STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465158	A. Building B. Wing	02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow Brook Rehabilitation and Nursing	433 East 2700 South Salt Lake City, UT 84115

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** 46232 Based on observation and interview it was determined, for 2 of 40 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 his or her quality of lift, recognizing each resident's individuality. Specifically, residents were provided cowbells as an alternative to a broken call light and a resident was not provided privacy during a brief change. Resident identifiers: 6 and 26. Findings include: 1. Resident 6 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included schizophrenia, type 2 diabetes mellitus, major depressive disorder, generalized anxiety disorder, dementia, repeated falls, vitamin b12 deficiency, extrapyramidal and movement disorder, and overactive bladder. On 2/21/24 at 9:16 AM, an observation was made of Certified Nursing Assistant (CNA) 2 assisting resident 6 with a brief change. CNA 2 was observed to leave resident 6's door open and the curtain was not fully closed to ensure resident 6 was provided privacy before the brief change. CNA 2 was observed to ask resident 6 if they were wet and then proceeded to check resident 6's brief. Resident 6's brief was removed and resident 6's buttocks area was observed to be erythematous with red dots of varying sizes present. CNA 2 was observed to wipe resident 6 clean and then applied barrier ointment to resident 6's posterior. CNA 2 stated they also tried to keep resident 6's diaper semi loose to prevent further skin irritation. A follow up interview was immediately conducted with the CNA 2 after they were done with resident cares. CNA 2 stated to ensure a patient's privacy during a brief change they either closed the door or closed the resident curtain. CNA 2 stated when there were a lot of people present, they closed both the door and the curtain. CNA 2 stated they did not close resident 6's door since the resident preferred the door open due to easily getting hot. On 2/21/24 at 10:44 AM, an interview was conducted with the Director of Nursing (DON). The DON stated they expected both the nurses and aids to provide privacy during patient cares such as brief changes. The DON stated privacy was to be provided to protect a resident's dignity. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident 26 was admitted to the facility on [DATE] with diagnoses that included osteomyelitis of right ankle and foot, generalized muscle weakness, polyneuropathy, type 2 diabetes mellitus with foot ulcer, non-pressure chronic ulcer of other part of right foot with bone involvement without evidence of necrosis, and necrotizing fasciitis. On 2/5/24 at 10:35 AM, an interview was conducted with resident 26. Resident 26 stated the call light had not been working for the last two days. Resident 26 stated their call light outside of the room was on for the last two days, so staff were unsure when they were actually calling. Resident 26 stated that using a cowbell made him feel as if he was being treated like an animal. On 2/5/24 at 10:39 AM, an observation was made of the Minimum Data Set Coordinator (MDSC) entering resident 26's room. The MDSC asked resident 26 what they needed help with since the call light was on. Resident 26 replied they did not need any help and that their call light would not turn off. The staff member was observed to briefly leave the room and returned with a red cow bell. The staff member explained the red cow bell was an alternative to the call light and they would need to ring the cowbell if they needed any assistance. On 2/14/24 at 3:15 PM, an interview was conducted with Nursing Assistant (NA) 3. NA 3 stated residents were provided cow bells if their call light was not working and stated it was not the best solution, but it was better than not having anything. On 2/20/24 at 1:23 PM, an interview was conducted with the Administrator (ADM). The ADM stated if a resident's call light was not working then residents were provided a cow bell within a short period of time until the call light was fixed. The ADM stated residents thought the cow bells were stupid at first. The ADM stated residents have used the cow bells when they were provided to them as an alternative to get a hold of staff. The ADM stated resident located further down the hall from the nurses' station were harder to hear then the ones located closer to the nurses station. On 2/20/24 at 2:06 PM, an interview was conducted with the DON. The DON stated they had a call light system located next to the nurses station. The DON stated staff were able to look at the system to see who's call light was going off. The DON stated if a call light had issues, they unplugged it to see if it fixed the issue. The DON stated if the call light was not working after unplugging it and plugging it back in then the resident's were given a bell. The DON stated the bell was used as a means to notify staff they needed help. The DON stated residents have expressed their dislike of the cow bells and have raised concerns about them. The DON stated residents have said they did not want to keep continually ringing their bell until someone could answer it. The DON stated they were able to understand how the bell was a dignity problem.

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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 interview and record review it was determined, for 1 of 40 sampled residents, that the facility did not ensure that the resident received services in the facility with reasonable accommodation of needs and preferences. Specifically, the resident requested a bed cane be provided for his bed to aid in mobility and the facility did not provide the assistive device. Resident identifier: 7. Findings include: Resident 7 was admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease, morbid obesity, alcoholic cirrhosis, hepatic failure, type II diabetes mellitus with polyneuropathy, portal hypertension, narcolepsy, major depressive disorder, obstructive sleep apnea, personality disorder, bipolar II disorder, alcoholic dependence, restless leg syndrome, male erectile dysfunction, hypertension, heart failure, anxiety disorder, hyperlipidemia, hyperaldosteronism, and osteoarthritis. On 2/5/24 at 10:12 AM, an interview was conducted with resident 7. Resident 7 stated that he had two falls and had asked for a bed cane to assist him in bed mobility. Resident 7 stated that the facility would not provide one so he had to purchase his own from Amazon. Resident 7 stated that the device cost him $35. On 9/24/23, the Admission Minimum Data Set (MDS) Assessment documented that resident 7 had a Brief Interview for Mental Status (BIMS) score of 14, which would indicate that the resident was cognitively intact. The assessment documented resident 7's mobility as a supervision with touch assist for rolling left to right, sit to lying, lying to sitting on side of the bed, sit to stand, chair/bed transfers, and toilet transfers. Resident 7's incident reports revealed the following: a. On 9/25/23 at 4:32 AM, the report documented that resident 7 had fallen and called the paramedics. Resident 7 claimed he was on the floor for half an hour and had used the call light to notify the staff. Minor skin tears were noted to the right lower extremity. The intervention identified was to educate resident 7 to call for assistance. b. On 10/4/23 at 12:05 PM, the report documented that resident 7 was found on the floor. Resident 7 stated that he missed the wheelchair when he tried to go to the bathroom. The report documented a skin cut and hematoma on the left leg, and bruise to the chest. The intervention identified was to encourage resident 7 to rise slowly and be sure of steadiness prior to ambulation or transfer. c. On 11/3/23 at 2:00 AM, the report documented that resident 7 reported a fall that happened last night. Resident 7 reported that he did not call for help because he did not want to bother anyone, and he got himself up by holding onto the bed. The intervention identified was a sign placed in the resident's room reminding him to call before ambulating. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	d. On 1/6/23 at 5:25 PM, the report documented that resident 7 called the nurse by phone to report that he had fallen. The report documented that there were a lot of things on the floor and he tripped and fell to his knees. No injuries were noted. The intervention identified was to declutter the resident's room. On 9/18/23, resident 7 had a care plan initiated for used a 1/4 repositioning bar for bed mobility. Interventions identified were that resident 7 would demonstrate the appropriate use of the 1/4 side rails to increase mobility; would not have any adverse effects from the assistive device; assess resident 7 for entrapment risk to ensure proper use of assistive device; check on resident 7 during rounds while in bed; provide education on proper bed mobility as indicated; and Physical Therapy/Occupational Therapy to evaluate and treat as ordered. On 11/13/23, a BED RAIL - 1/4 Side rail for bed mobility was ordered for resident 7. It should be noted that the order was initiated two months after the care plan was created for the use of the bed rail. On 2/8/24 at 10:18 AM, an interview was conducted with the Certified Nurse Assistant Coordinator (CNAC). The CNAC stated that resident 7 needed assistance with showers, could toilet himself, was independent in his room, and needed housekeeping assistance. The CNAC stated that staff were to provide care with two aides at a time for resident 7's aggressive behaviors. On 2/20/24 at 11:33 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that if a resident needed a mobility device they would refer them to therapy to evaluate and if it was deemed appropriate then the Administrator (ADM) would purchase the bed rail. On 2/20/24 at 11:39 AM, an interview was conducted with the Director of Therapy Services (DOT). The DOT stated that she never evaluated resident 7 for a bed rail. The DOT stated that she was not consulted about the bed rail, but did not think resident 7 would be a hazard with one. The DOT stated that resident 7 was not on therapy services and she was never consulted or told to evaluate resident 7 for a bed rail. On 2/20/24 at 11:52 AM, an interview was conducted with the ADM. The ADM stated that the process for obtaining a mobility device was to notify the nursing team about the request and either nursing or therapy would determine if it was appropriate, and then they would have an Interdisciplinary Team meeting to discuss it. The ADM stated that she did not recall if resident 7 was evaluated by nursing or therapy for a bed rail. The ADM stated that resident 7 informed her that he purchased a bed rail and she needed it evaluated to determine if it was safe. The ADM stated that she had informed resident 7 that she would purchase a bed rail but she needed to find a bed that would fit the rail. The ADM stated that the beds they had were old and were difficult to find parts for. The ADM stated that she did not reimburse resident 7 for the bed rail that was purchased from Amazon. The ADM stated that she did not recall the IDT meeting about the bed rail and did not recall who she asked to evaluate the device.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22992 Based on record review and interview, the facility did not promptly act upon the grievances and recommendations of the resident council concerning issues of resident care and life in the facility. In addition, the facility was not able to demonstrate their response and rationale for resident concerns. Specifically, recurring concerns were voiced by the resident council over the period of approximately 14 months with no follow up to or resolution of the concerns. Findings include: The resident council notes for the previous 14 months were reviewed and revealed the following concerns voiced by the residents: a. On 1/25/23: i. The parking lot is hard to maneuver, it's dangerous. People keep falling and hard to maneuver with a wheelchair. ii. Agency staff don't always understand specific needs. High turn over rate. Affecting care. iii. Dietary: I like him [name of staff member] he's doing better. Tray transfer needs to be thought over, need to use second cart so dirt/grime does not get on the bottom trays. Larger portions. b. On 2/24/23: i. Water jugs. (switch off.) instead of being picked up and waiting. Just switch them off. ii. Dietary: . Portions are too small, need another set of hands. c. On 3/31/23: i. Water (takes hours). [Note: There was no specific information regarding what this concern referred to.] ii. Call lights are not being answered (1 hr (hour) [and] 45 minutes went by). iii. Medications are late iv. A lot of slacking, there should always be someone on the floor. v. Speak to CNA's (Certified Nursing Assistants) about not forcing residents to go to sleep (not allowed). vi. Staff is slacking, every day can't be an emergency. Wait time is too long. They have to do what they have to do. I'm going backwards in my disability not getting the assistance I need. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	vii. Dietary: Food portions are small. Reassess drinks (many are not receiving milk.) Tickets are not being followed. Food is cold. They need to learn portion control. Bring out alternative menus to fill out. d. On 4/25/23: i. Water is still not being distributed (not being passed out). ii. CNA's are not answering call lights in appropriate timing. iii. Nurses are no where to be found (solution would be to hire another nurse. iv. CNA's only doing their section whey they can help. (Help where you can.) (Spend more time charting.) v. Run out of toilet paper. vi. Laundry: a lot of clothes have gone missing. vii. Dietary: Not being served enough food (reach out to corporate to fix portions or double up portions.) Need to serve mechanical soft food. e. On 5/30/23 i. Residents state that nurses need to pay better attention to them. ii. Residents want more ice cream! They also want their ice cream to not be melted by the time they are ready to eat it - Arrives directly with the meal. iii. Issues: Residents need to receive care within a timely matter. Cold food. Missing items in laundry. iv. Dietary: Food is often late 15 - 45 minutes better portions - they want. v: Nursing: need to be more attentive to residents [and] their needs. vi. Problems - Nurses don't pay attention to the people they need to pay attention to. Someone will be yelling to get nurse's attention and it takes forever to get attention and help they need. They need to be taken care of . Call lights not being answered. vii. [Resident name] his served is food, but no one is available to help him for at least a half hour. Food is always cold. viii. [Resident name] said she is missing several pairs of clothing - 6 times! She is concerned that the clothes always go missing. her clothes are getting washed and she is not getting them back . f. On 6/13/23: (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	i. Call lights not being answered promptly .CNA's need to do their job ii. Housekeeping: Wondering if they still work here?? Floors need to be cleaned, rooms need more attention - cockroaches iii. Laundry: Needs to make sure clothes are getting returned to residents. Multiple residents were documented to have missing laundry items. iv. Dietary: food is cold. v. Someone pooped outside [and] has been peeing [and] throwing up on side of the building. pooped over the weekend below the bird food area is - happened on Sunday. vi. Water mugs have not been consistently going out the last few days. g. On 7/27/23: i. Staff and other residents walking into other people's rooms without notice. ii. Residents want beds made. iii. Snacks not being passed out in evenings. iv: Dietary: Food could be better. h. On 8/8/23: i. Nursing: Working their tails off . Sad they lost hope. CNA's - short-handed. ii. Dietary: Cold food. Portions are too small. High turnover. Too salty .Chicken is not cooked all the way. Still pink in the middle. Worried that food is cold in kitchen before it comes out. i. On 9/12/23: i. [Name of resident] - wants to meet with dietician (sic) about high protein diet - wants protein drinks - not allowed to have them of (sic) the facility. Been told several [NAME] (sic) to remove from building. ii. Housekeeping: . doesn't sweep floor [and] just mops, pushes things around. iii. Nurses [and] CNA's . need to be more on top of it - waiting a long time answer residents. [Note: No documentation could be located to indicate what the facility's response to the resident council concerns were for the months of January, February, March April, May, June, July, August, and September 2023.] j. On 10/11/23: (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	i. Housekeeping: . doesn't sweep - just mops over it, bathrooms need more attention . black mold. ii. Dietary: cold food, [name of resident] receiving food she doesn't want . bland food, want more seasoning - veggies too mush or too hard. Never medium. iii. CNA's - call lights are taking 45 minutes - 1 hour. iv. New Business: String in bathroom for emergency .More access to ice - resident waited an hour. v. Issues: not getting water daily - 4/5 days no hydration cup. This month a Resident Council Departmental Response Form was attached to the resident council notes. In response to the dietary concerns, the interventions included Will have department head pull a test tray regularly to ensure consistency of food. In response to the housekeeping concerns, the interventions included Education completed on housekeeping cleaning procedures . correct mold spray purchased, facility housekeeping to clean bathrooms. k. No resident council notes for November 2023 were provided by the facility. l. On 12/19/23: i. Housekeeping: [Name of staff member] is nice but cleaning is not up to par. Community needs a deep clean. ii. Laundry: Clothes missing. Need follow through. This month a Resident Council Departmental Response Form was attached to the resident council notes. In response to the housekeeping concerns, the interventions included Housekeeping staff re-education on duties and cleaning responsibilities completed. m. On 1/9/24: i. Housekeeping - [Administrator] has had talks with housekeeping - re education however residents haven't seen a change. Place is not clean - Gotten better but still need work. ii. Nursing: . Residents don't feel heard by CNAs. iii. Maintenance: .Building seems run down needs TLC. iv. Dietary: . Feels like the same thing all the time. Portions are small. Not a lot of care put into it. Worn out menu. Food not up to par. Dining room not clean. Stuff runs out. Meals not Complete. Kitchen is just sad! v. Some residents feel neglect. [Note: There was no other specific information as to what the resident council discussed with regard to possible neglect.] (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	This month a Resident Council Departmental Response Form was attached to the resident council notes. In response to the dietary concerns, the interventions included Audited meal service on portion sizes with cook, RD (Registered Dietitian) and I. Admin (Administrator) pruchesed (sic) condiment holders for tables. [Note: Not all of the concerns voiced by the residents were addressed on the response form.] n. On 2/6/24: i. Issues: Water is not warm enough - Not enough hot water. ii. Administration: . I think she trys (sic) hard overall but need to stop making excuses for everyone. She sucks. iii. Housekeeping: . Does not thurgly (sic) clean - nice guy but cleaning is not good. iv. Maintenance: . Going down hill fast - they didn't even know we had one - Clean filters! MOLD! v. Dietary: . Like kitchen staff. Do not like food. Portions are small. Stay on top of stuff you run out off (sic). There was no Resident Council Departmental Response Form connected with the February 2024 resident council notes. On 2/14/24 at 11:26 AM, an interview was conducted with the facility Activities Director (AD). The AD stated that she has only worked here since December 2023. The AD stated that after she has conducted a resident council meeting, she brings the notes to stand up meeting the following morning, where department heads go over everything, and then they write out how they will correct the issue. The AD stated that the department heads then filled out a correction form, and would give the form to the Administrator (ADM). The AD stated that she would present the correction forms to the resident council the following month. On 2/14/23 at 1:03 PM, an interview was conducted with the facility ADM. The ADM stated that prior to October 2023, there were no response forms being completed by facility staff in regard to concerns voiced at resident council. The ADM stated that after a resident council was conducted, the AD would write out the response forms for the department that it goes to, then the department head comes up with a solution, and sends back the forms to her. When asked if recurring issues raised in resident council were incorporated into the facility Quality Assurance (QA) program, the ADM stated, theoretically if we are working on it, it should be in QA, but that it had not been brought to QA at that time. [Cross refer to F584 and F804]

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F 0578 Level of Harm - 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** 22992 Based on interview and record review, the facility did not ensure that 1 of 40 sampled residents had the right to refuse medical treatment and formulate an advance directive. Specifically, one resident with an advanced health care directive received treatment that was documented as against the resident's wishes. This resulted in a finding of harm. Resident identifier: 39. Findings include: Resident 39 was admitted to the facility on [DATE] with diagnoses that included encephalopathy, interstitial pulmonary disease, acute and chronic respiratory failure, severe protein calorie malnutrition, pulmonary fibrosis, endocarditis, transient ischemic attack, end stage heart failure, atrial fibrillation, pulmonary hypertension, abnormal weight loss, delirium, benign prostatic hypertension, pneumonia, pressure ulcer on sacrum, and history of skin cancer. Resident 39's medical record was reviewed from [DATE] through [DATE]. Resident 39's medical record included a document entitled Utah Advance Health Care Directive. The document included resident 39's initials next to the statement, I choose not to receive care for the purpose of prolonging life, including food and fluids by tube, antibiotics, CPR (Cardio Pulmonary Respiration), or dialysis being used to prolong my life. I always want comfort care and routine medical care that will keep me as comfortable and functional as possible, even if that care may prolong my life. The document was signed by resident 39 and a witness, and was dated [DATE]. Resident 39's medical record also included a Provider Order for Life-Sustaining Treatment (POLST). The POLST indicated that resident 39 did not want staff to attempt or continue any resuscitation and wished to have a status of Do Not Resuscitate (DNR). The POLST was signed by the physician on [DATE], and there was a note on the POLST that said the resident wanted to speak to his son before signing this POLST. On [DATE] at 1:57 PM, a nurses note for resident 39 documented that Patient DNR code status, facility to complete POLST paperwork. On [DATE] at 3:58 AM, a nurses note for resident 39 documented that Resident passed away. MD [Medical Doctor] and family notified. Resident discharged from facility. On [DATE] at 8:16 AM, a nurses note for resident 39 documented that Residents O2 (oxygen) saturation was not recording on pulse ox (oximeter) for CNA (Certified Nursing Assistant) and notified nurse. Nurse assessed situation and had CNA turn-up residents O2 to 5 L's (liters). Resident was having labored breathing. Nurse notified DON (Director of Nursing) to check code status and DON stated that that information was not signed so to start CPR. Aids started CPR and nurse called 911 per DON's request. (continued on next page)

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F 0578 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 9:47 AM, an interview was conducted with the Previous Director of Nursing (PDON). The PDON stated that she was the DON at the time that resident 39 passed away. The PDON stated that approximately 24 hours before the resident's death, resident 39 was experiencing some respiratory distress. The PDON stated that facility staff provided a nebulizer treatment, but resident 39 crashed quickly. The PDON stated that when resident 39 was found to not have any oxygen saturations, facility staff contacted her by phone. The PDON verified that she had instructed staff to perform CPR on the resident, because although resident 39 had expressed verbally that he wanted to be a DNR status, the resident also wanted his son to look at the POLST document prior to him signing. The PDON stated that she was not aware that resident 39 had a previous signed advanced directive on file indicating he did not want CPR. When asked about the process for completing advanced directives, the PDON stated that it was a collaborative thing. The PDON stated that there was a POLST binder at the nurses station, where the residents' advanced directives were kept. The PDON stated that the nurse working the night that resident 39 was an agency nurse so that's why he called me. When asked how agency staff were trained about the advanced directives of residents, the PDON stated that we have a binder for agency but he was not a nurse that came to our facility very often. I think he only came twice, including that night [that resident 39 passed away]. He was not as familiar with the facility and where everything was. The PDON stated that the nurse going off shift should have oriented the agency nurse coming on shift about where to locate resident information.

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38031 Based on interview and record review it was determined, for 2 out of 40 sampled residents, that the facility did not consult with the resident's physician when there was a significant change in the resident's physical, mental or psychosocial status, or when there was a need to alter treatment. Specifically, a resident had uncontrolled pain and the physician was not notified, and a resident's Trulicity was not administered for two consecutive weeks due to unavailability and the physician was not notified. Resident identifiers: 29 and 31. Findings include: 1. Resident 29 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included diffuse traumatic brain injury, hemiplegia and hemiparesis following a cerebral infarction, major depressive disorder, panic disorder, anxiety disorder, low back pain, acute hepatitis C, seizures, overactive bladder, benign prostatic hyperplasia, insomnia, migraine, schizoaffective disorder, lymphangioma, and a history of suicidal behavior. On 2/6/24 at 9:22 AM, an interview was conducted with resident 29. Resident 29 stated that he had pain in his back and head. Resident 29 stated that he received Oxycodone for the pain but it did not help. Resident 29 stated that his current pain level was a 9/10. Resident 29 stated that he would like the pain to be non-existent, but he had to live with the pain. On 2/6/24, resident 29's medical records were reviewed. On 9/28/23, resident 29 had an order for Oxycodone Capsule 5 milligram (mg), give 1 capsule by mouth every 4 hours as needed for moderate to severe pain initiated. On 1/26/24 at 7:56 PM, the Oxycodone 5 mg was administered for complaints of a headache. Resident 29 reported an initial pain score of 9/10. On 1/26/24 at 10:10 PM, resident 29's Oxycodone follow-up administration assessment was documented as Ineffective with a follow-up score of 7/10. No documentation could be found that the provider was notified of the ineffective pain control and no additional pain medication was administered. On 1/27/24 at 6:33 PM, the Oxycodone 5 mg was administered for complaints of bladder pain. Resident 29 reported an initial pain score of 9/10. On 1/27/24 at 8:22 PM, resident 29's Oxycodone follow-up administration assessment was documented as Ineffective with a follow-up score of 9/10. No documentation could be found that the provider was notified of the ineffective pain control and no additional pain medication was administered. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/21/23, resident 29's care plan for at risk for pain related to history of craniotomy, trauma and chronic migraines was initiated. Interventions identified included to anticipate the resident's need for pain relief and respond immediately to any complaints of pain; evaluate the effectiveness of pain interventions; review pain interventions for alleviation of symptoms, dosing schedules and resident satisfaction with results; monitor for side effects of pain medication and report occurrences to the physician; monitor/record/report any signs and symptoms of non-verbal pain; monitor/record/report to nurse loss of appetite, refusal to eat and weight loss; monitor/record/report to nurse resident complaints of pain or requests for pain treatment; notify physician if interventions are unsuccessful or if current complaint was a significant change from past experience of pain. Review of the facility policy for Administering Pain Medications documented that pain management was defined as the process of alleviating the resident's pain based on his or her clinical condition and established treatment goals. The policy stated that staff were to document the effectiveness of non-pharmacological interventions. The policy stated that staff were to re-evaluate the resident's level of pain 30-60 minutes after administering pain medication. The policy stated that staff should report information in accordance with facility policy and professional standards of practice. The policy was last revised in January 2024. On 2/12/24 at 12:37 PM, an interview was conducted with Registered Nurse (RN) 2. RN 2 stated resident 29 did not report pain. RN 2 stated that resident 29 would say that he had bladder pain and needed to urinate and wanted to be catheterized. RN 2 stated that resident 29 goes to the bathroom [ROOM NUMBER] times a day and his bladder was never full. RN 2 stated that resident 29 had as needed pain medication. RN 2 stated that the resident did not get the pain medication unless he asked for it. RN 2 stated that they would obtain a pain score and location of the pain prior to the medication administration and then they would evaluate the effectiveness 30 minutes after administration. RN 2 stated that if the pain medication was not effective they should contact the physician. RN 2 stated that the notification to the physician would be documented in a progress note. On 2/13/24 at 7:56 AM, an interview was conducted with the Director of Nursing (DON). The DON stated for uncontrolled pain or pain that was not alleviated with pain medication the nurse should notify the physician. The DON stated the expectation for unresolved pain was to follow-up with physician immediately, and document in the nursing note that the physician was notified. 2. Resident 31 was admitted to the facility on [DATE] with diagnoses which included hemiplegia and hemiparesis, type II diabetes mellitus, asthma, morbid obesity, anxiety disorder, major depressive disorder, insomnia, hypertension, pseudobulbar affect, hyperlipidemia, nondisplaced fracture of proximal phalanx left great toe, chondromalacia left knee, and dementia. On 2/10/24 resident 31's medical records were reviewed. On 11/3/23, resident 31 had an order initiated for Trulicity Subcutaneous Solution Pen-injector 0.75 milligram (mg)/0.5 milliliter (ml), Inject 0.75 mg subcutaneously one time a day every Friday related to type II diabetes mellitus. On 1/12/24 at 12:55 PM, the Orders - Administration Note documented that the Trulicity was not administered due to Pharmacy is to deliver today. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/12/24, the January 2024 Medication Administration Record (MAR) documented that the medication was not administered. On 1/19/24 at 5:14 PM, the Orders - Administration Note documented that the Trulicity was not administered due to waiting on pharmacy. On 1/19/24, the January 2024 MAR documented that the medication was not administered. It should be noted that no documentation could be found that the physician was notified that the Trulicity was not administered. On 2/12/24 at 7:44 AM, an interview was conducted with RN 2. RN 2 stated that the pharmacy usually had any medications delivered to the facility within in a day. RN 2 stated that the new pharmacy was taking longer, a couple of days, but they were getting better at having medications like antibiotics available. RN 2 stated if a medication was not available she would notify the DON and she would then notify the physician. RN 2 stated that the DON had been handling a lot of issues with the new pharmacy. RN 2 stated that if the medication was not available or if it was an insurance coverage issue the DON handled it. RN 2 stated that for a medication like Trulicity she would contact the DON or notify the physician. On 2/12/24 at 10:06 AM, an interview was conducted with the DON. The DON stated that if a medication was not available she would immediately let the pharmacy know and then pull from the Pixus overstock. The DON stated that they did not have Trulicity available in the Pixus. The DON stated that staff should notify her and she would notify the pharmacy immediately. The DON stated that any insulin should be at the facility within hours. The DON stated that staff should have notified the interim DON so that they could notify the Medical Director (MD) and get a new order or attempt to get the medication in the facility. The DON stated that staff should notify the MD immediately of something critical like insulin and then document the MD notification in a progress note.

