaking with her about repairing damage to the relationship by asking RT to qualify for a loan to make it up to him. RA has communicated this with RT therapist, and [name] RT, APRN [advanced practice registered nurse]. All treatment providers agree it is best to allow RT to make her own decisions and respect her autonomy. RT has been warned about scam, and is being offered support regardless of her choices. RT has been determined to be capable of making her own decisions. RA met with RT and offered support. RA also apologized for quickly acting on scam and having RT account closed, even with RT consent and being present for the calls to [bank]. RA explained this was done in an effort to help RT avoid suffering and that RT wishes are important and RA wants to honor them. RT stated she understood and appreciated the talk. On 8/22/24 at 3:59 PM, a social service progress note revealed, RA contacted APS [adult protective services] to file report about online relationship-RA explained the situation and APS provided case #180980. Resident 13's care plan revealed the following: a. Mood & Behavior: [resident 13] has potential for coping and adjustment issues, related to a desire for an online relationship and potential for online exploitation. Depression. Due to this desire, [resident 13] has had a capacity to consent evaluation done and has been found to have the ability to consent to relationship. Date initiated 8/14/2024, Revision on: 11/8/24. The goal was, Dignity will be preserved and quality of life improved by allowing [resident 13] to make her own informed decisions. Date initiated: 8/14/2024, Revision on: 8/14/2024, Target Date: 2/7/2025. Interventions included, Allow resident [resident 13] to calm down and reapproach at a later time if agitated. Date initiated: 8/14/2024, Revision on: 8/14/2024. Evaluate for need and refer to psychological counseling as recommended by physician. Date initiated: 8/14/2024. Monitor and document each behavioral event PRN [as needed]. Date initiated: 8/14/2024, Revision 8/14/2024. Offer 1:1 interaction as needed, Date initiated: 8/14/2024. Provide information to [resident 13] regarding potential financial and emotional exploitation. Assist PRN with banking issues if [resident 13] requests. Follow mandatory reporting policies if needed. Date initiated: 8/14/2024. b. The resident has a psychosocial well-being problem r/t sexual activity capacity. 11/8/24-Resident does not have capacity for sexual activity consent. Date initiated: 11/8/24, Revision: 11/8/24. The goal was, The resident will have no indications of psychosocial well-being problem by/through review date. Date initiated: 11/8/24, Revision on: 11/8/24. Interventions included, .conduct sexual activity capacity for consent every quarter, as needed, and with every change in condition. Consult with MD for input on sexual activity capacity for consent. Date initiated: 11/8/24 .Provide opportunities for the resident and family to participate in care. Date initiated: 11/8/24. The resident needs assistance/encouragement/support to identify causative and contributing factors. Date initiated: 11/8/24. Resident advocate was unable to be reached for interview. (continued on next page)		

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/13/24 at 8:59 AM, an interview was conducted with the Director of Nursing (DON) who stated that resident 13 believed she was in a relationship with a celebrity. The DON stated that APS and the ombudsman were involved. The DON stated she would check with the previous RA. The DON stated the police should be contacted if financial exploitation was suspected. The DON stated the previous RA had helped resident 13 with her bank accounts. The DON stated they had to get resident 13 new accounts to protect her information. The DON stated resident 13 was trying to cash a check that was fraudulent. The DON stated she would obtain and provide more information. The DON stated the MDS [minimum data set] coordinator was responsible to update resident care plans related to the ability to consent. The DON stated not properly updating the care plan could confuse staff who were providing care to the resident. It should be noted that the DON did not provide additional information about whether the police were contacted and if any additional follow-up was conducted. The facility abuse policy and procedures were reviewed. The policy revealed, The facility will ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown origin and misappropriation of resident property is reported immediately but no later than 2 hours, after the allegation is made . Resident abuse: .Abuse includes any type of abuse that is facilitated or enabled through use of technology or social media .Exploitation: Taking advantage of a resident for personal gain through use of manipulation, intimidation, threats or coercion .If there is suspicion that a crime occurred that did not result in major bodily injury, the incident must be reported to law enforcement within 24 hours in compliance with the Elder Justice Act. On 11/13/24 at 1: 01 PM, the facility Administrator (ADMIN) submitted an entity report 358 related to Misappropriation of Resident Property/ Exploitation. The entity 358 indicated [name redacted] was the perpetrator and the relationship was online. The entity 358 stated the facility became aware of the concern on 8/6/24 at 7:53 AM and the RA was the staff member who became aware. The entity 358 stated the ADMIN was notified around 10 am. The entity 358 stated there was a witness, however, the remainder of the section was left blank. The entity 358 report indicated police were notified on 11/13/24 at 1:00 PM. No report number was listed. APS and the ombudsman were notified on 8/6/24.		

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F 0603 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48709 Based on interview and record review it was determined, for 1 of 65 sampled residents, that the facility failed to ensure the resident was free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. Specifically, a resident was relocated to the locked memory care unit for not following the smoking policy. Resident identifier: 46. Findings included: Resident 46 was admitted to the facility on [DATE] with diagnoses which included hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, muscle weakness, aphasia, cognitive communication deficit, chronic obstructive pulmonary disease with acute exacerbation, lack of coordination, acute kidney failure, major depressive disorder and anxiety. On 11/4/24 at 2:20 PM, an observation was made of resident 46 in the smoking area behind the facility with Medical Records (MR) staff and two other residents. Resident 46 was observed being brought into the facility via wheelchair by MR staff and handed her cigarette box to MR staff. Resident 46 appeared calm and cooperative during observation. On 11/5/24 at 1:27 PM, an observation was made of resident 46 being taken by staff via wheelchair outside to the smoking area. On 11/5/24 at 2:28 PM, an observation of resident 46 was made. Resident 46 was observed smoking outside in front of the building in an open parking spot, while she was sitting in her wheelchair. No staff were observed outside. Resident 46's medical record was reviewed 11/3/24 through 11/13/24. A Minimum Data Set (MDS) assessment, dated 8/8/24, indicated the Brief Interview for Mental Status (BIMS) was not conducted due to the resident being rarely or never understood. It further indicated, Staff Assessment for Mental Status, Short-term Memory OK Seems or appears to recall after 5 minutes 0. Memory OK, Long-term Memory OK Seems or appears to recall long past 0. Memory OK. A Smoking Safety Screen, dated 5/9/24 at 11:56 PM, indicated resident 46 was not smoking in the proper areas and hid cigarettes and a lighter in her bra/room. A Wander/Elopement Risk Evaluation, dated 5/9/24 at 11:58 PM, indicated, Resident is not currently an elopement risk. (continued on next page)		

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F 0603 Level of Harm - Actual harm Residents Affected - Few	A General Progress Note, dated 7/2/24 at 4:22 PM, indicated, Behavior/Smoking Note: Resident was observed as non compliant with facility smoking policy. Per this policy, resident is placed back on restrictions and has cigarettes and lighter locked at nursing station. Resident has been informed of violation and was reeducated on smoking safety and facility policy. Resident was reeducated on resident smoke break times (times when the facility staff aides residents who are on smoking restrictions to the smoking area, allowing them to smoke.) Resident has also had an increase in verbal abuse towards staff. Resident was told that this behavior is not tolerated at this facility. Resident denied behavior, but agreed that using foul language towards staff was to not be tolerated. Nursing management, resident, nursing staff, RA [Resident Advocate], and administrator made aware of behavior and violation of smoking policy. An Alert Charting note, dated 7/6/24 at 12:24 PM, indicated, pt [patient] found out front smoking again, pt was already on smoking restrictions, removed 3 boxes of cigarettes from her and a lighter again today. management notified. An Alert Charting note, dated 8/11/24 at 1:40 PM, indicated, .pt did have episode of aggressive [sic] behaviors today and demanding other residents cigarettes. A Progress note, dated 8/14/24 at 11:33, indicated, Caught resident smoking outside of the smoking area. Told her she needed to put out her cigarette, resident complied. Educated resident verbally about smoking policy and smoking area. A Nursing Monthly Summary dated 9/6/24 at 9:55 PM, indicated, Resident with expressive aphasia. Uses hand gestures to communicate. No memory concerns or seizure activity. It further indicated a mental status of alert and fully oriented and that resident 46 understood verbal content with a clear comprehension. It further indicated, No new diagnoses. Frustration with communication difficulties r/t [related to] expressive aphasia. Does have some anxious behaviors. It further indicated, Resident continues to be non-compliant with smoking policy. Has also had some issues with taking things that are not hers. An Alert Charting note, dated 9/11/24 at 5:07 PM, indicated, Resident caught outside not following the smoking policy. Resident put cigarette out and came back inside. Was very agitated she was caught smoking the [sic] in the front of the building. Yelling out '[expletive redacted]'. A Social Service Note, dated 9/13/24 at 1:38 PM, indicated, RA contacted RT [resident] daughter [name redacted]- LMTC [left message to contact] regarding move RT to behavior unit due to RT refusal to follow smoking policy. An Alert Charting note, dated 9/29/24 at 5:46 PM, indicated, pt upset with nurse that her meds are given whole or crushed in a/s [applesauce] and or yogurt as pt was witnessed checking her meds last week. attempted to give pt her 1800 [6:00 PM] pain meds and she spit at nurse, pt than [sic] apologized and nurse got new norco [pain medication] ready, had 2nd nurse witness attempt to give pt her pain med at this time. pt also found out front smoking and educated again not allowed. cigarettes locked in med room that the pt daughter brought in. (continued on next page)		

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F 0603 Level of Harm - Actual harm Residents Affected - Few	A Nursing Monthly Summary dated 10/08/24 at 1:13 AM, indicated, Resident with expressive aphasia. Uses hand gestures to communicate. No memory concerns or seizure activity. It further indicated, Resident has had increased agitation, episodes of pocketing medications, taking items that are not hers and non-compliance with smoking policy. It further indicated a mental status of alert and fully oriented and that resident 46 understood verbal content with a clear comprehension. It further indicated, No new diagnoses. Frustration with communication difficulties r/t expressive aphasia. Does have some anxious behaviors. It further indicated, Resident continues to be non-compliant with smoking policy. Has also had some issues with taking things that are not hers. She has had increased agitation. A Psych Follow Up note, dated 10/8/24 at 6:00 AM, indicated, Discussion Notes Pt is seen today for follow up. She was recently moved to memory care unit as she was not compliant with rules surrounding smoking. This has been a somewhat hard transition for her. However, staff report that she seems to be doing better and meds are well tolerated at this time . It further indicated, .[Resident 46] is seen today for follow up. She is in her new room in the memory care unit. She is unhappy about this move but seems to understand that it is d/t [due to] her non compliance with smoking rules. She reports her mood as being stable and without concerns Staff report that [resident 46] was upset about move but remained non compliant with rules. She does not have cigarettes at this time which increases her frustration. They report that she seems to be doing better however with less crying spells and anxiety. Medications seems effective at this time. An Alert Charting note, dated 10/20/24 at 5:34 PM, indicated, pt non-compliant with smoking times, keeps putting her finger over her mouth in the 'shhh motion' tells nurse not to tell and let her have cigarettes have educated pt multiple times today she must smoke at designated times and has to be supervised. pt keeps telling nurse to 'F' off and wont leave nurse alone at the nurses station even after nurse has asked her multiple times to please quit asking to smoke when it is not time and to go sit in her room or find an activity to do. pt remains at nurses station telling nurse to 'F' off. A Smoking Safety Screen, dated 10/21/24 at 11:02 AM, indicated, Resident has been noncompliant with smoking in the smoking area. It further indicated, Resident is able to safely mobilize to the designated smoking area; Resident is able to safely handle lit smoking materials, including handling of ashes/embers; Resident is able to safely interact with others while smoking; and Resident is able to safely extinguish and/or dispose of smoking material in the designated receptacle when finished smoking. It further indicated, Resident has difficulty moving to the smoking area. An Alert Charting note, dated 10/21/24 at 5:20 PM, indicated, Pt caught outside smoking 3 times today unsupervised with packs of cigarettes in her bra. pt non-compliant with staff, resident scratched nurses arms and told her to [expletive redacted] off multiple times today. spoke with pt daughter [name redacted] about pt behaviors today and reported to management. A Psych Follow Up note, dated 10/22/24 at 6:00 AM, indicated, .[resident 46] is seen today for follow up. She has been moved back to previous room. She is sleeping late into the afternoon. When spoken to she opens her eyes, shakes her head and points to the door for me to leave. On 11/5/24 at 1:27 PM, an interview was conducted with Registered Nurse (RN) 4. RN 4 stated resident 46 was on supervised smoking because she was caught smoking out front and hiding cigarettes and lighters in her bra. (continued on next page)		

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F 0603 Level of Harm - Actual harm Residents Affected - Few	On 11/5/24 at 6:04 PM, an interview was conducted with the Director of Nursing (DON). The DON stated the only place residents could smoke was in the back of the facility and if they broke the rules they became supervised smokers. The DON stated resident 46 required supervision when she smoked and had been caught continuing to smoke by herself. On 11/6/24 at 3:15 PM, an interview was conducted with CNA 4. CNA 4 stated residents could not smoke out front because they had to be 25 feet from the entrance. CNA 4 stated residents used to be able to smoke out front but the policy changed about one year ago. CNA 4 stated resident 46 was on supervised smoking and that she could only go out at the designated smoking times. CNA 4 stated the facility had rules and if a resident was caught smoking in a non-designated area that they were put on supervised smoking. On 11/7/24 at 10:33 AM, an interview was conducted with RN 2. RN 2 stated that resident 46 was moved into the memory unit because of her smoking behaviors. RN 2 stated resident 46's family was not happy when resident 46 was found in here [interview was conducted in the memory care unit]. RN 2 stated residents who were prone to elopement or had memory problems were placed in the memory care unit. On 11/7/24 at 11:38 AM, an interview was conducted with the MDS Coordinator. The MDS Coordinator stated that the number one thing he did with resident 46 was to help her go smoke. The MDS Coordinator stated that resident 46 was able to understand that she was not supposed to smoke out front but that she was non-compliant with smoking. The MDS Coordinator stated resident 46 was put into the memory care unit to help her quit smoking in non-designated areas. The MDS Coordinator stated the residents in memory care were wanderers, at risk for elopement or dementia residents. The MDS Coordinator stated that resident 46 was moved into the memory care unit on 10/2/24 and moved back out on 10/17/24. On 11/7/24 at 12:13 PM, a telephone interview was conducted with the Resident Advocate (RA). The RA stated resident 46 had a hard time following the smoking policy and that she would smoke right in front of the entrance doors, so she was placed on supervised smoking. The RA stated the facility had a designated smoking area so others did not have to be exposed to second-hand smoke. The RA stated resident 46 had a history of chain smoking and that staff would take her to smoke at scheduled and off-times, but that she would request to smoke more often than the staff were able to take her. The RA stated she would have other residents buy her cigarettes and convince them to give her a lighter. The RA stated she would hide the cigarettes in her bra. The RA stated they had a meeting with her daughter and a friend and discussed moving resident 46 to the locked unit because they were at a loss. The RA stated the daughter said she wanted her mom to stay out of the memory unit. The RA stated resident 46 continued to break the rules so he and the ADMIN and DON decided to move her to the memory unit. The RA stated he tried to notify the daughter about the move but she did not answer the phone. The RA stated resident 46's daughter did call him back and then came to the facility and was shown the memory unit. The RA stated the daughter did not like the fact that resident 46 was moved but knew it was necessary. The RA stated resident 46 was in the memory unit for a few weeks and was moved out because her daughter came in and wanted us to consider moving her back out. (continued on next page)		

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F 0603 Level of Harm - Actual harm Residents Affected - Few	On 11/7/24 at 12:44 PM, a telephone interview was conducted with resident 46's daughter. She stated that she was very upset about her mom being placed in the memory care unit. She stated they called it isolation and they did it to punish her. She stated one staff member called her to warn me that they were going to do this because she was not following the rules. The daughter stated that the following week she showed up and her mom had been moved into the memory care unit and that staff had moved her there two hours before the daughter got to the facility. She stated she had told them that she did not want her mom moved into the memory care unit. The daughter stated her mom was very upset and crying the first time she saw her in the memory care unit. The daughter stated she worked with the ADMIN to get her mom moved out of the memory care unit. She stated when the ADMIN heard she wanted to move resident 46 to a different facility, she told him she wanted her mom moved out and she was moved out that day. The daughter stated her mom was a depressed person, so her behavior was not that different than her normal when resident 46 was in the memory care unit and after she had been moved out. On 11/7/24 at 1:17 PM, an interview was conducted with the Administrator (ADMIN). The ADMIN stated resident 46 was put into the memory care unit because she was noncompliant with the smoking policy. The ADMIN stated she should be able to understand the smoking policy. The ADMIN stated she was moved out of the memory care unit because her daughter was upset that the doors were locked and wanted her moved out. On 11/12/24 at 3:37 PM, an interview was conducted with the DON. The DON stated a wander risk assessment and an Interdisciplinary Team (IDT) meeting would need to be completed prior to moving a resident in or out of the memory care unit. The DON stated resident 46 was safe to be outside by herself.		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50200 Based on interview and record review it was determined for 5 out of 65 sampled residents, that the facility did not develop and implement written policies and procedures that prohibited and prevented abuse, neglect, and exploitation of residents and misappropriation of resident property. Specifically, facility staff did not conduct capacity to consent to sexual relationships for residents prior to residents engaging in sexual relationships. Resident identifiers: 6, 49, 54, 121 and 319. Findings include: The facility's Abuse Policy revised on 6/11/24, was reviewed and revealed the following: Definitions .3. Sexual abuse: Non-consensual sexual contact of any type with a resident . Abuse Prevention .4. This facility honors a resident's right to engage in consensual sexual relationships. a. A licensed nurse or social worker shall complete the facility's designated assessment in the resident's medical record to determine whether the resident has the capacity to consent upon becoming aware that a resident wishes to engage in a consensual sexual relationship with another individual. b. The facility will re-evaluate a resident's capacity to consent as needed based on changes in the individual resident's physical, mental and psychosocial needs. c. If a resident has a legal or other designated representative to make decisions on his or her behalf, it is important for the resident, resident representative and facility staff to understand the types and scope of decision-making authority of the representative . 1. Resident 54 was admitted to the facility on [DATE] with diagnoses which included, but not limited to, diffuse traumatic brain injury (TBI) with loss of consciousness, unspecified ataxia, adjustment disorder with mixed disturbance of emotions and conduct, unspecified depression, and cognitive communication deficit. On 4/23/24 a Brief Interview for Mental Status (BIMS) assessment was conducted on resident 54. Resident 54 scored a 12. A score of 8-12 indicated moderately impaired cognition. A review of resident 54's care plan revealed, Focus: Resident has mental health diagnoses of TBI [traumatic brain injury] and adjustment disorder with aggression and depression as well as impulsive sexual behaviors. He uses of [sic] anti-depressant, anti-anxiety, anti-psychotic medications. Date initiated: 3/28/24 Revision on 5/16/24 Interventions included the following: (continued on next page)		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. Administer medication per physician order. Monitor for side effects and notify MD [medical doctor] of any adverse or consistent side effects that occur r/t [related to] psychotropic drug use. Date initiated: 3/28/24 b. Document target symptoms Q [every] shift. Notify MD of any new/worsened symptoms of mental illness that are not effectively managed with current pharmacological and non-pharmacological interventions. Date initiated: 3/28/24 c. If resident's mental health symptoms become unmanageable in-house or a mental health crisis occurs, call the crisis line or notify the MD to obtain transfer orders for a psychiatric evaluation in the hospital setting. Date initiated: 3/28/24 d. MD will perform a medication review and make adjustments to medication regimen as indicated to target impulsive sexual behaviors that have not responded to non-pharmacological approaches. Date initiated: 5/15/24 e. Obtain informed consent for use of psychotropic medication. Medication regimen including black box warnings will be reviewed in each care conference meeting. Date initiated: 3/28/24 f. Psychotropic committee will review the medication regimen, target symptoms and side effects at least quarterly and make recommendations as indicated. Date initiated: 3/28/24 g. Staff should use the following non-pharmacological interventions to help manage resident's behavioral symptoms: 1) Provide opportunities for socialization 2) Provide encouragement, support and active listening 3) Provide reminders about appropriate interactions with others. Set boundaries and reminder [sic] resident about boundaries for interactions with others as needed. 4) Due to religious beliefs, resident's RP [responsible party] prefers that resident not have materials provided to him to be able to self-express sexual needs. 5) Involve resident's family in care. Family to take resident out of facility on outings as able. Resident's dad identified that working out is a helpful outlet for sexual frustration. Date initiated: 5/16/24 Revision on 5/16/24 A review of resident 54's progress notes revealed the following: a. On 4/24/24 at 4:46 PM, a social service note documented, Note Text: RA [resident advocate] met with RT [resident] and RT father to discuss RT being physical with one of facilities NA [nursing aides]. RT apologized for this and promised to not do it again. RT would like to apologize to NA and RA will facilitate this meeting. RT father explained to RT in office that this is not allowed and also apologized to facility for this happening. RA spoke with RT about sexual health and keeping it private. Father said that he is going to start taking RT to the gym more to help provide an outlet for RT. Pend [sic] b. On 5/6/24 at 9:49 AM, a social service note documented, Late Entry: Note Text: RA interviewed [resident 54] separately and asked what happened? [resident 54] stated he hugged [resident 319] and then grabbed her breast. RA asked resident why he would grab a woman's breast without consent? [resident 54] replied 'because I am a guy.' RA explained that just because he is a guy he cannot grab another woman's body without consent. [resident 54] stated 'I see a tit I grab one.' RA explained that the victim of this could press charges and call the police for assault, [resident 54] then reminded RA that his father is a retired police man. Resident then told RA that he was sorry. (continued on next page)		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. On 5/22/24 at 11:23 AM, an alert charting note documented, Note Text: Helped get resident some water and medications for the morning. Ensured that call light was in reach and asked if there was anything else I could get him. He asked 'can I see your tits?' I told him no and that it was not an appropriate thing to ask. d. On 5/23/24 at 5:27 PM, an alert charting note documented, Note Text: Resident asked CNA [Certified Nurses Aide] who was helping him to shower 'it is not fair that I have to be naked' and you are not. 'You should also get naked'. Also tried to spray CNA with the shower hose. When to talked to Resident and explained that it is not appropriate this type of comments and that it is also not appropriate to try to get CNA wet with the shower hose . It is becoming hard for female CNA to provide care for this resident who continue to be have inappropriate behavior. e. On 5/23/24 at 11:45 PM, a general progress note documented, Note Text: Resident continuously tried to convince aide to go out on a date with him. Aide continued to tell him no. Educated resident that this behavior is inappropriate. Resident apologized and went to his room. f. On 5/24/24 at 1:00 AM, a provider encounter note documented, .Patient seen today for behaviors. Nurses report patient has been having low moods and inappropriate sexual behaviors . g. On 5/31/24 at 6:02 PM, an alert charting note documented, Note Text: Resident is fixated on a female CNA. She reported that he is following her in the Facility. When confronted by CNA to stop this behavior, resident just continue [sic] following her. Resident has to be re- directed several times according to CNA by managementsand [sic] nurses but resident continue to pursed [sic] her unwanted attention. h. On 6/1/24 at 1:15 AM, a general progress note documented, Note Text: Aide reported to nurse that she and other aides have previously experienced inappropriate behaviors from resident while assisting with showers. Aide stated that when giving the resident a shower, resident began to inappropriately touch himself, aide told resident that it was inappropriate and resident stated 'he was almost finished', aide said she would return when he was ready to get out of shower. Aide did not report this until hearing of his continued behavior because she was scared she would get in trouble for leaving resident alone. i. On 6/1/24 at 6:13 PM, an alert charting note documented, Note Text: During lunch in Dinning [sic] room A CNA dropped something on the floor. When she bend down to pick it up resident make [sic] a comment 'Nice ass'. This unsolicited comment made the female CNA very uncomfortable. CNA told resident that those type of comments are very inappropriate. I also when to talk to resident privately about this comment and explain again that his actions and comments are very inappropriate towards females. j. On 6/1/24 at 11:07 PM, an alert charting note documented, .Pt [patient] kept staring at a female cna this evening. Pt kept asking female cna about her boyfriend. Made female cna feel uncomfortable . (continued on next page)		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	k. On 6/3/24 at 1:00 AM, a provider encounter documented, .Today I was also informed by the staff that patient has been displaying inappropriate sexual behaviors toward female staff at the facility, such as groping an underage CNA. When speaking to patient about this she [sic] denies doing anything wrong. At this point after discussion with the facility management we will arrange a care coordination meeting with the patient's power of attorney to help decide on the best course of action. This could possibly include additional medications to help suppress his behavior, or a possible referral to the behavioral health unit . l. On 6/4/24 at 5:32 PM, an alert charting note documented, Note Text: Resident is to be male only when performing [sic] cares due to hypersexual behaviors. Must have 2 females present if female staff is performing [sic] cares. m. On 6/28/24 at 9:00 PM, an alert charting note documented, Note Text: Resident had call light on. When CNA entered room and asked what he wanted he said 'your number.'CNA asked if he actually needed anything and resident started to use his urinal in front of her. CNA told resident to call when he was done and left the room. n. On 11/7/24 at 10:40 AM, a communication with resident note documented, Resident [resident 54] was observed kissing resident [resident 121] in his room. Administration met separately with [resident 54] to discuss his relationship with [resident 121]. [Resident 54] stated that they are just friends and confirmed that that both she and [resident 54] consented to the kiss. A review of resident 54's Monitoring Record revealed the following number of episodes of inappropriate sexual comments every shift: a. On 5/23/24 PM shift- 2 b. On 5/25/24 PM shift- 2 c. On 5/26/24 AM shift- 2 d. On 6/14/24 AM shift- 1 e. On 6/21/24 AM shift- 4 f. On 6/28/24 PM shift- 1 g. On 9/1/24 AM shift- 2 h. On 9/1/24 PM shift- 2 i. On 9/7/24 PM shift- 1 j. On 9/9/24 AM shift- 1 k. On 9/10/24 AM shift- 2 l. On 9/16/24 AM shift- 2 (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465152	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/13/2024
NAME OF PROVIDER OR SUPPLIER Bella Terra St George		STREET ADDRESS, CITY, STATE, ZIP CODE 178 South 1200 East St George, UT 84790	
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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	m. On 9/16/24 PM shift- 2 n. On 9/17/24 AM shift- 1 o. On 9/22/24 AM shift- 2 p. On 9/23/24 AM shift- 2 q. On 9/24/24 AM shift- 1 r. On 9/29/24 AM shift- 2 s. On 9/30/24 AM shift- 1 t. On 10/1/24 AM shift- 1 u. On 10/1/24 PM shift- 1 v. On 10/5/24 AM shift- 2 w. On 10/6/24 AM shift- 2 x. On 10/7/24 AM shift- 2 y. On 10/13/24 AM shift- 1 z. On 10/14/24 AM shift- 1 aa. On 10/15/24 AM shift- 1 bb. On 10/20/24 AM shift- 2 cc. On 10/21/24 AM shift- 2 dd. On 10/22/24 AM shift- 2 ee. On 10/26/24 AM shift- 2 ff. On 10/27/24 AM shift- 2 gg. On10/28/24 AM shift- 1 hh. On 11/3/24 AM shift- 2 ii. On 11/4/24 AM shift- 2 jj. On 11/4/24 PM shift- 2 (continued on next page)		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	kk. On 11/5/24 AM shift- 2 2. Resident 121 was admitted to the facility on [DATE] with diagnoses which included, but not limited to, metabolic encephalopathy, type 2 diabetes mellitus with hypoglycemia, acute respiratory failure with hypoxia, iron deficiency anemia, other seizures, unspecified dementia, restlessness and agitation, and mild neurocognitive disorder due to known physiological condition with behavioral symptoms. Resident 121's medical record was reviewed. On 9/30/24 a BIMS assessment was conducted on resident 121. Resident 121 scored a 10. A score of 8-12 would indicate moderately impaired cognition. A review of resident 121's care plan revealed, Focus: The resident has a behavior problem of angry outburst, wandering, hallucinations and delusions at times Date initiated: 10/25/24 Revision on: 11/5/24 Interventions included teh following: a. Anticipate and meet The resident's needs. Date initiated: 10/25/24 b. Caregivers to provide opportunity for positive interaction, attention. Stop and talk with him/her as passing by. Date initiated: 10/25/24 c. If reasonable, discuss The resident's behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable to the resident. Date initiated: 10/25/24 d. Praise any indication of The resident's progress/improvement in behavior. Date initiated: 10/25/24 e. Provide a program of activities that is of interest and accommodates residents status. Date initiated: 10/25/24 Another care plan revealed, Focus: The resident has an alteration in neurological status r/t disease process MILD NEUROCOGNITIVE DISORDER DUE TO KNOWN PHYSIOLOGICAL CONDITION WITH BEHAVIORAL DISTURBANCE Date initiated: 11/4/24 Revision on 11/4/24 Interventions included the following: a. Allow the resident a rest period when she is upset. Date initiated: 11/4/24 b. Cueing, reorientation as needed. Date initiated: 11/4/24 c. Discuss with resident/resident and family any concerns, fears, issues regarding diagnosis or treatments. Date initiated: 11/4/24 d. Give medications as ordered. Monitor/document for side effects and effectiveness. Date initiated: 11/4/24 e. Provide emotional support when the resident appears agitated. Date initiated: 11/4/24 (continued on next page)		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	f. Special attention provided when the resident has contact with her mother. Date initiated: 11/4/24 A review of resident 121's progress notes revealed the following: a. On 9/25/24 at 3:35 AM, an admission progress note documented, 9/25/2024 03:35 (3:35 AM) Admission Progress Note admitted /Time:: 9/24/2024 1930 (7:30 PM) admitted from/Transported by:: [Hospital Name] transported by mother Primary diagnosis for admission:: Pneumonitis Secondary diagnoses:: DM2 [diabetes mellitus type 2], Acute Respiratory Failure with hypoxia Hx [history] of methamphetamine abuse Vital signs upon admission:: 150/93 bp [blood pressure] 96 pulse 24 rr [respiratory rate] 97.5 t [temperature] 96 o2 [oxygen] 61 inches tall 148.5 lbs Pain level/interventions administered as applicable:: na [not applicable] Mental status upon admission:: Resident was very anxious and hysterically crying. Resident stated she was angry her mom left her here. Mother brought a few belongings in, and told the staff good luck and left facility. Pt very stressed and pacing in the halls. CNA showered resident andpt [sic] calmed down. During assessment patient was oriented and answered questions appropriately, but gets distracted and confused easily. Mobility status/mobility devices:: patient ambulates independently. States she used a walker in the hospital and is requesting a walker to use.Special devices used:: na Oriented to facility. b. On 9/25/24 at 11:45 AM, a skilled charting note documented, Late Entry: Note Text: Resident is A/A/O [sic] [alert and oriented] x 2 with intermittent confusion with auditory and visual hallucinations noted. c. On 9/26/24 at 12:28 AM, an alert charting note documented, Note Text: Pt very anxious at beginning of shift. Returned from an outing with her mother and was very upset and crying. pt stated her mom doesn't care about her and only wants to visit her so she can lecture her about using drugs. Nurse took pt to her room and talked to her for a few minutes while giving her, her medications. Pt took medications and stated she needed to go walk the halls because she continued to be so upset with her mom. After pacing the halls for 20 minutes patient returned to room to watch tv [television]. d. On 9/30/24 at 11:15 PM, a skilled charting note documented, Note Text: Resident alert and oriented to self. no resp [respiratory] distress noted, lungs clear. Denies pain at this time. Requires frequent redirection. talks to self and wanders up and down the hallways, yelling at self and staff and other residents. Neighbor reports she was kicking at the walls in the middle of the night last night. pt skin turgor supple, intact. continent of bowel and bladder. good appetite, eats rapidly. takes fluids well. e. On 10/1/24 at 8:00 AM, a psychological provider note documented, [resident 121] exhibits poor cognition throughout interview including poor attention, distractibility, poor memory, poor social understanding or decreased complex attention. She is unable to explain how she became homeless or how she took care of herself prior to or during homelessness. She is unable to verbalize a plan after discharge. [Resident 121] has persistent abnormal movements including rubbing at her face, neck and arms. She is unable to remain still. Subjective interview and objective assessment of MOCA [Montreal Cognitive Assessment] scoring 14 indicate Major Neurocognitive Disorder, most likely drug induced from many years of alcohol and methamphetamine abuse . (continued on next page)		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	f. On 10/1/24 at 9:19 AM, a skilled charting note documented, Note Text: pt had overdose on meth [methamphetamine] use. pt currently on augmentin for s/s [signs and symptoms] of resp [respiratory] infection. no resp distress noted. lungs clear. room air sats [saturation] at 97. Denies pain this am. needs redirected often. talks to self and wanders up and down the hallways, yelling at self and other staff and residents. pt educated to stop slamming doors and raising her voice at others. pt skin turgor supple, intact. continent of bowel and bladder. good appetite, eats rapidly. takes fluids well. Today pt reported by management that pt is going to be staying long term. g. On 10/6/24 at 9:27 AM, a skilled charting note documented, Note Text: pt wandering up and down hallways, talking loudly to self and arguing with staff and other residents. unable to redirect pt. h. On 10/7/24 at 1:34 AM, a skilled charting note documented, Late Entry: Note Text: Pt returned to facility from outing with mom and granddaughter. Pt very agitated and crying stating her mother makes her super upset. Pt states she does not want mother or granddaughter into the facility. Pt very upset and pacing the halls yelling at her self for 30 min [minutes]. i. On 10/18/24 at 11:21 PM, a skilled charting note documented, Note Text: Resident is alert and oriented x 2-3. Often confused, not oriented to situation. Pleasant with staff. Wanders hallways often. Good appetite. Compliant with BS [blood sugar] checks and insulin administration. Takes pills whole. Denies pain. Has not slept well the past two nights. j. On 10/27/24 at 3:36 PM, an alert charting note documented, Note Text: Corporate nurse found pt walking by street in front of facility this afternoon, nurse was able to direct pt back into the facility. notified DON [Director of Nursing] k. On 10/29/24 at 1:57 PM, a skilled charting note documented, Note Text: Resident is alert and oriented x 2 self, situation. Resident has episodes of confusion. Resident shows signs of anxiety and sadness. Resident is found often pacing the hallways and talking to self. Resident was redirected and invited to multiple activities during the day. Resident has redness under pannus. Resident is a limited assistance with dressing ADL [activities of daily living] and toileting. WCTM [will continue to monitor]. l. On 10/31/24 at 4:00 PM, a skilled nursing note documented, Late Entry: Note Text: No changes in LOC [level of consciousness]. Resident did have multiple verbal outburst. Resident was upset because mother would not take her trick or treating. Resident was given time to calm down and verbalize why she was upset. Resident calmed and went to socialize with other residents in the activity [sic] room. WCTM. m. On 11/8/24 at 8:49 AM a COMMUNICATION - with Resident note documented, Note Text: Resident [121] was observed kissing resident [54] in his room. Administration met separately with [resident 121] to discuss her relationship with [resident 54]. [Resident 121] stated that they are just friends and confirmed that both she and [resident 54] consented to the kiss. 3. Resident 319 was admitted to the facility on [DATE] and readmitted on [DATE] and discharged on [DATE] with diagnoses which included metabolic encephalopathy, hypothyroidism, bipolar II disorder, anxiety, disease of blood and blood-forming organs, hypertension, and traumatic brain injury. Resident 319's medical record was reviewed 11/3/24 through 11/13/24. (continued on next page)		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A quarterly MDS dated [DATE] revealed resident 319's BIMS score was 13 which indicated cognitively intact. A social services note dated 5/6/24 at 9:45 AM revealed a late entry RA met with [resident 121] to inquire about report that [resident 54] grabbed her breast. [Resident 121] stated that she was coming down 200 hall towards the gym area and stopped to give [resident 54] a hug and as he hugged her he moved his hand down her body and grabbed her breast, [resident 121] stated that she immediately told [resident 54] no and he said he was sorry and continued moving away from her towards 300 hall and she went outside. That was the end of it. A social services note dated 5/6/24 at 9:47 AM was a late entry created on 5/14/24. The note revealed, RA met with RT again and asked if RT would like to press charges against RT for what she reported? RT stated 'No, I don't want to cause trouble for anyone.' RA asked RT if she was sure, and maybe wanted to think about it longer? RT replied 'I am sure, I don't want to press charges, period.' Potential for Harm 4. Resident 6 was admitted to the facility on [DATE] with diagnoses which include hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting right dominant side, other abnormalities of gait and mobility, aphasia, dysphagia following cerebral infarction, epilepsy, cognitive communication deficit, and major depressive disorder. On 11/3/24 at 6:14 PM, an observation was made of resident 49 pushing resident 6 in her wheelchair in the 100 hallway. On 11/3/24 at 6:45 PM, an interview was conducted with resident 49. Resident 49 was sitting in the dining room when resident 6 entered the dining room in a wheelchair. Resident 6 was observed to sit at resident 49's table. Resident 49 pointed to resident 6 and stated that was his girlfriend. Resident 6 was observed to move her head in a yes motion and smiled. On 11/6/24 at 3:37 PM, an observation was made of resident 49 and resident 6 in the activity room. Resident 6 and resident 49 were sitting on a sofa. Resident 6 was observed to have her head on resident 49's chest and resident 49 had his arm around resident 6. Both residents were observed with their eyes closed. Resident 6's medical record was reviewed. On 2/6/24 a BIMS assessment was completed on resident 6. Resident 6 scored a 9. A score of 8-12 would indicate moderately impaired cognition. A review of resident 6's sexual activity capacity for consent dated 2/21/24 revealed: a. Describe resident's stated choice: She stated, 'I love him' she said and likes to cuddle with him, but does not want a sexual relationship. She does not want any sexual touching. (continued on next page)		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of resident 6's care plan revealed Focus: MOOD & BEHAVIOR: [Resident 6] has potential for mood and coping issues due to desire to have a romantic relationship with another resident. [Resident 6's] outside medical provider [name redacted] has been consulted and confirmed [resident 6] has capacity to make her own decisions and provide consent. Date initiated: 5/29/24 Revision on 6/26/24 Interventions included the following: a. Assess [resident 6's] capacity to give consent for romantic relations with another resident. Date initiated: 5/29/24 Revision on: 5/29/24 b. If any other resident requests romantic encounter with [resident 6], staff will verify if [resident 6] also wants encounter and if she doesn't, staff will make sure her rights are protected. Staff will make sure other resident respects [resident 6's] wishes. Date initiated: 5/29/24 c. Offer psychosocial support as needed Date initiated: 5/29/24 Revision on: 5/29/24 d. Whenever [resident 6] elects to spend time with other resident, staff will ask and verify that spending time is what she wants and that there is no coercion involved. Reinforce that any kind of romantic and/or sexual expression is her choice. Date initiated: 5/29/24 Revision on: 5/29/24 Another care plan revealed Focus: [Resident 6] has an on again off again relationship with another consenting resident. Date initiated: 6/26/24 An intervention included [Resident 6] will only have romantic companionship with other consenting residents. Staff will verify that 321B is interested in a romantic encounter with [resident 6] PRN [as needed]. [Resident 6] and 321B will confine their romantic relations to a location that is appropriate and separate from other residents. [Resident 6] and 321B will be respectful of other resident's and their rights. Date initiated: 6/26/24 A review of resident 6's progress notes revealed the following: a. On 3/4/24 at 11:22 AM, a social service note documented, RA met with resident and confirmed resident no longer wants to associate with [resident 49] after the incident at church yesterday. RA asked if resident has attempted to talk with resident since, and resident stated no. RA asked resident to notify staff if she feels unsafe. RA will meet with [resident 49] and talk with him about no contact with [resident 6]. b. On 3/4/24 at 1:27 PM, a social service note documented, RA received call from responsible party who is upset about learning of incident yesterday from her brother rather than us calling her directly. RA was able to ascertain that resident called her son and informed him of incident with [resident name redacted] through facetime [sic] with the help of her aid [sic] at her request. RA contacted responsible party back and explained situation. Responsible party stated she spoke with residents nurse and was able to learn the fact of the situation and it has put her mind to rest. RA assured responsible [sic] party that staff is aware of the interactions and will keep an eye on residents moving forward. (continued on next page)		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. On 3/6/24 at 1:21 PM, a social service note documented, RA was informed buy [sic] nurse aide that resident was seen exiting [resident 49's] room. Aide spoke with resident who told her everything was okay. RA visited with resident and asked why resident was in [resident 49's] room? Resident nodded smiling informing RA that it had to do with a blanket being returned. AR [sic] explained that since Sunday's incident, resident should not be visiting with resident in his room. If resident wants to visit with [resident 49] in his room it must be accompanied by a nurse or nurse aid [sic] otherwise visits should be kept to public areas. Resident stated that she agreed to this requirement going forward. RA explained that it is very confusing for staff when resident decides no contact last Sunday and then we see her visiting with resident alone in his room and we are told everything is ok. Resident replied with telling RA that 'they are friends'. RA explained that I will add notes to her chart. d. On 3/9/24 at 11:12 PM, an alert charting note documented, Pt [patient] was allowing resident [resident 49] to push her around in her w/c [wheelchair]. Pt. was sitting next to [resident 49] in the activity room. When pt was asked if she wanted to be with him, pt shook her head yes. c. On 4/1/24 at 4:44 PM, a social service noted documented, RA met with rt to discuss 'friendship' with [resident 49], and staff concerns for her safety. Rt states they are just friends, nothing more. RA explained that due to observed behavior from [resident 49], rt should not request to be pushed in her wheelchair anywhere by [resident 49] and she is not allowed in his room alone and vice versa. Rt agreed. d. On 4/9/24 at 11:26 AM, a social service note documented, Rt asked RA to follow her into activities room and transfer her to couch. She asked RA to grab [resident 49] from his room to come too. After both rt and [resident 49] were seated, Rt was able to say, No sex to [resident 49] 3 different times, and then stated she is catholic and then pointed at [resident 49]. When I addressed [resident 49] and asked him what Rt means with these statements, [resident 49] stated she is upset about her children and that this is why she is visibly crying. RA informed [resident 49] in frontof [sic] Rt that it seems to me Rt is making is clear, 'No Sex' to [resident 49] in front of me for a reason. RA explained [resident 49] that he is not allowed to push Rt in her wheelchair, and not allowed to transfer Rt at any time. RA also reiterated that [resident 49] is not allowed in Rt bedroom and she is not allowed in his. RA explained safety of all rt's is top priority. Rt and [resident 49] can be friends, but in public areas only. Both Rt said they agreed. e. On 9/26/24 at 9:49 AM, a communication with resident note documented, Admin [Administrator] and (Resident Advocate) spoke with resident. She stated that she no longer wants to marry another resident at BT [resident 49]. They had a disagreement and she realized getting married would not work. RA and admin were told by resident that she feels safe and would just like to not marry [resident 49]. 5. Resident 49 was admitted to the facility on [DATE] with diagnoses which included dementia, paroxysmal atrial fibrillation, heart failure, morbid obesity due to excess calories, cognitive communication deficit. Resident 49's medical record was reviewed. A BIMS score dated 5/3/24 revealed resident had a BIMS of 15 which indicated resident was cognitively intact. (continued on next page)		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A care plan dated 5/16/24 Resident has history of sexually inappropriate behaviors directed towards others. The goal Resident will have no s/s of unmanaged sexually inappropriate behaviors directed towards others daily through the review date. Interventions include If resident has sexually inappropriate behaviors that become unmanageable inhouse or a crime occurs, call the local police for legal assistance; Resident declines to be referred for mental health services through the local mental health authority: [name of behavioral health service]. Facility staff will refer resident for these services again in the future if resident expresses interest; Resident has history of a sexual crime and must register as a sex offender. Due to resident denial, resident requires staff assistance to remember to register as legally required every 6 months based on date of birth; RESOLVED: Resident is a 1:1 while in facility due to being sexually inappropriate with residents. Date Initiated: 05/30/2024 Revision on: 06/26/2024 Resolved Date: 06/26/2024; Staff should use the following non-pharmacological interventions to help manage resident's behavioral symptoms if observed: 1) Provide appropriate outlets for meeting resident's sexual needs, including providing private space as needed 2) Provide reminders as needed about appropriate boundaries with others 3) Conduct Sexual Capacity for Consent Assessments as indicated to determine if resident and any other applicable parties have capacity to consent to any desired sexual relationships and honor resident's rights if it is determined he and the other party hav [TRUNCATED]		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - 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 interview and record review, it was determined for 6 out of 65 sampled residents, that in response to an allegation of abuse, neglect, exploitation, or mistreatment, the facility failed to report immediately, but not later than 2 hours to the other officials including the State Survey Agency (SSA). Specifically, sexual abuse, a fall with a major injury, a fall from a hoier lift, exploitation of a resident, involuntary seclusion, and an elopment were not reported to the SSA. Resident Identifiers: 5,13, 46, 54, 121, 419 Findings Include: The facility's Abuse Policy and Procedures were reviewed. The following was documented in the policy: .The facility will ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown origin and misappropriation of resident property is reported immediately but no later than 2 hours, after the allegation is made . 1. Resident 54 was admitted to the facility on [DATE] with diagnoses which included, but not limited to, diffuse traumatic brain injury (TBI) with loss of consciousness, unspecified ataxia, adjustment disorder with mixed disturbance of emotions and conduct, unspecified depression, and cognitive communication deficit. 2. Resident 121 was admitted to the facility on [DATE] with diagnoses which included, but not limited to, metabolic encephalopathy, type 2 diabetes mellitus with hypoglycemia, acute respiratory failure with hypoxia, iron deficiency anemia, other seizures, unspecified dementia, restlessness and agitation, and mild neurocognitive disorder due to known physiological condition with behavioral symptoms. On 11/7/24 at 10:40 AM, a communication note documented, Note Text: Resident [54] was observed kissing resident [121] in his room. Administration met separately with [resident 54] to discuss his relationship with [resident 121]. [Resident 54] stated that they are just friends and confirmed that both she and [resident 54] consented to the kiss. On 11/7/24 at 1:41 PM, an interview was conducted with the Administrator (ADMIN). The ADMIN was asked for a copy of the 358 that was submitted to the state in reference of the incident that occurred with resident 54 and 121. The ADMIN asked the state surveyor if the incident was a reportable one and that he did not report the incident to the state. On 11/7/24 at 1:45 PM, a follow up interview was conducted with the ADMIN. The ADMIN stated that his definition of sexual abuse was exploiting or taking advantage of someone especially if they can't consent. The ADMIN stated he had contacted the Ombudsman and was told that as long as the residents were consenting then it was fine. The ADMIN stated that the residents 121 and 54 had their own right to kiss, he made a note in their medical records about it and thought everything was fine. On 11/7/24 at 3:38 PM, an interview was conducted with the ADMIN. The ADMIN stated that he had submitted the reportable 358 to the state. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	43212 3. Resident 13 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included Hereditary and idiopathic neuropathy, chronic respiratory failure, symptomatic epilepsy and epileptic syndromes with simple partial seizures, morbid obesity, hypertensive heart and chronic kidney disease with heart failure, muscle weakness, major depressive disorder, and chronic pain. On 11/3/24 at 4:04 PM, an interview was conducted with resident 13 who stated she had sustained several falls in the facility over the past year. Resident 13 stated earlier in the year, one of her falls resulted in a shoulder fracture. Resident 13's medical record was reviewed between 11/3/24 through 11/13/24. On 6/11/24, an Minimum Data Set (MDS) admission assessment revealed resident 13 had a Brief Interview for Mental Status (BIMS) score of 13 indicating normal cognition. Progress notes: On 5/27/24 at 4:45 PM, an alert charting progress note revealed, Found pt [patient] laying on her bed with a hematoma on her forehead. Pt with a laceration on her nose. Severe pain to her right shoulder and pain and bruising to her left knee. Pt states that her pant leg got caught on her electric w/c [wheelchair] and she fell forward. Pt got herself up into her bed and then called for assistance. Pt requested to go to ER [emergency room] for evaluation of her right shoulder. Non-emergent ambulance called. Notified physician on call and pt's [family member]. Pt sent out at this time. On 5/27/24 at 4:48 AM, a discharge progress note revealed, Date/time of discharge/transfer: 5-27-24 at 4:35 AM. Discharge/transfer location: [Hospital name]. Mode at transportation at time of discharge/transfer: non-emergency ambulance. Reason for transfer/discharge: severe pain to right shoulder- possible fracture. Discharge teaching/instructions completed during discharge/transfer: [blank]. Discharge paperwork released with resident at time of discharge/transfer: Transfer/discharge record, order summary, face sheet. Resident's response to discharge/transfer process: Pt wanting to go to the ER. How were the resident's personal effects stored/handled at time of discharge/transfer?: Personal items left in her room. Pt took her phone and phone charger with her. Name of individual to whom report was provided at new location: [blank]. Name of resident representative notified (if resident is not self-responsible): [family member]. Name of physician notified [name redacted] on call for [physician name]. On 6/4/24 at 6:46 PM, a progress note alert charting revealed, Pt readmitted to facility via facility transport. A/O [alert and oriented] x 4. Able to verbalize needs. Continent of bowel and bladder. Resident using sling to R [right] shoulder. Has bruises to: forehead, L [left] knee, Rt [right] shoulder, LFA [left femoral artery], L elbow, 2 small bruises on bilat [bilateral] ankle, RFA [right femoral artery]. She has small scan on bridge of nose. Incision to R chest area intact, no s/s [signs and symptoms] of infection. Uses motorized w/c for mobility. Last BM [bowel movement] 6/3/24. C/O [complains of] pain to R shoulder Oriented to facility. Call light is within reach. (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/6/24 at 7:53 AM, a social service progress note revealed, RA [Resident Advocate] met with RT [resident] to discuss help with setting up crypto account. RA quickly determined RT is victim of scam. Perpetrator is stating they are '[celebrity]' the singer and they are going to marry RT. RT is excited about this relationship and '[celebrity]' coming to St. [NAME] while touring in Las Vegas to meet RT. RA made it very clear that any requests for money, or crypto, loans is a scam and RT could fall victim to identity and financial theft. RA contacted [bank] after learning RT has provided log in information for her online banking. [Bank] closed down the accounts and froze the fraudulent deposit. RA facilitated RT visiting the DLD [Drivers License Division] to renew her license, this was first step for RT to visit the branch in person to have new accounts created. RA offered support to RT and explained feelings of grief are normal and expected when any relationship ends. RA made it clear that RT should no longer speak with this person and block any further communications. On 8/13/24 at 7:58 AM, a social service progress note revealed, RA has communicated with RT therapist [name], [Local Behavioral Health Center]. Therapist confirmed RT has continued online relationship, and is having difficulty accepting that relationship was a scam. RA has learned that RT was upset about account being closed, and was not happy RA intervened to help RT not fall victim to scam. RT has communicated with nursing staff that she is attempting to repair online relationship and that '[celebrity]'son is now speaking with her about repairing damage to the relationship by asking RT to qualify for a loan to make it up to him. RA has communicated with RT therapist, and [name] RT APRN [Advanced Practice Registered Nurse]. All treatment providers agree it is best to allow RT to make her own decisions and respect her autonomy. RT has been warned about scam, and is being offered support regardless of her choices. RT has been determined to be capable of making her own decisions. RA met with RT and offered support, RA also apologized for quickly acting on scam and having RT account closed, even with RT consent and being present for the calls to [bank]. RA explained this was done in an effort to help RT avoid suffering and that RT wishes are important and RA wants to honor them. RT stated she understood and appreciated the talk. On 8/22/24 at 3:39 PM, a social service progress note revealed, RA contacted APS [adult protective services] to file report about online relationship-RA explained the situation and APS provided case [number redacted]. Resident 13's care plan revealed: a. Risk for falls r/t [related to] neuropathy, gout, dependence on supplemental oxygen, impaired mobility with use of assistive device, hx [history] of falls. Date initiated: 7/18/22, Revision on 6/26/23. The goal was, The resident will be free of falls with injury through the review date. Date initiated: 7/18/22, Revision on: 4/12/24, Target Date: 2/7/25. Interventions included, .5/27/24- unwitnessed fall, risk management done, resident educated. Date initiated: 5/28/24 .Follow facility fall protocol if a fall occurs. Date initiated: 7/18/22 . b. The resident has had an actual fall. Poor balance, poor safety awareness. 10/12/24. Date initiated: 8/30/24, Revision on 10/21/24. The goal was, Resident will not have a fall with major injury. Date initiated: 8/30/24, Target date: 2/7/25. Interventions included, .Encourage resident to participate in fall prevention. Date initiated: 8/30/24 .Monitor/document/report PRN [as needed] x 72 h [hours] to MD [medical doctor] for s/sx [signs and symptoms]: Pain, bruises, change in mental status, new onset: confusion, sleepiness, inability to maintain posture, agitation. Date initiated: 8/30/24, Revision on 8/30/24 . (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. Mood & Behavior: [resident 13] has potential for coping and adjustment issues, related to a desire for an online relationship and potential for online exploitation. Depression. Due to this desire, [resident 13] has had a capacity to consent evaluation done and has been found to have the ability to consent to a relationship. Date initiated: 8/14/24, Revision on 11/8/24. The goal was, Dignity will be preserved and quality of life improved by allowing [resident 13] to make her own informed decisions. Date initiated 8/14/24, Revision on 8/14/24, Target date: 2/7/25. Interventions included, .Provide information to [resident 13] regarding potential financial and emotional exploitation. Assist PRN with banking issues if [resident 13] requests. Follow mandatory reporting policies if needed. Date initiated: 8/14/24. d. The resident has a psychosocial well-being problem r/t sexual activity capacity. 11/8/24: Resident does not have capacity for sexual activity consent: Date initiated: 11/8/24, Revision on: 11/8/24. The goal was, The resident will have on indications of psychosocial well being problem by/through review date. Date initiated: 11/8/24, Target date: 2/7/25. Interventions included, Allow the resident time to answer questions and to verbalize feelings, perceptions, and fears when conducting sexual activity capacity for consent assessment. Date initiated: 11/8/24; .Provide opportunities for the resident and family to participate in care. Date initiated: 11/8/24; The resident needs assistance/encouragement/support to identify causative and contributing factors. Date initiated: 11/8/24; The resident needs assistance/encouragement/support with identification of potential solutions to present problems. Date initiated: 11/8/24 On 11/7/24 at 11:59 AM, an interview was conducted with the MDS coordinator who stated the incident on 5/27/24 was a result of resident 13's pant leg getting caught on her wheelchair. The MDS stated resident 13 was given verbal education about wheelchair safety on the day of the fall. The MDS stated resident falls were reviewed in morning stand up meeting and then the IDT (interdisciplinary team) meeting. It should be noted that no IDT meeting progress note could be found for resident 13's fall on 5/27/24. The Resident Advocate could not be reached for an interview. On 11/13/24 at 8:59 AM, an interview was conducted with the Director of Nursing (DON) who stated resident 13 believed she was in a relationship with a celebrity. APS and the ombudsman were involved. The DON stated she would have to check with the RA about the situation. The DON stated the police should have been notified about the exploitation. The DON stated the RA helped resident 13 with her bank account. The DON stated resident 13 had to get a new bank account to protect her information. The DON stated resident 13 was trying to cash a check that was fraudulent. The DON stated she would provide more information after speaking with the RA. It should be noted that no additional information was provided regarding exploitation of resident 13. It should also be noted that this injury of unknown origin event was not reported to the SSA within the required 2 hours of becoming aware, and the resident's exploitation was not reported to the SSA until 11/13/24. [cross-refer 689] (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 602] 46232 4. Resident 419 was admitted to the facility on [DATE] and discharged on [DATE] with diagnoses of metabolic encephalopathy, schizophrenia, psychological and behavioral factors, and polydipsia. Resident 419's medical record was reviewed on 11/13/24. A hospital history and physical dated from 2/6/24 to 3/20/24 documented resident 419 was unable to care for themselves nor make medical decisions and lacked self-awareness. The physician documented resident 419 needed to be placed into a care facility with 24-hour supervision. On 3/7/24, an inpatient psychiatric (psych) evaluation was conducted on resident 419 and the psychiatrist deemed resident 419 decisionally incompetent and unable to reliably care for themselves. The psych note stated, Patient would be best suited for admission to long-term skilled nursing facility. Due to patient's current cognitive impairment and condition, she is unsafe to be discharged home as she is unable to safely take care of herself. On capacity testing again she remains unable to exhibit the four generally accepted decision-making abilities that constitute capacity, understanding, expressing a choice, appreciation, and reasoning. On 3/15/24 at 10:51 AM, an emergency court ordered appointed guardian was granted to resident 419, who was declared to be an incapacitated adult. The document stated the emergency guardian had the authority to make medical, financial, placement, and end-of-life decisions. The temporary guardianship was to be effective for 30 days. An admission wander/elopement risk evaluation completed on 3/20/24 stated resident 419 was a high wander/elopement risk. Resident 419 was documented to have the following risk factors: History of wandering, cognitive impairment, impaired decision-making skills, memory impairments, and previous elopement attempts. A care plan focus area initiated on 3/20/24 stated resident 419 wanted to discharge back into the community. Listed interventions included encouraging resident 419 to discuss feelings and concerns related to discharge and staff were to monitor and address sources of anxiety, fear, or distress in order to promote a calm and orderly discharge. Another intervention stated the resident advocate was to make a referral to the local contact agency when indicated to help facilitate resident 419's discharge plan. A care plan focus area initiated and revised on 4/12/24 stated resident 419 had impaired cognitive function/impaired through processes related to a BIMS of 6, and impaired safety awareness. [Note: It should be noted this was initiated 18 days after the resident left the facility against medical advice (AMA) and was charged with criminal trespassing and sent to jail.] An Admission MDS completed on 3/25/24 documented resident 419 had a BIMS score of 6 which indicated severe cognitive impairment. A care conference documented resident 419 wanted to look into housing and an evaluation was being set up with local housing for a possible housing transition. (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/25/24, a social service note created at 12:52 PM, stated resident 419 had walked out of the facility AMA. Resident 419 stated they were fine on their own and had packed their belongings in a plastic bag and were heading to a local homeless center where they could live by themselves. The RA stated resident 419 had not given a reason to their change of mind and left the facility on foot. The RA contacted resident 419's guardian and the local police. The RA contacted Adult Protective Services at 12:59 PM and filed a report due to resident 419 leaving the facility AMA. A discharge progress note created at 1:03 PM, stated resident 419 had left the facility AMA at 12:30 PM and was going to a local homeless center on foot. It was documented the case manager had called the local homeless center and was informed residents 419 was above their level of care. The homeless center was provided resident 419's guardian name and phone number by the RA. [Note: It should be noted this incident was not reported to the state survey agency. Resident 419 was appointed a guardian due to being unable to make medical decisions for themselves. Resident 419 did not have the cognitive capacity to sign out AMA and the facility did not notify the guardian about resident 419's desire to leave AMA before they left the facility.] On 11/13/24 at 11:07 AM, an interview was conducted with the ADMIN. The ADMIN stated an elopement was considered when staff lost sight of a resident who left the facility property. The ADMIN stated if a resident did not have the capacity to sign out AMA and they left the facility, they would consider it an elopement. The ADMIN stated resident 419's AMA occurred before they were the Administrator. A follow up interview was conducted with the ADMIN at 11:53 AM. The ADMIN stated they were working on submitting a report for resident 419's elopement. On 11/13/24 at 12:06 PM, an interview was conducted with the [NAME] President of Clinicals (VPC). The VPC stated a resident was appointed a guardian depending on their situation. The VPC stated a guardian was appointed to look out for the resident and their best interest. The VPC stated resident 419's discharge was not reported to the state agency because they believed the resident had left AMA and had not eloped. 48709 5. Resident 46 was admitted to the facility on [DATE] with diagnoses which included hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, muscle weakness, aphasia, cognitive communication deficit, chronic obstructive pulmonary disease with acute exacerbation, lack of coordination, acute kidney failure, major depressive disorder, and anxiety. On 11/7/24 at 11:38 AM, an interview was conducted with the MDS Coordinator. The MDS Coordinator stated that resident 46 was moved into the memory care unit on 10/2/24 and moved back out on 10/17/24. On 11/7/24 at 1:17 PM, an interview was conducted with the ADMIN. The ADMIN stated resident 46 was put into the memory care unit because she was noncompliant with smoking. The ADMIN stated she should be able to understand the smoking policy. The ADMIN stated she was moved out of the memory care unit because her daughter was upset that the doors were locked and wanted her moved out. Said surveyor reported the act of involuntary seclusion for resident 46 to the ADMIN during interview. On 11/13/24 at 11:07 AM, a follow-up interview was conducted with the ADMIN. The ADMIN stated that he had not reported the involuntary seclusion allegation for resident 46 to the SSA and that he should have reported it already. (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. Resident 5 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included quadriplegia, dysphagia, chronic kidney disease, chronic obstructive pulmonary disease, paralysis of vocal cords and larynx, congestive heart failure, and major depressive disorder. Resident 5's medical record was reviewed 11/3/24 through 11/13/24. An Alert Charting note, dated 11/8/2024 at 2:55 AM, indicated, Resident was being lifted up in the hoyer sling x2 [times two] CNAs [certified nursing assistant] from wheelchair to bed placed in bed to go to sleep. CNA's Stated that sling snapped and Pt [patient] slid onto floor. Pt was assessed by nurse and took Pt vitals were WNL [within normal limits] BP [blood pressure]= 133/80, P [pulse]=73, O2 [oxygen saturation]= 93, R [respirations]=20. Pt got skin tear to Left arm. no other injury appeared at this time. dressing applied by nurse. no other issues were noted at this time. On 11/13/24 at 11:53, an interview was conducted with the ADMIN. The ADMIN stated he should have reported the hoyer lift fall because the staff used the sling and it could have been neglect. The ADMIN stated he did look at the sling when it happened and saw that the sling was frayed. The ADMIN stated that he was still working on the report for resident 5's hoyer lift fall and that he should have reported it to the SSA last week when it happened. 30563		

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43212 Based on interview and record review, for 1 of 65 sampled residents, that the facility, in response to allegations of abuse, neglect, exploitation, or mistreatment, failed to provide evidence that all alleged violations were thoroughly investigated and failed to report the results of all investigations to the State Survey Agency, within 5 working days of the incident. Specifically, after a resident sustained a fall resulting in a major injury, the facility did not investigate the incident and did not update the resident's care plan to initiate interventions to prevent additional falls. Additionally, the incident was not reported and investigative results were not submitted to the State Agency within 5 working days. Resident identifier: 13. Findings included: Resident 13 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included hereditary and idiopathic neuropathy, chronic respiratory failure, symptomatic epilepsy and epileptic syndromes with simple partial seizures, morbid obesity, hypertensive heart and chronic kidney disease with heart failure, muscle weakness, major depressive disorder, and chronic pain. On 11/4/24 at 11:10 AM, an interview was conducted with resident 13 who stated she had several falls while at that the facility, one of which included a fracture of her shoulder. Resident 13's medical records were reviewed between 11/3/24 and 11/13/24. An admission MDS (minimum data set) dated 6/11/24 revealed resident 13 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated a normal cognition. On 5/27/24 at 4:45 AM, an alert charting progress note revealed, Found pt [patient] laying on her bed with a hematoma to her forehead. Pt with laceration to her nose. Severe pain to her right shoulder and pain and bruising to her left knee. Pt states that her pant leg got caught on her electric w/c [wheelchair] and she fell forward. Pt got herself up into there bed and then called for assistance. Pt requested to go to ER [emergency room] for evaluation of her right shoulder. Non-emergent ambulance called. Notified physician on call and pt's [family member]. Pt sent out at this time. Resident 13's care plan 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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Risk for falls r/t [related to] neuropathy, gout, dependence on supplemental oxygen, impaired mobility with use of assistive device, hx [history] of falls. Date initiated: 7/18/22; Revision on: 6/26/23. The goal was, The resident will be free of falls with injury through the review date. Date initiated 7/18/22; Revision on: 4/12/24; Target Date: 2/7/25. The interventions included, 1/22/23 Patient hat [sic] a fall in the community. Educated patient to be more aware of her surroundings when accessing the community. Date initiated 7/28/23; 5/27/24-unwitnessed fall, risk management done, resident educated. Date initiated: 5/28/24; 6/23/24-Resident educated and encouraged to ask for staff assistance with toileting so safety reminders/prompts can be provided as needed. Date initiated: 6/26/23; Anticipate and meet the resident's needs. Keep frequently used items within reach. Date initiated: 7/18/22; Educate and encouraged the resident to wear appropriate footwear, such as non-skid socks or shoes, when ambulating/mobilizing. Date initiated: 7/18/22; Follow facility fall protocol if a fall occurs. Date initiated: 7/18/22; Order placed for no transfers without assistance to prevent falls/injury d/t [due to] weakness. Date initiated: 10/1/24; Orient resident to call light. Keep the resident's call light within reach and encourage the resident to use it for assistance as needed. Date Initiated: 7/18/22. b. The resident has had an actual fall. Poor balance, Poor safety awareness. 10/12/24. Date initiated: 8/30/24, Revision on 10/21/24. The goal was, Resident will not have a fall with major injury. Date initiated 8/30/24, Target date 2/7/24. Interventions included, Carry out additional orders from PCP [Primary Care Provider]. Date initiated: 8/30/24; Encourage resident to participate in her fall intervention. Date initiated: 8/30/24; Monitor/document/report PRN [as needed] x 72 h [hours] to MD [medical doctor] for s/sx [signs and symptoms]: Pain, bruises, change in mental status, New onset: confusion, sleepiness, inability to maintain posture, agitation. Date initiated 8/30/24, Revision: 8/30/24; Neuro checks x 72 hours. Date initiated: 8/30/24, Revision on: 8/30/24. Promote participation in activities to help encourage and teach safety awareness. Date initiated: 8/30/24; Provide activities that promote exercise and strength building where possible. Provide 1:1 activities if bedbound. Date initiated: 8/30/24; Resident currently in therapy with additional therapy evaluation, for safety and education. Date initiated: 8/30/24; Resident reminded of the importance of using call button and therapy to evaluate. Date initiated: 10/21/24; Vital signs Q [every] shift/PRN. Take BP [blood pressure] lying/sitting/standing x 1 in first 24 hr [hours]. Date initiated: 8/30/24, Revision on 8/30/24. It should be noted that the only change to resident 13's care plan after her fall on 5/27/24 was, unwitnessed fall, risk management done, resident educated. On 11/7/24 at 9:31 AM, an interview was conducted with Licensed Practical Nurse [LPN] 4 who stated that resident 13 fell a lot and had poor safety awareness. LPN 4 stated resident 13 had been encouraged to call for help but she did not always call. LPN 4 stated resident 13 needed assistance getting out of bed and had fallen trying to transfer to her wheelchair. On 11/7/24 at 11:59 PM, an interview was conducted with the MDS [minimum data set] coordinator who stated if a resident had a fall it would be discussed in the next day's morning meeting. The MDS coordinator stated the discussion included what happened, why the fall happened and how it could be prevented. The MDS coordinator stated resident 13 caught her pant leg on her wheelchair on 5/27/24 and that was the reason for the fall. MDS coordinator stated resident was provided verbal education for wheelchair safety when she returned from the hospital on 6/4/24. (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/7/24 at 12:46 PM, an observation was made of resident 13 talking with another resident. Resident 13 was sitting in her wheelchair and was wearing long pants that draped over the foot rests of her wheelchair. On 11/12/24 at 2:45 PM, an interview was conducted with the Director of Nursing (DON) who stated for a resident who had frequent falls, there should be an evaluation of the resident's current care plan interventions and new interventions should be put into place. No documentation was provided regarding an investigation of the causative factors for resident 13's fall, and no new interventions were documented for prevention.		