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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** 46232 Based on observation, interview, and record review the facility did not provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Specifically, the facility did not have a full time maintenance worker, resident areas were dirty, there was a lack of hot water in resident bathrooms and communal shower room, a resident bathroom door was in disrepair, a resident had missing items which had not been replaced and a column from the gazebo area outside had a loose metal base which caused a resident to fall resulting in a laceration. Resident identifiers: 4, 21, 26, 30, 31, 33, and 34. Findings Include: MAINTENANCE AND HOUSEKEEPING 1. On 2/7/24 at 9:32 AM, an interview was conducted with resident 4. Resident 4 stated that the dining room tables and table linens were filthy and the dining room usually had a bad odor. Resident 4 stated that the drinking fountain in the dining room had a sewer smell. Resident 4 stated that they ran out of toilet paper a week ago and they were out for 3 days. Resident 4 stated that they had to use Kleenex or paper towels instead of toilet paper during that time. Resident 4 stated that the staff reported to her that they were out of toilet paper because supplies were not ordered. Resident 4 stated that her air conditioner/heater unit was full of dust and the unit itself was not sealed. Resident 4 stated that the heating unit had a big gap and it let cold air and spiders in from the outside. The heating unit was observed with a gap and the light from outside could be observed from inside. Resident 4 stated that she placed a ace wrap bandage over the top of the heating unit to cover the gap to the outside in an attempt to keep the cold and spiders out. 2. On 2/5/24 at 10:35 AM, an interview was conducted with resident 26. Resident 26 stated no one cleaned their room on the weekend. Resident 26 stated six residents shared a restroom and it had not been cleaned in 3 days. 3. On 2/5/24 at 9:34 AM, an observation was made of the floor directly inside the door of room [ROOM NUMBER]. The floor was dirty with dried splatter marks on the floor. 4. On 2/5/24 at 10:27 AM an observation of resident 33's room was made. The floor next the bed was observed to have dried dirt. The floor underneath the bed was observed to have cigarettes and food crumbs present. 5. On 2/22/24 at 8:45 AM, an observation was made of room [ROOM NUMBER]'s bathroom door with the Administrator (ADM). The bathroom door was observed to have wood missing and the bottom rail of the door was no longer intact. The administrator was observed to pull the wood panel away from the bottom rail. An interview was immediately conducted with the ADM. The ADM stated the door needed to be replaced because it was a hazard to residents. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. On 2/6/24 at 9:20 AM, an observation was made of resident 21's room. The bedside table by the window was observed to have multiple sticky areas and debris on it. The legs of the bedside table were noted to have black grime, dust and debris on them. The blinds in the room had several areas that were broken and/or missing. Resident 21's room was observed to have multiple spills with sticky and grimy areas on the floor. An interview was immediately conducted with resident 21. Resident 21 stated he had his own bedside table, so he was unsure what the extra table in his room was for. 7. On 2/13/24 at 9:48 AM, an observation was made of a brown substance on the white banisters near room [ROOM NUMBER]. 8. On 2/13/24 at 10:43 AM, an observation was made of the facility shower room. There was a plastic garbage liner covering the toilet in the room. There were several soiled wipes on top of the toilet tank. The trash bin next to the toilet was overflowing with visibly soiled incontinence wipes and paper towels. There was a bottle of Vagisil body wash laying in the middle of the floor in between the north shower and the toilet. There was black mold in the north shower near the drain and the southern wall of the shower. There was a soiled hospital gown laying on the floor near the toilet. There were numerous brown stains and streaks consistent with the texture and appearance of feces on the walls near the toilet and the sinks. The insides of all three doors in the shower room were visibly soiled, and the bottoms of the doors were peeling upwards. On 2/13/24 at 3:16 PM, an interview was conducted with the Certified Nursing Assistant Coordinator (CNAC). The CNAC stated that to her knowledge, the shower room was never cleaned unless it was in enough of a poor condition for staff to notice. The CNAC stated that up until the week prior, there had been mold on the ceiling of the shower room. The CNAC stated that she was unsure if the mold had been cleaned off or painted over. The CNAC stated that no one was assigned to clean the bathroom and that there was no cleaning schedule. The CNAC stated that laundry staff will go into the shower room and clean it to the best of their ability and that housekeeping staff will occasionally clean the room. The CNAC stated that the weekend housekeeping staff quit and that there was no coverage of Fridays, Saturdays, or Sundays. The CNAC stated that due to the absence of a weekend housekeeper this caused the weekday housekeeper to struggle to catch up. The CNAC stated that she had observed residents of the facility urinating on the plastic liner covering the toilet in the shower room. The CNAC stated that the facility ran out of toilet paper the week prior. On 2/14/24 at 8:54 AM, an interview was conducted with the Laundry Attendant (LA). The LA stated that the facility housekeeper was responsible for cleaning the shower room each day. The LA stated that there should be a housekeeper on the weekends and a laundry attendant on the weekends. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/14/24 at 8:58 AM, an interview was conducted with the Custodial Staff Member (CS). The CS stated that he worked Monday through Friday and weekends as needed. The CS stated that during the week he was the only housekeeper and on weekends as well. The CS stated that the weekend housekeeping staff member keeps quitting. The CS stated that there were currently no weekend housekeeping staff. The CS stated that the shower room should be cleaned by housekeeping once daily and that he cleaned it each day he worked. The CS stated that it would be too much work to clean the shower room after each individual shower. The CS stated that the Certified Nursing Assistants (CNAs) should sanitize the shower room after each shower. The CS stated that the sanitizer was stored in the utility closet at the end of the hall. The CS stated that the shower room did not get cleaned on the weekends that he did not work. The CS stated that when he comes in on Mondays the shower room was covered in feces due to there being no housekeeping staff on the weekends. The CS stated that the toilet in the shower room had not been functional for 2-3 days. The CS stated that residents frequently try to flush paper towels down the toilet and that it then become clogged afterwards. The CS stated that residents will continue to try and use the toilet while it was clogged despite him putting up an out of order sign on the door, which then further clogged the toilet. The CS stated that there was a toilet in room [ROOM NUMBER] that did not flush because of a broken chain. The CS stated that there were two other rooms with toilets that were not functional. The CS stated that the caulking on many of the toilets in the facility was damaged, and that he had addressed this with the facility administrator multiple times. The CS stated that it was difficult to keep the toilets clean in their current state as the caulking was stained and breaking off. The CS stated that the shower in room [ROOM NUMBER] did not have a shower curtain and that the shower in either room [ROOM NUMBER] or room [ROOM NUMBER] did not properly drain due to the drain being clogged. The CS stated the dining room should be cleaned at least three times a day, but he can only get to it twice a day. The CS stated that floors, tables, plastic clothes covers, sink area, water fountain, and microwave should all be cleaned in the dining room. The CS Stated that there had not been a deep cleaning in the dining room in several months. The CS stated that a deep cleaning would include cleaning the vents, baseboards, floorboards, and walls. The CS stated that the facility did not currently have any maintenance staff. The CS stated that the facility had not had maintenance staff for two weeks. The CS stated that the facility pest control was provided by an outside company named EcoLab. The CS stated that EcoLab had just visited the facility the week prior. The CS stated that the facility administrator was responsible for pest monitoring. The CS stated that EcoLab employees spray pesticides around the outside of the building, the baseboards in the hallways, and the baseboards in the dining room. The CS stated that EcoLab did not spray the pesticide inside of resident rooms. The CS stated that residents have complained about cockroaches, but he personally had not seen any. The CS stated that he had never seen rodent droppings or dead spiders in the facility. The CS stated that he frequently runs out of cleaning supplies including soap, paper towels, toilet paper, garbage liners, and floor cleaner. The CS stated that he had to put a lock on the cabinet where the small garbage liners were stored because the facility kept running out of liners too quickly. The CS stated that he leaves the key to the supply closet with the weekend laundry staff when he leaves for the weekend. The CS stated that if anything in the facility needed to be fixed, he had to call in the corporate maintenance staff and that it could be at least 1-2 days before the corporate maintenance staff could come in and make repairs. The CS stated that there was a maintenance log that staff members could fill out, however there was currently no maintenance staff to address the maintenance log. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/14/24 at 1:33 PM, an interview was conducted with the Corporate Maintenance (CM). The CM stated he was temporary and had only been here for 3 days. The CM stated that he got a text from the Administrator to replace the toilet and that was why he was here. The toilet he was replacing was old and worn out and got a lot of usage. The CM stated he was responsible for project management and helped with the building. The CM stated he came to the building depending on how big the project was. The CM stated they oversaw big projects such as replacing toilets, working on air conditioning (AC) units, doing floor repairs, and doing a fluff and puff on a new room. The CM stated he did not do the day-to-day maintenance stuff and generally did not look at the maintenance log. The CM stated the Administrator oversaw the maintenance log. The CM stated they assumed the Administrator would notify them of anything they needed to fix from the maintenance log. The CM stated he also oversaw other buildings. The CM stated he did not look at the facility maintenance log unless he was asked to. The CM visualized the black areas in the main shower room and stated the black areas were not mold and it looked more like algae. The CM stated the black areas could be removed if the area was cleaned/disinfected. The CM stated the caulking around the toilet was not a requirement. The CM stated the caulking served as a sealant. The CM stated if there was no sealant then fluid might be able to get under the toilet. The CM stated if a resident voided on the floor or had diarrhea on the floor and it happened to go under the toilet then he expected a smell to be present underneath it since there was no sealant to prevent the fluid from going underneath and there was no way to clean underneath the toilet. The CM stated depending on the substance spilled on the floor around the toilet, then a smell might have been present. The CM stated the in-house maintenance man was the one responsible for changing the vents. The CM stated if the vent was dusty then they expected there to be a restriction in the airflow due to the dust so it would not work as efficiently. The CM stated they recently looked at a resident's AC/heater system on Monday and stated there was nothing wrong with it. The CM stated they checked to make sure nothing was impeding the seal and then put the cover back on and screwed it on tight. The CM stated the resident told them they had bugs coming in from the vent, but they stated they believed the bugs were coming from all the plants she had in her room. The CM stated he believed the plants gave the bugs a place to live and that was where they were coming from. The CM stated he did not come to the building every day. 9. The resident council notes for the previous 14 months were reviewed and revealed the following concerns voiced by the residents regarding the cleanliness and maintenance of the facility: a. On 1/25/23: i. The parking lot is hard to maneuver, it's dangerous. People keep falling and hard to maneuver with a wheelchair. b. On 4/25/23: i. Run out of toilet paper. c. On 6/13/23: i. Housekeeping: Wondering if they still work here?? Floors need to be cleaned, rooms need more attention - cockroaches ii. Someone pooped outside [and] has been peeing [and] throwing up on side of the building. pooped over the weekend below the bird food area is - happened on Sunday. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was no Resident Council Departmental Response Form connected with the February 2024 resident council notes. 10. Resident 34 was admitted to the facility on [DATE] with diagnoses which included intracranial injury with loss of consciousness, unsteadiness on feet, history of Traumatic Brain Injury (TBI), intellectual disabilities, anxiety disorder, major depressive disorder, and impulse disorder. Resident 34's medical records were reviewed between 2/12/24 and 2/22/24. On 11/18/23, resident 34's Admission Minimum Data Set (MDS) Assessment documented a Brief Interview for Mental Status (BIMS) was conducted. Resident 34's scored a BIMS of 8, which indicated a moderate cognitive impairment. Resident 34's care plans were reviewed and indicated the following: a. A care plan dated 11/10/23, with a focus area documented resident 34 has limited physical mobility r/t [related to] neurological deficits r/t TBI, intellectual disability, weakness, altered gait, unsteadiness on feet. Interventions included, AMBULATION: Requires supervise/touching assist of 1 with ambulation (provide cues, reminders) with use of cane. Observe for changes in ability . Now has a quad cane but resident doesn't comprehend how to use at times-- will just care [sic] it. b. A care plan dated 11/8/23, with a focus area documented resident 34 was at risk for falls per standardized fall scale, wandering/elopement risk, unsteadiness on feet, altered gait . epilepsy, cognitive impairment . history of frequent falls, weakness an loss of balance. Interventions included, safety awareness training daily for 2 weeks, then weekly and therapy evaluation and treatment if indicated related to a fall. Nursing notes for resident 34 revealed the following: a. On 12/13/23 at 4:00 PM, a nurses progress note documented, Resident 34 had witnessed fall in backyard, tripping over a piece of the support pole of the awning, open laceration to right eyebrow, assessment completed, neuro-checks initiated, per physician resident to be transferred to ER [emergency room] for stitches to eyebrow. b. On 12/13/23 at 5:01 PM, a nurses progress note documented, resident 34 was Transferred to [a local hospital] via [emergency medical services] for stitches to eyebrow. c. On 12/14/23 at 5:54 AM, a nurses progress note documented, Resident returned from [a local hospital] at [9:00 PM]. Resident was seen for head laceration . Instructions: Sutures need to be removed in 7-10 days, keep wound clean and dry . d. On 12/14/23 at 9:30 AM, an Interdisciplinary Team (IDT) Event Review note documented, resident did fall, tripping on a piece of metal from a column, root cause found to be that the base of the column was coming loose--this has been removed and maintenance is also looking at all the columns in the backyard today to ensure that there are no tripping hazards, [Resident 34] did suffer an eyebrow laceration and was taken to [a local hospital] for stitches, intervention is that CNA Coordinator will meet with [Resident 34] once a day to discuss safety awareness x 14 days[on weekdays], all other least restrictive interventions in place, will continue with plan of care. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's risk report dated 12/13/24 at 7:52 PM, documented, Patient was outside smoking with the CNA [name removed] supervising. He was walking towards the table and his foot caught on the bottom of the pole that supports the roof. He fell and hit his R [right] eye and it cut his eyebrow line and was bleeding. He also hit the back of his heads [sic] after bouncing his eyebrow off the table. On 2/21/24 at 10:50 AM, an interview was conducted with the Director of Therapy services (DOT). DOT stated that she would perform safety checks for safety awareness. DOT stated that resident 34's retention was not amazing and that education had to be very repetitive. DOT stated that she was unsure if other staff educated resident 34 on his safety awareness. On 2/21/24 at 11:20 AM, an observation was made of the smoking area where resident 34 had fallen. An observation was made of 4 columns were holding up a gazebo. Three of the columns had a square metal base surrounding the columns and the bases were observed rusty and nailed into the concrete. On 2/21/24 at 11:34 AM, an interview was conducted with Registered Nurse (RN) 2. RN 2 stated that Resident 34 was difficult and that resident 34 needed more supervision than he could get at the facility. RN 2 stated that resident 34 needed supervision while smoking. RN 2 stated that the day resident 34 fell , he was outside smoking and had supervision. RN 2 stated that there was a column outside in the smoking area that had a metal piece on the metal plate that had lifted up off of the cement. The metal piece was no longer bolted down and was a tripping hazard. RN 2 stated that after resident 34 fell the metal piece had been removed. RN 2 stated that resident 34 had alterations with his gait and that he walked with a limp so staff should try to keep a close eye on him. On 2/21/24 at 12:20 PM, an interview was conducted with the Administrator in Training (AIT). The AIT stated that the metal base resident 34 had tripped on was in a high traffic area and was a tripping hazard. He stated that a screw holding the metal base to the concrete had fallen through and the metal base began flaring upward. The AIT stated that the metal bases resident 34 had tripped on had been removed. COLD WATER 11. On 2/6/24 at 8:44 AM, an interview was conducted with resident 30. Resident 30 they were having to take a cold shower because staff had recently turned down the water heater temperature. Resident 30 stated the sink in their restroom had no warm water. On 2/7/24 at 9:56 AM, an interview was conducted with resident 31. Resident 31 stated she wanted to shower yesterday, but management said that there was no hot water. On 2/8/24 at 10:18 AM, an interview was conducted with the Certified Nurse Assistant Coordinator (CNAC). The CNAC stated that if they had 3 or 4 showers back to back that they would run out of hot water and the aides would have to wait for a hour or so for the water to heat up On 2/6/24, the facility water temperatures were checked in the communal shower room and various resident rooms. At 12:37 the shower head was turned on in the communal shower room and the warmest temperature documented was 100.6 Fahrenheit (F). The water temperature for 3 resident bathrooms were randomly checked and the temperature varied from 54.7 F to 55.8 F. There was no hot water coming out of the resident sinks. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/14/24 at 1:33 PM, an interview was conducted with the Corporate Maintenance (CM). The CM stated the water regulator was set at 116 degrees, so they expected there to be a variation between 2-4 degrees from the set temperature due to a line droppage in temperature. The CM stated the rooms located the furthest away from the water heater had the greatest variation in water temperatures. MISSING ITEMS 12. Resident 31 was admitted to the facility on [DATE] with diagnoses which included hemiplegia and hemiparesis, type II diabetes mellitus, asthma, morbid obesity, anxiety disorder, major depressive disorder, insomnia, hypertension, pseudobulbar affect, hyperlipidemia, nondisplaced fracture of proximal phalanx left great toe, chondromalacia left knee, and dementia. On 2/05/24 at 1:55 PM, an interview was conducted with resident 31. Resident 31 stated she was missing a couple pairs of legging, a shirt, a blanket, and socks. Resident 31 stated that she reported it to the Director of Nursing (DON) and the Administrator (ADM). Resident 31 stated that they had not replaced anything. On 2/10/24 resident 31's medical records were reviewed. On 11/29/23, the grievance binder documented that resident 31 reported that someone went through her drawers and she was missing a [NAME] mac & cheese box. The facility replaced the missing item. No documentation could be found for any missing clothing items for resident 31. No documentation could be found of a personal inventory list for resident 31. On 2/12/24 at 9:05 AM, an interview was conducted with Nursing Assistant (NA) 4. NA 4 stated that missing items were reported to the DON and ADM. NA 4 stated that as she was cleaning a resident's room she would look for any reported missing items. On 2/13/24 at 11:46 AM, an interview was conducted with the DON. The DON stated that resident 31 did not report any missing personal items to her. On 2/12/24 at 11:12 AM, an interview was conducted with the Resident Advocate (RA). The RA stated that she handled all grievances. The RA stated that grievance forms were located all over the facility for resident access and staff could assist with filling out the form. The RA stated that if the form was not delivered directly to her it could be placed on her desk. The RA stated that depending on what the grievance was she would follow-up with the resident and verify the information contained on the form. The RA stated that the form contained a spot to document witness statements or other investigation documentation. The RA stated that sometimes the grievance was about missing clothing. The RA stated that if a piece of clothing goes missing the form was still filled out. The RA stated that sometimes they mark the clothing with the resident's name. The RA stated that she did not recall that resident 31 had missing clothing. The RA stated that during the investigation she would look through the resident room, ask other residents in the room about the missing item, go to laundry and look for it, and if she was not able to locate the items she would notify the ADM to replace the items. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/13/24 at 11:37 AM, a follow-up interview was conducted with the RA. The RA stated that the personal inventory list was at the nurses station, and staff would add items to the list. That form then was scanned into the electronic medical records. The RA stated that if the personal inventory list was not located in the electronic medical records than it probably did not get completed. The RA stated that she would still replace any missing items for the resident. 45490 38031 47432 22992

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 38031 Based on interview and record review it was determined, for 4 out of 40 sampled residents, that the facility did not ensure that the resident had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. Specifically, a resident to resident verbal altercation escalated to an incident of physical abuse when a resident threw a can of food at another resident and struck them in the leg. Additionally, a resident to resident verbal altercation escalated to an incident of physical abuse when a resident cut another resident with a razor. In addition, multiple areas of neglect were identfied during the survey. Resident identifiers: 7, 19, 31, and 36. Findings included: ABUSE 1. A. Resident 36 was admitted to the facility on [DATE] with diagnoses which included traumatic subdural hemorrhage, cirrhosis, type II diabetes mellitus, excoriation (skin picking) disorder, major depressive disorder, stimulant abuse, chronic pain, gout, polyneuropathy, hepatitis C, chronic kidney disease, insomnia, history of suicidal behavior, and unilateral inguinal hernia. On 2/05/24 at 9:45 AM, an interview was conducted with resident 36. Resident 36 stated that he had problems with resident 7 and he talked shit about him. Resident 36 stated that he used to be resident 7's roommate. On 2/07/24 at 9:43 AM, a follow-up interview was conducted with resident 36. Resident 36 stated that a couple of weeks ago he and resident 7 were arguing and resident 7 alleged he hit him. Resident 36 stated that the police were notified and he was moved to another room after this incident. Resident 36 stated that yesterday resident 7 threw a can of food at him and hit his left leg. Resident 36 stated he wanted to press changes. Resident 36 stated that the Administrator (ADM) told him not to go into resident 7's room. Resident 36 stated that he was outside of the room trying to speak to resident 29 who resided in that room and was his friend. Resident 36 stated that he did not enter the room. Resident 36 stated that resident 7 got up and threw the can at his leg and screwed it up. Resident 36 stated that resident 7 should have gone to jail for throwing the can. On 12/30/23, the Admission Minimum Data Set (MDS) assessment documented a Brief Interview for Mental Status (BIMS) score of 11, which would indicate a moderate cognitive impairment. Review of the facility abuse investigations revealed the following: (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. On 1/11/24 at 11:30 AM, the facility became aware of an allegation of verbal abuse between the resident 36 and resident 7. Resident 36 alleged that resident 7 was being racist and calling him names and it escalated to a verbal argument. Resident 36 stated that he was fine and that he was not hurt emotionally or mentally. The report documented that resident 36 stated that he was called the N word. He was upset because [resident 7] kept interrupting his conversations with the staff. [Resident 36] stated he only called [resident 7] fat after [resident 7] had called him the 'N*****'. Resident 36 denied calling resident 7 fat prior to this incident. The facility report documented an interview with the custodial staff (CS) who witnessed the incident. The CS reported that he was cleaning resident 36's room and resident 7 started antagonizing resident 36 saying he was dirty and used racial slurs. The CS reported that resident 36 requested he clean under his bed and resident 7 called resident 36 Dirty N*****. The CS reported, There was no reason for [resident 7] to say anything to [resident 36]. The report documented that resident 29 who was the roommate stated that he heard both resident 7 and resident 36 call each other names. The conclusion of the facility investigation confirmed the verbal altercation was verbal abuse and both parties engaged in inappropriate verbal dialogue. b. On 1/17/24 at 12:13 PM, the facility became aware of an allegation of physical abuse between the resident 36 and resident 7. Resident 7 alleged that resident 36 punched him in the forehead with an open-ended fist. The report documented that resident 7 refused a skin check, but that the regional nurse did not observe any redness or bruising in the area that the resident alleged he was hit. The summary of the interviews documented that resident 7 stated that he was in a verbal altercation with resident 36 because his phone was too loud. Resident 7 said that resident 36 was calling him names and getting in his face when resident 36 open fisted punched resident 7 in the forehead. Resident 7 reported that there was no marks but he felt dizzy. The report documented that resident 29, the roommate, stated that resident 36 did not hit or touch resident 7. Resident 36 denied ever touching resident 7. The report documented that no action was taken by the police as there was no evidence of assault. The interview with resident 36 stated that he got angry at resident 7 due to resident 7 talking smack. Resident 36 reported that he got in resident 7's face and told him to shut up. The report documented that resident 36 requested a room change. The conclusion of the facility investigation was that the allegation of physical abuse was not substantiated or verified. c. On 2/6/24 at 5:00 AM, the facility became aware of an allegation of physical abuse between resident 36 and resident 7. Resident 36 alleged that resident 7 threw a can at him during a verbal dispute. Resident 36 stated he was in the doorway talking to his friend (resident 29) who was the roommate of resident 7. The report documented that the incident occurred in the doorway to room [ROOM NUMBER], and redness and swelling was noted to resident 36's left ankle. The facility reported that resident 36 said he was going to see if resident 29 wanted to smoke when resident 7 started yelling at him and then threw a can at him hitting him on the ankle. The report documented that an agency aide heard from another room yelling and someone say get the F*** out. The aide stated she saw a can on the ground and resident 7's hand in the air like he had thrown it. The report documented that the nurse heard resident 36 yell, he threw a can at me. Resident 7 reported that he was woken up early in the morning by resident 36 talking to resident 29 from the doorway of his room. Resident 7 stated that he told resident 36 to get out of the doorway and resident 36 did not acknowledge him. Resident 7 verbalized he regrets what he did and apologizes and said it would not happen again. The conclusion of the facility investigation was that the allegation was verified and physical injury was sustained by resident 36. Resident 36's progress notes revealed the following: (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. On 2/6/24 at 6:30 AM, the Nurses Note documented, Resident had an altercation with another resident in building. Staff intervened immediately. Resident has minor swelling to left ankle d/t [due to] an object hitting bone area. Nurse wrapped ankle per residents request. Non-emergent contacted. Administration contacting state, aps [adult protective services], and ombudsman. NP [nurse practitioner] is aware and will be in to assess later in morning. b. On 2/6/24 at 8:17 AM, the Nurses Note documented that the NP assessed the swelling of left ankle and recommended that the resident rest the ankle, ice as needed and as needed Tramadol for pain. c. On 2/7/24 at 2:12 PM, the Nurses Note documented, After an altercation with another resident on 2/6/24 resident is managing well. Resident stated his ankle still hurts a bit but otherwise doing great. Stated he had 'cool' staff last night that chatted with him to help improve mood. Resident does not want ice or pain medication at this time. On 1/17/24, resident 36 had a care plan initiated for at risk for potential abuse related to history of abuse, history of behaviors and impaired cognition. Interventions identified included to encourage the resident to attend activities of his choice; follow abuse protocol if allegations were made; monitor for behavior changes; observe for symptoms of increased isolation, depression, agitation, combativeness; and social service visits monthly and as needed. On 2/6/24, resident 36 had a care plan initiated for has minor swelling to left ankle d/t [due to] an object hitting the bone area. Interventions identified included to wrap the area; NP notified and requested to assess injury; observe/document location, size and treatment of injury; and report any abnormalities such as failure to heal or signs of infection to the physician. On 2/08/24 10:18 AM, an interview was conducted with the Certified Nurse Assistant Coordinator (CNAC). The CNAC stated that resident 7's behaviors were being inappropriate with females, and yelling for no reason. The CNAC stated that resident 7 would drop items just to watch people bend over to pick them up. The CNAC stated that a month ago resident 7 attempted to hit her with a cane. He can have aggressive behaviors. The CNAC stated that they tried to have 2 staff provide cares with him for safety reasons. The CNAC stated that resident 7 did not get along with resident 36, it's a racial thing, racial slurs. The CNAC stated that resident 7 started calling resident 36 the N word. The CNAC stated that after the second altercation between resident 7 and resident 36 they initiated a room change. The CNAC stated after the first altercation the Administrator tried to move resident 36 but he declined until the second altercation occurred. The CNAC stated that she was not aware of any altercations with other residents and resident 36. The CNAC stated that the Administrator was the abuse coordinator. The CNAC stated staff should be calling the ADM immediately for any incidents of abuse. The CNAC stated that staff should attempt to de-escalate the situation right away and try to keep the resident safe. The CNAC stated that if the staff did not know what to do they should notify the nurse, but the first step was keeping the resident safe. The CNAC stated that the last abuse training was either January 2024 or December 2023. The CNAC stated that the education covered what verbal, physical, and sexual abuse was and who to notify. The CNAC stated that resident 7 had not made himself likable and only comes out of his room to shower. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/14/24 at 11:15 AM, an interview was conducted with the facility ADM. The ADM stated that the resident 36 was talking to resident 29 loudly and she educated him to grab a staff member to get resident 29 when he wanted to talk to him. The ADM stated that she provided resident 7 with education on not using personal items to harm another individual, and that they would store those items for him if it continued to be a behavior. The ADM stated that resident 36 was not happy about the intervention but that she had other residents complain that he had entered their personal space too. The ADM stated that they substantiated the physical abuse because resident 36 was hit with the can and when the Director of Nursing assessed it there was some redness and swelling. The ADM stated that resident 7 and resident 36 did not get along and had quite a few altercations. The ADM stated that the first verbal altercation resident 7 was calling resident 36 racial slurs. The ADM stated that she talked to resident 7 and he verified he had said the racial slur, but that resident 36 had called him fat. The ADM stated that the second altercation between resident 36 and resident 7 on 1/17/23 was not verified. The ADM stated that resident 7 initially declined skin checks, but a second attempt was made for a skin check and no evidence of a physical punch to the forehead was observed. The ADM stated that after the first altercation she asked if they could do a room change and both residents refused. The ADM stated that after the second altercation resident 36 agreed to a room change. B. Resident 7 was admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease, morbid obesity, alcoholic cirrhosis, hepatic failure, type II diabetes mellitus with polyneuropathy, portal hypertension, narcolepsy, major depressive disorder, obstructive sleep apnea, personality disorder, bipolar II disorder, alcoholic dependence, restless leg syndrome, male erectile dysfunction, hypertension, heart failure, anxiety disorder, hyperlipidemia, hyperaldosteronism, and osteoarthritis. On 2/16/24, the Quarterly MDS assessment documented a BIMS score of 15, which would indicate that resident 7 was cognitively intact. Resident 7's progress notes revealed the following: a. On 2/6/24 at 5:50, an Incident Note documented, Resident threw a full can of sliced tomatoes at another resident, [resident 36] Per [resident 36 and resident 29] [resident 36] stood at the doorway and was speaking to [resident 29] and asked for a cigarette. [Resident 7] then threw a closed can of sliced tomatoes and the can hit [resident 36] left ankle. During this time, CNA [6] was at the scene and saw [resident 7] standing after throwing the can. Per [resident 7], he stated he feels threatened and traumatized by [resident 36]. b. On 2/6/24 at 7:35 AM, the Nurses Note documented, Non-emergent police came to question resident about physical aggression to another resident. Police took statements and left. Will consult NP today about possible interventions for residents aggression. c. 2/6/24 at 8:14 AM, the Nurses Note documented, DON [Director of Nursing] and [NP] discussed physical aggression with resident. Resident stated 'I am a little grouchier lately.' NP recommended a medication be added into daily schedule. NP recommended trying out small dose of Depakote daily. Resident was firmly against adding Depakote. Resident wanted Clonazepam but NP stated it is contraindicated with other medications he currently takes. Resident does not want any medication changes at this time. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. On 2/7/24 at 7:44 AM, the Nurses Note documented, Resident polite with this nurse. Was [sic] Had an episode of agitation while roommate was talking to visitors. Able to redirect him and calm him down. On 1/1/24, resident 7 had a care plan initiated for at risk for abuse related to history of abuse and history of behaviors. Interventions identified included to follow the abuse protocol if allegations were made; monitor for behavior changes; and social services to visit monthly and as needed. On 11/29/23, resident 7 had a care plan initiated for had the potential to be physically aggressive related to anger, depression, and history of harm to staff. Interventions identified included administer medications as ordered; monitor/document for side effect and effectiveness of medication; provide physical and verbal cues to alleviate anxiety; give positive feedback; assist with verbalization of source of agitation; assist to set goals for more pleasant behavior; encourage seeking out staff when agitated; give the resident as many choices as possible; and document observed behavior and attempted interventions in behavior log. On 2/21/24 at 2:49 PM, an interview was conducted with Registered Nurse (RN) 4. RN 4 stated that resident 7 was able to get up and come out of his room. RN 4 stated that he had seen resident 7 independently transfer to his wheelchair. RN 4 stated that resident 7 was difficult to deal with most of the time. RN 4 stated that they try to have a second staff when administering medication. RN 4 stated that the company asked that we care with cares or use a two person to conduct any treatment. RN 4 stated that resident 7 could be aggressive and he was now in a room by himself because of his aggression. RN 4 stated that resident 7 had one roommate that he had issues with him and a can was thrown at him. RN 4 stated that resident 7 was such a mean person and really, really hard to deal with. RN 4 stated that on two occassions resident 7 had lunged towards him in an aggressive manner and had asked him inappropriate questions about his sexuality. RN 4 stated that there were little arguments that go on constantly and he felt like he was babysitting sometimes. RN 4 stated that if there was not anything physical, and it was a quick little shouting match then he would not report that to the DON. RN 4 stated that if it was a little quarrel don't pass it on. RN 4 stated that if it was something bigger it would be passed on. RN 4 stated that a lot of his job was about redirection with the residents. Review of the facility policy on Abuse, Neglect, Exploitation, and Misappropriation Prevention Program documented that the facility objective was to protect the residents from abuse, neglect, exploitation, and misappropriation of property by anyone. The policy stated that the facility would provide staff orientation and training on abuse prevention, identification and reporting of abuse, stress management, and handling verbally or physically aggressive resident behavior. The policy stated that all allegations of possible abuse would be investigated and reported within the timeframe's required by federal requirements. The policy was last revised in January 2024. 2. A. Resident 19 was initially admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnosis of dementia, muscle weakness, heart failure, anemia, major depressive disorder, primary pulmonary hypertension, and history of falling. Resident 19's medical record was reviewed on 2/6/24. On 1/23/24, an Annual Minimum Data Set (MDS) documented resident 19 had a Brief Interview for Mental Status (BIMS) score of 4 which indicated resident 19 had severe cognitive impairment. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/5/24 at 9:49 AM, an interview was conducted with resident 19. Resident 19 stated they had no recollection of being cut by a razor. Resident 19 stated if that had happened to them, they would have put up a fit. On 11/9/23 at 11:27 AM, a Facility Incident report documented resident 19 arguing with resident 31. Resident 31 was heard shouting expletives at resident 19 due to resident 19 attempting to use resident 31's restroom. Once staff intervened, resident 19 was observed to have a cut on their hand. Resident 19 stated the resident 31 had cut them with a used razor. The resident 31 was witnessed to have been holding a safety razor with the blunt end facing forward. Resident 31 stated resident 19 attempted to get into their room and use the restroom. Resident 31 stated resident 19 had cut their hand on resident 31's wheelchair after swinging at them. Resident 31 denied cutting resident 19 with a razor. Resident 19 was observed to have 5 small shallow parallel bleeding cuts. When resident 19 was asked about the incident they stated, she cut me, and I was just looking to see what was going on. Both residents were advised to avoid each other. The additional notes section of the incident report documented that an interdisciplinary team review had been done on 11/13. It documented that a physical altercation had occurred with another resident and the root cause of the incident was due to resident 19's dementia. B. Resident 31 was admitted to the facility on [DATE] with diagnoses which included hemiplegia and hemiparesis following a cerebral infarction, type II diabetes mellitus, asthma, morbid obesity, generalized anxiety disorder, major depressive disorder, insomnia, hypertension, pseudobulbar affect, hyperlipidemia, nondisplaced fracture of proximal phalanx of left great toe, and chondromalacia left knee. On 9/28/23, the Quarterly MDS assessment documented a BIMS score of 14, which would indicate that resident 31 was cognitively intact. On 11/9/23 at 1:56 PM, the facility reported to the State Survey Agency (SSA) resident 31's altercation with resident 19. The findings of the facility investigation documented that resident 31 used a razor to scratch resident 19. Resident 31 stated in her interview that resident 19 came into her room looking for the bathroom. I told her this is not your bathroom, then [resident 19] called me a bitch she was pushing her wheelchair at me and kept calling me names. I grabbed a razor and scratched her. The summary of interview documented, Staff witnessed [resident 19] outside of [resident 31's] room. Staff 4 NA saw [resident 31] take something off a table and swing at [resident 19]. The report documented that resident 19 had small cuts to the hand. The corrective action identified in the facility investigation was that resident 31 would no longer have access to sharp objects and the resident was educated to seek out a caregiver when feeling agitated. The conclusion of the investigation was that the allegation of physical abuse was verified. Resident 31's progress notes and incident report revealed the following: a. On 10/26/23 at 2:53 PM, the Social Service Note documented, Resident remains a valued LTC [long term care] resident of the facility. Resident continues to show signs of little to no cognitive impairment. Resident is oriented to person, place, and time. Resident denies any mood concerns at this time. She tends to be very pleasant upon contact and is a active member of the community. She tends not to participate in most of the scheduled activities but appears to socialize with other residents. She was recently approved for NCW [New Choice Waiver] and will start the process of transitioning to a ALF [assisted living facility]. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow Brook Rehabilitation and Nursing	433 East 2700 South Salt Lake City, UT 84115

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. On 11/9/23 at 11:27 AM, the Nurses Note documented, 1115 - an argument was heard coming from in front of room [ROOM NUMBER] where [resident 19] was witnessed in her chair arguing with [resident 31]. [Resident 31] was shouting explatives [sic] at [resident 19] and stating that she was trying to use the wrong bathroom. Staff quickly intervened and found that [resident 19's] hand was cut. [Resident 19] said that [Resident 31] cut her with a used razor. [Resident 31] was witnessed holding a safety razor in her hand with the blunt end of the handle facing forward in her closed fist, razor blades in her palm. SN [skilled nurse] asked [resident 31] to give the razor to them and [resident 31] threw it at the feet of the SN. [Resident 31] was asked what happened and she stated that [resident 19] tried to get into her room and bathroom and she didn't use the razor, rather [resident 19] 'probably cut her hand on her wheelchair when she swung at me'. [Resident 19's] hand was cleaned and dressed with wound cleanser, abx [antibiotic] ointment and an bandaid. There appeared to be 5 small, shallow, parallel cuts which were bleeding. [Resident 19] denied pain and tolerated treatment well. Razor was collected and labeled, MD [Medical Director] notified. Family notified. Resident was confused, polite, non-hostile. Residents advised to avoid each other. SN will monitor both residents for further hostile interactions. Management fully advised. On 11/9/23 at 1127 AM, the incident report documented that resident 31 initially stated that she used the end of the razor handle to cut resident 19. Resident 31 later stated that she did not strike resident 19 at all and thought that resident 19 cut her hand when reaching out to strike her. The immediate action taken was that the residents were separated and counseled on aggression avoidance. Resident 31 stated that she has a short temper. c. On 11/13/23 at 9:45 AM, the Interdisciplinary Team (IDT) Event Review note documented, IDT Review: Event: Physical altercation with another resident Root cause found to be other resident's dementia. Interventions: Medication changes, resident no longer allowed to have sharp objects in room and resident educated to seek staff assistance when agitated. All other least restrictive interventions in place, will continue plan of care. On 11/13/23, resident 31 had a care plan initiated for has the potential to be verbally aggressive related to history of shouting expletives at another resident. Interventions identified included administer medications as ordered and monitor for side effects and effectiveness; analyze key times, places, circumstances, triggers, and what de-escalates behavior and document; asses resident's understanding of the situation; allow time for the resident to express self and feelings toward the situation; when the resident becomes agitated intervene before agitation escalates; guide resident away from source of distress; engage calmly in conversation; and if response was aggressive staff to walk calmly away and approach later. On 11/13/23, resident 31 had a care plan initiated for has the potential to be physically aggressive related to History of harm to others. Interventions identified included the resident triggered for physical aggression when personal space was invaded; staff to provide appropriate personal space; administer medications as ordered and monitor for side effects and effectiveness; provide physical and verbal cues to alleviate anxiety; give positive feedback; assist with verbalization of source of agitation; assist to set goals for more pleasant behavior; encourage seeking out a staff member when agitated; resident should no longer have access to sharp objects; medication change, dose increased of psychotropic medication; and resident educated to go to staff when agitation occurs. Review of resident 31's Kardex report documented the following under Behavior/Mood: (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*The resident's triggers for physical aggression are (when personal space in invaded). The resident's behaviors is de-escalated by (intervention by staff to provide appropriate personal space.) *COMMUNICATION: provide physical and verbal cues to alleviate anxiety; give positive feedback, assist verbalization of source of agitation, assist to set goals for more pleasant behavior, encourage seeking out of staff member when agitated. *Monitor/record occurrence of for target behavior symptoms (SPECIFY pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others. etc.) and document per facility protocol. *When the resident becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later. On 2/12/24 at 9:10 AM, an interview was conducted with NA 1. NA 1 stated that resident 31 did not have any behaviors and was always calm with her. NA 1 stated that resident 31 did not have any restrictions. NA 1 stated resident 31 got along with almost everyone. On 2/12/24 at 9:14 AM, an interview was conducted with CNA 4. CNA 4 stated that resident 31 had not had any altercations with other residents. CNA 4 stated that resident 4 went fast in her wheelchair and needed to slow down. CNA 4 stated that resident 31 did not have any restrictions. On 2/21/24 at 7:31 AM, an interview was conducted with RN 2. RN 2 stated that resident 31 sometimes lashed out by yelling or threatening other residents. RN 2 stated that resident 31 could be redirected away from the situation. RN 2 stated that if there was aggression then they would document the incident in the progress notes or the Treatment Administration Record (TAR). RN 2 stated that depending on the intensity of the behavior they may not report it. RN 2 stated that if it was harmful aggression they would notify the DON and MD. RN 2 stated that she was not aware of any incidents of harmful aggression from resident 31. RN 2 stated that resident 31 had a lot of resident to resident altercations with yelling. RN 2 stated that resident 31 did not have any restrictions on things that she could do or things that she could have. RN 2 stated she was not aware of an incident where resident 31 cut another resident. RN 2 stated that she should be aware of it because it was a safety issue for them and for other residents. RN 2 stated that when residents were first admitted they could sometimes have a lot of aggression, with the change in environment. RN 2 stated that they addressed it with medication modification. RN 2 stated that any restrictions or alert charting should be on the pass off sheet during change of shift, and it could be listed on the dashboard under special instructions. RN 2 stated that they communicated updates on resident's care verbally when they arrived on shift. RN 2 stated she was not aware of the aides documentation to know where these instructions would be located. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/21/24 at 8:34 AM, an interview was conducted with the DON. The DON stated that resident 31 did not have any behaviors, but gets verbally aggressive and shouts. The DON stated that she was not aware of any resident to resident altercations with resident 31. The DON stated that she did not know resident 31 had any restrictions or monitoring. The DON stated that she would expect to see monitoring in a progress note or TAR. The DON stated that she was not aware of any incident of cutting. The DON stated she should be aware of any such incidents as they were potential abuse situations. The DON stated that education on behaviors and monitoring would be communicated to staff directly and the aides could find the information in the Kardex. The DON stated that she would expect to see interventions re-evaluated every 2 weeks initially. The DON stated that they needed to make sure that the resident was following any restrictions and that the staff were following it as well. 46232 3. NEGLECT [Cross refer to F624, F644, F676, F689, F690, F697, F725, F740, F760, and F804]

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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** 22992 Based on interview and record review it was determined, for 11 out of 40 sampled residents, that the facility did not implement polcies and procedures that ensured all allegations of neglect and/or abuse were reported and investigated timely. Resident identifiers: 4, 7, 16, 29, 38, 92, 93, 94, 96, 97 and 99. Findings included: 1. Resident 38 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease, protein calorie malnutrition, and dementia without behaviors. Resident 38's medical record was reviewed from [DATE] through [DATE]. Resident 38 had a Montreal Cognitive Assessment (MOCA) completed on [DATE]. Resident 38's MOCA score was ,d+[DATE] indicating mild cognitive impairment. A physician's note dated [DATE] for resident 38 indicated that resident 38 was homeless prior to his stay at the facility. Seen at the rescue home. He says biggest concern is he is losing his memory, says mostly short term. Had a TBI (traumatic brain injury) in the past he says. The note indicated that the physician diagnosed resident 38 with Vascular Dementia, Moderate/Severe, foot deformities, weakness, low vision, chronic pain, mass lesion of brain, and malnutrition. On [DATE], a quarterly Minimum Data Set (MDS) quarterly assessment indicated that resident 38 had a Brief Interview for Mental Status (BIMS) score of 12, indicating moderate cognitive impairment. Progress notes for resident 38 revealed the following: a. On [DATE] at 10:38 AM, a nurses note indicated that This resident did not return last night, his cell phone was called multiple times but resident did not respond, police called or welfare check this morning. b. On [DATE], an Interdisciplinary Team (IDT) note indicated that resident located by activities director at [name of local homeless shelter], he stated that he is okay and safe, and that he will not be returning to the facility. On [DATE] at 11:00 AM, the facility submitted form 358 with regard to resident 38 to the State Survey Agency (SSA). Form 358 indicated that on [DATE] at 10:00 AM, Registered Nurse (RN) 2 reported to the Previous Director of Nursing (PDON) that resident 38 had signed out on an Leave of Absence (LOA) and did not return from his going out yesterday. The form indicated that the PDON immediately reported this to the Administrator (ADM). The form 358 indicated that this was reported to the State Survey Agency (SSA) on [DATE] at 11:00 AM. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 1:33 PM, the facility submitted form 359 to the SSA. Form 359 stated that resident 38 was located and interviewed at a local homeless shelter. The form also documented that Staff members and co-residents noted it is common for [resident 38] to go out for hours and return to the facility and that [resident 38] always come back. CNA [Certified Nurse Assistant] stated he saw [resident 38] leave aprox (approximately) 5:40 am on Monday ([DATE]), normal behavior for him to leave. Per interview, nurses stated that [resident 38] checked out on monday ([DATE]) on NOC (night) shift. Day nurse noted he was not back by the time she left for her shift so she attempted to call patient and did not get through. Nurse arrived back on shift and NOC nurse informed Patient had still not returned. Nurse notified DON. On [DATE] at 9:47 AM, an interview was conducted with the PDON regarding resident 38. The PDON stated that when staff noticed that resident 38 did not return from an LOA on [DATE], they began calling the resident, but the resident would not answer their calls. The PDON stated that if a resident signed out on an LOA, they should indicate when they are returning, and that if a resident was not back within an hour of when they said they would return, then she would start trying to contact the resident. The PDON stated that she was upset that she was not informed that resident 38 did not return to the facility on the evening of [DATE]. The PDON stated that I should have gotten a call during the night of [DATE]. On [DATE] at 12:05 PM, an interview was conducted with the ADM regarding resident 38. The ADM stated that if someone signs out on an LOA, that information should be passed on to the next nurse on shift. The ADM also stated that the night shift staff should have done rounds and communicated the status of the residents overnight to the nurse on shift. The ADM stated that if a resident signed out on an LOA, they should indicate when they are returning, and that if a resident was not back within 30 to 60 minutes of when they said they would return, then action should be taken. 2. Resident 94 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included Wernicke's encephalopathy, dementia, major depressive disorder, other amnesia, and history of traumatic brain injury. Resident 94's medical record was reviewed from [DATE] through [DATE]. An admission Minimum Data Set (MDS) assessment dated [DATE] for resident 94 was reviewed. The MDS indicated that a Brief Interview for Mental Status (BIMS) was completed. The BIMS indicated that the resident was unable to report the correct month and year. The resident received a score of 8 on the BIMS, indicating that the resident was moderately cognitively impaired. Progress notes for resident 94 included the following: a. On [DATE] at 7:30 PM, Cna (Certified Nursing Assistant) supervising smoke break came to this nurse and said that while resident was outside smoking he went down the sidewalk and around the building and could hear the side gate rattling and that by the time she got there, the resident was gone. Said that sheyelled (sic) for the cna's to assist in the search for resident. The side gate door was opened inwards and bent. One cna followed resident while the other cna came and alerted this nurse. Cna . got in her car and drove around the near-by streetslooking (sic) for him while this nurse called 911 asking for assistance with the search. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. On [DATE] at 8:30 PM, a police officer contacted facility staff to inform them he had located the resident and was on his way back to the facility with the resident. On [DATE] at 9:22 PM, the facility submitted form 358 with regard to resident 94 to the SSA. The form 358 indicated that resident 94 went out to the back smoking patio during smoke break. He went down the side of the building and ripped open the gate that was locked with a pad lock (sic). Our CNA caught up with him in the process trying to get him to stop and come back in the building. As he continued out to the front of the property and the CNA, after repeated attempts realized that she wasn't going to be able to get him to come back into the building, she went to get help. When the rest of the staff came out, they started driving around searching for him while the nurse called the police. The police arrived and started their search. They later found him down the road and brought him back to the building. The facility did not submit a form 359 to the SSA regarding this incident until [DATE], approximately 2 months later. The form 359 indicated that all staff had been trained on elopement on [DATE], and not in February 2023 directly after the elopement occurred. On [DATE] at 4:05 PM, an interview was conducted with the PADM. The PADM stated that on [DATE], resident 94 shoved the locked gate open. The PADM stated that a staff member followed the resident out of the gate and into the parking lot, but that the staff member could not talk the resident into coming back inside the facility. The PADM stated that at that time, the staff member left the resident alone and came back inside the facility to report the elopment to other staff. The PADM stated that two staff members then went back outside to locate resident 94. The PADM did not state why the form 359 was submitted approximately 2 months after the incident instead of the required 5 days. [Cross refer to F609] 3. Resident 97 was admitted to the facility on [DATE] with diagnoses that included cardiomyopathy, severe protein-calorie malnutrition, viral hepatitis C, generalized anxiety disorder, muscle weakness, adjustment disorder with anxiety, major depressive disorder, dysphagia, and insomnia. Resident 97's medical record was reviewed from [DATE] through [DATE]. Resident 97's quarterly Minimum Data Set (MDS) assessment dated [DATE] documented that the resident's BIMS score was 9, indicating moderate cognitive impairment. Resident 97's progress notes indicated the following: a. On [DATE] at 4:00 PM, a nurses note read, Resident approached nurses' station and resident informed nurse that he was going to look at apartments with a friend. Resident had walker with him when leaving. Resident signed LOA (leave of absence) book and resident assisted to front door and visitor waiting at front door for resident. Resident did not return as of midnight and informed oncoming nurse he had not come back from LOA. b. On [DATE] at 8:18 PM, a social services note read, Resident 97 left with someone around 4:00pm signed out and said he was going to look for apartment. Hasn't returned yet. discharged him on LOA. (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 [DATE] at 11:55 AM, a nurses note read, Got a call from a lady by the name of [name deleted]. she was calling to check on [resident 97]. explained [resident 97] hasnt returned from LOA Visit. [name deleted] stated she brought him back at [DATE] around [8:00 PM]. stated she wound (sic) call his family but was adamant she dropped him off last night. per records [resident 97] checked himself out with [name deleted] but never checked back after his visit. d. On [DATE] at 9:30 PM, a nurses note read, Recieved (sic) a call from a female asking if resident is here at the facility. Says that she dropped him off around 830pm but did not watch him come inside of facility. Staff went outside and searched the premises for him but he was not there. Was not at ,d+[DATE] either. Notified DON of situation. Also mentioned this to [name of physician]. e. On [DATE] at 3:50 PM, a nurses note read, [Resident 97] showed up this afternoon and stated he was here to pick up his personal items. he appeared impaired and was arguing with staff. explained to him is admission required which was to go to the ER for readmission (sic). pt refused. told staff to get his electronic (sic) wheelchair and pack his electronics in his back pack. stated he will come back on monday to pick up the rest of his items. The facility filed an Initial Entity Report with the State Survey Agency (SSA) on [DATE], approximately 6 days after resident 97 left the facility. The report documented that resident 97 signed the leave of absense (sic) book on Wednesday ,d+[DATE] at around 4:30pm and left with a friend to go look at appartmnets (sic). It was our understanding that he would be back later that day however he has left with friends before, stayed at their place and not come back for a couple days. On Friday ,d+[DATE] at around 8:45pm the friend he left with reported that she had dropped him off in front of our building. He hadn't come in to the building at that time and so we sent some people out to search for him because he only had his walker. After we couldn't find him we thought that he must have called another friend and so we dediced (sic) to give him the weekend. We talked with the original friend he originally left with multiple times through the weekend and tried to reach out to the cell phone number we had for him as well in attempt to find him. The following Monday he still hadn't come back and so we reached out to the police to file a missing person's report. The Alleged Abuse Verification of Investigation Report form completed by staff on [DATE] for resident 97 was reviewed. The report indicates that on [DATE] one staff member was interviewed. The staff member stated that resident 97 signed our Leave of Absence book stating that he was going to look at apartments and would be back later that evening. He left with a friend who came to pick him up. He left with his walker and the clothes on his back. He never came back that night or several nights later. No other interviews were documented on the report. The Alleged Abuse Verification of Investigation Report form also documented that resident 97 has been at our facility for the better part of a year. He has progressed in all his care measures to the point that we have been trying to help him transition out to living on his own. The doctor was prepared to discharge him as soon as we found a safe discharge location. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 4:05 PM, an interview was conducted with the Previous Administrator (PADM). The PADM stated that resident 97 was often drunk or high due to a drug problem. The PADM stated that resident 97 would often leave for longer than a day, so we were telling him this wasn't a hotel. If he's there he has to follow the regulations in order to get care. The PADM stated that he attempted to reach out to resident 97 but that resident 97 was under the influence of whatever it was. The PADM stated that when it was evident he wasn't coming back after what we had done to try and get him back, the facility discharged resident 97. The PADM was unable to explain why the resident was not reported missing sooner, why no other staff were interviewed during the investigation, and why the resident was not appropriately oriented for discharge once he returned to the facility. [Cross refer to F644] 38031 4. Resident 4 was admitted to the facility on [DATE] with diagnoses which included mononeuropathy, chronic respiratory failure, type II diabetes mellitus, morbid obesity, chronic obstructive pulmonary disease, non-pressure ulcer of left calf, schizoaffective disorder, epilepsy, hypothyroidism, peripheral vascular disease, varicose veins, hypertension, bilateral osteoarthritis of hip, intervertebral disc disorder, edema, chronic pain syndrome, tremor, overactive bladder, hyperlipidemia, viral hepatitis C, insomnia, sleep apnea, post traumatic stress disorder, anxiety disorder, bipolar disorder, borderline personality disorder, and major depressive disorder. On [DATE] at 10:00 AM, the facility initial abuse investigation, form 358, documented that Registered Nurse (RN) 2 was informed of an allegation of verbal abuse by staff towards resident 4. The SSA was informed of the incident on [DATE] at 11:43 AM, and APS was informed of the incident on [DATE] at 11:42 AM. On [DATE] at 5:05 PM, the facility initial abuse investigation, form 358, documented that the facility Administrator (ADM) was informed of an allegation of verbal abuse by staff towards resident 4. The SSA was informed of the incident on [DATE] at 2:57 PM. It should be noted that both allegations of abuse were not reported to the SSA and APS within 2 hours of the allegation being made. 5. Resident 29 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included a traumatic brain injury (TBI), hemiplegia and hemiparesis, major depressive disorder, panic disorder, anxiety disorder, low back pain, hepatitis C, seizures, hyperlipidemia, overactive bladder, benign prostatic hyperplasia, insomnia, migraine, schizoaffective disorder, lymphangioma, history of transient ischemic attack, and history of suicidal behavior. On [DATE] at 9:24 AM, an interview was conducted with resident 29. Resident 29 stated that he recalled previously sharpening a butter knife with the intent to stick his old roommate under the arm. Resident 29 stated that his old roommate, resident 99, was having sex with his old girlfriend and because of this he was going to stab resident 99. Resident 29 stated that resident 4 witnessed him sharpening the knife and asked him not to do it. Resident 29 stated that resident 4 liked resident 99 and did not want to see him hurt. Resident 29 stated that he never tried to hurt resident 99. Resident 29 stated that he never spoke to anyone at the facility about the incident and never spoke to the nurse about it. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 10:55 AM, an interview was conducted with resident 4. Resident 4 stated that she vaguely recalled another resident sharpening a knife. Resident 4 stated that she took the knife away and gave it to the nurse. On [DATE] at 2:56 PM, the Nurses Note documented, Resident was depressed about his ex-girlfriend. Stated that she was here this am and left and he need to tell her to bring him money. then worry about her getting into his money. He told [name omitted] in activities that he wanted to cut his wrist or kill himself. MD [Medical Director] notified. new order to transfer resident to ER [emergency room] for eval. [evaluation] paramedic came and transported him to [local hospital name omitted] hospital at 14:56 [2:56 PM]. On [DATE] at 2:56 PM, the incident report documented, Resident made statements to several staff members today about wanting to kill himself, he told [name omitted] in Activities that he had attempted suicide this morning via cutting his wrists but was not successful. The resident stated, I just want to die. Immediate action taken was the resident was transferred to the hospital for a psychiatric evaluation. The report documented that the MD was informed on [DATE] at 3:03 PM. On [DATE] at 1:53 PM, the Nurses Note documented, It was brought to this nurses attention that resident was outside sharpening a butter knife to use to stab another resident. It should be noted that no documentation could be found of a facility investigation into the incident with the knife as documented in the nurse note on [DATE], and reporting to the SSA or APS was not completed. On [DATE] at 1:04 PM, an interview was conducted with the Administrator (ADM). The ADM stated that she had been conducting education at staff meetings on the types of abuse with examples, the reporting policy, and her phone number was on posters throughout the facility. The ADM stated that staff should report immediately the incident to her and she had 2 hours to report to the SSA. The ADM stated that was the expectation. The ADM stated that they communicated the abuse policy to agency staff and it was contained in the agency binder. The ADM stated that the agency staff were to sign the policy in acknowledgement that they had read it. The ADM stated that was a system that needed improvement. The ADM stated that they did not have a staff member responsible for verifying that agency staff had reviewed the education. The ADM stated that they had a lot of agency that were return staff, and she informed them of her phone number and they could reach out to her. The ADM stated that this was a verbal communication to those agency personnel. The ADM stated that this was an incident that should have been reported to her. The ADM stated that they had not seen aggression from resident 29 in the past. The ADM stated that he was sent out for a suicidal ideation evaluation. The ADM stated that this should have been brought to her attention. (continued on next page)