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50200 Based on interview and record review it was determined for 3 out of 65 sampled residents, that the facility did not ensure that the receiving health care institution had the resident's medical record information including: the contact information of the practitioner responsible for the care of the resident, resident representative information, advance directive information, special instructions for ongoing care, comprehensive care plan, and any other documentation to ensure a safe and effective transition of care. Specifically, the residents were transferred to the local area hospital emergency department (ED) without any accompanying medical records. Resident identifiers: 8, 123, and 371. Findings included: 1. Resident 8 was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses which included, but not limited to, unspecified intracranial injury with loss of consciousness, human immunodeficiency virus, acute respiratory failure with hypoxia, major depressive disorder, candidal stomatitis, acute kidney failure, unspecified speech disturbance, and history of falling. A review of resident 8's medical record revealed the following: On 8/1/23 at 2:43 PM, an alert charting note documented, Late Entry: Note Text: resident sent to ed [emergency department] via 911 for chest pain. np [nurse practitioner] in building did assessment and said to sent resident. called 911 sent resident via [ambulance company]. A review of resident 8's electronic medical record revealed no documentation of a transfer/discharge assessment or paperwork that might have accompanied the resident to the hospital. 2. Resident 123 was admitted to the facility on [DATE] with diagnoses which included, but not limited to, myotonic muscular dystrophy, cognitive communication deficit, type 1 diabetes mellitus with hyperglycemia, hyperlipidemia, gastro-esophageal reflux disease without esophagitis, cachexia, and hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage affecting right dominant side. A review of resident 123's medical record revealed the following: On 8/1/24 at 3:29 PM, an alert charting note documented, Note Text: Pt's [patient's] vomit appears dark brown/coffee ground. Per NP send to ED. Patient refuses stating he is fine. VS [vital signs] as follows: 101/57, 63, 97.8, 16 and 91% @ [at] ra [room air]. Cognition and ROM [range of motion] remains at baseline at this time. Fluids offered, taken fair. Will continue to assess. Resting in bed. On 8/1/24 at 4:42 PM, an alert charting note documented, Note Text: Sent to ED for eval [evaluation] and treat via facility transport. DON [Director of Nursing] and MD [medical doctor] notified. A review of resident 123's electronic medical record revealed no documentation of a transfer/discharge assessment or paperwork that might have accompanied the resident to the hospital. (continued on next page)		

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/7/24 at 8:55 AM, an interview was conducted with Registered Nurse (RN) 2. RN 2 stated that when a resident needed to be sent to the hospital the nurse should obtain vitals and inform the family. RN 2 stated she would obtain a SBAR (situation, background, assessment, recommendations), the resident's face sheet, the resident's medication list, and a POLST (Physician Orders for Life Sustaining Treatment) form to send with the resident. RN 2 stated that all of this information should be documented in the resident's medical chart. RN 2 stated this information was important for the hospital and the ambulance staff to understand what treatment the resident might need. On 11/12/24 at 10:22 AM, an interview was conducted with the Director of Nursing (DON). The DON stated there was a process for sending a resident to the hospital. The DON stated that for a period of time the facility was not able to use the e-interact form. The DON stated that her expectation from the nursing staff was to print out the discharge/transfer form and this got sent with transport. The DON stated the resident's medications and POLST form would be included on the e-interact form. The DON stated that some of the nursing staff might not document what documentation got sent to the hospital. 45490 3. Resident 371 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included paraplegia, cognitive communication deficit, and pressure ulcer of sacral region. Resident 371's medical record was reviewed 11/12/24 through 11/13/24. On 7/11/24 at 12:52 PM, an alert charting progress note revealed resident 371 was sent to the emergency department for an evaluation. There was no documentation provided in the medical record that indicated the basis for the hospital transfer. On 11/13/24 at 2:29 PM, an interview was conducted with the DON. The DON stated that when a resident was transferred or discharged there was a transfer form that was filled out and placed in the residents chart. The DON stated that it was the nurse's responsibility to write a progress note detailing the reason for a residents transfer or discharge.		

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prepare residents for a safe transfer or discharge from the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46232 Based on interview and record review, the facility did not provide and document sufficient preparation to 1 of 65 sampled residents to ensure a safe and orderly transfer or discharge from the facility. Specifically, one resident with cognitive impairment signed out of the facility against medical advice and was subsequently imprisoned and charged with criminal trespassing. Resident identifier: 419. Findings Included: Resident 419 was admitted to the facility on [DATE] and discharged on [DATE] with diagnoses of metabolic encephalopathy, schizophrenia, psychological and behavioral factors, and polydipsia. Resident 419's medical record was reviewed on 11/13/24. A hospital history and physical dated from 2/6/24 to 3/20/24 documented resident 419 was unable to care for themselves nor make medical decisions and lacked self-awareness. The physician documented resident 419 needed to be placed into a care facility with 24-hour supervision. On 3/7/24, an inpatient psychiatric (psych) evaluation was conducted on resident 419 and the psychiatrist deemed resident 419 decisionally incompetent and unable to reliably care for themselves. The psych note indicated, Patient would be best suited for admission to long-term skilled nursing facility. Due to patient's current cognitive impairment and condition, she is unsafe to be discharged home as she is unable to safely take care of herself. On capacity testing again she remains unable to exhibit the four generally accepted decision-making abilities that constitute capacity, understanding, expressing a choice, appreciation, and reasoning. On 3/15/24 at 10:51 AM, an emergency court ordered appointed guardian was granted to resident 419, who was declared to be an incapacitated adult. The document indicated the emergency guardian had the authority to make medical, financial, placement, and end-of-life decisions. The temporary guardianship was to be effective for 30 days. An admission wander/elopement risk evaluation completed on 3/20/24 stated resident 419 was a high wander/elopement risk. Resident 419 was documented to have the following risk factors: History of wandering, cognitive impairment, impaired decision-making skills, memory impairments, and previous elopement attempts. A care plan focus area initiated on 3/20/24 indicated resident 419 wanted to discharge back into the community. Listed interventions included encouraging resident 419 to discuss feelings and concerns related to discharge and staff were to monitor and address sources of anxiety, fear, or distress in order to promote a calm and orderly discharge. Another intervention indicated the resident advocate was to make a referral to the local contact agency when indicated to help facilitate resident 419's discharge plan. (continued on next page)		

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A care plan focus area initiated and revised on 4/12/24 indicated resident 419 had impaired cognitive function/impaired thought processes related to a BIMS (Brief Interview for Mental Status) score of 6, and impaired safety awareness. [Note: It should be noted this was initiated 18 days after the resident left the facility against medical advice and was charged with criminal trespassing and sent to jail.] An Admission Minimum Data Set (MDS) completed on 3/25/24 documented resident 419 had a BIMS score of 6 which indicated severe cognitive impairment. A care conference, dated 3/25/24, documented resident 419 wanted to look into housing and an evaluation was being set up with local housing for a possible housing transition. Resident 419's discharge progress notes were reviewed and documented as followed: a. On 3/25/24, a social service note created at 12:52 PM, indicated resident 419 had walked out of the facility Against Medical Advice (AMA). Resident 419 stated they were fine on their own and had packed their belongings in a plastic bag and was heading to a local homeless center where they could live by themselves. The Resident Advocate (RA) stated resident 419 had not given a reason to their change of mind and left the facility on foot. The RA contacted resident 419's guardian and the local police. The RA contacted Adult Protective Services at 12:59 PM and filed a report due to resident 419 leaving the facility AMA. A discharge progress note created at 1:03 PM, indicated resident 419 had left the facility AMA at 12:30 PM and was going to a local homeless center on foot. It was documented the case manager had called the local homeless center and was informed residents 419 was above their level of care. The homeless center was provided resident 419's guardian name and phone number by the RA. b. On 3/26/24 at 12:12 PM, a social service note indicated resident 419's whereabouts were unknown. c. On 4/1/24 at 3:41 PM, a social service note stated resident 419 was being held at the local jail for criminal trespassing. The RA and resident 419's guardian were documented to be working on resident 419's release from jail. d. On 4/2/24 at 11:26 AM, a social service note stated resident 419's guardian informed the RA that resident 419 was being held in the local jail until 4/9. The RA documented they were working on finding resident 419 another facility to go to. On 11/13/24 at 9:36 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that depending on a resident's individual situation, they were assigned a guardian. The DON stated a guardian was appointed to look out for the resident and their best interest and they helped the resident with informed consent. The DON stated if a resident wanted to sign out AMA, they notified the provider and ombudsman. They also notify the police to ensure resident safety and to follow up with them. The DON stated the resident also signed AMA paper work if they wanted to leave. The DON stated resident 419 was very insistent on leaving and walking out of the building. The DON stated resident 419 walked out of the building. The DON stated they were unsure if resident 419 signed the AMA paperwork but they did try to deescalated resident 419. The DON stated the Police and the guardian were called and notified that the resident had left AMA. (continued on next page)		

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/13/24 at 11:07 AM, an interview was conducted with the Administrator (ADMIN). The ADMIN stated an elopement was considered when staff lost sight of a resident who left the facility property. The ADMIN stated if a resident did not have the capacity to sign out AMA and they left the facility, they would consider it an elopement. The ADMIN stated resident 419's AMA occurred before they were the Administrator. A follow up interview was conducted with the ADMIN at 11:53 AM. The ADMIN stated they were working on submitting a report for resident 419's elopement. On 11/13/24 at 12:06 PM, an interview was conducted with the [NAME] President of Clinicals (VPC). The VPC stated a resident was appointed a guardian depending on their situation. The VPC stated a guardian was appointed to look out for the resident and their best interest. The VPC stated resident 419's discharge was not reported to the state because they believed the resident left AMA and had not eloped.		

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50200 Based on interview and record review it was determined, for 3 out of 65 sampled residents, that the facility did not provide written information to the resident or resident representative the duration of the state bed hold policy, during which the resident was permitted to return and resume residence in the nursing facility. Specifically, residents were transported to the hospital and were not informed of the facility bed hold policy. Resident identifiers: 5, 8, 123. Findings included: 1. Resident 8 was admitted to the facility on [DATE] and readmitted to the facility on 8/9/24 with diagnoses which included, but not limited to, unspecified intracranial injury with loss of consciousness, human immunodeficiency virus, acute respiratory failure with hypoxia, major depressive disorder, candidal stomatitis, acute kidney failure, unspecified speech disturbance, and history of falling. A review of resident 8's medical record revealed the following: a. On 8/1/23 at 2:43 PM, an alert charting note documented, Late Entry: Note Text: resident sent to ed [emergency department] via 911 for chest pain. np [nurse practitioner] in building did assessment and said to sent resident. called 911 sent resident via [ambulance company]. No documentation could be found that resident 8 or resident 8's representative were notified of the facility bed hold policy prior to transfer to the hospital. 2. Resident 123 was admitted to the facility on [DATE] with diagnoses which included, but not limited to, myotonic muscular dystrophy, cognitive communication deficit, type 1 diabetes mellitus with hyperglycemia, hyperlipidemia, gastro-esophageal reflux disease without esophagitis, cachexia, and hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage affecting right dominant side. A review of resident 123's medical record revealed the following: a. On 8/1/24 at 4:42 PM, an alert charting note documented, Note Text: Sent to ED for eval [evaluation] and treat via facility transport. DON [Director of Nursing] and MD [Medical Doctor] notified. No documentation could be found that resident 123 or resident 123's representative were notified of the facility bed hold policy prior to transfer to the hospital. On 11/12/24 at 10:22 AM, an interview was conducted with the DON. The DON stated that she was not aware if the bed hold policy had been given to resident's 8 and 123 as there was not documentation in their medical records. The DON stated that residents might have been given a copy of the bed hold policy in the admission packet. On 11/12/24 at 11:09 AM, the facility's bed hold policy revealed: (continued on next page)		

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	.Policy Statement Our facility shall inform residents upon admission and prior to a transfer for hospitalization or therapeutic leave of our bed-hold policy. Policy Interpretation and Implementation 1. Upon admission and when a resident is transferred for hospitalization or for therapeutic leave, a representative of the business office or designee will provide written information concerning the facility's bed hold policy. 2. When emergency transfers are necessary, the facility designee will provide the resident or resident representative with information concerning the facility's bed hold policy within 1 business day of such transfer . On 11/13/24 at 9:52 AM, an interview was conducted with the DON and Regional Nurse Consultant (RNC 1). The RNC 1 stated that she did not think the bed hold policy was getting done by the facility. 48709 3. Resident 5 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included quadriplegia, dysphagia, chronic kidney disease, chronic obstructive pulmonary disease, paralysis of vocal cords and larynx, congestive heart failure, and major depressive disorder. Resident 5's medical record was reviewed 11/3/24 through 11/13/24. An Alert Charting note, dated 10/5/24 at 8:15 AM, indicated, Upon entering pt [patient] room this am, noted pt had large amounts of dark brown,yellow phlegm to his trach [tracheostomy] site. pt with c/o [complaints of] of resp [respiratory] distress and c/o of not feeling well the past 4 days with vomiting, diarrhea, large amounts of sputum, phlegm. pt also reports not eating well and requesting nurse send him to the ER [emergency room] for eval [evaluation] and treatment as pt reports he is getting scared now due to increased suctioning and difficulty breathing. v/s [vital signs] 118/64, pulse 62, resp [respirations] 24, temp [temperature] 98.8, oxygen sats [saturation] at 91. Notified physician and [company name redacted] for transport to [hospital name redacted] for eval and treatment. Notified management and called pt spouse [name redacted] to let her know nurse transporting pt to ER, [name redacted] reports she is not at her home but will call her daughter to come and sit with him in the ER. An Alert Charting note, dated 10/5/24 at 8:20 AM, indicated, [Company name redacted] here for transport. An Alert Charting note, dated 10/5/24 at 4:17 PM, indicated, Pt admitted to [hospital name redacted] with bowel obstruction and ng [nasogastric] tube placed at hospital. No documentation could be found that resident 5 or resident 5's representative were notified of the facility bed hold policy prior to transfer to the hospital. (continued on next page)		

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/12/24 at 4:10 PM, an interview was conducted with the Administrator (ADMIN). The ADMIN stated residents were notified of the bed-hold policy when they were admitted . On 11/13/24 at 9:59 AM, an interview was conducted with the DON. The DON stated resident notification of the bed-hold policy was not being done. On 11/13/24 at 11:53 AM, a follow-up interview was conducted with the ADMIN. The ADMIN stated he was not able to find a bed-hold notification for resident 5's transfer to the hospital.		

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43212 Based on interview and record review, for 1 of 65 sampled residents, the facility failed to obtain the written and/or verbal physician orders to provide essential care to the resident upon admission to the facility. Specifically, a resident who was admitted with an indwelling catheter did not have physician orders for catheter care. Resident identifier: 221. Findings included: Resident 221 was admitted to the facility on [DATE] with diagnoses that included Multiple Sclerosis, paraplegia, infection and inflammation due to indwelling urethral catheter, and extended spectrum beta lactamase resistance. On 11/4/24 at 10:04 AM, an interview was conducted with resident 221. Resident 21 stated he had a catheter and staff would come to empty the bag or change it when he called them. Resident 221's medical record was reviewed between 11/3/24 and 11/13/24. On 10/18/24 an admission Minimum Data Set (MDS) revealed that resident 221 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated a normal cognition. On 10/11/24, resident 221's diagnoses revealed, Infection and inflammatory reaction due to indwelling urethral catheter, subsequent encounter. On 10/13/24 at 3:09 AM, a progress note alert charting revealed, Resident recently admitted to facility. Alert and oriented x 4 and able to make needs known and use call light appropriately. Resident takes pills whole without difficulty. 20 Fr [french] indwelling catheter with 30 mL [milliliters] balloon leaking and unable to flush. Replaced using sterile technique. Resident tolerated procedure well, insertion somewhat difficult r/t [related to] enlarged prostate. Head of penis completely split and healed with insertion of catheter starting at the shaft. Ostomy to L [left] abd [abdomen] dressings to bilateral lower abd and coccyx. Refused to take off compression socks. Refused HS [hour of sleep] dose. On 10/14/24 at 1:00 AM, a provider progress note revealed, .Visit type: New Patient .Patient was transferred to [facility] rehab on 11 October 2024 .Past medical history .indwelling Foley catheter .Physical exam . Genitourinary: Foley catheter in place .Diagnosis, Assessment and Plan .Infection and inflammatory reaction due to indwelling urethral catheter, subsequent encounter. Currently stable, continue to monitor . On 11/3/24, physician orders were placed for catheter care and revealed: a. 20 F [french]/ 30 cc [cubic centimeters] (Foley/Suprapubic) catheter to down drain for dx [diagnosis] of (Neurogenic bladder/obstructive uropathy) r/t (Neuromuscular Dysfunction of Bladder, Unspecified). May change PRN [as needed] if dislodged or clogged. as needed related to Neuromuscular dysfunction of bladder, unspecified. Active 11/3/24 7:11 PM. (continued on next page)		

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Change catheter down drain bag weekly. every night shift every Sun [Sunday]. Active 11/10/24 6:00 PM. c. Perform catheter care q [every] shift: cleanse tubing, ensure tubing is not kinked, ensuring tubing is not resting on the ground, ensure catheter bag is in a privacy bag. every shift for CATHETER USE. Active 11/4/24. Resident 221's care plan revealed: a. The resident has (indwelling suprapubic) Catheter: Neurogenic bladder. Date Initiated: 11/2/2024, Revision on 11/3/2024. The goal was, The resident will be/remain free from catheter-related trauma through review date. Date initiated: 11/3/2024. Target date: 1/10/2025. Interventions included, CATHETER: The resident has (20f 30 cc balloon) (suprapubic catheter). Position catheter bag and tubing below the level of the bladder and away from entrance room door. Date initiated: 11/3/2024. Revision: 11/3/2024. b. Check tubing for kinks each shift. Date initiated: 11/3/2024. Revision on 11/3/2024. c. Monitor and document intake and output as per facility policy. Date initiated: 11/2/2024. d. Monitor for s/sx [signs and symptoms] of discomfort on urination and frequency. Date initiated: 11/2/2024. e. Monitor/document for pain/discomfort due to catheter. Date initiated: 11/2/2024. f. Monitor/record/report to MD [medical doctor] for s/sx 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. Date initiated: 11/2/2024. On 11/12/24 at 1:22 PM, an interview was conducted with the Director of Nursing (DON) who stated the DON or the MDS (minimum data set) coordinator put physician orders into the resident's medical record on admission. The DON stated sometimes the nurse manager would enter orders. The DON stated the provider never entered physician orders into the resident's medical record. The DON stated that resident 221 was admitted with a catheter. The DON stated there should be an order for catheter care when a resident is admitted with a catheter. The DON stated if a nurse was aware that an order was missing, they should notify the DON so it could be corrected. The DON stated the order may have been missed and nursing staff should have checked orders.		

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38031 Based on interview and record review it was determined, for 2 of 65 residents sampled, that the facility did not ensure the timely transmission and completion of the Minimum Data Set (MDS) data to the Centers for Medicare and Medicaid (CMS) System. Specifically, two resident's MDS assessments were not encoded and transmitted within 14 days after the facility completed the resident assessment. Resident identifier: 13 and 32. Findings included: 1. Resident 13 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which consisted of neuropathy, chronic respiratory failure, epilepsy, chronic kidney disease, congestive heart failure, anterior dislocation of the right humerus, anxiety disorder, hypothyroidism, hypertension, thrombophilia, major depressive disorder, cataract, gout, suicidal ideation, mild cognitive impairment, chronic pain, osteoarthritis, scoliosis, insomnia, hyperlipidemia, obstructive sleep apnea, and fracture of right humerus. Resident 13's medical records were reviewed. On 9/5/24, resident 13's MDS Assessment documented a completion and accepted date of 9/25/24. It should be noted that the accepted date was 20 days after the Assessment Reference Date (ARD). 2. Resident 32 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included cerebral infarction, cognitive communication deficit, type 2 diabetes mellitus, major depressive disorder, mixed hyperlipidemia, flaccid hemiplegia of left side, morbid obesity, generalized anxiety disorder, metabolic encephalopathy, hypertension, acute duodenal ulcer with hemorrhage, atrial fibrillation, and insomnia. Resident 32's medical records were reviewed. On 9/20/24, resident 32's MDS Assessment documented a completion and accepted date of 11/4/24. It should be noted that the accepted date was 45 days after the ARD. On 11/13/24 at 11:30 AM, an interview was conducted with the MDS Coordinator. The MDS Coordinator stated that the time frames for submitting a annual comprehensive and quarterly assessment was 14 days from the ARD date. The MDS Coordinator stated that he was a Licensed Practical Nurse and a Registered Nurse had to transmit them. The MDS Coordinator stated that the Director of Nursing (DON) or Corporate Resource Nurse (CRN) transmitted the assessment for him. On 11/13/24 at 12:03 PM, an interview was conducted with the DON. The DON stated that she oversees the transmitting of the MDS Assessments along with the Corporate MDS staff. The DON stated that resident 13 and resident 32's MDS Assessments were not transmitted on time.		

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NAME OF PROVIDER OR SUPPLIER Bella Terra St George		STREET ADDRESS, CITY, STATE, ZIP CODE 178 South 1200 East St George, UT 84790	
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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48709 Based on interview and record review it was determined, for 1 of 65 sampled residents, that the facility did not accurately assess residents. Specifically, one resident's Minimum Data Set (MDS) assessment did not reflect a discharge to home. Resident identifier: 68. Findings included: Resident 68 was admitted to the facility on [DATE] with diagnoses which included fracture of unspecified part of neck of left femur and subsequent encounter for closed fracture with routine healing. Resident 68's medical record was reviewed 11/3/24 through 11/13/24. A Minimum Data Set (MDS) assessment, dated 8/7/24, indicated a discharge status of, Short-Term General Hospital (acute hospital, IPPS). A Discharge Progress Note, dated 8/7/24 at 12:53 PM, indicated resident was discharged to a private residence. On 11/7/24 at 11:38 AM, an interview was conducted with the MDS Coordinator. The MDS Coordinator stated he did not know why the MDS assessment reflected resident 68 went to the hospital because she was discharged home.		