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	465158	A. Building B. Wing	02/22/2024

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Meadow Brook Rehabilitation and Nursing	433 East 2700 South Salt Lake City, UT 84115

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 2:00 PM, an interview was conducted with the Corporate Social Service Worker (CSSW). The CSSW stated that resident 29 was sent to the hospital in [DATE] for suicidal ideation and the previous Resident Advocate (PRA) was supposed to have made a referral for mental health services. The CSSW stated that her understanding was that it was a suicidal ideation and not a suicidal attempt. The CSSW stated that resident 29's care plan should address the suicidal ideation, Preadmission Screening and Resident Review (PASRR) and recommendations and any mental health issues. The CSSW stated that interventions to prevent future attempts should address removing any sharp objects from the room, monitoring for access to those objects and re-assessing upon return to the facility to determine safety needs. The CSSW stated that the monitoring should occur until the MD made a determination to discontinue. The CSSW stated that the staff should also be monitoring for the resident's access to any sharp objects and they should be putting in a progress note or alert charting for the monitoring. The CSSW stated it should also be in the Kardex as well. The CSSW stated that staff should be able to tell her that they were monitoring resident 29 for this and if he had any restrictions. The CSSW stated that it would be concerning if resident 29 had repeat access to sharp objects again. [Cross-refer F740] 6. Resident 92 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included hemiplegia and hemiparesis due to cerebral infarction, type II diabetes mellitus, senile degeneration of brain, dysphagia, major depressive disorder, contracture left hand and left foot, osteoporosis, dementia, thyrotoxicosis, anxiety disorder, mood disorder, hypertension, gout, and urinary incontinence. On [DATE] at 4:10 PM, the Fall Note documented, found on floor next to bed. bed not low to ground. put in bed and assessed. c/o [complained of] left hip pain. MD notified. xray left hip ordered. family notified On [DATE] at 4:10 PM, the incident report documented that the CNA notified the nurse that resident 92 was found on the floor next to his bed and was complaining of hip pain. The resident was assisted to the bed and was assessed. The MD was notified and ordered an immediate (STAT) x-ray. The x-ray revealed a fracture and the resident was taken to the hospital for further evaluation. Hospital reports the fracture could be from the past. The report documented that the location of the injury was the left trochanter. Resident 92's Pain Assessment in Advanced Dementia (PAINAD) score was documented as a 5, which would indicate moderate pain. The predisposing environmental factors were documented as bed/chair height. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 10:18 AM, an interview was conducted with the Certified Nurse Assistant Coordinator (CNAC). The CNAC stated that resident 92 had fallen out of bed and broken his hip, and this resulted in him screaming more. The CNAC stated that at the time resident 92 resided in a room with resident 7 and resident 29. The CNAC stated that resident 7 and resident 29 did not like the commotion and would throw water on resident 92. The CNAC stated that they ended up moving resident 92 to another room. The CNAC stated that she witnessed resident 7 and resident 29 throwing water on resident 92. The CNAC stated that she asked resident 7 and resident 29 why they did that and they replied to make resident 92 be quieter. The CNAC stated that she asked resident 7 and resident 29, Do you think that will make him quieter? Now he's cold and wet. The CNAC stated that this was not the only time this had happened. The CNAC stated that she had talked to the other aides and was told that this had happened multiple times. The CNAC stated that she asked the aides why they did not say anything, and that behaviors like that are not okay. The CNAC stated that resident 92 was moved right after she walked in on this. The CNAC stated that the other aides did not know who to reach out to, what to say at the time, or knew that it was abuse. They didn't understand that it was abuse at the time. The CNAC stated that was when they started doing behavioral training and how to de-escalate situations. The CNAC stated that the previous Director of Nursing (DON) did the training. The CNAC stated that staff should be calling the Administrator (ADM) immediately, de-escalating the situation right away, and try to keep the resident safe. The CNAC stated, If they don't know what to do, notify the nurse. First step is keeping the resident safe. It should be noted that no documentation could be found of a facility investigation into the incident of resident 7 and resident 29 throwing water on resident 92 and reporting to the SSA or APS was not completed. [Cross-refer F689] 7. Resident 96 was admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses which included central cord syndrome at cervical (C)6, acute respiratory failure, type II diabetes mellitus, polyneuropathy, hepatic failure, pneumonia, lack of coordination, reduced mobility, muscle weakness, dysphagia, contusion of right wrist, cervicalgia, Parkinson's Disease, dementia, pressure ulcer of sacrum, atrial fibrillation, chronic kidney disease, hypertension and hyperlipidemia. On [DATE] at 1:53 PM, the Incident Note documented, I received a phone call today from the CNA Coordinator, who was providing transportation for this resident to an appointment at the [name of hospital omitted], the CNA Coordinator stated that when coming to a stop, the wheelchair became dislodged and tipped backwards, CNA Coordinator immediately stopped vehicle and called for assistance from EMS [emergency medical services], the Administrator and I arrived at the scene at about 14:20 [1:20 PM], the resident was complaining of head and neck pain, EMS was treating him, the police officer and the EMS workers all stated that the resident was still strapped into the wheelchair with the seatbelts (EMS reported that there was tension in the belts still), resident was transferred via EMS to [local area hospital] for evaluation, provider notified, family notified. On [DATE] at 1:04 PM, the Nurses Note documented, Central cord syndrome found on MRI [magnetic resonance imaging], resident currently in ICU [Intensive Care Unit] r/t [related to] he was having a difficult time maintaining his blood pressure, he is currently not on any supplemental blood pressure medication and the nurse stated that he will soon be ready to transfer either to a step down unit or back to facility, I gave them my name and phone number as a contact for [resident 96], will call again tomorrow for a new update. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 5:14 PM, the Nurses Note documented, Resident had hair cut today, then shower this afternoon. Within minutes after laying him back down he stopped breathing. The nurses performed assessment on him, he had no pulse and was not breathing. DNR [Do Not Resuscitate]. Family notified, MD notified. On [DATE] at 2:37 PM, an interview was conducted with the Certified Nurse Assistant Coordinator (CNAC). The CNAC stated that resident 96 passed away that day, and he was not on hospice and it was not expected. The CNAC stated that she assisted resident 96 during his hair cut. The CNAC stated that resident 96's cervical (c)-collar was removed for the haircut and she held his head still, with no sudden movements and no flexion or extension of the neck. The CNAC stated that Nurse Assistant (NA) 3 and NA 5 had assisted resident 96 with a shower. The CNAC stated that she believed resident 96's c-collar was removed for the shower under the direction of the PDON. The CNAC stated that NA 3 and NA 5 were both new aides that time. The CNAC stated that the PDON called her at approximately 5:15 PM, on the day that resident 96 received his haircut and shower and was told that resident 96 had just passed away. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 2:22 PM, an interview was conducted with NA 3. NA 3 stated that she showered resident 96 one time with the assistance of the CNAC on the day that he passed away. NA 3 stated that the CNAC told her that when resident 96 received a shower they took his c-collar off, and that the CNAC was the person who removed the collar. NA 3 stated that while the CNAC was holding the shower head she was guiding NA 3, saying that as long as she was washing the neck gently and the neck and spine were aligned it would be okay. NA 3 stated that no one was holding or stabilizing resident 96's head once the c-collar was removed, and the c-collar was off for approximately 20 minutes for the duration of the shower. NA 3 stated that she and NA 5 took resident 96 back to his room. NA 3 stated that they tried to transfer resident 96 back to bed, but they could not physically do it. NA 3 stated that she and NA 5 attempted to do the same transfer method as the PDON and CNAC, the towel transfer. NA 3 stated that this transfer method had a towel under the resident's knees and the staff arm under the resident armpit, and as you hold the towel you shift the resident's weight to transfer them. NA 3 described the towel transfer method as standing at the residents side facing him with the arm closest to the resident placed under his arm and the arm further away was crossed and holding the towel. NA 3 stated that when you transferred the resident the staff arms slightly uncross, enough to move the resident legs. NA 3 stated that this method caused the aide to twist her upper back during the transfers. NA 3 stated that she and NA 5 could lift resident 96. NA 3 stated that resident 96's bed was positioned against the wall, and they placed his wheelchair in front of the bed. NA 3 stated that she was on the side closest to the bed which was on the resident's left side. NA 3 stated that NA 5 was able to lift resident 96's weight, but as they were transferring him she felt like she did not have a good enough grip. NA 3 stated that they placed resident 96 back into the wheelchair and he was seated on the edge. He was starting to fall off of his chair. NA 3 stated that they grabbed resident 96's arms to pull him back, and his body went forward. NA 3 stated that she went behind him and tried to grab him from behind with both arms under his arms. NA 3 stated that resident 96 fell to the floor, he slipped down to the floor. NA 3 stated that resident 96 did not fall to the knees, but instead landed on his buttock with his legs extended in front of him. NA 3 stated that resident 96 did not say anything when he fell , and that resident 96 was really only able to say owe when he was in pain. NA 3 stated that resident 96 was a bigger man and weighed approximately 180 pounds. NA 3 stated that it was pretty hard to hold him. NA 3 stated that resident 96 was unable to assist with lowering himself to the ground, but once on the ground he was able to hold his weight up and was not slumped over. NA 3 stated that NA 5 went to go get help to lift resident 96 off the floor. NA 3 stated that when CNA 3 arrived in the room she asked what had happened and stated that she did not think the resident was breathing. NA 3 stated that she and CNA 3 placed the towel under resident 96's legs and lifted him back into the wheelchair. NA 3 and CNA 3 then transferred resident 96 to the bed. NA 3 stated that they placed him back on the bed and she noticed that resident 96 was not breathing. NA 3 stated that CNA 3 replied, oh ya I think he passed away. NA 3 stated that NA 5 went to find a nurse. On [DATE] at 10:13 AM, an interview was conducted with the previous Director of Nursing (PDON). The PDON stated that she was with resident 96 before he died . The PDON stated that resident 96 had a shower and a shave and she talked to him 5 minutes before he died . The PDON stated that she was in the shower room with resident 96 and he was already dressed. The PDON stated that one of the aides came and got her and said she thought resident 96 had passed. The PDON stated that resident 96 was in bed when she went down to assess him. The PDON stated that resident 96 had falls prior to the accident but not afterwards, I don't think so. The PDON stated that if resident 96 had fallen she should have been notified. The PDON stated that resident 96 was a one person assist for transfers, bed mobility, and brief changes prior to accident. After the accident he was a two person assist for transfers, bed mobility, and toileting. The PDON stated that resident 96 was a big guy and needed a 2 person assist. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 12:38 PM, a follow-up interview was conducted with the PDON. The PDON stated that resident 96's c-collar should stay on him, but nurses could remove it to assess his skin. The PDON stated that if someone took the c-collar off during showers that would not be consistent with care. The PDON stated that at the time he passed, she became aware immediately. The PDON stated that she assisted in resident 96's shower the day that he died . The PDON stated as his shower ended she asked him about it and

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38031 Based on interview and record review it was determined, for 10 out of 40 sampled residents, that the facility did not ensure that all alleged violations involving abuse, neglect, exploitation, injuries of unknown source and misappropriation of resident property was reported immediately, but not later than 2 hours after the allegation was made, to the State Survey Agency (SSA), Adult Protective Services (APS), and law enforcement. Specifically, reporting of alleged incidents of abuse and neglect were not submitted to the SSA or APS within 2 hours of the allegation being made. Resident identifiers: 4, 7, 16, 29, 38, 92, 93, 94, 96, and 97. Findings included: 1. Resident 4 was admitted to the facility on [DATE] with diagnoses which included mononeuropathy, chronic respiratory failure, type II diabetes mellitus, morbid obesity, chronic obstructive pulmonary disease, non-pressure ulcer of left calf, schizoaffective disorder, epilepsy, hypothyroidism, peripheral vascular disease, varicose veins, hypertension, bilateral osteoarthritis of hip, intervertebral disc disorder, edema, chronic pain syndrome, tremor, overactive bladder, hyperlipidemia, viral hepatitis C, insomnia, sleep apnea, post traumatic stress disorder, anxiety disorder, bipolar disorder, borderline personality disorder, and major depressive disorder. On [DATE] at 10:00 AM, the facility initial abuse investigation, form 358, documented that Registered Nurse (RN) 2 was informed of an allegation of verbal abuse by staff towards resident 4. The SSA was informed of the incident on [DATE] at 11:43 AM, and APS was informed of the incident on [DATE] at 11:42 AM. On [DATE] at 5:05 PM, the facility initial abuse investigation, form 358, documented that the facility Administrator (ADM) was informed of an allegation of verbal abuse by staff towards resident 4. The SSA was informed of the incident on [DATE] at 2:57 PM. It should be noted that both allegations of abuse were not reported to the SSA and APS within 2 hours of the allegation being made. 2. Resident 29 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included a traumatic brain injury (TBI), hemiplegia and hemiparesis, major depressive disorder, panic disorder, anxiety disorder, low back pain, hepatitis C, seizures, hyperlipidemia, overactive bladder, benign prostatic hyperplasia, insomnia, migraine, schizoaffective disorder, lymphangioma, history of transient ischemic attack, and history of suicidal behavior. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 9:24 AM, an interview was conducted with resident 29. Resident 29 stated that he recalled previously sharpening a butter knife with the intent to stick his old roommate under the arm. Resident 29 stated that his old roommate, resident 99, was having sex with his old girlfriend and because of this he was going to stab resident 99. Resident 29 stated that resident 4 witnessed him sharpening the knife and asked him not to do it. Resident 29 stated that resident 4 liked resident 99 and did not want to see him hurt. Resident 29 stated that he never tried to hurt resident 99. Resident 29 stated that he never spoke to anyone at the facility about the incident and never spoke to the nurse about it. On [DATE] at 10:55 AM, an interview was conducted with resident 4. Resident 4 stated that she vaguely recalled another resident sharpening a knife. Resident 4 stated that she took the knife away and gave it to the nurse. On [DATE] at 1:53 PM, the Nurses Note documented, It was brought to this nurses attention that resident was outside sharpening a butter knife to use to stab another resident. It should be noted that no documentation could be found of a facility investigation into the incident with the knife as documented in the nurse note on [DATE], and reporting to the SSA or APS was not completed. On [DATE] at 1:04 PM, an interview was conducted with the Administrator (ADM). The ADM stated that she had been conducting education at staff meetings on the types of abuse with examples, the reporting policy, and her phone number was on posters throughout the facility. The ADM stated that staff should report immediately the incident to her and she had 2 hours to report to the SSA. The ADM stated that was the expectation. The ADM stated that they communicated the abuse policy to agency staff and it was contained in the agency binder. The ADM stated that the agency staff were to sign the policy in acknowledgement that they had read it. The ADM stated that was a system that needed improvement. The ADM stated that they did not have a staff member responsible for verifying that agency staff had reviewed the education. The ADM stated that they had a lot of agency that were return staff, and she informed them of her phone number and they could reach out to her. The ADM stated that this was a verbal communication to those agency personnel. The ADM stated that this was an incident that should have been reported to her. The ADM stated that they had not seen aggression from resident 29 in the past. The ADM stated that he was sent out for a suicidal ideation evaluation. The ADM stated that this should have been brought to her attention. [Cross-refer F740] 3. Resident 92 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included hemiplegia and hemiparesis due to cerebral infarction, type II diabetes mellitus, senile degeneration of brain, dysphagia, major depressive disorder, contracture left hand and left foot, osteoporosis, dementia, thyrotoxicosis, anxiety disorder, mood disorder, hypertension, gout, and urinary incontinence. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 10:18 AM, an interview was conducted with the Certified Nurse Assistant Coordinator (CNAC). The CNAC stated that resident 92 had fallen out of bed and broken his hip, and this resulted in him screaming more. The CNAC stated that at the time resident 92 resided in a room with resident 7 and resident 29. The CNAC stated that resident 7 and resident 29 did not like the commotion and would throw water on resident 92. The CNAC stated that they ended up moving resident 92 to another room. The CNAC stated that she witnessed resident 7 and resident 29 throwing water on resident 92. The CNAC stated that she asked resident 7 and resident 29 why they did that and they replied to make resident 92 be quieter. The CNAC stated that she asked resident 7 and resident 29, Do you think that will make him quieter? Now he's cold and wet. The CNAC stated that this was not the only time this had happened. The CNAC stated that she had talked to the other aides and was told that this had happened multiple times. The CNAC stated that she asked the aides why they did not say anything, and that behaviors like that are not okay. The CNAC stated that resident 92 was moved right after she walked in on this. The CNAC stated that the other aides did not know who to reach out to, what to say at the time, or knew that it was abuse. They didn't understand that it was abuse at the time. The CNAC stated that was when they started doing behavioral training and how to de-escalate situations. The CNAC stated that the previous Director of Nursing (DON) did the training. The CNAC stated that staff should be calling the Administrator (ADM) immediately, de-escalating the situation right away, and try to keep the resident safe. The CNAC stated, If they don't know what to do, notify the nurse. First step is keeping the resident safe. It should be noted that no documentation could be found of a facility investigation into the incident of resident 7 and resident 29 throwing water on resident 92 and reporting to the SSA or APS was not completed. [Cross-refer F689] 4. Resident 96 was admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses which included central cord syndrome at cervical (C)6, acute respiratory failure, type II diabetes mellitus, polyneuropathy, hepatic failure, pneumonia, lack of coordination, reduced mobility, muscle weakness, dysphagia, contusion of right wrist, cervicalgia, Parkinson's Disease, dementia, pressure ulcer of sacrum, atrial fibrillation, chronic kidney disease, hypertension and hyperlipidemia. On [DATE] at 1:53 PM, the Incident Note documented, I received a phone call today from the CNA [Certified Nurse Assistant] Coordinator, who was providing transportation for this resident to an appointment at the [name of hospital omitted], the CNA Coordinator stated that when coming to a stop, the wheelchair became dislodged and tipped backwards, CNA Coordinator immediately stopped vehicle and called for assistance from EMS [emergency medical services], the Administrator and I arrived at the scene at about 14:20 [1:20 PM], the resident was complaining of head and neck pain, EMS was treating him, the police officer and the EMS workers all stated that the resident was still strapped into the wheelchair with the seatbelts (EMS reported that there was tension in the belts still), resident was transferred via EMS to [local area hospital] for evaluation, provider notified, family notified. On [DATE] at 1:04 PM, the Nurses Note documented, Central cord syndrome found on MRI [magnetic resonance imaging], resident currently in ICU [Intensive Care Unit] r/t [related to] he was having a difficult time maintaining his blood pressure, he is currently not on any supplemental blood pressure medication and the nurse stated that he will soon be ready to transfer either to a step down unit or back to facility, I gave them my name and phone number as a contact for [resident 96], will call again tomorrow for a new update. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 5:14 PM, the Nurses Note documented, Resident had hair cut today, then shower this afternoon. Within minutes after laying him back down he stopped breathing. The nurses performed assessment on him, he had no pulse and was not breathing. DNR [Do Not Resuscitate]. Family notified, MD notified. On [DATE] at 2:37 PM, an interview was conducted with the Certified Nurse Assistant Coordinator (CNAC). The CNAC stated that resident 96 passed away that day, and he was not on hospice and it was not expected. The CNAC stated that she assisted resident 96 during his hair cut. The CNAC stated that resident 96's cervical (c)-collar was removed for the haircut and she held his head still, with no sudden movements and no flexion or extension of the neck. The CNAC stated that Nurse Assistant (NA) 3 and NA 5 had assisted resident 96 with a shower. The CNAC stated that she believed resident 96's c-collar was removed for the shower under the direction of the PDON. The CNAC stated that NA 3 and NA 5 were both new aides that time. The CNAC stated that the PDON called her at approximately 5:15 PM, on the day that resident 96 received his haircut and shower and was told that resident 96 had just passed away. (continued on next page)

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Meadow Brook Rehabilitation and Nursing	433 East 2700 South Salt Lake City, UT 84115