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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 4 out of 65 sampled residents, that the facility did not ensure that baseline care plans were developed and implemented within 48 hours of the resident's admission and contained the minimum information necessary to care for the resident including, but not limited to, initial goals, physician orders, dietary orders, therapy services, social services and PreAdmission Screening and Resident Review (PASRR). Specifically, baseline care plans were not completed for residents timely and they did not contain the minimum healthcare information. Resident identifier: 38, 51, 65, and 66. Findings included: 1. Resident 51 was admitted to the facility on [DATE] with diagnoses which included intracerebral hemorrhage, hemiplegia and hemiparesis of left side, neurologic neglect syndrome, chronic kidney disease, hypertension, congestive heart failure, cognitive communication deficit, aphasia, visual loss both eyes, and insomnia. On 1/11/24, resident 51's care plan had focus areas initiated for The resident has expressed a desire to remain in the facility for long term care and The resident has a potential nutritional problem related to modified diet, blindness and reminder to eat slowly with small bites. It should be noted that resident 51 did not have any additional care plan focus areas initiated within the first 48 hours after admission. 2. Resident 65 was admitted to the facility on [DATE] with diagnoses which included dementia, seizures, hypothyroidism, obstructive sleep apnea, depression, presence of a cardiac pacemaker, and violent behaviors. On 10/19/24, resident 65's baseline care plan was initiated and included the resident's initial goals, functional status, health conditions, dietary services, therapy services, and social services. It should be noted that the baseline care plan was initiated 39 days after admission. On 11/06/24 at 8:55 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that the baseline care plans were completed by the Minimum Data Set (MDS) Coordinator. The DON stated that the resident baseline care plans should be completed within 48 hours after a resident's admission. The DON confirmed that resident 65 did not have a baseline completed within 48 hours after admission. 43212 3. Resident 38 was admitted to the facility on [DATE] with diagnoses that included Parkinson's disease, type 2 diabetes with skin ulcer and neuropathy, cirrhosis of liver, morbid obesity, hemiplegia affecting right dominant side, anxiety disorder, aphasia, major depressive disorder, seizures and dysphagia. Resident 38's medical record was reviewed between 11/3/24 and 11/13/24. (continued on next page)		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 38's baseline care plan was reviewed. The date the baseline care plan was signed was on 9/17/24, 4 days after admission. Resident 38's care plan was reviewed. All care areas that were initiated after the resident was admitted were dated 9/17/24. On 11/12/24 at 1:22 PM, an interview was conducted with the DON who stated that the MDS coordinator was responsible to ensure resident care plans were up to date. 48709 4. Resident 66 was admitted to the facility on [DATE] with diagnoses which included acute and subacute hepatic failure, perforation of intestine, suicide attempt, anxiety disorder, and major depressive disorder (MDD). Resident 66's medical record was reviewed 11/3/24 through 11/13/24. A Minimum Data Set (MDS) Section V Care Area Assessment (CAA) Summary, dated 9/18/24, indicated resident 66 had the following care area's triggered: Cognitive Loss/ Dementia, Functional Abilities (Self-Care and Mobility), Urinary Incontinence and Indwelling Catheter, Psychosocial Well-Being, Mood State, Behavioral Symptoms, Activities, Falls, Nutritional Status, Feeding Tube, Dehydration/Fluid Maintenance, Pressure Ulcer/Injury, Psychotropic Drug Use, and Pain. An Alert Charting note, dated 9/12/24 at 5:56 PM, indicated, Resident is admitted to the facility from [Hospital name redacted] via facility transport on wheelchair around 15:15 [3:15 PM] She is admitted with hospital discharged diagnosis of Gastric [sic] perforation, Acute liver perforation, Spleen absent Abnormal digestive function, Major depression Abdominal pain, etc. Resident has JP [Jackson Pratt] drain on L [left] side of abdomen. Has NGT [nasogastric tube]. NPO [nothing by mouth] and on feeding set and ongoing. Resident is alert and oriented to person, place, time and situation. NO skin issue noted. She is on every 2 hours monitoring for possible suicidal . V/S [vital signs] BP [blood pressure] 158/101, PR [pulse rate] 127, T [temperature] 99.3, O2 sat [oxygen saturation] 89 in RA [room air]. A Care Plan indicated one Plan of: [Resident 66] has need for Clear Liquid diet & TF [tube feed] of Glucerna 1.2 @ 65 mls [milliliters]/hr [hour] x [times] 22 hrs & additional 80 mls free water q [every] 6 hrs & is at risk for nutritional decline d/t [due to] dx [diagnosis] hepatic failure, perforated intestines, absence of spleen, MDD, & hx [history] of suicide attempt & suicide behavior. Date Initiated: 09/13/2024 Revision on: 09/13/2024- The resident has nutritional problem or potential nutritional problem (SPECIFY) r/t [related to] Date Initiated: 09/13/2024. A Discharge Progress Note, dated 9/23/24 at 2:55 PM, indicated resident 66 was discharged home on 9/23/24 at 3:30 PM. On 11/12/24 at 4:12 PM, an interview was conducted with the Administrator (ADMIN). The ADMIN stated resident 66 should have a baseline care plan completed. No baseline care plan was provided.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43212 Based on observation, interview, and record review, for 7 of 65 sampled residents, 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, a resident's care plan was not updated to reflect current ostomy care and wound care being provided, a resident did not have a care plan regarding bowel and bladder care, care plan interventions were not updated after resident falls, and a resident's care plan did not reflect the need for supervised eating. Resident identifiers: 1, 3, 13, 34, 38, 51, and 55. Findings included: 1. Resident 3 was admitted to the facility on [DATE] with diagnoses that included Arnold Chiari Syndrome with spina bifida and hydrocephalus, severe protein-calorie malnutrition, osteomyelitis right ankle and foot, paraplegia, borderline personality disorder, major depressive disorder, morbid obesity, bipolar disorder, and anxiety disorder. On 11/3/24 at 5:16 PM, an interview was conducted with resident 3 who stated she was not being included in care conferences. Resident 3 stated her colostomy bag had burst yesterday because it was not changed. Resident 3 also stated her urostomy bag leaked frequently. Resident 3's medical record was reviewed between 11/3/24 and 11/13/24. On 8/24/24, a quarterly MDS (Minimum Data Set) assessment revealed that resident 3 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated a normal cognition. Physician orders included: a. Ostomy care for colostomy type of wafer/bag to be used: Collar 125261 (2.75) Pouch 416242 (2.75)-change wafer/bag; two times a day for wound care. Start date 8/8/24. b. Ostomy care for colostomy type of wafer/bag to be used: Collar 125261 (2.75) Pouch 416242 (2.75)-change wafer/bag; every 4 hours as needed. PRN [as needed]. Start date 8/8/24. c. Urostomy care: remove old urostomy. cleanse with wound cleanser of choice. cut Natura [NAME]-FIT to fit. Current size 1 3/4 in[inches] or 45 mm [millimeters]. apply skin prep. place flexible collar. snap bag to fit. connect tubing. check for privacy bag. every 24 hours for wound care. start date 4/18/24. d. Perform catheter/urostomy care q [every] shift. cleanse tubing, ensure tubing is not kinked, ensuring tubing is not resting on the ground ensure catheter bag is in privacy bag; every day shift for catheter care. Start date 3/28/24. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	e. Urostomy care: empty bag q shift and document output in POC [point of care]. Burp bag PRN to prevent hyperinflation. Check stability and seal of water daily. CNA [Certified Nursing Assistant] may be assigned task to report to licensed nurse; every shift after ostomy care. Start date 3/28/24. f. Wound tx [treatment]: L [left] and R [right] buttock: remove old dressing, cleanse with NS [normal saline] and gauzes [sic]. Place Dakins soak 2 Kerlex to open wound beds. Apply triad cream to peri wound. Cover with ABD [abdominal] or Kerramax and secure with tape. Cover with incontinence brief. Perform daily and PRN every day shift for wound care PRN if needed. Start date: 10/4/24, Discontinue date: 10/23/24. g. Wound tx: L and R buttock: remove old dressing, cleanse with NS and gauze. Place Dakins soak 2 Kerlex to open wound beds. Apply triad cream to peri wound. Cover with ABD or Kerramax and secure with tape. Cover with incontinence brief. Perform daily and PRN. Call wound clinic for any wound care refusals [phone number]. every day shift for wound care PRN if needed. Start date: 10/23/24, Discontinue date 10/28/24. h. Wound tx: L and R buttock: Apply Vashe soaked gauze for 10 min. [minutes] Wound Bed: SSD [Silver Sulfadiazine]. Secure with: layer of gauze against wound bed. Cover: highly absorbent dressing; every day shift for wound care PRN if needed. Start date: 10/28/24. A review of resident 3's care plan revealed: a. Potential for complications related to colostomy and urostomy. Date initiated: 4/19/22, Revision on: 9/23/22. The goal was, Resident will be able to demonstrate assisted ability to care for ostomy daily through next 90 day review. Date initiated: 4/19/22, Revision on 9/23/22. Resident will have no complications r/t [related to] colostomy and/or urostomy through the next review date. Date initiated: 10/7/22, Revision on: 12/12/23, Target date: 1/31/25. Interventions included, Medications as ordered. Date initiated: 4/19/22, Revision on: 4/19/22. Monitor ostomy site for swelling, pain, and redness and report to MD [medical doctor]. Date initiated: 4/19/22, Revision on: 4/19/22. Ostomy care as needed to prevent odor. Date initiated: 4/19/22, Revision on: 4/19/22. Resident enjoys assisting with colostomy bag changes. Allow resident to change colostomy bag under supervision of licensed nurse. Date initiated 9/23/22. Resident teaching on ostomy care if appropriate. Date initiated: 4/19/22, Revision on: 4/19/22. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. [Resident 3] is at risk for impaired skin integrity due to decreased ADL [activities of daily living] function r/t maceration, immobility, cognitive loss, poor nutrition, depression, paraplegia, shortness of breath, pain, malnutrition, presence of wounds. Wounds managed by Outside provider/clinic; R groin/buttock-Followed by outside clinic. Date initiated 4/19/22, Revision on 11/17/23 The goal was, Residents' wounds will improve or not worsen through next 90-day review. Date initiated: 4/19/22, revision on: 12/12/23, Target Date: 1/31/25. Interventions included, Administer treatments for skin impairment per physician order, Notify MD [Medical Doctor] if skin impairment does not respond to current treatment regimen or resident experiences an adverse reaction. Date initiated: 4/19/22, Revision on 4/19/22; Encourage good nutrition and oral fluid intake. Date initiated 4/19/22, Revision on 4/19/22; Encourage/prompt resident to change positions regularly to off-load pressure points. Resident is able to make major and frequent position changes without staff assistance. Date initiated: 4/19/22, Revision on: 4/19/22; Nurses to perform weekly skin assessments. Notify MD of any new skin impairments and obtain treatment orders as indicated. Date initiated: 4/19/22, Revision on 4/19/22; Staff will help promote clean skin by encouraging/assisting resident to bathe regularly. Dry skin thoroughly after bathing. Keep skin moisturized by applying lotion as indicated. Date initiated: 4/19/22, Revision on 4/19/22; Staff will provide peri-care after incontinent episodes and may apply barrier cream as a skin protectant. CNA's may apply unmedicated barrier creams. Date initiated: 4/19/22, Revision on 4/19/22; The resident uses the following devices for pressure reduction: heel protectors, wheelchair cushion, APP [alternating pressure pad]. Date initiated: 4/19/22, Revision on 4/19/22; Use Hoyer for transfers, not slide board to help preserve skin integrity and prevent damage to wounds. Date initiated: 1/23/24, Revision on 1/23/24, Wound care: Right buttock, right posterior thigh: Remove old drsg [dressing], irrigate with NS, apply ACETIC ACID RINSE x [times] 10 minutes then apply Dakins soaked gauze to wound beds. Apply skin prep para wound and allow to dry. Cover with ABD pad and secure with DISPOSABLE BRIEF. Complete daily. Date initiated: 5/24/23. On 11/7/24 at 9:48 AM, an interview was conducted with Licensed Practical Nurse (LPN) 4 who stated resident 3's urostomy bag leaked a lot. LPN 4 stated resident 3 use to change her own bag but was no longer doing so. LPN 4 stated there was an order to change the bag more frequently. On 11/13/24 at 9:24 AM, an interview was conducted with the Director of Nursing (DON) who stated resident 3's care plan should be updated to reflect the needs she has with her ostomy care if it changed. The DON stated she was unsure if the resident's care plan had been updated. The DON stated that resident 3 just changed over from wound care out of the facility to in-house wound care and the care plan should have been updated to reflect those changes. 2. Resident 13 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included hereditary and idiopathic neuropathy, chronic respiratory failure, symptomatic epilepsy and epileptic syndromes with simple partial seizures, morbid obesity, long term use of anticoagulants, personal history of pulmonary embolism, muscle weakness, history of falling, and chronic pain. On 11/4/24 at 11:10 AM, an interview was conducted with resident 13. Resident 13 stated she had several falls while in the facility, including a fracture of her right arm and nose. Resident 13's medical record was reviewed between 11/3/24 and 11/13/24. On 6/11/24, an admission MDS assessment revealed a BIMS score of 13 which indicated a normal cognition. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Physician orders included: a. Per hospital no transfers without at least standby assistance to prevent falls. Start date 10/2/24. Resident 13's care plan included: a. Pain medication therapy use r/t multiple comorbidities including radiculopathy and muscle weakness. Date initiated: 10/12/2022, Revision on: 10/12/2022. The goal was, The resident will be free of any discomfort or adverse side effects from pain medication through review date. Date initiated: 10/12/2022, Revision on: 4/12/2024, Target Date: 2/7/2025. Interventions included, Administer ANALGESIC medication as ordered by physician. Monitor/document side effects and effectiveness Q-SHIFT [every shift]; .Monitor for increased fall risk for falls. Date initiated: 10/12/2022. b. Risk for falls r/t neuropathy, gout, dependence on supplemental oxygen, impaired mobility with use of assistive device, hx [history] of falls. Date initiated: 7/18/2022, Revision on: 6/26/2023. The goal was, The resident will be free of falls with injury through the review date. Date initiated: 7/18/2022, Revision on: 4/12/2024, Target date: 2/7/2025. Interventions included, 1/22/2023 Patient had a fall in the community. Educated patient to be more aware of her surroundings when accessing the community. Date initiated: 7/28/2023; 5/27/2024-unwitnessed fall, risk management done, resident educated. Date initiated: 5/28/2024; 6/26/2023-Resident educated and encouraged to ask for staff assistance with toileting so safety reminders/prompts can be provided as needed. Date initiated: 6/26/2023. Anticipate and meet the resident's needs. Keep frequently used items within reach. Date initiated: 7/18/2022. Educate and encourage the resident to wear appropriate footwear, such as non-skid socks or shoes, when ambulating/mobilizing. Date initiated: 7/18/2022. Follow facility fall protocol if a fall occurs. Date initiated: 7/18/2022. Order placed for no transfers without assistance to prevent falls/injury d/t [due to] weakness. Date initiated: 10/1/2024. Orient resident to call light. Keep the resident's call light. Keep the resident's call light within reach and encourage the resident to use it for assistance as needed. Date initiated: 7/18/2022. c. The resident has had an actual fall. Poor Balance, Poor safety awareness. 10/12/24. Date initiated: 8/30/2024, Revision on: 10/21/2024. The goal was, Resident will not have a fall with major injury. Date initiated: 8/30/2024, Target Date: 2/7/2025. Interventions included, Carryout additional orders from PCP [Primary Care Physician]. Date initiated: 8/30/2024, Encourage resident to participate in her fall prevention. Date initiated: 8/30/2024. Monitor/document/report PRN x 72 h [hours] for MD for s/sx [signs and symptoms]: Pain, bruises, change in mental status, New onset: confusion, sleepiness, inability to maintain posture, agitation. Date initiated: 8/30/2024, Revision on: 8/30/2024, Neuro-checks x 72 hours. Date initiated: 8/30/2024, Revision on: 8/30/2024, Promote participation in activities to help encourage and teach safety awareness. Date initiated: 8/30/2024. Provide activities to promote exercise and strength building where possible. Provide 1:1 activities if bedbound. Date initiated: 8/30/2024. Resident currently in therapy with additional therapy evaluation, for safety and education. Date initiated: 8/30/2024. Resident reminded of the importance of using call button and therapy to evaluate. Date initiated: 10/21/2024. Vital signs QSHIFT/PRN. Take BP [blood pressure] lying/sitting/standing x1 in first 24 hr. Date initiated: 8/30/2024, Revision on: 8/30/2024. Progress notes revealed: (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. On 5/27/2024 at 4:45 AM, Found pt [patient] laying on her bed with a hematoma to her forehead. Pt with laceration to her nose. Severe pain to her right shoulder and pain and bruising to her left knee. Pt states that her pant leg got caught on her electric w/c [wheelchair] and she fell forward. Pt got herself up into her bed and then called for assistance. Pt requested to go to ER [emergency room] for evaluation of her right shoulder. Non-emergent ambulance called. Notified physician on call and pt's daughter. Pt sent out at this time. Cross Reference 656, 609, 610 b. On 6/4/2024 at 6:46 PM, Pt readmitted to facility via facility transport. A/O [alert and oriented] x 4 [person, place, time and situation]. Able to verbalize needs. Continent of bowel and bladder. Resident using sling to R shoulder. Has bruises to: forehead, L knee, Rt shoulder, LFA [left forearm], L elbow, 2 small bruises on bilat [bilateral] ankle, RFA [right forearm]. She has small scan [sic] on bridge of nose. Incision to R chest area intact, no s/s of infection. Uses motorized w/c for mobility. Last BM [bowel movement] 6/3/24. C/O [complains of] pain to R shoulder Oriented to facility. Call light within reach. c. On 8/18/24 at 4:31 PM, Upon entering the room resident sitting in the floor stating, 'I went down the floor to pick up a something and could not get up.' Called for assistance to help transfer resident during assessment no injuries noted at this time. Resident alert and oriented x 4. Neuro checks started. Educated resident on the importance to ask for assistance. Dr. notified. d. On 8/18/24 at 6:01 PM, Upon continuous assessment resident complaining of dizziness and headache post fall. Dr. called provided this information. Resident requested to go to the hospital. [Ambulance provider] called. e. On 8/18/24 at 11:04 PM, Resident returned from [hospital] ED [emergency department] at 8:51 PM. No findings found on CT [computed tomography scan] or x-ray. VSS [vital signs stable]. f. On 9/23/24 at 1:00 AM, Encounter, Date of service: 9/23/2024, Type of service: Follow up .Chief complaint/Nature of Presenting Problem: Follow-up from hospital visit .On 23 September 2024 patient presents to the emergency department with a chief complaint of fall. Patient states over the last couple days she has been experiencing more frequent falls beyond her baseline. Patient states this morning she had a ground-level fall and experienced a positive loss of consciousness. Patient states that she has had 2 breakthrough DVTs [Deep Vein Thrombosis] and noted some swelling in her legs yesterday associated with pain. Patient states since the fall yesterday she has been experiencing some bruising of her right periorbital region, without any changes in her vision. Patient denies chest pain shortness of breath numbness, back pain, or deformities. On arrival to the ER patient was hemodynamically stable. Exam noted nonpitting edema to bilateral lower extremities, ecchymosis to right side of face. CT images of head/cervical spine/face, chest x-ray, sternum labs ordered that revealed no abnormalities. The only significant injury noted was a nondisplaced nasal bone fracture without any other acute abnormalities. There is a chronic fracture to the right shoulder. Bilateral venous duplex ultrasounds revealed no evidence of DVT to lower extremities All other labs were within normal limits. Patient was readmitted to [facility] on 23 September 2024. Upon speaking with the patient today she states that she is still in a bit of pain. She is currently on a pain management regimen of oxycodone and morphine. Patient does have another follow-up coming up with her orthopedic specialist regarding her shoulder. Patient also states she will be going to see her neurologist about her balance issues. We will place patient on fall precautions at this point. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Bella Terra St George		STREET ADDRESS, CITY, STATE, ZIP CODE 178 South 1200 East St George, UT 84790	
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	g. On 9/23/24 at 9:01 AM, Late Entry: resident had witnessed fall, resident reported losing balance when walking in room. Resident hit head and neuro checks started. Resident alert and oriented x 4. VS [vital signs] stable. Resident appears to have a repetitive behavior continue to be lack of self-limitations and safety. Reported to Dr. educated resident on safety measures. Daughter no answer the phone, unable to leave message to report this concern. h. On 9/23/24 at 10:46 PM, Pt with fall this morning. Pt was in another pt's room. Pt states that she fell forward and hit her face. Pt with bruising under both eyes. Pt continues to c/o pain in legs. Pt went to ER after infusion appointment today. Pt was afraid that she had a DVT, but no DVT, just inflammation from fluid in her legs. Pt stated that her doctor's are working on a plan of what to do. i. On 9/25/24 at 3:15 AM, Resident had a fall, and has a bruise on her left cheek. No other injuries noted. States she feels like her legs are giving out and she is concerned about this. Has a dr [doctor] appointment on 9/26 and is wanting to address issue with dr. It should be noted that resident 13's care plan was not updated after a fall with major injury on 5/27/24, or the additional falls on 8/18/24, 9/23/24, and 9/25/24, [Cross-refer F689] 3. Resident 38 was admitted to the facility on [DATE] with diagnoses that included Parkinson's disease, type 2 diabetes with skin ulcer and neuropathy, cirrhosis of liver, morbid obesity, hemiplegia affecting right dominant side, anxiety disorder, aphasia, major depressive disorder, seizures and dysphagia. Resident 38's medical record was reviewed between 11/3/24 and 11/13/24. An admission MDS assessment dated [DATE] revealed resident 38 had a BIMS score of 15 which indicated a normal cognition. The MDS care area summary revealed psychosocial well-being, mood state, and behavioral symptoms were not triggered. Psychotropic drug use was triggered and marked that it was included in the resident's care plan. Physician orders revealed: a. Behavior monitoring: verbalization of sadness Q shift. Order date: 10/30/24. b. Behavior monitoring: # of verbal outbursts Q shift. Order date: 10/30/24. c. Antipsychotic medication side effect monitoring: 0=none; 1=drowsiness; 2=sedation; 3=dry mouth; 4=constipation; 5=blurred vision; 6=extrapyramidal reaction; 7=wt [weight] gain; 8=edema; 9=sweating; 10=loss of appetite; 11=urinary retension. Order date: 9/13/24. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. Resident also had behavior monitoring orders for: hours of sleep, itching, picking at skin, restlessness, hitting, increase in complaints, biting, kicking, spitting, cussing, racial slurs, elopement, stealing, delusions, hallucinations, psychosis, aggression, refusing care. Document any behaviors and enter findings in progress note. Additionally behavior monitoring for paranoid statements, episodes of agitation, expression of hopelessness, anti-depressant medication side effects, anti-anxiety medication side effects, and anxious statements. Order date: 9/13/24. e. Duloxetine HCL [hydrochloride] oral capsule Delayed release particles 60 MG [milligrams]; Give 1 capsule by mouth one time a day for depression. Order date: 9/13/24. It should be noted that resident 38 was not taking any antianxiety medications. Care plan revealed: a. The resident has diagnosis/diagnoses of (depression and anxiety). Resident requires the use of (antidepressant medications) to help manage this condition. Date initiated 11/2/24, Revision on: 11/3/24. The goal was, The resident will have no adverse side effects r/t psychotropic medications use through the review date. Date initiated: 11/3/24, Target date: 1/1/25. The interventions included, Administer psychotropic medications per physician order. Monitor/document adverse side effects. Notify MD of any consistent, adverse side effects that resident experiences r/t psychotropic medication use. Date initiated: 11/2/24; Follow PASRR [Pre-Admission Screening and Resident Review] level II recommendations: monitor for worsening anxiety or SI [suicidal ideation]. Date initiated: 11/9/24, Revision ob [sic] 11/9/24; Monitor/document occurrence of target symptoms. Report any new/worsened symptoms that are not effectively managed with current pharmacological and/or non-pharmacological interventions. Date initiated: 11/2/24; Psychotropic committee will review resident's medication regimen, target symptoms, and side effects at least quarterly. Committee will make recommendations for psychotropic regimen as indicated. Date initiated: 11/2/24; Staff should use the following non-pharmacological interventions to help manage resident's symptoms: Active listening/support/encouragement, validation, reality orientation, re-direction/distraction, identify/eliminate triggers for resident's symptoms or behaviors. Date initiated: 11/2/24. b. The resident has a potential psychosocial well-being problem actual r/t anxiety and MDD [major depressive disorder]. Date initiated: 11/9/24, revision on: 11/9/24. The goal was, The resident will have no indications of psychosocial well-being problem by/through the review date. Date initiated: 11/9/24 Target date: 1/1/25. Interventions included, He needs to have something in life that gives him purpose. Ensure he has activities that are meaningful to him. Date initiated: 11/9/24, Increase communication between resident/family/caregivers about care and living environment: Explain all procedures and treatments, medications, results of labs/tests, condition, all changes, rules, options. Date initiated: 11/9/24; Provide opportunities for the resident and family to participate in care. Date initiated: 11/9/24; When conflict arises, remove residents to a calm safe environment and allow to vent/share feelings. Date initiated: 11/9/24. It should be noted that while resident 38 was admitted with a diagnosis of depression and had orders for an antidepressant and several monitoring orders, the care plan was not updated to reflect care concerns regarding depression until 11/2/24 and 11/3/24. 30563 (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Resident 55 was admitted to the facility on [DATE] with diagnoses which included Parkinson's disease with dyskinesia without mention of fluctuations, chronic obstructive pulmonary disease, type 2 diabetes mellitus, tremor, and personal history of other infectious and parasitic disease. On 11/4/24 at 8:40 AM, an interview was conducted with resident 55. Resident 55 stated he had pain in his back, that radiated down his right side to his groin and left hip. Resident 55 stated he thought it was a pinched nerve but the nurse got a urine sample on 10/28/24. Resident 55 stated he had not heard about the results from his urine and was not sure if he was taking antibiotics. Resident 55 stated the pain from his back to his groin was new. Resident 55 stated that his catheter was removed about a month ago. Resident 55's medical record was reviewed 11/5/24 through 11/13/24. Resident 55's Admit/Readmit Screener dated 4/29/24 revealed resident 55 had a catheter when admitted . An admission MDS assessment dated [DATE] revealed resident 55 had an indwelling catheter, was not on a toileting program and was always continent of bowel. The care area assessment revealed resident 55 was care planned for urinary incontinence and indwelling catheter. There was no care plan regarding resident's bowel and bladder. Resident 55's CNA documentation in POC revealed resident 55 was continent of bladder from 10/20/24 until 10/24/24 when there was an incontinent episode, Resident 55 was incontinent on 10/28/24, 10/31/24, 11/4/24, 11/6/24 and 11/13/23. A physician's order dated 5/1/24 (16_ F [french]/ 10_ cc [cubic centimeter]) (Foley) catheter to down drain for dx [diagnosis] of (urinary retention). May change PRN if dislodged or clogged. Another physician's order dated 10/28/24 revealed UA [urinalysis] C&S [culture and sensitivity] one time only for 1 Day. Progress notes revealed the following entries: a. On 8/4/24 at 5:25 AM, Resident stated he took catheter out himself. Resident states he no longer wants to have one in . b. On 8/4/24 at 6:16 PM, .Refuses foley catheter reinsertion . b. On 8/5/24 at 1:00 AM, .Today patient is being followed up on regarding a catheter displacement.Over the weekend patient's catheter was dislodged. Some how the catheter became tangled up in patient's bed and was dislodged. The catheter has since been replaced. After examination it appears to be placed correctly. There is normal color urine in the bag. Patient states that he feels fine at this point. Patient had no other questions or concerns today. Nursing staff had no new additional concerns on this patient . c. On 8/11/24 at 8:28 PM, Change catheter down drainbag every 2 weeks. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. On 8/26/24 at 1:00 AM, a physician's note revealed .Foley catheter in place . e. On 9/5/24 at 1:00 AM, a physician's note revealed .Foley catheter in place . f. On 10/7/24 at 1:00 AM, a physician's note revealed .Foley catheter in place g. On 10/26/2024 at 1:31 AM, patient complained of pain in-between his lower and upper right abdominal quadrant. The skin looked normal upon palpation no abnormal mass could be felt. Pain only increased when pressing in not on release. Patient said he had no nausea; he has passed gas recently and had a recent bowel [sic] movement. Patient said it's been hurting on and off since yesterday. Gave patient 650 mg acetaminophen for pain. h. On 10/28/24 at 1:00 AM, .Today patient is being seen regarding flank pain on his right side. Patient states this came on over the past couple days. He states it is around the area of his right kidney. Patient is concerned he might have some type of infection going on. We discussed options of diagnosis including urinalysis. Today we will go ahead and obtain a urinalysis with culture. I did encourage the patient to hydrate as much as possible, as this can be an effective way to help clear an infection as well. We did also discuss the possibility of a kidney stone. Patient states that the pain is not very severe at this point. If urinalysis is inconclusive, we can obtain a kidney ultrasound if patient is still having pain. Patient is okay with this plan. Patient had no additional questions or concerns today. Nursing staff had no new concerns on this patient .Continue Foley catheter use . i. On 10/28/2024 at 9:01 PM, New order received from [name removed] NP [nurse practitioner] for UA with C&S. This note was created by Registered Nurse (RN) 3. j. On 11/2/24 at 8:36 PM, revealed, Orders -Administration Note: Acetaminophen Oral Tablet Give 650 mg by mouth every 4 hours as needed for Pain, fever c/o pain right lower back and hip. k. On 11/6/24 at 9:21 AM revealed, Orders -Administration Note: Acetaminophen Oral Tablet Give 650 mg by mouth every 4 hours as needed for Pain ,fever C/O back pain. Will monitor for effectiveness. l. On 11/7/24 at 2:15 PM revealed, Resident has redness on his groins, perineal area and under R side of abdominal fold. Cleaned with warm wet wash cloth and hand towel to dry, nystatin applied. m. On 11/10/24 at 1:19 AM revealed, Orders -Administration Note: Acetaminophen Oral Tablet Give 650 mg by mouth every 4 hours as needed for Pain ,fever R side flank pain. n. On 11/10/24 at 2:23 AM revealed, Alert Charting: Resident c/o R flank pain 8/10. Denies pain in bladder or with urination but does state that he has urgency and frequency with small amounts of urine. States he provided a urine sample already. Called lab to get results faxed. UA abnormalities: slightly cloudy, leukocytes 500 (large), WBC [white blood cells] > [greater than] 30, RBC [red blood cells] H [high] 5, bacteria 1+. bacteria from culture is aerococcus urinae. o. On 11/10/24 at 2:34 AM, Alert Charting: Secure message sent to [physician's name removed] and his team regarding symptoms and UA results. p. On 11/10/24 at 12:40 PM, Alert Charting: Called on call provider and got order for abx [antibiotic]. Order added and pulled from stat safe. Faxed to [name removed] Pharmacy. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/12/24 at 10:17 AM, an interview was conducted with resident 55. Resident 55 stated he was now taking antibiotics for his urine test. Resident 55 stated he started antibiotics on Sunday but did not know what the results were. Resident 55 stated he was having back pain on the right side, no burning upon urination, had some incontinent episodes and his brief overflowed during the night. Resident 55 stated it was not normal to have a full brief at night. Resident 55 stated in the last month or so, he had been using a brief at night and it had been overflowing. Resident 55 stated he was using the bathroom every 3.5 to 4 hours. Resident 55 stated he was able to get to the restroom to use the bathroom in the past, but not lately. Resident 55 stated staff had been changing his brief more often. Resident 55 stated he felt like there had been a change to his bladder in the last month or so. Resident 55 stated since starting the antibiotics his back was feeling better. Resident 55 stated his pain in his back was a 7 or 8 and sometimes up to a 9 out of 10. Resident 55 stated he used Tylenol usually but last week he took Tylenol for his back pain. Resident 55 stated he did not have a catheter for a long time. On 11/12/24 at 10:09 AM, an interview was conducted with RN 3. RN 3 stated if a resident had signs and symptoms of a UTI [urinary tract infection], she would contact the physician for a urine analysis. RN 3 stated she documented the UA on 10/28/24 for the day shift nurse. RN 3 stated the day shift nurse obtained the physician's order for the UA. RN 3 stated the UA was obtained on 10/28/24. RN 3 stated resident 55 complained of signs and symptoms of a UTI on 11/10/24. RN 3 stated she called the laboratory to obtain the UA results. RN 3 stated she notified the physician and DON about the results. RN 3 stated she passed it on in report to the day shift nurse that she found resident 55's UA results. RN 3 stated she was unable to find any follow-up for resident 55 from 10/28/24 until 11/10/24. RN 3 stated the UA results should be done by the next day and the culture and sensitivity within 3 days. RN 3 stated there was a glitch in the system with receiving the results from the lab. RN 3 stated the physician's order for the laboratory always had to fax results to the facility. RN 3 stated nursing staff usually had to call the laboratory and ask for results. RN 3 stated laboratory draws should be passed on verbally during nursing report. RN 3 stated there was a lab book up at nursing station A and had a copy of every lab draw that was done at the facility. RN 3 stated she was not sure if anyone audited the book. RN 3 stated resident 55 was complaining of flank pain on 11/10/24 and that he was having some incontinent episodes, frequency of urination and had small amounts of urine. RN 3 stated resident 55 told her that a UA probably needed to be done and resident 55 stated he already had his urine collected for one. RN 3 stated she worked as needed so she worked 10/28/24 and then again on 11/10/24. RN 3 stated resident had a catheter a long time ago but did not have one any more. On 11/12/24 at 10:36 AM, an interview was conducted with Licensed Practical Nurse (LPN) 3. LPN 3 stated if someone had signs and symptoms of a UTI, she would ask what the problems were like if the resident had flank pain, fever, frequency of urination or burning with urination. LPN 3 stated if the resident was unable to verbalize signs and symptoms, then she would monitor for a change in condition. LPN 3 stated if a re [TRUNCATED]		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 30563 Based on interview and record review it was determined, for 4 of 65 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, resident's were not provided bathing/shower assistance, nail care, and incontinence care for over 3 hours. Resident identifier: 15, 49, 51 and 60. Findings included: 1. Resident 49 was admitted to the facility on [DATE] with diagnoses which included dementia, psychotic disturbance, mood disturbance and anxiety. On 11/3/24 at 6:44 PM, an interview and observation was made of resident 49. Resident 49 stated he did not get showers as often as he wanted. Resident 49 stated when his roommate showered there was water everywhere because of how poorly the drain for the shower was designed. Resident 49 stated he would like to shower daily, but was only getting showers once per week because of the poorly designed showers. On 11/3/24 through 11/8/24, an observation was made of resident 49. Resident 49 was observed in the same clothing those days. Resident 49 was observed to have stubby facial hair. On 11/11/24, an observation was made of resident 49. Resident 49 was observed in the same clothing he was wearing the week before. Resident 49 was observed to have different clothing on 11/13/24. Resident 49's medical record was reviewed. A Brief Interview for Mental Status (BIMS) assessment was completed on 5/3/24 and locked on 5/22/24. The BIMS score was 15 which indicated resident 49 was cognitively intact. An admission Minimum Data Set (MDS) dated [DATE] revealed resident 49 required supervision or touching assistance with bathing. A quarterly MDS dated [DATE] revealed resident 49 had a BIMS of 15. A care plan dated 2/12/24 revealed The resident has an ADL [activities of daily living] self-care performance deficit r/t [related to] Confusion, Dementia, needing some assistance from staff with ADLs. The goal was The resident will maintain current level of function with ADLs through the review date. Interventions included Encourage the resident to participate to the fullest extent possible with each interaction; Encourage the resident to use bell to call for assistance; Monitor/document/report PRN [as needed] any changes, any potential for improvement, reasons for self-care deficit, expected course, declines in function; Praise all efforts at self care; and PT/OT [Physical Therapy/Occupational Therapy] evaluation and treatment as per MD [Medical Doctor] orders. (continued on next page)		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Another care plan dated 10/25/24 revealed, The resident is resistive to care (refuses to wear briefs) r/t Dementia and incontinence. The goal was The resident will cooperate with care through next review date. Interventions included Encourage as much participation/interaction by the resident as possible during care activities; Give clear explanation of all care activities prior to an as they occur during each contact; If resident resists with ADLs, reassure resident, leave and return 5-10 minutes later and try again; Praise the resident when behavior is appropriate; and Provide resident with opportunities for choice during care provision. The Certified Nursing Assistant (CNA) documentation in the plan of care tasks section for shower and bathing revealed the following: a. On 10/14/24, it was documented as not applicable (N/A), b. On 10/16/24, the shower was provided, c. On 10/22/24, the shower was refused, d. On 10/23/24, the shower was provided, e. On 10/31/24, it was documented as N/A, f. On 11/5/24, the shower was refused, g. On 11/6/24, the shower was provided, h. On 11/8/24, the resident was unavailable, i. On 11/11/24, the shower was documented as N/A. On 11/12/24 at 11:06 AM, an interview was conducted with CNA 8. CNA 8 stated she was not sure which days resident 49 was scheduled to have showers. CNA 8 stated if a resident did their own shower then N/A might be marked by CNA's. CNA 8 stated she was not sure if resident 49 needed assistance with showering. On 11/12/24 at 1:51 PM, an interview was conducted with the Director of Nursing (DON). The DON stated resident 49 should get showers twice per week. The DON stated she was unsure why showers for resident 49 were marked as N/A. On 11/13/24 at 8:54 AM, an interview was conducted with License Practical Nurse (LPN) 3. LPN 3 stated that resident 49 was scheduled for a shower during the night shift, so she was not sure if resident 49 was getting showered. LPN 3 stated if a resident refused a shower, then staff tried to make accommodations for the resident to shower when they wanted. LPN 3 stated on 11/12/24 CNA 6 told her resident 49 needed a shower. LPN 3 stated she asked to see resident 49's Lidocaine patch and she told resident 49 his back was dirty and smelled, so she offered to shower him. LPN 3 stated resident 49 told her she could shower himself. LPN 3 stated she was not sure the last time resident 49 had showered prior to 11/12/24. LPN 3 stated she sometimes did not notice when resident smelled, but she did notice resident 49 smelled. LPN 3 stated resident 49 was pleasant, fine and picked out his own clothing. LPN 3 stated she had no problem getting resident 49 to shower. (continued on next page)		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident 60 was admitted to the facility on [DATE] with diagnoses which included type 2 diabetes mellitus, hypertension, dysphagia, history of falling, constipation and dementia. On 11/3/24 at 3:59 PM, an interview was conducted with resident 60. Resident 60 stated he had only had 1 shower since being admitted to the facility. Resident 60 stated he would like to get showers weekly. Resident 60 was observed to have blood on his shirt. Resident 60 had long fingernails that were dirty. Resident 60 stated he would like to have his nails cut and cleaned. Resident 60's medical record was reviewed. A BIMS assessment dated [DATE] revealed a score of 15 which indicated resident 60 was cognitively intact. An MDS assessment dated [DATE] revealed resident 60 required limited to extensive 1 person assistance with ADLs. Resident 60 required partial to moderate assistance with showering or bathing self which included washing, rinsing, and drying self. An admission MDS dated [DATE] revealed resident had BIMS of 9 which indicated moderate cognitive impairment. The MDS revealed that with mobility in and out of the bath tub or shower resident 60 required partial to moderate assistance which meant the helper (staff) does less than half. A care plan dated 8/27/24 revealed Potential for altered skin integrity related to: Diabetes Type 2, falls, incontinence. The goal was Resident will have no s/s [signs and symptoms] of skin breakdown at all times through next 90 day review. One intervention was Staff will help promote clean skin by encouraging/assisting resident to bathe regularly. Dry skin thoroughly after bathing. Keep skin moisturized by applying lotion as indicated. Another care plan dated 8/27/24 revealed Potential for alteration in Health Maintenance related to: Type 2 Diabetes Mellitus, Hypertension, Gastro-esophageal reflux disease, dysphagia, history of falling, constipation. The goal was Resident will have no complications related to disease processes through the review date. One of the interventions was Provide assistance with ADLs as needed. A review of CNA charting in PoC Response history revealed no documented baths or showers from 10/6/24 through 11/6/24. On 11/12/24 at 10:51 AM, an interview was conducted with CNA 8. CNA 8 stated resident 60 was scheduled for shower at night and she was not sure how much assistance he needed or if he preferred a bed bath or a shower. CNA 8 stated when she came into work and was waiting for the vital signs cart, she logged into the CNA charting system to see who needed showers that day. CNA 8 stated as she went through to do vital signs she asked when the resident wanted a shower. CNA 8 stated after a shower was completed she documented in the computer system. CNA 8 stated there were shower sheets that CNA's signed and they were placed in the managers folder. CNA 8 stated the nurses performed nail care, unless CNA's were given different instructions. CNA 8 stated nurses were the only ones to touch residents nails. (continued on next page)		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/12/24 at 10:04 AM, an interview was conducted with CNA 5. CNA 5 stated there was a shower schedule in the CNA charting system. CNA 5 stated that was how CNA's knew who needed a shower. CNA 5 stated there should not be an N/A marked for showers. CNA 5 stated CNA's should be marking how much assistance resident's needed with showers. CNA 5 stated resident 49 received showers during the night shift so she was not sure why N/A was marked. CNA 5 stated if a resident requested nail care, then CNA's could do it unless the resident was diabetic. CNA 5 stated if a resident was diabetic then the nurse needed to clip fingernails. CNA 5 stated resident's needed to ask if they want to be shaved. CNA 5 stated every time resident 60 was showered he wanted to be shaved. CNA 5 stated she was not sure if resident 60 had diabetes. CNA 5 stated CNA's did nail care every 2 weeks or once per week. CNA 5 stated she completed nail care once because it was requested by a resident. On 11/7/24 at 11:59 AM, an interview was conducted with CNA 4. CNA 4 stated the shower schedules were in the CNA charting system, there was a shower icon to alert CNA's the resident needed a shower that day. CNA 4 stated the shower was to be documented in the CNA charting system and then a skin shower sheet was completed. CNA 4 stated if the resident refused, then CNA tired two more times and then the nurse had the resident sign a refusal form. CNA 4 stated the refusals were placed in the nurse manager folder. CNA 4 stated she performed the shower audits starting a few weeks ago. CNA 4 stated nail care was documented on the shower sheet. On 11/13/24 at 8:54 AM, an interview was conducted with LPN 3. LPN 3 stated if a resident had diabetes then the podiatrist cut their toenails. LPN 3 stated for residents that did not have diabetes she preferred to have a nurse cut their nails. LPN 3 stated CNA's should be looking at residents nails and facial hair. LPN 3 stated CNA's should ask residents if they would like to be shaved and nails cut and inform the nurses when those things needed to be done. On 11/7/24 at 11:39 AM, an interview was conducted with the DON. The DON stated the shower process started upon admission when staff asked how the resident wanted to be bathed. The DON stated residents were able to have as many showers as they wanted but at least 2 per week. The DON stated the CNA's charting system alerted CNA's to who needed showers that day. The DON stated the CNA's knew the residents and their preferences. The DON stated if a resident refused, then the CNA offered another time and then the nurse was notified. The DON stated the nurse determined why the resident did not want to shower and the resident signed a refusal form. The DON stated she reviewed why a resident was refusing to determine the root cause. The DON stated there would be information in the CNA charting system and shower sheet were handed to nurse when a shower was completed. The DON stated nail care should be done with showers and documented on the shower sheet. The DON stated if the resident was non-diabetic then CNA's were able to cut their fingernails. The DON stated nurses and the CNA coordinator have come in to preform nail care in the past. The DON provided shower sheets for resident 60. Resident 60 was bathed on 10/31/24 and fingernails and toenails were cleaned. There were no other shower sheets provided. On 11/12/24 at 2:48 PM, a follow-up interview was conducted with the DON. The DON stated that resident 60's showers were not alerting CNA's on his shower days in the CNA computer system. The DON stated she found 1 shower sheet that was completed for resident 60. The DON stated staff say that they have given resident 60 showers but she unable find more shower sheets or any documentation. The DON stated the nail care would be done with showers and was documented on the shower sheets. 38031 (continued on next page)		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Resident 15 was admitted to the facility on [DATE] with diagnoses which included hereditary ataxia, cognitive communication deficit, dysphagia, hypothyroidism, major depressive disorder, anemia, peripheral neuropathy, dysarthria and anarthria, speech disturbance, wedge compression fracture of third lumbar, edema, and insomnia. On 11/03/24 at 2:04 PM, an interview was conducted with resident 15. Resident 15 stated she was incontinent and wore a brief. Resident 15 stated that the brief was changed approximately every 3 hours, but that she needed it changed more frequently than that. Resident 15 stated that she did not currently have any issues with a urinary tract infection. A strong odor of urine was noted from resident 15 during the interview. Resident 15's medical record was reviewed. On 9/11/24, resident 15's MDS Assessment documented a BIMS score of 15, which would indicate that the resident was cognitively intact. The assessment documented that resident 15 required a two-person extensive assist for bed mobility, transfer, and toilet use. The assessment documented that the resident was not on a toileting program for urinary or bowel continence. On 5/2/24, resident 15 had an order initiated for Furosemide Tablet 20 milligrams (mg), give 3 tablet by mouth one time a day related to edema. Resident 15's Bowel and Bladder Elimination task for urinary continence documented that the resident 15 was incontinent of bladder. The task documented that incontinence care was provided 1 to 3 times per day. No documentation could be found of a bowel and bladder program for resident 15. Resident 15's care plan revealed a focus area for ADL [activities of daily living] Self Care Performance Deficit r/t [related to] impaired mobility, physical limitations, pain, and neuropathy. On 2/24/17, the care plan was initiated and the following interventions were implemented: the resident requires extensive to total dependence with 1-2 staff for toilet use; the resident requires limited to extensive assistance with 1-2 staff member for personal hygiene/oral care; and the resident requires mechanical lift with 2 staff for transfers. On 11/5/24 at 12:48 PM, an interview was conducted with CNA 6. CNA 6 stated that resident 15 was a two-person assist for repositioning, hoyer use, transfer, and incontinence care. CNA 6 stated that resident 15 was incontinent of bowel and bladder. CNA 6 stated that resident 15's bowel and bladder program included medication to treat constipation and a medication for increased urinary output. CNA 6 stated that they provided resident 15 with brief changes every 2 hours unless she called for assistance before that. CNA 6 stated that resident 15's briefs were usually saturated with urine at the time of incontinence care. CNA 6 stated that they documented brief changes and incontinence care in the electronic medical records. CNA 6 stated that he was usually able to complete his tasks during a shift. CNA 6 stated that it was always helpful to have more staff. CNA 6 stated that sometimes it was difficult to provide incontinence care every two hours, but they made sure to get it done before shift change. CNA 6 stated that all incontinent residents were changed at least once a shift. (continued on next page)		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/6/24 at 8:10 AM, a continuous observation was started for resident 15. At 8:17 AM, a breakfast meal tray was delivered to resident 15 by CNA 4. Resident 15 was seated in bed in a high fowlers position with the bedside table positioned over their lap. No incontinence care was provided by CNA 4. At 8:46 AM, CNA 5 delivered bed sheets to resident 15's room and placed them at the bedside. No incontinence care was provided by CNA 5. At 9:17 AM, CNA 5 removed resident 15's breakfast tray from the bedside. No incontinence care was provided by CNA 5. At 10:49 AM, the DON and LPN 3 walked by resident 15's room. No incontinence care was provided. At 10:50 AM, CNA 5 was observed to enter resident 15's room. CNA 5 was interviewed upon exit of the room. CNA 5 stated that resident 15 was sleeping and she checked to ensure that the resident was okay. No incontinence care was provided by CNA 5. At 11:51 AM, resident 15's continual observation was completed. It should be noted that a continual observation was conducted of resident 15 from 8:10 AM to 11:51 AM and no observations of incontinence care were provided. On 11/6/24 at 3:17 PM, an interview was conducted with CNA 5. CNA 5 stated that she and another aide got resident 15 up at approximately noon. CNA 5 stated that resident 15's brief was saturated with urine, she doesn't soak that bad. On 11/6/24 at 3:26 PM, an interview was conducted with the DON. The DON stated that incontinence care expectations were that staff rounded on the residents every 2 hours and checked to see if briefs needed to be changed. The DON stated that staff should check with any resident that required assistance with toileting every 2 hours for toileting needs. 4. Resident 51 was admitted to the facility on [DATE] with diagnoses which included intracerebral hemorrhage, hemiplegia and hemiparesis of left side, neurologic neglect syndrome, chronic kidney disease, hypertension, congestive heart failure, cognitive communication deficit, aphasia, visual loss both eyes, and insomnia. On 11/3/24 at 2:48 PM, an interview was conducted with resident 51. Resident 51 stated that she had fallen previously in the morning when attempting to get up and toilet herself. Resident 51 stated that sometimes she had to change her brief because the staff did not come to help her. Resident 51 stated that the call light did not always work either. Resident 51 stated that she could put a pull up brief on by herself but she could not put the tab briefs on by herself. It should be noted that resident 51 had hemiplegia and hemiparesis of the left side that limited her ability to perform toileting tasks independently. Resident 51 stated that she waited 2 hours the other night for assistance. Resident 51 stated that she requested pull up briefs a couple of days ago but never received them. Resident 51's call light was pushed at the bedside and in the bathroom and both were observed not functioning. On 10/9/24, resident 51's MDS Assessment documented a BIMS score of 14, which indicated that the resident was cognitively intact. The assessment documented that the resident was a one-person limited assist for bed mobility and eating, and a one-person extensive assist for transfers and toilet use. The assessment documented that the resident was not on a urinary or bowel toileting program. Resident 51's physician orders revealed the following: a. On 5/22/24, an order was initiated for Spironolactone Oral Tablet 25 mg, give 0.5 tablet by mouth one time. (continued on next page)		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. On 5/1/24, an order was initiated for a fluid Restriction of 2000 milliliters per 24 hours. Resident 51's Bowel and Bladder Elimination task for urinary continence and bowel continence documented by the CNA's revealed that resident 51 was incontinent of bladder and bowel. The task documented that incontinence care was provided 1 to 4 times per day. Resident 51's Care plan revealed a focus area for The resident has an ADL self-care performance deficit r/t [related to] blindness, Hemiplegia. On 1/24/24, the care plan was initiated and the following interventions were implemented: the resident requires touching to partial assistance by 1 staff for toilet use; the resident requires partial/moderate assistance by 1 staff for personal hygiene and oral care; and the resident requires partial to substantial assistance by 1 staff to move between surfaces with transfers. On 11/5/24 at 12:53 PM, an interview was conducted with CNA 6. CNA 6 stated that resident 51 required a one-person assist for incontinence care due to the resident's visual impairment and paralysis in the left arm. CNA 6 stated that resident 51 was incontinent of bowel and bladder. CNA 6 stated that they used either pull up briefs or tab briefs for resident 51 and that resident 51 did not have a preference. CNA 6 stated that resident 51 would inform them when she needed a brief change. On 11/06/24 at 8:10 AM, a continuous observation was started for resident 51. No incontinence care was provided by CNA 5. At 8:28 AM, a breakfast meal tray was delivered to resident 51 by CNA 5. No incontinence care was provided. At 9:17 AM, an observation was made of CNA 4 assisting resident 51 with dressing. CNA 4 then removed resident 51's breakfast tray from the bedside. No incontinence care was provided by CNA 4. At 10:04 AM, CNA 5 entered resident 51's room and placed clean linen on the bedside table. CNA 5 assisted resident 51 into bed. No incontinence care was provided by CNA 5. At 10:49 AM, the DON and LPN 3 walked by resident 51's room. No incontinence care was provided. At 10:50 AM, CNA 5 was observed to enter resident 51's room. CNA 5 was interviewed upon exit of the room. CNA 5 stated that resident 51 was sleeping and she checked to ensure that the resident was okay. No incontinence care was provided by CNA 5. At 11:51 AM, resident 51's continual observation was completed. It should be noted that a continual observation was conducted of resident 51 from 8:10 AM to 11:51 AM and no observations of incontinence care were provided. [Cross-refer F689, F725, and F919]		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30563 Based on observation, interview and record review it was determined, 3 out of 65 sampled residents, that the facility did not provide an ongoing program to support resident in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interest of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community based on the residents comprehensive assessment and care plan. Specifically, there was no activity calendar, there were no activities on the weekends, resident complained of not enough activities, activities were observed during meal times, and there were complaints in resident council minutes. Resident identifiers: 26, 38 and 49. Findings included: 1. On 11/3/24 at 1:04 PM, an observation was made of the activity calendar. The calendar was for October 2024. On 11/4/24 an observation was made of the activity calendar for November 2024 hanging on the wall by the nurses station. 2. On 11/5/24 at 6:31 PM, an observation was made in the activity room. There were residents in there attending a bible study. An observation was made of the Housekeeping Supervisor (HS) taking resident 38's meal tray into the activity room. The HS was observed to move resident 38's things and put his meal tray in front of him while the activity was going. 3. Resident 49 was admitted to the facility on [DATE] with diagnoses which included dementia, paroxysmal atrial fibrillation, heart failure, cognitive communication deficit, and chronic pain. On 11/3/24 at 6:43 PM, an interview was conducted with resident 49. Resident 49 stated he would like to have more activities to stimulate his brain. Resident 49 stated he would like to play chess, horse shoe or other games like that. Resident 49's medical record was reviewed 11/3/24 through 11/13/24. Resident 49's admission Minimum Data Set (MDS) dated [DATE] revealed it was very important for resident 49 listen to music and participate in religious services or practices. It was somewhat important to go outside to get fresh air when the weather was good, do his favorite activities, do things with groups of people, be around animals such as pets, and read books, newspapers, and magazines. A quarterly MDS revealed resident 49 had a Brief Interview of Mental Status (BIMS) score of 15. (continued on next page)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A care plan dated 3/25/24 and revised on 8/19/24 revealed Recreational Therapy: [resident 49] exhibits impaired activity patterns manifested by: impaired mobility, need for adaptive equipment, sensory problems, poor health/pain limits activity involvement, need for reminders and assistance to/from activities, fatigue from treatments; problems with coping skills; exhibits behaviors, at times. The goal was [Resident 49] will continue life roles and maintain independence in accordance with preferences, strengths, and functional capacity by being oriented to make decisions regarding leisure participation, communicating wants/needs during interventions, and participating in leisure activities regularly, through the review period. [Resident 49] will accept at least 1 1:1 visit OR attend 1 group per week, through the review period, for coping and social skill development, enhancing self esteem, positive self-expression, goal-setting, improving problem solving and decision-making skills, anger and stress management, improving self perceived wellness, and/or building and strengthening interpersonal relationships. Interventions included the following: a. Invite and involve in present/past activities of importance/interest including: Book Club, Mystery Person Trivia, C/C [coffee and choc] social, walking groups, Ping-Pong and Chess tournaments, religious groups. b. Voting: move here, if he decides to stay living here. c. Religious: Church of Jesus Christ of Latter-day Saints, Consents to receiving services d. Trauma r/t [related to]: perceived religious persecution. e. Monitor for satisfaction with my leisure choices. f. Please post the calendar in my room. g. Supply me with independent leisure materials PRN [as needed]. h. Please invite and/or assist to/from group activities. i. Please encourage me to participate in activities of interest. j. Please help ensure I have proper lighting & sufficient space for activities both in and out of my room. k. Please encourage and support the continuation of my life roles. Please support my family/friend involvement & my need for privacy during visits. l. Monitor for fall risk. m. Coordinate with CNA to help assist with my setup/positioning/toileting needs during activities PRN. n. Monitor for my diet precautions for food related activities. Provide adaptations to activities PRN: (continued on next page)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	o. Cognition: provide opportunities to recall memories and/or make decisions. Provide assistance with orientation and decision-making, PRN. p. Vision: provide me with large print material q. Hearing: increase volume and speak clearly to me r. physical: adapt size/height/weight of items to match my physical abilities, low energy programming s. communication: allow me time to speak and encourage to communicate during activities, attend to non-verbal cues. Use validation to help re-direct my behaviors and be calm with me. t. Use validation to help me express my feelings appropriately. u. Encourage me to make positive statements and help uplift my mood during activities. v. Encourage me to interact appropriately with others and provide me with positive feedback when I do. w. Encourage/support the development of old/new interests, hobbies, or skills. On 8/15/24, there was a care conference conducted. The following was noted in the care conference [Resident 49] expressed that he has no concerns/issues, but would like to see a couple of particular activities on the resident Calendar (Ping-Pong/Chess Tournament), and have the facility create an outdoor Horseshoes arena. [Resident 49] enjoys sitting & socializing with his significant other watching TV in the act. [activity] room. He enjoys participating in Book Club, Coffee/Cocoa Social, walking groups, and Church groups for the Church of Jesus Christ of Latter-day Saints. He has enjoyed Chess and Ping Pong Tournaments, in the past. A form titled Activities - Quarterly/Annual Participation Review completed on 8/19/24 revealed [Resident 49] enjoys independent leisure activities including sitting and socializing with his significant other watching TV in the activity room. He enjoys participating in Book Club, Coffee/Cocoa Social, walking groups, and Church groups for the Church of Jesus Christ of Latter-day Saints. He has enjoyed Chess and Ping Pong Tournaments, in the past. Changes to interventions and approaches revealed Adjusted to personalize/update, per MDS and observation/interview information. Added interests and personalized adaptations. On 11/12/24 at 3:09 PM, an interview was conducted with the Director of Nursing (DON). The DON stated the Activities Director (AD) was in charge of activities. The DON stated the AD had a staff member trained to do activities on the memory care unit. The DON stated there had been miscommunication regarding the time of activities lately. The DON stated the activity was usually paged over the intercom system if there was a change in the time. The DON stated resident's have not been able to hear the changes in times. The DON stated meals did not usually overlap with meals, but there was a Bible study that overlapped with dinner last week. The DON stated the AD provided activities Monday through Friday and a resident volunteer to did activities on the weekends. (continued on next page)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/13/24 at 9:13 AM, an interview was conducted with the AD. The AD stated resident 49 loved trivia, prides himself on history, book club, loves walks, coffee and hot chocolate social, napping, news and walks. The AD stated resident 49 watched a lot of TV on the weekends. The AD stated activities on the weekends included resident led activities and church. The AD stated sometimes every other Sunday there were card games. The AD stated she referenced community events because residents can use the bus system to go to activities. On 11/12/24 at 11:04 AM, an interview was conducted with Certified Nursing Assistant (CNA) 8. CNA 8 stated there were activities every day but the activities were things like book club that people did not like. CNA 8 stated usually resident 49 watched TV in the activities room or in his room. CNA 8 stated there was nothing going on during the weekends. 50200 2. Resident 26 was admitted to the facility on [DATE] with diagnoses which include, but not limited to, facioscapulohumeral muscular dystrophy, unspecified protein-calorie malnutrition, hyperlipidemia, hypomagnesemia, hypo-osmolality and hyponatremia, and weakness. On 11/3/24 at 3:36 PM, an interview was conducted with resident 26. Resident 26 stated she liked to attend activities at the facility but lately they had been getting canceled or were occurring during meal times. Resident 26 stated that this was very disappointing to her as she relies on activities to get her out of her room and gives her something to do. Resident 26's medical record was reviewed 11/3/24-11/13-24. A care plan dated 7/12/23 and revised on 6/19/24 revealed Recreational Therapy: [resident 26] exhibits impaired activity patterns manifested by: muscular dystrophy; impaired mobility, need for adaptive equipment, poor health/pain limits activity involvement, need for reminders and assistance to/from activities, fatigue for treatments/therapies. sensory problems, difficulties communicating other relevant conditions: hx [history] of falling; eye pain/difficulty seeing; heart palpitations; difficulty walking. The goal was [Resident 26 will attend 1 social activity or 1:1 per week for building a support system as evidenced by connecting with other residents and/or family; Will continue life roles/independent activities in accordance with preferences, strengths, and functional capacity weekly x 90 days, Will engage in 1 spiritual activity per week to decrease in signs of symptoms of depression as evidenced by increase in positive attitude during activities x 90 days. Interventions included the following: a. Invite and involve me in my activities of importance/interest including: dog visits, plants/horticulture, arts and crafts, musical performances, Christmas light drives, visiting with family/posterity, and watching the news and Calvary Chapel services on the TV, [resident 26] used to enjoy some of the following, that she is interested in trying again/learning: knitting/crocheting, drawing/sketching, checkers, fishing, nature walks, and using her devices for gaming/guided imagery. b. Monitor for satisfaction with my leisure choices. c. Please post the calendar in my room. d. Supply me with independent leisure materials PRN [as needed]. (continued on next page)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	e. Please invite and/or assist to/from group activities. f. Please encourage me to participate in activities of interest. g. Please help ensure I have proper lighting & sufficient space for activities both in and out of my room. h. Please encourage and support the continuation of my life roles. i. Please support my family/friend involvement & my need for privacy during visits. j. Monitor for fall risk. k. Coordinate with CNA [certified nurse aide] to help assist with my setup/positioning/toileting needs during activities PRN. l. Monitor for my diet precautions for food related activities. m. Provide adaptations to activities PRN: n. Vision: provide me with large print material, be mindful of my eye sensitivity and difficulty seeing; o. physical: adapt/size/height/weight of items to match my physical abilities; monitor for fatigue p. communication: allow me time to speak and encourage to communicate during activities or attend to non-verbal cues q. Use validation to help me express my feelings appropriately, r. Encourage me to make positive statements and help uplift my mood during activities. s. Provide 1:1 visits 1x per week, PRN. On 9/20/24, there was a care conference conducted. The following was noted in the care conference: [Resident 26] expressed that she feels RT [recreation therapy] needs more staff because the Act. [Activities] Director is doing more assessments and meetings than previous activities people did. On 11/6/24 at 9:26 AM, an interview was conducted with the Activities Director (AD). The AD stated that the Resident Advocate at the facility recently took another position and she had to schedule all the care conferences and this took up a significant amount of her time. The AD stated that every once in a while there had been times that other duties overlapped and she was not able to do the scheduled activity. The AD stated that meal times have interfered with activities and meals weren't getting out on time and residents would not go to group because of meal time. The AD stated that every once in awhile a volunteer had canceled and she had to let management know that the activity was canceled. The AD stated that she did not work on the weekends and she relied on volunteers to carry out the activities on the weekend or the residents would lead the activities themselves. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Bella Terra St George		STREET ADDRESS, CITY, STATE, ZIP CODE 178 South 1200 East St George, UT 84790	
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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/7/24 at 8:28 AM, an observation was made of the facility's activity calendar posted in the 100 hallway. The 4:00 PM activity of a piano performance scheduled for 11/7/24 was crossed out and Canceled-Sorry! was written. It was also observed that on 11/28 and 11/29 the calendar showed that (AD) on vacation; reduced programming in her absence. On 11/13/24 at 9:09 AM, a follow up interview was conducted with the AD. The AD stated that she did not have an assistant and she was responsible for all of the resident activities. The AD stated that she always posted the activities calendar on the first of the month. The AD stated that for the month of November there were some difficulties because there was no money in the budget to get the calendar printed. The AD stated she was going to be off for a few days and there was no one to fill in her for, so that was why the calendar stated reduced programing. (Cross Refer to F725)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45490 Based on record review and interview it was determined, for 1 of 65 sampled residents, based on the comprehensive assessment of a resident the facility did not ensure that a resident with a pressure ulcer received the necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Specifically a resident's wound Vacuum-Assisted Closure (VAC) was not working for approximately 24 hours and the physician was not notified until the resident was somnolent. Resident identifier: 371. Findings included: Resident 371 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included paraplegia, cognitive communication deficit, and pressure ulcer of sacral region. Resident 371's medical record was reviewed 11/12/24 through 11/13/24. An admission Minimum Data Set (MDS) dated [DATE] revealed resident 371 had a Brief Interview of Mental Status (BIMS) score of 11 which suggested moderate cognitive impairment. The MDS further revealed resident 371 had one unhealed stage 3 pressure ulcer and one stage 4 pressure ulcer. The MDS revealed skin and ulcer treatments were pressure reducing device for chair and bed, turning/repositioning program, nutrition or hydration interventions to manage skin problems, pressure ulcer care, and application of non-surgical dressing other than to feet. A care plan dated 5/23/24 and revised on 6/20/24 revealed, resident 371 had a Documented pressure ulcer. The care plan did not list a goal. The care plan's only intervention included, Provide wound care per treatment order. On 5/9/24 a physician wrote an order for wound care to be completed every Monday, Thursday, and Friday with the wound VAC pressure set at a constant setting. On 5/23/24 at 5:53 PM, a skin/wound progress note revealed that resident 371 was seen by the wound specialist physicians assistant, and wound care was completed which included an increase in the wound vac pressure setting. On 5/29/24 at 1:00 AM, a physician documented a progress note that revealed, that they were informed by nursing staff, that resident 371's wound VAC had not been working for at least 24 hours and resident 371 had been somnolent for most of the day. The physician noted that resident 371 had a recent bout of sepsis due to this previously. The physician then immediately went to check resident 371's and upon entry of the room the smell from patient's wounds was overwhelming. The physician assessed the wound and resident 371's mental status, resident 371 was arousable to pain only. The physician called 911 and had resident 371 transferred to a local Emergency Department (ED) due to possible septic shock. [It should be noted that there was no documentation indicated that the physician was contacted about the malfunctioning wound VAC.] (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 5/29/24, resident 371 was admitted to a local hospital. The document revealed the wound VAC had broken at some point in the last few days. In the physical exam the skin assessment revealed the physician was unable to assess the ulcer as the patient was unable to roll all the way over, however there was a foul odor distinguishable . A Computed Tomography (CT) obtained in the hospital revealed resident 371 had an abscess in the left gluteal region, findings were suspicious for osteomyelitis., an abscess in the posterior sacral soft tissue, and inflammation in the right gluteal. The hospital documents revealed, resident 371 was diagnosed with osteomyelitis of the sacrum and placed on antibiotics. On 11/13/24 at 2:39 PM, an interview was conducted with the Director of Nursing (DON). The DON stated wound VAC's are just checked when they are being changed. The DON stated that if the wound VAC was not working then the nurses should troubleshoot, check for adequate battery, look for a replacement and if none of that helped then the nurses should contact the provider. The DON stated when the nurses contact the provider they should document the response in the progress note. The DON stated the nurses should have contacted the provider for resident 371's wound VAC.		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48709 Based on observation, interview, and record review, it was determined for 5 of 65 sampled residents that the facility failed to 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 fell as a result of the use of damaged medical equipment; no updated interventions were implemented after resident falls, with one resident having sustained a major injury; neurological assessments were not completed after falls and a call light was not within reach. Resident identifiers: 1, 5, 13, 18, 51, 52 and 60. Findings included: Harm 1. Resident 5 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included quadriplegia, dysphagia, chronic kidney disease, chronic obstructive pulmonary disease, paralysis of vocal cords and larynx, congestive heart failure, and major depressive disorder. Resident 5's medical record was reviewed 11/3/24 through 11/13/24. A Minimum Data Set (MDS) Admission assessment Section GG- Functional Abilities and Goal, dated 10/21/24, indicated resident 5 had impairment on one side of his upper extremity and impairment on both sides of his lower extremities and used a wheelchair. It further indicated, Chair/bed-to-chair transfer: The ability to safely come to a standing position from sitting in a chair or on the side of the bed .Dependent - Helper does ALL of the effort. Resident does none of the effort to complete the activity. An Alert Charting note, dated 11/8/24 at 2:55 AM, indicated, Resident was being lifted up in the hoyer sling x2 CNAs [Certified Nurse Assistant] from wheelchair to bed placed in bed to go to sleep. CNA's Stated that sling snapped and Pt [patient] slid onto floor. Pt was assessed by nurse and took Pt vitals were WNL [within normal limits] BP [blood pressure]= 133/80, P [pulse]=73, O2 [oxygen]= 93, R [respirations]=20. Pt got skin tear to Left arm. no other injury appeared at this time. dressing applied by nurse. no other issues were noted at this time. An Alert Charting note, dated 11/8/24 at 1:05 PM, indicated, Resident denies c/o [complaints of] pain/discomfort r/t [related to] fall last night. New order for wound care to skin tear on LFA [left forearm]. Silvadene and dressing change QD [every day]. A physician order, dated 11/8/24 at 10:14 AM, indicated, Silvadene External Cream 1 % (Silver Sulfadiazine) Apply to L [left] arm topically one time a day for skin tear Cleanse arm with NS [normal saline] or wound cleanser; apply silvadene and cover with a bordered dressing QD until healed. (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	An IDT (Interdisciplinary Team) note, dated 11/9/24 at 1:47 PM, indicated, Data: Resident had a fall due to hoyer sling breaking during transfer. Action: All hoyer slings investigated to determine if there are any ones that need to be thrown away. New slings ordered Response: IDT team met to discuss fall and care plan updated. On 11/13/24 at 8:48 AM, an interview was conducted with the Maintenance Supervisor. The Maintenance Supervisor stated he fixed the facility's medical equipment and that he had not heard about any hoyer lifts that needed repair. On 11/13/24 at 9:21 AM, an interview was conducted with Certified Nurse Assistant (CNA) 6. CNA 6 stated that after resident 5's fall occurred, the CNA Coordinator trained him about what to do when he used a hoyer sling and what to check for. CNA 6 stated the main problem found for the fall was wear and tear of the sling. A concurrent observation was conducted in room [ROOM NUMBER]. Resident 18 was laying in bed and a hoyer sling was laying on a wheelchair next to the bed. The hoyer sling had a ripped strap loop which was not intact at any point. CNA 6 stated that the strap was ripped and that he would not use that on the resident. CNA 6 stated if he found that sling, he would notify the CNA Coordinator. CNA 6 stated resident 18 used that sling multiple times a day to get in and out of her bed to her wheelchair. On 11/13/24 at 10:00 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that they had a mishap with the hoyer lift sling and that it was broken on one of the strap loops, which led to resident 5's fall. The DON stated that after the fall, all of the hoyer lift slings were observed and any damaged slings were taken out of use. The DON stated she did not know how many slings the facility had. The DON stated that the CNA's were then educated to look for any tears or damage before using a sling and that if they noticed any issues they should not use it and notify the CNA Coordinator. The DON stated she was not aware if the facility had a process for this prior to resident 5's fall. The DON stated that the CNA Coordinator, headed that up and that she was not directly involved in the corrective action plan. The DON was notified of the broken hoyer lift sling found in room [ROOM NUMBER]. The DON stated she was not aware of the broken hoyer lift sling in room [ROOM NUMBER] before the surveyor [NAME] it up to staff. On 11/13/24 at 1:41 PM, an interview was conducted with the Administrator (ADMIN). The ADMIN stated that another sweep of hoyer lift slings was completed today through the whole building and that the hoyer lift sling in room [ROOM NUMBER] was removed from use. On 11/13/24 at 1:45 PM, an interview was conducted with the CNA Coordinator. The CNA Coordinator stated that after resident 5's fall, the CNA's were educated to look for any frayed or damaged slings and to not use them and give them to her. The CNA Coordinator stated the CNA's were to check for damage on the slings before use every time they were used. The CNA stated they did a sweep of all hoyer lift slings in the facility, removed any damaged slings, and ordered new ones. A Quality Assurance and Performance Improvement Plan (PIP), dated 11/13/24, was provided to the State Agency. 43212 (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	2. Resident 13 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included Hereditary and idiopathic neuropathy, chronic respiratory failure, symptomatic epilepsy and epileptic syndromes with simple partial seizures, morbid obesity, long term use of anticoagulants, personal history of pulmonary embolism, muscle weakness, history of falling, and chronic pain. On 11/3/24 at 4:04 PM, an interview was conducted with resident 13. Resident 13 stated that she had been told that she needed assistance but that staff were too busy to help her. Resident 13 stated she was provided a walker after her last fall. Resident 13 stated her knees buckled on her contributing to her falls. On 11/4/24 at 11:10 AM, an interview was conducted with resident 13. Resident 13 stated she had several falls while in the facility, including a fracture of her right arm and nose. Resident 13's medical record was review between 11/3/24 and 11/13/24. On 6/11/24, an admission Minimum Data Set (MDS) assessment revealed a Brief Interview for Mental Status (BIMS) score of 13 indicating normal cognition. Resident 13's care plan revealed: a. Pain medication therapy use r/t [related to] multiple comorbidities including radiculopathy and muscle weakness. Date initiated: 10/12/2022, Revision on: 10/12/2022. The goal was, The resident will be free of any discomfort or adverse side effects from pain medication through review date. Interventions included, Administer ANALGESIC medication as ordered by physician. Monitor/document side effects and effectiveness Q-SHIFT [every shift]; Monitor for increased fall risk for falls. Date initiated: 10/12/2022. b. Risk for falls r/t neuropathy, gout, dependence on supplemental oxygen, impaired mobility with use of assistive device, hx [history] of falls. Date initiated: 7/18/2022, Revision on: 6/26/2023. The goal was, The resident will be free of falls with injury through the review date. Date initiated: 7/18/2022, Revision on: 4/12/2024, Target date: 2/7/2025. Interventions included, 1/22/2023 Patient had a fall in the community. Educated patient to be more aware of her surroundings when accessing the community. Date initiated: 7/28/2023; 5/27/2024-unwitnessed fall, risk management done, resident educated. Date initiated: 5/28/2024; 6/26/2023- Resident educated and encouraged to ask for staff assistance with toileting so safety reminders/prompts can be provided as needed. Date initiated: 6/26/2023. Anticipate and meet the resident's needs. Keep frequently used items within reach. Date initiated: 7/18/2022. Educate and encourage the resident to wear appropriate footwear, such as non-skid socks or shoes, when ambulating/mobilizing. Date initiated: 7/18/2022. Follow facility fall protocol if a fall occurs. Date initiated: 7/18/2022. Order placed for no transfers without assistance to prevent falls/injury d/t [due to] weakness. Date initiated: 10/1/2024. Orient resident to call light. Keep the resident's call light. Keep the resident's call light within reach and encourage the resident to use it for assistance as needed. Date initiated: 7/18/2022. (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	C. The resident has had an actual fall. Poor Balance, Poor safety awareness. 10/12/24. Date initiated: 8/30/2024, Revision on: 10/21/2024. The goal was, Resident will not have a fall with major injury. Date initiated: 8/30/2024, Target Date: 2/7/2025. Interventions included, Carryout additional orders from PCP [Primary Care Physician]. Date initiated: 8/30/2024, Encourage resident to participate in her fall prevention. Date initiated: 8/30/2024. Monitor/document/report PRN [as needed] x 72 h [hours] for MD [Medical Doctor] for s/sx [signs and symptoms]: Pain, bruises, change in mental status, New onset: confusion, sleepiness, inability to maintain posture, agitation. Date initiated: 8/30/2024, Revision on: 8/30/2024, Neuro-checks x 72 hours. Date initiated: 8/30/2024, Revision on: 8/30/2024, Promote participation in activities to help encourage and teach safety awareness. Date initiated: 8/30/2024. Provide activities to promote exercise and strength building where possible. Provide 1:1 activities if bedbound. Date initiated: 8/30/2024. Resident currently in therapy with additional therapy evaluation, for safety and education. Date initiated: 8/30/2024. Resident reminded of the importance of using call button and therapy to evaluate. Date initiated: 10/21/2024. Vital signs QSHIFT [every shift]/PRN. Take BP [blood pressure] lying/sitting/standing x1 in first 24 hr. Date initiated: 8/30/2024, Revision on: 8/30/2024. Resident 13's progress notes revealed: a. On 5/27/24 at 4:45 AM, an alert note revealed, Found pt laying on her bed with a hematoma to her forehead. Pt with laceration to her nose. Severe pain to her right shoulder and pain and bruising to her left knee. Pt states that her pant leg got caught on her electric w/c [wheelchair] and she fell forward. Pt got herself up into her bed and then called for assistance. Pt requested to go to ER [emergency room] for evaluation of her right shoulder. Non-emergent ambulance called. Notified physician on call and pt's daughter. Pt sent out at this time. It should be noted that information of resident 13's vital signs, assessment or neuro checks could not be found in the resident's medical record or progress notes. b. On 6/4/24 at 6:46 PM, an alert note revealed, Pt readmitted to facility via facility transport. A/O [alert and oriented] x 4. Able to verbalize needs. Continent of bowel and bladder. Resident using sling to R shoulder. Has bruises to: forehead, L knee, Rt shoulder, LFA [left forearm], L elbow, 2 small bruises on bilat [bilateral] ankle, RFA [right forearm]. She has small scan [sic] on bridge of nose. Incision to R chest area intact, no s/s [signs or symptoms] of infection. Uses motorized w/c for mobility. Last BM [bowel movement] 6/3/24. C/O [complains of] pain to R shoulder Oriented to facility. Call light within reach. c. On 6/6/24 at 10:17 PM, an alert note revealed, Resident c/o high pain this evening. She states she isn't able to move R arm or hand. Gave PRN medication and placed ice pack on shoulder. d. A Work/School Release document dated 6/7/24 revealed, This notice verifies that [resident 13] was seen in the emergency department on 6/7/2024. The accompanying discharge handout revealed, Diagnosis from Today's Visit: 1. Humeral head fracture; 2. Shoulder dislocation. Tests performed included x-ray of right shoulder, EKG (electrocardiogram)/Cardiovascular. (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	e. On 6/7/24 at 7:18 PM, a discharge note revealed, Discharge progress note: Date/time of discharge/transfer: 6/7/2024 7:45 PM; Discharge/transfer location: [hospital ER]. Mode of transportation at time of discharge/transfer: [ambulance provider]. Reason for transfer/discharge: uncontrolled pain. Discharge teaching/instructions completed during discharge/transfer process: n/a [not applicable]. Discharge paperwork released with resident at time of discharge/transfer: transfer sheet, order summary, polst. Resident's response to discharge/transfer process: resident requested. How were resident's personal effects stored/handled at time of discharge/transfer? Kept at facility. Name of individual to whom report was provided at new location: n/a. Name of resident representative notified (if resident is not self-responsible) daughter was present when resident requested transfer. Name of physician notified: [provider name]. It should be noted that there was no alert notes indicating a fall on 6/7/24. f. On 6/17/24 at 1:00 AM, a provider encounter note revealed, .Chief complaint/ Nature of presenting problem: New patient history and physical exam/ left wrist pain/ left knee pain .On 27 May 2024 patient presented to the emergency department due to a fall. Patient fell from her wheelchair onto her right shoulder and also striking her head, In the emergency room department imaging of the shoulder showed glenohumeral joint dislocation with fracture of the right humeral head. Patient has a hematoma on her right forehead. CT [computer tomography] of the brain showed no acute bleeding or abnormality. After discussing the case with orthopedic surgery they were unable to reduce the shoulder and immobilize it in the emergency room . Patient would likely benefit from surgical repair. They discussed this with [physician] who is agreed to evaluate patient. Patient was given morphine in the emergency department for pain. Patient was admitted to [facility] rehab on 4 June 2024. Today after speaking the patient states she has had a recent fall. She has a displaced fracture of the proximal humeral head. Patient is also stating that she is having pain in her right wrist and right knee. She is following up with her orthopedic surgeon later today to come up with a plan for surgery. I advised her to mention the wrist and knee so they can get x-rays in office. She states that these are the only things bothering her right now. g. On 8/18/24 at 4:31 PM, an alert charting note revealed, Upon entering the room resident sitting in the floor stating, 'I went down the floor to pick up a something and could not get up.' Called for assistance to help transfer resident during assessment no injuries noted at this time. Resident alert and oriented x 4. Neuro checks started. Educated resident on the importance to ask for assistance. Dr. notified. h. On 8/18/24 at 6:01 PM, an alert charting note revealed, Late Entry: Resident requested to go to the ER due to having severe pain in her right shoulder that has not been able to be managed with her current regimen. On call Dr [name removed] notified of situation and suggested we increase her Oxycodone 10-325 mg [milligram] to 20 mg every 6 hours and prescribe baclofen 10 mg. Resident denied and still requested to go to ER. [Ambulance provider] called and resident picked up at 6:35 PM. (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	i. On 8/19/24 at 1:00 AM, an encounter note revealed, .Today I was informed by the nursing staff patient suffered a ground-level fall yesterday. Patient was seen at the emergency department. Patient does have a large hematoma on the back of her right leg. Patient had a full workup done at the emergency department to include CT brain, right knee x-ray ,and pelvic x-ray. Patient did not have any other acute injury. It was discovered that patient has severe tricompartmental right knee arthritis. Patient will follow-up with her orthopedic provider regarding possible cortisone injections and the knee replacement. Today we will proceed with bracing of the leg. Patient says she does feel unstable on her feet . It should be noted, there was no update to the resident's care plan after this fall. j. On 9/23/24 at 1:00 AM, an provider encounter note revealed, Encounter, Date of service: 9/23/2024, Type of service: Follow up .Chief complaint/Nature of Presenting Problem: Follow-up from hospital visit .On 23 September 2024 patient presents to the emergency department with a chief complaint of fall. Patient states over the last couple days she has been experiencing more frequent falls beyond her baseline. Patient states this morning she had a ground-level fall and experienced a positive loss of consciousness. Patient states that she has had 2 breakthrough DVTs [Deep Vein Thrombosis] and noted some swelling in her legs yesterday associated with pain. Patient states since the fall yesterday she has been experiencing some bruising of her right periorbital region, without any changes in her vision. Patient denies chest pain shortness of breath numbness, back pain, or deformities. On arrival to the ER patient was hemodynamically stable. Exam noted nonpitting edema to bilateral lower extremities, ecchymosis to right side of face. CT images of head/cervical spine/face, chest x-ray, sternum labs ordered that revealed no abnormalities. The only significant injury noted was a nondisplaced nasal bone fracture without any other acute abnormalities. There is a chronic fracture to the right shoulder. Bilateral venous duplex ultrasounds revealed no evidence of DVT to lower extremities All other labs were within normal limits. Patient was readmitted to [facility] on 23 September 2024. Upon speaking with the patient today she states that she is still in a bit of pain. She is currently on a pain management regimen of oxycodone and morphine. Patient does have another follow-up coming up with her orthopedic specialist regarding her shoulder. Patient also states she will be going to see her neurologist about her balance issues. We will place patient on fall precautions at this point. k. On 9/23/24 at 9:01 AM, an alert charting note revealed, Late Entry: resident had witnessed fall, resident reported losing balance when walking in room. Resident hit head and neuro checks started. Resident alert and oriented x 4. VS [vital signs] stable. Resident appears to have a repetitive behavior continue to be lack of self-limitations and safety. Reported to Dr. educated resident on safety measures. Daughter no answer the phone, unable to leave message to report this concern. It should be noted that no neuro checks were found in resident 13's medical record for the fall related to the fall on 9/23/24. l. On 9/23/24 at 10:46 PM, an alert charting note revealed, Pt with fall this morning. Pt was in another pt's room. Pt states that she fell forward and hit her face. Pt with bruising under both eyes. Pt continues to c/o pain in legs. Pt went to ER after infusion appointment today. Pt was afraid that she had a DVT, but no DVT, just inflammation from fluid in her legs. Pt stated that her doctor's are working on a plan of what to do. (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	m. On 9/24/24 at 9:29 AM, an IDT note revealed, IDT met to discuss recent RT fall. See care plan for all updated interventions. Alert charting x72 HR. Reminded RT to use call light for assistance. OT [Occupational Therapy] to evaluate. PT [Physical Therapy] to supply walker for RT to use in room. Staff will continue to monitor as needed. It should be noted there was no update to the resident's care plan after this fall. n. On 9/25/24 at 3:15 AM, an alert charting note revealed, Resident had a fall, and has a bruise on her left cheek. No other injuries noted. States she feels like her legs are giving out and she is concerned about this. Has a dr [doctor] appointment on 9/26 and is wanting to address issue with dr. It should be noted there were no neuro checks found related to this fall and there was no update to the resident's care plan after this fall. o. On 9/30/24 at 9:18 AM, an IDT note revealed, IDT met to discuss recent RT potential fall. See care plan for all updated interventions. Alert charting x 72HR. Action: Reminded Rt to not transfer self without assistance. RT was sent to hospital for an x-ray of her knee. Response: Staff will continue to monitor as needed. p. On 10/12/24 at 10:16 PM, an alert charting progress note revealed, Resident in another resident's room socializing. When this nurse in to see other resident this resident report that before dinner today she was leaning over to get something out of her bookcase and she slid out of her chair and landed on her bottom. Reports that she was able to get herself up by scooting to her recliner, grabbing the back of the seat and pulling herself up. Did not tell any staff until she told this nurse. Denies any pain related to occurrence. Refused skin assessment at this time .Message left for MD, DON notified. On 11/6/24 at 4:06 PM, an interview was conducted with CNA 4 and 5 who stated that resident 13 had injured herself after falling, but mostly just had bruising. CNA 5 stated that resident 13 tried to transfer herself from her bed to her chair without calling for help. CNA 5 stated resident 13 was supposed to call for help. On 11/7/24 at 9:31 AM, an interview was conducted with Licensed Practical Nurse (LPN) 4 who stated that resident 13 fell a lot. LPN 4 stated resident 13 had poor safety awareness and she had been encouraged to call for help. LPN 4 stated resident 13 did not always call when she needed assistance getting out of bed and the falls happened when transferring to a wheel chair. LPN 4 stated the staff asked resident 13 what time she wanted to get up and the residents choose when they want to get out of bed. (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 11/7/24 at 11:59 AM, an interview was conducted with the MDS coordinator who stated if a resident had a fall, it would be reviewed in the morning stand up meeting, and then in an IDT meeting. The MDS coordinator stated in the meetings the staff reviewed the fall, what happened, why it happened, and then discuss how it can be prevented. The MDS coordinator stated the IDT meetings typically occurred the next day, unless it was an extremely urgent concern. The MDS stated the incident on 5/27/24 was a result of resident 13's pant leg getting caught on her wheelchair. The MDS stated resident 13 was given verbal education about wheelchair safety on the day of her fall. The MDS stated the education included making sure resident 13 was wearing pants that would not get caught on her chair when she was ambulating. The MDS also stated that staff were given education that would be passed through report to inform them of the interventions being put into place. The MDS stated he personally educated staff members. The MDS stated the care plan intervention that resident should wear non-skid and proper footwear implicated that it should include clothing. The MDS stated resident 13's emergency room visit on 6/7/24 was likely related to her fall on 5/27/24. The MDS stated for the fall resident 13 sustained on 9/23/24, the resident fell on her face again. The MDS stated around 9/18/24, the facility received a concern from resident 13's neurologist about her being over medicated. The MDS stated sometimes talking to outside providers or the pharmacy was hard because they do not want to play fair. The MDS stated a pharmacist should be reviewing resident 13's pain medications each time she attended the pain clinic. The MDS stated reviewing resident 13's pain medications should be an intervention for her falls, but there is not an intervention about going over her medications. It should be noted that IDT meetings regarding resident 13's falls could not be found for the following dates: 5/27/24, 8/18/24, and 10/12/24. On 11/7/24 at 12:46 PM, an observation was made of resident 13 talking with another resident. Resident 13 was sitting in her wheelchair and was noted to be wearing long pants that were falling over the foot rest on her wheelchair. On 11/12/24 at 2:45 PM, an interview was conducted with the DON. The DON stated the MDS coordinator was responsible for updating the resident care plans. The DON stated if he could not do it, she would be responsible. The DON stated for resident 13's frequent falls there should be an evaluation of current interventions and new interventions should be updated. 30563 Potential for Harm 3. Resident 60 was admitted to the facility on [DATE] with diagnoses which included type 2 diabetes mellitus, hypertension, dysphagia, history of falling, constipation and dementia. On 11/3/24 at 4:03 PM, an interview was conducted with resident 60. Resident 60 stated that he had fallen waiting for staff to answer his call light. Resident 60 stated he got himself up to go to the bathroom and had fallen with no injuries. Resident 60's bed was about 4 feet off the ground. On 11/7/24 at 8:34 AM, an observation was made of resident 60. Resident 60 was in bed with his bed about 4 feet off the ground. CNA 6 was observed to check if resident 60's bed was in the lowest position. CNA 6 was observed to lower resident 60's bed and stated it was close to the lowest position. (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 11/7/24 at 11:16 AM, an observation was made of resident 60's call light flashing outside resident 60's room. Resident 60 was observed in bed trying to pull himself to a seated position using the 1/4 side rails. Resident 60 was observed yelling he needed help. Resident 60 was observed to get himself to a seated position. Resident 60 stated he wanted help to get up. Resident 52 was observed to exit her room and look in resident 60's room and ask resident 60 if he needed help. Resident 60 stated he needed assistance. Resident 60 was observed to yell an expletive. Resident 52 stated to resident 60 to not to get out of bed and just stay there. At 11:20 AM, a nurse, Administrator, and Corporate staff were observed to walk past resident 60's room. There was a strong bowel movement odor into the hallway. At 11:22 AM, resident 52 stopped the Administrator and stated resident 60 needed assistance. Resident 60 was observed to have bowel movement on him. The Administrator was observed to ask CNA 6 to assist resident 60. On 11/7/24 at 11:54 AM, an interview was conducted with resident 60. Resident 60 was asked if there were enough staff to meet his needs. Resident 60 responded Oh [expletive removed] his call light was on for a while and he needed to use the restroom. Resident 60 stated he had to get himself up and ambulated to the bathroom on his own usually. Resident 60 stated sometimes he waited for 15 to 20 minutes before getting himself up to get to the bathroom. On 11/12/24 at 10:34 AM, an observation was made of resident 60's room. The call light was observed to be wrapped up on the nightstand on the other side of his privacy curtain. The call light was not within reach of resident 60. Resident 60's medical record was reviewed 11/3/24 through 11/13/24. An admission MDS dated [DATE] revealed resident 60 had a BIMS score of 9 which indicated moderate cognitive impairment. The MDS indicated resident required partial to moderate assistance with mobility and walking 10 feet. Resident 60 had falls prior to admission. Resident 60's care plan revealed The resident is at risk for falls r/t history of falls, weakness, incontinence. The goal was The resident will be free of falls with injury through the review date. Interventions included Anticipate and meet the resident's needs. Keep frequently used items within reach. Date Initiated: 08/27/2024; Bed in lowest position, call light within reach and commonly used items within reach. Remind resident to use call light for assistance. Date Initiated: 09/01/2024; Educate and encourage the resident to wear appropriate footwear, such as nonskid socks or shoes, when ambulating/mobilizing. Date Initiated: 08/27/2024; Educate the resident/family/caregivers about safety reminders and what to do if a fall occurs. Date Initiated: 08/27/2024; Follow facility fall protocol if a fall occurs. Date Initiated: 08/27/2024; Orient resident to call light. Keep the resident's call light within reach and encourage the resident to use it for assistance as needed. Date Initiated: 08/27/2024; Refer to therapy for evaluation and treatment as indicated to address fall risk. Date Initiated: 08/27/2024; Reminded to ask for assistance when reaching for items. Date Initiated: 09/25/2024; Staff shall assist to provide the resident with a safe environment to reduce the risk for falls: even floors free from spills and/or clutter; adequate, glare-free light; handrails on walls in the hallway; Date Initiated: 08/27/2024 and revised on: 10/11/2024. Resident 60's progress notes and risk management reports revealed the following: (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	a. On 8/26/24 at 7:39 PM, an alert charting note revealed, Resident admitted to facility, at 1530 (3:30 PM). resident VS stable at this time. alert and oriented x4. Resident requires 1 person assist with ADLS [activities of daily living]. bruises noted in Left leg and other bruised noted right arm. from previous fall. prior to admission. resident high risk for falling due to not asking for assistance. resident accommodating to facility. continuously monitoring resident. b. On 8/29/24 at 12:53 AM, an alert charting note revealed, Resident is able to make needs known. Resident has call light within reach. Resident is pleasant. c. On 8/27/24 at 7:35 PM, an alert charting note revealed, Resident compliant with cares and treatment. resident currently resting in bed with call light in reach. d. On 8/27/24 at 3:31 AM, an alert charting note revealed, Pt asleep in his room in bed with no concerns at this time. Call light within reach and will continue with plan of care. e. On 9/1/24 at 11:55 AM, a risk management report revealed resident calling for help. upon entering room resident is on the floor on his knees. bed was in the lowest position. The resident description reported was I slid of the bed trying to reach for TV remote. The immediate action taken was Assessed resident for injuries. started neuro checks. educated resident to request help when needed. resident Alert X4. continuously monitoring. family and Dr notified. f. On 9/1/24 at 12:59 PM, an alert charting note revealed, resident unwitnessed fall upon entering resident on the floor on his knees reporting 'I slid of the bed trying to reach for Tv remote'. no physical injuries noted. resident alert and oriented x4. neuro checks started. family and Dr notified. A care plan intervention dated 9/1/24 was to have resident 60's bed in lowest position, call light within reach and commonly used items within reach and remind resident to use call light for assistance. There was no neuro checks located in resident 60's medical record. g. On 9/3/24 at 12:27 AM, an alert charting note revealed, Pt shows no new injuries or c/o of pain. VS WNL and pt bed in low position and call light within reach/ Will continue with plan of care. It should be noted there was no other alert charting after the fall. h. On 9/6/24 at 10:02 AM, an IDT note revealed, IDT met to discuss recent RT fall. See care plan for all updated interventions. Alert charting x72HR Action: Care plan updated - call light and commonly used items within reach Response: Staff will continue to monitor as needed. i. On 9/25/24, a risk management report revealed resident 60 was found kneeling beside bed by nurse after roommate reported resident needing help. The resident description revealed resident 60 verbalized picking up the TV remote, but he slid from the bed. The desc [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** 30563 Based on observation, interview and record review, for 3 of 65 sampled residents, the facility did not ensure a resident who was continent of bladder and bowel on admission received services and assistance to maintain continence unless his or her clinical condition is or became such that continence was not possible to maintain. Specifically, a resident had a urine analysis (UA) obtained and 12 days later staff obtained the results and treatment was started for a urinary tract infection (UTI). The resident complained of flank pain during the 12 days and was administered Tylenol. Another resident was occasionally incontinent of bladder upon admission was not provided a bladder retraining program. In addition, the same resident was observed to have a call light on for 8 minutes, yelling for help, and another resident found staff to clean him up after having a bowel movement. Those 2 examples will be cited at a harm level. Another resident had an antibiotic for a UTI discontinued prior to finishing the course of the antibiotic. Resident identifiers: 1, 52, 55 and 60. Findings included: 1. Resident 55 was admitted to the facility on [DATE] with diagnoses which included Parkinson's disease with dyskinesia without mention of fluctuations, chronic obstructive pulmonary disease, type 2 diabetes mellitus, tremor, and personal history of other infectious and parasitic disease. On 11/4/24 at 8:40 AM, an interview was conducted with resident 55. Resident 55 stated he had pain in his back, that radiated down his right side to his groin and hip. Resident 55 stated he thought it was a pinched nerve but a nurse got a urine sample on 10/28/24. Resident 55 stated he had not heard about the results from his urine and was not sure if he was taking antibiotics. Resident 55 stated the pain from his back to his groin was new. Resident 55 stated that his catheter was removed about a month ago. Resident 55's medical record was reviewed 11/5/24 thought 11/13/24. Resident 55's Admit/Readmit Screener dated 4/29/24 revealed resident 55 had a catheter when admitted . An admission Minimum Data Set (MDS) dated [DATE] revealed resident 55 had an indwelling catheter, was not on a toileting program and was always continent of bowel. The care area assessment revealed resident 55 was care planned for urinary incontinence and indwelling catheter. There was no care plan regarding resident's bowel and bladder. Resident 55's Certified Nursing Assistant (CNA) documentation in POC (point of care) revealed resident 55 was continent of bladder from 10/20/24 until 10/24/24 when there was an incontinent episode. Resident 55 was incontinent on 10/28/24, 10/31/24, 11/4/24, 11/6/24 and 11/13/23. A physician's order dated 5/1/24 (16_ F [french]/ 10_ cc [cubic centimeter]) (Foley) catheter to down drain for dx [diagnosis] of (urinary retention). May change PRN [as needed] if dislodged or clogged. The order was active and had not been discontinued. (continued on next page)		

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Another physician's order dated 10/28/24 revealed UA [urine analysis] C&S [culture and sensitivity] one time only for 1 Day. Progress notes revealed the following entries: a. On 8/4/24 at 5:25 AM, Resident stated he took catheter out himself. Resident states he no longer wants to have one in . b. On 8/4/24 at 6:16 PM, .Refuses foley catheter reinsertion . c. On 8/5/24 at 1:00 AM, .Today patient is being followed up on regarding a catheter displacement. Over the weekend patient's catheter was dislodged. Some how the catheter became tangled up in patient's bed and was dislodged. The catheter has since been replaced. After examination it appears to be placed correctly. There is normal color urine in the bag. Patient states that he feels fine at this point. Patient had no other questions or concerns today. Nursing staff had no new additional concerns on this patient . d. On 8/11/24 at 8:28 PM, Change catheter down drain bag every 2 weeks. e. On 8/26/24 at 1:00 AM, a physician's note revealed .Foley catheter in place . f. On 9/5/24 at 1:00 AM, a physician's note revealed .Foley catheter in place . g. On 10/7/24 at 1:00 AM, a physician's note revealed .Foley catheter in place h. On 10/26/24 at 1:31 AM, patient complained of pain in-between his lower and upper right abdominal quadrant. The skin looked normal upon palpation no abnormal mass could be felt. Pain only increased when pressing in not on release. Patient said he had no nausea; he has passed gas recently and had a recent bowl [sic] movement. Patient said it's been hurting on and off since yesterday. Gave patient 650 mg acetaminophen for pain. i. On 10/28/24 at 1:00 AM, .Today patient is being seen regarding flank pain on his right side. Patient states this came on over the past couple days. He states it is around the area of his right kidney. Patient is concerned he might have some type of infection going on. We discussed options of diagnosis including a urinalysis. Today we will go ahead and obtain a urinalysis with culture. I did encourage the patient to hydrate is [sic] much as possible, as this can be an effective way to help clear an infection as well. We did also discuss the possibility of a kidney stone. Patient states that the pain is not very severe at this point. If urinalysis is inconclusive, we can obtain a kidney ultrasound if patient is still having pain. Patient is okay with this plan. Patient had no additional questions or concerns today. Nursing staff had no new concerns on this patient . Continue Foley catheter use . j. On 10/28/24 at 9:01 PM, New order received from [name removed] NP [Nurse Practitioner] for UA with C&S. This note was created by Registered Nurse (RN) 3. k. On 11/2/24 at 8:36 PM, revealed, Orders -Administration Note: Acetaminophen Oral Tablet Give 650 mg [milligrams] by mouth every 4 hours as needed for Pain, fever c/o [complaints of] pain right lower back and hip. (continued on next page)		

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F 0690 Level of Harm - Actual harm Residents Affected - Few	l. On 11/6/24 at 9:21 AM revealed, Orders -Administration Note: Acetaminophen Oral Tablet Give 650 mg by mouth every 4 hours as needed for Pain ,fever C/O back pain. Will monitor for effectiveness. m. On 11/7/24 at 2:15 PM revealed, Resident has redness on his groins, perineal area and under R [right] side of abdominal fold. Cleaned with warm wet wash cloth and hand towel to dry, nystatin applied. n. On 11/10/24 at 1:19 AM revealed, Orders -Administration Note: Acetaminophen Oral Tablet Give 650 mg by mouth every 4 hours as needed for Pain, fever R side flank pain. o. On 11/10/24 at 2:23 AM revealed, Alert Charting: Resident c/o R flank pain 8/10. Denies pain in bladder or with urination but does state that he has urgency and frequency with small amounts of urine. States he provided a urine sample already. Called lab to get results faxed. UA abnormalities [sic]: slightly cloudy, leukocytes 500(large), WBCH [white blood cells] >30, RBC [red blood cells] H [high] 5, bacteria 1+. bacteria from culture is aerococcus urinae [sic]. p. On 11/10/24 at 2:34 AM, Alert Charting: Secure message sent to [physician's name removed] and his team regarding symptoms and UA results. q. On 11/10/24 at 12:40 PM, Alert Charting: Called on call provider and got order for abx [antibiotic]. Order added and pulled from stat safe. Faxed to [name removed] Pharmacy. On 11/12/24 at 10:17 AM, an interview was conducted with resident 55. Resident 55 stated he was now taking antibiotics for his urine test. Resident 55 stated he started antibiotics on Sunday (11/10/24) but did not know what the results were. Resident 55 stated he was having back pain on the right side, no burning upon urination, had some incontinent episodes and his brief overflowed during the night. Resident 55 stated it was not normal to have a full brief at night. Resident 55 stated in the last month or so, he had been using a brief at night and it had been overflowing. Resident 55 stated he was using the bathroom every 3.5 to 4 hours. Resident 55 stated he was able to get to the restroom to use the bathroom in the past, but not lately. Resident 55 stated staff had been changing his brief more often. Resident 55 stated he felt like there had been a change to his bladder in the last month or so. Resident 55 stated since starting the antibiotics his back was feeling better. Resident 55 stated his pain in his back was a 7 or 8 and sometimes up to a 9 out of 10. Resident 55 stated he used Tylenol usually but last week the he took Tylenol for his back pain. Resident 55 stated he did not have a catheter for a long time. (continued on next page)		

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F 0690 Level of Harm - Actual harm Residents Affected - Few	On 11/12/24 at 10:09 AM, an interview was conducted with Registered Nurse (RN) 3. RN 3 stated if a resident had signs and symptoms of a UTI, she contacted the physician for an order to obtain a urine analysis. RN 3 stated she documented the UA on 10/28/24 for the day shift nurse. RN 3 stated the day shift nurse obtained the physician's order for the UA. RN 3 stated the UA was obtained on 10/28/24. RN 3 stated resident 55 complained of signs and symptoms of a UTI on 11/10/24. RN 3 stated she called the laboratory to obtain the UA results. RN 3 stated she notified the physician and DON about the results. RN 3 stated she passed on in report to the day shift nurse that she found resident 55's UA results. RN 3 stated she was unable to find any follow-up for resident 55 from 10/28/24 until 11/10/24. RN 3 stated a UA results should be available by the next day and the culture and sensitivity within 3 days. RN 3 stated there was a glitch in the system with receiving the results from the lab. RN 3 stated the laboratory did not always fax the results to the facility. RN 3 stated nursing staff usually had to call the laboratory and ask for results. RN 3 stated laboratory draws should be passed on verbally during nursing report. RN 3 stated there was a lab book up at nursing station A and with a copy of every lab draw that was done at the facility. RN 3 stated she was not sure if anyone audited the book. RN 3 stated resident 55 complained of flank pain on 11/10/24, some incontinent episodes and frequency of urination with small amounts of urine. RN 3 stated resident 55 told her that a UA probably needed to be done and resident 55 stated he already had his urine collected. RN 3 stated she worked as needed so she worked 10/28/24 and then again on 11/10/24. RN 3 stated resident had a catheter a long time ago but did not have one anymore. On 11/12/24 at 10:36 AM, an interview was conducted with Licensed Practical Nurse (LPN) 3. LPN 3 stated if someone had signs and symptoms of a UTI, she would ask what the symptoms were. LPN 3 stated she would ask if the resident had flank pain, fever, frequency of urination or burning with urination. LPN 3 stated if the resident was unable to verbalize signs and symptoms, then she would monitor for a change in condition. LPN 3 stated if a resident had signs and symptoms she would encourage fluids, let the physician know, obtain a physician's order for a urine sample, send the sample to lab and monitor for a change in condition. LPN 3 stated she would not want a resident to become septic for not treating a UTI. LPN 3 stated she would enter the physicians order for a UA into the residents medical record and then would report that to the next nurse. LPN 3 stated it was very important to communicate to the oncoming nurse. LPN 3 stated if there was a progress note, then the DON or nurse managers would see it and watch for the results. LPN 3 stated at times she has had trouble getting laboratory results. LPN 3 stated she had obtained a urine sample for a UA, but then the lab had not communicated the results like sometimes the urine was contaminated and that was not reported to the facility. LPN 3 stated usually the results for a UA were ready by the next day. LPN 3 stated the DON, physician and nurse manager had access to results from the hospital laboratory. LPN 3 stated resident 55 was on antibiotics for a UTI and the results were provided on 11/11/24. LPN 3 stated she was not sure when the UA was obtained but resident 55 should not have waited 12 days for the results and treatment. LPN 3 stated she was not sure what happened with the UA and results. LPN 3 stated there were no residents on bowel and bladder retraining program. On 11/13/24 at 12:32 PM, an interview was conducted with the MDS coordinator. The MDS coordinator stated resident 55's urinary catheter was replaced on 7/25/24 and then was removed on 7/26/24 and discontinued. (continued on next page)		