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 2:22 PM, an interview was conducted with NA 3. NA 3 stated that she showered resident 96 one time with the assistance of the CNAC on the day that he passed away. NA 3 stated that the CNAC told her that when resident 96 received a shower they took his c-collar off, and that the CNAC was the person who removed the collar. NA 3 stated that while the CNAC was holding the shower head she was guiding NA 3, saying that as long as she was washing the neck gently and the neck and spine were aligned it would be okay. NA 3 stated that no one was holding or stabilizing resident 96's head once the c-collar was removed, and the c-collar was off for approximately 20 minutes for the duration of the shower. NA 3 stated that she and NA 5 took resident 96 back to his room. NA 3 stated that they tried to transfer resident 96 back to bed, but they could not physically do it. NA 3 stated that she and NA 5 attempted to do the same transfer method as the PDON and CNAC, the towel transfer. NA 3 stated that this transfer method had a towel under the resident's knees and the staff arm under the resident armpit, and as you hold the towel you shift the resident's weight to transfer them. NA 3 described the towel transfer method as standing at the residents' side facing him with the arm closest to the resident placed under his arm and the arm further away was crossed and holding the towel. NA 3 stated that when you transferred the resident the staff arms slightly uncross, enough to move the resident legs. NA 3 stated that this method caused the aide to twist her upper back during the transfers. NA 3 stated that she and NA 5 could lift resident 96. NA 3 stated that resident 96's bed was positioned against the wall and they placed his wheelchair in front of the bed. NA 3 stated that she was on the side closest to the bed which was on the resident's left side. NA 3 stated that NA 5 was able to lift resident 96's weight, but as they were transferring him she felt like she did not have a good enough grip. NA 3 stated that they placed resident 96 back into the wheelchair and he was seated on the edge. He was starting to fall off of his chair. NA 3 stated that they grabbed resident 96's arms to pull him back, and his body went forward. NA 3 stated that she went behind him and tried to grab him from behind with both arms under his arms. NA 3 stated that resident 96 fell to the floor, he slipped down to the floor. NA 3 stated that resident 96 did not fall to the knees, but instead landed on his buttock with his legs extended in front of him. NA 3 stated that resident 96 did not say anything when he fell , and that resident 96 was really only able to say owe when he was in pain. NA 3 stated that resident 96 was a bigger man and weighed approximately 180 pounds. NA 3 stated that it was pretty hard to hold him. NA 3 stated that resident 96 was unable to assist with lowering himself to the ground, but once on the ground he was able to hold his weight up and was not slumped over. NA 3 stated that NA 5 went to go get help to lift resident 96 off the floor. NA 3 stated that when CNA 3 arrived in the room she asked what had happened and stated that she did not think the resident was breathing. NA 3 stated that she and CNA 3 placed the towel under resident 96's legs and lifted him back into the wheelchair. NA 3 and CNA 3 then transferred resident 96 to the bed. NA 3 stated that they placed him back on the bed and she noticed that resident 96 was not breathing. NA 3 stated that CNA 3 replied, oh ya I think he passed away. NA 3 stated that NA 5 went to find a nurse. On [DATE] at 10:13 AM, an interview was conducted with the previous Director of Nursing (PDON). The PDON stated that she was with resident 96 before he died . The PDON stated that resident 96 had a shower and a shave and she talked to him 5 minutes before he died . The PDON stated that she was in the shower room with resident 96 and he was already dressed. The PDON stated that one of the aides came and got her and said she thought resident 96 had passed. The PDON stated that resident 96 was in bed when she went down to assess him. The PDON stated that resident 96 had fallen prior to the accident but not afterwards, I don't think so. The PDON stated that if resident 96 had fallen she should have been notified. The PDON stated that resident 96 was a one person assist for transfers, bed mobility, and brief changes prior to accident. After the accident he was a two person assist for transfers, bed mobility, and toileting. The PDON stated that resident 96 was a big guy and needed a 2 person assist. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 12:38 PM, a follow-up interview was conducted with the PDON. The PDON stated that resident 96's c-collar should stay on him, but nurses could remove it to assess his skin. The PDON stated that if someone took the c-collar off during showers that would not be consistent with care. The PDON stated that at the time he passed, she became aware immediately. The PDON stated that she assisted in resident 96's shower the day that he died . The PDON stated as his shower ended she asked him about it and the resident replied, ya. The PDON stated that not many minutes went by before the aide came to get her and said something was wrong and he had passed. The PDON stated that she did not recall who the aide was and it was not someone she knew well. The PDON stated that resident 96 was laying in bed when she assessed him and determined he was dead. The PDON stated It was so unusual for it to happen like that. I was just talking to him. The PDON stated that when she went to assess resident 96 at the time of his death the aides and the nurse were already in the room with him. The PDON stated that she thinks it may have been Registered Nurse (RN) 1 who was in the room. On [DATE] at 3:58 PM, a telephone interview was conducted with RN 1. RN 1 stated that she was working the 4:00 PM to 8:00 PM medication pass shift the day that resident 96 died . RN 1 stated that she recalled a resident at the facility that had a c-collar. RN 1 stated that the aides had taken the resident to the shower. RN 1 stated that later one of the aides came and got her and said resident 96 had fallen. RN 1 stated the aide was asking if resident 96 was a Do Not Resuscitate (DNR). RN 1 stated that the aide told her to hurry down to the room. RN 1 stated that she replied Oh gosh his neck. Did he fall? What part of his body hit the floor? RN 1 stated that the aides said he just went forward and his knees went down but they caught him. RN 1 stated that the aides reported that resident 96 was really pale in bed. RN 1 stated that she went running down to the resident's room, and when she entered he was in bed and had already died . RN 1 stated that the PDON entered the room after her. RN 1 stated that she was not present at the time of the fall and they thought he may have died right after the fall. RN 1 stated that she thought she informed the PDON of the fall but cannot say with certainty. RN 1 stated that there was no indication that resident 96 was going to pass away. It should be noted that no documentation could be found of a facility investigation into resident 96's fall on [DATE], and reporting to the SSA or APS was not completed. [Cross-refer F689] Review of the facility policy on Abuse, Neglect, Exploitation, and Misappropriation Prevention Program documented that the facility objective was to protect the residents from abuse, neglect, exploitation, and misappropriation of property by anyone. The policy stated that the facility would provide staff orientation and training on abuse prevention, identification and reporting of abuse, stress management, and handling verbally or physically aggressive resident behavior. The policy stated that all allegations of possible abuse would be investigated and reported within the timeframe's required by federal requirements. The policy was last revised in [DATE]. 22992 5. Resident 38 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease, protein calorie malnutrition, and dementia without behaviors. Resident 38's medical record was reviewed from [DATE] through [DATE]. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 38 had a Montreal Cognitive Assessment (MOCA) completed on [DATE]. Resident 38's MOCA score was ,d+[DATE] indicating mild cognitive impairment. A physician's note dated [DATE] for resident 38 indicated that resident 38 was homeless prior to his stay at the facility. Seen at the rescue home. He says biggest concern is he is losing his memory, says mostly short term. Had a TBI (traumatic brain injury) in the past he says. The note indicated that the physician diagnosed resident 38 with Vascular Dementia, Moderate/Severe, foot deformities, weakness, low vision, chronic pain, mass lesion of brain, and malnutrition. On [DATE], a quarterly Minimum Data Set (MDS) quarterly assessment indicated that resident 38 had a Brief Interview for Mental Status (BIMS) score of 12, indicating moderate cognitive impairment. Progress notes for resident 38 revealed the following: a. On [DATE] at 10:38 AM, a nurses note indicated that This resident did not return last night, his cell phone was called multiple times but resident did not respond, police called or welfare check this morning. b. On [DATE], an Interdisciplinary Team (IDT) note indicated that resident located by activities director at [name of local homeless shelter], he stated that he is okay and safe, and that he will not be returning to the facility. On [DATE] at 11:00 AM, the facility submitted form 358 with regard to resident 38 to the State Survey Agency (SSA). Form 358 indicated that on [DATE] at 10:00 AM, RN 2 reported to the Previous Director of Nursing (PDON) that resident 38 had signed out on an a Leave of Absence (LOA) and did not return from his going out yesterday. The form indicated that the PDON immediately reported this to the ADM. The form 358 indicated that this was reported to the State Survey Agency (SSA) on [DATE] at 11:00 AM. On [DATE] at 1:33 PM, the facility submitted form 359 to the SSA. Form 359 stated that resident 38 was located and interviewed at a local homeless shelter. The form also documented that Staff members and co-residents noted it is common for [resident 38] to go out for hours and return to the facility and that [resident 38] always come back. CNA stated he saw [resident 38] leave aprox (approximately) 5:40 am on Monday ([DATE]), normal behavior for him to leave. Per interview, nurses stated that [resident 38] checked out on monday ([DATE]) on NOC (night) shift. Day nurse noted he was not back by the time she left for her shift so she attempted to call patient and did not get through. Nurse arrived back on shift and NOC nurse informed Patient had still not returned. Nurse notified DON. On [DATE] at 9:47 AM, an interview was conducted with the PDON regarding resident 38. The PDON stated that when staff noticed that resident 38 did not return from an LOA on [DATE], they began calling the resident, but the resident would not answer their calls. The PDON stated that if a resident signed out on an LOA, they should indicate when they are returning, and that if a resident was not back within an hour of when they said they would return, then she would start trying to contact the resident. The PDON stated that she was upset that she was not informed that resident 38 did not return to the facility on the evening of [DATE]. The PDON stated that I should have gotten a call during the night of [DATE]. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 12:05 PM, an interview was conducted with the ADM regarding resident 38. The ADM stated that if someone signs out on an LOA, that information should be passed on to the next nurse on shift. The ADM also stated that the night shift staff should have done rounds and communicated the status of the residents overnight to the nurse on shift. The ADM stated that if a resident signed out on an LOA, they should indicate when they are returning, and that if a resident was not back within 30 to 60 minutes of when they said they would return, then action should be taken. 6. Resident 94 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included Wernicke's encephalopathy, dementia, major depressive disorder, other amnesia, and history of traumatic brain injury. Resident 94's medical record was reviewed from [DATE] through [DATE]. An admission Minimum Data Set (MDS) assessment dated [DATE] for resident 94 was reviewed. The MDS indicated that a Brief Interview for Mental Status (BIMS) was completed. The BIMS indicated that the resident was unable to report the correct month and year. The resident received a score of 8 on the BIMS, indicating that the resident was moderately cognitively impaired. Progress notes for resident 94 included the following: a. On [DATE] at 7:30 PM, Cna (Certified Nursing Assistant) supervising smoke break came to this nurse and said that while resident was outside smoking he went down the sidewalk and around the building and could hear the side gate rattling and that by the time she got there, the resident was gone. Said that sheyelled (sic) for the cna's to assist in the search for resident. The side gate door was opened inwards and bent. One cna followed resident while the other cna came and alerted this nurse. Cna . got in her car and drove around the near-by streetslooking (sic) for him while this nurse called 911 asking for assistance with the search. b. On [DATE] at 8:30 PM, a police officer contacted facility staff to inform them he had located the resident and was on his way back to the facility with the resident. On [DATE] at 9:22 PM, the facility submitted form 358 with regard to resident 94 to the SSA. The form 358 indicated that resident 94 went out to the back smoking patio during smoke break. He went down the side of the building and ripped open the gate that was locked with a pad lock (sic). Our CNA caught up with him in the process trying to get him to stop and come back in the building. As he continued out to the front of the property and the CNA, after repeated attempts realized that she wasn't going to be able to get him to come back into the building, she went to get help. When the rest of the staff came out, they started driving around searching for him while the nurse called the police. The police arrived and started their search. They later found him down the road and brought him back to the building. The facility did not submit a form 359 to the SSA regarding this incident until [DATE], approximately 2 months later. The form 359 indicated that all staff had been trained on elopement on [DATE], and not in February 2023 directly after the elopement occurred. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 4:05 PM, an interview was conducted with the PADM. The PADM stated that on [DATE], resident 94 shoved the locked gate open. The PADM stated that a staff member followed the resident out of the gate and into the parking lot, but that the staff member could not talk the resident into coming back inside the facility. The PADM stated that at that time, the staff member left the resident alone and came back inside the facility to report the elopment to other staff. The PADM stated that two staff members then went back outside to locate resident 94. The PADM did not state why the form 359 was submitted approximately 2 months after the incident instead of the required 5 days. 7. Resident 97 was admitted to the facility on [DATE] with diagnoses that included cardiomyopathy, severe protein-calorie malnutrition, viral hepatitis C, generalized anxiety disorder, muscle weakness, adjustment disorder with anxiety, major depressive disorder, dysphagia, and insomnia. Resident 97's medical record was reviewed from [DATE] through [DATE]. Resident 97's quarterly Minimum Data Set (MDS) assessment dated [DATE] documented that the resident's BIMS score was 9, indicating moderate cognitive impairment. Resident 97's progress notes indicated the following: a. On [DATE] at 4:00 PM, a nurses note read, Resident approached nurses' station and resident informed nurse that he was going to look at apartments with a friend. Resident had walker with him when leaving. Resident signed LOA (leave of absence) book and resident assisted to front door and visitor waiting at front door for resident. Resident did not return as of midnight and informed oncoming nurse he had not come back from LOA. b. On [DATE] at 8:18 PM, a social services note read, Resident 97 left with someone around 4:00pm signed out and said he was going to look for apartment. Hasn't returned yet. discharged him on LOA. c. On [DATE] at 11:55 AM, a nurses note read, Got a call from a lady by the name of [name deleted]. she was calling to check on [resident 97]. explained [resident 97] hasnt returned from LOA Visit. [name deleted] stated she brought him back at [DATE] around [8:00 PM]. stated she wound (sic) call his family but was adamant she dropped him off last night. per records [resident 97] checked himself out with [name deleted] but never checked back after his visit. d. On [DATE] at 9:30 PM, a nurses note read, Recieved (sic) a call from a female asking if resident is here at the facility. Says that she dropped him off around 830pm but did not watch him come inside of facility. Staff went outside and searched the premises for him but he was not there. Was not at ,d+[DATE] either. Notified DON of situation. Also mentioned this to [name of physician]. e. On [DATE] at 3:50 PM, a nurses note read, [Resident 97] showed up this afternoon and stated he was here to pick up his personal items. he appeared impaired and was arguing with staff. explained to him is admission required which was to go to the ER for readmission (sic). pt refused. told staff to get his electronic (sic) wheelchair and pack his electronics in his back pack. stated he will come back on monday to pick up the rest of his items. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility filed an Initial Entity Report with the State Survey Agency (SSA) on [DATE], approximately 6 days after resident 97 left the facility. The report documented that resident 97 signed the leave of absense (sic) book on Wednesday ,d+[DATE] at around 4:30pm and left with a friend to go look at appartmnets (sic). It was our understanding that he would be back later that day however he has left with friends before, stayed at their place and not come back for a couple days. On Friday ,d+[DATE] at around 8:45pm the friend he left with reported that she had dropped him off in front of our building. He hadn't come in to the building at that time and so we sent some people out to search for him because he only had his walker. After we couldn't find him we thought that he must have called another friend and so we dediced (sic) to give him the weekend. We talked with the original friend he originally left with multiple times through the weekend and tried to reach out to the cell phone number we had for him as well in attempt to find him. The following Monday he still hadn't come back and so we reached out to the police to file a missing person's report. The Alleged Abuse Verification of Investigation Report form completed by staff on [DATE] for resident 97 was reviewed. The report indicates that on [DATE] one staff member was interviewed. The staff member stated that resident 97 signed our Leave of Absence book stating that he was going to look at apartments and would be back later that evening. He left with a friend who came to pick him up. He left with his walker and the clothes on his back. He never came back that night or several nights later. No other interviews were documented on the report. The Alleged Abuse Verification of Investigation Report form also documented that resident 97 has been at our facility for the better part of a year. He has progressed in all his care measures to the point that we have been trying to help him transition out to living on his own. The doctor was prepared to discharge him as soon as we found a safe discharge location. On [DATE] at 4:05 PM, an interview was conducted with the Previous Administrator (PADM). The PADM stated that resident 97 was often drunk or high due to a drug problem. The PADM stated that resident 97 would often leave for longer than a day, so we were telling him this wasn't a hotel. If he's there he has to follow the regulations in order to get care. The PADM stated that he attempted to reach out to resident 97 but that resident 97 was under the influence of whatever it was. The PADM stated that when it was evident he wasn't coming back after what we had done to try and get him back, the facility discharged resident 97. The PADM was unable to explain why the resident was not reported missing sooner, why no other staff were interviewed during the investigation, and why the resident was not appropriately oriented for discharge once he returned to the facility. 46232 8. Resident 16 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE] with the following diagnosis that included type 2 diabetes mellitus, stage 4 pressure ulcer of sacral region and stage 4

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22992 Based on interview and record review, the facility did not have evidence that all allegations of abuse were thoroughly investigated for 3 of 40 sampled residents. Resident identifiers: 16, 33, and 97. Findings included: 1. Resident 97 was admitted to the facility on [DATE] with diagnoses that included cardiomyopathy, severe protein-calorie malnutrition, viral hepatitis C, generalized anxiety disorder, muscle weakness, adjustment disorder with anxiety, major depressive disorder, dysphagia, and insomnia. Resident 97's medical record was reviewed from 2/5/24 through 2/22/24. Resident 97's quarterly Minimum Data Set (MDS) assessment dated [DATE] documented that the resident's Brief Interview for Mental Status (BIMS) score was 9, indicating moderate cognitive impairment. Resident 97's progress notes indicated the following: a. On 9/28/22 at 4:00 PM, a nurses note read, Resident approached nurses' station and resident informed nurse that he was going to look at apartments with a friend. Resident had walker with him when leaving. Resident signed LOA (leave of absence) book and resident assisted to front door and visitor waiting at front door for resident. Resident did not return as of midnight and informed oncoming nurse he had not come back from LOA. b. On 9/28/22 at 8:18 PM, a social services note read, Resident 97 left with someone around 4:00pm signed out and said he was going to look for apartment. Hasn't returned yet. discharged him on LOA. c. On 9/30/22 at 11:55 AM, a nurses note read, Got a call from a lady by the name of [name deleted]. she was calling to check on [resident 97]. explained [resident 97] hasnt returned from LOA Visit. [name deleted] stated she brought him back at 9/29/22 around [8:00 PM]. stated she wound (sic) call his family but was adamant she dropped him off last night. per records [resident 97] checked himself out with [name deleted] but never checked back after his visit. d. On 9/30/22 at 9:30 PM, a nurses note read, Received (sic) a call from a female asking if resident is here at the facility. Says that she dropped him off around 830pm but did not watch him come inside of facility. Staff went outside and searched the premises for him but he was not there. Was not at 7-11 either. Notified DON of situation. Also mentioned this to [name of physician]. e. On 10/8/22 at 3:50 PM, a nurses note read, [Resident 97] showed up this afternoon and stated he was here to pick up his personal items. he appeared impaired and was arguing with staff. explained to him is admission required which was to go to the ER for readmission (sic). pt refused. told staff to get his electronic (sic) wheelchair and pack his electronics in his back pack. stated he will come back on Monday to pick up the rest of his items. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility filed an Initial Entity Report with the State Survey Agency (SSA) on 10/3/22, approximately 6 days after resident 97 left the facility. The report documented that resident 97 signed the leave of absence (sic) book on Wednesday 9/28 at around 4:30pm and left with a friend to go look at appartmnets (sic). It was our understanding that he would be back later that day however he has left with friends before, stayed at their place and not come back for a couple days. On Friday 9/30 at around 8:45pm the friend he left with reported that she had dropped him off in front of our building. He hadn't come in to the building at that time and so we sent some people out to search for him because he only had his walker. After we couldn't find him we thought that he must have called another friend and so we dediced (sic) to give him the weekend. We talked with the original friend he originally left with multiple times through the weekend and tried to reach out to the cell phone number we had for him as well in attempt to find him. The following Monday he still hadn't come back and so we reached out to the police to file a missing person's report. The Alleged Abuse Verification of Investigation Report form completed by staff on 10/3/22 for resident 97 was reviewed. The report indicates that on 10/3/22 one staff member was interviewed. The staff member stated that resident 97 signed our Leave of Absence book stating that he was going to look at apartments and would be back later that evening. He left with a friend who came to pick him up. He left with his walker and the clothes on his back. He never came back that night or several nights later. No other interviews were documented on the report. The Alleged Abuse Verification of Investigation Report form also documented that resident 97 has been at our facility for the better part of a year. He has progressed in all his care measures to the point that we have been trying to help him transition out to living on his own. The doctor was prepared to discharge him as soon as we found a safe discharge location. On 2/13/24 at 4:05 PM, an interview was conducted with the Previous Administrator (PADM). The PADM stated that resident 97 was often drunk or high due to a drug problem. The PADM stated that resident 97 would often leave for longer than a day, so we were telling him this wasn't a hotel. If he's there he has to follow the regulations in order to get care. The PADM stated that he attempted to reach out to resident 97 but that resident 97 was under the influence of whatever it was. The PADM stated that when it was evident he wasn't coming back after what we had done to try and get him back, the facility discharged resident 97. The PADM was unable to explain why the resident was not reported missing sooner, why no other staff were interviewed during the investigation, and why the resident was not appropriately oriented for discharge once he returned to the facility. 46232 2. Resident 16 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE] with the following diagnoses that included type 2 diabetes mellitus, stage 4 pressure ulcer of sacral region and stage 4 pressure sore of left heel, generalized anxiety disorder, post-traumatic stress disorder, personal history of adult physical and sexual abuse, and suicidal ideation. Resident 16's medical records were reviewed from 2/6/24 through 2/15/24. On 1/5/24, an annual minimum data set (MDS) assessment documented resident 16 had a Brief Interview for Mental Status (BIMS) score of 14 which indicated they were cognitively intact. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A care plan focus area initiated on 4/26/23 documented resident 16 was at increased risk for potential abuse due to a history of abuse and behaviors. It stated resident 16 had a history of making allegations/accusations of abuse. An identified intervention included following the abuse protocol if allegations were made. Resident 16's progress notes were reviewed and documented the following sexual abuse allegation: a. On 4/27/23 at 9:09 PM, a nurse note stated, Pt [patient] told a CNA [certified nursing assistant] that she had been touched and grabbed inappropriately a few weeks ago. [name removed] the Rn [registered nurse] questioned the pt and I listened. The pt stated that an aid that work the later in the night but not the all night shift had come in to reposition her and grabbed her forcefully and touched her breast with his other hand. She then stated that he asked if that felt good and if she would do a Blowjob for him. She stated that this happened about two weeks ago and that she just now remembering it because of a nightmare. She stated that the patient was tall and skinny. He also had dark shorter hair. [name removed] has been informed. b. On 4/28/23 at 7:27 AM, a nurse note stated, During HS [nighttime] med pass residents CNA asked this nurse to come and speak to her in her room. Resident reports that a guy grabbed her really hard on the right arm then grabbed her lt [left] breast. Said that this happened 2 weeks ago. Said that she doesn't know his name but he was thin, tall, and had black hair. Showed her a pic [picture] of a CNA and she said that he is the person. Said that this happened on night shift then said that it happened on evening shift around 2100. c. On 4/28/23 at 10:05 AM, a nurse note stated, At approximately 0930 resident was up in the main activity room for bingo when the practitioners came in for an assessment it was reported to them that the resident has stated she was now raped. the conversation was cut to preserve patient privacy as there were other residents very near the table. this was then reported to myself at which point the DON [Director of Nursing] was notified with myself and the Practitioners present. d. On 4/28/23 at 10:45 AM, a nurse note stated, Checked residents skin head to toe. Small 3mm [millimeter] round bruise on back of left arm. Appears to be approx. [approximately] 4-5 days old, faded dark with yellowish haze around it. Catheter in place draining well, no redness noted to peri-area, cleansed peri area well . On 4/13/23 at 9 PM, a Facility Incident Report documented resident 16 had reported to a nurse that they had been roughly grabbed by a male CNA who then proceeded to grab their left breast and rub it. The male CNA then asked resident 16 if it felt good and stated if resident 16 reported them, then they would lie. Resident 16 stated this had happened 2 weeks ago on the evening shift around 9 pm. The Nursing description documented resident 16's right arm had been grabbed while the resident description documented their left arm had been grabbed prior to the left breast. The incident report documented resident 16 described the male CNA to be thin, tall and dark haired and when showed a picture was able to identify them. It documented both the administrator and the DON had been notified of the incident. In the notes section of the incident report, it documented that on 5/22/23 an investigation had been done on the incident and it had been reported to the state. [Note: there was no documentation located to indicate this had been reported to the State Survey Agency (SSA).] (continued on next page)

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Meadow Brook Rehabilitation and Nursing	433 East 2700 South Salt Lake City, UT 84115

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/27/23 at 9:32 PM, a Facility Incident Report documented resident 16 stated an aid had come in to reposition them and was forcefully grabbed by the aid who then touched resident 16's breast and asked for a blow job. It documented resident 16 remembered these details due to a nightmare they had. No new information was provided in the incident report. A Form titled Exhibit 358 was submitted to the State Survey Agency (SSA) on 4/27/23 at 10:15 PM. The form revealed there was an allegation of sexual abuse. The form revealed that resident 16 reported a CNA had touched her breast over clothing approximately 2 weeks prior to 4/27/23. Resident 16 stated this had happened in their room during the evening hours. Resident 16 was documented not having any changes in behaviors after the incident, but it stated resident 16 did not want to be around the CNA. The following steps taken to ensure the safety of resident 16 after the incident included the suspension of the CNA involved and resident cares needed to be provided in pairs of two. The form documented that the accused CNA had not been working at the time resident 16 made the allegation. A Form titled Exhibit 359 was submitted to the SSA on 5/3/23 at 9:02 PM. The form revealed the detailed summary of resident 16's account which stated, Interviews started with her saying that a male CNA was turning her and in the process grasped her arm very firmly as he helped her turn (she said that was all). Next nurse interviewed her and inadvertently leaded her into more (as stated by the nurse and 2 witnesses). Story then became he grasped her arm, brushed up against a breast and asked for a blow job and she stated that was all. The next morning, she was telling people she was raped. Then later that day she told me it was just the second story. She said that it had happened about 2 weeks prior. Staff and her roommate all said that during those 2 weeks up until when she told the story, she had acted normal with no signs this [NAME] [sic]. The witness summary interview documented, All staff interviewed independently said that she showed no signs of psychological [NAME] [sic] for the 2 weeks after the timeframe she stated it happened to the day after she made the accusations all the way to the day I'm writing this report. Completely normal behaviours [sic] until she would relate her 3 different versions of the story that happened. Two witness of the interview both independently stated that the unintended leading interview seemed to have her embellishing what happened. 2 nurse practitioners that spoke with her on the day of the accusation both said she did not exhibit any typical signs that a rape victim. The alleged perpetrator interview revealed the male CNA was not working at the time resident 16 alleged the incident had occurred. It documented the male CNA worked earlier that day, but he was not assigned to care for resident 16 and they had no idea of what resident 16 was talking about. The form revealed the summary of the investigation findings to be No typical signs exhibited of rape or other sexual [NAME] [sic]. Nurse performed detailed inspection of [resident 16] for possible rape or other [NAME] [sic] and found none. The form revealed that the sexual allegation had not been verified since the allegations did not match the findings or testimonies. The form also documented that due to resident 16's past of similar allegations at other facilities, cares needed to be provided by 2 CNAs with no males if possible. [Note: There was no documentation available to identify when staff were interviewed and who all was interviewed and what staff member had performed resident 16's inspection. There was no documentation located to indicate the accused CNA had been interviewed by the administrator. The detailed assessment done on resident 16 to rule out rape and trauma was not located in the resident records.] (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 - Some	On 2/20/24 at 10:26 AM, an interview was conducted with the Administrator (ADM). The ADM stated if there was any allegation of abuse such as physical, emotional, mental or neglects then it was reported to the state. The ADM stated there should be risk management associated with the 358. The ADM stated an incident report was an internal document they use to follow up with the resident on top of doing their investigation. On 2/21/24 at 10:17 AM, a phone interview was conducted with the Previous Administrator (PADM). The PADM stated when they got any sort of abuse allegation they tried to report it within the two hours. The PADM stated they recalled resident 16 had accused a CNA of a sexual allegation. The PADM stated they had done the investigation and determined the person who they accused had not been in the building during the time of the incident. The PADM stated they believed there was one incident where they had mistakenly filed two incident reports and stated this might have been that incident. The PADM stated this incident happened a while ago but believed a head to toe was done on resident 16. The PADM stated they included any additional documentation with the investigation. 3. Resident 33 was initially admitted to the facility on [DATE] and readmitted with the following diagnoses that included severe protein calorie malnutrition, alcoholic cirrhosis of liver without ascites, dementia, opioid dependence, esophageal obstruction, gastrointestinal hemorrhage, generalized anxiety disorder, and, alcohol dependence. Resident 33's medical record was reviewed on 2/6/24 through 2/15/24. On 1/14/24, a Quarterly Minimum Data Set (MDS) assessment documented resident 33 had a Brief Interview Mental Status (BIMS) score of 11 which indicated resident 33 had moderate cognitive impairment. On 12/9/23 at 10 AM, a late entry nurse note stated, An alleged physical altercation occurred between this resident and another resident today. On 12/13/23 at 9:28 AM, an IDT (Interdisciplinary Team) event review stated, root cause is found to be the other resident's dementia, medication review completed on other resident with medication changes, alert charting added to [resident 33] to monitor for s/s [signs/symptoms] of abuse, all other least restrictive interventions in place, will continue to monitor. On 12/14/23 at 9:41 AM, an IDT event review stated, upon investigation it was found that the other resident did not push [resident 33], but merely brushed past her on his way out of her room and that [resident 33] states she feels safe here, all other least restrictive interventions in place, will continue with plan of care. On 12/9/23 at 10 AM, a Facility Incident Report documented another resident had come into resident 33's room and was going through the drawers and cupboards when resident 33 asked them to leave and resident 33 was pushed as the other resident left the room. Resident 33's statement of the incident stated, He was going through everything making a mess. I told him to 'get out, this is not your room' and then he pushed me. The immediate actions identified a change in the other resident medication. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Form titled Exhibit 358 was submitted to the State Survey Agency (SSA) on 12/11/23 at 10:50 AM. It documented an allegation of physical abuse had been made. The following statement was made by resident 33 about the allegation, [Resident 33] alleged that [name of other resident removed] Walked into her room and was going through her items. When [resident 33] Asked him to leave, he got mad and got physical. It documented that a CNA had witnessed the altercation between the two residents. The written witness statement documented, he went inside 11 room (women's room) and started slamming the drawers in the 11c room. [resident 33] was yelling at him to get out then he was walking out. He pushed [resident 33] and attempted to flip over a wheelchair. A Form titled Exhibit 359 was submitted to the SSA on 12/12/23 at 5:10 PM. The summary of the investigation documented that another resident had entered resident 33's room and started going through resident 33's stuff. Resident 33 then asked the other resident to leave and resident 33 was moved out of the way by the other resident as they left resident 33's room. Resident 33 stated they did not feel threatened by the other resident and understood the other resident was confused and was a big man. The form revealed the summary of the investigation findings to not have been substantiated. It documented resident 33 did not feel abused or harmed and the contact made had been by accident and there was no intention of harm perceived by the patient or victim. [Note: There was no documentation located to indicate the staff that had witness the altercation had been interviewed to obtain the clarification needed on if resident 33 had been pushed or moved out of the way when the other resident exited the room.] On 2/20/24 at 10:26 AM, an interview was conducted with the Administrator (ADM). The ADM stated if there was any allegation of abuse such as physical, emotional, mental or neglects then it was reported to the state. The ADM stated there should be risk management associated with the 358. The ADM stated an incident report was an internal document they use to follow up with the resident on top of doing their investigation. The ADM stated they conducted their investigation by interviewing all parties involved in the incident which included the victim, perpetrator, and witnesses. The ADM stated if no witness were available then they interviewed residents that were near the surrounding area and staff on shift. The ADM stated there had been an incident between resident 33 and another resident. The ADM stated it had initially been reported that resident 33 had been shoved and it had been physical. The ADM stated resident 33 then reported the other resident brushed past them when they were interviewed. The ADM stated resident 33 had said it was not a threatening brush and had walked past resident 33. The ADM stated what happened between resident 33 and the other resident was an accident. The ADM stated there needed to be more clarification with the written witness statement on what pushed meant and stated they obtained that clarification with resident 33's interview. On 2/20/24 at 10:56 AM, a follow up interview was conducted with the ADM. The ADM stated the other resident was confused did not intend to harm resident 33. The ADM stated when resident 33 was interviewed resident 33 made it seem like the other resident's actions were not willful and the other resident brushed up against resident 33 as they were leaving the room. The ADM stated resident 33 believed it was an accident and based their investigation findings off of what resident 33 said during their interview. The ADM stated they had a written witness statement from the CNA that saw the incident. The ADM stated based of the witness statement they should have obtained more clarification by interviewing the CNA. The ADM stated they were the one responsible for obtaining the clarifying information.