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F 0690 Level of Harm - Actual harm Residents Affected - Few	On 11/12/24 at 1:24 PM, an interview was conducted with the Director of Nursing (DON) and Regional Nurse Consultant (RNC) 1. The DON stated nurses obtained urine for a UA and then the laboratory picked up the samples twice daily. The DON stated there was a local laboratory and one in Salt Lake City. The DON stated she would expect to get UA results within 1 to 2 days and 3 days for the culture results. The DON stated nurses passed on verbally in report that there was a laboratory draw completed. The DON stated staff should be watching for the results within a few days. The DON stated nurses could call the lab if results were not sent to the facility within a few days. The DON stated results were faxed to the facility but the DON also had access to pull the labs from the lab computer system. The DON stated nurses did not have access to the lab portal. The DON stated if nurses did not receive results within 2 to 3 days, they should be contacting the lab via phone. The DON stated nurses could notify the DON to see if the results were in the system and nurses aware she had access to the portal. The DON stated the culture would provide information to determine the antibiotic that the resident needed. The DON stated the physician will order the antibiotic depending on the culture resulted. The DON stated the nurses entered the antibiotic order into the medical record and staff then monitored for signs and symptoms. The DON stated if the signs and symptoms were not resolved then nurses should contact physician to see if they need another UA or another antibiotic. The DON stated she monitored to ensure the culture was correct. The DON stated the antibiotic and physician notification was on the lab results form that was faxed from the lab and then the lab results form was uploaded into the residents document section of the medical record. The DON stated there was no timeframe to have documents uploaded, it was just when medical records staff had time. RNC 1 stated the facility should have the results of a UA and culture no longer than a week after the sample was obtained and for the results to be uploaded into the system. The DON stated resident 55's UA and culture results were longer than the expected time frame. The DON stated resident 55's catheter was removed but not sure how long ago. 2. Resident 60 was admitted to the facility on [DATE] with diagnoses which included type 2 diabetes mellitus, hypertension, dysphagia, history of falling, dementia. On 11/3/24 at 4:03 PM, an interview was conducted with resident 60. Resident 60 stated there were not enough staff and he wet his pants waiting for staff to come and help him to the bathroom. Resident 60 stated he might be able to get to the bathroom if there were enough staff to answer his call light timely. Resident 60 stated that he had fallen waiting for staff to answer his call light. Resident 60 stated he got himself up to go to the bathroom and had fallen. On 11/7/24 at 11:54 AM, an interview was conducted with resident 60. Resident 60 was asked if there were enough staff to meet his needs. Resident 60 responded Oh [expletive removed] his call light was on for a while and he needed to use the restroom. Resident 60 stated he had to get himself up and ambulated to the bathroom on his own usually. Resident 60 stated sometimes he waited for 15 to 20 minutes before getting himself up to get to the bathroom. (continued on next page)		

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F 0690 Level of Harm - Actual harm Residents Affected - Few	On 11/7/24 at 11:16 AM, an observation was made of resident 60's call light flashing outside resident 60's room. Resident 60 was observed in bed trying to pull himself to a seated position using the side rails. Resident 60 was observed yelling he needed help. Resident 60 was observed to get himself to a seated position. Resident 60 stated he wants help to get up. Resident 52 was observed to exit her room and look in resident 60's room and ask resident 60 if he needed help. Resident 60 stated he needed assistance. Resident 60 was observed to yell an expletive. Resident 52 stated to resident 60 to not to get out of bed and just stay there. At 11:20 AM, a nurse, Administrator, and Corporate staff member were observed to walk past resident 60's room. There was a strong bowel movement odor into the hallway. At 11:22 AM, resident 52 stopped the Administrator and stated resident 60 needed assistance. Resident 60 was observed to have bowel movement on him. The Administrator was observed to ask CNA 6 to assist resident 60. On 11/12/24 at 10:34 AM, an observation was made of resident 60's room. The call light was observed to be wrapped up on the nightstand on the other side of his privacy curtain. The call light was not within reach of resident 60. Resident 60's medical record was reviewed on 11/3/24 through 11/13/24. An admission MDS dated [DATE] revealed resident 60 was not provided a urinary toileting program. The MDS revealed resident 60 was occasionally incontinent of urine and was occasionally incontinent of bowel. It was marked no to Is a toileting program currently being used to manage the resident's bowel continence? A care area assessment revealed that bowel and bladder would be care planned. A baseline care plan dated 8/26/24 revealed resident 60 was frequently incontinent of bowel and bladder. A care plan dated 8/27/24 revealed Potential for altered skin integrity related to: Diabetes Type 2, falls, incontinence. The goal was Resident will have no s/s of skin breakdown at all times through next 90 day review. The interventions included Encourage good nutritional and oral fluid intake; Staff will help promote clean skin by encouraging/assisting resident to bathe regularly. Dry skin thoroughly after bathing. Keep skin moisturized by applying lotions indicated and Staff will provide prompt peri-care after incontinent episodes and may apply barrier cream as a skin protectant. CNAs may apply unmedicated barrier creams. A care plan dated 8/27/24 revealed The resident is at risk for falls r/t history of falls, weakness, incontinence. The goal was The resident will be free of falls with injury through the review date. The interventions included Anticipate and meet the resident's needs. Keep frequently used items within reach; Bed in lowest position, call light within reach and commonly used items within reach. Remind resident to use call light for assistance and Orient resident to call light. Keep the resident's call light within reach and encourage the resident to use it for assistance as needed. On 11/6/24 at 3:40 PM, an interview was conducted with CNA 5 and CNA 4. CNA 5 and CNA 4 stated resident 60 was continent of bowel and used his call light to call for assistance to the bathroom. CNA 5 and CNA 4 stated resident 60 was incontinent of bladder and was changed every 2 to 2.5 hours. CNA 5 and CNA 4 stated they were not aware of any residents that were on a toileting program. On 11/12/24 at 10:36 AM, an interview was conducted with Licensed Practical Nurse (LPN) 3. LPN 3 stated there were no residents on bowel and bladder retraining program. (continued on next page)		

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F 0690 Level of Harm - Actual harm Residents Affected - Few	On 11/12/24 at 10:47 AM, an interview was conducted with CNA 8. CNA 8 stated resident 60 usually did not press his call light, normally resident 60 yelled out for help. CNA 8 stated he was checked every 2 hours for a brief change. CNA 8 stated she was not aware of a bowel and bladder retraining program. CNA 8 stated resident 60 was not on a bowel and bladder retraining program. On 11/7/24 at 11:26 AM, an interview was conducted with the DON. The DON stated resident 60's cognition depended on the time of day. The DON stated resident 60 was able to use a call light. The DON stated she believed resident 60 was incontinent of bowel and bladder. The DON stated if someone was incontinent, staff should still attempt to get the resident to the bathroom. The DON stated a lot of residents got up on their own, so staff needed to watch them a little closer. The DON stated if a resident was consistently trying to get up, staff could do an hourly rounding checklist that was filled out to see what the resident was doing every hour. The DON stated if a resident needed hourly rounds that would be decided by the interdisciplinary team. The DON stated resident 60 was not on a bowel and bladder retaining program. The DON stated that retraining programs were done when a resident had a catheter removed. The DON stated the facility was working on getting a bladder scanner. The DON stated that resident 60 was potentially a candidate for a bowel and bladder retraining program. The DON stated she had not thought of trying a bowel and bladder retraining program. (Cross Refer to F689 and F725) 38031 3. Resident 1 was admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses which included cerebral infarction, cognitive communication deficit, chronic obstructive pulmonary disease, morbid obesity, type 2 diabetes mellitus, chronic viral hepatitis C, non-pressure chronic ulcer of left lower leg, mood disorder, encephalopathy, atrial fibrillation, pulmonary embolism, hypospadias, retention of urine, chronic kidney disease, major depressive disorder, pyelonephritis, multiple fractures of ribs, bipolar disorder, dysphonia, insomnia, peripheral vascular disease, chronic pain syndrome, opioid dependence, extended spectrum beta lactamase resistance, obstructive and reflux uropathy, anxiety disorder, polyosteoarthritis, hypertension, gout, and methicillin resistant staphylococcus aureus infection classified elsewhere. On 11/4/24 at 9:07 AM, an observation was made of resident 1 lying in bed. The bed was positioned with the left side of the bed against the wall. A fall mat was observed on the right side of the bed and was pushed out of the way to accommodate a side table. A sign was posted outside of resident 1's room for enhanced barrier precautions (EBP) and a personal protective equipment (PPE) cart was located outside the door. The cart contained gowns and gloves. On 11/4/24 at 9:22 AM, an interview was conducted with Licensed Practical Nurse (LPN) 3. LPN 3 stated that resident 1 was on EBP for a suprapubic (SP) catheter and had an ongoing extended-spectrum beta-lactamase (ESBL) infection. LPN 3 stated that they obtained a urinalysis (UA) this past weekend for resident 1 and that the resident always had a urinary tract infection (UTI). LPN 3 stated that they pushed fluids but sometimes resident 1 was non-compliant with care. Resident 1's electronic medical records were reviewed. (continued on next page)		

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F 0690 Level of Harm - Actual harm Residents Affected - Few	On 8/2/24, resident 1's Minimum Data Set (MDS) Assessment documented a Brief Interview of Mental Status (BIMS) score of 5 out of 15, which would indicate a severe cognitive impairment. The assessment documented that the resident was a two-person total dependence assist for bed mobility, transfer, and toilet use. Resident 1's physician orders revealed the following: a. On 8/19/24, an order was initiated to change the suprapubic catheter monthly, every 30 days. b. On 5/1/24, an order was initiated to perform suprapubic catheter care every shift: cleanse tubing and site, and apply a drain sponge. Ensure the tubing was not kinked, not resting on the ground, and ensure the catheter bag was in a privacy bag. c. On 7/6/24, an order was initiated to change the catheter down drain bag weekly, every night shift on Saturday. d. On 5/10/24, an order was initiated to offer 240 milliliters (ml) of fluid three times a day for hydration. e. On 5/2/24, an order was initiated to change the suprapubic site bandage daily. Cleanse with normal saline (NS), pat dry, and apply t-drain sponge daily. f. On 10/31/24, an order was initiated for a UA with culture (C) and sensitivity (S) for uremia. g. On 10/31/24, an order was initiated for a swab of the purulent drainage on the suprapubic area for possible urine infection. Resident 1's progress notes revealed the following: a. On 10/14/2024 at 3:46 AM, the note documented, 18F [french] / 15 cc [cubic centimeter] suprapubic catheter to down drain for dx [diagnosis] of obstructive uropathy r/t [related to] hypospadias and CKD [chronic kidney disease]. May change PRN [as needed] if dislodged or clogged. CNA [Certified Nurse Assistant] notified nurse that residents brief was soaked with urine. Nurse attempted to flush suprapubic catheter but it was not patent. Catheter was removed and a new 18F 15cc suprapubic catheter was placed with sterile technique and urine return was noted. Resident tolerated the removal and insertion well. Will continue to monitor. b. On 10/14/2024 at 5:09 AM, the note documented, 18F / 15 cc suprapubic catheter to down drain for dx of obstructive uropathy r/t hypospadias and CKD. May change PRN if dislodged or clogged. PRN Administration was: Effective An additional 100cc output noted since insertion. c. On 10/17/2024 at 4:23 PM, the note documented, Resident is able to listen to writer's instruction. Clean his suprapubic catheter site which at first he was covering by hand . His scrotal area is with redness and moist , tried to explain the need to clean it but writer was able to just wiped the groin area. He does not have behavior. Will continue monitor resident. d. On 10/27/2024 at 4:42 AM, the note documented, Residents suprapubic dressing was saturated. Cleansed suprapubic site with NS and redressed area with drain sponge. Will continue to monitor. (continued on next page)		

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F 0690 Level of Harm - Actual harm Residents Affected - Few	e. On 10/30/2024 at 1:00 AM, the provider note documented, Since patient's admission he has multiple trips to the emergency department related to urinary tract infection that evolved to sepsis, along with multiple strokes. Lab workup showed normal white blood cell count at 9.5. UA was positive for infection, urine collected yesterday was also positive for infection. Patient's Foley catheter was recently changed out the day before on the 15th. f. On 10/31/2024 at 6:25 PM, the note documented, Resident has a foul smelling drainage from his suprapubic catheter site and his [sic] blood in urine and reported to PCP [primary care provider] via telephone and [doctor's name omitted] ordered a UA and purulent drainage swab test. PCC updated g. On 11/6/2024 at 5:41 AM, the note documented, Nurse assessed patient catheter and it wasn't draining. Attempted to flush catheter and found it to be clogged. Suprapubic catheter was changed using 18F 15cc, and sterile technique with no complications. Old catheter was removed, and bladder drained upon removal. After successful placement of new catheter urine was draining appropriately. Urine continues to be red tinged, with drainage at the suprapubic site. Dr aware. Resident very aggressive and combative throughout night during catheter cares and brief changes. Yelling, kicking, punching, and attempting to bite staff. Educated pt [patient] the need for the brief change as he had a bowel movement, to prevent sores and skin breakdown. h. On 11/6/2024 at 1:19 PM, the note documented, Per [Physician Assistant name omitted] start contact precautions. Infection to supra pubic site w/ [with] MDRO [multidrug-resistant organism]. Precautions implemented. i. On 11/6/2024 at 5:10 PM, the note documented that the culture and sensitivity report was sent to the PA and they were awaiting orders. j. On 11/9/2024 at 12:54 AM, the note documented, Pt on IM [intramuscular] abx [antibiotics] for UTI and po [by mouth] abx for suprapubic cath site infection. Urine yellow with small amount of sediment. Suprapubic cath site dressing changed. No drainage noted. Pt also with recent fall. Pt with a bandage in place on his back and bandage in place to his left leg. Denies pain. 2 people assist with bed mobility and brief changes. Pt's bed in low position and fall mat in place. On 11/1/24, resident 1's suprapubic site culture documented the organisms identified as Staphylococcus aureus Methicillin Sensitive, Escherichia coli ESBL (extended beta-lactamase) producer, Proteus Mirabilis, and Klebsiella pneumoniae ESBL producer. The susceptibility report for the suprapubic site documented that the Staphylococcus was resistant to Penicillin; the Escherichia coli was susceptible to Ertapenem; and the Klebsiella was susceptible to the Ertapenem. The laboratory results had a handwritten note that it was reviewed by the provider on 11/7/24 and Ertapenem 1 gram (gr) daily for 10 days was ordered. It should be noted that the laboratory results were faxed to the facility on [DATE]. On 11/1/24, resident 1's urine culture documented the organisms identified as Proteus Mirabilis and Escherichia coli. The result was documented as reviewed by the provider on 11/7/24 and ordered Ertapenem 1 gr daily for 10 days. The susceptibility report for the urine culture documented that the Proteus Mirabilis and Escherichia coli were susceptible to Ertapenem. Resident 1's November Medication Administration Record (MAR) revealed the following: (continued on next page)		

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F 0690 Level of Harm - Actual harm Residents Affected - Few	a. On 11/7/24 at 3:06 PM, an order was initiated for Ertapenem Sodium Injection Solution Reconstituted 1 gram, inject 1 gram intramuscularly one time a day for 10 days related to a local infection of the skin. The order was discontinued on 11/11/24. The medication was documented as administered on 11/7/24 through 11/10/24 for a total of 4 doses administered out of 10 ordered. b. On 11/7/24 at 2:24 PM, an order was initiated for Penicillin V Potassium Oral Tablet 500 milligrams (mg), give 1 tablet by mouth three times a day for 10 days for infection of suprapubic site. The order was discontinued on 11/11/24. The medication was documented as administered on 11/7/24 through 11/11/24 for a total of 12 doses administered out of 30 ordered. On 7/26/24, resident 1 had a care plan initiated for SP catheter use r/t obstructive uropathy and nonfunctioning bladder, Urinary obstruction/stricture with retention complicated by DM [diabetes mellitus], hx [history] false urethral passageway, Failed bladder training attempt, and Urethral dilation 5/22/19. Interventions identified on the care plan included catheter care every shift; change catheter monthly and as needed; obtain a UA with C & S if indicated with each catheter change; follow-up with a urologist when indicated; position catheter bag and tubing below the level of the bladder; check tubing for kinks; cleanse peri area from front to back; monitor for signs and symptoms of discomfort on urination or increased frequency; monitor for pain due to catheter; monitor and report to provider any signs and symptoms of UTI. On 11/6/24 at 3:26 PM, an interview was conducted with the DON. The DON stated that incontinence care expectations were that staff rounded on the residents every 2 hours and checked to see if briefs needed to be changed. The DON stated that staff should check with any resident that required assistance with toileting every 2 hours for toileting needs. On 11/7/24 at 8:45 AM, an interview was conducted with Registered Nurse (RN) 2. RN 2 stated that she needed to call the lab to see if they had the urine C & S results back for resident 1. On 11/7/24 at 8:53 AM, an interview was conducted with CNA 3. CNA 3 stated that resident 1 was fully dependent on staff for most all of his ADLs. CNA 3 stated that resident 1 required assistance with incontinence care. CNA 3 stated that resident 1 refused care daily for everything including bed bath, brief changes, linen changes, and eating. CNA 3 stated that resident 1 had his catheter changed recently and since that treatment the resident's urine had been bloody. CNA 3 stated that on average resident 1's urine was cloudy and dark. CNA 3 stated that they encouraged resident 1 to drink fluids but he sometimes ref [TRUNCATED]		

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43212 Based on interview and record review, for 1 of 65 sample residents, the facility did not ensure a resident who required colostomy services received care consistent with professional standards of practice, the person-centered care plan, and the resident's goals and preferences. Specifically, the facility ran out of colostomy supplies and when the supplies were ordered, the wrong item was ordered leaving the resident without colostomy supplies. Resident identifier: 3. Resident 3 was admitted to the facility on [DATE] with diagnoses that included Arnold Chiari Syndrome with spina bifida and hydrocephalus, severe protein-calorie malnutrition, osteomyelitis right ankle and foot, paraplegia, borderline personality disorder, major depressive disorder, morbid obesity, bipolar disorder, and anxiety disorder. On 11/4/24 at 10:59 AM, an interview was conducted with resident 3 who stated the facility had run out of wafers needed for her colostomy care and then the wrong ones were ordered. Resident 3's medical record was reviewed between 11/3/24 and 11/13/24. An annual Minimum Data Set (MDS) dated [DATE] revealed resident 3 had a Brief Interview for Mental Status (BIMS) score of 15 indicating normal cognition. Physician orders included: a. Ostomy care for colostomy type of wafer/bag to be used: Collar 12561 (2.75) Pouch 416242 (2.75)-change wafer/bag two times a day for wound care. Order date: 8/8/24. b. Ostomy care for colostomy type of wafer/bag to be used: Collar 125261 (2.75) Pouch 416242 (2.75)-change wafer/bag every 4 hours as needed for wound care. Order date 8/8/24. Resident 3's care plan revealed, Potential for complications related to colostomy and urostomy. Date initiated: 4/19/22, Revision on: 9/23/22. The goal was, Resident will be able to demonstrate assisted ability to care for ostomy daily through next 90 day review. Date initiated: 4/29/22, Revision on: 12/12/23, Target date: 1/31/25; Resident will have no complications r/t [related to] colostomy and/or urostomy through the next review date. Date initiated: 10/7/22, Revision on 12/12/23, Target date: 1/31/25. Interventions included, Medications as ordered. Date initiated: 4/19/22, Revision on 4/29/22; Monitor ostomy site for swelling, pain, and redness and report to MD [medical doctor]. Date initiated: 4/19/22, Revision on 4/19/22; Ostomy care as needed to prevent odor. Date initiated: 4/19/22, Revision on: 4/19/22; Resident enjoys assisting with colostomy bag change. Allow resident to change colostomy bag under supervision of licensed nurse. Date initiated: 9/23/22. Resident teaching on ostomy care if appropriate. Date initiated: 4/19/22, Revision on 4/19/22. (continued on next page)		

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/7/24 at 9:48 AM, an interview was conducted with Licensed Practical Nurse (LPN) 4 who stated the facility waited until she was completely out before ordering additional wafers. LPN 4 stated when they finally came, the wrong wafer's had been ordered. LPN 4 stated resident 3 went a week without the wafers needed in the colostomy changes. LPN 4 stated after that incident, the product codes were put into the resident's Medication Administration Record (MAR) so they would not have that happen again. On 11/13/24 at 9:19 AM, an interview was conducted with the Director of Nursing (DON) who stated that she and Certified Nursing Assistant (CNA) 1 were responsible for ordering supplies for colostomy care. The DON stated she was unsure about how often they were being ordered or how things were being tracked for ordering purposes. The DON stated the facility had a good relationship with their neighbors who would help with supplies if the facility ran out. The DON stated they could also reach out to the resident's provider for an alternative. The DON stated the wafer was to protect the skin and if a wafer was not in place the resident could experience skin breakdown and irritation. The DON stated they have borrowed from their neighbors before. The DON stated that over the summer, the wafer's were back ordered and the problem was an issue with the supply chain. The DON stated if there was a negative outcome such as skin irritation, the nurse would document it in the skin assessment and notify the wound nurse. The DON stated resident 3's order was for assessing the need for a colostomy bag change every other day.		

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NAME OF PROVIDER OR SUPPLIER Bella Terra St George		STREET ADDRESS, CITY, STATE, ZIP CODE 178 South 1200 East St George, UT 84790	
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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30563 Based on observation, interview and record review, for 4 of 65 sampled residents, the facility did not ensure residents maintained acceptable parameters of nutritional status. Specifically, residents meal portion sizes were not adequate, residents weights were not obtained and residents nutrition assessments were not being completed. Resident identifiers: 3, 4, 55, 60, and 65. Findings included: 1. Resident 60 was admitted to the facility on [DATE] with diagnoses which included type 2 diabetes mellitus, hypertension, dysphagia, history of falling, constipation and dementia. On 11/3/24 at 4:04 PM, an interview was conducted with resident 60. Resident 60 stated he had not been weighed so he did not know if he had lost weight. Resident 60's medical record was reviewed. Resident 60's weight on 8/26/24 was 170.0 pounds and on 10/6/24 was 178.5 pounds. An admission Nutritional assessment dated [DATE] was in progress and had not been completed by the Registered Dietitian (RD). Progress notes revealed the following skin/wound notes: a. On 10/7/24 at 11:13 AM, oral intake was about 75% on a CCHO (Consistent Carbohydrate Diet) mechanical soft with nectar thick liquids. b. On 10/14/24 at 10:34 AM, oral intake was about 75% on a CCHO mechanical soft with nectar thick liquids. c. On 10/21/24 at 4:03 PM, oral intake was about 75% CCHO mechanical soft with nectar thick liquids. On 11/5/24 at 11:34 AM, a phone interview was conducted with the RD. The RD stated it was a struggle to obtain weights. The RD stated there was a print out of weekly weights provided to the CNA coordinator or DON. The RD stated sometimes the weights were done and sometimes not done. The RD stated that if weights were not done she let the DON know. The RD was asked if weights were not done, how did she complete an accurate nutritional assessment, the RD stated That's a challenge. The RD stated every new admission should be weighed weekly for 4 weeks. The RD stated she can only request weights and hope they were done. The RD stated resident 60's admission nutrition assessment had not been completed. The RD stated in a perfect world nutrition assessments would be done every 90 days. The RD stated from what she understood from the the electronic medical assessment, once an assessment was competed then a new one triggered every 90 days. The RD stated she was trying to keep her head above water with assessments, weights and wound meetings. The RD stated she was unable to get to the back log of assessments that need to be done. (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/7/24 at 10:14 AM, an interview was conducted with the facility RD. The RD stated the regular diet order provided each resident about 2400 calories and 21 to 28 grams of protein per day. The RD stated if a resident ate 75% of the meal, it would provide 1800 -1950 calories. The RD stated the previous RD calculated resident 60's nutritional needs and did not finish the assessment. The RD stated she had been the RD since September 2024 and the portion sizes were not entirely accurate. The RD stated the other day there was chicken served and it was a larger portion than usual. The RD stated she knew there was a new Dietary Manager, so she did not want to go in and demand things from the kitchen. The RD stated she was grateful they were providing sanitary foods and portion sizes that were close to the correct size. The RD stated if resident 60 was eating less than 75%, then she would add a protein supplement. The RD stated if portion sizes were not correct that would change how she calculated a residents oral intake. The RD stated resident 60's last weight was obtained on 10/6/24. The RD stated she was reviewing resident 60's oral intake and it had decreased this last week to about 50-75%. The RD stated meal intake was how she evaluated if a resident was getting enough to eat. The RD stated if she noticed a decrease in meal intake, or the resident was no feeling well then she added supplements. The RD stated she did not know if there was a snack program. The RD stated she would be surprised if there was a snack program. The RD stated without weekly or monthly weights it was hard to evaluate a resident nutritional needs. On 11/12/24 at 3:22 PM, an interview was conducted with the Director of Nursing (DON). The DON stated Nutrition At Risk (NAR) meetings were on Mondays. The DON stated during the meeting resident weights, dietary concerns were reviewed and adjustments were made. The DON stated her and the RD attended the meeting either in person or over the phone. The DON stated the Assistant Director of Nursing attended the meeting but the facility had not had one since August 2024. The DON stated the Certified Nursing Assistant's obtained weights at the first of every month. The DON stated weekly weight should be done for the first month after admission and anytime there was a change. The DON stated obtaining weights helped in identifying nutritional needs for residents. The DON stated the RD would use weights to calculate what each residents nutritional needs were. The DON stated supplements were guided by the RD or physician if they were seeing a need to order them. The DON stated the facility had problems with getting supplements so they had to borrow some from other facilities or reach out to provider in the mean time. The DON stated if the supplements were not available then, the nurses should let the DON know so that something equivalent could be ordered. 2. Resident 55 was admitted to the facility on [DATE] with diagnoses which included Parkinson's disease with dyskinesia without mention of fluctuations, chronic obstructive pulmonary disease, type 2 diabetes mellitus, tremor, and personal history of other infectious and parasitic disease. On 11/4/24 at 8:45 AM, an interview was conducted with resident 55. Resident 55 stated there were no beverages offered between meals. On 11/12/24 at 10:24 AM, an interview was conducted with resident 55. Resident 55 stated he gets beverages with meals but not between meals. Resident 55 stated he had his own bottled water in his closet. Resident 55 stated he went shopping with a friend to buy the bottled water he stored in his closet. Resident 55's medical record was reviewed. (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 55's care plan dated 5/28/24 revealed, The resident has nutritional problem r/t [related to] enteral feedings, difficulty swallowing, poor intake. The goal was The resident will maintain adequate nutritional status as evidenced by no unplanned/undesired significant weight changes, no s/s [signs and symptoms] of malnutrition, and adequate nutritional intake at meals through review date. Some of the interventions included Obtain and monitor lab/diagnostic work as ordered. Report results to MD [Medical Doctor]and follow up as indicated and RD to evaluate and make diet change recommendations PRN. A physician's order dated 7/1/24 revealed weekly cmp [comprehensive metabolic panel]/cbc [complete blood count] with auto diff for monitoring of kidney function. One time a day every Mon [Monday] for monitoring. Laboratory results were reviewed. Labs were completed 9/32/24 and 11/4/24. It should be noted there was an order to have a CMP and CBC weekly. On 9/23/24 resident 55's Blood Urea Nitrogen (BUN) was a 22 which was high with a reference range of 8/22 milligrams per deciliter (mg/dL) and a Creatinine level of 1.56 which was high with a reference range of 0.77-1.35 mg/dL. Resident 55's Glomerular filtration rate (GFR) was high at 50 milliliters per minute/1.73 m to the power squared (mL/min/1.73sq m2). On 11/4/24 resident 55's BUN was 29 which was high, Creatinine was 1.48 which was high and GFR was 53 was low. On 11/12/24 at 11:08 AM, an interview was conducted with CNA 8. CNA 8 stated CNAs completed rounds and asked residents about water and snacks. CNA 8 stated some resident came to ice stations and asked for waters. CNA 8 stated she usually provided water when residents asked for it. CNA 8 stated residents had their own mugs or the kitchen provided reusable ones. CNA 8 stated she changed out the mugs when mugs look dirty or if the resident requested a new one. A resident was observed walking to the ice station asking staff for water. CNA 8 stated that was how most resident got their water mugs filled was by asking at the ice station. On 11/12/24 at 1:48 PM, an interview was conducted with the DON. The DON stated each resident had a water mug, when CNA's did rounds they asked if the resident needed water. The DON stated residents could go to the nurses station and ask for their mug to be filled up. The DON stated mugs were washed or cleaned daily. The DON stated the CNA's were responsible for picking up mugs and taking them to the kitchen to be cleaned. The DON stated residents families provided water mugs for residents to have in their rooms. On 11/13/24 at 9:52 AM, a follow up interview was conducted with the DON. The DON stated fluid intake was monitored for resident that had catheters or were on a fluid restriction. The DON stated the amount of brief changes and lab work were monitored for dehydration. The DON stated a CBC and CMP would be obtained to determine hydration status. The DON stated staff would also look for physical signs of dehydration like skin turgor. The DON stated resident 55 did not have weekly labs in his medical record since 9/23/24 as ordered by the physician to determine kidney function. (Cross refer to F807, F770, F725) 38031 (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Resident 65 was admitted to the facility on [DATE] with diagnoses which included dementia, seizures, hypothyroidism, obstructive sleep apnea, depression, presence of a cardiac pacemaker, and violent behaviors. On 11/03/24 at 3:56 PM, an observation was made of resident 65 sleeping in a recliner in his room. The resident's call light was observed on the arm rest within reach and a walker was located near the door. On 11/04/24 at 3:24 PM, an observation was made of resident 65 sleeping in a chair in the dining room. Resident 65's electronic medical records were reviewed. On 9/17/24, resident 65's Minimum Data Set (MDS) Assessment documented a Brief Interview for Mental Status (BIMS) score of 4/15, which would indicate a severe cognitive impairment. The assessment documented that resident 65 required set up assistance for eating. On 09/10/24, resident 65 weighed 187.39 pounds (lbs.). On 10/08/24, resident 65 weighed 167.5 pounds which is a -10.61 % weight loss. On 9/10/24, resident 65's diet orders were for a regular diet, regular RG7 (dysphagia diet level 7) texture, and thin liquids consistency. Resident 65's eating task for the past 30 days documented 68 episodes when the resident had eaten 75-100% of his meal. On 9/16/24, resident 65's admission nutritional assessment documented that the resident was eating 75% of his meal intake, had no chewing or swallowing problems, and was independent with dining. The assessment documented that resident 65 was confused and disoriented and depressed. The assessment documented that resident 65's caloric needs were 2520 kilocalories (kcal) with a factor of 30 kcal/kilogram (kg); and the hydration needs were 2520 milliliters (mls) with a factor of 30 mls/kg. The assessment documented that the resident needed 84-126 grams (gms) of protein with a factor of 1.0 -1.5 gms/kg. The assessment documented that resident 65 was on a regular diet with an average by mouth intake of 75%. The assessment documented resident 65's height was 68 inches, weight (wt.) was 187.4 lbs., the ideal body weight was 122%, and the body mass index (BMI) was 28.4 and was within normal limits. The assessment documented that resident 65 weight and intake would monitored and evaluated weekly for four weeks and then monthly if stable. On 10/14/24 at 11:40 AM, the weight change note documented, WEIGHT WARNING: Value: 167.5 Wt is down 19.8# (lbs.) since admission. RD [Registered Dietician] questions accuracy of admit wt. Resident is active and walks with a walker around facility. BMI 25.5. No nutritional concerns this time. Will have Resident reweighed. Cont [continue] POC [plan of care]. Resident & MD [Medical Doctor] aware of wt loss. It should be noted that no documentation could be found for any repeat weights of resident 65 as requested by the RD. On 10/16/24 at 1:00 AM, the provider note documented Weight: 167.5 pounds (Warnings: -5.0% change, False. -7.5% change, False. -10.0% change, False). (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/19/24, resident 65 had a care plan initiated for .at risk for nutritional decline d/t [due to] dx [diagnosis] dementia, hx [history] seizures and depression. Interventions identified on the care plan included to invite the resident to activities that promoted additional intake; monitor/record/report to MD any signs and symptoms of malnutrition such as significant wt. loss of 3 lbs in 1 week, greater than 5 % in 1 month, and greater than 7.5 % in 3 months; provide and serve a regular diet as ordered; and weigh per facility protocol or Nutrition At Risk (NAR) committee recommendations. On 11/04/24 at 3:27 PM, an interview was conducted with Certified Nurse Assistant (CNA) 3. CNA 3 stated that they needed to constantly remind resident 65 to eat or else he would fall asleep. CNA 3 stated that resident 65 typically ate about 80% of his meals. CNA 3 stated that resident 65 did not have any dietary supplements. On 11/04/24 at 3:30 PM, an interview was conducted with Licensed Practical Nurse (LPN) 3. LPN 3 stated that resident 65 did not have any dietary supplements. LPN 3 stated that resident 65 was able to feed himself and if he did not like a food item he would not eat it. LPN 3 stated that resident 65 refused to eat today because he was really sleepy in the morning. On 11/05/24 at 11:03 AM, a telephone interview was conducted with the Registered Dietitian (RD). The RD stated that she had been employed at the facility since September 2024. The RD stated that she was at the facility one time a week for approximately 8 hours. The RD stated that she ran the NAR meetings with the DON and made recommendations to the DON for the residents that were reviewed. The RD stated that she did the nutritional assessments on admission, but had not done any quarterly assessments. The RD stated that she had asked the corporate resource nurse how to do the quarterly assessments because the electronic medical records was not populating them automatically. The RD stated that the previous RD had not been conducting the quarterly assessments. The RD stated that she was just barely keeping her head above water with the NAR reviews and admission assessments. The RD stated that she had not been able to get to the back log of residents that were not newly admitted or were on the NAR list. The RD stated that they struggled with obtaining weights in the building and that they were not consistently being done. The RD stated that she was not sure if resident 65's weight that was entered on 9/10/24 was a hospital weight or an admission weight. The RD stated that she provided the CNA Coordinator or the Director of Nursing (DON) a weekly list of those residents that needed a weight completed. The RD stated that sometimes they were done and sometimes they were not obtained. The RD stated that it was a challenge to conduct an accurate nutritional assessment without a weight. The RD stated that resident 65's weight on 10/8/24 was 167.5 lbs. and she questioned the accuracy of the admission weight on 9/10/24. The RD stated that she requested a repeat weight for resident 65, but she could not demand it that same day. The RD stated that she did not put any new interventions in place for resident 65 when she identified the recorded weight loss. The RD stated that resident 65 had a good BMI, was active and was eating well. The RD stated that every week she informed the DON of the residents that needed weights, but what happened beyond that she was not aware of. On 11/05/24 at 3:32 PM, an interview was conducted with CNA 6 and CNA 8. CNA 6 stated that they tried to get everyone's weight each Monday or the beginning of the month. CNA 6 stated that the weekly weights on Monday were those residents that had issues with their weight and for everyone else it was obtained monthly. CNA 6 stated that the licensed nurse notified them of which residents needed a weight obtained. CNA 8 stated that they documented the weights in the electronic medical records. CNA 8 stated that they obtained the weight anytime of the day. CNA 8 stated that if the resident was wheelchair bound they would obtain the weight of the chair and then the weight of the resident in the chair and subtract the chair weight from the resident weight. (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/05/24 at 3:36 PM, an interview was obtained with Licensed Practical Nurse (LPN) 3. LPN 3 stated that no one in the unit was on weekly weights and that they did not have a scale in the locked unit. LPN 3 stated that all residents on the locked unit were weighted monthly. LPN 3 stated that depending on the resident's physician orders they might have weights more frequently. LPN 3 stated that if they took resident 65 off the unit to obtain a weight it would be difficult to get him back on the unit and it may agitate him. On 11/05/24 at 3:47 PM, an interview was conducted with the Administrator (ADMIN). The ADMIN stated that he communicated with the RD and that he tried to attend the NAR meetings. The ADMIN stated that when the RD was done with the NAR meeting she would send him her note. The ADMIN stated that the NAR meeting was attended by the RD, DON, and himself. The ADMIN stated that the RD would notify them of which residents needed weights and he was not aware that it was not getting done. The ADMIN stated that if the RD did not have the update weights it would put the resident's at risk because it was good indicator if the residents were gaining or losing weight. The ADMIN stated that they only had the one scale and the residents on the unit came out off the unit to get their weights obtained. The ADMIN stated that they did not have any residents on the locked unit that was difficult to take off of the locked unit or to get back inside afterwards. On 11/05/24 at 4:46 PM, an interview was conducted with the DON. The DON stated that resident 65 should have weights obtained on the small scale that was located in the unit. The DON stated that resident 65 was on monthly weights and was not addressed in the NAR meeting. The DON stated that she was not aware of any issues with resident 65's weight. The DON stated that the CNA supervisor was responsible for ensuring that all the weights were obtained. The DON stated that she was not aware of resident 65's weight loss or that his weights were not being obtained. The DON stated that she would discuss resident 65 at the NAR meeting and discuss if he needed supplements and what percentage of his meals were eaten. On 11/06/24 at 2:19 PM, a follow-up interview was conducted with LPN 3. LPN 3 stated that resident 65 was pushing staff away and refusing to eat or drink. LPN 3 stated that resident 65's blood pressure was 95/54 and he was not drinking. LPN 3 stated that she was not worried about the blood pressure as resident 65 was currently lying down and in the morning he was eating and drinking. 43212 4. Resident 3 was admitted to the facility on [DATE] with diagnoses that included Arnold Chiari Syndrome with spina bifida and hydrocephalus, severe protein-calorie malnutrition, osteomyelitis right ankle and foot, paraplegia, borderline personality disorder, major depressive disorder, morbid obesity, bipolar disorder, and anxiety disorder. Resident 3's medical record was reviewed between 11/3/24 and 11/13/24. Physician orders included: a. Med Pass 2.0, two times a day for NUTRITION. Order date: 12/17/23. b. Pro-Stat AWC (Advanced Wound Care), one time a day for SUPPLEMENT. Order date: 12/11/23. (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. Boost Breeze. Give 4 oz. [ounces] of Boost Breeze three times a day for SUPPLEMENT/NUTRIENT. Order date 3/25/24. Resident 3's care plan revealed, Potential nutritional problem r/t [related to] impaired skin integrity. Hx [history] malnutrition, wounds, paraplegia, weight loss, antipsychotics, anemia, depression, pain, pressure ulcers. Date initiated: 11/30/23, Revision on 11/30/23. The goal was, The resident will maintain adequate nutritional status as evidenced by no unplanned/undesired significant weight changes, no s/sx [signs and symptoms] of malnutrition, and adequate nutritional intake at meals through next review. Resident's weight goal is 140-155 lbs. [pounds]. Date initiated: 11/30/23, Revision on: 12/12/23, Target Date: 1/31/25. Interventions included, Monitor/document/report PRN [as needed] any s/sx of chewing/swallowing problems r/t [related to] dysphagia or oral health problems such as pocketing, choking, coughing, drooling, holding food in mouth, several attempts at swallowing, refusing to eat, appears concerned during meals. Refer to SLP [Speech Language Pathologist] or dentist as indicated to address dysphagia or oral health. Date initiated: 4/19/22, Revision on: 4/19/22; Monitor/record/report to MD [medical doctor] PRN [as needed] s/sx of malnutrition: Emaciation (cachexia), muscle wasting, significant weight loss: 3 lb. in 1 week, >5% in 1 month, >7.5% in 3 months, >10% in 6 months. Date initiated: 4/19/22, Revision on: 4/19/22; Obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated. Date Initiated: 4/19/22, Revision on: 4/19/22; Provide, serve diet as ordered. Monitor intake and record q [every] meal. Date initiated: 4/19/22, Revision on: 4/19/22; RD [Registered Dietitian] to evaluate and make diet change recommendations PRN. Date initiated: 4/19/22, Revision on: 4/19/22; Weigh per facility protocol and/or NAR [nutrition at risk] committee recommendations. Date initiated: 4/19/22, Revision on: 4/19/22. Progress notes revealed: On 8/20/24 at 8:50 PM, an Orders-Administration progress note revealed, Med Pass 2.0 two times a day for NUTRITION. Out of stock. On 8/21/24 at 8:57 PM, an Orders-Administration progress note revealed, Med Pass 2.0 two times a day for NUTRITION. Out of stock. On 8/22/24 at 8:20 PM, an Orders-Administration progress note revealed, Med Pass 2.0 two times a day for NUTRITION. Out of stock. On 8/23/24 at 9:24 AM, an Orders-Administration progress note revealed, Med Pass 2.0 two times a day for NUTRITION. Unavailable. On 8/23/24 at 7:24 PM, an Orders-Administration progress note revealed, Med Pass 2.0 two times a day for NUTRITION. Out of stock. On 8/24/24 at 12:05 PM, an Orders-Administration progress note revealed, Med Pass 2.0 two times a day for NUTRITION. Awaiting delivery. On 8/24/24 at 6:32 PM, an Orders-Administration progress note revealed, Med Pass 2.0 two times a day for NUTRITION. Out of stock. On 8/25/24 at 10:21 AM, an Orders-Administration progress note revealed, Med Pass 2.0 two times a day for NUTRITION. Waiting for pharmacy delivery. (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/25/24 at 8:56 PM, an Orders-Administration progress note revealed, Med Pass 2.0 two times a day for NUTRITION. OOS [out of stock]. On 8/26/24 at 9:09 PM, an Order-Administration progress note revealed, Med Pass 2.0 two times a day for NUTRITION. Waiting for pharmacy delivery. On 8/26/24 at 10:11 PM, an Order-Administration progress note revealed, Med Pass 2.0 two times a day for NUTRITION. On order. On 8/27/24 at 9:15 AM, an Order-Administration progress note revealed, Med Pass 2.0 two times a day for NUTRITION. Waiting for pharmacy delivery. On 8/27/24 at 10:27 PM, an Order-Administration progress note revealed, Med Pass 2.0 two times a day for Nutrition. Resident offered equivalent. 8/28/24 at 10:08 AM, an Order-Administration progress note revealed, Boost Breeze. Give 4 oz of Boost Breeze three times a day, three times a day for SUPPLEMENT/NUTRIENT. Waiting for delivery. On 8/28/24 at 10:49 AM, a nutrition progress note revealed, RD note: Nutrition at risk: Significant weight loss of 20.9#/11.9% x 17 days. Significant weight loss of 18.9#/10.9% x 1 month; Sig. [significant] wt [weight] loss 17.7#/10.2% in 3 months; sig wt loss 19.9#/11.4% x 6 months. Skin: PI [pressure ulcer] noted bilateral heels and R [right] and L [left] buttocks. Current weight 155.1#. PO [by mouth] intake ~ 46% of Reg [regular], reg. thin liquids meals with 7 meals refused this week. Facility snacks accepted 1-3x daily. Resident usually eats outside meals and snacks in addition to facility meals/snacks. However, in light of most recent weight loss, RD is uncertain of current eating habits of resident. Resident has been refusing weights recently, so it is likely resident refused re-weight. Supplements; Boost Breeze 4 oz [ounces] TID [three times daily] 100%, Pro-stat AWC QD [once daily] 100%, MP [Med Pass] 60 ml [milliliters] BID [two times daily] 100% as available. No recent nutrition related labs. CBW [current body weight] 155.1#, HT [height] 59, 163% IWR [ideal weight range] for para: 78-96#. Estimated nutrition needs: 1527 calories, 87 grams protein, 2257 ml fluid (adjusted for obesity). % Estimated needs Met: 100% calories needs should be met, however ,weight loss noted, 86% protein. Some weight loss may be desirable and beneficial per resident preference and d/t [due to] morbid obesity and decreased mobility. Weight loss and skin breakdown considered unavoidable. Staff continues to encourage good po intake of meals, snacks, and supplements. Recommend: Discuss with resident if wt. loss is intentional. F/up [follow-up] re-wt as resident allows. It should be noted that no additional follow-up was documented by the Registered Dietitian. On 8/28/24 at 2:11 PM, an Orders-Administration progress note revealed, Boost Breeze. Give 4 oz of Boost Breeze three times a day, three times a day for SUPPLEMENT/NUTRIENT. Waiting for delivery. On 8/29/24 at 7:06 AM, an Orders-Administration progress note revealed, Boost Breeze. Give 4 oz of Boost Breeze three times a day, three times a day for SUPPLEMENT/NUTRITION. Waiting for delivery. On 8/29/24 at 2:00 PM, an Orders-Administration progress note revealed, Boost Breeze. Give 4 oz of Boost Breeze three times a day, three times a day for SUPPLEMENT/NUTRITION. Waiting for delivery. (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/28/24 at 7:37 PM, an Orders-Administration progress note revealed, Med Pass 2.0 two times a day for NUTRITION. Ordered. On 9/29/24 at 10:11 AM, an Orders-Administration progress note revealed, Med Pass 2.0 two times a day for NUTRITION. Waiting for pharmacy delivery. On 9/29/24 at 10:44 PM, an Orders-Administration progress note revealed, Med Pass 2.0 two times a day for NUTRITION. On order. On 9/30/24 at 9:33 AM, an Orders-Administration progress note revealed, Boost Breeze. Give 4 oz of Boost Breeze three times a day, three times a day for SUPPLEMENT/NUTRITIENT [sic]. Waiting for pharmacy delivery. On 9/30/24 at 9:34 AM, an Orders-Administration progress note revealed, Med Pass 2.0 two times a day for NUTRITION. Waiting for pharmacist delivery. On 9/30/24 at 11:49 AM, an Orders-Administration progress note revealed, Boost Breeze. Give 4 oz of Boost Breeze three times a day, three times a day for SUPPLEMENT/NUTRIENT. Waiting for pharmacist delivery. On 9/30/24 at 5:06 PM, an Orders-Administration progress note revealed, Boost Breeze. Give 4 oz of Boost Breeze three times a day, three times a day for SUPPLEMENT/NUTRIENT. Waiting for pharmacist delivery. On 9/30/24 at 9:05 PM, an Orders-Administration progress note revealed, Med Pass 2.0 two times a day for NUTRITION. Out of stock. On 10/1/24 at 8:23 AM, an Orders-Administration progress note revealed, Med Pass 2.0 two times a day for NUTRITION. Waiting for pharmacist delivery. On 10/1/24 at 8:23 AM, an Orders-Administration progress note revealed, Boost Breeze. Give 4 oz of Boost Breeze three times a day, three times a day for SUPPLEMENT/NUTRIENT. Waiting for pharmacist delivery. On 10/1/24 at 12:00 PM, an Orders-Administration progress note revealed, Boost Breeze. Give 4 oz of Boost Breeze three times a day, three times a day for SUPPLEMENT/NUTRIENT. Waiting for pharmacy delivery. On 10/1/24 at 4:42 PM, an Orders-Administration progress note revealed, Boost Breeze. Give 4 oz of Boost Breeze three times a day, three times a day for SUPPLEMENT/NUTRIENT. Waiting for pharmacist delivery. On 10/1/24 at 7:57 PM, an Orders-Administration progress note revealed, Med Pass 2.0 two times a day for NUTRITION [sic]. Not available. On 10/3/24 at 10:07 AM, an Orders-Administration progress note revealed, Med Pass 2.0 two times a day for NUTRITION. In progress with delivery. (continued on next page)		

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Centers for Medicare & Medicaid Services

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/7/24 at 9:48 AM, an Orders-Administration progress note revealed, Med Pass 2.0 two times a day for NUTRITION. Waiting for pharmacist delivery. On 10/7/24 at 7:50 PM, an Orders-Administration progress note revealed, Med Pass 2.0 two times a day for NUTRITION. On order. On 10/8/24 at 10:07 AM, an Orders-Administration progress note revealed, Med Pass 2.0 two times a day for NUTRITION. In progress with delivery. On 10/10/24 at 10:20 AM, an Orders-Administration progress note revealed, Med Pass 2.0 two times a day for NUTRITION. In progress with delivery. On 10/10/24 at 8:20 PM, an Orders-Administration progress note revealed, Med Pass 2.0 two times a day for NUTRITION. Out of stock. On 10/11/24 at 9:24 AM, an Orders-Administration progress note revealed, Med Pass 2.0 two times a day for NUTRITION. Delivery in progress. On 10/12/24 at 10:10 AM, an Orders-Administration progress note revealed, Med Pass 2.0 two times a day for NUTRITION. In progress with pharmacy. On 10/13/24 at 10:05 AM, an Orders-Administration progress note revealed, Med Pass 2.0 two times a day for NUTRITION. In progress with pharmacy. On 10/13/24 at 10:21 PM, an Orders-Administration progress note revealed, Med Pass 2.0 two times a day for NUTRITION. Waiting for shipment to arrive. On 10/14/24 at 10:48 PM, an Orders-Administration progress note revealed, Med Pass 2.0 two times a day for NUTRITION. Out of stock. On 10/15/24 at 8:58 PM, an Orders-Administration progress note revealed, Med Pass 2.0 two times a day for NUTRITION. Not available. On 10/31/24 at 12:51 PM, an Orders-Administration progress note revealed, Boost Breeze. Give 4 oz of Boost Breeze three times a day, three times a day for SUPPLEMENT/NUTRIENT. In progress with pharmacy. On 10/31/24 at 3:05 PM, an Orders-Administration progress note revealed, Boost Breeze. Give 4 oz of Boost Breeze three times a day, three times a day for SUPPLEMENT/NUTRIENT. In progress with pharmacy. On 11/1/24 at 10:46 AM, an Orders-Administration progress note revealed, Boost Breeze. Give 4 oz of Boost Breeze three times a day, three times a day for SUPPLEMENT/NUTRIENT. In progress with pharmacy. On 11/1/24 at 1:20 PM, an Orders-Administration progress note revealed, Boost Breeze. Give 4 oz of Boost Breeze three times a day, three times a day for SUPPLEMENT/NUTRIENT. In progress with delivery. (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/1/24 at 3:12 PM, an Orders-Administration progress note revealed, Boost Breeze. Give 4 oz of Boost Breeze three times a day, three times a day for SUPPLEMENT/NUTRIENT. In progress with delivery. On 11/2/24 at 10:16 AM, an Orders-Administration progress note revealed, Boost Breeze. Give 4 oz of Boost Breeze three times a day, three times a day for SUPPLEMENT/NUTRIENT. Delivery in progress. On 11/2/24 at 10:25 AM, an Orders-Administration progress note revealed, Boost Breeze. Give 4 oz of Boost Breeze three times a day, three times a day for SUPPLEMENT/NUTRIENT. In progress with pharmacy. On 11/2/24 at 3:57 PM, an Orders-Administration progress note revealed, Boost Breeze. Give 4 oz of Boost Breeze three times a day, three times a day for SUPPLEMENT/NUTRIENT. In progress with delivery. On 11/3/24 at 9:39 AM, an Orders-Administrat [TRUNCATED]		

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F 0725 Level of Harm - Actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30563 Based on interview, observation and record review it was determined, for 7 of 65 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, a resident was soiled and calling for help, incontinence cares were not being completed every 2 hours, showers were not provided to residents, there were complaints of staff not answering call lights and resident council minutes revealed complaints of not enough staff. Resident identifiers: 15, 26, 27, 49, 52, 55, 60 and 120. Findings included: 1. Resident 60 was admitted to the facility on [DATE] with diagnoses which included type 2 diabetes mellitus, hypertension, dysphagia, history of falling, dementia. On 11/3/24 at 4:03 PM, an interview was conducted with resident 60. Resident 60 stated there were not enough staff and he wet his pants waiting for staff to come and help him to the bathroom. Resident 60 stated he might be able to get to the bathroom if there were enough staff to answer his call light timely. Resident 60 stated that he had fallen waiting for staff to answer his call light. Resident 60 stated he got himself up to go to the bathroom and had fallen. On 11/7/24 at 11:54 AM, an interview was conducted with resident 60. Resident 60 was asked if there were enough staff to meet his needs. Resident 60 responded Oh [expletive removed] his call light was on for a while and he needed to use the restroom. Resident 60 stated he had to get himself up and ambulated to the bathroom on his own usually. Resident 60 stated sometimes he waited for 15 to 20 minutes before getting himself up to get to the bathroom. On 11/7/24 at 11:16 AM, an observation was made of resident 60's call light flashing outside resident 60's room. Resident 60 was observed in bed trying to pull himself to a seated position using the side rails. Resident 60 was observed yelling he needed help. Resident 60 was observed to get himself to a seated position. Resident 60 stated he wants help to get up. Resident 52 was observed to exit her room and look in resident 60's room and ask resident 60 if he needed help. Resident 60 stated he needed assistance. Resident 60 was observed to yell an expletive. Resident 52 stated to resident 60 to not get out of bed and just stay there. At 11:20 AM, a nurse, Administrator, and Corporate staff were observed to walk past resident 60's room. There was a strong bowel movement odor into the hallway. At 11:22 AM, resident 52 stopped the Administrator and stated resident 60 needed assistance. Resident 60 was observed to have bowel movement on him. The Administrator was observed to ask CNA (Certified Nursing Assistant) 6 to assist resident 60. On 11/12/24 at 10:34 AM, an observation was made of resident 60's room. The call light was observed to be wrapped up on the nightstand on the other side of his privacy curtain. The call light was not within reach of resident 60. (continued on next page)		

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F 0725 Level of Harm - Actual harm Residents Affected - Some	(Cross Refer to F690 and F689) 2. Resident 49 was admitted to the facility on [DATE] with diagnoses which included dementia, psychotic disturbance, mood disturbance and anxiety. On 11/3/24 at 6:32 PM, an interview was conducted with resident 49. Resident 49 stated he Can't find a CNA when he needed one. Resident 49 stated if he pushed the call light, staff did not come. Resident 49 stated he talked to the Administrator and he was a good guy but he ran this facility like a union shop. Resident 49 stated the staff had the attitude of No one wants to do more than they are assigned to do. Resident 49 stated he had to go to the nurses station to get help and CNA's would say it was not their area. Resident 49 stated he wanted showers more often. On 11/3/24 through 11/8/24, an observation was made of resident 49. Resident 49 was observed in the same clothing those days. Resident 49 was observed to have stubby facial hair. On 11/11/24, an observation was made of resident 49. Resident 49 was observed in the same clothing he was wearing the week before. Resident 49 was observed to have different clothing on 11/13/24. Resident 49's medical record was reviewed. A Brief Interview for Mental Status (BIMS) assessment was completed on 5/3/24 and locked on 5/22/24. The BIMS score was 15 which indicated resident 49 was cognitively intact. An admission Minimum Data Set (MDS) dated [DATE] revealed resident 49 required supervision or touching assistance with bathing. A quarterly MDS dated [DATE] revealed resident 49 had a BIMS of 15. The Certified Nursing Assistant (CNA) documentation in the plan of care tasks section for shower and bathing revealed the following: a. On 10/14/24, it was documented as not applicable (N/A), b. On 10/16/24, the shower was provided, c. On 10/22/24, the shower was refused, d. On 10/23/24, the shower was provided, e. On 10/31/24, it was documented as N/A, f. On 11/5/24, the shower was refused, g. On 11/6/24, the shower was provided, h. On 11/8/24, the resident was unavailable, i. On 11/11/24, the shower was documented as N/A. (continued on next page)		

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F 0725 Level of Harm - Actual harm Residents Affected - Some	On 11/12/24 at 11:06 AM, an interview was conducted with CNA 8. CNA 8 stated she was not sure which days resident 49 was scheduled to have showers. CNA 8 stated if a resident did their own shower then N/A might be marked by CNA's. CNA 8 stated she was not sure if resident 49 needed assistance with showering. On 11/12/24 at 1:51 PM, an interview was conducted with the Director of Nursing (DON). The DON stated resident 49 should get showers twice per week. The DON stated she was unsure why showers for resident 49 were marked as N/A. On 11/13/24 at 8:54 AM, an interview was conducted with License Practical Nurse (LPN) 3. LPN 3 stated that resident 49 was scheduled for a shower during the night shift, so she was not sure if resident 49 was getting showered. LPN 3 stated if a resident refused a shower, then staff tried to make accommodations for the resident to shower when they wanted. LPN 3 stated on 11/12/24 CNA 6 told her resident 49 needed a shower. LPN 3 stated she asked to see resident 49's Lidocaine patch and she told resident 49 his back was dirty and smelled, so she offered to shower him. LPN 3 stated resident 49 told her she could shower himself. LPN 3 stated she was not sure the last time resident 49 had showered prior to 11/12/24. LPN 3 stated she sometimes did not notice when resident smelled, but she did notice resident 49 smelled. LPN 3 stated resident 49 was pleasant, fine and picked out his own clothing. LPN 3 stated she had no problem getting resident 49 to shower. (Cross refer to F676) 38031 3. Resident 15 was admitted to the facility on [DATE] with diagnoses which included hereditary ataxia, cognitive communication deficit, dysphagia, hypothyroidism, major depressive disorder, anemia, peripheral neuropathy, dysarthria and anarthria, speech disturbance, wedge compression fracture of third lumbar, edema, and insomnia. On 11/3/24 at 2:04 PM, an interview was conducted with resident 15. Resident 15 stated she was incontinent and wore a brief. Resident 15 stated that the brief was changed approximately every 3 hours, but that she needed it changed more frequently than that. Resident 15 stated that she did not currently have any issues with a urinary tract infection. A strong odor of urine was noted from resident 15 during the interview. On 9/11/24, resident 15's Minimum Data Set (MDS) Assessment documented a Brief Interview for Mental Status (BIMS) score of 15, which would indicate that the resident was cognitively intact. The assessment documented that resident 15 required a two-person extensive assist for bed mobility, transfer, and toilet use. The assessment documented that the resident was not on a toileting program for urinary or bowel continence. (continued on next page)		

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F 0725 Level of Harm - Actual harm Residents Affected - Some	On 11/5/24 at 12:48 PM, an interview was conducted with Certified Nurse Assistant 6. CNA 6 stated that resident 15 was a two-person assist for repositioning, hoyer use, transfer, and incontinence care. CNA 6 stated that resident 15 was incontinent of bowel and bladder. CNA 6 stated that they provided resident 15 with brief changes every 2 hours unless she called for assistance before that. CNA 6 stated that resident 15's briefs were usually saturated with urine at the time of incontinence care. CNA 6 stated that they documented brief changes and incontinence care in the electronic medical records. CNA 6 stated that he was usually able to complete his tasks during a shift. CNA 6 stated that it was always helpful to have more staff. CNA 6 stated that sometimes it was difficult to provide incontinence care every two hours, but they made sure to get it done before shift change. CNA 6 stated that all incontinent residents were changed at least once a shift. On 11/06/24 at 8:10 AM, a continuous observation was started for resident 15. At 8:17 AM, a breakfast meal tray was delivered to resident 15 by CNA 4. Resident 15 was seated in bed in a high fowlers position with the bedside table positioned over their lap. No incontinence care was provided by CNA 4. At 8:46 AM, CNA 5 delivered bed sheets to resident 15's room and placed them at the bedside. No incontinence care was provided by CNA 5. At 9:17 AM, CNA 5 removed resident 15's breakfast tray from the bedside. No incontinence care was provided by CNA 5. At 10:49 AM, the DON and LPN 3 walked by resident 15's room. No incontinence care was provided. At 10:50 AM, CNA 5 was observed to enter resident 15's room. CNA 5 was interviewed upon exit of the room. CNA 5 stated that resident 15 was sleeping and she checked to ensure that the resident was okay. No incontinence care was provided by CNA 5. At 11:51 AM, resident 15's continual observation was completed. It should be noted that a continual observation was conducted of resident 15 from 8:10 AM to 11:51 AM and no observations of incontinence care were provided. On 11/6/24 at 3:17 PM, an interview was conducted with CNA 5. CNA 5 stated that she and another aide got resident 15 up at approximately noon. CNA 5 stated that resident 15's brief was saturated with urine, she doesn't soak that bad. On 11/6/24 at 3:26 PM, an interview was conducted with the DON. The DON stated that incontinence care expectations were that staff rounded on the residents every 2 hours and checked to see if briefs needed to be changed. The DON stated that staff should check with any resident that required assistance with toileting every 2 hours for toileting needs. (Cross refer to F676) 4. Resident 51 was admitted to the facility on [DATE] with diagnoses which included intracerebral hemorrhage, hemiplegia and hemiparesis of left side, neurologic neglect syndrome, chronic kidney disease, hypertension, congestive heart failure, cognitive communication deficit, aphasia, visual loss both eyes, and insomnia. (continued on next page)		

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F 0725 Level of Harm - Actual harm Residents Affected - Some	On 11/3/24 at 2:48 PM, an interview was conducted with resident 51. Resident 51 stated that she had fallen previously in the morning when attempting to get up and toilet herself. Resident 51 stated that sometimes she had to change her brief because the staff did not come to help her. Resident 51 stated that the call light did not always work either. Resident 51 stated that she could put a pull up brief on by herself but she could not put the tab briefs on by herself. It should be noted that resident 51 had hemiplegia and hemiparesis of the left side that limited her ability to perform toileting tasks independently. Resident 51 stated that she waited 2 hours the other night for assistance. Resident 51 stated that she requested pull up briefs a couple of days ago but never received them. Resident 51's call light was pushed at the bedside and in the bathroom and both were observed not functioning. Resident 51's medical record was reviewed. On 10/9/24, resident 51's MDS Assessment documented a BIMS score of 14, which indicated that the resident was cognitively intact. The assessment documented that the resident was a one-person limited assist for bed mobility and eating, and a one-person extensive assist for transfers and toilet use. The assessment documented that the resident was not on a urinary or bowel toileting program. On 11/5/24 at 12:53 PM, an interview was conducted with CNA 6. CNA 6 stated that resident 51 required a one-person assist for incontinence care due to the resident's visual impairment and paralysis in the left arm. CNA 6 stated that resident 51 was incontinent of bowel and bladder. CNA 6 stated that they used either pull up briefs or tab briefs for resident 51 and that resident 51 did not have a preference. CNA 6 stated that resident 51 would inform them when she needed a brief change. On 11/6/24 at 8:10 AM, a continuous observation was started for resident 51. No incontinence care was provided by CNA 5. At 8:28 AM, a breakfast meal tray was delivered to resident 51 by CNA 5. No incontinence care was provided. At 9:17 AM, an observation was made of CNA 4 assisting resident 51 with dressing. CNA 4 then removed resident 51's breakfast tray from the bedside. No incontinence care was provided by CNA 4. At 10:04 AM, CNA 5 entered resident 51's room and placed clean linen on the bedside table. CNA 5 assisted resident 51 into bed. No incontinence care was provided by CNA 5. At 10:34 AM, a continual observation continued of resident 51. At 10:49 AM, the DON and LPN 3 walked by resident 51's room. No incontinence care was provided. At 10:50 AM, CNA 5 was observed to enter resident 51's room. CNA 5 was interviewed upon exit of the room. CNA 5 stated that resident 51 was sleeping and she checked to ensure that the resident was okay. No incontinence care was provided by CNA 5. At 11:51 AM, resident 51's continual observation was completed. It should be noted that a continual observation was conducted of resident 51 from 8:10 AM to 11:51 AM and no observations of incontinence care were provided. (Cross-refer F676) 5. Resident 55 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Parkinson's disease with dyskinesia, type 2 diabetes mellitus, tremor, and unsteadiness on feet. On 11/4/24 at 8:47 AM, an interview was conducted with resident 55. Resident 55 stated there were not enough staff. Resident 55 stated if he pushed the call light, he had to wait about 20 minutes. (continued on next page)		

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F 0725 Level of Harm - Actual harm Residents Affected - Some	6. Resident 26 was admitted to the facility on [DATE] with diagnoses which include facioscapulohumeral muscular dystrophy, unspecified protein-calorie malnutrition, hyperlipidemia, hypomagnesemia, hypo-osmolality and hyponatremia, and weakness. On 11/3/24 at 3:43 PM, an interview was conducted with resident 26. Resident 26 stated that there was less and less staff working at the facility. Resident 26 stated that she required assistance with showers and they were not getting completed because she wanted to be showered by female staff. Resident 26 stated that the meal times had not been consistent and every day meals were getting served later and later. Resident 26 stated that there were usually only CNA's that were working at a time in the facility. Resident 26 stated that the CNA's did not have time to provide her with water and she had to get it for herself. Resident 26 stated that activities at the facility were late or canceled because of the lack of staff. (Cross refer to 676 and F802) 7. Resident 27 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which include, but not limited to, aftercare following joint replacement surgery, difficulty in walking, muscle weakness, type 2 diabetes mellitus with hyperglycemia, major depressive disorder, anxiety disorder, essential hypertension, unsteadiness on feet, and history of falling. On 11/4/24 at 8:19 AM, an interview was conducted with resident 27. Resident 27 stated there was not enough staff especially at night. Resident 27 stated that she never pushed her call light anymore because she knew it would not get answered by staff and she had waited almost 90 minutes for the call light to be answered. 8. Resident 120 was admitted to the facility on [DATE] with diagnoses which include, but not limited to lymphedema, superficial mycosis, cellulitis of right lower limb, activated protein c resistance, cellulitis of left lower limb, and morbid (severe) obesity due to excess calories. On 11/3/24 at 2:18 PM, an interview was conducted with resident 120. Resident 120 stated that she had to wait over 90 minutes for the call light to be answered by staff. Resident 120 stated that there had been times that there were only two CNA's to cover all the hallways in the facility. Resident 120 stated that activities were late because of late meal times from the kitchen. Resident 120 stated she required assistance to get out of bed and there had been times she had been incontinent because the call lights were not getting answered. A review of the facility resident council notes revealed the following: a. June 2024: .RC [resident council] Pres. [president] heard nursing staff are slow to answer call lights. Other concerns mentioned about frequency of (and services offered during) showering, to be followed up with each individual's situation by RA [Resident Advocate] with Nurse Management. b. July 2024: .Call light issues: seems broken/not regularly working .Nurse Management addressed issue of longer call-light response time and asked if there were any trends residents have noticed and residents responded that night shift seems to take longer to respond . c. August 2024: .yesterday's all-staff a training in-service was conducted to educate staff on physically rounding every 2 hours . (continued on next page)		

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F 0725 Level of Harm - Actual harm Residents Affected - Some	On 11/7/24 at 10:38 AM, an interview was conducted with Certified Nurse Aide (CNA) 8. CNA 8 stated that lately she had been responsible for 20 or more residents daily. CNA 8 stated that resident showers have not been completed on residents because she did not have time to complete them. CNA 8 stated that she had tried to ask for help from other staff but all staff were very busy and could not always help. On 11/7/24 at 11:11 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that there were 6 CNA's scheduled during the day and 4.5 CNA's during the night. The DON stated that if there were call outs that management would fill in the shifts. The DON stated that she had had staff come to her with workload concerns. The DON stated that her expectation from staff was to reach out and let management know they needed help. The DON stated that if resident showers were not completed during the day then this should be passed on to the night shift to get completed and she was unaware if that was being completed. On 11/7/24 at 12:04 PM, an interview was conducted with the Administrator (ADMIN). The ADMIN stated staffing needs was based off of the acuity of the residents in the facility. The ADMIN stated that if staff call out then a member of the management team would come in and cover the shift. The ADMIN stated that the facility was fully staffed and all nursing positions were filled. The ADMIN stated that he heard about residents concerns with staffing when he attended the November resident council meeting held on 11/6/24. The ADMIN stated that he was not sure how to review call light logs, but believed there was a system for it. 50200		

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F 0726 Level of Harm - Actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30563 Based on observation, interview and record review it was determined that the facility did not have sufficient nursing staff with the appropriate competencies and skills set 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. Specifically, inadequate oversight by the Director of Nursing resulted in multiple system failures in resident care areas which placed residents at harm. Resident identifiers: 1, 3, 4, 5, 9, 10, 13, 15, 16, 20, 26, 27, 28, 29, 32, 34, 38, 45, 46, 49, 51, 52, 53, 55, 57, 61, 65, 120, 269, and 371. Findings included: 1. Based on interviews and record review, for 8 of 65 sampled residents, 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, a resident's care plan was not updated to reflect current ostomy care and wound care being provided, a resident did not have a care plan regarding bowel and bladder care, care plan interventions were not updated after resident falls, and a resident's care plan did not reflect the need for supervised eating. Resident identifiers: 1, 3, 13, 34, 38, 51, and 55. [Cross-refer F656] 2. Based on interview and record review it was determined, for 4 of 65 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, resident's were not provided bathing/shower assistance, nail care, and incontinence care for over 3 hours. Resident identifier: 15, 49, 51 and 60. [Cross-refer F676] 3. Based on record review and interview it was determined, for 1 of 65 sampled residents, based on the comprehensive assessment of a resident the facility did not ensure that a resident with a pressure ulcer received the necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Specifically a resident's wound Vacuum-Assisted Closure (VAC) was not working for approximately 24 hours and the physician was not notified until the resident was somnolent. Resident identifier: 371. [Cross-refer F686] (continued on next page)		

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F 0726 Level of Harm - Actual harm Residents Affected - Some	4. Based on observation, interview, and record review, it was determined for 5 of 65 sampled residents that the facility failed to 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 fell as a result of the use of damaged medical equipment; no updated interventions were implemented after resident falls, with one resident having sustained a major injury; neurological assessments were not completed after falls and a call light was not within reach. Resident identifiers: 1, 5, 13, 51, and 60. [Cross-refer F689] 5. Based on observation, interview and record review, for 3 of 65 sampled residents, the facility did not ensure a resident who was continent of bladder and bowel on admission received services and assistance to maintain continence unless his or her clinical condition is or became such that continence was not possible to maintained. Specifically, a resident had a urine analysis (UA) obtained and 12 days later staff obtained the results and treatment was started for a urinary tract infection (UTI). The resident complained of flank pain during the 12 days and was administered Tylenol. Another resident was occasionally incontinent of bladder upon admission was not provided a bladder retraining program. In addition, the same resident was observed to have a call light on for 8 minutes, yelling for help, and another resident found staff to clean him up after having a bowel movement. Those 2 examples will be cited at a harm level. Another resident had an antibiotic for a UTI discontinued prior to finishing the course of the antibiotic. Resident identifiers: 1, 52, 55 and 60. [Cross-refer F690] 6. Based on observation, interview and record review, for 1 of 65 sample residents, the facility did not ensure a resident who required colostomy services received care consistent with professional standards of practice, the person-centered care plan, and the resident's goals and preferences. Specifically, the facility ran out of colostomy supplies and when the supplies were ordered, the wrong item was ordered leaving the resident without colostomy supplies. Resident identifier: 3. [Cross-refer F691] 7. Based on observation, interview and record review, for 4 of 65 sampled residents, the facility did not ensure residents maintained acceptable parameters of nutritional status. Specifically, residents meal portion sizes were not adequate, residents weights were not obtained and residents nutrition assessments were not being completed. Resident identifiers: 3, 4, 55, 60, and 65. [Cross-refer F692] 8. Based on observation, interview, and record review it was determined that the facility did not 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, it was determined that the facility did not provide sufficient nursing staff to meet the residents' needs in the areas of assistance with toileting, providing hydration to residents, and answering call lights in a timely manner. Resident identifiers: 15, 26, 27, 51, 60, 120. (continued on next page)		

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F 0726 Level of Harm - Actual harm Residents Affected - Some	[Cross-refer F725] 9. Based on interview and record review it was determined, for 1 of 65 sampled residents, the facility did not provide the necessary behavioral health care and services to attain or maintain the highest practical physical, mental, and psychosocial well-being. Behavioral health encompasses a resident's whole emotional and mental well-being. Specifically, a resident with a history of suicidal ideations had a traumatic life event occur with no behavioral health services provided. The resident was found to have taken 4 to 5 bottles of Tylenol and was sent to the emergency room for an overdose. Resident identifier: 45, 57. [Cross-refer F740] 10. Based on interview, and record review it was determined, for 1 out of 64 sampled residents, that the facility did not ensure that it had sufficient staff who provided direct services with the appropriate competencies and skills set to provide nursing and related services to assure resident safety and to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. Specifically, a resident experienced a traumatic life event and staff were not provided education on how to help resident through the traumatic life event. The resident overdosed on Tylenol after the traumatic life event. Resident identifier: 57. [Cross-refer F741] 11. Based on interview and record review it was determined, for 1 out of 64 sampled residents, that the facility did not ensure that a resident who displayed or was diagnosed with dementia, received the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Specifically, staff reported ignoring resident behaviors and were not able to identify person-centered interventions or non-pharmacological approaches to resident's dementia care. Resident identifier: 65. [Cross-refer F744] 12. Based on observation, interview and record review it was determined, for 6 of 65 sampled residents, that the facility did not ensure that each resident received the food and drink that accommodated the resident allergies, intolerances, and preferences. Specifically, residents with food allergies and intolerances were served food containing identified allergens, and one resident who was admitted on [DATE] had not been questioned about food allergies until 11/5/24. Resident identifiers: 1, 10, 16, 26, 28, and 38. [Cross-refer F806] 13. Based on observation, interview and record review, it was determined for 1 of 65 sampled resident, that the facility did not provide therapeutic diets as prescribed by the attending physician. Specifically, a resident with a physician's order for thickened liquids was observed to have thin water at the bedside. Resident identifier: 60. [Cross-refer F808] (continued on next page)		

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F 0726 Level of Harm - Actual harm Residents Affected - Some	14. Based on observation, interview and record review it was determined, for 12 of 65 sampled residents, the facility failed to provide each resident with 3 meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. Additionally, snacks were not provided to residents who wanted to eat at non-traditional times or outside of the scheduled meal service times and consistent with the resident plan of care. Specifically, meals were not served according to meal times, meal times were changed without resident input, snacks were not being provided regularly. Resident identifiers: 9, 13, 16, 26, 27, 29, 32, 49, 53, 55, 60, and 120. [Cross-refer F809] 15. Based on observation, interview, and record review, it was determined for 1 of 64 sampled residents, that the facility failed to provide special eating equipment and utensils for residents who needed them to ensure that the resident could use the assistive devices when consuming meals and snacks. Specifically, one resident was not provided with a lipped plate when identified as needing one. Resident identifier: 5. [Cross-refer F810] 16. Based on interview and record review it was determined, for 1 of 65 sampled residents, that the facility did not ensure that the hospice services met professional standards and principles that applied to individuals providing services in the facility, and to the timeliness of those services. Specifically, facility staff documented they were unable to contact hospice, the facility did not obtain from the hospice provider the nursing notes and there were no coordination of care notes. Resident identifier: 4. [Cross-refer F849] 17. Based on observation, interview and record review it was determined, for 2 of 65 sampled residents, that the facility did not establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment to prevent the development and transmission of communicable diseases and infections. Specifically, observations were made of staff not performing hand hygiene during meal service and medication pass, food was delivered to resident rooms uncovered, and the facility did not have a Legionella prevention and monitoring plan in their water management program. Resident identifiers: 20 and 46. [Cross-refer F880] 18. Based on interview and record review it was determined, for 1 of 65 sampled residents, that the facility did not establish an infection prevention and control program (IPCP) that included an antibiotic stewardship program with protocols and a system to monitor antibiotic use. Specifically, a resident was treated for a urinary tract infection (UTI) with an antibiotic that the organism was resistant to. Resident identifier: 1. [Cross-refer F881] (continued on next page)		

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F 0726 Level of Harm - Actual harm Residents Affected - Some	19. Based on interview and record review it was determined, for 3 of 5 sampled residents, that the facility did not ensure that residents were offered the influenza and pneumococcal immunizations and that the medical records included documentation that the resident either received the immunization or did not due to medical contraindications or refusal. Specifically, three residents did not have immunizations documentation in their medical records. Resident identifiers: 49, 61, and 269. [Cross-refer F883] 20. Based on interview and record review it was determined, for 3 of 5 sampled residents, that the facility did not ensure that residents were offered the COVID-19 immunization and that the medical records included documentation that the resident either received the immunization or did not due to medical contraindications or refusal. Specifically, three residents did not have immunization documentation in their medical records. Resident identifiers: 49, 61, and 269. [Cross-refer F887]		

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 50200 Based on observation and interview, it was determined that the facility did not have the nurse staffing information posted. The facility must post the following information on a daily basis: Facility name, the current date, the total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: Registered Nurses, Licensed practical nurse, Certified Nurse aides, and resident census. The facility must post the nurse staffing data on a daily basis at the beginning of each shift and maintain the posted daily nurse staffing data for a minimum of 18 months. Additionally, the information must be displayed in a prominent place readily accessible to residents and visitors. Specifically, there were days when the nurse staffing information was not posted by 6:00 AM with the current date and the nurse staffing information was not posted on 11/8/24. Findings include: a. On 11/3/24 at 1:04 PM, during the initial tour of the facility, the nurse staff posting was dated 11/1/24. b. On 11/5/24 at 7:54 AM, the nurse staff posting was dated 11/4/24. c. On 11/6/24 at 7:41 AM, the nurse staff posting was dated 11/5/24. d. On 11/8/24 at 8:36 AM, the nurse staff posting was not readily accessible. e. On 11/8/24 at 11:29 AM, the nurse staff posting was not readily accessible. On 11/7/24 at 11:11 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that Certified Nurse Assistant (CNA) 1 and CNA 4 were responsible for staffing and posting the nurse staffing sheet. On 11/7/24 at 12:04 PM, an interview was conducted with the Administrator (ADMIN). The ADMIN stated that the staffing coordinators were responsible for posting the staffing sheets. The ADMIN stated that CNA 1 and CNA 4 were the staffing coordinators. On 11/12/24 at 9:24 AM, an interview was conducted with CNA 1. CNA 1 stated she was responsible for filling out the daily nurse staff posting. CNA 1 stated that the shifts for nursing staff were 6:00 AM-6:00 PM and 6:00 PM-6:00 AM. CNA 1 stated that the nurse staff posting was located right outside the business office on the wall. CNA 1 stated that she would have CNA 4 post the daily nurse staff posting before she left her shift at 6:00 AM. CNA 1 stated there had never been a day that the daily nurse staffing post had not been posted.		

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F 0740 Level of Harm - Actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30563 Based on interview and record review it was determined, for 1 of 65 sampled residents, the facility did not provide the necessary behavioral health care and services to attain or maintain the highest practical physical, mental, and psychosocial well-being. Behavioral health encompasses a resident's whole emotional and mental well-being. Specifically, a resident with a history of suicidal ideation's had a traumatic life event occur with no behavioral health services provided. The resident was found to have taken 4 to 5 bottles of Tylenol and was sent to the emergency room for an overdose. Resident identifier: 45, 57. Findings include: 1. Resident 57 was admitted to the facility on [DATE] and readmitted on [DATE] and discharged on [DATE] with diagnoses which included spondylosis without myelopathy or radiculopathy, lumbosacral region, type 2 diabetes mellitus, morbid obesity, bipolar disorder, major depressive disorder, suicidal ideation's, auditory hallucinations, generalized anxiety disorder and manic episode. On 11/3/24 at 4:01 PM, an interview was conducted with Registered Nurse (RN) 5. RN 5 stated that resident 57 initially resided on the locked memory unit with her mother, resident 45. RN 5 stated that resident 45 was placed on hospice services and was bed bound, and was subsequently moved off the locked memory unit. RN 5 stated that resident 45 passed away a week ago. RN 5 stated that resident 57 was currently in the hospital. RN 5 stated that resident 57 was admitted to the hospital for a Tylenol overdose. RN 5 stated that resident 57 had Tylenol at the bedside and no one was aware that she had it. RN 5 stated that resident 57 overdosed last Friday (11/1/24) and they found the bottle of medication at the bedside. RN 5 stated that resident 57 was alert and oriented and was on depression monitoring. RN 5 stated that she was not aware of resident 57 having a history of suicidal ideation (SI). On 11/3/24 at 5:34 PM, a follow-up interview was conducted with RN 5. RN 5 stated that if a resident had a history of suicidal ideation it should be documented in their medical record. RN 5 stated that if a resident had made statements of self harm then they would be placed on every 2 hour visual checks. RN 5 stated that she was not sure where to locate documentation of a past history of suicidal ideation for resident 57. RN 5 stated that any history of SI should be past on in report especially if that was something that they were monitoring for. RN 5 stated that staff were monitoring resident 57 for her mood throughout the shift and every resident with a history of depression was on 2 hour visual checks. RN 5 stated that both the licensed nurse and the Certified Nurse Assistant (CNA) were to conduct visual checks on the resident. RN 5 stated that the CNAs charted on a paper copy and the licensed nurse charted in the Treatment Administration Record (TAR). RN 5 stated that any behavior monitoring should be a part of the resident care plan. RN 5 stated that if they noted an increase in depressive statements they would chart in an alert charting progress note. RN 5 stated that they conducted a facility wide inspection of all patient rooms, and cleared out all supplies that were shipped and not provided by the facility. RN 5 stated that a lot of residents had items shipped from outside retailers and if it included over the counter (OTC) medication the facility would not have known about it. (continued on next page)		

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F 0740 Level of Harm - Actual harm Residents Affected - Few	On 11/3/24 at 6:01 PM, an interview was conducted with the Administrator (ADMIN) and the Minimum Data Set (MDS) Coordinator. The ADMIN stated that resident 57 had taken too many Tylenol. The ADMIN stated that after resident 57's incident they conducted a room sweep of all residents. The ADMIN stated that they consulted with the Ombudsman prior to the room sweep. The ADMIN stated that the intention of the room sweep was to ensure that no other residents had any medications at the bedside that they should not have access to. The ADMIN stated that the facility notified the State Survey Agency of the incident with resident 57 on Saturday for the event that occurred on Friday. The MDS Coordinator stated that he was in charge of the room sweep. The MDS Coordinator stated that they identified two other residents that had medication at the bedside. The MDS Coordinator stated that the staff who participated in the room sweep were himself, the CNA Coordinator, Admissions staff, Housekeeping Supervisor, and Medical Records staff. The ADMIN stated that CNA 10 found resident 57 confused and vomiting blue stained emesis. The ADMIN stated that RN 6 assessed that resident 57's pupil was nonreactive to light and sent them out to the hospital for evaluation. The ADMIN stated that RN 6 observed 5 empty bottles of Tylenol at resident 57's bedside. The ADMIN stated that they thought resident 57 used the Walmart order delivery and that was how she obtained the medication. The ADMIN stated that they were still in the process of their investigation as the incident had just occurred on Friday. The ADMIN stated that resident 57 had a history of SI that was documented in the PreAdmission Screening and Resident Review (PASRR) Level II. The ADMIN stated that resident 57's mother passed away about a week before her suicide attempt. The ADMIN stated that since the incident they had created a protocol to make sure that a resident's care plan needs addressed SI. The ADMIN stated that they provided staff education on Friday on recognition of the signs and symptoms of SI and depression. The ADMIN stated that the education included the Centers for Disease Control and Prevention (CDC) Guidelines for Preventing Suicide, Guiding Others Through Grief, and National Institute of Health (NIH) Depression training. The ADMIN stated that he had began working at the facility 3 months ago and prior to last Friday's education he had not provided education for the identification of risk factors for SI. The ADMIN stated that staff were providing frequent checks of resident 57, the activities coordinator was visiting daily and the resident's religious services had also visited. The ADMIN stated that he was in the process of obtaining staff attestations that demonstrated documentation of the frequent monitoring that was being conducted of resident 57. The ADMIN stated that if staff noted an increase in depressive statements by a resident they should notify the Director of Nursing (DON) and the ADMIN and then document the observations in the electronic medical records. The ADMIN stated that staff did not notify him of any increase in depressive statements made by resident 57 prior to the suicide attempt. Resident 57's medical record was reviewed 11/3/24 through 11/13/24. An admission Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 15 which indicated resident 57 was cognitively intact. A mood interview with resident 57 revealed she had thoughts that she would be better off dead or of hurting herself in some way about half or more days. A quarterly MDS dated [DATE] was not completed for the question above. A Suicide Lethality form dated 4/24/24 revealed Rt [resident] responded 'the details of how I would kill myself was supposed to happen on April 8th' 'I don't think about those things anymore.' When RA [Resident Advocate] prompted RT for more info - why don't you think about them anymore? Resident replied, 'I forgot about my obligation' 'My obligation to my mom, I did code, but I was told to come back and take care of my mom.' RA asked RT what would happen if your mom does pass away? RT replies she wants to live because that is what her mom wants, 'Mom wants me to live, and Mom will want me to keep living.' (continued on next page)		

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F 0740 Level of Harm - Actual harm Residents Affected - Few	A Preadmission Screening Resident Review (PASRR) Level II signed 8/26/24 by the evaluator revealed Patient was referred for level 2 evaluation due to diagnoses of bipolar, mood disorder due to medical condition, manic episode, major depression, generalized anxiety, auditory hallucinations, and suicidal ideation's. She did not report all the criteria for GAD [generalized anxiety disorder] and she disagreed that she was psychotic during her mania. She denied hearing a command hallucination to kill herself. She said it was her own thought. On 4/3/24 patient was admitted to [name removed] Psychiatric Hospital due to a threat to suicide via overdose. The SI was precipitated by the fact that she was being evicted from her apartment. During that stay she presented with symptoms of bipolar disorder with psychosis. She was grandiose and reported auditory hallucinations commanding her to overdose. Prior to this episode she had not been taking her medications. Bipolar and schizophrenia run in the family. She scored 21 on the PHQ-9 this week indicating significant depression and continued thoughts of suicide. At the age of 15 she had her first depression following grandmother's death. Her father [sic] dad was very depressed and expressed SI and attempted suicide. She said, 'I Turned to drinking.' She also said her mom's side of the family also has depression. At age 18 she started having SI. This SI was precipitated by job loss and money troubles. She felt worthless and attempted to cut her wrist but stopped because it hurt too much. In regards to mania she said, 'I have had manic episodes before, but didn't realize it now'. She said, 'I battle SI every day. But I try to remember that I'm here for a reason.' She said she feels safe and indicated she has no imminent plan to take her life. She said one of the biggest reasons for her current thoughts of wanting to be dead is her back. 'The pain in my back is so bad that I can't take care of myself.' The PASRR further revealed Patient suffers from a severe mental illness (bipolar) which has gone untreated for most of her life. Medication is helping. She will also need psychotherapy and possibly case management to remain safe and stable. Lastly, she would benefit from recreation therapy to address social isolation related to her depression. The recommendations for Specialized Services for mental illness treatment revealed, Please refer for psychotherapy. May also need a psychiatric consultation as she reports agitation just before her next dose of medication. Please refer for recreational therapy to address social isolation related to her depression. A PASRR Letter of Determination dated 8/26/24 revealed that Recommendations for specialized services are available on the PASRR evaluation which may be obtained through the Nursing Facility. Please consider behavioral health services to ensure present medications and other therapy services are best for your care. The right medications at the correct dosing, paired with appropriate and directed therapy services can be helpful with your overall mental health. (continued on next page)		

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F 0740 Level of Harm - Actual harm Residents Affected - Few	A care plan dated 4/23/24 revealed Resident has mental health diagnoses of Mood disorder, hx [history of] of SI, bipolar disorder, anxiety, MDD [major depressive disorder], mania, auditory command hallucinations and requires the use of antidepressant and anti-psychotic medication. The goal was Resident will have no adverse side effects r/t [related to] use of psychotropic medication through the review date. Interventions included Resident will have no s/s [signs or symptoms] of unmanaged mental health symptoms daily through the review date; Administer medication per physician order. Monitor for side effects and notify MD [medical doctor] of any adverse or consistent side effects that occur r/t psychotropic drug use; Document target symptoms Q [every] shift. Notify MD of any new/worsened symptoms of mental illness that are not effectively managed with current pharmacological and nonpharmacological interventions; Follow PASRR [Preadmission Screening Resident Review] level II recommendations: SI, bipolar disorder, anxiety, MDD, mania, auditory command hallucinations; If resident's mental health symptoms become unmanageable in-house or a mental health crisis occurs, call the crisis line or notify the MD to obtain transfer orders for a psychiatric evaluation in the hospital setting; Obtain informed consent for use of psychotropic medication. Medication regimen including black box warnings will be reviewed in each care conference meeting; Psychotropic committee will review medication regimen, target symptoms and side effects at least quarterly and make recommendations as indicated; PASRR II: Has a Level II PASRR due to their diagnosis of General Anxiety Disorder, Bi-Polar Disorder, Major Depressive Disorder; Psychosocial, mental and physical needs will be met through the next review date; Administer medications as ordered and monitor for adverse effects and notify physician as needed; Follow PASRR II plan of care; Psychology consult as needed/recommended; Staff will utilize facility resources to meet the needs of the resident and; Updates will be made to PASRR and appropriate agencies notified as necessary. Progress notes revealed the following: a. On 4/24/24 at 9:45 PM, .Resident recently admitted to facility, shares room with her mother. Reports having a rough couple of days, but states things are improving . b. On 7/18/24 at 6:15 AM, a Psych [psychiatric] Evaluation revealed .She usually shares a room with her mother who is on hospice. She has a significant history of depression with one past suicide attempt with hospitalization . c. On 8/15/24 at 7:30 AM, a Psych Follow Up note revealed .has returned to her regular room that she shares with her mother. This has improved her mood and anxiety . d. On 11/1/24 at 3:14 PM, Psychosocial Note: Asked the resident if she would like to move rooms. She stated she wanted to stay in her room, but didn't want another roommate. She was worried about someone else coming in the space her mom used to be in. She stated that she didn't want anything taken out of the room. Asked if there was anything we can do for her at [sic] during this difficult time. She denied any needs. e. On 11/1/24 at 9:30 AM and was created on 11/2/24 at 12:12 PM by the Director of Nursing (DON), IDT Late Entry: Data: Resident was found throwing up blue vomit by CNA. She was observed to have dilated pupils that was unreactive to the light. 5 empty bottles of Tylenol pm in Pts electric wheelchair. Action: IDT [interdisciplinary team] team met to discuss resident including: Admin, DON, regional nurse, activities director, MDS, CNA coordinator, medical records. Response: Resident was taken to the hospital immediately after nurse was notified of incident. (continued on next page)		

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F 0740 Level of Harm - Actual harm Residents Affected - Few	f. On 11/1/24 at 3:27 AM, Discharge Progress Note Date/time of discharge/transfer:: 11/1/2024 0327 [3:27 AM] Discharge/transfer location:: [name of facility] room [ROOM NUMBER] Mode at transportation at time of discharge/transfer:: [local ambulance company] ambulance on stretcher Reason for Transfer/Discharge: Pt [patient] was found throwing up blue vomit by PN [?]. Pt was observed to have dilated pupils that was unreactive to the light. Pt thought she was at [local hospital] and stated [sic] to throw away her fathers ashes. PN found 5 empty bottles of Tylenol pm in Pts electric wheel chair. Discharge teaching/instructions completed during discharge/transfer process:: discharge teaching to [local ambulance company] Discharge paperwork released with resident at time of discharge/transfer:: paperwork realized [sic] to [local ambulance company] Resident's response to discharge/transfer process:: Resident confused and unaware of situation. How were resident's personal effects stored/handled at time of discharge/transfer?:: Pt was not sent with personal effects. Name of individual to whom report was provided at new location:: [local ambulance company]dispatch Name of resident representative notified (if resident is not self-responsible):: [name removed] Name of Physician notified:: [name removed]. It should be noted there was no information about resident 57's mother passing away in the progress notes. The October 2024 TAR revealed the following: a. Behavior monitoring: # of anxious statements every shift. There were no documented episodes until 10/31/23 when there were 6 episodes during the night shift. b. Behavior monitoring: # of episodes of agitation every shift. There were no episodes until 10/31/23 when there were 8 episodes during the night shift. c. Behavior monitoring: # of episodes of expressions of hopelessness every shift. There were no episodes until 10/28/24 with 1 on day shift and then 2 on the night shift on 10/31/24. (continued on next page)		

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F 0740 Level of Harm - Actual harm Residents Affected - Few	On 11/6/24 at 9:08 PM, an interview was conducted with the RA. The RA stated The Director of Acquisitions and Risk Management was not a Social Service Worker (SSW) but was extremely knowledgeable with the federal regulations and the PASRR. The RA stated that the Director of Acquisitions and Risk Management coordinated facility monthly calls for all RA's. The RA stated the monthly calls included RA duties. The RA stated there was another SSW that was willing to sit down with him but was not willing to supervise him. The RA stated for the first 6 months he did not have anyone who was willing to help train him. The RA stated the SSW came by the facility for about an hour a couple times a month and then he took her advise. The RA stated the Business Office Manager at a sister facility, helped with assessments and PASRR level II's. The RA stated the PASRR evaluator was also very helpful. The RA stated the previous RA showed him a lot of what he did. The RA stated he was a mental health case manager prior to working at the facility. The RA stated the previous RA showed him how to track things, priorities and things like that. The RA stated it took a lot of time for him to learn the position. The RA stated that care planning was a big deal and hard for him to understand. The RA stated there was no Licensed Clinical Social Worker (LCSW) to provide guidance. The RA stated if a resident was having behaviors, nurses notified the DON and RA. The RA stated then behaviors were discussed with the clinical team and MD. The RA stated the clinical team included the DON and Administrator. The RA stated the facility had psychiatrist with a local behavioral health facility who came weekly to visit residents. The RA stated the psychiatrist met with resident 57 weekly and notes were in the progress notes of the residents medical record. The RA stated resident 57 was immediately set up with services because of her level II. The RA stated the the PASRR was straight forward with her needing psychiatric services. The RA stated resident 57 was seen on 10/22/24. The RA stated resident 57 shared a room with her mom and resident 57 was upset since her mother passed away. The RA stated if he was at the facility full time, he would have met with the resident 57 the day after her mother had passed away, checked on her, had staff monitor her, and would have set up a psychiatric appointment. The RA stated he had been notified that resident 57's mother passed away through a manager group chat. The RA stated he planned to talk with resident 57 on 11/2/24 when he was planning to work at the facility. The RA stated he worked a few hours on Saturday and Sundays. The RA stated resident 57 had tried to commit suicide, ordered Tylenol through a mobile application and had it delivered to the facility. The RA stated she took the Tylenol and resident 57 was rushed to the hospital. The RA stated that resident 57 had not had suicidal ideation's. The RA stated upon admission he completed a Suicidal Lethality form. The RA stated based on the form, with the answers resident 57 provided, he would complete a safety plan. It should be noted there was no safety plan located in resident 57's medical record. (continued on next page)		

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F 0740 Level of Harm - Actual harm Residents Affected - Few	On 11/7/24 at 4:17 PM, a follow-up interview was conducted with the DON and Administrator (ADMIN). The ADMIN stated if someone was admitted with a history of suicidal ideation, facility staff needed to create a care plan based on their PASRR. The ADMIN stated the IDT team which included the RA, ADMIN, Activities Director (AD), DON and MDS coordinator, met to discuss the residents needs. The ADMIN stated while there was not a full time RA, the AD and Medical Records Director helped with RA duties. The ADMIN stated the Regional Nurse Consultant was involved and there was a consultant LCSW that provided oversight to the RA. The ADMIN stated staff were trying to make sure care plans were up-to-date, PASRR's and level II's were done. The ADMIN stated resident 57 ordered a bunch of stuff from a local store and had it delivered. The ADMIN stated the Tylenol was in delivery and he was not sure when the resident took it. The ADMIN stated when a CNA was doing rounds about 3:00 to 3:30 AM, resident 57 had vomited and it was blue. The ADMIN stated resident 57 was confused, eyes were not reacting to light, the nurse sent her to hospital, and then noticed there were 5 empty Tylenol bottles on the ground. The ADMIN stated nurse called the ADMIN, when they found the bottles. The ADMIN stated it was reported to the State Survey Agency and an investigation was being completed. The ADMIN stated that the hospital reported resident 57's Acetaminophen level was 135. The ADMIN stated a sweep of residents rooms was completed to make sure no other residents had medications in their room. The ADMIN stated education was provided to staff on depression, medication labeling and storage, coping with grief, and another one. The ADMIN stated once resident 57's mother passed away the AD made sure that relief society came to visit, the AD checked in on her daily. The ADMIN stated that resident 57 was sad about her mother passing but nothing triggering. The ADMIN stated that during the investigation he obtained statements from staff that had interacted with her, including the housekeeping staff. The ADMIN stated CNA's and nurses reached out to resident 57, when nurses were doing medication pass they were making sure resident 57 was okay. The ADMIN stated he was able to get statements after, but the AD had daily notes. It should be noted there were no progress notes from the AD. (continued on next page)		

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F 0740 Level of Harm - Actual harm Residents Affected - Few	On 11/12/24 at 2:05 PM, an interview was conducted with the Director of Nursing (DON). The DON stated the facility did not currently have a full time RA, Social Service Worker or LCSW. The DON stated any behavioral concerns would be referred to behavioral health services who was in contact with the facility. The DON stated if a resident was in a crisis, facility staff would send the resident to the hospital or call the crisis hotline. The DON stated the AD was able to do trauma informed training, but the DON was not sure what the AD's training was. The DON stated the AD could do RA duties if she was trained but not sure who or what she had been trained on. The DON stated there was a mental health screening and a Suicidal Legality assessment done with the RA upon admission. The DON stated resident 57's mental health triggers would be assessed in those assessments. The DON stated the death of resident 57's mother would be a trigger for her. The DON stated staff were checking in on resident 57 and there were statements provided by staff after the resident went to the hospital. The DON stated resident 57 was experiencing escalating episodes of behaviors, there needed to be more training on documenting alert charting, monitoring and letting management know. The DON stated resident 57 needed a safety plan and suicide monitoring. The DON stated there was extra monitoring of resident 57 but there was no documentation of the monitoring. The DON stated when a resident had behaviors, staff were educated on de-escalation and management of trauma. The DON stated the care plan was how staff knew de-escalation techniques, but the DON did not know how CNA's were able to access the care plans. The DON stated she was not sure if the CNA's had access to the Kardex system that was triggered from the care plans. The DON stated nurses should be aware of residents with a history of suicidal ideation by the care plan or diagnoses. The DON stated there would be physician's orders for monitoring of behaviors. The DON stated the number of episodes were documented by nurses in the TAR. The DON stated if nurses noted an increase in episodes of behaviors, the nurses should notify the DON or RA. The DON stated medication adjustments might be needed. On 11/13/24 at 9:03 AM, an interview was conducted with Licensed Practical Nurse (LPN) 3. LPN 3 stated she was on shift when resident 57's mom passed away. LPN 3 stated resident 57 was sad and called her family for comfort. LPN 3 stated it seemed like resident 57 was coping well with her mom passing away. LPN 3 stated that she did not know if the psychologist was contacted after her mom passed away. LPN 3 stated the DON asked a few weeks ago, if resident 57 could call the DON if she was in a crisis. LPN 3 stated she just wanted to listen to resident 57 and let administration know if there were any indications that she had SI. LPN 3 stated staff could let the RA know and behavioral health services know if the resident needed help. LPN 3 stated she was provided company training on a computer for Post Traumatic Stress Disorder and how to deal with traumatic events. On 11/13/24 at 12:43 PM, an interview was conducted with Regional Nurse Consultant (RNC) 2. RNC 2 stated the facility hired an RA but then they took another position at the last minute. RNC 2 stated the facility currently did not have a full time RA. 38031		

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38031 Based on interview and record review it was determined, for 1 out of 64 sampled residents, that the facility did not ensure that a resident who displayed or was diagnosed with dementia, received the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Specifically, staff reported ignoring resident behaviors and were not able to identify person-centered interventions or non-pharmacological approaches to resident's dementia care. Resident identifier: 65. Finding included: Resident 65 was admitted to the facility on [DATE] with diagnoses which included dementia, seizures, hypothyroidism, obstructive sleep apnea, depression, presence of a cardiac pacemaker, and violent behaviors. On 11/03/24 at 3:56 PM, an observation was made of resident 65 sleeping in a recliner in his room. The resident's call light was observed on the arm rest within reach and a walker was located near the door. On 11/05/24 at 1:08 PM, an observation was made of resident 65 exiting his room and pushing a walker. The resident said hello and had a smile on his face. Resident 65's electronic medical records were reviewed. On 9/17/24, resident 65's Minimum Data Set (MDS) Assessment documented a Brief Interview for Mental Status (BIMS) score of 4/15, which would indicate a severe cognitive impairment. The assessment documented a PHQ-9 mood score of 7 which would indicate a mild depression severity. The assessment documented that physical or verbal behavioral symptoms were not exhibited. Resident 65's physician orders revealed: a. On 10/18/24, an order was initiated for Haloperidol Tablet 5 milligram (mg), give 1 tablet by mouth every 1 hours as needed for agitation at bedtime, if still showing agitation after one hour give another 5 mg tablet. b. On 10/18/24, an order was initiated for Haloperidol Tablet 5 mg, give 1 tablet by mouth every 22 hours as needed for agitation at bedtime, if still showing agitation after one hour give another 5 mg tablet. c. On 10/17/24, an order was initiated for Hydroxyzine Tablet 25 mg, give 1 tablet by mouth every 6 hours as needed for anxiety. d. On 9/10/24, an order was initiated for Sertraline Tablet 100 mg, give 1 tablet by mouth two times a day for depression. (continued on next page)		

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	d. On 9/10/24, an order was initiated for Risperidone Tablet 0.5 mg, give 1 tablet by mouth two times a day for dementia/depression. Resident 65's October Medication Administration Record (MAR) documented the following: a. The Haloperidol PRN order was administered on 10/20/24 at 7:45 PM for agitation and was documented as effective. b. The Hydroxyzine PRN order was administered on 10/18/24 at 8:17 AM, on 10/19/24 at 8:49 AM, on 10/20/24 at 3:24 PM, on 10/22/24 at 4:31 PM, on 10/26/24 at 1:45 PM, and on 10/27/24 at 3:39 PM for anxiety and all were documented as effective. c. The behavior monitoring for number of episodes of agitation every shift documented a total of 29 episodes for the month. d. The behavior monitoring for number of verbal outbursts every shift documented a total of 23 episodes for the month. It should be noted that no documentation was found of non-pharmacological interventions that were provided to resident 65 in response to his episodes of behavior for October 2024. Resident 65's November MAR documented the following: a. The Haloperidol PRN order was administered on 11/2/24 for agitation and was documented as effective. It should be noted that behavior monitoring for episodes of agitation or verbal outburst did not document any episodes on 11/2/24 at the time the medication was administered. b. The Hydroxyzine PRN order was administered on 11/2/24 for anxiety and was documented as effective. It should be noted that behavior monitoring for episodes of agitation or verbal outburst did not document any episodes on 11/2/24 at the time the medication was administered. It should be noted that no documentation was found of non-pharmacological interventions that were provided to resident 65 in response to his episodes of behavior for November 2024. Resident 65's progress notes revealed the following: a. On 9/11/2024 at 1:00 AM, the provider note documented, Patient is a [AGE] year-old male with past medical history significant for dementia, seizure disorder, hypothyroidism, history of sick sinus syndrome status post cardiac pacemaker, and BPH [benign prostatic hyperplasia]. He presented to the emergency department via EMS [emergency medical services] with agitation and violent behavior. The patient is currently a resident at the [name omitted] memory care assisted living facility. Staff report that he was assaulting them and the police were called. EMS services were then contacted and the patient was picked up with police assistance and brought here to the emergency department under a pink sheet. The patient continued to be violent and agitated upon arrival. b. On 9/13/2024 at 3:23 AM, the note documented, Resident aggressive during brief change. He was kneeling CNA [Certified Nurse Assistant] and attempting to hit CNA and stating 'don't touch me, get out.' (continued on next page)		

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. On 9/25/2024 at 9:46 AM, the note documented, CNA reports resident standing by Memory Care Unit door attempting to exit. When CNA intervened, pt [patient] states 'I'm going to slap.' Per CNA, patient poured water on her. CNA notified this nurse. Pt redirected. Call place to SO [significant other]. Pt able to calm down. Sitting next to nurse cart at this time. d. On 9/29/2024 at 1:26 PM, the note documented, Pt wandered out of unit, was stopped by Nurse and Aid and redirected back to memory care. Pt stated that he would like to go outside and is not happy about being here. e. On 10/15/2024 12:30 AM, the note documented, Resident came out of room and went to the memory care doors in attempt to leave, when he realized he could not leave he asked why he could not. Nurse attempted to redirect resident but resident became very agitated and threatened to call the police and went back to his room and slammed his door shut. Resident then preceded to barricade his door from the inside made out of his wheelchair, walker, and a small cardboard box. f. On 10/15/2024 at 6:36 PM, the note documented, RA [resident] agitated and exit seeking this afternoon. Blocked Memory Unit main door. Difficult to redirect. POA [Power of Attorney] on phone unable to redirect. RA appear to calm down when female friend in to visit at About 1720 [5:20 PM]. RA in room resting on recliner chair at this time. g. On 10/16/2024 1:00 AM, the provider note documented, Today patient is being seen for concern for agitation and exit seeking. Nursing staff reported that he has had 2 episodes of agitation over the last two days. Yesterday he became agitated after he was let put of [sic] the memory care unit on accident and was difficult to get him back into his room. A family friend was able to calm him down yesterday. The provider ordered Hydroxyzine for agitation. h. On 10/16/2024 at 4:00 PM, the note documented, Resident pushed his way past the housekeeper when she was trying to exit the unit. Resident became agitated and stated that he was going to leave. Attempted to reassure resident. Resident was sitting in his walker outside the unit and threw himself on the floor and began to try to kick and punch staff. Resident assisted from floor x [times] 6 [staff] and walked back into unit and into room. Resident assessed once he had a chance to calm down. No injuries noted. Will continue to monitor. MD [Medical Doctor] notified. i. On 10/16/2024 at 6:31 PM, the note documented, RA continue to require assistance w/ [with] med administration and ADLs [activities of daily living]. Denies pain. Skin intact. Agitated, combative to staff this pm. Is exit seeking. Difficult to redirect. Family and MD aware. j. On 10/17/2024 at 1:00 AM, the provider note documented, Today patient is being seen for a clarification regarding orders. Patient was seen recently by [provider name omitted]. Nursing staff is unable to locate the hydroxyzine order that was left for them. We will go ahead and do this today. Will begin patient on hydroxyzine 25 mg, will give 1 tablet by mouth every 6 hours as needed for agitation. (continued on next page)		

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	k. On 10/18/2024 at 1:00 AM, the provider note documented, Today patient is being seen for concern for aggression and nursing staff reports that he has had multiple episodes over the last several days. Previously he had episodes of exit seeking. Family friends were able to calm him down previously. He had previously gotten out of the memory care unit and it was difficult to get him back into his room. Previously had a diagnoses of depression but also was placed on Haldol in the past We will place referral for behavioral health. In the meantime we will place the patient on Haldol 5 mg for aggression, may give 5 more milligrams after 1 hour if needed. No documentation could be found of any behavioral health services that were provided to the resident. l. On 10/18/2024 at 3:03 AM, the note documented, Aide alerted nurse that resident was being extremely erratic in the hallway. When nurse walked into memory care unit, resident was slamming on the unit doors very aggressively. Nurse attempted to have resident stop slamming on the door. Resident began yelling at the staff saying 'get me the f*** out of here' and 'open the G** d*** door'. Nurse attempted to explain to the resident that he could not leave he then told nurse 'you're a f***** lying b****'. Nurse and aide attempted to stop resident from hitting door because he stated his hand hurt. Resident then struck nurse in the arm. Nurse and aides then tried to walk him to his room but he started to lower himself to the floor, so with assistance we lowered resident to the floor. While resident was sitting on the floor he reached out and struck the nurse on the hand. Resident lowered himself to where he was lying on the floor. We left resident on the floor to calm down for a few minutes, he continued to yell at staff threatening to 'bloody your noses'. When aide touched residents knee and asked him if he was ready to go back to his room, resident stated 'I'm gonna slap the s*** out of you'. Resident continued to be verbally aggressive towards all 3 staff members that were attempting to help him. When it became evident that he wasn't going to calm down and that he was not safe to stay laying on the floor in front of the memory unit door, we decided to escort him back to his room. During this process the resident slammed his head into the aides head. Resident was put back in his recliner in his room and left to calm down. CNA's sat in chairs in the hallway to continue to monitor him from a distance. When nurse returned to the room to assess resident, he was asleep in his recliner, no injuries were noted to his hands or head. m. On 10/18/2024 at 11:14 AM, the note documented, [Doctor name omitted] seen the resident and ordered Haloperidol 5 mg every bedtime and may add another dose if not effective after an hour of administration. Called his son, [name omitted] and left a message saying about the new order and asked to return call. n. On 10/19/2024 at 6:39 AM, the note documented, Resident is on Hydroxyzine, Risperidone and Haldol and seems helping well with the resident's behavior. He is able to use call light when needed. Will continue monitor resident. o. On 10/20/2024 at 5:43 PM, the note documented, Observed resident w/ [with] increasing anxiety/agitation, PRN [as needed] hydroxyzine administered w/ effective result. No exits seeking this shift. p. On 10/21/2024 at 2:09 AM, the note documented, Observed resident w/ increasing anxiety/agitation, PRN haloperidol administered w/ effective result. No exit seeking this shift. q. On 10/22/2024 at 5:42 PM, the note documented, RA appears anxious and exit seeking. Redirection appears unsuccessful. PRN hydroxyzine administered. Will monitor for effectiveness. (continued on next page)		

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	r. On 10/23/2024 12:01 AM, the note documented, Pt had episode of agitation during med pass. Stating he felt like he is in prison and cant trust any of the staff members. PRN hydroxyzine was not given do to previous dose given two hours before. No further episodes of aggression or agitation. s. On 10/26/2024 at 10:34 PM, the note documented, Pt with exit seeking behavior. Pt sat by the doors until his supper came. After supper, pt would walk around in his room. No other behaviors noted this evening. Received 1 person assist with adl's. t. On 10/27/2024 at 5:25 PM, the note documented, Resident w/ increasing anxiety and exit seeking. Multiple interventions offered, appears unsuccessful. PRN hydroxyzine administered per order and is effective. Pt appears calm. Safety precautions in place. u. On 10/31/2024 9:52 PM, the note documented, Pt is seeking to leave the building on this shift asking staff to take him outside. When offered to go on the back patio he stated he knows that does not go anywhere. Pt then proceed to sit on his wheelchair by the locked door in order to leave. Pt later sat in room for the rest of the night. Pt adhered to medication administration and cares. v. On 10/31/2024 at 10:50 PM, the note documented, Pt stated that he needed to leave. Pt proceed to stand by exit for a period of time waiting for someone to open the door. w. On 11/2/2024 at 10:15 PM, the note documented, Pt verbalized that he wanted to leave the facility and was sitting by the memory care doors this shift. Attempted to redirect with dinner and tv. PRN anxiety medications administered. x. On 11/5/2024 at 11:57 PM, the note documented, Resident was very agitated tonight, banging on the door and yelling stating he needed to get out. He wouldn't let staff leave the unit and got very agitated and aggressive with staff. Resident hit nurse when she tried to exit the unit and walk around him. After about an hour resident went into his room and went to bed. On 10/18/24, resident 65 had a care plan initiated for The resident is/has potential to be physically aggressive r/t [related to] Dementia. Interventions identified on the care plan were to administer medications as ordered and monitor for effectiveness; analyze times of day, places, circumstances, triggers, and what de-escalates behavior and document; assess and anticipate resident's needs; give the resident as many choices as possible; psychiatric/psychogeriatric consult as indicated; On 10/21/24, resident 65 had a care plan initiated for MOOD & BEHAVIOR: [resident 65] has a history for an alteration in mood or exhibition of behavioral symptoms r/t: Alzheimer's/Dementia, Physically Aggressive and Violent Behaviors. Interventions identified on the care plan were to administer medication as ordered, allow time to calm down and approach later, interact in an empathetic and supportive manner, monitor and document each behavioral event, and offer one-to-one interaction as needed. (continued on next page)		

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/2/24, resident 65 had a care plan initiated for The resident has diagnosis/diagnoses of (depression, dementia, history of violent behaviors). Resident requires the use of (psychotropic medications) to help manage this condition. Interventions identified on the care plan were administer psychotropic medications per physician order and monitor for ASE; monitor and document occurrence of target symptoms; psychotropic committee will review medication regimen, ASE, and target symptoms quarterly; and staff should use the following non-pharmacological interventions to manage symptoms (active listening/support/encouragement, validation, reality orientation, re-direction/distraction, and identification and elimination of triggers). It should be noted that the resident had been receiving psychotropic medications since admission on 9/10/24 and the care plan for the psychotropic medications was not initiated until 11/2/24. On 11/04/24 at 3:27 PM, an interview was conducted with CNA 3. CNA 3 stated that resident 65 would forget where he was and attempted to escape a lot. CNA 3 stated that resident 65 thought he did not belong at the facility and he was trying to get home. CNA 3 stated that resident 65 would push on the door and knock on the windows. On 11/04/24 at 3:30 PM, an interview was conducted with Licensed Practical Nurse (LPN) 3. LPN 3 stated that resident 65 had behaviors of exit seeking and was aggressive. LPN 3 stated that resident 65 would block the door so no one could enter or exit, he would push staff, and yells at staff. LPN 3 stated that when she noticed his anxiety was increasing she gave Hydroxyzine. LPN 3 stated that resident 65 had a PRN order for Haldol for anxiety and aggression. LPN 3 stated that resident 65 had only needed that medication a couple of times. LPN 3 stated that when resident 65 focused on leaving they attempted to re-direct him. LPN 3 stated that some days he was not able to be re-directed. LPN 3 stated that on those days they tried to contact his son or girlfriend. LPN 3 stated that resident 65 received Risperidone for depression and dementia and that he had a diagnoses of behavioral disturbance. LPN 3 stated that resident 65 did not have a diagnosis of schizophrenia, or bipolar disorder, just dementia with violent behaviors. LPN 3 stated one time resident 65 became really aggressive. They had a new housekeeper that let him out of the locked unit and it was hard to bring him back into the unit. On 11/05/24 at 1:27 PM, an interview was conducted with CNA 5. CNA 5 stated that she completed dementia training in October 2024. CNA 5 stated that all she recalled from her dementia training was to re-direct the resident when behaviors occurred. CNA 5 stated that she sometimes ignored residents with behaviors and if they became more agitated would tell them to go lie down. CNA 5 was not able to identify any other resident specific interventions for behaviors of agitation, aggression or verbal outbursts. (continued on next page)		

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/06/24 at 8:55 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that resident 65's psychotropic medication should have monitoring for behaviors and adverse side effects. The DON stated that any non-pharmacological interventions were listed in the resident care plan and should address de-escalation techniques. The DON stated that they conducted staff training for de-escalation techniques for each resident upon admission. The DON stated that they conducted a psychotropic meeting monthly to see how the resident trends and any PRN medication usage. The DON stated that typically they did not administer antipsychotics for dementia, but it would depend on each resident's case. The DON stated that she would like to have a list of interventions that were attempted to manage behaviors prior to medication management. The DON stated that those non-pharmacological interventions should also be documented in the resident progress notes. The DON stated that for resident 65 if the staff called his son or girlfriend they were good at calming him down. The DON stated that typically PRN antipsychotics were only ordered for 14 days. The DON stated that to justify the extended use of the PRN antipsychotics they had a form that was filled out by the MD. The DON stated that they conducted a monthly psychotropic review and they just reviewed resident 65 in October. The DON stated that she had not filled out any of the paperwork for resident 65's October review yet. On 11/06/24 at 11:59 AM, an interview was conducted with CNA 6. CNA 6 stated that he had been employed at the facility for a year and had not received dementia training from the facility. CNA 6 stated that the training that was provided to him upon hire was on each resident care needs and how to use a mechanical lift. CNA 6 stated that he also completed some computer based training. On 11/06/24 at 1:59 PM, an interview was conducted with CNA 3. CNA 3 stated that she had not received dementia training from the facility. CNA 3 stated that the training she did receive was to shadow another employee when she was first hired and that orientation period was two weeks. CNA 3 stated that resident 65 had behaviors of exit seeking. CNA 3 stated that resident 65 would sit by the door, yell at staff, and would grab staff if they came too close. CNA 3 stated that resident 65 had struck out at her, hit her, and yelled at her in the past. CNA 3 stated that she gave resident 65 space to calm down, and when he was really paranoid they let him talk to his girlfriend. CNA 3 was not able to identify any other resident specific interventions for behaviors of agitation, aggression or verbal outbursts for resident 65. On 11/07/24 at 12:13 PM, an interview was conducted with the Resident Advocate. The Resident Advocate stated that resident 65 had end stage dementia induced aggression and was exit seeking. The Resident Advocate stated that staff should approach resident 65 from the front, use calm tones when speaking, explain what they were doing, validate what he was feeling in the moment, and let him know that he was safe. The Resident Advocate also stated that he would get down on resident 65's eye level and not tower over him. The Resident Advocate stated that whenever he had other staff with him he would communicate what he was doing to them and why. The Resident Advocate stated that he never conducted any formal training with staff on dementia care, de-escalation techniques or how to handle resident 65's behaviors. On 11/12/24 at 1:46 PM, a follow-up interview was conducted with the DON. The DON stated that the CNA Supervisors were in charge of training but that they were newly hired as coordinators in September. The DON stated that they had computer based training modules that were required and included dementia training. The DON stated that they also conducted in-service training for staff. The DON stated that the Activities Director was certified in dementia care and had conducted some dementia training for all staff. (continued on next page)		

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/4/24, the facility conducted dementia training for all staff. An Agenda and attendance roster was provided. It should be noted that CNA 3 and CNA 5 were not in attendance of the training. On 11/13/24 at 9:02 AM, a follow-up interview was conducted with the DON and included the Regional Nurse Consultant (RNC)1. The RNC 1 stated that they were not currently using the Kardex system that would link the care plan interventions for the CNAs to view. The DON stated that they had a CNA report sheet that they utilized and it contained resident specific information. The DON stated that the information was updated on a google sheet and all staff had access to update it. The DON stated that it was a collective effort to make sure the information was accurate but was supervised by the CNA Coordinator. A copy of the CNA report sheet was viewed with the DON. The report sheet was not filled in with resident names or any resident specific information. The DON stated that she would look into how the care plan interventions and resident specific care was communicated to the aides.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30563 Based on interview and record review it was determined, for 1 of 65 sampled residents, that the facility did not provide pharmaceutical services which included procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biological's to meet the needs of each resident. Specifically, Darbepoetin Alfa injection for anemia was not available from the pharmacy for administration and laboratory values were abnormal. Additional medications were not available for administration. Resident identifier: 55. Findings included: Resident 55 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Parkinson's disease with dyskinesia, chronic obstructive pulmonary disease, type 2 diabetes mellitus, and anemia. On 11/12/24 at 10:26 AM, an interview was conducted with resident 55. Resident 55 stated he had not been administered an injection and had not been told why he had not received it. Resident 55's medical record was reviewed from 11/3/24 through 11/13/24. a. A physician's order dated 9/14/24 and discontinued on 10/13/24 revealed Darbepoetin Alfa Injection Solution 40 MCG [microgram] / [per] ML [milliliter]. Inject 1 ml subcutaneously one time a day every Sun [Sunday] for anemia. According to the October 2024 Medication Administration Record (MAR) Darbepoetin Alfa was not administered on 10/6/24 with the code held- see progress note. On 10/13/24, there was no documentation the medication was administered. An Orders - Administration progress note dated 10/6/24 at 12:05 PM revealed, waiting for pharmacist delivery. There were no progress notes for 10/13/24. A physician's order dated 10/13/24 Darbepoetin Alfa Injection Solution 40 MCG/ML. Inject 1 ml subcutaneously one time a day every Tues [Tuesday], Sun for anemia. According the the October 2024 MAR resident 55 was not administered the injection on 10/15/24, 10/20/24, 10/22/24 and 10/29/24. The November 2024 MAR Darbepoetin was not administered on 11/3/24, 11/5/24, 11/10/24 and 11/12/24. An order - Administration progress note dated 10/20/24 at 3:03 PM revealed Weighting [sic] on pharmacy. An order - Administration progress note dated 10/22/24 at 7:39 PM revealed Will verify delivery from pharmacy. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An order - Administration progress note dated 10/29/24 at 2:13 PM revealed Awaiting PA [prior authorization] from insurance. An order - Administration progress note dated 11/3/24 at 12:50 PM revealed waiting for pharmacist delivery. An order - Administration progress note dated 11/5/24 at 2:06 PM revealed waiting for pharmacist delivery. An order - Administration progress note dated 11/10/24 at 11:31 AM revealed weighting [sic] on pharmacy. There were no progress note regarding the medication not administered on 11/12/24. b. A physician's order dated 9/25/24 revealed Valbenazine Tosylate Oral Capsule 80 MG [milligrams]. Give 1 capsule by mouth at bedtime for Tardive dyskinesia. Needs to go through [name removed] pharmacy. According to the October 2024 MAR Valbenazine Tosylate was not administered on 10/4/24 through 10/9/24, 10/14/24 and 10/22/24. An order - Administration progress note dated 10/4/24 at 7:03 PM revealed Waiting for order too [sic] come. An order - Administration progress note dated 10/5/24 at 8:15 PM revealed, need insurance approval. An order - Administration progress note dated 10/6/24 at 6:58 PM revealed waiting for insurance approval. An order - Administration progress note dated 10/7/24 at 7:27 PM revealed Waiting for approval from insurance. An order - Administration progress note dated 10/8/24 at 6:54 PM revealed unavailable. An order - Administration progress note dated 10/9/24 at 7:09 PM had no information why the medication was not administered. An order - Administration progress note dated 10/14/24 at 11:45 PM revealed out of stock. An order - Administration progress note dated 10/22/24 at 7:39 PM revealed waiting for delivery. According to the November 2024 MAR Valbenazine was not administered 11/5/24, 11/6/24 and 11/7/24. An order -Administration progress note dated 11/5/24 at 8:16 PM revealed Waiting for pharmacy delivery. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An order - Administration progress note dated 11/6/24 at 7:08 PM revealed out of stock. Pharmacy will be called 11/7 for restock. An alert charting progress note dated 11/7/24 at 9:17 AM revealed Called [name removed] pharmacy but just able to leave a message regarding Valbenazine Tosylate 80 mg.for [sic] this resident requested delivery and asked to call if there is a problem delivering it. Laboratory results of a Complete Blood Count (CBC) for resident 55 dated 9/23/24 revealed a Red blood cells (RBC) 3.62 was low with a reference range on 4.5 - 5.9 M/uL (million red blood cells per microliter), Hemoglobin (hgb) level of 11.9 which was low with a reference range of 13.5 - 17.5 g/dL (grams per deciliter), Hematocrit (HCT) level was 36.8 which was low with a reference range of 41.0 - 53.0 percent (%). Resident 55's mean corpuscular volume (MCV) was 101.7 which was high with a reference range of 80.0 - 100.0 fL (femtoliters). A physician's encounter note dated 9/25/24 at 1:00 AM revealed, .CBC RBC 3.62 Hemoglobin 11.9 Hematocrit 36.8 MCV [Mean Corpuscular Volume] 36.8 RDW [red cell distribution width] . Diagnosis, Assessment and Plan. Anemia, unspecified Folic acid 1 mg, give 1 tablet by mouth once daily. Darbepoetin alpha injection solution 40 mcg/mL, inject 0.4 mg subcutaneously every Friday. Cyanocobalamin oral tablet 1000 mcg, give 1 tablet by mouth once daily. We will obtain routine lab work every 6 months to monitor this. A physician's encounter note dated 10/15/24 at 1:00 AM, .Chief Complaint / Nature of Presenting Problem: Lab review.CBC RBC 3.61 Hemoglobin 11.9 Hematocrit 37.3 MCV 103.3 MCHC [Mean corpuscular hemoglobin concentration] 31.9 RDW SD [actual measurement of the width of the red cell distribution curve in femtoliters] 48.6.Anemia, unspecified Folic acid 1 mg, give 1 tablet by mouth twice daily. Darbepoetin alpha injection solution 40 mcg/mL, inject 0.4 mg subcutaneously every Friday. Cyanocobalamin oral tablet 1000 mcg, give 1 tablet by mouth twice daily. We will obtain routine lab work every 6 months to monitor this. Continue plan of care as outlined. Today we discussed the plan with the patient and nurse. All questions answered. Patient states understanding and agrees to plan. Reviewed vital signs and medication list today. Continue medications as ordered. It should be noted there was a new physician's order dated 10/13/24 for Darbepoetin Alfa Injection Solution 40 MCG/ML to be administered twice weekly on Tuesday and Sunday not once weekly as noted in the physician's encounter note. Laboratory results for resident 55 dated 11/4/24 revealed RBC was 2.95 which was low, hgb was 10.0 which was low, HCT was 30.2 which was low and MCV was 102.4 which was high. The reference values were the same as above. There was no physician's encounter note after the laboratory results were obtained on 11/4/24. On 11/12/24 at 10:43 AM, an interview was conducted with Licensed Practical Nurse (LPN) 3. LPN 3 stated she had not administered Darbepoetin Alfa because it might be in the fridge and nurses did not know it was in there. LPN 3 stated the medication might also need a preauthorization or a physician's approval. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/12/24 at 1:38 PM, an interview was conducted with the Director of Nursing (DON). The DON stated the process for obtaining medications from the pharmacy depended on the medication. The DON stated if the medication was a narcotic, then the nurse faxed the order to the pharmacy and then the pharmacy delivered daily except for Sunday night to the facility. The DON stated she was not sure why resident 55's Valbenazine and Darbepoetin Alfa were not available for administration. The DON stated she would have to look into why resident 55 was not receiving his medications as ordered. It should be noted the DON did not provide additional information. (Cross Refer to F775)		

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NAME OF PROVIDER OR SUPPLIER Bella Terra St George		STREET ADDRESS, CITY, STATE, ZIP CODE 178 South 1200 East St George, UT 84790	
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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 50200 Based on interview and record review, it was determined for 5 out of 65 sampled residents, that the facility did not ensure that a resident who used psychotropic drugs was not given these drugs unless the medication was necessary to treat a specific condition as diagnosed and documented in the clinical record. Further, as needed (PRN) orders for psychotropic drugs are limited to 14 days, unless the attending physician or prescribing practitioner believes that it was appropriate for the PRN order to be extended beyond 14 days, and should document their rationale in the resident's medical record and indicate the duration for the PRN order. Specifically, a resident was prescribed an antipsychotic without a supporting diagnosis and no gradual dose reduction was initiated. In addition, residents were given PRN psychotropic medications beyond 14 days, a resident was not monitored for adverse side effects to the psychotropic medication, behaviors were not monitored, and non-pharmacological interventions prior to the medication administration were not initiated. Resident identifiers: 13, 46, 54, 65, 270. Findings included: 1. Resident 54 was admitted to the facility on [DATE] with diagnoses which included, but not limited to, diffuse traumatic brain injury (TBI) with loss of consciousness, unspecified ataxia, adjustment disorder with mixed disturbance of emotions and conduct, unspecified depression, and cognitive communication deficit. On 11/4/24, resident 54's medical record was reviewed. A review of resident 54's physician's orders dated 5/1/24, revealed that resident 54 was to receive Fanapt 8 milligrams (mg) twice daily (BID) for Adjustment disorder. A review of resident 54's care plan revealed the following: a. Focus: The resident uses psychotropic medications (Fanapt) r/t [related to] adjustment disorder. Date initiated: 5/14/24 Revision on: 5/14/24 b. Interventions: Administer PSYCHOTROPIC medications as ordered by physician. Monitor for side effects and effectiveness Q [every]-shift. Date initiated: 5/14/24 Monitor/document/report PRN [as needed] any adverse reactions of PSYCHOTROPIC medications: unsteady gait, tardive dyskinesia, EPS [extra pyramidal symptoms] (shuffling gate, 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 [sic], vomiting, behavior symptoms not usual to the person. Date initiated: 5/14/24 (continued on next page)		