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F 0624 Level of Harm - 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** 22992 Based on interview and record review, the facility did not provide and document sufficient preparation to 2 of 40 sampled residents to ensure safe and orderly transfer or discharge from the facility. Specifically, one resident with cognitive impairment was discharged to a hotel room, but was subsequently seen at a local emergency room after becoming lost. This resulted in a finding of harm. In addition, one resident left on a leave of absence, and was not oriented for discharge upon return to the facility. Resident identifiers: 94 and 97. Findings include: HARM 1. Resident 94 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included Wernicke's encephalopathy, dementia, major depressive disorder, other amnesia, and history of traumatic brain injury (TBI). Resident 94's medical record was reviewed from [DATE] through [DATE]. An admission Minimum Data Set (MDS) assessment dated [DATE] for resident 94 was reviewed. The MDS indicated that a Brief Interview for Mental Status (BIMS) was completed. The BIMS indicated that the resident was unable to report the correct month and year. The resident received a score of 8 on the BIMS, indicating that the resident was moderately cognitively impaired. Resident 94's care plans were reviewed and included the following: a. On [DATE], resident requires long term care services related to: TBI w/ (with) major neurocognitive DO (disorder). b. On [DATE], resident was admitted to facility with diagnoses of Severe cognitive dysfunction, inability to take care of himself, dementia, wernick's (sic) encephalopathy, amnesia, hx (history) of traumatic brain injury . c. On [DATE], resident has an ADL (activities of daily living) self-care performance deficit r/t (related to) TBI with major neurocognitive disorder. d. On [DATE], resident has limited physical mobility r/t TBI with major neurocognitive [disorder). e. On [DATE], resident has a behavior problem, making inappropriate comments to female resident's (sic) r/t poor impulse control s/t (secondary to) TBI. f. On [DATE], resident is an elopement risk/wanderer r/t TBI Impaired safety awareness. g. On [DATE], resident has impaired cognitive function/dementia or impaired thought processes. (continued on next page)

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F 0624 Level of Harm - Actual harm Residents Affected - Few	h. On [DATE], resident has a communication problem r/t Expressive Aphasia, Head Injury, Neurological symptoms, Receptive Aphasia. i. On [DATE], resident is at Low, Moderate Risk for Falls per standardized fall scale Cognitive deficits, Confusion, Gait/balance problems, Incontinence, Psychoactive Drug Use, Unaware of Safety needs, Wandering. j. On [DATE], resident is at risk for bladder incontinence and requires assistance with toileting cares r/t Confusion, Neurogenic disorder, Poor toileting habits s/t TBI . There was no discharge care plan in resident 94's medical record. Resident 94's emergency room (ER) notes from a local hospital dated [DATE] were reviewed. The ER notes documented that the resident presented to the ER after an apparent altercation at a previous facility and was not aware of circumstances as to why he came here. The ER notes documented that resident 94 was diagnosed at that time with violent behavior and frontal lobe and executive function deficit. The ER notes documented that The patient does not have the mental capacity to be discharged from the ER and there is no place to discharge him safely. He therefore unfortunately remains in the emergency department for lack of any other viable options. The Behavioral Consultation notes from the ER stay during [DATE] were reviewed and documented the following: resident 94 . is a [AGE] year-old male with past psychiatric history significant for major current cognitive disorder, history of TBI, history of Warnicke (sic) Korsakoff syndrome, frontal lobe and executive function deficit, who was brought to the [name of local ER] after episode in which he assaulted his roommate . Patient has a well documented history of major neurocognitive disorder that is likely multifactorial given history of alcohol use and history of TBI, as well as frontal lobe and executive function deficit, and recently documented diagnosis of major neurocognitive disorder via neuropsychological testing. On my evaluation, patient was oriented to himself, though had difficulty articulating the events leading to ED (Emergency Department) presentation, as well as not being aware of the date or place that he was currently in. I suspect that this is reflective of his baseline cognitive abilities given the previous mentioned diagnoses. The patient's behavior is certainly concerning, though I do suspect that his assaultive behavior and threats of homicide are likely manifestations of his underlying neurocognitive disorder as well as TBI. I suspect that both of these disorders are contributing to frontal and executive function deficits, which are likely impairing his judgment. (continued on next page)

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F 0624 Level of Harm - Actual harm Residents Affected - Few	The Behavioral Consultation notes from the ER also indicated that in [DATE], resident 94 had been residing in skilled nursing facility . until recently when he self-discharged . According to family, patient has been calling frequently with bizarre request including request to talk to his father and mother who have both been deceased for 5 and 3 years respectively. Additionally, patient talked to sister about his son who is now 22 as if he is [AGE] years old still. With concern, family was initially unable to locate [resident 94]. After searching the city, they found him in his old neighborhood from [AGE] years prior when he owned to house (sic). He was trying to meet up with old friends and was clearly confused. Patient has furthermore exhibited wandering behavior, inappropriate gestures toward female staff and poor short-term recall. Accordingly patient is not deemed to have decision-making capacity . Patient has not demonstrated decision-making capacity, which has been corroborated by several physician evaluations as well as neuropsychiatric testing during this hospital admission. the role of an Alzheimer's fronto-temporal dementia process cannot be ruled out at this point but either way a neurodegenerative disorder is apparent. Resident 94's Level II PreAdmission Screening Resident Review (PASRR) dated [DATE] was reviewed. The PASRR indicated that resident 94 was brought to a local ER by law enforcement on [DATE]. The PASRR evaluator documented that during one of his hospital stays, resident 94 underwent this evaluation and it was evident that he is not able to make informed decisions on his own and requires the assistance of a facility to provide the appropriate care on a daily basis. Testing results indicate that [resident 94] is not able to reside in a less restrictive environment and will likely require not only skilled nursing services ongoing but a memory care unit. The PASRR evaluator also documented that resident 94 struggled to answer questions, was a poor historian, was unable to remember that his parents passed away, and has no level of insight into the fact that he has not owned [his] home for over [AGE] years. The PASRR evaluator concluded that resident 94 would continue to benefit from skilled nursing services. He will require this on an ongoing basis and he is not able to perform several of his ADLs without assistance. He would benefit from cognitive stimulation, support, encouragement and group activities with socialization. He would have the greatest benefit in a memory care unit. He would also benefit from someone having guardianship to ensure that his needs are met. Resident 94's progress notes indicated the following: a. On [DATE] at 1:30 PM, a physician note documented, Spoke with patient this morning. He answers some questions but refuses to answer some, says frustrated with being woken up and asks to leave the facility. More communicative through the day: he explains he can go to the rescue mission and will follow up with other doctors he's had. He wants to stay at a hotel after discussion. Also given options for the [name of local homeless shelter]. He has capacity to make decisions for himself and has a logical discharge plan. Communicated to facility to arrange discharge when able. [Note: This is in direct conflict with multiple specialist assessments from resident 94's previous hospitalization s and evaluations.] b. On [DATE] at 5:34 PM, Resident educated on following the prescribed doses on the medication cards. Resident stated understanding. c. On [DATE] at 6:15 PM, Resident discharged from facility today at 1815 (6:15 PM). Drive to destination by administrator. [Note: It should be noted that resident 94's medical record did not discuss any discharge plans prior to [DATE].] (continued on next page)

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F 0624 Level of Harm - Actual harm Residents Affected - Few	On [DATE], resident 94 was seen at a local ER. The ER notes documented that resident 94 was brought to the ED after found wandering streets in the rain knocking on his old childhood home door. He has significant neurocognitive deficits and resided in care of (sic) facilities for approximate (sic) last 3 [plus] years. he does not have capacity for decision making/to leave against medical advice. He will require supervision for nutrition and medication management as well as protection from potential exploitation (to which he would be vulnerable if he were not in a secured setting.[resident 94] lacks capacity to make decisions on his own behalf regarding his living situation. It is my professional opinion that [resident 94] requires a secure and structured environment for his own safety. The resident was diagnosed with alcohol-induced persisting amnestic disorder. On [DATE] at 4:05 PM, an interview was conducted with the previous Administrator (PADM). The PADM stated that resident 94 wanted to discharge from the facility, stating we knew he didn't want to be there (at the facility) and I talked to him and said 'do you want to be here?' and he said 'no I want to go'. The PADM stated that he then had a conversation with the doctor to see if he was well enough to go out on his own, and the doctor said we can't keep him here. The PADM stated that he then spoke with resident 94 again and told the resident that the facility would pay for a hotel for several nights. The PADM stated that he drove resident 94 to the local homeless shelter to show him and talk to him about the fact that they have people that can help him out. The PADM stated he provided resident 94 with food and printed a map to make sure he was fine getting there. The PADM acknowledged that resident 94 had cognitive impairment but stated that resident 94 was experiencing increasing behaviors, and the PADM relied on the physician's opinion that the resident was capable of making his own decisions. POTENTIAL FOR HARM 2. Resident 97 was admitted to the facility on [DATE] with diagnoses that included cardiomyopathy, severe protein-calorie malnutrition, viral hepatitis C, generalized anxiety disorder, muscle weakness, adjustment disorder with anxiety, major depressive disorder, dysphagia, and insomnia. Resident 97's medical record was reviewed from [DATE] through [DATE]. Resident 97's quarterly Minimum Data Set (MDS) assessment dated [DATE] documented that the resident's BIMS score was 9, indicating moderate cognitive impairment. Resident 97's progress notes indicated the following: a. On [DATE] at 4:00 PM, a nurses note read, Resident approached nurses' station and resident informed nurse that he was going to look at apartments with a friend. Resident had walker with him when leaving. Resident signed LOA (leave of absence) book and resident assisted to front door and visitor waiting at front door for resident. Resident did not return as of midnight and informed oncoming nurse he had not come back from LOA. b. On [DATE] at 8:18 PM, a social services note read, Resident 97 left with someone around 4:00pm signed out and said he was going to look for apartment. Hasn't returned yet. discharged him on LOA. (continued on next page)

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F 0624 Level of Harm - Actual harm Residents Affected - Few	c. On [DATE] at 11:55 AM, a nurses note read, Got a call from a lady by the name of [name deleted]. she was calling to check on [resident 97]. explained [resident 97] hasnt returned from LOA Visit. [name deleted] stated she brought him back at [DATE] around [8:00 PM]. stated she wound (sic) call his family but was adamant she dropped him off last night. per records [resident 97] checked himself out with [name deleted] but never checked back after his visit. d. On [DATE] at 9:30 PM, a nurses note read, Received (sic) a call from a female asking if resident is here at the facility. Says that she dropped him off around 830pm but did not watch him come inside of facility. Staff went outside and searched the premises for him but he was not there. Was not at ,d+[DATE] either. Notified DON [Director of Nursing] of situation. Also mentioned this to [name of physician]. e. On [DATE] at 3:50 PM, a nurses note read, [Resident 97] showed up this afternoon and stated he was here to pick up his personal items. he appeared impaired and was arguing with staff. explained to him is admission required which was to go to the ER for readmission (sic). pt refused. told staff to get his electronic (sic) wheelchair and pack his electronics in his back pack. stated he will come back on Monday to pick up the rest of his items. The facility filed an Initial Entity Report with the State Survey Agency (SSA) on [DATE], approximately 6 days after resident 97 left the facility. The report documented that resident 97 signed the leave of absence (sic) book on Wednesday ,d+[DATE] at around 4:30pm and left with a friend to go look at appartmnets (sic). It was our understanding that he would be back later that day however he has left with friends before, stayed at their place and not come back for a couple days. On Friday ,d+[DATE] at around 8:45pm the friend he left with reported that she had dropped him off in front of our building. He hadn't come in to the building at that time and so we sent some people out to search for him because he only had his walker. After we couldn't find him we thought that he must have called another friend and so we dediced (sic) to give him the weekend. We talked with the original friend he originally left with multiple times through the weekend and tried to reach out to the cell phone number we had for him as well in attempt to find him. The following Monday he still hadn't come back and so we reached out to the police to file a missing person's report. The Alleged Abuse Verification of Investigation Report form completed by staff on [DATE] for resident 97 was reviewed. The report indicates that on [DATE] one staff member was interviewed. The staff member stated that resident 97 signed our Leave of Absence book stating that he was going to look at apartments and would be back later that evening. He left with a friend who came to pick him up. He left with his walker and the clothes on his back. He never came back that night or several nights later. No other interviews were documented on the report. The Alleged Abuse Verification of Investigation Report form also documented that resident 97 has been at our facility for the better part of a year. He has progressed in all his care measures to the point that we have been trying to help him transition out to living on his own. The doctor was prepared to discharge him as soon as we found a safe discharge location. (continued on next page)

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Meadow Brook Rehabilitation and Nursing	433 East 2700 South Salt Lake City, UT 84115

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F 0624 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 4:05 PM, an interview was conducted with the Previous Administrator (PADM). The PADM stated that resident 97 was often drunk or high due to a drug problem. The PADM stated that resident 97 would often leave for longer than a day, so we were telling him this wasn't a hotel. If he's there he has to follow the regulations in order to get care. The PADM stated that he attempted to reach out to resident 97 but that resident 97 was under the influence of whatever it was. The PADM stated that when it was evident he wasn't coming back after what we had done to try and get him back, the facility discharged resident 97. The PADM was unable to explain why the resident was not reported missing sooner, why no other staff were interviewed during the investigation, and why the resident was not appropriately oriented for discharge once he returned to the facility.

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F 0644 Level of Harm - Actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38031 Based on interview and record review it was determined, for 3 of 40 sampled residents, that the facility did not incorporate the recommendations from the pre-admission screening and resident review (PASRR) level II determination and the PASRR evaluation report into the resident assessment, care planning, and transitions of care. Specifically, residents had PASRR level II recommendations for mental health services and none were provided. Resident identifiers: 21, 29, and 34. Findings included: 1. Resident 29 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included a traumatic brain injury (TBI), hemiplegia and hemiparesis, major depressive disorder, panic disorder, anxiety disorder, low back pain, hepatitis C, seizures, insomnia, migraine, schizoaffective disorder, and history of suicidal behavior. On 6/22/23, resident 29's Patient Health Questionnaire (PHQ)-9 depression assessment documented a score of 17, which indicated moderately severe depression. On 9/21/23, resident 29's PHQ-9 depression assessment documented a score of 11, which indicated moderate depression. On 10/4/23, resident 29's PHQ-9 depression assessment documented a score of 7, which indicated mild depression. On 8/14/23, resident 29's Brief Interview for Mental Status (BIMS) assessment documented a score of 9, which indicated a moderate cognitive impairment. On 10/9/23, resident 29's BIMS assessment documented a score of 11, which indicated a moderate cognitive impairment. (continued on next page)

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F 0644 Level of Harm - Actual harm Residents Affected - Few	On 6/27/23, resident 29's PreAdmission Screening and Resident Review (PASRR) Level II documented the resident's past medical history of a TBI was due to assault that resulted in a craniotomy. Resident 29 then sustained a car accident that affected the right hemisphere with paralysis of the left upper extremity. On 4/28/23, resident 29 was hospitalized with increased extracranial fluid and periorbital cellulitis with Methicillin-resistant Staphylococcus aureus (MRSA) bacteremia. Resident 29's history of psychiatric symptoms documented a history of depression and anxiety dating back to childhood. Resident 29 reported that his mother was abusive and neglectful and she forced him to go with a man who was a pedophile for money. Resident 29 endorsed a history of depressed mood, anhedonia, problems with sleep, problems with concentration, feeling of worthlessness and history of suicidal ideation. Resident 29 stated, I am depressed and I'm anxious and I have panic attacks. I feel like I'm absolutely no good. Resident 29 reported that he was hospitalized multiple times for mental health and attempted suicide at least twice. Resident 29 reported worsening of depression since accident and stated, I just wish life would be over. I just want to give this body back. Resident 29 stated he was depressed and very anxious. The assessment documented resident 29's mental illness diagnoses as major depressive disorder, panic disorder, and anxiety disorder. The assessment recommendations for specialized services for mental illness treatment were individual counseling and review of psychotropic medications. On 9/21/23, resident 29's PASRR level II documented the current psychiatric functioning was that resident 29 was struggling with feeling he needed to use the bathroom constantly and not being able to urinate. Resident 29 reported that this made him extremely anxious and he perseverated about this all the time. Resident 29 reported that his depression was less and he felt he was doing okay. The assessment recommendations for specialized services for mental illness treatment were individual counseling and review of psychotropic medications. On 9/21/23 at 10:33 AM, the Social Service Note documented, [resident 29] returned to the facility after going to hospital for suicidal comments and stating that he has a plan. He will be referred to [local mental health services] today. No documentation could be found that resident 29 was referred to any behavioral or mental health services. On 7/18/23, resident 29 had a care plan initiated for Level II PASRR determination for serious mental illness due to major depressive disorder, anxiety disorder, and panic disorder. Interventions identified included assist case worker with obtaining any needed information; coordinate services with habilitative coordinator; invite the habilitative coordinator and be responsible to the quarterly care plan meeting that discussed resident status; recommendations for services to be provided by the facility for physical therapy (PT), occupational therapy (OT), medication management and assist with activities of daily living (ADLs); monitor for increase in symptoms of depression; recommendations for specialized services for mental illness treatment: patient was in need of mental health services including individual counseling and a review of his psychotropic medications; and report any need to re-evaluate for additional specialized services (continued on next page)

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F 0644 Level of Harm - Actual harm Residents Affected - Few	On 8/2/23, resident 29 had a care plan initiated for patient meets PASRR Level II level of determination secondary to major depression, generalized anxiety disorder, and panic disorder. The care plan documented that resident 29 had a history of recurrent depression, anhedonia, problems with sleep and appetite, fatigue, concentration, history of suicidal ideation and attempts. The care plan further documented that resident 29 had difficulty controlling worry, had a history of panic where he feels abrupt surge of fear, trembling, shaking, abdominal distress, fear of dying, feelings of light-headedness, numbness, tingling. Interventions identified included would receive appropriate specialized services as indicated on the PASRR Level II; refer to mental health Services as needed; arrange for PASRR re-evaluation if there was a significant change in status that results in new evidence of possible mental disorder, intellectual disability and/or related condition; coordinate and/or inform the appropriate agency to conduct the PASRR evaluation and obtain results if it was learned that Resident's/Patients PASRR was not completed or was incorrect; recommendation for specialized services for mental illness was mental health services needed including individual counseling and a review of his psychotropic medications; recommendations for services to be provided by the facility for physical therapy (PT), occupational therapy (OT), medication management and assist with activities of daily living (ADLs); and monitor for increase in symptoms of depression. On 2/08/24 at 10:18 AM, an interview was conducted with the Certified Nurse Assistant Coordinator (CNAC). The CNAC stated that the facility provided behavioral training which covered de-escalation techniques for the residents. The CNAC stated that the techniques were resident specific and she along with the previous Director of Nursing (DON) would identify interventions and care plan them together. The CNAC stated that they had a Resident Advocate that had been at the facility for about a month. The CNAC stated that prior to that they had been without a social service worker for approximately 3 months. The CNAC stated that they had a local behavioral health provider that came to the facility to provide mental health services. The CNAC stated that they came to the facility weekly and as needed. On 2/12/24 at 9:06 AM, an interview was conducted with Nursing Assistant (NA) 1. NA 1 stated that resident 29 did not have any behaviors that she was aware of. NA 1 stated that on one occasion she witnessed resident 29 yelling from the bathroom. NA 1 stated that resident 29 stayed in his room a lot, and maybe was depressed. On 2/12/24 at 9:47 AM, a follow-up interview was conducted with the CNAC. The CNAC stated that resident 29 liked to sleep a lot. The CNAC stated that resident 29 reported sad thoughts and that he had some issues with his ex-girlfriend. The CNAC stated that resident 29 was suicidal a few months ago and it had to do with his girlfriend. The CNAC stated that resident 29 gets down when he was lonely. The CNAC stated that resident 29 needed to feel more valued as an individual. He may be a little depressed, a lot of the residents feel that way when they don't have 1:1. The CNAC stated that resident 29 reported to one of the employees, I'm down, I want to die. The CNAC stated that they took this statement seriously. He needed a bit more help. The CNAC stated that they transferred resident 29 to the hospital. (continued on next page)

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F 0644 Level of Harm - Actual harm Residents Affected - Few	On 2/12/24 at 11:57 AM, an interview was conducted with the Resident Advocate (RA). The RA stated that the Minimum Data Set (MDS) Coordinator was arranging the residents referrals to the contracted behavioral health provider but now they were training her on how to do it. The RA stated that a couple of weeks ago the MDS Coordinator provided her a list of residents that needed referrals to the behavioral health provider. The RA stated that the Director of Nursing (DON) stated that they were no longer using the previous contracted behavioral health provider and would need to send the referrals to the new mental health provider. The RA stated that she was still waiting for the new provider information. On 2/12/24 at 1:12 PM, an interview was conducted with the MDS Coordinator. The MDS Coordinator stated that she was in charge of referrals to behavioral health services for the time period between when the previous RA (PRA) left and when the new Resident Advocate arrived. The MDS Coordinator stated it was not clear that she should have been doing referrals, and she did not make any new referrals during this time. The MDS Coordinator stated that as of 12/5/23 the residents that were receiving mental health services through the contracted behavioral health provider did not include resident 29. The MDS Coordinator stated that if the resident was receiving mental health services then the notes would be located in the electronic medical records under miscellaneous. On 2/12/24 at 2:00 PM, an interview was conducted with the Corporate Social Service Worker (CSSW). The CSSW stated that the facility contracted with a behavioral health provider for mental health services, but they were in the process of obtaining a new contracted provider. The CSSW stated that residents were also able to use their own provider if they already had one. The CSSW stated that if the residents had not been seen by the contracted provider then they had not been seen for mental health services. The CSSW stated that they had identified that there was a need for residents to be connected with behavioral health services. The CSSW stated that for a lot of the residents they could not find documentation that mental health services had been provided. The CSSW stated that they reviewed all the residents two weeks ago and made a bunch of referrals. The CSSW stated that when they received a PASRR in the admission process that identified a mental illness they should be asking the resident about behavioral health services and if they have a provider. If the resident was open to services the CSSW stated that someone in the facility should be coordinating those services. The CSSW stated that the referrals and coordination of care should be documented in the resident progress notes. The CSSW stated that resident 29 would like to get counseling. The CSSW stated that resident 29 was sent to the hospital in September 2023 for suicidal ideation and the PRA was supposed to have made a referral for mental health services. On 2/12/24 at 2:52 PM, a follow-up interview was conducted with the CSSW. The CSSW stated that resident 29 was referred to the contracted behavioral health provider on 1/19/24 and again on 1/23/24. The CSSW stated that resident 29 was not referred for mental health services prior to this. 22992 2. Resident 34 was admitted on [DATE] and readmitted on [DATE] with diagnoses that included moderate protein calorie malnutrition, intellectual disabilities, chronic pain, scoliosis, major depressive disorder, anxiety disorder, impulse control disorder, mood disorder, and intracranial injury. Resident 34's medical record was reviewed from 2/5/24 through 2/22/24. (continued on next page)