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Monitor/record occurrence of for target behavior symptoms (pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others. etc) and document per facility protocol. Date initiated: 5/14/24 Revision on: 5/14/24 A review of resident 54's behavior monitoring record revealed the following: a. June 2024- no behavior symptoms had been documented b. July 2024- no behavior symptoms had been documented c. August 2024- no behavior symptoms had been documented d. September 2024- behavior symptoms documented on 9/11/24 e. October 2024- behavior symptoms documented on 10/3/24, 10/10/24, 10/14/24, 10/15/24, 10/16/24, 10/22/24, 10/23/24, 10/24/24, 10/25/24, 10/27/24, 10/28/24, 10/29/24, 10/30/24 On 10/30/24 at 1:00 AM, a provider progress note documented the following, .The patient has been on fanapt for adjustment disorder, but this is not an appropriate indication for this medication. We will begin tapering down on this and observe the patient closely. Decrease to 4mg [sic] BID with plans to continue the taper until it is DC'd [discontinued]. May consider alternative medications more appropriate for his dx [diagnosis] in the future if needed. On 11/12/24 at 10:16 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that residents on psychotropic medications were reviewed on the last Wednesday of every month. The DON stated that psychotropic meetings were attended by the DON, Medical Director, behavioral health medical director, MDS (Minimum Data Set) Coordinator, Resident Advocate, and pharmacist. The DON stated that the medical doctor prescribed psychotropic medications. The DON stated that if a medication needed to be changed the orders would be placed in the computer by the MDS Coordinator or the DON depending on what the tapering process was. The DON stated the resident would be monitored for any changes when a medication was being tapered. The DON stated she was unsure if the taper for resident 54 was ordered. On 11/13/24 at 9:52 AM, an interview was conducted with the DON. The DON stated that resident 54's Fanapt was a medication that they were going to taper, but the facility medical director was not the prescriber for Fanapt. The DON stated she was going to reach out to the prescribing medical provider but had not yet. The DON stated that she should have done this the same day as the psychotropic meeting. The DON stated she should have written a progress note regarding this information. 38031 2. Resident 65 was admitted to the facility on [DATE] with diagnoses which included dementia, seizures, hypothyroidism, obstructive sleep apnea, depression, presence of a cardiac pacemaker, and violent behaviors. On 11/03/24 at 3:56 PM, an observation was made of resident 65 sleeping in a recliner in his room. The resident's call light was observed on the arm rest within reach and a walker was located near the door. (continued on next page)		

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 65's electronic medical records were reviewed. On 9/17/24, resident 65's MDS Assessment documented a Brief Interview for Mental Status (BIMS) score of 4/15, which would indicate a severe cognitive impairment. The assessment documented a PHQ-9 (patient health questionnaire) mood score of 7 which would indicate a mild depression severity. The assessment documented that physical or verbal behavioral symptoms were not exhibited. Resident 65's physician orders revealed: a. On 10/18/24, an order was initiated for Haloperidol Tablet 5 milligram, give 1 tablet by mouth every 1 hours as needed for agitation at bedtime, if still showing agitation after one hour give another 5 mg tablet. b. On 10/18/24, an order was initiated for Haloperidol Tablet 5 mg, give 1 tablet by mouth every 22 hours as needed for agitation at bedtime, if still showing agitation after one hour give another 5 mg tablet. c. On 10/17/24, an order was initiated for Hydroxyzine Tablet 25 mg, give 1 tablet by mouth every 6 hours as needed for anxiety. d. On 9/10/24, an order was initiated for Sertraline Tablet 100 mg, give 1 tablet by mouth two times a day for depression. d. On 9/10/24, an order was initiated for Risperidone Tablet 0.5 mg, give 1 tablet by mouth two times a day for dementia/depression. Resident 65's September Medication Administration Record (MAR) was reviewed and revealed no documentation for monitoring of behaviors, adverse side effects (ASE) or non-pharmacological interventions for the Risperidone and Sertraline medications. Resident 65's October MAR documented the following: a. The Haloperidol PRN order was administered on 10/20/24 at 7:45 PM for agitation and was documented as effective. b. The Hydroxyzine PRN order was administered on 10/18/24 at 8:17 AM, on 10/19/24 at 8:49 AM, on 10/20/24 at 3:24 PM, on 10/22/24 at 4:31 PM, on 10/26/24 at 1:45 PM, and on 10/27/24 at 3:39 PM for anxiety and all were documented as effective. c. The behavior monitoring for number of episodes of agitation every shift documented a total of 29 episodes for the month. d. The behavior monitoring for number of verbal outbursts every shift documented a total of 23 episodes for the month. e. The behavior monitoring for number of verbalizations of sadness documented a total of 2 episodes for the month. (continued on next page)		

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	It should be noted that no documentation was found of non-pharmacological interventions that were provided to resident 65 in response to his episodes of behavior for October 2024. Additionally, no documentation was found of monitoring for adverse side effects of the psychotropic medications. Resident 65's November MAR documented the following: a. The Haloperidol PRN order was administered on 11/2/24 at 6:30 PM for agitation and was documented as effective. It should be noted that behavior monitoring for episodes of agitation or verbal outburst did not document any episodes on 11/2/24 at the time the medication was administered. b. The Hydroxyzine PRN order was administered on 11/2/24 at 6:31 PM for anxiety and was documented as effective. It should be noted that behavior monitoring for episodes of agitation or verbal outburst did not document any episodes on 11/2/24 at the time the medication was administered. c. The behavior monitoring for number of episodes of agitation every shift documented a total of 3 episodes for the month. d. The behavior monitoring for number of verbal outbursts every shift documented a total of 3 episodes for the month. e. The behavior monitoring for number of verbalizations of sadness documented no episodes for the month. It should be noted that no documentation was found of non-pharmacological interventions that were provided to resident 65 in response to his episodes of behavior for November 2024. On 10/18/24, resident 65 had a care plan initiated for The resident is/has potential to be physically aggressive r/t Dementia. Interventions identified on the care plan were to administer medications as ordered and monitor for effectiveness; analyze times of day, places, circumstances, triggers, and what de-escalates behavior and document; assess and anticipate resident's needs; give the resident as many choices as possible; psychiatric/psychogeriatric consult as indicated; On 10/21/24, resident 65 had a care plan initiated for MOOD & BEHAVIOR: [resident 65] has a history for an alteration in mood or exhibition of behavioral symptoms r/t: Alzheimer's/Dementia, Physically Aggressive and Violent Behaviors. Interventions identified on the care plan were to administer medication as ordered, allow time to calm down and approach later, interact in an empathetic and supportive manner, monitor and document each behavioral event, and offer one-to-one interaction as needed. (continued on next page)		

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/2/24, resident 65 had a care plan initiated for The resident has diagnosis/diagnoses of (depression, dementia, history of violent behaviors). Resident requires the use of (psychotropic medications) to help manage this condition. Interventions identified on the care plan were administer psychotropic medications per physician order and monitor for ASE; monitor and document occurrence of target symptoms; psychotropic committee will review medication regimen, ASE, and target symptoms quarterly; and staff should use the following non-pharmacological interventions to manage symptoms (active listening/support/encouragement, validation, reality orientation, re-direction/distraction, and identification and elimination of triggers). It should be noted that the resident had been receiving psychotropic medications since admission on 9/10/24 and the care plan for the psychotropic medications was not initiated until 11/2/24. On 11/04/24 at 3:30 PM, an interview was conducted with Licensed Practical Nurse (LPN) 3. LPN 3 stated that resident 65 had behaviors of exit seeking and was aggressive. LPN 3 stated that resident 65 would block the door so no one could enter or exit, he would push staff, and yells at staff. LPN 3 stated that when she noticed his anxiety was increasing she gave Hydroxyzine. LPN 3 stated that resident 65 had a PRN order for Haldol for anxiety and aggression. LPN 3 stated that resident 65 had only needed that medication a couple of times. LPN 3 stated that when resident 65 focused on leaving they attempted to re-direct him. LPN 3 stated that some days he was not able to be re-directed. LPN 3 stated that on those days they tried to contact his son or girlfriend. LPN 3 stated that resident 65 received Risperidone for depression and dementia and that he had a diagnoses of behavioral disturbance. LPN 3 stated that resident 65 did not have a diagnosis of schizophrenia, or bipolar disorder, just dementia with violent behaviors. LPN 3 stated one time resident 65 became really aggressive. They had a new housekeeper that let him out of the locked unit and it was hard to bring him back into the unit. On 11/06/24 at 8:55 AM, an interview was conducted with the DON. The DON stated that resident 65's psychotropic medication should have monitoring for behaviors and adverse side effects. The DON stated that any non-pharmacological interventions were listed in the resident care plan and should address de-escalation techniques. The DON stated that they conducted staff training for de-escalation techniques for each resident upon admission. The DON stated that they conducted a psychotropic meeting monthly to see how the resident trends and any PRN medication usage. The DON stated that Haldol and Risperidone were indicated for the treatment of Schizophrenia, Tourette's and Parkinson's Disease. The DON stated that typically they did not administer antipsychotics for dementia, but it would depend on each resident's case. The DON stated that she would like to have a list of interventions that were attempted to manage behaviors prior to medication management. The DON stated that those non-pharmacological interventions should also be documented in the resident progress notes. The DON stated that for resident 65 if the staff called his son or girlfriend, they were good at calming him down. The DON stated that typically PRN antipsychotics were only ordered for 14 days. The DON stated that to justify the extended use of the PRN antipsychotics they had a form that was filled out by the MD. The DON stated that they conducted a monthly psychotropic review, and they just reviewed resident 65 in October. The DON stated that she had not filled out any of the paperwork for resident 65's October review yet. On 11/06/24 at 3:42 PM, a follow-up interview was conducted with the DON. The DON stated that she did not have a physician rationale, re-evaluation for the continued use of, or duration of use for the PRN order for the antipsychotic medication that exceeded 14 days. The DON stated that she would reach out to the physician. (continued on next page)		

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/06/24 at approximately 5:00 PM, an interview was conducted with the DON. The DON stated that she spoke to resident 65's provider and was informed that the provider prescribed the antipsychotic medication because the resident had requested them. No additional documentation was provided for the PRN Haldol order that exceeded 14 days. [Cross-refer F744] 3. Resident 270 was admitted to the facility on 10//14/24 and readmitted on [DATE] with diagnoses which consisted of metabolic encephalopathy, paranoid schizophrenia, and generalized anxiety disorder. On 11/03/24 at 3:44 PM, an observation was made of resident 270 pacing the hallway on the phone. The resident was heard asking someone on the phone to bring him more cigarettes. The resident asked the nurse if he had anymore cigarettes and the nurse responded that he had smoked his last one during the last smoke break. Resident 270's electronic medical records were reviewed. On 10/20/24, resident 270's Admission MDS Assessment documented a BIMS score of 14/15 which would indicate that the resident was cognitively intact. The assessment documented that physical or verbal behavioral symptoms were not exhibited. Resident 270's physician orders revealed the following: a. On 10/15/24, an order was initiated for Risperidone Tablet 0.5 mg, give 1 tablet by mouth one time a day for Health Maintenance Daily before breakfast. b. On 10/21/24, an order was initiated for Risperidone Tablet 2 mg, give 1 tablet by mouth at bedtime for Schizophrenia. c. On 10/15/24, an order was initiated for Buspirone Tablet 30 mg, give 1 tablet by mouth three times a day for Health Maintenance. No documentation could be found of monitoring for episodes of behavior, ASE, or non-pharmacological interventions for the Risperidone or Buspirone medications. On 11/2/24, resident 270 had a care plan initiated for Has a Level II PASRR [Pre-Admission Screening and Resident Review] due to their diagnosis of Paranoid Schizophrenia and Alcohol Dependence. Interventions identified on the care plan were to administer medications as ordered and monitor for adverse effects. On 11/05/24 at 1:27 PM, an interview was conducted with Certified Nurse Aide (CNA) 5. CNA 5 stated that resident 270's behaviors were banging on the door, and he was agitated today. CNA 5 stated that resident 270 wanted to go outside to smoke right now. CNA 5 stated that she took him out 10 minutes early because he was agitated and was going to scream at her. CNA 5 stated that nothing calmed resident 270 down. CNA 5 stated that she sometimes ignored residents with behaviors and if they became more agitated would tell them to go lie down. CNA 5 was not able to identify any other resident specific interventions for behaviors of agitation, aggression or verbal outbursts. (continued on next page)		

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/06/24 at 8:35 AM, an interview was conducted with LPN 3. LPN 3 stated that resident 270's behaviors were restlessness related to smoking, and he became agitated. LPN 3 stated she would remind the resident of the smoking times, but he forgets. LPN 3 stated that resident 270 did not fidget about anything else, and when he returned from smoking he was fine. On 11/06/24 at 11:45 AM, a follow-up interview was conducted with LPN 3. LPN 3 stated that she documented resident 270's agitation in a progress note. LPN 3 stated that she did not have documented episodes of behaviors or monitoring for ASE of Risperidone or Buspirone in the Treatment Administration Record (TAR). LPN 3 stated that there should be monitoring on resident 270 in the TAR for this. 43212 4. Resident 13 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included Hereditary and idiopathic neuropathy, chronic respiratory failure, symptomatic epilepsy and epileptic syndromes with simple partial seizures, morbid obesity, hypertensive heart and chronic kidney disease with heart failure, muscle weakness, major depressive disorder, and chronic pain. Resident 13's medical records were reviewed between 11/3/24 and 11/13/24. Physician orders included: a. Hydroxyzine HCL [hydrochloride] oral tablet 10 MG (Hydroxyzine HCL); Give 1 tablet by mouth every 8 hours as needed for anxiety. Order date: 7-11-24. b. Behavior Monitoring: # of anxious statements Q shift. On 7/12/24 at 1:00 AM, a provider encounter progress note revealed, .Today patient is in need of a refill on her Hydroxyzine 10 mg. She is taking this for anxiety. Patient does see psychiatry and is being well-managed. She does report good results with this medication and that her anxiety is under control .They are happy with the current dosage and frequency . Care plan included: a. Focus area: Psychotropic medications use r/t depression and anxiety. Date initiated: 10/12/22, Revision: 10/12/22. The goal was, The resident 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. Date initiated: 10/12/22, Revision 4/12/24, Target date: 2/7/25. Interventions included, Administer PSYCHOTROPIC medications as ordered by physician. Monitor for side effects and effectiveness Q-SHIFT. Date initiated: 10/12/22; Consult with pharmacy, MD [medical doctor] to consider dosage reduction when clinically appropriately at least quarterly. Date initiated: 10/12/22; Discuss with MD, family re [regarding] ongoing need for use of medication. Review behaviors/interventions and alternate therapies attempted and their effectiveness as per facility policy. Date initiated: 10/12/22; Monitor/document/report PRN any adverse reactions of PSYCHOTROPIC medications: unsteady gait, tardive dyskinesia, EPS (shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideation, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps nausea, vomiting, behavior symptoms not usual to the person. Date initiated: 10/12/22. (continued on next page)		

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reviewed MAR and TAR: a. July 2024 MAR revealed Hydroxyzine HCL oral tablet 10 mg was started on 7/11/24 with no discontinue date and provided PRN. b. August 2024 MAR revealed Hydroxyzine was provided PRN throughout the month with no discontinue date. c. September 2024 MAR revealed Hydroxyzine was provided PRN throughout the month with no discontinue date. d. October 2024 MAR revealed Hydroxyzine was provided PRN throughout the month with no discontinue date. e. November 2024 MAR revealed Hydroxyzine was provided PRN, as of 11/4/24, with no discontinue date. Reviewed the Pharmacist Consultation documents for 7/24, 8/24, 9/24, 10/24 and 11/24. No concerns or recommendations were noted related to the length of the Hydroxyzine prescription. On 11/7/24 at 9:22 AM, an interview was conducted with LPN 4 who stated resident 13 was taking Hydroxyzine for anxiety. LPN 4 stated resident 13 was taking morphine, oxycodone and Lyrica for pain and that it was prescribed by the pain clinic. LPN 4 stated the pain clinic was trying to adjust her medications due to her being on too many medications. On 11/12/24 at 3:47 PM, an interview was conducted with the DON who stated PRN psychotropic medications needed to be ordered for 14 days. No rationale for extended use was provided. 48709 5. Resident 46 was admitted to the facility on [DATE] with diagnoses which included hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, muscle weakness, aphasia, cognitive communication deficit, chronic obstructive pulmonary disease with acute exacerbation, lack of coordination, acute kidney failure, major depressive disorder, and anxiety. Resident 46's medical record was reviewed 11/3/24 through 11/13/24. A Physician's Order, dated 6/27/24 at 4:00 PM, indicated, Clonazepam Oral Tablet 0.5 MG (Clonazepam) *Controlled Drug* Give 0.25 mg by mouth every 12 hours as needed for Anxiety until 8/31/2024 at 23:59 [11:59 PM]. A MAR, dated 7/2024, indicated the ordered clonazepam oral tablet 0.5 mg (Clonazepam) Give 0.25 mg by mouth every 12 hours as needed for anxiety was given as needed at least once every day in July and twice a day on 7/2/24, 7/4/24, 7/8/24, 7/11/24, 7/16/24, 7/18/24, 7/21/24, 7/23/24, 7/25/24, 7/26/24, 7/30/24, and 7/31/24. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A MAR, dated 8/2024, indicated the ordered clonazepam oral tablet 0.5 mg (Clonazepam) Give 0.25 mg by mouth every 12 hours as needed for anxiety was given as needed once a day from 8/1/24 through 8/5/24, and twice on 8/3/24. On 11/12/24 at 3:47 PM, an interview was conducted with the DON. The DON stated the PRN Ativan order needed to be ordered for a 14-day period. No rationale for an extension beyond 14 days was provided.		

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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** 38031 Based on interview and record review it was determined, for 2 of 65 sampled residents, that the facility did not provide or obtain laboratory services timely to meet the needs of its residents. Specifically, a resident's urinalysis (UA) with culture and sensitivity (C & S) was not followed up on timely resulting in a delay of treatment and another resident did not have weekly labs completed for an ordered Complete Blood Count (CBC) and a Comprehensive Metabolic Panel (CMP). Resident identifiers: 1 and 55. Findings included: 1. Resident 1 was admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses which included but were not limited to hypospadias, retention of urine, chronic kidney disease, pyelonephritis, extended spectrum beta lactamase resistance, obstructive and reflux uropathy, and methicillin resistant staphylococcus aureus infection classified elsewhere. On 11/4/24 at 9:07 AM, an observation was made of resident 1's room. A sign was posted outside of resident 1's room for enhanced barrier precautions (EBP) and a personal protective equipment (PPE) cart was located outside the door. The cart contained gowns and gloves. On 11/4/24 at 9:22 AM, an interview was conducted with Licensed Practical Nurse (LPN) 3. LPN 3 stated that resident 1 was on EBP for a suprapubic (SP) catheter and had an ongoing extended-spectrum beta-lactamase (ESBL) infection. LPN 3 stated that they obtained a urinalysis (UA) this past weekend for resident 1 and that the resident always had a urinary tract infection (UTI). LPN 3 stated that they pushed fluids but sometimes resident 1 was non-compliant with care. Resident 1's electronic medical records were reviewed. Resident 1's physician orders revealed the following: a. On 10/31/24, an order was initiated for a UA with C & S for uremia. b. On 10/31/24, an order was initiated for a swab of the purulent drainage on the suprapubic area for possible urine infection. Resident 1's November Medication Administration Record (MAR) revealed the following: a. On 11/7/24 at 3:06 PM, an order was initiated for Ertapenem Sodium Injection Solution Reconstituted 1 gram (gr), inject 1 gram intramuscularly one time a day for 10 days related to a local infection of the skin. b. On 11/7/24 at 2:24 PM, an order was initiated for Penicillin V Potassium Oral Tablet 500 milligrams (mg), give 1 tablet by mouth three times a day for 10 days for infection of suprapubic site. Resident 1's progress notes 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 10/31/2024 at 6:25 PM, the note documented, Resident has a foul smelling drainage from his suprapubic catheter site and his [sic] blood in urine and reported to PCP [primary care provider] via telephone and [doctor's name omitted] ordered a UA and purulent drainage swab test. PCC updated b. On 11/6/2024 at 5:10 PM, the note documented that the culture and sensitivity report was sent to the PA and they were awaiting orders. On 11/1/24, resident 1's suprapubic site culture documented the organisms identified as Staphylococcus aureus Methicillin Sensitive, Escherichia coli ESBL (extended beta-lactamase) producer, Proteus Mirabilis, and Klebsiella pneumoniae ESBL producer. The susceptibility report for the suprapubic site documented that the Staphylococcus was resistant to Penicillin; the Escherichia coli was susceptible to Ertapenem; and the Klebsiella was susceptible to the Ertapenem. The laboratory results had a handwritten note that it was reviewed by the provider on 11/7/24 and Ertapenem 1 gram (gr) daily for 10 days was ordered. It should be noted that the laboratory results were faxed to the facility on [DATE]. Additionally, the laboratory results were obtained from the provider binder and were not located in resident 1's electronic medical records. On 11/1/24, resident 1's urine culture documented the organisms identified as Proteus Mirabilis and Escherichia coli. The susceptibility report for the urine culture documented that the Proteus Mirabilis and Escherichia coli were susceptible to Ertapenem. The result was documented as reviewed by the provider on 11/7/24 and ordered Ertapenem 1 gr daily for 10 days. It should be noted that the laboratory results were faxed to the facility on [DATE]. Additionally, the laboratory results were obtained from the provider binder and were not located in resident 1's electronic medical records. On 11/7/24 at 8:45 AM, an interview was conducted with Registered Nurse (RN) 2. RN 2 stated that she needed to call the lab to see if they had the urine C & S results back for resident 1. On 11/07/24 at 9:11 AM, an interview was conducted with RN 2. RN 2 stated that she received the culture results and placed them in the doctor notification book. RN 2 stated that the doctors were always in the building. RN 2 stated that the Physician Assistant (PA) or Nurse Practitioner (NP) were at the facility Monday through Friday and they could review the laboratory results when they arrived. RN 2 stated that resident 1's urine culture grew out Escherichia coli. RN 2 stated that the laboratory usually faxed the results to the facility but lately they were not doing that. RN 2 stated that the urine cultures usually took 3 days to grow out any organisms. RN 2 stated that resident 1's SP site was draining and had a foul odor, and the urine had blood in it so the provider ordered a UA. It should be noted that the labs were ordered on 10/31/24 and the results were obtained on 11/7/24. [Cross-refer F690] 30563 2. Resident 55 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Parkinson's disease with dyskinesia, chronic obstructive pulmonary disease, type 2 diabetes mellitus, and anemia. Resident 55's medical record was reviewed 11/3/24 through 11/13/24. (continued on next page)		

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician's order dated 6/27/24 revealed weekly CMP/CBC for monitoring of kidney function. One time a day every Monday for monitoring. Another physician's progress note dated 5/1/24 revealed routine labs to draw a CBC, CMP, HBA1c (hemoglobin A1c) every 6 months starting on the 25th for 3 days for routine labs. Laboratory values in resident 55's medical record were the following: a. A CBC and CMP completed on 11/4/24. b. A CBC and CMP completed on 9/24/24. c. A CBC and CMP completed on 9/17/24. On 11/12/24 at 1:24 PM, an interview was conducted with the Director of Nursing (DON) and Regional Nurse Consultant (RNC) 1. The DON stated nurses obtained the specimen and the laboratory picked up the sample. The DON stated the results were faxed to the facility. The DON stated nurses passed on verbally in report that there was a laboratory draw completed. The DON stated staff should be watching for the results within a few days. The DON stated nurses could call the lab if results were not sent to the facility within a few days. The DON stated results were faxed to the facility but the DON also had access to pull the labs from the lab computer system. The DON stated nurses did not have access to the lab portal. The DON stated if nurses did not receive results within 2 to 3 days, they should be contacting the lab via phone. The DON stated nurses could notify the DON to see if the results were in the system and nurses were aware she had access to the portal. The DON stated the physician was notified of the lab results form that was faxed from the lab and then the lab results form was uploaded into the residents document section of the medical record. The DON stated there was no timeframe to have documents uploaded, it was just when medical records staff had time.		

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F 0775 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep complete, dated laboratory records in the resident's record. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43212 Based on interview and record review, for 7 of 65 sampled residents, 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, results from laboratory tests completed at outside facilities were not obtained and filed into resident's medical record. Resident identifiers: 1, 2, 13, 50, 52, 54, and 55. Findings included: 1. Resident 13 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included Hereditary and idiopathic neuropathy, chronic respiratory failure, symptomatic epilepsy and epileptic syndromes with simple partial seizures, morbid obesity, hypertensive heart and chronic kidney disease with heart failure, muscle weakness, major depressive disorder, and chronic pain. Resident 13's medical records were reviewed between 11/3/24 and 11/13/24. On 7/10/24 at 11:01 AM, a general progress note revealed, Phlebotomist was unable to obtain lab draw this morning for CBC [complete blood count], CMP [complete metabolic panel] and RFT [renal function test]. Orders sent to infusion clinic with pt [patient] to see if they can get the labs drawn there. It should be noted that no laboratory results could be found for resident 13 for 7/10/24. On 11/6/24, results from resident 13's laboratory results drawn on 7/10/4 were provided to the state agency and uploaded to the resident's medical record. On 11/13/24 at 8:57 AM, an interview was conducted with the Director of Nursing (DON) who stated that resident 13's labs were drawn at the center where she received her magnesium infusions. The DON stated the center was supposed to be faxing the results to the facility. The DON stated she could pull them from the medical record system if they were not sent. 38031 2. Resident 1 was admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses which included but was not limited to hypospadias, retention of urine, chronic kidney disease, pyelonephritis, extended spectrum beta lactamase resistance, obstructive and reflux uropathy, and methicillin resistant staphylococcus aureus infection classified elsewhere. On 11/4/24 at 9:07 AM, an observation was made of resident 1's room. A sign was posted outside of resident 1's room for enhanced barrier precautions (EBP) and a personal protective equipment (PPE) cart was located outside the door. The cart contained gowns and gloves. (continued on next page)		

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F 0775 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/4/24 at 9:22 AM, an interview was conducted with Licensed Practical Nurse (LPN) 3. LPN 3 stated that resident 1 was on EBP for a suprapubic (SP) catheter and had an ongoing extended-spectrum beta-lactamase (ESBL) infection. LPN 3 stated that they obtained a urinalysis (UA) this past weekend for resident 1 and that the resident always had a urinary tract infection (UTI). Resident 1's electronic medical records (eMR) were reviewed. On 9/12/24, resident 1's had a physician order for a UA with a culture and sensitivity (C & S). No documentation could be found for the results of the UA with C & S in resident 1's eMR. On 11/13/24 at 11:55 AM, the facility emailed a copy of resident 1's UA results for 9/13/24. The results report documented that the report was printed on 11/13/24. On 11/13/24 at 3:02 PM, the facility emailed a copy of resident 1's C & S report for for 9/17/24. The results report documented that the report was printed on 11/4/24. On 11/12/24 at 1:22 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that the laboratory process was that the nurse would obtain the specimen and the lab picked up two times a day or immediately if ordered stat. The DON stated that the lab was located across the street at the hospital. The DON stated that the timeframe for when she would expect to see a UA result was within 1-2 days and within 3 days for a C & S result. The DON stated that staff should be checking for the results within a couple of days and that any pending information should be passed on in report to the next shift. The DON stated that the nurse should call the lab if they did not see the results faxed over within that timeframe. The DON stated that she also had access to the laboratory computer portal and could see the lab results that way. The DON stated that once the results were obtained they should be uploaded into the resident's eMR and should not take longer than a week to be placed in the medical records. The DON stated that when a resident returned from the hospital she would monitor the antibiotics prescribed from the hospital for the appropriateness and she would print those labs and upload them into the resident's chart. [Cross-refer F690] 3. Resident 2 was admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses which included but was not limited to metabolic encephalopathy, cognitive communication deficit, hemiplegia and hemiparesis, hydronephrosis, hematuria, history of urinary tract infections, obstructive and reflux uropathy, and autistic disorder. On 11/12/24, the facility infection control tracking and trending log was reviewed for October 2024. The log documented that resident 2 had a urinary tract infection on 10/18/24 that was treated with Bactrim DS 800-160 milligram (mg), give 1 tablet two times a day for 14 days. No documentation could be found for the results of the UA with C & S in resident 2's eMR. (continued on next page)		

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F 0775 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/12/24, resident 2's hospital history and physical documented urinalysis shows UTI with WBC [white blood cells] more than 30, RBC [red blood cells] more than 30 and bacteria 4+. Resident 2's hospital discharge orders revealed an order for Bactrim DS 800 mg-160 mg, give one tablet two times a day for 14 days; and Bactrim DS 800 mg- 160 mg, give 1 tablet every day for 30 days after the completion of the 14 day course of twice daily dose. It should be noted that no documentation could be found of resident 2's culture and sensitivity report for the UTI. On 11/12/24, the DON printed the hospital urine culture and sensitivity results. The culture grew out Providencia stuartii (multi drug resistant organism) and Proteus mirabilis. The culture documented that the organism was susceptible to Bactrim. 4. Resident 50 was admitted to the facility on [DATE] with diagnoses which included but was not limited to spina bifida, hydrocephalus, paraplegia, nueromuscular dysfunction of the bladder, and a history of urinary tract infections. On 11/12/24, the facility infection control tracking and trending log was reviewed for October 2024. The log documented that resident 50 had a urinary tract infection on 10/21/24 that was treated with Cipro Tablet, give 500 mg two times a day for 14 days. No documentation could be found for the results of the UA with C & S in resident 50's eMR. On 11/12/24, the DON printed the hospital urine culture results obtained on 10/25/24. The culture grew Pseudomonas aeruginosa, Escherichia coli, and Streptococcus anginosus. The culture documented that the organism was susceptible to Cipro. 5. Resident 52 was admitted to the facility on [DATE] with diagnoses which included but was not limited to rheumatoid arthritis, fibromyalgia, type 2 diabetes mellitus, cognitive communication deficit, major depressive disorder, anxiety disorder, and post-traumatic stress disorder. On 11/12/24, the facility infection control tracking and trending log was reviewed for September 2024. The log documented that resident 52 had a urinary tract infection on 9/16/24 that was treated with Macrobid Capsule, give 100 mg two times a day for 5 days. No documentation could be found for the results of the UA with C & S in resident 52's eMR. On 11/12/24, the DON printed the hospital urine culture results obtained on 9/15/24. The culture grew Escherichia coli. The culture documented that the organism was susceptible to Macrobid. 50200 6. Resident 54 was admitted to the facility on [DATE] with diagnoses which included, but not limited to, diffuse traumatic brain injury (TBI) with loss of consciousness, unspecified ataxia, adjustment disorder with mixed disturbance of emotions and conduct, unspecified depression, and cognitive communication deficit. On 11/4/24, resident 54's medical record was reviewed. (continued on next page)		

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F 0775 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A physician's orders dated 4/5/24 and 9/26/24 revealed, CBC [complete blood count]. There were no laboratory results in resident 54's electronic medical record that corresponded to the orders from 4/5/24 and 9/26/24. On 11/12/24 at 1:30 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that the labs for resident 54 had been viewed by the medical doctor. The DON stated that it should not take longer than one week for lab results to be uploaded into the resident's electronic health record. The DON stated that she was not sure why the results were not in resident 54's medical record. 30563 7. Resident 55 was admitted to the facility on [DATE] with diagnoses which included Parkinson's disease with dyskinesia without mention of fluctuations, chronic obstructive pulmonary disease, type 2 diabetes mellitus, tremor, and personal history of other infectious and parasitic disease. On 11/4/24 at 8:40 AM, an interview was conducted with resident 55. Resident 55 stated he had pain in his back, that radiated down his right side to his groin and hip. Resident 55 stated he thought it was a pinched nerve but a nurse got a urine sample on 10/28/24. Resident 55 stated he had not heard about the results from his urine and was not sure if he was taking antibiotics. Resident 55 stated the pain from his back to his groin was new. Resident 55 stated that his catheter was removed about a month ago. Resident 55's medical record was reviewed 11/5/24 thought 11/13/24. Another physician's order dated 10/28/24 revealed UA [urine analysis] C&S [culture and sensitivity] one time only for 1 Day. On 10/28/24 at 1:00 AM a nursing progress note revealed .Today patient is being seen regarding flank pain on his right side. Patient states this came on over the past couple days. He states it is around the area of his right kidney. Patient is concerned he might have some type of infection going on. We discussed options of diagnosis including a urinalysis. Today we will go ahead and obtain a urinalysis with culture. I did encourage the patient to hydrate is [sic] much as possible, as this can be an effective way to help clear an infection as well. We did also discuss the possibility of a kidney stone. Patient states that the pain is not very severe at this point. If urinalysis is inconclusive, we can obtain a kidney ultrasound if patient is still having pain. Patient is okay with this plan. Patient had no additional questions or concerns today. Nursing staff had no new concerns on this patient .Continue Foley catheter use . On 10/28/24 at 9:01 PM a nursing progress note revealed, New order received from [name removed] NP [Nurse Practitioner] for UA with C&S. This note was created by Registered Nurse (RN) 3. On 11/10/24 at 2:23 AM a nursing progress note revealed, Alert Charting: Resident c/o R flank pain 8/10. Denies pain in bladder or with urination but does state that he has urgency and frequency with small amounts of urine. States he provided a urine sample already. Called lab to get results faxed. UA abnormalities [sic]: slightly cloudy, leukocytes 500(large), WBCH [white blood cells] >30, RBC [red blood cells] H [high] 5, bacteria 1+. bacteria from culture is aerococcus urinae [sic]. (continued on next page)		

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F 0775 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/10/24 at 2:34 AM a nursing progress note revealed Alert Charting: Secure message sent to [physician's name removed] and his team regarding symptoms and UA results. There were no UA with C&S located in resident 55's medical record. On 11/12/24 at 10:17 AM, an interview was conducted with resident 55. Resident 55 stated he was now taking antibiotics for his urine test. Resident 55 stated he started antibiotics on Sunday (11/10/24) but did not know what the results were. On 11/12/24 at 10:09 AM, an interview was conducted with Registered Nurse (RN) 3. RN 3 stated if a resident had signs and symptoms of a UTI, she contacted the physician for an order to obtain a urine analysis. RN 3 stated she documented the UA on 10/28/24 for the day shift nurse. RN 3 stated the day shift nurse obtained the physician's order for the UA. RN 3 stated the UA was obtained on 10/28/24. RN 3 stated resident 55 complained of signs and symptoms of a UTI on 11/10/24. RN 3 stated she called the laboratory to obtain the UA results. RN 3 stated she notified the physician and DON about the results. RN 3 stated she passed on in report to the day shift nurse that she found resident 55's UA results. RN 3 stated she was unable to find any follow-up for resident 55 from 10/28/24 until 11/10/24. RN 3 stated a UA results should be available by the next day and the culture and sensitivity within 3 days. RN 3 stated there was a glitch in the system with receiving the results from the lab. RN 3 stated the laboratory did not always fax the results to the facility. RN 3 stated nursing staff usually had to call the laboratory and ask for results. RN 3 stated laboratory draws should be passed on verbally during nursing report. RN 3 stated there was a lab book up at nursing station A and with a copy of every lab draw that was done at the facility. RN 3 stated she was not sure if anyone audited the book. RN 3 stated resident 55 complained of flank pain on 11/10/24, some incontinent episodes and frequency of urination with small amounts of urine. RN 3 stated resident 55 told her that a UA probably needed to be done and resident 55 stated he already had his urine collected. RN 3 stated she worked as needed so she worked 10/28/24 and then again on 11/10/24. RN 3 stated resident had a catheter a long time ago but did not have one anymore. On 11/12/24 at 10:36 AM, an interview was conducted with Licensed Practical Nurse (LPN) 3. LPN 3 stated if a resident had signs and symptoms she would encourage fluids, let the physician know, obtain a physician's order for a urine sample, send the sample to lab and monitor for a change in condition. LPN 3 stated she would not want a resident to become septic for not treating a UTI. LPN 3 stated she would enter the physician's order for a UA into the residents medical record and then would report that to the next nurse. LPN 3 stated it was very important to communicate to the oncoming nurse. LPN 3 stated if there was a progress note, then the DON or nurse managers would see it and watch for the results. LPN 3 stated at times she has had trouble getting laboratory results. LPN 3 stated she had obtained a urine sample for a UA, but then the lab had not communicated the results like sometimes the urine was contaminated and that was not reported to the facility. LPN 3 stated usually the results for a UA were ready by the next day. LPN 3 stated the DON, physician and nurse manager had access to results from the hospital laboratory. LPN 3 stated resident 55 was on antibiotics for a UTI and the results were provided on 11/11/24. LPN 3 stated she was not sure when the UA was obtained but resident 55 should not have waited 12 days for the results and treatment. LPN 3 stated she was not sure what happened with the UA and results. LPN 3 stated there were no residents on bowel and bladder retraining program. (continued on next page)		

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F 0775 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/12/24 at 1:24 PM, an interview was conducted with the Director of Nursing (DON) and Regional Nurse Consultant (RNC) 1. The DON stated nurses obtained urine for a UA and then the laboratory picked up the samples twice daily. The DON stated there was a local laboratory and one in Salt Lake City. The DON stated she would expect to get UA results within 1 to 2 days and 3 days for the culture results. The DON stated nurses passed on verbally in report that there was a laboratory draw completed. The DON stated staff should be watching for the results within a few days. The DON stated nurses could call the lab if results were not sent to the facility within a few days. The DON stated results were faxed to the facility but the DON also had access to pull the labs from the lab computer system. The DON stated nurses did not have access to the lab portal. The DON stated if nurses did not receive results within 2 to 3 days, they should be contacting the lab via phone. The DON stated nurses could notify the DON to see if the results were in the system and nurses aware she had access to the portal. The DON stated the antibiotic and physician notification was on the lab results form that was faxed from the lab and then the lab results form was uploaded into the residents document section of the medical record. The DON stated there was no timeframe to have documents uploaded, it was just when medical records staff had time. RNC 1 stated the facility should have the results of a UA and culture no longer than a week after the sample was obtained and for the results to be uploaded into the system. The DON stated resident 55's UA and culture results were longer than the expected time frame.		

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43212 Based on observation, interview, and record review it was determined, for 30 of 65 sampled residents, that the facility did not provide each resident with a nourishing, palatable, well-balanced diet that met his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. Specifically, meals were served late, menus were not meeting nutritional needs, portion sizes were not appropriate, food was not palatable, resident food allergies and preferences were not honored, beverages were not offered between meals, therapeutic diets were not followed, snacks were not provided, adaptive equipment was not provided, and the kitchen was not sanitary. In addition, weights and nutritional assessments were not being completed. Resident identifiers: 1, 3, 5, 4, 9, 10, 12, 13, 14, 15, 16, 22, 24, 26, 27, 28, 29, 30, 32, 36, 38, 44, 49, 50, 52, 53, 55, 60, 65 and 120. Findings include: 1. Based on observation, interview and record review it was determined, for 17 of 65 sampled residents, that the facility did not employ sufficient staff with the appropriate competencies and skills set to carry out the function of the food and nutrition services, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment. Specifically, meals were observed to be served over an hour later than the posted meal times, a resident was observed to be yelling he was hungry, residents were in the hallways waiting for food, residents were upset in the dining room waiting for meals and residents council minutes revealed complaints of late meals. Resident 16 will be cited at a harm level. Resident identifiers: 9, 13, 14, 22, 24, 26, 27, 30, 32, 36, 38, 44, 50, 52, 55 and 120. (Cross refer F802) 2. Based on observation, interview and record review it was determined, for 3 of 65 sampled residents, that the facility did not have menus that met the nutrition needs of residents in accordance with established nutritional guidelines. Specifically, menus were not followed and correct portion sizes were not provided to residents. Resident identifiers: 15, 16 and 55. (Cross refer to F803) 3. Based on observation, interview and record review it was determined, for 11 out of 65 sampled residents, that the facility did not provide food prepared by methods that conserve flavor and appearance or provide food and drink that was palatable, attractive, and at an appetizing temperature. Specifically, there were multiple complaints from residents about the quality of food, there were multiple resident council complaints about the flavor of food, and when surveyors pulled a test tray during the lunch meal, the food was found to be lacking in flavor and appearance. Resident identifiers: 9, 12, 16, 22, 26, 27, 28, 32, 50, 55, and 120. (Cross Refer to F804) (continued on next page)		

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4. Based on observation, interview and record review it was determined, for 6 of 65 sampled residents, that the facility did not ensure that each resident received the food and drink that accommodated the resident allergies, intolerances, and preferences. Specifically, residents with food allergies and intolerances were served food containing identified allergens, and one resident who was admitted on [DATE] had not been questioned about food allergies until 11/5/24. Resident identifiers: 1, 10, 16, 26, 28, and 38. (Cross Refer to F806) 5. Based on observation, interview and record review for 4 of 65 sampled residents, the facility did not ensure each resident received drinks, including water and other liquids, consistent with the residents' needs and preferences and sufficient to maintain resident hydration. Specifically, water was not being provided to residents between meals, residents had to seek out staff to obtain fresh water and resident water mugs were not being cleaned regularly. Resident identifiers: 26, 27, 55 and 120. (Cross Refer to 807) 6. Based on observation, interview and record review, it was determined for 1 of 65 sampled resident, that the facility did not provide therapeutic diets as prescribed by the attending physician. Specifically, a resident with a physician's order for thickened liquids was observed to have thin water at the bedside. Resident identifier: 60. (Cross Refer to 808) 7. Based on observation, interview and record review it was determined, for 12 of 65 sampled residents, the facility failed to provide each resident with 3 meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. Additionally, snacks were not provided to residents who wanted to eat at non-traditional times or outside of the scheduled meal service times and consistent with the resident plan of care. Specifically, meals were not served according to meal times, meal times were changed without resident input, snacks were not being provided regularly. Resident identifiers: 9,13, 16, 26, 27, 29, 32, 49, 53, 55, 60, and 120. (Cross Refer to 809) 8. Based on observation, interview, and record review, it was determined for 1 of 65 sampled residents, that the facility failed to provide special eating equipment and utensils for residents who needed them to ensure that the resident could use the assistive devices when consuming meals and snacks. Specifically, one resident was not provided with a lipped plate when identified as needing one. Resident identifier: 5. (Cross Refer to 810) (continued on next page)		

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	9. Based on observation and interview, the facility did not store, prepare, distribute and serve food in accordance with professional standards for food service safety. Specifically, the kitchen was dirty with spills and dried food down near the burners, the large mixer had a white substance on the arms that hold the bowl and under the mixer, the oven floor was caked with spilled food on the bottom, food items in the walk-in freezer were open to air, food items in the reach in refrigerator were not labeled, and food items in the dry storage room were open to air. Additionally, staff with facial hair were not wearing a beard cover, personal phones were in the food preparation area, there was damage to several areas of the wall, tiles missing around the baseboard, and there was crumbs and food particles under the dish machine, stove and oven. (Cross Refer to 812) 10. Based on observation, interview and record review, for 4 of 65 sampled residents, the facility did not ensure residents maintained acceptable parameters of nutritional status. Specifically, residents meal portion sizes were not adequate, residents weights were not obtained and residents nutrition assessments were not being completed. Resident identifiers: 3, 4, 55, 60, and 65. (Cross Refer to 692) On 11/3/24 at 1:15 PM, an interview was conducted with the Dietary Manager (DM). The Dietary Manager (DM) who stated he was trying to find the old cleaning schedules so that he could create new ones. The DM stated, This place looks like a mess right now, but it is far better than when I came. On 11/5/24 at 11:03 AM, an interview was conducted with the Registered Dietitian (RD)who stated she had worked at the facility since September and had started making suggestions in the kitchen. The RD stated she learned quickly that the staff were doing their best to get the food out to the residents, but the kitchen was a disaster. The interview also revealed: a. The RD stated the current Dietary Manager (DM) had only been at the facility for a short time. The RD stated the Assistant Dietary Manager (ADM) was acting as the DM prior to bringing on a new DM. The RD stated the current DM had a lot of experience, was very knowledgeable and had been through a survey many times in the past. The RD stated the DM was working on putting things in the facilities QAPI (Quality and Performance Improvement) program. The RD stated the DM was working on cleanliness in the kitchen, labeling and dating food items, menus, and staffing. The RD stated a lot of areas needed work. b. The RD stated she was only doing resident assessments when the residents were admitted . The RD stated the facility medical software was not populating quarterly assessments. The RD acknowledged that she needed to start doing the quarterly assessments that had not been done by the previous dietitian. The RD stated the facility did not even have an annual assessment form for documenting. The RD stated when she did admission assessments, if there were recommendations they would be on the bottom of the assessment and she would notify the Director of Nursing (DON) of her recommendations. The RD stated she met with residents when they were admitted . The RD stated if a resident had a special request, she would meet with them. The RD stated resident goals were communicated to the staff verbally through the DON. (continued on next page)		

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	c. The RD stated kitchen audits should be completed once a month, but she had not completed one since the beginning of her employment. The RD stated the information from a kitchen audit should be given to the DM or the administrator. The RD stated during a kitchen audit the refrigerators and freezers should be checked for food being labeled and dated, cleanliness and proper temperatures. The RD stated during a kitchen audit an overall observation should be done of the kitchen for cleanliness, proper food temperatures, that the dish machine is functioning properly to sanitize the dishes, and that staff were following proper food handling techniques including wearing hair nets and wearing clean aprons. The RD stated she had not done any audits because she did not have anyone to address the problems with before the new DM was hired. The RD stated she did not know if the ADM had any training. The RD stated she did not know who should be providing education to the dietary staff. The RD stated if she identified something that needed to be fixed she would tell the administrator about it, but she did not provide the education. The RD stated the process for fixing problems in the kitchen should be that she would tell the DM and then the administrator. The RD stated she reviewed some things with the current DM and his response to her was that he was working on it. The RD stated a week ago she went through the kitchen with a corporate nurse and identified problems with the cleanliness in the kitchen, that the shelving in the store rooms were not 6 inches off the floor and when stock was delivered it was left sitting on the floor of the refrigerator or freezer. The RD stated she was making sure all staff were wearing hair nets. The RD stated she did not know if there was a cleaning schedule for the kitchen. The RD stated she has not been monitoring the temperature logs for the dish machine, refrigerator, freezer, or trayline. d. The RD stated she had not completed a tray audit since she was hired. The RD stated the process to complete a tray audit was to ask for a test tray, take the temperature of the food, taste the food and evaluate the presentation and if it was following the menu and was meeting the nutritional needs of the residents. The RD stated if a substitution needed to be made to the menu she had the ability to go into the dietary software and substitute food items in and out of the menu. The RD stated if substitutions were being made they should be posted. The RD stated there should also be a record kept of the substitutions and the record should be kept for a year. The RD stated the DM did not have to contact her if he wanted to make a substitution to the menu. The RD stated the software would make suggestions for alternations to the menu. The RD stated she sort of knew that the kitchen was not following the posted menu. The RD stated depending on what came on the delivery truck, a substitution could be necessary. The RD stated she did not know who trained the DM on the kitchen software and she was not sure if that was part of her role. The RD stated she was new to using that particular software herself. The RD stated she thought the DM should be self-monitoring what is going on in the kitchen. The RD stated when looking at the substitutions, she would look for adequate protein, vegetables, if the menu was meeting the 5 a day guidelines and requirements for vitamin A for the week. The RD stated she had not looked at the menu for that particular week. The RD stated there should be a seasonal rotation being used. e. The RD stated she did not know if there was a schedule for providing snacks or how the residents would receive a snack. The RD stated the DM could call or text her any time and that they have worked together for a long time. The RD stated the DM did not have a problem asking questions. The RD stated the DM should be assessing residents for their food preferences and that the preferences should be updated once a year. The RD stated the residents should also be assessed again after coming back from a hospital stay. (continued on next page)		

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	f. The RD stated food allergies should be addressed when a resident was admitted and that the information should be communicated to the kitchen to be put on the resident's meal ticket. The RD stated she had not heard of any residents having a problem with food allergies or had any resident complaints. The RD stated she had not seen resident 16, who had a food allergy. The RD stated in a perfect world she would assess the residents every 90 days. The RD stated she needed to set up a schedule so the resident assessments would be getting done. The RD stated she had observed meal service at the facility. The RD stated not many residents were eating in the dining room. The RD stated the benefits of eating in the dining room were that the resident could get out of their room, a different food item could be obtained right away if needed, dietary staff could be communicated with more easily and the meal service would go faster. The RD stated the meal service had been off and it was brought to her attention 2 weeks ago. The RD stated it was a struggle to get dinner and breakfast out in a timely manner. The RD stated she did not know if there was enough dietary support in the kitchen and that it would be a good question for the DM. The RD stated she was not aware that residents had expressed concerns that meals were being delivered late. g. The RD stated under the previous dietary manager kitchen supplies were not being ordered, things were not coming in and the staff were doing a lot of running to the store for supplies. The RD stated she did not know if there were enough pellets to keep meals hot. The RD stated she did not know why residents were receiving food in Styrofoam bowls, or if kitchen staff were using those to cut down on the time it takes to do the dishes. h. The RD stated her contract was for 8-12 hours per week, and that was the number of hours she was currently working at the facility. The RD stated when she was hired the census was significantly lower. The RD stated with a higher census she would need at least 20 hours per week to complete resident visits and get the quarterly assessments up and going. The RD stated that would not include kitchen duties. 30563		

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F 0802 Level of Harm - Actual harm Residents Affected - Few	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30563 Based on observation, interview and record review it was determined, for 17 of 65 sampled residents, that the facility did not employ sufficient staff with the appropriate competencies and skills set to carry out the function of the food and nutrition services, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment. Specifically, meals were observed to be served over an hour later than the posted meal times, a resident was observed to be yelling he was hungry, residents were in the hallways waiting for food, residents were upset in the dining room waiting for meals and residents council minutes revealed complaints of late meals. Resident 16 will be cited at a harm level. Resident identifiers: 9, 13, 14, 16, 22, 24, 26, 27, 30, 32, 36, 38, 44, 50, 52, 55 and 120. Findings included: Posted facility meal time were as follows: Breakfast: 7:30 - 8:30 Lunch: 12:30 - 1:30 Dinner: .L5:30 [sic] - 6:30 1. Resident 16 was admitted to the facility on [DATE] with diagnoses which included cerebral infarction due to embolism of left middle cerebral artery, cognitive communication deficit, diabetes mellitus and major depressive disorder. On [DATE] at 9:19 AM, an observation was made of resident 16. Resident 16 was observed at the kitchen door yelling I'm [expletive removed] hungry, man! Resident 16 was observed to tell the Maintenance Director he needed to talk to the kitchen staff. The Maintenance Supervisor was observed to tell resident 16 that he needed to talk to the nurse and could not come through any door he wanted. Resident 16 was observed to tell the kitchen staff he was [Expletive removed] hungry and he had not received breakfast. The Dietary Manager (DM) was observed to intervene between resident 16 and the Maintenance Supervisor. The DM asked resident 16 what he would like to eat for breakfast. Resident 16 was observed to tell the DM what he wanted for breakfast. Resident 16 was observed to use his wheelchair to motorize through the hallway to his room. (continued on next page)		

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F 0802 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 9:23 AM, an interview was conducted with resident 16. Resident 16 stated he was a [Expletive removed] Chef and it was 9:30 AM. Resident 16 stated he needed food before 9:30 AM. Resident 16 stated he asked staff about his food and staff say I don't know or they were not sure. Resident 16 stated that he was really trying to be patient but breakfast was always late. Resident 16 stated he was okay if his breakfast came before 9:00 AM, but the food never came that early. Resident 16 stated the food was either loved or hated. Resident 16 stated the portions were too small. Resident 16 stated he should be getting double portions but never got that much. Resident 16 stated I'm hungry. Resident 16 stated he had a stroke 7 years ago and that was why he was at the facility. Resident 16 stated he had been hungry for about a year and a half. Resident 16 stated he was not getting snacks and staff told him that corporate did not allow for snacks. Resident 16 stated that he had to go to the kitchen to get food because if he asked any other staff they tell him he had to wait a minute and then he would not get anything to eat. Resident 16 stated once he yelled about food, then he was able to get food. Resident 16 stated he loved the kitchen staff but they were so slow and delayed. Resident 16 stated the kitchen staff he received dinner the night before at almost 8:00 PM and he did not get enough food. Resident 16 stated he was not offered a snack last night. Resident 16's room was observed to have 3 cans of Campbell's chicken noodle soup, a bag with uncooked rice, bag of small candy and spicy nacho chips. Resident 16 stated his sister had to bring him snacks. On [DATE] at 9:45 AM, an interview was conducted with Housekeeping Supervisor (HS) who was passing meal trays in the 300 hallway. The HS stated resident 16's meal tray should have been on the 300 hallway cart but she did not know where it was. On [DATE] at 9:47 AM, an observation was made of resident 16's tray leaving the kitchen. An interview was conducted with the DM. The DM stated resident 16's tray went to the dining room and that was why resident 16 did not have a tray delivered to his room. The DM stated resident 16 should have asked to have his tray sent to his room. The DM stated if a resident wanted to go to the dining room, then their tray was served there. The DM stated staff did not monitor which food trays were not eaten in the dining room. On [DATE] at 1:13 PM, an interview was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 stated that resident 16 was friendly with her, as long as everyone respected him and they allowed him time to communicate. CNA 1 stated resident 16 cussed at times which seemed aggressive. CNA 1 stated resident 16 sometimes slept in and often missed breakfast. CNA 1 stated resident 16 tried to store food in his room to eat later. CNA 1 stated resident 16 usually communicated with the kitchen staff regarding his meals. CNA 1 stated if he felt like he was not being heard or listen to, then he would get upset, yell and cuss. Resident 16's progress note revealed the following on [DATE] at 11:37 PM, Order - Administration Note: BEHAVIOR MONITORING: # OF ANGRY OUTBURSTS Q [every] SHIFT. every shift for Behavior monitoring pt [patient] was upset that supper was late. (continued on next page)		

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F 0802 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 9:47 AM, an interview was conducted with the Administrator (ADMIN) and Assistant Dietary Manager (ADM). The ADM stated if a resident requested to eat in dining room, then dietary staff put their tray in the dining room. The ADM stated staff were not aware resident 16 wanted to eat in his room. The ADM stated after a meal was left out for longer 5 minutes, then staff needed to find out why the resident was not in the dining room and they needed to take the meal to their room. The ADM stated normally the CNA's put the trays out in the dining room. The ADM also stated the dietary staff put the trays on the table. The ADM stated the dietary staff should be checking in the dining room. On [DATE] at 1:07 PM, an interview was conducted with Licensed Practical Nurse (LPN) 5. LPN 5 stated when resident 16 did not get what he needed he became angry and yelled. LPN 5 stated if they did not bring food on time or the food was cold then resident 16 yelled. LPN 5 stated resident 16 was easy to get along with and was able to verbalize his needs. LPN 5 stated if resident 16 received small portions he yelled. LPN 5 stated there were new staff in the kitchen that had not been educated, so they did not send the right food to residents. 2. Observations: a. On [DATE] at 1:15 PM, an initial walk-through of the kitchen was conducted. The ADM and a cook were present in the kitchen at the time and 1 dietary aide. The DM arrived at approximately 1:30 PM. On [DATE] at 1:15 PM, an interview was conducted with the ADM who stated she had been working 18 hour days and was glad the kitchen was fully staffed. On [DATE] at 1:30 PM, an interview was conducted with the DM who stated there was a cook and a dietary aid for the morning shift and the afternoon shift, and the DM or the ADM. The DM stated that on some days there was a prep aide that would come in to help. The DM stated meal service took between 1 hour and 1 , d+[DATE] hours. The DM stated meal trays went out to the hallways first and the dining room was served last, which was about an hour after the first hall cart left the kitchen. The DM stated for the breakfast meal, the first cart would leave the kitchen at 6:30 AM, for the lunch meal, the first cart was out by 12:30 PM, and for the dinner meal, the first cart left the kitchen at 6:30 PM. b. On [DATE] at 1:30 PM, an observation was made of Certified Nursing Aide (CNA) 2 delivering lunch trays to the 300 hallway. CNA 2 stated that the tray delivery had just begun. CNA 11 stated that lunch usually started on the 300 hallway at around 1:00 PM. CNA 11 stated that approximately 10 residents ate in the main dining room and the majority of residents ate in their room. CNA 2 stated that room [ROOM NUMBER], 214, 303 and 317 B needed assistance with dining. c. On [DATE] at 1:35 PM, an observation was made of the lunch meal tray for room [ROOM NUMBER] A. The tray contained one chicken leg, mashed sweet potatoes, green beans, a roll, and a pie dessert with the chocolate topping melted. The dessert appeared to be a pudding that was no longer solid. d. On [DATE] at 6:10 PM, an observation was made of the 100 hallway meal cart being delivered. e. On [DATE] at 6:12 PM, the food cart was observed to arrive on the 100 hallway. At 6:16 PM, LPN 1 arrived to check meal tickets and food. At 6:16 PM, the first meal tray was delivered in the 100 hallway by CNA 7. At 6:21 PM, the last meal tray was delivered in the 100 hallway. (continued on next page)		

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F 0802 Level of Harm - Actual harm Residents Affected - Few	f. On [DATE] at 8:06 PM, an observation was made of the dining room. Residents were observed to be seated in the dining room and the dinner meal had not been delivered. g. On [DATE] at 8:49 AM, the breakfast meal trays arrived on the memory unit (300 hallway), and the last tray was delivered by 9:00 AM. h. On [DATE] at 9:00 AM, an observation was made of the 2nd 300 hallway meal cart being delivered to the 300 hallway. At 9:02 AM, an observation was made of resident 14. Resident 14 was observed to wheel himself in his wheelchair to the meal cart. CNA 5 was observed to tell resident 14 that he needed to be patient and wait for the nurse. Resident 14 was observed to put his head down and wheel toward his room. At 9:05 AM, resident 14 was observed pacing the hallway in his wheelchair between his room and the meal cart. A CNA was observed to get resident 14's tray and stated this was his meal. Resident 14 was observed to say YAY!. i. On [DATE] at 9:03 AM, an observation was made of the facility kitchen. [NAME] 1 was observed to be plating the breakfast meal for the 300 hallway cart. j. On [DATE] at 12:45 PM, an observation was made of 100 hallway. The lunch meal cart was delivered. k. On [DATE] at 1:24 PM, an observation was made of resident 30. Resident 30 stated that she was hungry and she was going to see if they had some lunch for her. On [DATE] at 1:41 PM, resident 30 again stated that she was hungry. LPN 3 stated that she could give her some water until her lunch arrived. Resident 30 was observed pacing the hallway. l. On [DATE] at 1:45 PM, the lunch meal trays were delivered to the memory care unit and the first tray was delivered to room [ROOM NUMBER]. On [DATE] at 1:49 PM, all trays were delivered to the residents on the unit. m. On [DATE] at 6:17 PM, the meal cart was delivered to the unit and was parked outside of room [ROOM NUMBER]. On [DATE] at 6:19 PM, the first meal tray was delivered to room [ROOM NUMBER]. n. On [DATE] at 8:43 AM, an observation was made of the 300 hallway meal cart was delivered to the hallway. The first tray was served at 8:46 AM. 3. Resident Interviews: a. On [DATE] at 2:05 PM, an interview was conducted with resident 50 who stated she had just received her lunch. Resident 50 stated that because of low staffing, they were bringing a big cart to the dining room, but they had a hard time finding a staff member who could pass the trays in the dining room. Resident 50 stated the kitchen decided to bring individual trays out and did not bring the trays until the residents came to the dining room, and the residents do not know when they were going to be served. b. On [DATE] at 2:37 PM, an interview was conducted with resident 120. Resident 120 stated that meals have never been on time since she was admitted to the facility in September. Resident 120 stated that meals have gotten later in the past few weeks and staff have not told her why when she had asked. Resident 120 stated that her meals arrive barely warm. (continued on next page)		

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F 0802 Level of Harm - Actual harm Residents Affected - Few	c. On [DATE] at 3:20 PM, an interview was conducted with resident 26. Resident 26 stated that the newest cook served meals an hour or more later than what they should be. Resident 26 stated that she had to wait more than two hours for meals to be delivered to her room. d. On [DATE] at 5:32 PM, the resident residing in room [ROOM NUMBER] was heard stating to a CNA What is up with the kitchen? Last week dinner was served at 3:30 PM. They are so damn inconsistent. The CNA informed the resident that the dinner was scheduled for 6:00 PM. The resident stated that this place sucked. e. On [DATE] at 5:33 PM, an interview was conducted with resident 9 who stated the food was cold 90 percent of the time. Resident 9 stated dinner arrived to the residents somewhere between ,d+[DATE] PM or whenever. Resident 9 stated that breakfast usually did not arrive until about 9:00 AM. f. On [DATE] at 5:45 PM, an interview was conducted with resident 24. Resident 24 stated the dinner meal was served anywhere from 3:00 PM to 6:00 PM. Resident 24 stated the food was very inconsistent and sometimes it was served at 7:00 PM which was Damn late. At 6:44 PM, an interview was conducted with resident 24. Resident 24 stated he normally got dinner around 3 and 4 PM. Resident 24 had not been served dinner. g. On [DATE] at 6:14 PM, an observation and interview was made of the dining room. Resident 44 was observed to be sitting in the dining room. Resident 44 stated he was waiting for dinner since 3:00 PM with no snacks offered. Resident 44 stated dinner was usually served about 6:30 PM. At 8:00 PM, resident 44 had not received his dinner meal. h. On [DATE] at 7:12 PM, resident 50 was sitting in the hallway outside of her room and had not been served dinner. Resident 50 was observed commenting about the late dinner to residents and staff walking by. i. On [DATE] at 8:09 AM, an interview was conducted with resident 22. Resident 22 stated the meals were always late. Resident 22 stated she should be served at 5:30 PM for dinner but did not usually get her meal till after 7:30 PM. Resident 22 stated breakfast should be served at 7:30 AM and she was not served till after 9:00 AM. j. On [DATE] at 8:14 AM, an interview was conducted with resident 27. Resident 27 stated that she was tired of complaining about the meals and never knew when she was going to get her food. k. On [DATE] at 8:22 AM, an interview was conducted with resident 32. Resident 32 stated that meals were always late. Resident 32 stated that breakfast should be at 7:30 AM but was not served until 9:00 AM. Resident 32 stated when he was admitted the meals were at 7:00 AM, 12:00 PM and 5:00 PM. Resident 32 stated he was not sure when he had received a meal on time. Resident 32 stated his dinner the night before was served at 8:15 PM. Resident 32 stated he was diabetic and had not had problems with low blood sugars. l. On [DATE] at 8:43 AM, an interview was conducted with resident 26. Resident 26 stated that meals were sporadic and came at unknown times. Resident 26 stated she has had to miss therapy and activities because meals have come late. (continued on next page)		

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F 0802 Level of Harm - Actual harm Residents Affected - Few	m. On [DATE] at 8:51 AM, an interview was conducted with resident 55. Resident 55 stated he had not received breakfast yet. n. On [DATE] at 8:51 AM, an interview was conducted with resident 52 who stated she was still waiting for breakfast. Resident 52 stated she received dinner the night before at 7:30 PM. o. On [DATE] at 9:23 AM, an interview was conducted with resident 36. Resident 36 stated the meals were late and he was not sure why the meals were so late. p. On [DATE] at 11:07 AM, an interview was conducted with resident 13 who stated the food was always served late. q. On [DATE] at 12:38 PM, an interview was conducted with resident 38 who stated meals were being delivered 2 - 2 ,d+[DATE] hours late. Resident 38 stated he had to remind staff that he needed to eat. Resident 38 stated breakfast in the morning was 2 hours late and then his tray was not picked up. r. On [DATE] at 1:07 PM, an interview was conducted with resident 24. Resident 24 stated he did not get dinner until 7:45 PM on Sunday night. s. On [DATE] at 10:25 AM, a follow up interview was conducted with resident 55. Resident 55 stated meals were still served late. 4. Staff interviews: On [DATE] at 2:46 PM, an interview was conducted with staff member 1 who stated the kitchen was not doing what they were supposed to. Staff member 1 stated the dinner meal had been served as late as 9:00 PM, food was not properly covered. Staff member 1 stated residents should have regularly scheduled meals so their medications can be provided appropriately. Staff member 1 stated residents were not getting meals that were according to their meal tickets. On [DATE] at 10:24 AM, an interview was conducted with Registered Nurse (RN) 4. RN 4 stated that residents complained of late meals. RN 4 stated she was not sure why meals were late most of the time. On [DATE] at 1:32 PM, an interview was conducted with CNA 5. CNA 5 stated that breakfast was served around 9:00 AM and lunch around 1:00 PM. On [DATE] at 5:54 PM, an interview was conducted with the ADMIN. The ADMIN stated the meals would be late because a surveyor was in the kitchen talking to kitchen staff. The ADMIN stated there were 3 staff members in the kitchen and if 1 person was asked a question it delayed the meals. The ADMIN stated the dinner meal was to be served between 5:30 PM and 6:30 PM. The ADMIN stated the meals were served in the order of 100 hallway, 200 hallway, 300 hallway, 400 hallway and then the dining room. On [DATE] at 5:48 PM, the DM stated that his Dietary Aide had walked out. The DM was at the steam table serving the dinner meal. The HS was observed in the kitchen and making quesadillas and preparing salad in a bowl. The morning cook, cook 2, was plating the food. At 6:45 PM, all of the hall carts had not been brought out and the kitchen staff were still cooking food because there had not been enough food prepared. (continued on next page)		