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F 0644 Level of Harm - Actual harm Residents Affected - Few	Resident 34's Level II PASRR dated 10/31/23 was reviewed. The Level II evaluator documented the following: Diagnostic Formulation: [Resident 34] has a history of recurring depressive symptoms which have contributed to recurring functional impairment and distress, and is presenting with [signs and symptoms] of anxiety at this time as well. He has significant cognitive limitations/deficits secondary to a TBI. He has a history of alcohol, tobacco, and illicit substance use. Recommendations for services to be provided by the Nursing Facility: Medical management, assistance with ADLs (activities of daily living), therapies for rehabilitation, support from SNF staff, referrals for community resources Recommendation for Specialized Services for mental illness treatment: [Resident 34] feels he would benefit from the support of mental health treatment services, although his memory impairment might limit the benefit he gets from said services. Resident 34's care plan dated 11/9/23 indicated that resident 34 had a serious mental illness. One of the interventions listed was to Refer to Mental Health Services As needed. In addition, the care plan indicated that resident 34 was at risk for suicidal impulsive/ideations of self-harm related to Psychiatric Disorder. (continued on next page)

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F 0644 Level of Harm - Actual harm Residents Affected - Few	Resident 34's Level II PASRR dated 1/15/24 was reviewed. The Level II indicated that resident 34 had been hospitalized in the inpatient psychiatric unit at a local hospital in June 2023 secondary to depression and suicidal ideation. He has been in the ER or hospital at multiple locations 15 [plus] times in the past 6 months due to recurring back pain, SI (suicidal ideations), neck pain, and when found wandering in stores or in parking lots.He was taken to the [emergency room of a local hospital] on 10/23/23 secondary to suicidal ideation with a plan to cut his throat. He was readmitted to the inpatient psychiatric unit for safety, stabilization, and treatment. After admission to SNF (skilled nursing facility) [resident 34] was documented to have multiple behavioral issues and a significant altercation with another resident. Notes and SNF staff report that pt would become easily angered if he did not get what he wanted, especially when told he cannot go outside and smoke as much as he wants. He was noted to put hand sanitizer in his eyes and on his face; he told staff he had done this multiple times prior to his being observed. Notes indicate; 'Resident had many unusual behaviors during shift but was easily redirected' .'angry about having to wait for supervised smoking times.' On 11/12/23 notes state: 'Patient has been easily explosive for the last two days especially when he doesn't get what he wants. Patient exploded at nurse 11/11 around 2200 (10:00 PM) because he wanted a cigarette called this nurse every name in the book. Most of the time he is easily calmed down, but 20 minutes later another resident turned the lights off in the dining room and this patient became explosive and yelled an expletive and punched the resident the (sic) turned off the light 3 times in the face causing the patient's ear to bleed. When the resident stood up to defend himself being unstable with the assault the resident fell to the floor.' . The police were called, [resident 34] was cited, and [resident 34] was blue sheeted and taken back to the ER at [name of local hospital] for re-evaluation. Since returning to the SNF [resident 34] has still struggled with mood dysregulation and agitation/aggression and he was put on 1:1 supervision for a time. His records do indicate issues with impulsivity, anger management, rapid mood swings/mood dysregulation, and recurring depression with SI (suicidal ideation). It was recommended to hospital staff by this evaluator that [resident 34] be referred for services through DSPD (Division of Services for People with Disabilities) if appropriate to engage more community resources on [resident 34's] behalf, such as moving to a group home where pt could have more flexibility but also have supervision and structure/safety. The evaluator for the Level II PASRR documented the following: Diagnostic Formulation: [Resident 34] has a very complex presentation. He has a documented history of recurring depressive symptoms which have contributed to functional impairment and distress, and is presenting with sxs (signs and symptoms) of anxiety at this time as well. He has significant cognitive limitations/deficits and severe mood dysregulation/difficulty managing his anger and actions secondary to a TBI. He has been prescribed multiple psychotropic medications to try to regulate his severe behavioral concerns, agitation, and impulsivity . Recommendations for services to be provided by the Nursing Facility: Medical management, assistance with ADL's (activities of daily living), therapies for rehabilitation, support from SNF staff, referral to a neuropsychiatrist/neuropsychologist for further cognitive testing, referrals for community resources including DSPD services if applicable Recommendation for Specialized Services for mental illness treatment: [Resident 34] feels he might benefit from the support of mental health treatment services, although his memory impairment would likely limit the benefit he gets from said services. [Resident 34's] father stated the he feels pt would benefit 'from a good psychiatrist'. (continued on next page)

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F 0644 Level of Harm - Actual harm Residents Affected - Few	On 2/13/24 an interview was conducted with the local county mental health provider (CMHP). The CMHP stated that resident 34 was not referred over to their services until February 2024. 3. Resident 21 was admitted to the facility on [DATE] with diagnoses that included hepatic failure, generalized anxiety disorder, major depressive disorder, cirrhosis of liver, dementia, and history of traumatic brain injury. Resident 21's medical record was reviewed from 2/5/24 through 2/22/24. Resident 21's Level II PASRR dated 5/24/23 was reviewed. The Level II evaluator documented that resident 21 presented to a local emergency roiagnom on [DATE] secondary to increasing depression/anxiety with suicidal ideation. The Level II evaluator documented the resident 21 reported being hospitalized on multiple occasions in the past d/t (due to) severe depression and suicidal ideations. He endorsed symptoms including depressed mood, anhedonia, loss of energy and motivation, sadness, isolation and withdrawal from others, feelings of worthlessness and hopelessness, loss of appetite, impaired sleep/concentration, thoughts of being better off dead, and recurring SI (suicidal ideations). He endorsed problems with excessive anxiety and worry about many things, inability to control feelings of worry, restlessness/tension, trouble sleeping, and difficulty concentrating when anxious. The evaluator for the Level II PASRR documented the following: Diagnostic Formulation: [Resident 21] appears to have experienced recurring symptoms of both depression and anxiety which have contributed to significant disruption and distress in his life, and which have required treatment with psychotropic medications for years. He was also involved in outpatient and inpatient treatment d/t (due to) the severity of his symptoms. He has a long history of alcohol use and used alcohol as a way to cope with his psychiatric symptoms. Recommendations for services to be provided by the Nursing Facility: Medical management, assistance with ADL's, therapies for rehabilitation, support from SNF staff Recommendation for Specialized Services for mental illness treatment: Pt would like a referral for mental health services (counseling, psychotropic medication management). Resident 21's care plans were reviewed and revealed the following: a. On 5/15/23, a hospice care plan was developed which documented, Makes statements that he wishes there is something that would speed up the process of dying but he would like to make amends with people from his past . Pt denies wanting to hurt himself or having any kind of plan. Pt. endorses that he is trying to cope and process information and having fleeting thoughts, but nothing related to self harm. b. On 8/23/23, a level II care plan was developed. One of the interventions listed was Refer to Mental Health Services As needed . Pt would like a referral for mental health services (counseling, psychotropic medication management .) (continued on next page)

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F 0644 Level of Harm - Actual harm Residents Affected - Few	c. On 12/5/23, a suicidal ideations care plan was developed. One of the interventions listed was Obtain/provide for Psych/Behavioral Health consult. Resident 21's progress notes indicated that on 1/23/24, resident 21 had been referred over to the local county mental health provider for counseling and medication management. No evidence could be found to indicate resident 21 had been referred over for mental health services between admission in May 2023 until January 2024.

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38031 Based on interview and record review it was determined, for 1 out of 40 sampled residents, that the facility did not ensure that the comprehensive care plan was prepared by the interdisciplinary team that included the attending physician, a registered nurse, a nurse aide, a member of the food and nutrition services, the resident or representative, and any other appropriate staff as determined by the resident's need; and that the plan was reviewed and revised by the Interdisciplinary team (IDT) after each assessment including quarterly review assessments. Specifically, nursing staff were not present at the resident's quarterly care conference. Resident identifier: 4. Findings included: Resident 4 was admitted to the facility on [DATE] with diagnoses which included mononeuropathy, chronic respiratory failure, type II diabetes mellitus, morbid obesity, chronic obstructive pulmonary disease, non-pressure ulcer of left calf, schizoaffective disorder, epilepsy, hypothyroidism, peripheral vascular disease, varicose veins, hypertension, bilateral osteoarthritis of hip, intervertebral disc disorder, edema, chronic pain syndrome, tremor, overactive bladder, hyperlipidemia, viral hepatitis C, insomnia, sleep apnea, post traumatic stress disorder, anxiety disorder, bipolar disorder, borderline personality disorder, and major depressive disorder. On 2/6/24 at 10:50 AM, an interview was conducted with resident 4. Resident 4 stated she had an IDT meeting the other day and only the Resident Advocate (RA), Activities, and therapy were present. Resident 4 stated that she thought the Administrator (ADM), Director of Nursing (DON), and Human Resource (HR) were supposed to be there. On 2/1/24, a quarterly care conference was conducted. The report documented that resident 4 attended the conference The report documented the staff members who participated in the care development were Physician Extenders (NP, PA), Licensed Nurse, Certified Nurse Assistant, Dietary Manager, Social Services, Activities, and Skilled Rehab. The report documented under Mood/Behavior Management, Resident states she is unhappy and feels emotionally overwhelmed. She wants to continue to speak with her therapist through [local behavioral health provider]. She has her therapist's phone number. The report documented under Activities and Daily Routine Preferences declines invitation to activities and prefers to do her own thing. [Resident 4] is our Resident Council President and enjoys helping others, visiting and being outdoors. We will continue to offer encouragement and support. The report documented under Interdisciplinary Team Member Attendees that the RA, Activities Director (AD) and the Director of Therapy Services (DOT) were present. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow Brook Rehabilitation and Nursing	433 East 2700 South Salt Lake City, UT 84115

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/20/24 at 10:00 AM, an interview was conducted with the DON. The DON stated that the staff that attended the IDT Care Conference meetings were herself, the RA, AD, DOT. The DON stated that they tried to have 3 departments present with the social services and DON as the primary attendees. The DON stated that ADM sometimes attended but not all the time. The DON stated that she did not attend resident 4's care conference on 2/1/24 because she was late, and no one from nursing attended in her absence. The DON stated that if she was not able to attend they should ask another nurse such as the Minimum Data Set (MDS) Coordinator or one of the experienced nurses for their feedback. The DON stated that someone from nursing should be present to discuss cares and medication. The DON stated that they do not have a process or policy that they follow for the IDT meetings. On 2/20/24 at 10:12 AM, an interview was conducted with the RA. The RA stated that she attended the resident IDT care conference meetings. The RA stated that the meetings were attended by herself, the DON, Activities, dietary, and resident and/or family, HR, and therapy. The RA stated that if the DON was not available she was not sure what to do. The RA stated that if the DON was not present then one of her nurses should be there in her place. I don't think we can not have nursing represented. The RA stated that she documented the 2/1/24 care conference for resident 4. The RA stated that on resident 4's quarterly care conference on 2/1/24 she indicated in section 2 that the Physician Extenders (NP, PA), Licensed Nurse, Certified Nurse Assistant, Dietary Manager, Social Services, Activities, Skilled Rehab were checked off. The RA stated that she was told by the corporate Licensed Clinical Social Worker (LCSW) to check these boxes. The RA stated that in section 4 she puts who actually attended the care conference and it did not reflect the checked departments in section 2. The RA stated that on 2/1/24 the people in attendance for resident 4's care conference were the RA, Activities, and Director of Activities. The RA stated that no one from nursing was present.

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38031 Based on interview and record review it was determined, for 1 of 40 sampled residents, that the facility did not ensure that the discharge needs of the resident was identified and resulted in the development of a discharge plan for the resident; that regular re-evaluation to identify changes that required modification to the discharge plan was completed; and referrals to local agencies for the purpose of returning to the community were documented. Specifically, the resident desired to return to the community through the New Choice Waiver (NCW) program and the facility did not submit the required paperwork. Resident identifier: 4. Findings included: Resident 4 was admitted to the facility on [DATE] with diagnoses which included mononeuropathy, chronic respiratory failure, type II diabetes mellitus, morbid obesity, chronic obstructive pulmonary disease, non-pressure ulcer of left calf, schizoaffective disorder, epilepsy, hypothyroidism, peripheral vascular disease, varicose veins, hypertension, bilateral osteoarthritis of hip, intervertebral disc disorder, edema, chronic pain syndrome, tremor, overactive bladder, hyperlipidemia, viral hepatitis C, insomnia, sleep apnea, post traumatic stress disorder, anxiety disorder, bipolar disorder, borderline personality disorder, and major depressive disorder. On 2/6/24 at 10:46 AM, an interview was conducted with resident 4. Resident 4 stated that she wanted to discharge with NCW, but the facility did not submit the paperwork and she was denied. Resident 4 stated she asked the Resident Advocate (RA) for a new application and she said she would lay it on her bed, this was on the previous Friday. Resident 4 stated that on Monday she asked again and it still was not given to her. On 10/14/23, resident 4's Annual Minimum Data Set (MDS) assessment documented that the Brief Interview for Mental Status score was 15, which would indicate that the resident was cognitively intact. Resident 4's progress notes revealed the following: a. On 11/2/23 at 11:21 AM, the Social Service Note documented, New Choice Waiver requested additional paperwork for processing. A new H&P [history and physical] might need to be done by facility Dr [doctor], waiting to her back from NCW. Paperwork was submitted. b. On 2/12/24 at 3:35 PM, the Social Service Note documented, Resident would like to apply for New Choices Waiver. Application submitted with supporting documents (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/12/24 at 11:12 AM, an interview was conducted with the RA. The RA stated that she started at the facility on 12/19/23. The RA stated that the previous social worker handled all the NCW applications but she was going to be taking on that responsibility now. The RA stated that she was not sure of the application process for the NCW and she would find out more from the Corporate Social Service Worker (CSSW). The RA stated that she was not exactly sure who handled the NCW application prior to her as the facility did not have a SSW for awhile and there was no one here when she arrived. The RA stated that a couple of the residents had asked about their NCW status. The RA stated that the CSSW had just showed her how to access the NCW login. The RA stated that resident 4's application was returned and because it had been so long it needed to be re-submitted again. The RA stated that resident 4 had stated that she wanted to fill out the paperwork and have the facility fax it back to them. The RA stated that she did not know how the previous social worker was tracking the NCW applications prior to her. On 2/13/24 at 11:31 AM, a follow-up interview was conducted with the RA. The RA stated that resident 4's NCW application was submitted on 11/22/23 and the NCW program had requested additional information. The RA stated that on 12/22/23 the application was closed because the facility did not submit the additional information that was requested. The RA stated that she just barely got login access to the NCW. The RA stated that the login page did not reflect where the residents were in the application process. The RA stated that the website would say accepted but that only meant that the application was accepted and not that they had been accepted to the program.

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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** 38031 Based on observation, interview and record review, the facility did not provide the appropriate treatment and services to 5 of 40 sampled residents to maintain or improve his or her ability to carry out the activities of daily living. Specifically, multiple residents did not receive showers as desired or scheduled. Resident identifiers: 7, 8, 28, 31, and 34. Findings include: 1. Resident 7 was admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease, morbid obesity, alcoholic cirrhosis, hepatic failure, type II diabetes mellitus with polyneuropathy, portal hypertension, narcolepsy, major depressive disorder, obstructive sleep apnea, personality disorder, bipolar II disorder, alcoholic dependence, restless leg syndrome, male erectile dysfunction, hypertension, heart failure, anxiety disorder, hyperlipidemia, hyperaldosteronism, and osteoarthritis. On 2/5/24 at 10:21 AM, an interview was conducted with resident 7. Resident 7 stated that his scheduled shower days were Wednesday and Saturday. Resident 7 stated that the last month they had been following the schedule, but prior to that he was not provided showers. Resident 7 stated that he needed assistance with washing his genitals and back and needed his oxygen while showering. On 2/16/24, the Quarterly Minimum Data Set (MDS) assessment documented a Brief Interview for Mental Status (BIMS) score of 15, which would indicate that resident 7 was cognitively intact. The assessment documented that resident 7 required substantial maximal assistance for bathing and the helper did more than half the effort. On 2/20/24, resident 7's bathing tasks documented the bathing schedule was Wednesday and Saturday morning, and the last 30 days documented no showers were provided. On 12/6/23, resident 7's skin check/shower sheet documented that a shower was provided. No other shower sheets were noted. Resident 7's progress notes revealed the following: a. On 9/20/23 at 1:58 PM, the admission note documented, refused shower from hospice. He said he will do it tomorrow. poor hygiene noted. b. On 9/21/23 at 2:57 PM, the Nurses Note documented, He was assisted in the shower by hospice cna today. He refused shower yesterday. and he got upset when the nurse asked him to shower today. After the shower today, he refused to wear clean pants. He still wants to wear dirty pants. hospice nurse notified. c. On 9/21/23 at 5:00 PM, the Admission: 72 Hour Charting note documented, required 1 person extensive with shower, dressing. pull up use for incontinent of bowel. refused to change his pants even he has stool on after the shower. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. On 11/22/23 at 2:14 PM, the Nurses Note documented, RNC [regional nurse consultant] and Administrator went to speak with this resident regarding his care concerns. resident expressed he does not want 2 staff for his cares including showers and housekeeping to clean. He often refuses when attempts are made to clean his room and it has a foul odor and belongings everywhere which he will not allow to be cleaned up. He did report that he was showered yesterday. e. On 11/29/23 at 5:11 AM, the Nurses Note documented, Resident came out of his room demanding a shower, although he was not on the list for showers. Resident is to shower on Saturdays. Resident proceeded to yell at staff and scratched a CNA [certified nurse assistant]. Nurse informed the DON [Director of Nursing] and was instructed to call 911 for a police report. Nurse encouraged resident to be polite, respectful and patient. Resident continued to yell and argue with the staff. Police came to facility and completed a police report. f. On 12/10/23 at 1:18 AM, the Nurses Note documented, no issues with behaviors although patient claims to have asked for a shower and didn't receive one. g. On 12/10/23 at 11:47 AM, the Nurses Note documented, Resident has been calm and cooperative with cares. Took meds as prescribed minus lactulose. Resident still looking for armodafinil prescription that hasn't been filled. He claims he wasn't showered yesterday, nurse asked CNAs to please accommodate him today. h. On 1/31/24 at 10:47 AM, the Social Service Note documented, He was excited to be having pizza for dinner and then have a shower. He states he has no other concerns at this time. i. On 2/1/24 at 3:16 PM, the Nurses Note documented, Patient has not been abusive to this nurse or residents but earlier he was demanding to have a shower when he refused his shower yesterday, He kept telling his aid that he was busy. j. On 2/1/24 at 3:23 PM, the Nurses Note documented, When the patient was demanding a shower the aid explained to him that it was not his shower day and that it was 12 oclock and lunch was being served and he needed to get the lunch trays out. the resident started yelling and said that he is a priority patient, and needed a shower. The patient went to his room. The aid that tried to shower him yesterday said that he would try and get him in the shower today. On 9/18/23, resident 7 had a care plan initiated for had a Activities of Daily Living (ADL) self-care performance deficit. Interventions identified included Cares with Pairs: Assist of 2 with cares when in room related to behaviors; adjust ADL assistance per level of need at time of care; and required limited/ partial/ moderate assist of 2 due to behaviors for bathing/showering; On 2/8/24 at 10:18 AM, an interview was conducted with the CNA Coordinator (CNAC). The CNAC stated that the shower sheet was posted in a binder so that the aides could see who was scheduled for a shower that day. The CNAC stated that they were struggling with showers being completed due to staff turn over. The CNAC stated that the shower sheet should be uploaded into the residents' electronic medical records. The CNAC stated that if a resident wanted more showers they were allowed, but first they would complete that days scheduled showers. The CNAC stated that if a resident refused a shower the aides were to fill out the refusal sheet and take it to the nurse to sign. The CNAC stated that resident 7 needed 2 staff to provide cares for moody and aggressive behaviors. The CNAC stated that resident 7 needed assistance with showers. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/20/24 at 1:06 PM, an interview was conducted with Nursing Assistant (NA) 1. NA 1 stated that resident 7 required a two person assist for transferring and a one person assist for showers. NA 1 stated that they documented showers in the shower sheet and in the electronic medical records. On 2/20/24 at 1:11 PM, and interview was conducted with NA 2. NA 2 stated that they documented the showers on the shower sheet and any refusals. On 2/20/24 at 1:16 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that she could not locate any shower sheets for resident 7. 2. Resident 31 was admitted to the facility on [DATE] with diagnoses which included hemiplegia and hemiparesis following a cerebral infarction, type II diabetes mellitus, asthma, morbid obesity, generalized anxiety disorder, major depressive disorder, insomnia, hypertension, pseudobulbar affect, hyperlipidemia, nondisplaced fracture of proximal phalanx of left great toe, and chondromalacia left knee. On 2/5/24 at 1:45 PM, an interview was conducted with resident 31. Resident 31 stated that she needed stand by assist for showers due to her stroke. Resident 31 stated that she was able to transfer herself but need assistance with washing her feet and and lower legs. Resident 31 stated she would ask for a shower and sometimes it never gets done. Resident 31 stated that her showers were supposed to be on Monday, Wednesday, and Friday. On 2/7/24 at 9:56 AM, a follow-up interview was conducted with resident 31. Resident 31 stated she wanted to shower yesterday, but management said that there was no hot water. Resident 31 stated she liked to shower daily. Resident 31 stated that the other day she wanted to shower, but the aide told her it was not her day to shower. Resident 31 stated that she had to have a shower today because she had an accident this morning. On 6/28/23, resident 31's Admission MDS assessment documented a one person physical assist with supervision for personal hygiene. The assessment documented that resident 31 required supervision with bathing and set up assistance. On 9/28/23, the Quarterly MDS assessment documented a BIMS score of 14, which would indicate that resident 31 was cognitively intact. The assessment documented that resident 7 required substantial maximal assistance for bathing and the helper did more than half the effort. On 1/31/24, resident 31 had an order initiated to shower two times a week on Wednesday and Saturday in the evening. On 2/8/24, resident 31's bathing tasks documented the bathing schedule was Wednesday and Saturday in the evening. The task stated must assist at all times in shower and that resident 31 was a high risk for falls. Resident 31's bathing task for the last 30 days documented that the resident received a shower on 1/27/24 at 3:13 PM. Resident 31's skin check/shower sheet documented that an assessment was completed on 9/24/23, 12/11/23, 12/19/23, and 1/3/24. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	It should be noted that per the skin check/shower sheet and bathing task resident 31 was provided 2 showers in December 2023 and 2 showers in January 2023. On 7/11/23, resident 31 had a care plan initiated for had an ADL self-care performance deficit related to hemiplegia and hemiparesis affecting the left non-dominant side. Interventions identified included to adjust the ADL assistance per the level of need at the time of care and that resident 31 required a one person partial to moderate assistance for bathing or showering. On 2/8/24 at 11:52 AM, a follow-up interview was conducted with the CNAC. The CNAC stated that resident 31 showers, I know we shower her. I don't know why it isn't documented. The CNAC stated that resident 31 needed a one person standby assist for showers. The CNAC stated that she told the aides to go back and recall who was given a shower the previous week and then go and document it. The CNAC stated that the skin check was completed when a shower was provided, but confirmed that the skin check sheet did not document anywhere that a shower or bed bath had been provided. On 2/8/24 at 12:06 PM, an interview was conducted with the DON. The DON stated that she had been at the facility for 3 weeks. The DON stated that the shower schedules were two times a week. The DON stated that if a resident refused a shower then it was documented and given to the charge nurse. The DON stated that refusals were documented on a sheet with the resident name and the nurse had to sign it. The DON stated that if the aides could not give the shower then the nurse should attempt to do it. The DON stated that if a resident requested more showers than the twice weekly schedule they would accommodate them. The DON stated that they would fit those extra shower requests into the schedule but sometimes it did not happen until the following day. The DON stated that those extra shower requests would have to wait until the scheduled showers were completed first. The DON stated that the aides had been instructed to document showers in the electronic medical records under tasks. The DON stated that the facility did not have a designated shower aide. The DON stated that she would expect to see at least 8 plus showers each month for a twice weekly and as needed shower schedule. 22992 3. Resident 34 was admitted on [DATE] and readmitted on [DATE] with diagnoses that included moderate protein calorie malnutrition, intellectual disabilities, chronic pain, scoliosis, major depressive disorder, anxiety disorder, impulse control disorder, mood disorder, and intracranial injury. On 2/5/24 at 10:09 AM, an interview was conducted with resident 34. Resident 34 stated that his preference was to shower every day, but that he was not being assisted with showers every day. Resident 34 stated that it had been two weeks since his last shower. Resident 34 stated that he had been asking for showers but that I just gave up asking because they aren't helping. The resident was observed to have an odor of stale urine at the time of the interview. Resident 34's medical record was reviewed from 2/5/24 through 2/22/24. Resident 34's Admission Minimum Data Set (MDS) assessment dated [DATE] documented that resident 34 could not shower independently, but required partial/moderate assistance of staff for showers. A care plan dated 11/10/23 documented that resident 34 requires substantial/maximum assistance of 1 for showering. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/20/24, the resident's history of showers over the previous 30 days was reviewed. Only one shower had been documented in the previous 30 days, on 1/24/24. On 2/8/24 at 10:18 AM, an interview was conducted with the Certified Nursing Assistant Coordinator (CNAC). The CNAC stated that there were shower sheets for resident because there was a lot of paper charting. The CNAC stated that staff used showers for resident 34 as a de-escalation technique. The CNAC stated that if a resident wants a shower every day, they have to wait to make sure the scheduled showers were completed first. No shower sheets could be located for resident 34. On 2/20/24 at 11:35 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that resident 34 received a shower on 2/19/24, and that staff were supposed to be documenting resident showers in the electronic health record. The DON stated that there was also a shower binder located at the nurses station, and that staff often documented showers in the shower binder instead of the electronic health record. 4. Resident 28 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included dementia, subarachnoid hemorrhage, muscle weakness, and generalized anxiety disorder. Resident 28's medical record was reviewed from 2/5/24 through 2/22/24. Resident 28's admission MDS assessment dated [DATE] indicated that resident 28 required physical assistance from one staff member to bathe. Resident 28's care plan dated 7/19/23 documented that the resident had an Activities of Daily Living (ADL) self-care performance deficit related to activity intolerance, confusion, dementia and impaired balance. The ADL care plan indicated that resident 28 required substantial/maximum assist of 1 staff member for bathing. On 2/5/24, an observation was made of resident 28. Resident 28's hair was observed to be uncombed and greasy. On 2/8/24, the resident's history of showers over the previous 30 days was reviewed. No showers had been documented in the previous 30 days. Resident 28's skin sheets and shower refusals were reviewed. Only three skin sheets were located for resident 28, dated 12/8/23, 12/11/23 and 1/8/24. Only one shower refusal for resident 28 could be located and was dated 12/14/23. On 2/8/24 at 11:53 AM, an interview was conducted with the CNAC. The CNAC stated that resident 28 required total assistance for showering. The CNAC stated that skin checks were completed when a resident received a shower, so if a skin check was done, a shower was done. When asked about the missing documentation, the CNAC stated that I just tell the staff to go in and document their showers from the previous week if they aren't there. 5. Resident 8 was readmitted to the facility on [DATE] with diagnoses that included diabetes, dementia, Parkinson's disease, and schizoaffective disorder. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/5/24 at 11:13 AM, an interview was conducted with resident 8. Resident 8 stated that the facility used to schedule three showers a week for residents, but the schedule was changed, and now residents were only scheduled for two showers a week. Resident 8 stated she would like showers three times a week. Resident 8 stated that she was not receiving the scheduled showers twice a week. Resident 8's hair was observed to be greasy all over, and matted in the back. Resident 8's medical record was reviewed from 2/5/24 through 2/22/24. Resident 8's care plan was reviewed. A care plan dated 7/11/19 indicated that resident required the supervision of one staff member for showers due to her physical limitations such as weakness, poor coordination and poor balance. On 2/8/24, the resident's history of showers over the previous 30 days was reviewed. Only two showers had been documented as occurring in the previous 30 days.