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F 0802 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 8:39 AM, an interview was conducted with the ADM who stated usual kitchen staffing had been 1 [NAME] and 1 Dietary Aide in the morning at 5 AM leaving at 1 PM, and a Prep Aide between ,d+[DATE] AM. The ADM stated the afternoon/evening cook arrived at noon until 8 PM or when the shift ended. On [DATE] at 11:03 AM, an interview was conducted with the Registered Dietitian (RD) who stated the kitchen was a disaster. The RD stated she had been employed by the facility since [DATE]. The RD stated she learned quickly that the kitchen staff were doing their best to get the food out to the residents. The RD stated she had recommended the DM to the facility. The RD stated that meal delivery had been off and she brought it to their attention 2 weeks ago. The RD stated it was a struggle to get dinner and breakfast meals out and she did not know if they had enough support. The RD stated that would be a good questions for the DM. The RD stated she was not aware that residents had expressed concerns that meals were being served late. The DM stated under the last dietary manager food items were not ordered and not being delivered. The RD stated kitchen staff were having to run to the store all the time. The RD stated she did not think that should be happening now. The RD stated her contract was for ,d+[DATE] hours per week. The RD stated with a census of 75 residents she would need at least 20 hours per week just to do the resident assessments and did not include kitchen duties. On [DATE] at 3:47 PM, an interview was conducted with the ADMIN. The ADMIN stated the meal times were Breakfast 7:30 AM to 8:30 AM, Lunch 12:30 PM to 1:30 PM and Dinner 5:30 PM to 6:30 PM. The ADMIN stated the meal times recently changed because kitchen staff were not getting meals out on time so the new schedule worked better. The ADMIN stated the change was communicated to the residents by talking to all residents and posting updated meal times at the nurses station. The ADMIN stated the meals were served to 100 hallway, 200 hallway, 300 hallway, 400 hallway and then the dining room. The ADMIN stated the dining room was served last because that was how it was when he started at the facility. The ADMIN stated he had not seen residents request their meal in their room because it was served to the rooms before the dining room. The ADMIN stated the dietary department needed to get the process down for residents to get their meals in a timely manor. The ADMIN stated if meals were late, staff should call managers to help pass the trays as quickly as possible. The ADMIN stated there were all kinds of impacts to residents if meals were served late like blood sugars for diabetics and increase behaviors and moods. The ADMIN stated there was a Performance Improvement Plan (PIP) started on [DATE]. On [DATE] at 4:46 PM, an interview was conducted with the Director of Nursing (DON). The DON stated serving meals on time was a work in progress. The DON stated there was a PIP going on for the last month. The DON stated the DM had health concerns which had delayed the correction. The DON stated some residents were frustrated with meal times not being consistent. The DON stated she had not heard about resident 16 being upset about breakfast being late. The DON stated if a resident was not in the dining room for a meal, then a CNA should take the meal tray to the residents room. The DON stated meals being late could cause blood sugar management problems like feeling dizzy, cranky, light headed, and overall not feeling good. The DON stated if a resident received insulin without food their blood sugar could drop. 50200 (continued on next page)		

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F 0802 Level of Harm - Actual harm Residents Affected - Few	The Facility assessment dated [DATE] revealed the average census each month was between 56 and 72 residents. Resident Support and Care Needs section revealed specific care and practices for nutrition included individualized dietary requirements, liberal diets, specialized diets, nutrition, tube feeding, cultural or ethic dietary needs, assistive devices, fluid monitoring or restrictions. The Facility Resources Needed to Provide Competent Support and Care for our Residents Population Every Day and During Emergencies revealed for Food and Nutrition Services needed a Dietitian, Dietary Manager and [NAME] Support Staff. The Staffing Plan was to have a contracted Registered Dietitian approximately ,d+[DATE] hours per week and a Dietary Manger who completed the Certified Dietary Manager (CDM) course. The Food and Nutrition services needed a full time CDM, ,d+[DATE] total dietary personnel working 6:00 AM through clean-up of the evening meal. A review of resident council meeting minutes revealed the following: a. [DATE]: .timing inconsistent with serving meals . b. [DATE]: .There were multiple complaints with meals. Nursing staff reported that the scheduled mealtimes are approx. [approximately] 7:40am, 11:45am, and 4:30pm. Multiple residents reported that their meals were arriving late, usually. Several residents commented that the meals are often missing condiments and that their plates do not match their preferences. Some residents indicated that they thought some of their food was expired. Some residents stated that they have noted improvements with some meals. The drinks also do not match some residents' expectations . c. [DATE]: .Several residents reported that food is cold. [Activities Director] shared that maintenance is in the process of replacing a heating element necessary to keep the trays warmer and those are actively being replaced. Some residents regularly receive clamshells instead of trays and asked why, as they get cold faster. It was reported that sometimes dishes are in short supply . d. [DATE]: .Residents reiterated that food is arriving after 2PM [sic] for lunch, most days (breakfast usually arrives by 9AM [sic] and dinner around 7PM [sic]) . On [DATE] at 3:00 PM, the facility resident council was attended. It was reported by many residents that meal times were not consistent and varied day to day. Many residents voiced concerns over the delay in receiving meals. 38031 43212 48709		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43212 Based on observation, interview and record review it was determined, for 3 of 65 sampled residents, that the facility did not have menus that met the nutrition needs of residents in accordance with established nutritional guidelines. Specifically, menus were not followed and correct portion sizes were not provided to residents. Resident identifiers: 15, 16 and 55. Findings included: 1. On 11/3/24 at 1:15 PM, an initial observation was made in the kitchen. Several additional observations were made in the kitchen between 11/3/24 and 11/13/24. a. On 11/3/24 at 1:15 PM an observation was made of the lunch meal being plated. The meal served included 1 piece of chicken, a 4 ounce (oz) slotted spoon of cubed yams, a 6 oz slotted spoon of green beans, 1 dinner roll with a pat of butter, and a slice of chocolate cream pie, serving size unknown. A review of the spreadsheet for the lunch meal revealed the recipe called for a 1-3 oz piece of chicken, 1-5 oz baked sweet potato, a 4 oz serving of green beans, 1 slice of bread or roll, 1 pat of butter and 1/10 slice of cherry pie. b. On 11/3/24 at 5:48 PM, an observation was made of the dinner meal being plated. The meal served included 1 grilled tortilla with a hand-full of cheese, folded in half and cut into 2 pieces, a 4 oz ladle of herbed fettuccine noodles, a green side salad, and a small cup of tapioca pudding. It should be noted that the menu posted listed the main course for the dinner meal on 11/3/24 was to be a savory ham wrap. A review of the spreadsheet for the dinner meal revealed the recipe called for 1 grilled tortilla with 1/2 cup of cheese, folded in half, 4 oz of rotini-tri-colored pasta, a #8 scoop (4 oz) of creamy coleslaw, and an assorted dessert-1 each. c. On 11/5/24 at 9:13 AM, an interview was conducted with the Dietary Manager (DM) who stated that on 11/4/24 the lunch meal included Pasta [NAME] and vegetables. The DM stated the pasta was made with a white sauce and had peas and broccoli, maybe cauliflower. The DM stated he was not sure if the recipe was in the recipe book. It should be noted that the menu posted listed the main course for the lunch meal on 11/4/24 as Cheese Ravioli with Pesto Sauce. A review of the spreadsheet for the lunch meal on 11/4/24 revealed that the recipe called for 2/3 cup or 8 oz of Pasta [NAME], a 4 oz serving of a cucumber salad, a breadstick with butter, and a 2 x 3 inch piece of chocolate cake with peanut butter frosting. (continued on next page)		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. On 11/5/24 at 9:35 AM, an observation was made of 2 resident plates during the breakfast meal. The plates contained 3-3 inch waffles, a large serving of scrambled eggs (covering almost 1/2 of the plate), and 5 pieces of bacon. One tray ticket was for a regular diet, the second tray ticket was for a regular diet but had double portions written on it. A review of the spreadsheet for the breakfast meal on 11/5/24 revealed that the recipe called for 1-3 inch Belgian waffle, 2 slices of bacon 1/2 cup of seasonal fruit, and a #16 scoop (1/4 cup) of eggs, and 1 1/2 cups of hot cereal. e. On 11/5/24 at 6:02 PM, an observation was made of the dinner meal being plated. The meal served was 1 chicken thigh, a small ladle of marinara sauce, a small amount of shredded cheese, apple maple stuffing, and mixed steamed vegetables (cauliflower, broccoli, and carrots). It should be noted that the menu posted listed the menu for the dinner meal on 11/5/24 as Pineapple braised chicken with herbed rice and buttered spinach. A review of the spreadsheet for the dinner meal on 11/5/24 revealed the recipe called for a 4 oz breaded chicken thigh, 2 oz of spaghetti sauce sprinkled with 2 tsp (teaspoons) of parmesan cheese, an #8 scoop (1/2 cup) of apple maple stuffing, a #8 scoop (1/2 cup) of California blend vegetables. f. On 11/7/24 at 12:48 PM, an observation was made of the lunch meal being plated. The meal consisted of 2-4 oz spoons of creamy ranch macaroni and cheese, a 1/2 cup of cooked zucchini, and a pudding parfait with chocolate and vanilla pudding. For residents who could not have the zucchini or preferred not to have it a side salad was provided. For residents who were lactose intolerant, some noodles with marinara sauce were provided. It should be noted that residents that received the noodles with marinara sauce did not receive a source of protein for that meal. A review of the spreadsheet for the lunch meal revealed the recipe called for 1 cup of creamy ranch macaroni, a #8 or 1/2 cup of sauteed zucchini, 1 breadstick with butter and 1 Tbsp (tablespoon) of the pudding parfait. On 11/7/24 at 1:32 PM, an interview was conducted with the Assistant Dietary Manager (ADM) about the noodles with marinara sauce. The ADM stated it was not put into the [dietary software] to compare the meal for nutritional adequacy because there was not an alternate so they just had to wing it . The ADM stated they should look at the substitutions because I didn't realize it did not have the protein in it. 30563 2. Resident 55 was admitted to the facility on [DATE] with diagnoses which included Parkinson's disease with dyskinesia without mention of fluctuations, chronic obstructive pulmonary disease, type 2 diabetes mellitus, tremor, and personal history of other infectious and parasitic disease. On 11/4/24 at 8:45 AM, an interview was conducted with resident 55. Resident 55 stated he did not feel like he got enough food to eat and was not offered snacks. (continued on next page)		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Resident 16 was admitted to the facility on [DATE] with diagnoses which included cerebral infarction due to embolism of left middle cerebral artery, cognitive communication deficit, diabetes mellitus and major depressive disorder. On 11/5/24 at 9:19 AM, an observation was made of resident 16. Resident 16 was observed at the kitchen door yelling I'm [expletive removed] hungry, man! Resident 16 was observed to tell the Maintenance Director he needed to talk to the kitchen staff. The Maintenance Supervisor was observed to tell resident 16 that he needed to talk to the nurse and could not come through any door he wanted. Resident 16 was observed to tell the kitchen staff he was [Expletive removed] hungry and he had not received breakfast. The DM was observed to intervene between resident 16 and the Maintenance Supervisor. The DM asked resident 16 what he would like to eat for breakfast. Resident 16 was observed to tell the DM what he wanted for breakfast. Resident 16 was observed to use his wheelchair to motorize through the hallway to his room. On 11/5/24 at 9:23 AM, an interview was conducted with resident 16. Resident 16 stated the portions were too small. Resident 16 stated he should be getting double portions but never got that much. Resident 16 stated I'm hungry. On 11/5/24 at 6:08 PM, an observation was made resident 16's meal. Resident 16 had 1 breaded chicken breast with marinara sauce and cheese on it over pasta. Resident 16's medical record was reviewed. Resident 16's diet order revealed Consistent Carbohydrate diet regular texture, thin liquids consistency, double protein portions and extra 8 oz fluid with each meal. A care plan dated 7/29/23 and updated on 10/21/24 revealed Potential nutritional problem r/t [related to] diabetes, cognitive communication deficit, depression, aphasia, dysarthria, and anarthria. Non compliance with meals and food safety. Resident refuses to have tray pickup after 1 hour. He is at risk for infection, malnutrition, and potential food poisoning. The goal was The resident will comply with recommended diet for weight reduction daily through review date. Some of the interventions included 6/5/2024: Resident has expressed that he would like to gain weight, wanting to increase weight to 250 pounds. Resident is receiving double protein portions. Resident educated on weight gain.; Explain and reinforce to the resident the importance of maintaining the diet ordered. Encourage the resident to comply. Explain consequences of refusal, obesity/malnutrition risk factors; and Provide and serve diet as ordered. On 11/5/24 at 1:07 PM, an interview was conducted with Licensed Practical Nurse (LPN) 5. LPN 5 stated if resident 16 received small portions he yelled. LPN 5 stated there were new staff in the kitchen that had not been educated, so they did not send the right food to residents. 38031 4. Resident 15 was admitted to the facility on [DATE] with diagnoses which included hereditary ataxia, cognitive communication deficit, dysphagia, hypothyroidism, major depressive disorder, anemia, peripheral neuropathy, dysarthria and anarthria, speech disturbance, wedge compression fracture of third lumbar, edema, and insomnia. (continued on next page)		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/03/24 at 2:02 PM, an interview was conducted with resident 15. Resident 15 stated that the food was alright, but that sometimes she did not get enough to eat. Resident 15's electronic medical records were reviewed. On 9/11/24 the Annual MDS (Minimum Data Set) Assessment documented that the resident had a BIMS of 15, which would indicate that she was cognitively intact. On 5/1/24, resident 15's diet order was for a Regular (Reg) diet, Chopped Meat texture, Thin liquids consistency. Patient to be upright in wheel chair for all meals. On 9/11/24, the care conference summary documented under Food and Nutrition summary that resident 15 wanted to participate in the snack program and would like snacks at 10:00 AM, 3:00 PM, and 8:00 PM. Resident 15's eating task for the last 30 days documented 59 occasions when the resident consumed 75% to 100% of their meal. The task documented that the resident required set up assist for dining. [Cross-refer F809] On 11/4/24 at 4:37 PM, an interview was conducted with the ADM who stated the spreadsheets for each meal showed the different therapeutic diets and if residents who were on therapeutic diets could have the food items on the menu. The ADM stated for residents with specific therapeutic diets, an alternate would be listed that would be an appropriate substitution. The ADM stated normally if a substitution had to be made, the Administrator would have to be notified or the Registered Dietitian (RD). The ADM stated the software for the menus could be used to put in a substitution and it would verify if the substitution was nutritionally comparable to the item on the menu. The ADM stated if the app did not approve the substitution, it would suggest how to fix it. The ADM stated she had not had a problem reaching the Administrator or the RD when a substitution needed to be made. The ADM stated she would need to know in the morning if a substitution needed to be made so she could be sure there was enough food for the meal. The ADM stated if a resident did not like what was on the menu, they could ask for an alternative. The ADM stated she was told if a resident wanted something they could give it to them. (continued on next page)		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/5/24 at 11:03 AM, an interview was conducted with the RD. The RD stated she started working at the facility in September. The RD stated the ADM, who was previously working as the DM did not have experience in long term care. The RD stated the ADM did not receive much training from the previous DM. The RD stated she was not sure who should be providing education to the dietary staff. The RD stated if she identified a problem she would tell the administrator and would not provide the education. The RD stated the current DM had a lot of experience in long term care. The RD stated she had spoken to the current DM about some of her concerns and the DM told her he was working on it. The RD stated she had not completed any tray audits since she began working at the facility. The RD stated if she did a tray audit it would include asking for a test tray, taking the temperature of the food, looking at the presentation of the food, tasting the food, and compare what was served with the menu. The RD stated she could make substitutions on the menu for the day, which would require going into the software and changing the menu items. The RD stated if substitutions were made, they would be posted for the residents to see and a log of the substitutions would be kept in a binder for a year. The RD stated the DM could go into the software and make substitutions. The RD stated the software would make suggestions for an alternate when a substitution needed to be made. The RD stated she sort of knew if the dietary staff were not following the menu. The RD stated the previous week the DM was making a substitution and she looked it over and it was complete and had a protein on it. The RD stated the substitution would depend on what food items came on the truck in the food delivery. The RD stated the software company offered online training on how to use the software. The RD stated she was not sure if it was part of her role to train the DM on how to use the software. The RD stated she was new to using the software and those particular menus. The RD stated if the software was being used correctly, there was a help line for support. The RD stated when putting in a substitution, the menu would populate and let you know what needed to be added. The RD stated the DM should be self-monitoring when following the menus. The RD stated when reviewing a menu and the substitutions, she looked to ensure there was adequate protein, vegetables and that the menu was meeting the 5-a-day recommendations as well as vitamin A. The RD stated she had not looked at the menu for the current week, but there should be a seasonal rotation of the menu. The RD stated there were menus posted in the hallways, and menus the residents could take to their rooms. The RD stated if a resident did not want what was on the menu they could mark the menu and provide it to the kitchen. The RD stated she thought the Certified Nursing Assistants (CNA)s were taking menus to the resident rooms to ask the residents if they wanted to make any changes to the menu and then bringing the menus to the kitchen at the beginning of the week. The RD stated if the DM had questions or needed to contact her he could always call or text her. The RD stated she had worked with the DM for a long time and he did not have a problem asking questions. The RD stated her contract was for 8 to 12 hours per week. The RD stated with the current census she would need at least 20 hours per week to keep up with resident visits and quarterly assessments. The RD stated the 8 to 12 hours she was currently working did not include kitchen duties. On 11/5/24 at 3:48 PM, an interview was conducted with the Administrator (ADMIN) who stated the RD's responsibilities were in her contract. The ADMIN obtained a copy of the RD contract and stated her duties included, oversees dietary plans for resident's dietary needs based on medical needs .review and approve all menus to ensure they meet resident's nutritional needs in compliance with state and federal regulation . provide staff training on food and nutrition. The ADMIN stated the kitchen always made a little extra to ensure that everyone who wanted a meal would get one.		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43212 Based on observation, interview and record review it was determined, for 11 out of 65 sampled residents, that the facility did not provide food prepared by methods that conserve flavor and appearance or provide food and drink that was palatable, attractive, and at an appetizing temperature. Specifically, there were multiple complaints from residents about the quality of food, there were multiple resident council complaints about the flavor of food, and when surveyors pulled a test tray during the lunch meal, the food was found to be lacking in flavor and appearance. Resident identifiers: 9, 12, 16, 22, 26, 27, 28, 32, 50, 55, and 120. Findings included: 1. Observations: On [DATE] at 5:48 PM, an observation was made of the kitchen staff plating the dinner meal. The meal consisted of a grilled cheese quesadilla, herbed fettuccini noodles and a green salad. The Dietary Manager (DM) was at the steam table plating the food, cook 2 was putting the meal trays together. The Housekeeping Supervisor (HS) was helping in the kitchen, making salad and cooking the quesadillas. The DM put 2 quarters of a quesadilla onto the plate, 4 oz of herbed fettuccini noodles using a slotted serving spoon and handed the plate to cook 2. [NAME] 2 put the plate into a plate holder and covered the plate. For residents who required a mechanical meal, the quesadilla was torn into smaller pieces or cut into smaller pieces. A side salad covered with plastic wrap was placed on the tray. A small plastic cup of tapioca pudding was also placed on the tray. Silverware and drinks were put on the tray and it was placed into the meal cart. On [DATE] at 6:12 PM, the DM requested a cup of hot water from [NAME] 2. The DM poured the hot water into the noodles because they were drying out and mixed them up. On [DATE] at 6:43 PM, an observation of resident 12's dinner tray was made. The resident's plate had a quesadilla and bowtie pasta cut into bite-sized pieces. On [DATE] 8:06 AM, an observation was made of resident 27's breakfast meal. The banana was cut up into pieces and appeared brown in color and mushy. 2. Resident Interviews: On [DATE] at 2:05 PM, an interview was conducted with resident 50 who stated, There is room for improvement. Some of the meals are edible and some are not. On [DATE] at 2:37 PM, an interview was conducted with resident 120. Resident 120 stated the same menu items are repeated. Resident 120 stated the food temperatures were not consistent and food did not always taste good. On [DATE] at 5:33 PM, an interview was conducted with resident 9 who stated, The food is cold 90% of the time. (continued on next page)		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 8:06 AM, an interview was conducted with resident 27. Resident 27 stated that the food was undercooked and the bread was dry. Resident 27 stated that the food was not good and looked even worse. On [DATE] at 8:09 AM, an interview was conducted with resident 22. Resident 22 stated the portions were small and the food was not good. Resident 22 stated the food that should be hot was always cold and the cold food was warm. Resident 22 stated she wanted hot food hot and cold food cold. Resident 22 stated she ordered meals from a local delivery company because she did not like the meals served. On [DATE] at 8:22 AM, an interview was conducted with resident 32. Resident 32 stated the meals were not good and the kitchen had gone through 5 to 6 cooks. Resident 32 stated last night he was not sure what the food was, so he only ate the dessert. On [DATE] at 8:43 AM, an interview was conducted with resident 55. Resident 55 stated he had eaten better food than what the facility served. Resident 55 stated he was served a quesadilla and noodles last night. Resident 55 stated he did not get enough food to eat. On [DATE] at 8:43 AM, an interview was conducted with resident 26. Resident 26 stated that she was given a banana that was black inside and she was not going to eat it. Resident 26 stated that twice she had been given spoiled cottage cheese and she needed the extra protein in her diet. Resident 26 stated that the pancakes are tough and unable to be eaten. On [DATE] at 9:23 AM, an interview was conducted with resident 16. Resident 16 stated he either loved the food or hated it. On [DATE] at 12:43 PM, an interview was conducted with resident 28. Resident 28 stated there was not a good cook on the weekends. Resident 28 stated they needed a Dietitian, like one of the real ones that would know about things. 3. Observations in Kitchen On [DATE] at 9:03 AM, an observation was made of tray line. There were 6 trays for the hallway that did not have hot pellets. [NAME] 1 stated there were not enough hot pellets so about 6 trays did not have them. On [DATE] at 12:48 PM, an observation of the lunch meal tray line was conducted. The lunch meal was ranch macaroni and cheese and zucchini, a bread stick and pudding parfait. For the residents who could not eat zucchini, a salad was served. A container with noodles mixed with marinara sauce was also on the steam table. When asked about the noodles with marinara sauce, the Assistant Dietary Manager (ADM) stated the menu was not entered into the [Vender software] system for an alternate recommendation because there was not an alternate for the ranch macaroni and cheese so she just had to wing it. The ADM stated, they should look at the substitution because she did not realize it did not have any protein in it. (continued on next page)		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 1:35 PM, the trays for the memory unit were started, after the 200, 300, 400 and 500 hallway trays were sent out. A test tray was requested at 1:42 PM, before the cart for the memory care unit left the kitchen. At 1:49 PM, the cart for the memory care unit left the kitchen and was brought to the 300 hallway just outside of the memory care unit doors. At 1:52 PM, a CNA brought the cart into the memory care unit and began to pass meals. All residents were eating in their rooms. 4. Test Tray On [DATE] at 1:56 PM, the test tray was taken off of the meal cart after all residents had been served and it was brought to the conference room for testing. The results were as follows: a. Ranch macaroni and cheese- 106.4 degrees Fahrenheit, acceptable flavor, not warm to the taste. b. Marinara macaroni- 107.1 degrees Fahrenheit, tasted like spaghetti sauce on noodles, bland flavor, not warm to the taste. c. Zucchini- 109.2 degrees Fahrenheit, lacking in seasoning, bland, with an over cooked/mushy texture. d. Breadstick- not warm to the taste and dry to the taste e. Passion fruit juice- 52.7 degrees Fahrenheit with a nice flavor It should be noted that the cup the fruit juice was served in was not clean. On [DATE] at 11:03 AM, an interview was conducted with the Registered Dietitian (RD) who stated tray audits included asking for a test tray, taking the temperature of the food, tasting the food, observing the presentation of the food and if it was meeting the dietary guidelines and was what was stated on the menu. The RD stated she had not conducted any tray audits since she started working at the facility in September. On [DATE] at 3:47 PM, an interview was conducted with the Administrator (ADMIN). The ADMIN stated there were residents not happy with the food quality. The ADMIN stated a new Dietary Manager (DM) was hired with a lot of experience and the complaints had gone away. The ADMIN stated the DM started 3 weeks ago. The ADMIN stated there was an alternative menu. 50200 5. Resident council Minutes: A review of resident council notes revealed the following regarding the dietary department: a. [DATE]: .taste/quality concerns-deteriorated, of late . b. [DATE]: .Food Committee: Items to be addressed at next meeting with new dietary manager include allergies/ dietary restrictions being accommodated, snacks available, portions, preferences (fish/eggs served) etc . (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. [DATE]: Food improvement noted. Coffee/Cocoa Social supplies or able to increase the potency of the coffee left out in the Bistro. A couple of specific residents noted issues with their recent orders, which will be addressed on a case by case basis. d. [DATE]: .Some residents indicated that they thought some of their food was expired .The drinks also do not match some resident's expectations . e. [DATE]: .Several residents reported that food is cold. [Activities Director] shared that maintenance is in the process of replacing a heating element necessary to keep the trays warmer and those are actively being replaced. Some residents regularly receive clamshells instead of trays and asked why, as they get cold faster. It was reported that sometimes dishes are in short supply . 30563		

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43212 Based on observation, interview and record review it was determined, for 6 of 65 sampled residents, that the facility did not ensure that each resident received the food and drink that accommodated the resident allergies, intolerances, and preferences. Specifically, residents with food allergies and intolerances were served food containing identified allergens, and one resident who was admitted on [DATE] had not been questioned about food allergies until 11/5/24. Resident identifiers: 1, 10, 16, 26, 28, and 38. Findings included: 1. Resident 38 was admitted to the facility on [DATE] with diagnoses that included Parkinson's disease, type 2 diabetes with skin ulcer and neuropathy, cirrhosis of liver, morbid obesity, hemiplegia affecting right dominant side, anxiety disorder, aphasia, major depressive disorder, seizures and dysphagia. On 11/5/24 at 12:38 PM, an interview was conducted with resident 38 who stated he was allergic to onions and was provided a lunch entree that contained onions. Resident 38 stated his allergic reaction to onions was that he began to have anaphylaxis. Resident 38 stated that 2 to 3 weeks ago he was served tuna salad with onions and pickles. Resident 38 stated he was unaware that there were onions in the tuna salad. Resident 38 stated he started to feel his throat swell and went to the nurse immediately and was given a pink pill. Resident 38's medical chart was reviewed. Documentation under allergies in the medical chart dated 9/13/24 included onions. On 9/13/24 at 3:30 PM, an alert charting progress note revealed, Received report from [facility name] . Pt [patient] has an allergy to onions. On 9/16/24 at 1:00 AM, a provider progress note included, .Allergy list: Onions 9/13/24. On 10/18/24 at 7:44 PM, an administration progress note revealed, Benedryl allergy Oral Tablet 25 MG [milligrams]; Give 2 tablet by mouth every 4 hours as needed for Allergies. Do not take more than 6 doses in a 24 hour period. (continued on next page)		

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/5/24 at 5:36 PM, an interview was conducted with Licensed Practical Nurse [LPN] 1 who stated that during the dinner meal resident 38 stated his meal contained onions. The tray had been removed already. LPN 1 stated that she obtained a different tray and asked the resident if he had been given the same meal. The meal shown to the resident contained green onions. A meal from another cart was observed resident 38 was asked if the meal was the same as what he was given and he replied, yes. Vital signs were WNL [within normal limits], resident 38 had no complaints, vital signs were documented in [medical software], and the Director of Nursing [DON] was texted. The DON was called to see what should be done in the instance. The DON stated to LPN 1 to look in the stat [immediate] safe epi-pen, and if anything happened to call EMS [emergency medical services]. A vial of epinephrine was found to be in the stat safe. LPN 1 stated she assessed for any difficulty breathing, itchiness in throat or body, tingling in throat or mouth, and resident 38 denied any s/sx [signs or symptoms]. LPN 1 stated there was no swelling of the lips observed and resident 38 sat at the nurse's station for 30-40 minutes for monitoring and the resident was fine. LPN 1 stated that she did not notify the MD [medical doctor]. LPN 1 stated that she did not document a note about the incident but just called the DON. LPN 1 stated that after the incident, the nurses were checking resident meals tickets to verify that the meals were correct. LPN 1 stated resident 38 had a behavior of saying his food had onions in an effort to obtain more food. On 11/5/24 at 6:02 PM, an observation was made during the dinner meal service. The meal being served was chicken parmesan with steamed vegetables and apple maple stuffing. The Assistant Dietary Manager (ADM) plated the food by first putting a chicken breast on the plate, covered it in marinara sauce and sprinkled some shredded whole milk cheese on top. The ADM then added stuffing and a serving of steamed mixed vegetables. The ADM stated there were no onions in the stuffing. It should be noted that the marinara sauce contained tomatoes, sea salt, dehydrated onions, dehydrated garlic, spices, natural flavorings, sweet bell pepper, and citric acid. On 11/5/24 at 6:08 PM, an observation was made of Registered Nurse (RN) 1. RN 1 was observed at the meal cart in the 300 hallway. RN 1 was observed to look at each residents meal and meal ticket before handing it to a CNA. RN 1 was observed to look at resident 1's meal and meal ticket and handed it to the Laundry Supervisor (LS). On 11/5/24 at 6:24 PM, the LS brought a tray back to the kitchen and asked if any of the food items had onions. The Assistant Dietary Manager (ADM) stated there was no onion in the stuffing, but made another tray without stuffing as the resident thought there were onions in the stuffing. On 11/5/24 at 6:29 PM, a Certified Nursing Assistant (CNA) came to the kitchen stating that resident 1 received a plate with vegetables on it when vegetables were listed on his dislikes for meals. The ADM prepared another plate for resident 1 without vegetables. On 11/5/24 at 6:31 PM, the LS was observed enter the activity room and provide resident 1 a dinner tray during the activity. On 11/5/24 at 6:32 PM, an interview was conducted with the ADM. The ADM stated she was not aware that that the marinara sauce had dehydrated onions in the ingredients. The ADM stated resident 38 had eaten the sauce a million times and it had not done anything, so he should be fine with it. (continued on next page)		

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/5/24 at 6:35 PM, an interview was conducted with the DON. The DON stated she was not aware the marinara sauce had dehydrated onions in it. The DON stated Thank you for letting us know. On 11/5/24 at 6:41 PM, the facility Administrator (ADMIN) came to the kitchen and requested another plate for resident 38. The ADMIN stated resident 38 had received a meal with marinara sauce on it and there was onion in the marinara sauce. The ADMIN took the stuffing off of the plate and put it on a new plate and prepared a chicken breast with just cheese on top and vegetables and brought it to the resident. 2. Resident 10 was admitted to the facility on [DATE] with diagnoses that included personal history of traumatic brain injury, type 2 diabetes, bipolar disorder, post-traumatic stress disorder, morbid obesity, major depressive disorder, anxiety disorder, and cognitive communication deficit. On 11/6/24 at 8:51 AM, an interview was conducted with resident 10 who stated facility staff had come to his room on 11/5/24 and asked if he had any food allergies. Resident 10 stated his meal ticket now indicated he had food allergies to grapefruit, salmon, tuna, and green peas. A review of resident 10's medical record revealed no information about food allergies on admission assessment, or in the provider assessment completed on 8/22/24, or the admission nutrition assessment completed on 8/24/24. On 11/13/24 at 9:11 AM, an interview was conducted with the DON who stated staff were made aware of resident food allergies by what was printed on the resident's meal ticket. The DON stated meal trays were checked by the nurses and CNAs as well as the kitchen staff. The DON stated having the nurses check the meal tickets was initiated after the kitchen was struggling to catch food allergies and preferences on the resident's meal ticket. The DON stated when a resident was admitted, allergies should be on the resident's history and physical, and from that, the information was put in the resident's medical record and on the resident's meal ticket. The DON stated the Dietary Manager (DM) should be filling out a form with the resident about allergies and food preferences, but was unsure if that was being done. The DON was asked about resident 38 and the Benedryl that was provided to him on 10/18/24. The DON stated she did not remember the exact situation and as far as she was aware, there had not been any incidents of residents having a reaction as a result of a food allergy. The DON stated staff should be documenting why they were administering allergy medication and what the symptoms were when the medication was provided. The DON also stated allergy testing was ordered for all residents with food allergies so the reactions could be documented. 30563 3. Resident 16 was admitted to the facility on [DATE] with diagnoses which included cerebral infarction due to embolism of left middle cerebral artery, cognitive communication deficit, diabetes mellitus and major depressive disorder. On 11/5/24 at 1:00 PM, an interview was conducted with resident 16. Resident 16 stated he would die if he ate tomatoes. Resident 16 stated as a little kid thought he had one. Resident 16 stated the facility served him tomatoes. Resident 16 stated he was able to see if he had tomatoes were on his tray and did not eat them. Resident 16 stated he told staff Hello, tomatoes Die. Resident 16 stated that staff said they were sorry but did not stop sending him tomatoes. Resident 16's medical record was reviewed. (continued on next page)		

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 16 had allergies listed as Penicillin and Tomato. A Diet Type Report dated 11/3/24 revealed resident 16 had additional directions of double protein portions, extra 8 ounces fluid with each meal, per patient report highly allergic to tomatoes. On 10/8/24 at 9:08 PM a nursing progress note revealed, Resident extremely upset that his tray had tomatoes. He says he will 'die' if he eats it. added allergy to profile. On 11/5/24 at 6:08 PM, an observation was made of RN 1 at the 300 hallway meal cart. RN 1 was observed to look at resident 16's meal ticket and then lifted the lid of the tray. There was marinara sauce on the tray. RN 1 was observed to hand it to a CNA. The CNA was observed to take the tray to resident 16's room and place it on his bed. Resident 16 was not in his room. On 11/5/24 at approximately 6:30 PM, an interview was conducted with RN 1. RN 1 stated that she checked all the residents meal tickets and their meals to make sure they were not served foods they were allergic to or food they did not like. RN 1 stated that resident 16 was allergic to tomatoes but was not sure what his allergy was. RN 1 stated that marinara sauce was made of tomatoes and resident 16 should have not been served the sauce. On 11/5/24 at 7:15 PM, an interview was conducted with resident 16. Resident 16 nodded yes when asked if he was allergic to all tomatoes. Resident 16 stated, raw die. Resident 16 made a quarter-sized circle with his hand and pointed to the circle and stated, there, die. Resident 16 was asked if he could eat marinara sauce, and he responded, love marinara, raw die. On 11/5/24 at 11:34 AM, an interview was conducted with the Registered Dietitian (RD). The RD stated the DM or ADM updated food preferences a minimum of once per year. The RD stated if a resident went to the hospital then their allergies and preferences were reviewed upon readmission. The RD stated upon admission, there was admission paper work the nurse completed to let the kitchen know there was a resident with a food allergy. The RD stated she was not sure if resident 16 had food allergies but the kitchen should not serve the resident foods they were allergic to. 48709 4. Resident 28 was admitted to the facility on [DATE] with diagnoses which included hypertension, severe persistent asthma with acute exacerbation, and muscle weakness. On 11/3/24 at 1:33 PM, an interview and observation were conducted with resident 28. Resident 28 was in her room and had her lunch tray in front of her, a bowl of chocolate pudding with red thick liquid was observed on her tray. Resident 28 stated it was pudding and that it was supposed to be cherry pie. Resident 28 stated that she cannot have any dairy and that it would cause a system wide reaction and would make her nauseated and to have uncontrollable diarrhea. Resident 28's meal ticket was observed on her tray, it indicated, no pudding no cream pies cakes are ok .Alerts: [blank] .Dislikes: Dairy products (ALL DAIRY PRODUCTS) Pineapple rice. Resident 28's medical record was reviewed 11/3/24 through 11/13/24. A Minimum Data Set (MDS) Assessment, dated 9/23/24, indicated resident 28 had a Brief Interview for Mental Status (BIMS) of 10, which indicated a moderately impaired cognition. (continued on next page)		

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident's banner included, Allergies: Aspirin, Ibuprofen, Penicillin, Dairy, BLEACH. A Nutrition (Dietary) note, dated 6/25/24 at 11:54 AM, indicated, .Res [resident] is not agreeable to accepting supplement d/t [due to] stomach issues. She is also particular regarding food preferences, and has an allergy to dairy. A Nutrition (Dietary) note, dated 8/7/24 at 2:07 PM, indicated, RD Note/Consult: RD met with res regarding c/o [complains of] possible dietary issues. Res stated that her dietary issues/abdominal pain has resolved. She had eaten her whole hamburger at lunch and stated it was good. Res stated she ate some saltine crackers for a few days and this allowed her stomach to settle. Res was agreeable. Stated she didn't need any major changes. Res does have a dairy allergy. Continue to monitor and educate staff regarding dairy allergy. On 11/5/24 at 11:54 AM, an interview was conducted with RD. The RD stated resident 28 was allergic to dairy and should not have dairy, no milk, and no ice cream. The RD stated the pudding served on Sunday was probably made with milk. On 11/5/24 at 1:03 PM, an interview was conducted with CNA 8. CNA 8 stated she did not know of any allergies that resident 28 had, but that it would say it on the meal ticket if she had an allergy. On 11/5/24 at 1:27 PM, an interview was conducted with RN 4. RN 4 stated she did not know if resident 28 had any allergies. RN 4 stated if she did it should have been listed on the meal ticket. RN 4 looked at resident 28's electronic medical record and stated that it was listed on the clinical sheet that she was allergic to dairy. On 11/5/24 at 4:25 PM, an interview was conducted with the ADMIN. The ADMIN stated that if a resident had any allergies that it should have been listed on their meal ticket. The ADMIN stated that the kitchen would verify that the resident's allergies and preferences listed on the meal ticket were correctly followed. On 11/12/24 at 2:40 PM, an interview was conducted with the ADM. The ADM stated the dessert that was served on Sunday for lunch was a pie but it did not hold it's shape so it probably looked like a bowl of chocolate pudding. The ADM stated the chocolate pudding from the pie could have had dairy in it but was not able to provide the ingredients. 50200 5. Resident 26 was admitted to the facility on [DATE] with diagnoses which included facioscapulohumeral muscular dystrophy, unspecified protein-calorie malnutrition, hyperlipidemia, hypomagnesemia, hypo-osmolality and hyponatremia, and weakness. On 11/3/24 at 3:20 PM, an interview was conducted with resident 26. Resident 26 stated that she had an allergy to wheat and that it caused her to get blisters on her body. Resident 26 stated that she was recently given a grilled cheese sandwich that was made on wheat bread and that she could not eat it. Resident 26's meal card revealed that seafood and wheat were listed as allergies. (continued on next page)		

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/5/24 at 5:57 PM, an interview was conducted with resident 26. Resident 26 stated that she had eaten all of the stuffing that had come with her dinner. Resident 26 stated that she believed the stuffing was made out of cornbread because the kitchen staff should know that she had an allergy to wheat. Resident 26 stated that the meal ticket also stated that she had a wheat allergy. On 11/5/24 at 3:32 PM, an interview was conducted with the ADM. The ADM stated she did not add onions to the apple maple stuffing and the other ingredients were the same. According to the recipe, the Apple Maple Stuffing was made with bread, white wheat, whole grain. A review of facility resident council meetings revealed: a. May 2024: .Items to be addressed at next meeting with new dietary manager include allergies/dietary restrictions being accommodated, snacks available, portions, preferences (fish/eggs served) etc . b. June 2024: .Want to get issues resolved, once we have a manager: cheese sticks and pudding are usually available, missing often are: sandwiches, yogurt, juice, chips, cookies, crackers, etc. For some, they prefer to take their pills with these as a medium or are used for 'quick fixes' with low blood sugar #s [numbers] . c. August 2024: .Several residents commented that the meals are often missing condiments and that their plates do not match their preferences .		

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50200 Based on observation, interview and record review for 4 of 65 sampled residents, the facility did not ensure each resident received drinks, including water and other liquids, consistent with the residents' needs and preferences and sufficient to maintain resident hydration. Specifically, water was not being provided to residents between meals, residents had to seek out staff to obtain fresh water and resident water mugs were not being cleaned regularly. Resident identifiers: 26, 27, 55 and 120. Findings include: 1. Resident 26 was admitted to the facility on [DATE] with diagnoses which included, but not limited to, facioscapulohumeral muscular dystrophy, unspecified protein-calorie malnutrition, hyperlipidemia, hypomagnesemia, hypo-osmolality and hyponatremia, and weakness. Resident 26's meal ticket revealed an alert to encourage fluids. A review of resident 26's care plan revealed the following: a. Focus: Potential for Health Maintenance related to: Facioscapulohumeral muscular dystrophy, malnutrition, hyperlipidemia, hypomagnesemia, hyponatremia, headache, hx [history] of falling, osteopenia, palpitations, weakness, nausea, hx of nicotine use. Date Initiated: 6/26/23 b. Interventions: Administer medications as ordered by the physician Date initiated: 6/26/23 Assess for and provide adaptive equipment/assistive devices as needed Date initiated: 6/26/23 Educate resident on identifying signs and symptoms of worsening health conditions/disease processes and reporting them to staff Date initiated: 6/26/23 Elevate HOB [head of bed] PRN [as needed] for comfort Date initiated: 6/26/23 Monitor for increased pain and report to nurse/MD [medical doctor] Date initiated 6/26/23 Monitor labs per physician order Date initiated: 6/26/23 Offer and encourage fluid intake Date initiated: 6/26/23 Provide assistance with ADLs [activities of daily living] as needed Date initiated: 6/26/23 Refer to therapy to evaluate and treat as indicated Date initiated: 6/26/23 (continued on next page)		

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Report changes from baseline function/change of condition to MD Date initiated: 6/26/23 On 11/3/24 at 3:20 PM, an interview was conducted with resident 26. Resident 26 stated that she was not receiving water during the day. Resident 26 stated she had to ask for water or go out to the nurse's station to ask someone there for water. Resident 26 stated the kitchen did not have clean mugs for her to use. Resident 26 stated that she had to buy smaller mugs to fit in her sink so that she could wash them herself. Resident 26 stated she washed the mugs with hand soap at first, but was able to buy some dish soap. 2. Resident 27 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included, but not limited to, aftercare following joint replacement surgery, difficulty in walking, muscle weakness, type 2 diabetes mellitus with hyperglycemia, major depressive disorder, anxiety disorder, essential hypertension, unsteadiness on feet, and history of falling. A review of resident 27's care plan revealed the following: a. Focus: Risk for falls related to Arthritis, anxiety, Fatigue, weakness, Incontinence, Pain, Use of Antidepressants and Use of Narcotic analgesics. Date initiated: 7/22/20 Revision on: 10/12/22 b. Interventions: Ensure that resident is wearing appropriate non-skid footwear when transferring, ambulating or mobilizing in w/c [wheelchair]. Date initiated: 7/22/20 Revision on: 9/23/22 I prefer to keep all needed items like water pitcher, tissue box, urinal, etc, within reach Date initiated: 7/22/20 I would like staff to keep furniture in locked position during transfers and nursing care. Date initiated: 7/22/20 I would like staff to provide me a safe environment: even floors, free from spills and/or clutter; adequate, glare-free light; a working and reachable call light, the bed in low position at night; Side rails as ordered, handrails on walls Date initiated: 7/22/20 Offer me toileting assistance every 2-3hours [sic] while awake and PRN. Date initiated: 7/22/20 Revision on: 7/22/20 Please avoid repositioning the furniture in my room. Date initiated 7/22/20 On 11/04/24 8:22 AM , an interview was conducted with resident 27. Resident 27 stated that she had to get water for herself down at the nurse's station because she was not provided water throughout the day and call lights were not answered. On 11/6/24 at 5:30 PM, an observation was made of resident 27 walking down the hallway towards the nurse's station. Resident 27 asked Certified Nurse Aide (CNA) 6 for some water. (continued on next page)		

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Resident 120 was admitted to the facility on [DATE] with diagnoses which included, but not limited to lymphedema, superficial mycosis, cellulitis of right lower limb, activated protein c resistance, cellulitis of left lower limb, and morbid (severe) obesity due to excess calories. A review of resident 120's care plan revealed the following: a. Focus: Potential for altered skin integrity related to: incontinent, skin moisture, morbid obesity Date initiated: 9/17/24 b. Interventions: Administer treatments for skin impairment per physician order. Notify MD is skin impairment does not respond to current treatment regimen or resident experiences and adverse reaction. Date initiated: 9/17/24 Encourage good nutritional and oral fluid intake Date initiated: 9/17/24 Encourage/prompt resident to change positions regularly to offload pressure points. Resident is able to make major and frequent position changes without staff assistance. Date initiated: 9/17/24 Nurses to perform weekly skin assessment, Notify MD of any new skin impairments and obtain treatment orders as indicated. Date initiated: 9/17/24 Staff will help promote clean skin by encouraging/assisting resident to bathe regularly. Dry skin thoroughly after bathing. Keep skin moisturized by applying lotion as indicated. Date initiated: 9/17/24 Staff will provide prompt peri-care after incontinent episodes and may apply barrier cream as a skin protectant. CNAs may apply unmedicated barrier creams. Date initiated: 9/17/24 On 11/3/24 at 2:37 PM, an interview was conducted with resident 120. Resident 120 stated that the facility was not providing her with water throughout the day and that if she wanted water she had to go to the nurse's station and request water. 30563 4. Resident 55 was admitted to the facility on [DATE] with diagnoses which included Parkinson's disease with dyskinesia without mention of fluctuations, chronic obstructive pulmonary disease, type 2 diabetes mellitus, tremor, and personal history of other infectious and parasitic disease. On 11/4/24 at 8:45 AM, an interview was conducted with resident 55. Resident 55 stated there were no beverages offered between meals. (continued on next page)		

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/12/24 at 10:24 AM, an interview was conducted with resident 55. Resident 55 stated he got beverages with meals but not between meals. Resident 55 stated he had his own bottled water in his closet. Resident 55 stated he went shopping with a friend to buy the bottled water he stored in his closet. Resident 55's medical record was reviewed. Resident 55's care plan dated 5/28/24 revealed, The resident has nutritional problem r/t [related to] enteral feedings, difficulty swallowing, poor intake. The goal was The resident will maintain adequate nutritional status as evidenced by no unplanned/undesired significant weight changes, no s/s [signs and symptoms] of malnutrition, and adequate nutritional intake at meals through review date. Some of the interventions included Obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated and RD [Registered Dietician] to evaluate and make diet change recommendations PRN. A physician's order dated 7/1/24 revealed weekly cmp [comprehensive metabolic panel]/cbc [complete blood count] with auto diff [automatic differentiation] for monitoring of kidney function. One time a day every Mon [Monday] for monitoring. Laboratory results were reviewed. Labs were completed 9/32/24 and 11/4/24. It should be noted there was an order to have a CMP and CBC weekly. On 9/23/24 resident 55's Blood Urea Nitrogen (BUN) was 22 which was high with a reference range of 8/22 milligrams per deciliter (mg/dL) and a Creatinine level of 1.56 which was high with a reference range of 0.77-1.35 mg/dL. Resident 55's Glomerular filtration rate (GFR) was high at 50 milliliters per minute/1.73 m to the power squared (mL/min/1.73sq m2). On 11/4/24 resident 55's BUN was 29 which was high, Creatinine was 1.48 which was high and GFR was 53 which was low. On 11/12/24 at 11:08 AM, an interview was conducted with CNA 8. CNA 8 stated CNA's completed rounds and asked residents about water and snacks. CNA 8 stated some residents came to ice stations and asked for waters. CNA 8 stated she usually provided water when residents asked for it. CNA 8 stated residents had their own mugs or the kitchen provided reusable ones. CNA 8 stated she changed out the mugs when mugs looked dirty or if the resident requested a new one. A resident was observed walking to the ice station asking staff for water. CNA 8 stated that was how most residents got their water mugs filled was by asking at the ice station. On 11/6/24 at 8:51 AM, an interview was conducted with CNA 5. CNA 5 stated that when she started a shift at work that she would check residents to see if they wanted water, but that was the only time she would ask. On 11/6/24 at 9:38 AM, an interview was conducted with CNA 6. CNA 6 stated that in the past the kitchen staff would get the resident mugs cleaned and ready for resident use, but that had not been happening. CNA 6 stated that he tried his best to provide water to the residents, but that it did not always happen. On 11/7/24 at 9:15 AM, an interview was conducted with Licensed Practical Nurse (LPN) 2. LPN 2 stated that residents were supposed to be provided provided water at 10:00 AM and 2:00 PM. LPN 2 stated that CNA's and nurses helped to pass the water to residents. LPN 2 stated that most of the residents just go to the nurse's station and asked for water. (continued on next page)		

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/7/24 at 10:56 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that the CNA's would go around as part of their rounding and check with the residents and see if they would like water. The DON stated that rounding was done every two hours and the residents should be asked if they wanted something to drink. The DON stated that the residents got a new mug every morning and staff would take the dirty mugs away to get them clean. The DON stated that the nursing staff should be checking water cups throughout the day and making sure that residents were getting fluid. The DON stated that residents could go to the nurse's station and ask for water and that it was typical of residents to do that. The DON stated residents families provided water mugs for residents to have in their rooms. On 11/13/24 at 9:52 AM, a follow up interview was conducted with the DON. The DON stated fluid intake was monitored for residents that had catheters or were on a fluid restriction. The DON stated the amount of brief changes and lab work were monitored for dehydration. The DON stated a CBC and CMP would be obtained to determine hydration status. The DON stated staff would also look for physical signs of dehydration like skin turgor. The DON stated resident 55 did not have weekly labs in his medical record since 9/23/24 as ordered by the physician to determine kidney function.		

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30563 Based on observation, interview and record review, it was determined for 1 of 65 sampled resident, that the facility did not provide therapeutic diets as prescribed by the attending physician. Specifically, a resident with a physician's order for thickened liquids was observed to have thin water at the bedside. Resident identifier: 60. Findings include: Resident 60 was admitted to the facility on [DATE] with diagnoses which included type 2 diabetes mellitus, hypertension, dysphagia, history of falling, Gastroesophageal reflux disease (GERD), constipation and dementia. On 11/7/24 at 11:51 AM, an observation was made of resident 60. Resident 60 was laying in bed with 2 bottles half full with water on his bedside table. An interview was conducted with Certified Nursing Assistant (CNA) 4. CNA 4 stated the water on resident 60's bedside table was not thickened. CNA 4 stated resident 60 requested regular water. CNA 4 stated she needed to ask the nurse if resident 60 was able to drink regular water. CNA 4 was observed asking Registered Nures (RN) 3 if resident 60 had a risk vs. benefit to drink thin liquid. RN 3 was observed to tell CNA 4 she would have to ask the Director of Nursing (DON) about the water. Resident 60's medical record was reviewed. An admission Minimum Data Set (MDS) dated [DATE] revealed resident 60 had no signs and symptoms of a possible swallowing disorder. Resident 60 was on a therapeutic diet and mechanically altered diet. A care plan dated 8/27/24 revealed The resident has potential nutritional problem r/t [related to]dysphagia. The goal was The resident will maintain adequate nutritional status as evidenced by no unplanned/undesired significant weight changes, no s/sx [signs or symptoms] of malnutrition, and adequate nutritional intake at meals through review date. Interventions included Provide, serve diet as ordered. Monitor intake and record q [every] meal; RD [Registered Dietitian] to evaluate and make diet change recommendations PRN [as needed]; Weigh per facility protocol or NAR [nutrition at risk] committee recommendation. A physician's order dated 8/27/24 revealed CCHO (carbohydrate controlled) diet Mechanical soft texture with nectar consistency. An Admission Nutritional Assessment that was started on 8/28/24 was in progress and had not been completed. The diet was CCHO, mech (mechanical) soft, nectar thick liquids. Resident 60 had chewing and swallowing difficulty. There was no other information in the assessment. (continued on next page)		

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Speech Language Pathology (SLP) Evaluation and Plan of Treatment dated 8/27/24 revealed Treatment of swallowing dysfunction and/or oral function for feeding. It further revealed resident was newly downgraded to mechanical soft/nectar thick liquids. The reason for referral or current illness was resident was an [AGE] year old male with a history of dementia, dysphagia and GERD referred to skilled Speech Therapy (ST) services to assess and treat dysphagia and cognition/communication. Patient was provided with regular trials with thin liquids. Resident 60 exhibited immediate cough on thin liquids in small amounts by cup, despite self feeding with small sips without cues. He exhibited mild oral phase delays and moderate impulsivity of self feeding on regular solids, with mild to moderate pocketing and lingual residue noted. Diet was downgraded to mech soft/nectar thick liquids for safety, with further observation of tolerance to follow newly downgraded diet. A SLP Evaluation and Plan of Treatment dated 10/23/24 revealed Patient remains on mech soft/nectar thick liquids, with suboptimal positioning while eating in bed his current barrier to dietary trials and advance. Patient was focused on cognitive tasks provided, and was very fatigued - trials of higher level solids and liquids to follow. The Medical Factors were Precautions: Falls risk, mech soft/nectar thick liquids, aspiration precautions. There was no information regarding resident's swallowing or treatments provided for swallowing. A SLP Therapy Discharge Summary dated 10/27/24 revealed resident 60 was treated from 10/23/24 through 10/27/24. There treatments provided were for cognition. There was no information that resident 60's swallowing had been evaluated or treated. There was no risk verse benefits for thin liquids located in resident 60's medical record. On 11/12/24 at 11:17 AM, an interview was conducted with CNA 8. CNA 8 stated she thought resident 60 needed thickened liquids because the kitchen sent thickened with his meals. CNA 8 stated she was not sure what staff were to do for thickened drinks between meals. CNA 8 stated she had heard there were packs for the beverages but she had never seen them. On 11/7/24 at 9:20 AM, an interview was conducted with the Registered Dietitian (RD). The RD stated resident 60 was on nectar thickened liquids. The RD stated she asked Director of Nursing (DON) to reach out to SLP to do an evaluation on him to see if he still needs thickened liquids. The RD stated if a resident was on thickened liquids then there was usually a decreased liquid intake. The RD stated maybe the SLP had approved resident 60 to drink thin water between meals. The RD stated she was not able to access the therapy notes in the medical record. The RD stated she had not contacted the SLP regarding coordination of care for resident 60. On 11/12/24 at 2:58 PM, an interview was conducted with the DON. The DON stated there were packets of thickener in the nurses carts to thicken the beverages. The DON stated maybe on the CNA report sheet, it showed who required thickened liquids. The DON stated there was not a system to ensure residents were provided thickened liquids. The DON stated there was a risk vs. benefit after last week for resident 60 to drink regular water between meals. The DON stated resident 60 wanted to be able to drink his water bottles when eating his peanuts. The DON stated a Speech Therapy evaluation was done after the CNA found the water at resident 60's bedside. It should be noted the surveyor identified the thin liquid. (Cross refer to F807)		

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43212 Based on observation, interview and record review it was determined, for 12 of 65 sampled residents, the facility failed to provide each resident with 3 meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. Additionally, snacks were not provided to residents who wanted to eat at non-traditional times or outside of the scheduled meal service times and consistent with the resident plan of care. Specifically, meals were not served according to meal times, meal times were changed without resident input, snacks were not being provided regularly. Resident identifiers: 9,13, 16, 26, 27, 29, 32, 49, 53, 55, 60, and 120. Findings include: 1. Resident 9 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included heart failure, renal insufficiency, depression, and hypertension. On 11/3/24 at 5:33 PM, an interview was conducted with resident 9 who stated the food was cold 90% of the time. Resident 9 stated dinner came at 6 or 7 or whenever. Resident 9 stated there were no snacks available in the evenings. Resident 9 stated occasionally there would be a cheese thing or a small bag of chips, if they have them. 2. Resident 13 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included Hereditary and idiopathic neuropathy, chronic respiratory failure, symptomatic epilepsy and epileptic syndromes with simple partial seizures, morbid obesity, hypertensive heart and chronic kidney disease with heart failure, muscle weakness, major depressive disorder, and chronic pain. On 11/4/24 at 11:07 AM, an interview was conducted with resident 13 who stated meals were coming late regularly. 30563 3. Resident 16 was admitted to the facility on [DATE] with diagnoses which included cerebral infarction due to embolism of left middle cerebral artery, cognitive communication deficit, diabetes mellitus, major depressive disorder. (continued on next page)		

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/5/24 at 9:23 AM, an interview was conducted with resident 16. Resident 16 stated he was not served enough food because the portion sizes were too small. Resident 16 stated he should be getting double portions all the time. Resident 16 stated he was hungry. Resident 16 stated he had been hungry for about a year and a half. Resident 16 stated he did not get snacks and was told that corporate did not give snacks. Resident 16 stated he had to go to the kitchen to get food because if he asked anyone else they told him to wait a minute and did not get food. Resident 16 stated he was always told to wait a minute when asked for food. Resident 16 stated he had not been offered a snack last night and had gone to the kitchen yelling for food that morning. Resident 16 state he had not been served breakfast. Resident 16 was observed to have 3 cans of Campbell's chicken noodle soup, a bag with some rice in it, bag of small candy and a bag of spicy nacho chips. Resident 16 stated his sister had to bring him snacks all the time. 4. Resident 32 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included cerebral infarction, cognitive communication deficit, type 2 diabetes mellitus, and major depressive disorder. On 11/4/24 at 8:22 AM, an interview was conducted with resident 32. Resident 32 stated the meals were always late. Resident 32 stated last night he was not sure what the food was, so he only ate the dessert. Resident 32 stated he had diabetes and he was provided applesauce and chips if he got snacks. Resident 32 stated he use to get snacks but not anymore. Resident 32 stated last night he was offered Oreo's for a snack before bed. Resident 32 stated his blood sugars were usually good so he did not need protein with his carbohydrate before going to bed. Resident 32's medical record was reviewed. A Care Conference Summary Form dated 9/20/24 and locked on 10/3/24 revealed 32 wanted to participate in the snack program and be offered a snack at 10:00 AM, 3:00 PM, 8:00 PM. 5. Resident 49 was admitted to the facility on [DATE] with diagnoses which included unspecified dementia, paroxysmal atrial fibrillation, heart failure, and chronic kidney disease. On 11/3/24 at 6:39 PM, an interview was conducted with resident 49. Resident 49 stated snacks were a joke. Resident 49 stated if you did not get enough to eat and tried to get a snack, you have to find out who to trust at the facility. Resident 49 stated for example he asked staff for snacks and they said there was nothing but then he saw other residents with sandwiches and chips. Resident 49's medical record was reviewed. On 8/15/24 a Care conference revealed, Small Portions diet, Regular texture, Thin liquids consistency. Meal times are inaccurate and not according to schedule provided. Resident 49 wanted to participate in the snack program and desired to be offered a snack at 10:00 AM, 3:00 PM and 8:00 PM. 6. Resident 55 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Parkinson's disease with dyskinesia, type 2 diabetes mellitus, tremor, and atrial fibrillation. On 11/4/24 at 8:43 AM, an interview was conducted with resident 55. Resident 55 stated he was not offered snacks consistently. (continued on next page)		

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/12/24 at 10:25 AM, an interview was conducted with resident 5. Resident 5 stated he was not offered snacks and meals were late. 7. Resident 60 was admitted to the facility on [DATE] with diagnoses which included type 2 diabetes mellitus, hypertension, gastroesophageal reflux disease, dysphagia, history of falling, constipation and dementia. On 11/3/24 at 03:57 PM, an interview was conducted with resident 60. Resident 60 stated he did not get enough food. Resident 60 stated no snacks were offered and he would like snacks especially before bed. Resident 60 stated prior to admission he ate a snack before bed. Resident 60's medical record was reviewed. A Care Conference dated 8/27/24 and locked on 9/4/24 revealed a care conference was held on 9/2/24 revealed that resident 60 did not want to participate in the snack program and he would provided his own snacks. On 11/6/24 at 9:04 PM, a phone interview was conducted with the Resident Advocate (RA). The RA stated he was in charge of getting the care conference scheduled with the family and then filled out the form. The RA stated he asked each resident if they had any needs or concerns with the dietary department. The RA stated he asked residents if the food was palatable food and then triggered it to a grievance form. The RA stated he did not know why resident 60 had it documented that he would provide his own snacks. 38031 8. Resident 29 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included drug induced secondary Parkinsonism, adult failure to thrive, dementia, bipolar disorder, anxiety disorder, drug induced akathisia, suicidal ideation, post-traumatic stress disorder, nephrogenic diabetes insipidus, hyperparathyroidism, chronic kidney disease, schizoaffective disorder, hyperlipidemia, Meniere's disease, non-ST elevation (NSTEMI) myocardial infarction, obstructive sleep apnea, cognitive communication deficit, insomnia, hypertension, and chronic pain. On 11/3/24 at 2:21 PM, an interview was conducted with resident 29. Resident 29 stated that the facility was short on snacks and quite often they did not have snacks available. Resident 29 stated that she had informed staff of this problem. Resident 29 stated that the new guy in the kitchen said he would work on it. Resident 29 stated that both day and night time snacks were not available. Resident 29 stated that when they did have snacks they went fast, and they did not have enough for everyone. Resident 29 stated that staff did not offer snacks and the residents had to ask for them. Resident 29's medical record was reviewed. On 5/1/24, resident 29's diet order was Regular diet Regular texture, Thin liquids consistency. On 9/30/24, resident 29's care conference summary documented under the food and nutrition summary, RT [resident] states that combinations of items has been weird. The assessment documented that resident 29 wanted to participate in the snack program and would like snacks delivered at 10:00 AM, 3:00 PM, and 8:00 PM. (continued on next page)		

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	50200 9. Resident 26 was admitted to the facility on [DATE] with diagnoses which include facioscapulohumeral muscular dystrophy, unspecified protein-calorie malnutrition, hyperlipidemia, hypomagnesemia, hypo-osmolality and hyponatremia, and weakness. On 11/3/24 at 3:30 PM, an interview was conducted with resident 26. Resident 26 stated that she was never offered snacks, but if you asked certain CNA's they would go and look to see if they had any snacks. Resident 26 stated that on occasion there would possibly be yogurt or string cheese available. 10. Resident 27 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which include difficulty in walking, muscle weakness, type 2 diabetes mellitus with hyperglycemia, major depressive disorder, anxiety disorder, essential hypertension, unsteadiness on feet, and history of falling. On 11/4/24 at 8:06 AM, an interview was conducted with resident 27. Resident 27 stated that she had asked for snacks and had been told on multiple occasions that there were not any snacks available. Resident 27 stated that the staff knew her family brought in food and snacks for her and that was why she was rarely asked if she wanted a snack. 11. Resident 53 was admitted to the facility on [DATE] with diagnoses which included, osteomyelitis of vertebra, anxiety disorder, type 1 diabetes mellitus with hyperglycemia, unspecified protein-calorie malnutrition, sepsis, psoas muscle abscess, alcohol abuse, and major depressive disorder. On 11/6/24 at 1:26 PM, an interview was conducted with resident 53. Resident 53 stated that she was a diabetic and needed snacks when her blood sugar got low and this happened quite often. Resident 53 stated that she had to have family provide her with snacks because the facility had not offered any to her. 12. Resident 120 was admitted to the facility on [DATE] with diagnoses which included lymphedema, superficial mycosis, cellulitis of right lower limb, activated protein c resistance, cellulitis of left lower limb, and morbid (severe) obesity due to excess calories. On 11/3/24 at 5:39 PM, an observation was made of resident 120 knocking on the kitchen door and asking the kitchen staff if she could have some snacks. On 11/3/24 at 5:40 PM, an interview was conducted with resident 120. Resident 120 stated that she was hungry and the kitchen staff only had some string cheese that they could provide her with. Resident 120 stated that this occurred quite often. Resident 120 stated that snacks were not provided unless she went to the kitchen and asked. (continued on next page)		

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/5/24 at 12:53 PM, an interview was conducted with Certified Nursing Assistant (CNA) 6. CNA 6 stated that resident 29's biggest complaint was not getting enough food. CNA 6 stated that the snacks available for residents were chips, cheese sticks, and yogurt. CNA 6 stated that it depended on if it was available and they had those snacks about 80% of the time. CNA 6 stated that if there were no snacks they recommended to the residents that they provide their own snacks. CNA 6 stated that otherwise they tell the residents that they had to wait for the next meal. CNA 6 stated that they use to have sandwiches available for snacks but none recently due to the staff fluctuations in the kitchen. CNA 6 stated that they provided snacks at 8:00 AM, 10:00 AM, 3:00 PM, and 8:00 PM. CNA 6 stated that they wanted to keep snacks available to those times so it stays a snack an not a meal. On 11/5/24 at 1:32 PM, an interview was conducted with CNA 5. CNA 5 stated that the facility snacks were graham crackers, Oreo cookies, chips, pudding, yogurt, and string cheese. CNA 5 stated that she could get a ham and cheese sandwich or a peanut butter and jelly sandwich from the kitchen but there were times that those items were not available. CNA 5 stated that snacks were offered at 10:00 AM, 2:00 PM, and 8:00 PM. On 11/5/24 at 2:46 PM, an interview was conducted with staff member 1 who stated meals were not being served at regular times and sometimes as late as 9:00 PM. Staff member 1 also stated that residents needed scheduled meals due to having diabetes and needed a certain amount of time between their meals to sustain blood sugar levels. Staff member 1 stated snacks were provided once in a while. Staff member 1 stated at night between dinner and breakfast, there was nothing in the hydration room because dietary staff did not deliver them. Staff member 1 stated often the snacks provided were not appropriate for the residents. On 11/12/24 at 10:54 AM, an interview was conducted with CNA 8. CNA 8 stated there were specific times for snacks. CNA 8 stated the kitchen was slow to getting snacks to the CNA's us, so it was hard to offer the snacks. CNA 8 stated the hydration room should be stocked with chips, yogurt, applesauce but they were usually empty. CNA 8 stated staff had to go to kitchen to obtain snacks. CNA 8 stated she offered residents snacks, but then told residents she could not guarantee that there was a snack. CNA 8 stated if she offered a snack or a resident asked for a snack, then she went to hydration room for a snack. CNA 8 stated if there were no snacks in the hydration room then she went to the kitchen for a snack. CNA 8 stated sometimes the kitchen did not have snacks and she went back to the residents and apologized to the resident that there were no snacks. CNA 8 state it was hard to get rounds done, snacks delivered, meals done and showers with 2 people because there was not enough staff. On 11/5/24 at 3:47 PM, an interview was conducted with the Administrator (ADMIN). The ADMIN stated that there was a list posted with the snacks that were available to residents. The ADMIN stated that whenever he looked snacks were available. The ADMIN stated that snacks were located in the nutrition rooms. The ADMIN stated that snacks are available at anytime, but mostly at night. The ADMIN stated that he had heard some residents say that there were not snacks available. (continued on next page)		

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/5/24 at 4:46 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that snacks were available to residents. The DON stated that the CNA's went around and offered snacks to the residents. The DON stated that snack times had changed since meal times have changed. The DON stated that there were sandwiches, chips, and fruit cups available to residents for snacks. The DON stated that all residents should be asked if they wanted a snack at the designated snack time. The DON stated that typically there was one snack per resident so that not everyone was taking all the snacks. The DON stated the snack program meant that residents who wanted to be asked if they wanted a snack. The DON stated residents usually wanted to be offered a snack. The DON stated she could not think of a time when the facility ran out of snacks. The DON stated there were sugar free snack options for diabetic residents. The DON stated she had not heard of any residents having to go and buy their own snacks. The DON stated typically one snack per resident was offered to ensure that they did not run out. On 11/7/24 at 9:20 AM, an interview was conducted with the facility Registered Dietitian (RD). The RD stated she did not know how the snack program worked. The RD stated she would be surprised if there was a snack program at the facility. On 11/12/24 at 2:55 PM, a follow-up interview was conducted with the DON. The DON stated some people have preferences for their own snacks and staff had not asked what snacks residents want. The DON stated that would be a good idea to look at residents preferences. The DON stated resident's should not have to buy their own snacks. A review of the facility resident council minutes revealed the following: a. May 2024: .Items to be addressed at next meeting with the new dietary manager include allergies/dietary restrictions being accommodated, snacks available, . b. June 2024: .Want to get issues resolved, once we have a manager: cheese sticks and pudding are usually available, missing often are: sandwiches, yogurt, juice, chips, cookies, crackers, etc. For some, they prefer to take their pills with these as a medium or are used for 'quick fixes' with low blood sugar #s [numbers] . c. October 2024: .Many residents commented that snacks are not available or there is very little variety, most days . On 11/6/24 at 3:00 PM, the facility resident council was attended. Several residents in attendance stated that they were not offered or given snacks. (Cross Refer to F725, F802 and F803)		

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48709 Based on observation, interview, and record review, it was determined for 1 of 65 sampled residents, that the facility failed to provide special eating equipment and utensils for residents who needed them to ensure that the resident could use the assistive devices when consuming meals and snacks. Specifically, one resident was not provided with a lipped plate when identified as needing one. Resident identifier: 5. On 11/4/24 at 10:06 AM, an observation was made of resident 5 feeding himself in his room. The resident was eating off of a flat plate, no lip or divided plate was observed. A meal ticket was observed on his tray and indicated, Adaptive Equip: Lip Plate. Findings included: Resident 5 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included quadriplegia, dysphagia, chronic kidney disease, chronic obstructive pulmonary disease, paralysis of vocal cords and larynx, congestive heart failure, and major depressive disorder. Resident 5's medical record was reviewed 11/3/24 through 11/13/24. A Minimum Data Set (MDS) Admission assessment Section GG- Functional Abilities and Goal, dated 10/21/24, indicated resident 5 had impairment on one side of his upper extremity. A physician's order, dated 6/21/24, indicated, Regular diet Regular texture, Thin liquids consistency, Divided plate. The Care Plan included a focus of, [Resident 5] requires a Regular diet, Regular texture and thin liquids & is at risk for nutritional decline d/t [due to] dx [diagnosis] quadriplegia, Tracheotomy, dysphagia, COPD [chronic obstructive pulmonary disease], protein calorie malnutrition, GERD [gastroesophageal reflux disease], Constipation & ileus, & recent bowel obstruction & pneumonia. It indicated a goal of, The resident will maintain adequate nutritional status as evidenced by no undesired significant weight changes, no s/sx [signs or symptoms] of malnutrition, and adequate nutritional intake at meals through review date. Date Initiated: 07/29/2023 Revision on: 12/20/2023 Target Date: 02/04/2025. It further indicated interventions that included, Patient to use divided plate to promote adequate nutrition. Date Initiated: 02/22/2023. On 11/12/24 at 2:34 PM, an interview was conducted with Certified Nurse Assistant (CNA) 6. CNA 6 stated resident 5 needed assistance with setting up but that he could feed himself. CNA 6 stated he needed a lipped plate because he did not have a full range of motion with his arms, and it helped him from dropping food. On 11/12/24 at 2:40 PM, an interview was conducted with the Assistant Dietary Manager (ADM). The ADM was reading resident 5's meal ticket and stated that staff would provide a lipped plate unless they were out of them. The ADM stated that a lipped plate should be provided and that they were ordering more lipped plates. (continued on next page)		

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/12/24 at 2:52 PM, an interview was conducted with the Occupational Therapist (OT). The OT stated that she talked to resident 5 about using a scooped plate and that he did not find it useful for him. The OT stated that they were struggling to find him an extended fork that would help him eat. The OT stated it was important for resident 5 to get his nutrition but when he feeds himself, the food will drop off the utensil and he would miss his mouth. The OT stated he practiced using an extended fork when she could help him but that he was currently using a regular fork when she could not assist him.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43212 Based on observation and interview, the facility did not store, prepare, distribute and serve food in accordance with professional standards for food service safety. Specifically, the kitchen was dirty with spills and dried food down near the burners, the large mixer had a white substance on the arms that hold the bowl and under the mixer, the oven floor was caked with spilled food on the bottom, food items in the walk-in freezer were open to air, food items in the reach in refrigerator were not labeled, and food items in the dry storage room were open to air. Additionally, staff with facial hair were not wearing a beard cover, personal phones were in the food preparation area, there was damage to several areas of the wall, tiles missing around the baseboard, and there was crumbs and food particles under the dish machine, stove and oven. Findings included: 1. On 11/3/24 at 1:15 PM, an initial walk-through of the kitchen was conducted. In the reach in refrigerator, hash brown patties were in a pan and were covered, but not labeled. There was no thermometer in the reach in refrigerator, and no temperature log on the outside. The walk in freezer had a temperature of -4 degrees Fahrenheit on the outside, but no thermometer could be found inside. A box of frozen dinner roll dough was open to air and a box of sausage patties was open to air. In the dry storage room, a bag of granulated sugar was open to air, and a container of graham cracker crumbs was open to air. In the food service area, there were 2 bags of cold cereal on top of a tray rack that were open to air. The large mixer had a white substance on the arms that hold the bowl and on the floor underneath. The burner plates on the stove were dirty, and crumbs were down around the burners. There was a large amount of crumbs and spills on the floor of the oven. There was rust around the drain behind the ice machine. Tiles were missing around the baseboard outside the freezer, and there was a loose tile along the wall behind the meal carts. The wall behind where the meal carts were stored was damaged and there was a white substance on the floor beneath the carts. On 11/3/24 at 1:20 PM, an observation was made of the cook and dietary aid serving the lunch meal. A cell phone was sitting above the steam table playing music. The cook, who had facial hair, was not wearing a beard cover. On 11/3/24 at 5:49 PM, an observation was made of the kitchen during the time the dinner meal was being plated. The large mixer had a white substance on the arms that hold the bowl, and there was a white substance on the floor beneath the large mixer. A tray on the tray cart had a brown substance on it and a piece of plastic wrap. The burner plates on the stove were dirty with crumbs down around the burners. There was food splatter on the front of the griddle and stove. On 11/5/24 at 6:02 PM, an observation was made of the kitchen during dinner meal service. The large mixer had a white substance on the arms that hold the bowl and below the mixer. Inside the large bowl was some dough that was covered with plastic wrap. The plastic wrap was labeled S.D. 11/5. There were apple slices on the floor, and a white substance that looked like dough on the floor that had been stepped on. A personal cell phone was above the steam table playing music. There was food crumbs and spills on the floor of the oven. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 11/7/24 at 1:35 PM, an observation was made of the kitchen during lunch service. A personal cell phone was above the steam table playing music while food was being plated. The cell phone was observed to fall into the macaroni and cheese below it. The Assistant Dietary Manager (ADM) who was serving the food removed the phone and continued to serve the meals. On 11/8/24 at 10:06 AM, an additional walk-through the kitchen was conducted. The large mixer was observed to have a white substance on the arms that hold the bowl and under the mixer. The stove and griddle had dried food splatter on them, the splash panel behind the griddle and stove was not clean. Temperature logs were observed outside of the walk in refrigerator and freezer, and the reach in refrigerator. The logs had been filled out through the beginning of November. In the reach in refrigerator, a bag of cheese and a bag of meat were observed to not be labeled, there was a container of red onions that were not labeled or dated. There were 12 Styrofoam bowl with what appeared to be dry cereal in them that were not labeled or dated, and a bag of lettuce that was not dated. In the dry storage room, a large bag of oats was not sealed or covered, sea salt caramel toffee sauce was not dated, and canned roasted red pepper strips were not labeled. In the walk in refrigerator, a bucket of chicken base was not dated. There was a leaking pipe that was dripping on a bottle of sea salt caramel toffee syrup that was not labeled and on the top shelf. There were bowls of what appeared to be pudding that were covered but not dated. A package of provolone cheese was observed to be open to air on the shelf and was not dated. A bag of cheddar cheese was not dated. There was chicken on the bottom shelf that was not dated. A box of raw bacon was open to air, and 2 bags of chives were not dated. In the walk in freezer, two boxes of frozen hash browns were open to air, a package of tater tots was not dated. Two boxes of frozen cookie dough were open to air, a box of whole frozen strawberries was open to air, a box of turkey franks was open to air, pork sausage links were open to air, a package of what appeared to be large sausage franks was open to air. There was ice on top of the back shelf, and icicles hanging from a hose in the freezer. The wall near the hand washing sink was damaged and the dry wall was exposed. The wall behind the mixer was damaged with the dry wall exposed. The drain behind the dish machine was rusty and dirty. There was a white substance on the wall behind the ice machine. The drain under the 3 sink area had rust around it and the drain under the defrost sink was rusty. Boxes of butter packets, jelly packets, sweetener, moist towelettes and a silverware holder with spoons and a paring knife was observed to be on the floor. The wall was dirty behind the coffee machine On 11/3/24 at 1:15 PM, an interview was conducted with the ADM who stated she was checking the dish machine temperatures after she finished all the dishes for the meal. The ADM stated if the temperature did not meet appropriate levels, she would report it to the Dietary Manager (DM). The ADM stated the dish machine was a low temperature machine. The ADM stated she was not positive as to what the appropriate temperature should be while running the dish machine, but had been going by 100 degrees Fahrenheit. The ADM was unable to find strips to check the chemical sanitizer level and stated the staff had not been checking it. The ADM stated they had not been keeping a log of the dish machine. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 11/8/24 at 10:37 AM, an interview was conducted with the ADM. The ADM stated she knew the dishes were being sanitized because the sanitizer, soap and rinse aid were visible dropping into the machine. The ADM stated she did not know what the required temperature should be for the dish machine. The ADM stated if the temperatures were not meeting requirements there was no way to verify that the dishes were being sanitized. The temperatures observed after several cycles of the dish machine were 74 degrees for the wash cycle, and 90 degrees for the rinse cycle. The ADM stated she did not know where the strips were to check the sanitizer in the dish machine. The ADM stated when the company who serviced the machine came last, the chemicals were adjusted and checked but the staff had not been checking since then. After the additional walk-through of the kitchen, the DM was not available for an interview. 50200 2. Resident 26 was admitted to the facility on [DATE] with diagnoses which include, but not limited to, facioscapulohumeral muscular dystrophy, unspecified protein-calorie malnutrition, hyperlipidemia, hypomagnesemia, hypo-osmolality and hyponatremia, and weakness. On 11/3/24 at 3:20 PM, an interview was conducted with resident 26. Resident 26 stated that the kitchen used to clean the mugs that residents used on a daily basis. Resident 26 stated that mugs were not getting clean and she began to wash the mugs she received with hand soap prior to using them. Resident 26 stated that washing the mugs in her bathroom sink was difficult due to size and that she purchased her own smaller mugs to use. Resident 26 stated that she purchased dish soap and washed the mugs in her bathroom sink because clean mugs were not provided to her.		

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F 0835 Level of Harm - Actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 38031 Based on observation, interview and record review it was determined, for 45 out of 65 sampled residents, that the facility was not administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Specifically, deficient practice identified during the survey regarding abuse was found to have occurred at an Immediate Jeopardy level. Additionally, deficient practice identified during the survey regarding involuntary seclusion, pressure ulcers, accident hazards, bowel and bladder incontinence, sufficient staffing, competent nursing staff, behavioral health services and sufficient dietary personnel were found to have occurred at a harm level. Resident identifiers: 1, 3, 4, 5, 6, 9,10, 13, 14, 15, 16, 18, 20, 22, 24, 26, 27, 28, 29, 30, 32, 34, 36, 38, 44, 45, 46, 49, 50, 51, 52, 53, 54, 55, 57, 60, 61, 65, 67, 120, 121, 269, 319, 371, and 419. Findings included: 1. Based on interview and record review, it was determined for 7 out of 65 sampled residents that the facility did not ensure that each resident had the right to be free from abuse and neglect. Specifically, residents were not assessed for the capacity to consent to a sexual relationship. This was cited at an immediate jeopardy level, Another resident experienced unwanted sexual contact from another resident. In addition, a resident without capacity was able to leave the facility against medical advice and was charged with trespassing. The last 2 examples were cited at a harm level. Resident identifiers: 6, 49, 54, 67, 121, 319, 419. (Cross refer to F600) 2. Based on interview and record review it was determined, for 1 of 65 sampled residents, that the facility failed to ensure the resident was free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. Specifically, a resident was relocated to the locked memory care unit for not following the smoking policy. Resident identifier: 46. (Cross refer to F603) 3. Based on record review and interview it was determined, for 1 of 65 sampled residents, based on the comprehensive assessment of a resident the facility did not ensure that a resident with a pressure ulcer received the necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Specifically a resident's wound Vacuum-Assisted Closure (VAC) was not working for approximately 24 hours and the physician was not notified until the resident was somnolent. Resident identifier: 371. (Cross refer to F686) (continued on next page)		

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F 0835 Level of Harm - Actual harm Residents Affected - Some	4. Based on observation, interview, and record review, it was determined for 5 of 65 sampled residents that the facility failed to 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 fell as a result of the use of damaged medical equipment; no updated interventions were implemented after resident falls, with one resident having sustained a major injury; neurological assessments were not completed after falls and a call light was not within reach. Resident identifiers: 1, 5, 13, 18, 51, 52 and 60. (Cross refer to F689) 5. Based on observation, interview and record review, for 3 of 65 sampled residents, the facility did not ensure a resident who was continent of bladder and bowel on admission received services and assistance to maintain continence unless his or her clinical condition is or became such that continence was not possible to maintained. Specifically, a resident had a urine analysis (UA) obtained and 12 days later staff obtained the results and treatment was started for a urinary tract infection (UTI). The resident complained of flank pain during the 12 days and was administered Tylenol. Another resident was occasionally incontinent of bladder upon admission was not provided a bladder retraining program. In addition, the same resident was observed to have a call light on for 8 minutes, yelling for help, and another resident found staff to clean him up after having a bowel movement. Those 2 examples will be cited at a harm level. Another resident had an antibiotic for a UTI discontinued prior to finishing the course of the antibiotic. Resident identifiers: 1, 52, 55 and 60. (Cross refer to F690) 6. Based on interview, observation and record review it was determined, for 7 of 65 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, a resident was soiled and calling for help, incontinence cares were not being completed every 2 hours, showers were not provided to residents, there were complaints of staff not answering call lights and resident council minutes revealed complaints of not enough staff. Resident identifiers: 15, 26, 27, 49, 52, 55, 60 and 120. (Cross refer to F725) 7. Based on observation, interview and record review it was determined that the facility did not have sufficient nursing staff with the appropriate competencies and skills set 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. Specifically, inadequate oversight by the Director of Nursing resulted in multiple system failures in resident care areas which placed residents at harm. Resident identifiers: 1, 3, 4, 5, 9, 10, 13, 15, 16, 20, 26, 27, 28, 29, 32, 34, 38, 45, 46, 49, 51, 52, 53, 55, 57, 61, 65, 120, 269, and 371. (Cross refer to F726) (continued on next page)		

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F 0835 Level of Harm - Actual harm Residents Affected - Some	8. Based on interview and record review it was determined, for 1 of 65 sampled residents, the facility did not provide the necessary behavioral health care and services to attain or maintain the highest practical physical, mental, and psychosocial well-being. Behavioral health encompasses a resident's whole emotional and mental well-being. Specifically, a resident with a history of suicidal ideation's had a traumatic life event occur with no behavioral health services provided. The resident was found to have taken 4 to 5 bottles of Tylenol and was sent to the emergency room for an overdose. Resident identifier: 45, 57. (Cross-refer 740) 9. Based on observation, interview and record review it was determined, for 17 of 65 sampled residents, that the facility did not employ sufficient staff with the appropriate competencies and skills set to carry out the function of the food and nutrition services, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment. Specifically, meals were observed to be served over an hour later than the posted meal times, a resident was observed to be yelling he was hungry, residents were in the hallways waiting for food, residents were upset in the dining room waiting for meals and residents council minutes revealed complaints of late meals. Resident 16 will be cited at a harm level. Resident identifiers: 9, 13, 14, 16, 22, 24, 26, 27, 30, 32, 36, 38, 44, 50, 52, 55 and 120. (Cross refer to F802) 30563		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43212 Based on interview and record review, the facility did not ensure that, for 6 of 65 sample residents, medical records were complete and accurately documented. Specifically, neuro checks were not documented in the resident's medical record, records were not obtained after a resident went to and returned from the hospital, a resident's medical information was found in another resident's medical record, and a physician documented a progress note in the wrong resident's medical chart. Resident identifiers: 10, 13, 26, 220, 221 and 371. Findings include: 1. Resident 221 was admitted to the facility on [DATE] with diagnoses that included Multiple Sclerosis, paraplegia, infection and inflammation due to indwelling urethral catheter, and extended spectrum beta lactamase resistance. Resident 221's medical records were reviewed between 11/3/24 and 11/13/24. On 10/18/24 at 8:07 PM, an alert charting progress note revealed, At 7:00 PM CNA [Certified Nursing Assistant] informed me that resident was acting really wierd [sic]. I came into the room and resident appeared [sic] asleep but breathing. I rubbed his arm and said his name, he responded with than you, please, I asked him if he knew where we are, he responded with thank you I asked him how old he was he said thank you please. He would only open his eyes when asked to and would close them shortly after. Upon shining my pen light on his pupils they constricted only slightly going from 7 mm [millimeters] to 4 mm. Residents vital signs were normal with a low grade fever of 99.5 which later jumped to 100.5 F [Fahrenheit]. Upon auscultation lungs were clear, heart rate was rapid, and I wasn't able to tell but it may have sounded abnormal. Upon contacting [name redacted] the DON [Director of Nursing] we determined we should send him to the hospital. [ambulance provider] was called and came. The Paramedics assessed him and also agreed his was needing to go to the hospital. Resident was taken to the hospital. On 10/19/24 at 3:07 AM, an alert charting progress note revealed, Resident returned to facility from ER [emergency room] visit via [ambulance provider] at 2:05 AM. Resident yelling out oh god oh god repeatedly. Usually wants several pillows used for positioning of arms and legs in bed, refused to allow staff to place any of them. Refused podis boots. Went to sleep only a few minutes after EMS [emergency medical services] left. Nurse [name redacted] at [hospital] called in report and stated resident was given IV [intravenous], catheter and ostomy changed, wound dressings changed and CT [computer tomography] of head negative. Reports resident is alert and oriented to self and date only. DC [discharge] paperwork lists diagnoses as: decubitus ulcers, chronic indwelling foley catheter, h/o [history of] brain tumor, paraplegia and anemia. tests performed while at ER: CBC [complete blood count], CMP [complete metabolic panel], drug of abuse screen-urine toxology, free T4 [free thyroxine], lactic acid-plasma, PT/INR [protime/international normalized ration], Sars-CoV-2 [Severe acute respiratory syndrome-Corona Virus-2], Flu [influenza], RSV [Respiratory syncytial virus] by RT PCR [real time polymerase chain reaction], serum drug tox [toxicity] screen, TSH [thyroid]stimulating hormone] with reflex free T4, UA [urinalysis] with micro [microscopic], CT brain/head without contrast, and ECG [electrocardiogram] 12 lead. No new orders. (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	It should be noted that no hospital summary or discharge documentation, laboratory tests, or CT test results could be found in resident 221's medical record. 2. Resident 13 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included Hereditary and idiopathic neuropathy, chronic respiratory failure, symptomatic epilepsy and epileptic syndromes with simple partial seizures, morbid obesity, hypertensive heart and chronic kidney disease with heart failure, muscle weakness, major depressive disorder, and chronic pain. On 5/27/24 at 4:45 AM, an alert charting progress note revealed, Found pt [patient] laying on her bed with a hematoma on her forehead. Pt with a laceration to her nose. Severe pain to her right shoulder and pain and bruising to her left knee. Pt states that her pant leg got caught on her electric w/c [wheelchair] and she fell forward. Pt got herself up into her bed and then called for assistance. Pt requested to go to ER for evaluation of her right shoulder. Non-emergent ambulance called. Notified physician on call and pt's daughter. Pt sent out at this time. On 5/27/24 at 4:48 AM, a discharge progress note revealed, Date/time of discharge/transfer: 5-27-24 at 4:35 AM; Discharge/transfer location: [hospital]; Mode of transportation at time of discharge/transfer: non-emergency ambulance; Reason for transfer/discharge: severe pain to right shoulder-possible fracture; Discharge teaching/instructions completed during discharge/transfer process: [blank]; Discharge paperwork released with resident at time of discharge/transfer: Transfer/discharge record, order summary, face sheet; Resident's response to discharge/transfer process: Pt wanting to go to the ER; How were resident's personal effects stored/handled at time of discharge/transfer?: Personal items left in her room. Pt took her phone and phone charger with her; Name of individual to whom report was provided at new location: [blank]; Name of resident representative notified (if resident is not self-responsible): [family member]; Name of physician notified: [name redacted] on call for [name redacted]. On 6/4/24 at 6:46 PM, an alert charting progress note revealed, Pt readmitted to facility via facility transport. A/O [alert and oriented] x 4. Able to verbalize needs. Continent of bowel and bladder. Resident using sling to R [right] shoulder. Has bruises to: forehead, L [left] knee, Rt [right] shoulder, LFA [left forearm] L elbow, 2 small bruises to bilat [bilateral] ankle, RFA [right forearm]. She has small scan on bridge of nose. Incision to R chest area intact, no s/s [signs/symptoms] of infection. Uses motorized w/c for mobility. Las BM [bowel movement] 6/3/24. C/O [complains of] pain to R shoulder Oriented to facility. Call light is within reach. On 8/18/24 at 4:31 PM, an alert charting progress note revealed, upon entering the room resident sitting in the floor. stating I went down the floor to pick up a something and I could not get up. called for assistance to help transfer resident during assessment no injuries noted at this time. resident alert and oriented x 4. Neuro checks started. educated resident on the importance to ask for assistance. Dr. Notified. (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/18/24 at 6:01 PM, an alert charting progress note revealed, upon continuous assessment resident complaining of dizziness and headache post fall. Dr. called provided this information. resident requested to go to the hospital. [ambulance provider] called. On 8/18/24 at 11:04 PM, an alert charting progress note revealed, Resident returned from [hospital] ED [emergency department] at 8:51 PM. No findings found on CT OR X-ray. VSS [vital signs stable]. On 8/29/24 at 9:37 AM, an alert charting progress note revealed, Resident was in the Therapy room using a balloon when she tried to reach for the balloon and fell on her face on the floor bleeding from the nose. Used towel and applied ice pack. Called 911. Resident is alert and oriented to person, time, situation. Waiting for ambulance. On 8/29/24 at 9:51 AM, an alert charting progress note revealed, [ambulance provider] arrived and resident decided to go to ER to be checked. V/S [vital signs] BP [blood pressure] 170/84, PR [pulse rate] 95, RR [respiration rate] 18, T [temperature] 98.2, O2 sat[oxygen saturation] 93 RA [room air]. Called the daughter to inform her of the incident and she appreciates the call. On 8/29/24 at 2:53 PM, an alert charting progress note revealed, Resident came back from [hospital] with an order for Ibuprofen 600 mg [milligrams] TID [three times daily] for 7 days. PCC [medical record software] updated. On 9/23/24 at 9:01 AM, an alert charting progress note revealed, resident had a witnessed fall, resident reported losing her balance when walking in room. resident hit head and neuro checks started. resident alert and oriented x 4. Vs [vital signs] stable. resident appears to have a repetitive behavior continue to be lack of self-limitations and safety. reported to Dr [educated]. educated resident on safety measures, daughter no answer on phone, unable to leave message to report this concern. On 9/23/24 at 7:22 PM, an alert charting progress note revealed, resident returned from infusion appointment. no changes noted. On 9/23/24 at 10:46 PM, an alert charting progress note revealed, Pt with fall this morning. Pt was in another pt's room. Pt states that she fell forward and hit her face. Pt with bruising under both eyes. Pt continues to c/o pain to legs. Pt went to ER after infusion appointment today. Pt was afraid that she had a DVT [deep vein thrombosis], but no DVT, just inflammation from fluid in her legs. Pt stated that her doctor's are working on a plan of what to do. It should be noted, hospital records could not be found in resident 13's medical record for this hospital visits on 5/27/24, 8/18/24, 8/29/24, and 9/23/24. 3. Resident 10 was admitted to the facility on [DATE] with diagnoses that included personal history of traumatic brain injury, type 2 diabetes, bipolar disorder, post-traumatic stress disorder, morbid obesity, major depressive disorder, anxiety disorder, and cognitive communication deficit. (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/10/24 at 2:29 PM, a behavior progress note revealed, Guardian contacted about sending to b med [behavior medicine] to get stabilized on medications due to refusals of medications and care. Guardian [name redacted] stated that she was okay with that plan to help him stabilize his mental health and requested that he be sent to the hospital. Spoke with resident about plan and he stated he was just going to leave AMA [against medical advice]. Reassured resident and allowed him to verbalize feelings about this decision. He agreed to be sent to be stabilized and was taken to hospital via [ambulance service]. On 11/10/24 at 7:07 PM, an alert charting progress note revealed, Attempted to do a nurse to nurse and a doc to doc and the hospital refused to do so. No interventions taken and he was medically and psychiatrically cleared to come back to the facility. They stated he was only not taking Gabapentin which didn't constitute an admission. I educated the nurse that wasn't the case. He said there was nothing they could do for him and he was already on his way back. It should be noted that hospital documentation for 11/10/24 was not found in resident 10's medical record. On 11/7/24 at 11:59 AM, an interview was conducted with the Minimum Data Set (MDS) coordinator who stated the hospital records for resident 13 were not in the medical records. The MDS stated typically the resident returned from the hospital with a history and physical. The MDS stated he was not sure why it was not in the residents medical records. The MDS stated when a resident returned from the hospital, the nurse should go over the paperwork, put in a progress note, and put the documents in a manager's folder that went to the DON. The MDS stated the DON would be reviewed and then to go medical records and scanned into the resident's medical record so there was a date associated with it. On 11/12/24 at 1:22 PM, an interview was conducted with the DON who stated typically hospital documentation comes back from the hospital with the resident. The DON if the hospital records did not come back with the resident, she was able to pull the records from the hospital medical records. The DON stated she would obtain the records, print them off for medical records and it could take about a week to upload. The DON stated nurses could call for order changes, or the hospital would call you. The DON stated the expectation she has is that discharge orders from the hospital would be in the resident's medical records. The DON stated 90% of the time, resident's came back with orders and documentation. The DON stated the nurse or the DON were responsible for obtaining documentation from the hospital. 4. Resident 220 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included polyneuropathy, cognitive communication deficit, anxiety disorder, acute respiratory failure with hypoxia, congestive heart failure, panic disorder, chronic obstructive pulmonary disease, morbid obesity, major depressive disorder, and chronic kidney disease. Resident 220's medical records were reviewed between 11/3/24 and 11/13/24. On 10/5/24 at 1:41 AM, an alert charting progress note revealed, Resident A & O x 3-thinks it is 2012. Equal hand grips, sluggish pupil response, Equal hand drift. States she feels 'not normal'. On 10/5/24 at 2:18 AM, an alert charting progress note revealed, Neuro checks completed on resident. Left pulses diminished. Lung sounds clear. Skin cold and dry. Still very confused. Called [ambulance provider] to be sent to the ED [emergency department]. (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	It should be noted that no neuro check documentation could be found in resident 220's medical record and the facility was unable to provide the documentation. 45490 5. Resident 371 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included paraplegia, cognitive communication deficit, and pressure ulcer of sacral region. Resident 371's medical record was reviewed 11/12/24 through 11/13/24. On 7/12/24 at 1:00 AM, a physician documented in resident 371's chart detailing why the resident was sent out for a blood transfusion for a low hemoglobin. On 11/13/24 at 2:39 PM an interview was conducted the the DON. The DON stated that resident 371 did not have a low hemoglobin and was not sent out for a transfusion. The DON stated there was a resident in the facility similar to 371 and that it would have be easy to mix them up. The DON confirmed that the physicians progress note was in regards to a different resident in the facility and the progress note was inaccurate for resident 371. 50200 6. Resident 26 was admitted to the facility on [DATE] with diagnoses which include, but not limited to, facioscapulohumeral muscular dystrophy, unspecified protein-calorie malnutrition, hyperlipidemia, hypomagnesemia, hypo-osmolality and hyponatremia, and weakness. Resident 26's record was reviewed on 11/7/24. Resident 26's progress notes revealed the following: a. On 12/6/23 at 2:42 PM, a nutrition/dietary note documented: Late Entry: Note Text: NAR: [Resident 13] WEIGHT LOSS OF 7.1 LBS. CURRENT WEIGHT: 255.9 IWR: 107.8-145.6 BMI:43.9 OBESE CLASS III PO [oral] INTAKE NSA,REG [regular],THIN; <50%INTAKE SUPPLEMENT [sic]: CHOLECALCIFFEROL [sic] 1250MCG [sic], B12 500MCG. MEDS [medications]: MORPHINE INCREASE TO 15 MG. FUROSOMIDE [sic] 20 MG FOR 1 WEEK. NO NEW LABS (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	EDEMA NOTED DISCUSS AT NAR MEETING: TIME THE WEIGHTS TAKE PLACE, CHANGE WEIGHT DUE TO BEING PREVIOUS TO INFUSION OR AFTER. RESIDENT HAS STATED WOULD LIKE TO LOOSE WEIGHT. NEW MEDICATIONS FOR EDEMA b. On 2/28/24 at 10:37 AM, a physician progress note documented,Note Text: [Name Redacted] Name: [Resident 29] Sex: FeMale [sic] DOB [date of birth]: [redacted] Age: [redacted] Yrs Service Date: 02/28/2024 Provider: [name redacted] Chart#: [number redacted] Chief Complaint: [Resident 29] presents for a comprehensive assessment of chronic conditions. History Of Present Illness: [Resident 29] is . On 11/12/24 at 3:50 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that resident charts were routinely audited for inaccurate information. The DON stated that other resident information should not be in resident 26's electronic medical record.		

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30563 Based on interview and record review it was determined, for 1 of 65 sampled residents, that the facility did not ensure that the hospice services met professional standards and principles that applied to individuals providing services in the facility, and to the timeliness of those services. Specifically, facility staff documented they were unable to contact hospice, the facility did not obtain from the hospice provider the nursing notes and there were no coordination of care notes. Resident identifier: 4. Findings include: On 11/4/24 at 8:06 AM, an interview was conducted with resident 4. Resident 4 stated she needed her brief changed. Resident 4 was laying in bed with greasy hair and a substance coming out the side of her mouth. On 11/6/24 at 1:23 PM, an observation was made of resident 4. Resident 4 was laying in bed with her eyes closed. At 1:36 PM, an observation was made of Certified Nursing Assistant (CNA) 6 standing and feeding resident 4. Resident 4's bed was in a high position with the head of her bed elevated and she was holding a sandwich and was observed to take a bite. Resident 4's medical record was reviewed. A significant Minimum Data Set (MDS) dated [DATE] revealed resident did not have a condition or chronic disease that may result in a life expectancy of less than 6 months. A care plan dated 11/3/24 revealed The resident has a terminal prognosis and RESIDENT RECEIVES HOSPICE SERVICES THROUGH [name and phone number removed]. The goal was The resident's comfort will be maintained through the review date. Some of the interventions included: a. Consult with physician and Social Services to have Hospice care for resident in the facility. b. Encourage resident to express feelings, listen with non-judgmental acceptance, compassion. A Physician's order dated 9/21/23 revealed resident was to receive hospice services through a local company. A Physician's order dated 10/4/24 revealed Ordered by [Name removed] RN [Registered Nurse] of [hospice company name removed] hospice to assist the resident with meals. every shift resident's care. A binder at the nurses station with resident 4's name on it revealed skin sheets for bathing for resident 4. Resident 4 had skin sheets which revealed resident 4 was bathed 2 times per week. The last nursing visit form was dated 5/23/24 in the binder at the nurses station by an aide. There was no other documentation from the nurses or plan of care information in the binder. (continued on next page)		

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 4's documentation tab in the medical record was reviewed and the last hospice note was from 8/17/24. An alert charting nursing progress note dated 10/18/24 at 5:48 AM revealed, Resident vomited on herself. Face is flushed and hot to the touch. Resident lethargic, but not verbally responsive. Vitals as follows BP [blood pressure] 181/99, Pulse 105, O2 [oxygen] 92% on RA [room air], Temp [temperature] 99.8 F orally, Resp [respirations] 18 breaths/min [minute]. Attempted to notify hospice at 0552 [5:52 AM], no answer. On 11/6/24 at 3:29 PM, an interview was conducted with Licensed Practical Nurse (LPN) 4. LPN 4 stated if she needed to communicate with hospice she called the hospice nurse. LPN 4 stated that when the nurse visited a resident, the hospice nurse talked to the facility nurse and let her know what was going on. LPN 4 stated the hospice nurses phone number was available. LPN 4 stated hospice staff usually did not leave paper work unless it was a physician's order. On 11/12/24 at 10:45 AM, an interview was conducted with LPN 3. LPN 3 stated she was friends with resident 4's hospice case manager. LPN 3 stated she was able to contact her friend and leave a message if the resident needed something. LPN 3 stated she did not know if hospice staff provide documentation. On 11/12/24 at 3:04 PM, an interview was conducted with the Director of Nursing (DON). The DON stated the hospice team checked in with the nurse and signed a sheet when they visited the resident. The DON stated hospice staff should meet with nurse or Certified Nursing Assistant (CNA) to coordinate care. The DON stated physician's orders and notes were faxed to the facility or given to the nurse from hospice. The DON stated she was not sure how often hospice notes were provided to the facility. The DON stated she was not sure why there were no hospice notes in resident medical record since 8/17/24.		

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F 0867 Level of Harm - Actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 30563 Based on interview, observation and record review, the facility did not ensure that policies were established and implemented to ensure that identified quality deficiencies were corrected. Specifically, multiple areas of immediate jeopardy and harm were identified. In addition, multiple areas of non compliance were cited on the previous survey and again during the current recertification survey. Resident identifiers: 1, 3, 4, 5, 6, 9,10, 13, 14, 15, 16, 18, 20, 22, 24, 26, 27, 28, 29, 30, 32, 34, 36, 38, 44, 45, 46, 49, 50, 51, 52, 53, 54, 55, 57, 60, 61, 65, 67, 120, 121, 269, 319, 371, and 419. Findings included: 1. Based on interview and record review, it was determined for 7 out of 65 sampled residents that the facility did not ensure that each resident had the right to be free from abuse and neglect. Specifically, residents were not assessed for the capacity to consent to a sexual relationship. This was cited at an immediate jeopardy level, Another resident experienced unwanted sexual contact from another resident. In addition, a resident without capacity was able to leave the facility against medical advice and was charged with trespassing. The last 2 examples were cited at a harm level. Resident identifiers: 6, 49, 54, 67, 121, 319, 419. (Cross refer to F600) 2. Based on interview and record review it was determined, for 1 of 65 sampled residents, that the facility failed to ensure the resident was free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. Specifically, a resident was relocated to the locked memory care unit for not following the smoking policy. Resident identifier: 46. (Cross refer to F603) 3. Based on record review and interview it was determined, for 1 of 65 sampled residents, based on the comprehensive assessment of a resident the facility did not ensure that a resident with a pressure ulcer received the necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Specifically a resident's wound Vacuum-Assisted Closure (VAC) was not working for approximately 24 hours and the physician was not notified until the resident was somnolent. Resident identifier: 371. (Cross refer to F686) (continued on next page)		

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F 0867 Level of Harm - Actual harm Residents Affected - Some	4. Based on observation, interview, and record review, it was determined for 5 of 65 sampled residents that the facility failed to 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 fell as a result of the use of damaged medical equipment; no updated interventions were implemented after resident falls, with one resident having sustained a major injury; neurological assessments were not completed after falls and a call light was not within reach. Resident identifiers: 1, 5, 13, 18, 51, 52 and 60. (Cross refer to F689) 5. Based on observation, interview and record review, for 3 of 65 sampled residents, the facility did not ensure a resident who was continent of bladder and bowel on admission received services and assistance to maintain continence unless his or her clinical condition is or became such that continence was not possible to maintained. Specifically, a resident had a urine analysis (UA) obtained and 12 days later staff obtained the results and treatment was started for a urinary tract infection (UTI). The resident complained of flank pain during the 12 days and was administered Tylenol. Another resident was occasionally incontinent of bladder upon admission was not provided a bladder retraining program. In addition, the same resident was observed to have a call light on for 8 minutes, yelling for help, and another resident found staff to clean him up after having a bowel movement. Those 2 examples will be cited at a harm level. Another resident had an antibiotic for a UTI discontinued prior to finishing the course of the antibiotic. Resident identifiers: 1, 52, 55 and 60. (Cross refer to F690) 6. Based on interview, observation and record review it was determined, for 7 of 65 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, a resident was soiled and calling for help, incontinence cares were not being completed every 2 hours, showers were not provided to residents, there were complaints of staff not answering call lights and resident council minutes revealed complaints of not enough staff. Resident identifiers: 15, 26, 27, 49, 52, 55, 60 and 120. (Cross refer to F725) 7. Based on observation, interview and record review it was determined that the facility did not have sufficient nursing staff with the appropriate competencies and skills set 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. Specifically, inadequate oversight by the Director of Nursing resulted in multiple system failures in resident care areas which placed residents at harm. Resident identifiers: 1, 3, 4, 5, 9, 10, 13, 15, 16, 20, 26, 27, 28, 29, 32, 34, 38, 45, 46, 49, 51, 52, 53, 55, 57, 61, 65, 120, 269, and 371. (Cross refer to F726) (continued on next page)		

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F 0867 Level of Harm - Actual harm Residents Affected - Some	8. Based on interview and record review it was determined, for 1 of 65 sampled residents, the facility did not provide the necessary behavioral health care and services to attain or maintain the highest practical physical, mental, and psychosocial well-being. Behavioral health encompasses a resident's whole emotional and mental well-being. Specifically, a resident with a history of suicidal ideation's had a traumatic life event occur with no behavioral health services provided. The resident was found to have taken 4 to 5 bottles of Tylenol and was sent to the emergency room for an overdose. Resident identifier: 45, 57. (Cross-refer 740) 9. Based on observation, interview and record review it was determined, for 17 of 65 sampled residents, that the facility did not employ sufficient staff with the appropriate competencies and skills set to carry out the function of the food and nutrition services, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment. Specifically, meals were observed to be served over an hour later than the posted meal times, a resident was observed to be yelling he was hungry, residents were in the hallways waiting for food, residents were upset in the dining room waiting for meals and residents council minutes revealed complaints of late meals. Resident 16 will be cited at a harm level. Resident identifiers: 9, 13, 14, 16, 22, 24, 26, 27, 30, 32, 36, 38, 44, 50, 52, 55 and 120. (Cross refer to F802) On 11/13/24 at 2:41 PM, an interview was conducted with the Administrator (ADMIN) and the Regional [NAME] President (RVP). The RVP stated he was the Administrator at the facility until July 2024. The ADMIN stated he started July 2024 at the facility. The ADMIN stated the department heads and Medical Director attended the Quality Assurance and Performance Improvement (QAPI) meeting that was held quarterly. The ADMIN stated the pharmacist and Registered Dietitian were invited but had not attended. The ADMIN stated for the QAPI meeting each department reviewed any issues. The ADMIN stated if there were issues identified, then a root cause analysis was completed, then the committee looked to see what to do to fix the issues and a plan was put into place to resolve it. The ADMIN stated the Dietary department was brought up as an issue in the October 2024 meeting. The RVP stated that it was identified in a QAPI meeting in April 2024 that there were dietary concerns. The RVP stated that things were backed up in the kitchen because everything bottled necked at the dish machine, so the facility replaced the dish machine July 2024. The ADMIN stated the QAPI identified that they needed qualified staff members with experience and staff needed education. The ADMIN stated he checked the kitchen almost daily. The ADMIN stated falls and allegations of abuse that were reported to the State Survey Agency and staffing were discussed in QAPI. The ADMIN stated bowel and bladder programs had not been discussed.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38031 Based on observation, interview and record review it was determined, for 2 of 65 sampled residents, that the facility did not establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment to prevent the development and transmission of communicable diseases and infections. Specifically, observations were made of staff not performing hand hygiene during meal service and medication pass, food was delivered to resident rooms uncovered, and the facility did not have a Legionella prevention and monitoring plan in their water management program. Resident identifiers: 20, 46. Findings included: 1. DINING OBSERVATIONS On 11/03/24 at 1:35 PM, an observation was made of the lunch meal service. Certified Nurse Assistant (CNA) 2 was observed to deliver a lunch tray to room [ROOM NUMBER] A. The tray contained one chicken leg, mashed sweet potatoes, green beans, a roll, and a pie dessert with the chocolate topping melted. The dessert was not covered and was walked from the nurse's station down the hallway to the end of the hall for delivery. On 11/05/24 at 6:17 PM, an observation was made of CNA 12 during meal service. At 6:19 PM, CNA 12 delivered the dinner tray to room [ROOM NUMBER]. CNA 12 did not perform hand hygiene and was wearing gloves. At 6:19 PM, CNA 12 delivered the dinner tray to room [ROOM NUMBER] A. CNA 12 was observed wearing gloves and touched their face. No hand hygiene was performed. On 11/12/24 at 1:46 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that her expectation with hand hygiene during meal service was that staff should perform hand hygiene after exiting a resident room and in between passing food trays. 2. On 11/13/24 at 10:24 AM, an interview was conducted with the Maintenance Supervisor (MS). A copy of the facility Legionella prevention and monitoring plan was requested. The MS stated that he was not in charge of the Legionella system, had not heard anything about it and did not know what it was. The MS stated that he was not aware of the facility water maintenance plan to prevent contaminants or measures to reduce the risk of Legionella. The MS stated that the facility had an emergency water agreement with a supplier but could not recall who that supplier was. The MS stated that they did not have a water management plan and he had not seen one in all the documentation left from the previous Maintenance Supervisor. It should be noted that the MS was newly hired and had only been on the job for approximately two weeks. No additional information was provided by the facility about the water management program. Review of the facility Water-borne Contaminants policy documented, The maintenance director or designee is responsible to identify the facility's risk for water-borne contaminants, including Legionella growth and spread, using a designated risk assessment tool approved and to implement appropriate prevention measures, including Legionella testing as indicated based on the risk assessment outcome. The policy was adopted on 12/16/19. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	48709 3. On 11/6/24 at 7:54 AM, a medication pass was observed with Registered Nurse (RN) 2. RN 2 was observed to come out of room [ROOM NUMBER] with a food tray, placed it in the meal cart, and then went to the medication cart and poured medication into a cup. No hand hygiene was performed. RN 2 prepared the rest of resident 20's medications and then went into room [ROOM NUMBER]. No hand hygiene was performed. RN 2 poured resident 20's water into the cup with the liquid medication. Resident 20 took all the liquid medication and other oral medications. RN 2 proceeded to instill eyedrops into both of resident 20's eyes. No hand hygiene was performed. On 11/6/24 at 8:21 AM, a medication pass was observed with RN 2. RN 2 went into resident 46's room and turned off her call light. RN 2 left the room and went to the medication cart. No hand hygiene was performed. RN 2 proceeded to pull out resident 46's medications and put them into a medication cup. RN 2 was observed to open and close different medication drawers, used keys to open a locked drawer, and use the computer keyboard. RN 2 went into room [ROOM NUMBER] and handed the resident her medications in the medication cup. Resident 46 took the medications. RN 2 left room and went back to the medication cart, no hand hygiene was performed. RN 2 pulled out a requested pain medication from the cart and placed it in a medication cup. RN 2 was observed to rub her nose. No hand hygiene was observed. RN 2 went back into room [ROOM NUMBER] and handed resident 46 the medication cup and a cup of water. No hand hygiene was performed. Resident 46 took the medication and RN 2 left the resident's room. On 11/6/24 at 1:47 PM, an interview was conducted with Licensed Practical Nurse (LPN) 4. LPN 4 stated hand sanitizer should be used before and after going in each resident's room. LPN 4 stated hand hygiene should be performed at every interaction with a resident even if you do not touch anything. On 11/6/24 at 2:06 PM, an interview was conducted with RN 2. RN 2 stated you should hand sanitize between each resident and wash your hands after using hand sanitizer three times. On 11/7/24 at 4:17 PM, an interview was conducted with the Director of Nursing (DON). The DON stated the expectation was to perform hand hygiene in between each resident during medication pass, before entering a room, and before preparing medications.		

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38031 Based on interview and record review it was determined, for 1 of 65 sampled residents, that the facility did not establish an infection prevention and control program (IPCP) that included an antibiotic stewardship program with protocols and a system to monitor antibiotic use. Specifically, a resident was treated for a urinary tract infection (UTI) with an antibiotic that the organism was resistant to. Resident identifier: 1. Findings included: Resident 1 was admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses which included but was not limited to hypospadias, retention of urine, chronic kidney disease, pyelonephritis, extended spectrum beta lactamase resistance, obstructive and reflux uropathy, and methicillin resistant staphylococcus aureus infection classified elsewhere. On 11/4/24 at 9:07 AM, an observation was made of resident 1's room. A sign was posted outside of resident 1's room for enhanced barrier precautions (EBP) and a personal protective equipment (PPE) cart was located outside the door. The cart contained gowns and gloves. On 11/4/24 at 9:22 AM, an interview was conducted with Licensed Practical Nurse (LPN) 3. LPN 3 stated that resident 1 was on EBP for a suprapubic (SP) catheter and had an ongoing extended-spectrum beta-lactamase (ESBL) infection. LPN 3 stated that resident 1 always had a UTI. Resident 1's electronic medical records (eMR) were reviewed. On 9/12/24, resident 1 had a physician order for a urinalysis (UA) with a culture and sensitivity (C & S). No documentation could be found for the results of the UA with C & S in resident 1's eMR. On 11/12/24, the facility infection control tracking and trending log was reviewed for September 2024. The log documented that resident 1 had a urinary tract infection on 9/16/24 that was treated with Bactrim DS Tablet 800 milligram (mg) - 160 mg, give one tablet by mouth two times a day for 10 days. On 11/13/24 at 11:55 AM, the facility emailed a copy of resident 1's UA results for 9/13/24. The UA documented abnormal results for the following: Nitrite 1+, urine hemoglobin (Hgb) 2+ moderate, urine protein 1+, large leukocyte esterase, high [NAME] Blood Cell (WBC) at greater (>) than 30, high Red Blood Cell (RBC) at 27, bacteria 3+, and mucus 1+. The results report documented that the report was printed on 11/13/24. On 11/13/24 at 3:02 PM, the facility emailed a copy of resident 1's C & S report for 9/17/24. The results report documented that the report was printed on 11/4/24. The urine culture documented the organism as Escherichia coli with ESBL (extended beta-lactamase) producer. The susceptibility report documented that the organism was resistant to Bactrim DS. (continued on next page)		

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The September Medication Administration Record (MAR) documented that resident 1 was administered Bactrim DS 800 milligram (mg) - 160 mg, give one tablet by mouth two times a day for UTI for 10 days. The medication was documented as administered from 9/16/24 through 9/26/24 with a total of 20 doses administered. The facility Antibiotic Stewardship Policy stated that the purpose of the program was to monitor the use of antibiotics for facility residents. The guidance further documented, When a culture and sensitivity (C&S) or other diagnostic tests are ordered, test results and the current clinical situation will be communicated to the prescriber as soon as available to determine if antibiotic therapy should be started, continued, modified, or discontinued. The policy was last revised on 7/21/23. The facility Infection Prevention and Control Program Policy documented, The infection preventionist is chiefly responsible to ensure that antibiotics are used consistently with best practice standards. The policy further stated that Antibiotic usage is evaluated and tracked and practitioners are provided feedback on reviews. The policy was last revised on 12/19/16. On 11/12/24 at 1:22 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that she was the facility infection preventionist (IP) and had her certification. The DON stated that they had an antibiotic stewardship form to track if the antibiotics ordered were appropriate for the organism identified. The forms were located in the electronic medical records and included the antibiotic prescribed, the time, dose, any changes, and if the infection was resolved. The DON stated that they utilized the McGreer criteria for surveillance tracking. The DON stated that she was responsible for tracking and ensuring that the antibiotic ordered was susceptible to the organism identified on the urine culture. The DON stated that the timeframe for when she would expect to see a UA result was within 1-2 days and within 3 days for a C & S result. The DON stated that she also had access to the laboratory computer portal and could see the lab results that way.		

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38031 Based on interview and record review it was determined, for 3 of 5 sampled residents, that the facility did not ensure that residents were offered the influenza and pneumococcal immunizations and that the medical records included documentation that the resident either received the immunization or did not due to medical contraindications or refusal. Specifically, three residents did not have immunizations documentation in their medical records. Resident identifiers: 49, 61, and 269. Findings included: 1. Resident 49 was admitted to the facility on [DATE] with diagnoses which included dementia, paroxysmal atrial fibrillation, heart failure, cognitive communication deficit, and pain. On 11/12/24 resident 49's medical records were reviewed. No documentation could be found for the administration or declination for the Influenza or Pneumococcal vaccine for the current season. 2. Resident 269 was admitted to the facility on [DATE] with diagnoses which included encephalopathy, severe sepsis, cognitive communication deficit, dementia, anxiety disorder, cardiac arrhythmia, acute respiratory failure, rhabdomyolysis, and acute kidney failure. On 11/12/24 resident 269's medical records were reviewed. No documentation could be found for the administration or declination for the Influenza and Pneumococcal vaccine for the current season. 3. Resident 61 was admitted to the facility on [DATE] with diagnoses which consisted of fibromyalgia, dementia, hypertension, edema hypothyroidism, and insomnia. On 11/12/24 resident 61's medical records were reviewed. No documentation could be found for the administration or declination for the Influenza and Pneumococcal vaccine for the current season. On 11/12/24 at 9:21 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that they already offered the Respiratory syncytial virus (RSV) vaccine, Hepatitis B vaccine, Hepatitis A vaccine, influenza vaccine, COVID vaccine, pneumonia vaccine, and Human papillomavirus (HPV) for the current season. The DON stated that she had not filed the paper copies of the vaccines administered into the resident medical records yet. On 11/12/24 at 1:22 PM, the DON stated that resident 269 and resident 61 had declined the vaccine and wanted to discuss it with their POA first. The DON stated that she was going to approach them again later. The DON stated that resident 49 had initially consented but on the day of the vaccine clinic he declined. The DON stated that she had no documentation of resident 49's refusal. (continued on next page)		

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/13/24 at 9:02 AM, a follow-up interview was conducted with the DON and the Regional Nurse Consultant (RNC) 1. The DON stated she should have had documentation of the resident 269, resident 61 and resident 49's vaccine declinations. The DON stated that the immunization clinic was held the first Tuesday in October.		

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38031 Based on interview and record review it was determined, for 3 of 5 sampled residents, that the facility did not ensure that residents were offered the COVID-19 immunization and that the medical records included documentation that the resident either received the immunization or did not due to medical contraindications or refusal. Specifically, three residents did not have immunization documentation in their medical records. Resident identifiers: 49, 61, and 269. Findings included: 1. Resident 49 was admitted to the facility on [DATE] with diagnoses which included dementia, paroxysmal atrial fibrillation, heart failure, cognitive communication deficit, and pain. On 11/12/24 resident 49's medical records were reviewed. No documentation could be found for the administration or declination for the COVID-19 vaccine for the current season. 2. Resident 269 was admitted to the facility on [DATE] with diagnoses which included encephalopathy, severe sepsis, cognitive communication deficit, dementia, anxiety disorder, cardiac arrhythmia, acute respiratory failure, rhabdomyolysis, and acute kidney failure. On 11/12/24 resident 269's medical records were reviewed. No documentation could be found for the administration or declination for the COVID-19 vaccine for the current season. 3. Resident 61 was admitted to the facility on [DATE] with diagnoses which consisted of fibromyalgia, dementia, hypertension, edema hypothyroidism, and insomnia. On 11/12/24 resident 61's medical records were reviewed. No documentation could be found for the administration or declination for the COVID-19 vaccine for the current season. On 11/12/24 at 9:21 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that they already offered the Respiratory syncytial virus (RSV) vaccine, Hepatitis B vaccine, Hepatitis A vaccine, influenza vaccine, COVID vaccine, pneumonia vaccine, and Human papillomavirus (HPV) for the current season. The DON stated that she had not filed the paper copies of the vaccines administered into the resident medical records yet. (continued on next page)		

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/12/24 at 1:22 PM, the DON stated that resident 269 and resident 61 had declined the vaccine and wanted to discuss it with their POA (Power of Attorney) first. The DON stated that she was going to approach them again later. The DON stated that resident 49 had initially consented but on the day of the vaccine clinic he declined. The DON stated that she had no documentation of resident 49's refusal. On 11/13/24 at 9:02 AM, a follow-up interview was conducted with the DON and the Regional Nurse Consultant (RNC) 1. The DON stated she should have had documentation of the resident 269, resident 61 and resident 49's vaccine declinations. The DON stated that the immunization clinic was held the first Tuesday in October.		

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38031 Based on observation, interview and record review it was determined, for 3 of 65 residents sampled, that the facility did not adequately equip residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from each resident's bedside and toilet and bathing facilities. Specifically, resident's bedside and toilet call lights were not in working condition or were not present at all. Resident identifiers: 44, 51, and 55. Findings included: 1. Resident 51 was admitted to the facility on [DATE] with diagnoses which included intracerebral hemorrhage, hemiplegia and hemiparesis of left side, neurologic neglect syndrome, chronic kidney disease, hypertension, congestive heart failure, cognitive communication deficit, aphasia, visual loss both eyes, and insomnia. On 11/03/24 at 2:48 PM, an interview was conducted with resident 51. Resident 51 stated that she had fallen previously in the morning when attempting to get up and toilet herself. Resident 51 stated that sometimes she had to change her brief because the staff did not come to help her. Resident 51 stated that the call light did not always work either. Resident 51 stated that she could put a pull up brief on by herself but she could not put the tab briefs on by herself. It should be noted that resident 51 had hemiplegia and hemiparesis of the left side that limited her ability to perform toileting tasks independently. Resident 51 stated that she waited 2 hours the other night for assistance. Resident 51's call light was pushed at the bedside and in the bathroom and both were observed not functioning. On 10/9/24, resident 51's MDS Assessment documented a BIMS score of 14, which indicated that the resident was cognitively intact. The assessment documented that the resident was a one-person limited assist for bed mobility and eating, and a one-person extensive assist for transfers and toilet use. The assessment documented that the resident was not on a urinary or bowel toileting program. Review of the Daily Maintenance Log for Station B for September and October 2024 documented the following: a. On 9/23/24 at 10:25 AM, bed remote is broken room [ROOM NUMBER]. b. On 9/30/24 at 10:30 AM, call lights do not work bedroom and bathroom in room [ROOM NUMBER]. c. On 10/2/24 at 1:24 PM, call light still does not work, please fix in room [ROOM NUMBER] B. d. On 10/13/24 at 4:00 PM, the TV was broken in room [ROOM NUMBER] B. e. On 10/14/24 at 6:54 PM, the call light wont turn off in room [ROOM NUMBER]. f. On 10/17/24 at 4:01 PM, call light wont turn off in room [ROOM NUMBER]. (continued on next page)		

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	g. On 11/7/24 at 9:48 AM, call light not working in room [ROOM NUMBER] B. Review of the Daily Maintenance Log for Station A for October and November 2024 documented the following: a. On 10/8/24 at 11:00 AM, call lights did not turn on in room [ROOM NUMBER]. b. On 10/13/24 at 5:01 PM, the call light was stuck in room [ROOM NUMBER]. c. On 10/22/24, the call light wont turn off in room [ROOM NUMBER]. On 11/05/24 at 12:53 PM, an interview was conducted with Certified Nurse Assistant (CNA) 6. CNA 6 stated that resident 51 required one-person assist for incontinence care due to vision issues and paralysis in left arm. CNA 6 stated that resident 51 was incontinent of bowel and bladder and she would let staff know when she needed a brief change. On 11/07/24 at 9:35 AM, a follow-up interview was conducted with CNA 6. CNA 6 stated that resident 51 had maybe 4 falls since she was admitted and none with any injuries. CNA 6 stated resident 51 would call for assistance to get out of bed, but if staff did not come immediately she would try to do it herself and would fall. CNA 6 stated that interventions to prevent falls were to encourage the resident to call for help when getting up. CNA 6 stated that the call light system was difficult at times, and sometimes they would do a system reset. CNA 6 stated that the last time the call light system was not working was approximately 4 weeks ago. CNA 6 was observed to push resident 51's bedside call light and it did not alarm. CNA 6 was observed to attempt to activate the call light from resident 51's bathroom and it did not alarm. CNA 6 stated that the bathroom light was not working either. CNA 6 stated that maybe it was resident 51's roommate that was calling for help for resident 51. CNA 6 stated that things were difficult with maintenance and they just hired a new maintenance staff. CNA 6 stated that they would document any maintenance issues in a binder and the maintenance staff should look at it daily to see what needed to be fixed. CNA 6 stated that according to the maintenance binder it looked like resident 51's call light was documented not functioning 5 times prior. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465152	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/13/2024
NAME OF PROVIDER OR SUPPLIER Bella Terra St George		STREET ADDRESS, CITY, STATE, ZIP CODE 178 South 1200 East 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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/13/24 at 10:24 AM, an interview was conducted with the Maintenance Supervisor (MS). The MS stated that he started at the facility approximately 2 weeks ago. The MS stated that the process for maintenance requests or repairs was that staff would text him in an emergency situation and if it was not an emergency, staff would write it in the daily maintenance log. The MS stated that he checked the log daily, Monday through Friday. The MS stated that he documented in the log any issues that were resolved or passed off to another department. The MS stated that the service technician for the company that installed and repaired the call light system walked him through the process of repairing and trouble shooting the call lights. The MS stated that it depended on what the issue was with the call light. The MS stated that if it was a ripped cord then he would just replace the cord. The MS stated that if the call light did not alarm he would check the ID on the back of the call light to verify that it registered in the system. The MS stated that each call light ID had to be registered in the system for that specific location or room. The MS stated that sometimes in the past staff would take call lights from other rooms to replace non-functioning lights. The MS stated that this solution did not work because then the light would not register correctly in the system. The MS stated that resident 51's call light was repaired at the bedside and in the bathroom. The MS stated that the bathroom was broken and had to be replaced completely. The MS stated that resident 51's call light at the bed registered to another room location and he replaced it. The MS stated the bedside call light also had black electrical tape on it from being frayed. The MS stated that he had a lot of call lights that needed repair and that needed to be correctly registered in the system. The MS stated that he found approximately 5 call lights that needed to be repaired or registered. The MS stated that he did not verify with the maintenance logs the reports of the broken call lights. The MS stated that he did daily rounds to verify that the call lights were in working condition. The MS stated that he repaired the call lights in rooms 106, 116, 117, 318, 319, 322, 323, 327, 329, 338, 337, 401, 403, and 507 on 11/7/24 when he was informed that they were not working. It should be noted that resident 51's call light was repaired on 11/12/24 according to the new maintenance log. The MS stated that he would have to locate the previous maintenance logs and he did not know who removed and replaced them. [Cross-refer F689 and F690] 30563 2. On 11/3/24 at 4:27 PM, an observation was made of room [ROOM NUMBER] B. Resident 23 resided in room [ROOM NUMBER] B. There was no call light cord for bed B. There was a 1 call light cord to bed A. 3. On 11/3/24 at 4:33 PM, an observation was made of room [ROOM NUMBER] A. Resident 44 resided in 321 A. There was no call light cord for the A bed. There was 1 call light cord from the call to the B bed. An interview was immediately conducted with CNA 11. CNA 11 stated resident 44 resided in room [ROOM NUMBER] A. CNA 11 stated that resident 44 did not use a his call light but was able to use a call light. CNA 11 was observed to look at room [ROOM NUMBER] A and stated she did not know why resident 44 did not have a call light cord. CNA 11 stated all residents should have call lights cords available. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Bella Terra St George		STREET ADDRESS, CITY, STATE, ZIP CODE 178 South 1200 East 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.			
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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. On 11/3/24 at 4:18 PM, an observation was made of room [ROOM NUMBER] A. Resident 55 resided in room [ROOM NUMBER] A. There was no call light cord observed to bed A. There was one call light cord from the wall to bed B. On 11/12/24 at 10:32 AM, a follow-up observation of room [ROOM NUMBER] was conducted. There was only one bed for 307 B. There was one call light cord that was attached to the wall. There was one hole for a call light cord and not 2 call light cords. On 11/12/24 at 10:26 AM, an interview was conducted with resident 55. Resident 55 stated he moved rooms because his other room did not have a call light. Resident 55 stated he did not know why he did not have a call light. Resident 55 stated there was not a call light. Resident 55 stated when he needed assistance, he used his roommate's call light or asked his roommate to use the call light for him. Resident 55 stated he felt abandoned when he did not have a call light. Resident 55 stated that he had not had any accidents as a result of not having a call light. On 11/12/24 at 1:41 PM, an interview was conducted with the Director of Nursing (DON). The DON stated there was room change papers that was filled out with the reason for the move. The DON stated resident 55 was able to use a call light. The DON stated every resident should have a call light to call for staff. The DON stated she was not aware that resident 55 did not have a call light. The DON stated resident 55 requested a room move but could not remember why. The DON stated if resident 55 did not have a call light, then that was probably why he did want to move rooms.		