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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** 47432 Based on observation, interview, and record review, it was determined that for 2 of 40 sampled residents, that the facility did not provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. Specifically, the facility did not provide or maintain documentation of one on one activities for residents that had care plans for one on one activities and did not provide activities for residents on weekends. Resident Identifiers: 21 and 22. Findings include: 1. Resident 21 was admitted on [DATE] with diagnoses including unspecified cirrhosis of liver, generalized anxiety disorder, unspecified dementia moderate without behavioral disturbance psychotic disturbance mood disturbance and anxiety, personal history of traumatic brain injury, and major depressive disorder recurrent moderate. On 2/6/24 at 9:20 AM, an interview was conducted with Resident 21. Resident 21 stated that he was isolated and that staff do not provide him with activities. On 2/13/24, Resident 21's medical record was reviewed. Resident 21's most recent Brief Interview for Mental Status (BIMS) score was a 10, indicating a moderate cognitive impairment. On 8/16/23 at 12:53 PM, an Activity Interview for Daily and Activity Preferences assessment was completed. The answer not assessed was selected for all of the answers. No other Activity Interview for Daily and Activity Preferences assessments had been completed. There was a notification at the top of the resident's assessment tab that stated, ACT: ACTIVITY INTERVIEW FOR DAILY AND ACTIVITY PREFERENCES (3. 0) 89 DAYS OVERDUE - 11/16/2023). A care plan dated 6/9/23 revealed a focus of, [Resident 21] exhibits impaired activity patterns manifested by: impaired mobility, little interest/pleasure in doing things (D0200/D0500), poor health/pain limits activity involvement, need for reminders and assistance to/from activities, mood diagnosis, cognitive impairment. The goal documented for this care area was, Will participate in independent leisure activities including stated interest of tv/movies, music, reading, etc. daily x 90 days. Will state or demonstrate an increase in interest/pleasure during activity involvement through next review. Will be oriented to make daily decisions regarding leisure participation x 90 days. Will accept at least 1 1: visit OR attend 1 social group per week for social engagement/leisure involvement x 90 days. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The interventions for this care area were documented as, Monitor for satisfaction with leisure choices. Please post the calendar in room. Supply with independent leisure materials PRN [as needed]. Support independent leisure choices. Invite and/or assist to/from group activities. Help ensure proper lighting & sufficient space for activities both in and out of room. Encourage and support the continuation of life roles. Provide adaptation to activities PRN: Cognitive: short interventions Physical: low energy programming Please support family/friend involvement & need for privacy during visits. Use validation to help express my feelings appropriately. Provide assistance with orientation and decision making PRN. Provide 1:1 visit prn. On 2/14/24 at 12:23 PM, the Activity Director's one on one and group social engagement and leisure involvement documentation was reviewed. For the week of December 26th through December 29th, there was nothing documented for Resident 21. For the week of January 8th through January 12th, there was nothing documented for Resident 21. For the week of January 15th through January 19th, there was nothing documented for Resident 21. For the week of February 5th through February 9th, there was nothing documented for Resident 21. 2. Resident 22 was originally admitted on [DATE] and readmitted on [DATE] with diagnoses including schizophrenia unspecified, mild protein-calorie malnutrition, generalized anxiety disorder, major depressive disorder recurrent unspecified, cognitive communication deficit, and mild cognitive impairment of uncertain or unknown etiology. On 2/13/24, Resident 22's medical record was reviewed. Resident 22's most recent Brief Interview for Mental Status (BIMS) score was an 8, indicating a moderate cognitive impairment. A care plan dated 4/5/21, revised 8/29/23 revealed a focus of, [Resident 22} exhibits impaired activity patterns manifested by: impaired mobility, need for adaptive equipment, sensory problems, little interest/pleasure in doing things (D0200/D0500), poor health/pain limits activity involvement, need for reminders and assistance to/from activities, mood diagnosis, cognitive impairment, bed bound. The goal documented for this care area was,[Resident 22] will accept at least 1 1:1 visit per week for social engagement/leisure involvement x 90 days. [Resident 22] will state or demonstrate an increase in interest/pleasure during activities/1:1's weekly x 90 days. Will be oriented to make daily decisions regarding leisure participation x 90 days. The interventions for this care area were documented as, Monitor for satisfaction with leisure choices. Please post the calendar in room. Supply with independent leisure materials PRN. Support independent leisure choices. Invite and/or assist to/from group activities. Help ensure proper lighting & sufficient space for activities both in and out of room. Encourage and support the continuation of life roles. Monitor for fall risk. Provide adaptation to activities PRN: Cognitive: short interventions Vision: sit close to speaker Hearing: increase volume and speak clearly Physical: low energy programming Please support family/friend involvement & need for privacy during visits. Provide 1:1 visits weekly. Use validation to help express my feelings appropriately. Provide assistance with orientation and decision making PRN. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/14/24 at 12:23 PM, The Activity Director's one one one and group social engagement and leisure involvement documentation was reviewed. For the week of December 26th through 29th, Resident 22 declined to participate in a one on one activity. For the week of January 8th through January 12th, there was nothing documented for Resident 22. For the week of January 15th through January 19th, there was nothing documented for Resident 22. For the week of February 5th through February 9th, there was nothing listed for Resident 22. On 2/14/24 at 11:27 AM an interview was conducted with the Activities Director (AD). The AD stated she had a list of residents that required one on one visits. The AD stated that residents were identified to be on the one on list if they do not leave their room, frequently isolate, do not socialize, or if the facility interdisciplinary team requested for a resident to be added to the list. The AD stated that there was no set schedule for her weekly one on one visits with residents, the visits with residents just occur for 15-30 minutes sometime during the week. The AD stated that when she goes from room to room to visit residents, she will invite them to attend Bingo in the dining room or ask if there was anything the resident needed. The AD stated that she was unable to locate any documentation of one on one visits prior to her hire date in November. The AD stated that unless a resident was admitted on the weekend, their initial activities assessment should be completed within 24 hours of admission to the facility. The AD stated that there would be no reason to not assess a new resident for their activities preferences. The AD stated that she was responsible for completing yearly and quarterly activity assessments for residents. On 2/14/24 at 11:47 AM, an additional interview was conducted with the AD. The AD stated that there was no one on one documentation for the week of January 1st 2024 due to her being sick with COVID. On 2/14/24 at 12:33 PM, the Recreational Therapy Consultant's (RTC) documentation of resident activity care plans was reviewed. Resident 21's intervention was documented as ,1:1 or group weekly for social engagement/leisure involvement. On 2/18/24 at 2:30 PM, an observation was made of the facility activity calendar for the month of February 2024. There were no activities listed for Saturdays or Sundays other than, at your leisure. In addition, an observation was made of five residents sitting at a table in the dining room doing nothing.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38031 Based on interview and record review it was determined, for 1 of 40 sampled residents, that the facility did not ensure that residents received proper treatment and care to maintain mobility and good foot health. Specifically, a resident was not provided care with trimming his toenails and appointments to podiatry services were not made. Resident identifier: 7. Findings included: Resident 7 was admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease, morbid obesity, alcoholic cirrhosis, hepatic failure, type II diabetes mellitus with polyneuropathy, portal hypertension, narcolepsy, major depressive disorder, obstructive sleep apnea, personality disorder, bipolar II disorder, alcoholic dependence, restless leg syndrome, male erectile dysfunction, hypertension, heart failure, anxiety disorder, hyperlipidemia, hyperaldosteronism, and osteoarthritis. On 2/5/24 at 10:21 AM, an interview was conducted with resident 7. Resident 7's toenails were observed to extend past the end of his toe. Resident 7 stated that the staff refused to cut his toenails and they needed to be cut by a podiatrist. Resident 7 stated that he had not seen a podiatrist since he had been at the facility. Resident 7 stated that he had asked the nurse to cut his nails and they said they could not. Resident 7 stated he was told that the facility did not have a podiatrist to provide services. On 2/16/24, the Quarterly Minimum Data Set (MDS) assessment documented a Brief Interview for Mental Status (BIMS) score of 15, which would indicate that resident 7 was cognitively intact. The assessment documented that resident 7 required substantial maximal assistance for bathing and the helper did more than half the effort. On 2/6/24, resident 7's medical records were reviewed. No documentation could be found to demonstrate that resident 7 had been provided podiatry services or foot care. On 9/18/23, resident 7 had a care plan initiated for had an Activities of Daily Living (ADL) self-care performance deficit. Interventions identified included Cares with Pairs: Assist of 2 with cares when in room related to behaviors; adjust ADL assistance per level of need at time of care; required limited/ partial/ moderate assist of 2 due to behaviors for bathing/showering; and required partial/ moderate assistance with putting on /taking off footwear. On 2/20/24 at 1:37 PM, an interview was conducted with Registered Nurse (RN) 3. RN 3 stated that the facility had a podiatrist, but she was not sure how often he came to the facility. RN 3 stated that the social worker would set up appointments with the podiatrist. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/20/24 01:44 PM, an interview was conducted with the Resident Advocate (RA). The RA stated that she would be making the podiatry appointments, but she had not scheduled any yet. The RA stated that the nurses could help with the toenails if the resident did not have problems with their feet. The RA stated that her plan was to check with the residents to see if they need an appointment. The RA stated that the podiatrist office asked her to compile a list so they could set up a time. The RA stated that prior to her arrival she did not know who the facility podiatrist was or who was seen by them. On 2/21/24 at 2:19 PM, a follow-up interview was conducted with the RA. The RA stated that she contacted the previous facility podiatrist. The RA stated that they did not call her back to inform her of their last visit date and who they provided services to.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** 38031 Based on observation, interview, and record review it was determined, for 10 out of 40 sampled residents, that the facility failed to ensure that the resident environment remained as free of accident hazards as was possible and each resident received adequate supervision and assistance devices to prevent accidents. Specifically, a resident was transported via the facility van and the wheelchair was not secured properly inside the vehicle which resulted in the resident falling backwards causing hyperextension of his neck. The resident was diagnosed with central cord syndrome and edema at the level of C6 and C7 of his cervical spine. Upon return to the facility the resident's cervical collar was removed by Certified Nursing Assistant(s) (CNA) during grooming and bathing cares. After the resident's shower, the CNAs attempted to transfer the resident to bed unsuccessfully and the resident was assisted to the floor. These identified deficient practices were found to have occurred at the Immediate Jeopardy (IJ) Level. Additionally, a resident sustained four falls in the facility with the last one resulting in a fractured hip; a resident tripped over the broken base of a structural column outside the facility and sustained a laceration requiring sutures; and a resident had an unsafe discharge to the community, was found wandering the streets and was subsequently placed on a medical hold in the hospital. These identified deficient practices were found to have occurred at a Harm Level. Lastly, two residents eloped from the facility; a resident struck another resident with a razor cutting them and was not monitored or restricted from further sharp objects after the incident; a resident was provided a germicidal cleaning wipe by another resident and used it to blow and clean their nose; and a resident was hit by the meal cart during delivery service of the meals. Resident identifiers: 3, 6, 19, 31, 34, 91, 92, 93, 94, and 96. NOTICE On [DATE] at 4:00 PM, an Immediate Jeopardy was identified when the facility failed to implement Centers for Medicare and Medicaid Services (CMS) recommended practices to identify hazard(s) and risk(s): evaluate and analyze the hazard(s) and risk(s); implement interventions to reduce hazard(s) and risk(s); and monitor for effectiveness and modify the interventions when necessary. Specifically, the facility failed to ensure that staff transporting residents and their equipment were trained on how to secure residents properly to prevent falls or injury; that residents with medical devices or fixtures surgically placed, or otherwise applied to, or adjacent to their person were reviewed to validate monitoring orders, care planning, and appropriate staff training were in place; and that resident's mobility and transfer status including type of transfers and number of staff to perform were assessed and care planned. Notice of the IJ was given verbally and in writing to the Chief Nursing Officer (CNO), Regional [NAME] President (RVP), Administrator (ADM), Administrator in Training (AIT), Director of Nursing (DON), and the Corporate Resource Nurse (CRN) and they were informed of the findings of IJ pertaining to F689 for resident 96. On [DATE], the Administrator provided the following revised abatement plan for the removal of the Immediate Jeopardy effective [DATE] at 11:59 PM. F689/F726: Free of Accident/Hazards & Competent Nursing Staff. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #96 is no longer a resident of this facility; therefore, an individualized plan of action is not possible. The Certified Nursing Assistant Coordinator's employment with the facility was self-terminated on [DATE]. The Director of Nursing who was at the facility in [DATE] is no longer an employee of this facility. Abatement Plan. Accident/Hazards Prevention The Director of Nursing/Designee to do an audit of all residents on [DATE] to identify residents with medical devices or fixtures surgically placed, or otherwise applied to, or adjacent to their person. Identified devices reviewed to validate monitoring orders, care planning, and appropriate staff training are in place. The Director of Rehab/Designee to complete an assessment of all resident's transfer status, including type of transfer and number of staff to perform safely. Care Plans Reviewed and Updated as indicated to reflect current needs. The Director of Nursing/Designee to provide training on safe transfers and accident/hazards prevention to Facility Nurses and Nursing Assistants on [DATE]. Training to include proper transfer techniques utilized in the facility, the prohibition of using towel transfers, and where to find information in the care plan regarding individualized requirements for transfers. This training will be validated by a post-test to validate understanding of the material and Physical Therapist to complete return demonstration of transfer techniques with staff. The Director of Nursing to provide training on [DATE] to all Facility Nurses and Nursing Assistants on the definition of a fall and what documentation must be completed when a fall occurs. This training will be validated by a post-test to validate understanding of the material. Transportation The Administrator reviewed all individuals who perform transport duties and validated they have received training including securement of wheelchairs, securement of ambulatory residents, and securement of equipment in the transport van. A return demonstration checklist will be completed with transportation staff prior to their next transport. Any future staff member(s) providing transport services are to receive this training prior to beginning transport duties. Existing drivers to receive refresher training annually and as needed. Staffing Training/Orientation The Chief Nursing Officer (CNO)/designee will provide education to the Inter-disciplinary team (IDT) on [DATE] about company policy on orientation and training to staff who provide direct patient care to residents of the facility and how to properly transfer residents. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Director of Nursing/Designee to review employees who have been hired in the past three months to verify orientation training has been completed on [DATE]. Any employee who does not have the orientation completed will meet with the Director of Nursing/Designee prior to the start of their next shift to create a plan to complete their training and review key interventions to keep residents safe. Agency The Director of Nursing/Designee to create a summary of this training and put this in the agency binder, to provide agency staff resources to prevent accident/hazards. Training Timeline All Staff will receive training by Director of Nursing/Designee prior to their next working shift. Monitoring The Director of Nursing/Designee to do interview with Charge Nurse(s) for each shift and review expectations for accident/hazards prevention and reporting until the IJ abatement is completed. The facility to review the 24-hour report in daily (M-F) stand-up meetings, and as needed to validate that any accidents/hazards were followed up with in accordance with professional accepted standards of care. This audit to continue ongoing. On [DATE], while completing the recertification survey, surveyors conducted an onsite revisit to verify that the Immediate Jeopardy had been removed. The surveyors determined that the Immediate Jeopardy was removed as alleged on [DATE]. Findings included: IMMEDIATE JEOPARDY 1. Resident 96 was admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses which included central cord syndrome at C6, acute respiratory failure, type II diabetes mellitus, polyneuropathy, hepatic failure, pneumonia, lack of coordination, reduced mobility, muscle weakness, dysphagia, contusion of right wrist, cervicalgia, Parkinson's Disease, dementia, pressure ulcer of sacrum, atrial fibrillation, chronic kidney disease, hypertension and hyperlipidemia. On [DATE], resident 96's Admission Assessment documented that resident 96 required extensive assistance for bed mobility, transfers, dressing, toilet use, and personal hygiene. The assessment documented that resident 96 was alert and oriented to person and situation, had poor memory and could not recall place and time. Resident 96 was assessed as requiring extensive assistance for locomotion on and off the unit and a wheelchair was used as a mobility device. On [DATE], the Morse fall scale documented a score of 65, which would indicate high risk for falls. The assessment documented that resident 96 had fallen before. The assessment documented that resident 96's gait was weak and he overestimated or forgets his limits with his ability to ambulate safely. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE], resident 96's Minimum Data Set (MDS) Assessment documented that resident 96 required a one-person extensive assist for bed mobility, transfers, and toilet use. The assessment documented a Brief Interview for Mental Status (BIMS) score of 3, which would indicate a severe cognitive impairment. On [DATE] at 4:40 PM, an order for C-Collar to be worn AT ALL TIMES, please check to make sure that collar is on resident was initiated for resident 96. The order indicated that it was indefinite with no end date. The [DATE] Treatment Administration Record (TAR) revealed the order for the C-collar to be worn AT ALL TIMES. The order was discontinued on [DATE]. The November and [DATE] TAR did not have any orders monitoring for the c-collar. Resident 96's progress notes and incident reports revealed the following: a. On [DATE] at 1:53 PM, the Incident Note documented, I received a phone call today from the CNA [Certified Nurse Assistant] Coordinator, who was providing transportation for this resident to an appointment at the [name of hospital omitted], the CNA Coordinator stated that when coming to a stop, the wheelchair became dislodged and tipped backwards, CNA Coordinator immediately stopped vehicle and called for assistance from EMS [emergency medical services], the Administrator and I arrived at the scene at about 14:20 [1:20 PM], the resident was complaining of head and neck pain, EMS was treating him, the police officer and the EMS workers all stated that the resident was still strapped into the wheelchair with the seatbelts (EMS reported that there was tension in the belts still), resident was transferred via EMS to [local area hospital] for evaluation, provider notified, family notified. On [DATE] at 1:53 PM, the incident report further documented that resident 96 was very agitated, clutching his head while leaned over, unable to provide description of what occurred (resident has dementia). Resident 96 Pain Assessment in Advanced Dementia (PAINAD) score was assessed as a 9, which would indicate severe pain. The report documented that resident 96 required extensive assistance with transfers. The report further documented, resident possibly secured improperly, improper instruction given to CNA Coordinator about how to strap patient down properly in wheelchair. b. On [DATE] at 6:16 PM, the Incident Note documented, I have called [local hospital] for update: no fractures, some weakness on left side, they will do MRI [Magnetic Resonance Imaging] to rule out any damage to brain, they will call and update me when information is available. I called family of resident to update them on situation. They will continue to await any call on an update on his condition. c. On [DATE] at 10:23 PM, the Nurses Note documented, Hospital called facility and stating they are going to admit him and continue to monitor overnight. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	d. On [DATE] at 1:04 PM, the Nurses Note documented, Central cord syndrome found on MRI, resident currently in ICU [Intensive Care Unit] r/t [related to] he was having a difficult time maintaining his blood pressure, he is currently not on any supplemental blood pressure medication and the nurse stated that he will soon be ready to transfer either to a step down unit or back to facility, I gave them my name and phone number as a contact for [resident 96], will call again tomorrow for a new update. e. On [DATE] at 4:26 PM, the MDS Note documented, [Resident 96] readmitted from hospital on [DATE] on Medicare part A services with dx [diagnosis] of central cord syndrome at C6 level. f. On [DATE] at 9:26 AM, the Incident Note documented, Investigation completed. Facility will be completing training on all drivers and 2 sets of trained eyes will verify proper strap placement on transports. Interventions put in place. MD [Medical Director] to follow up. g. On [DATE] at 8:44 AM, the Nurses Note documented, Resident had episode of syncope this morning, NP [Nurse Practitioner] orders vital signs to be taken BID [two times a day]. It should be noted that no other documentation could be found for the syncopal episode. h. On [DATE] at 5:37 AM, the Incident Note documented, Resident was up in chair in dining room for dinner, CNA noticed and reported to nurse that resident did not look well. VS [vital signs]: BP [blood pressure]:, d+[DATE], P [pulse]: 62, o2[oxygen saturation]: 74%, R [right] pupil enlarged, L [left] pupil smaller, A&O [alert and oriented] x1. CNA transferred resident to bed, Nurse administered oxygen at 3L [liters], and raised head of bed. Vitals taken every 10 min [minutes] until stable and o2 at 85%. Nurse informed MD and DON, per MD, transfer to hospital. EMT [Emergency Medical Technician] arrived at 1900 [7:00 PM] and transferred resident to [local hospital]. DON notified family. On [DATE] at 5:37 AM, the incident note further documented that the predisposing physiological factors were drowsy, hypotensive, recent change in condition, and weakness/fainted. i. On [DATE] at 11:13 AM, the Nurses Note documented, I spoke to nurse at [local hospital] today. Resident is on diltalazem (sic) drip, insulin drip. He is normo-tensive. Now on 13L high flow oxygen, lung sounds are diminished. No discharge date set yet. I informed provider and family. j. On [DATE] at 1:44 PM, the incident report documented, resident was about to slide out of his chair. so the nurse tried to help him up but he slid down more and more and the nurse assisted him to the floor and asked for more help to assist him back to the chair. no apparent injury, no head hitting. He denied of pain. The report documented that the therapy staff assisted the resident back to the chair and 4 staff members were needed for the transfer. k. On [DATE] at 9:37 AM, the Interdisciplinary Team (IDT) Event Review documented, IDT fall review: root cause is found to be this resident's change in condition after accident that resulted in central cord syndrome, intervention: new wheelchair is in process of being purchased, resident will also be moved to room [ROOM NUMBER] to be closer to nurse station, current wheelchair has been modified by physical therapy to help prevent further falls, all other least restrictive interventions in place, will continue with plan of care. Attendees: Administrator (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	DON MDS Nurse Office Manager l. On [DATE] at 10:00 AM, the IDT Event Review documented, Follow up [DATE] incident: [Resident 96] has been moved to room [ROOM NUMBER] for increased monitoring. Therapy is getting tilt-in-space wheelchair. m. On [DATE] at 3:20 PM, the Nurses Note documented, MD in to visit per MD if we don't already have a end date neck brace lets do end date to come off after 12 weeks x-ray cervical spine 2 view 1 week prior to that. n. On [DATE] at 5:14 PM, the Nurses Note documented, Resident had hair cut today, then shower this afternoon. Within minutes after laying him back down he stopped breathing. The nurses performed assessment on him, he had no pulse and was not breathing. DNR [Do Not Resuscitate]. Family notified, MD notified. On [DATE], the Hospital History & Physical documented the chief complaint as a fall. An MRI of the cervical spine documented the impression as Focal edema within the spinal cord at and below the level of the C6/C7 disc space which may be secondary to contusion from adjacent osteophytes at C6/C7. The MRI further documented, Diffuse edema within the paravertebral soft issue from the occiput through the craniocervical junction and a Small amount of fluid in the C6/C7 disc space. Findings could be secondary to hyperextension injury. The Medical Decision Making documented that the MRI revealed a central cord syndrome with cord edema at C,d+[DATE] level secondary to adjacent osteophytes. The resident was admitted to ICU so that the mean arterial pressure could be monitored and kept at greater than 85 millimeters of mercury (mmHg). The resident was transitioned from a hard collar into an Aspen collar. The assessment documented that the resident suffered a hyperextension injury of the C-spine when he toppled in his wheelchair in a transport vehicle, and this resulted in central cord syndrome involving C6/C7. On [DATE], the Hospital Discharge Summary documented that resident 96 was to follow-up with a neurosurgeon in four weeks with a repeat CT of the cervical spine. On [DATE], the Record of Death documented that resident 96 had expired. Resident 96's Care Plans revealed the following: a. A care area for central cord syndrome r/t trauma related to motor vehicle incident that was initiated on [DATE]. The interventions identified included: Discuss with resident/resident and family any concerns, fears, issues regarding diagnosis or treatments; Ensure that c-collar is in place every shift; Give medications as ordered. Monitor/document for side effects and effectiveness; and Physical Therapy (PT), Occupational Therapy (OT), Speech Therapy (ST) to evaluate and treat as ordered. b. A care area for Activities of Daily Living (ADL) selfcare performance deficit r/t Confusion, (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Dementia, Fatigue, Impaired balance, BUE [bilateral upper extremity] tremors, recent motor vehicle incident with injury to neck and right wrist, pain. The interventions identified included: Resident has a neck brace and right wrist restriction due to pain and injury, use caution and assist with ADLs; scheduled every 2 hour turning to keep resident off of his tailbone (coccyx); Adjust ADL assistance per level of need at time of care; The resident required substantial/maximum assistance of 1 staff for bathing/showering, bed mobility, dressing, personal hygiene, and toileting; The resident required substantial/maximum assistance of 1 staff for 1:1 dining assistance and the resident was at risk for choking and aspiration; The resident required substantial/maximum assistance of 2 staff for transfers; and PT/OT evaluation and treatment as per MD orders. On [DATE] at 1:50 PM, the facility investigation documented that the resident was involved in an accident while being transported in the facility van. The initial report documented that the resident fell back in the transport vehicle on his way to an appointment. The facility's final investigation documented that the resident outcome to the incident was a Central Cord Syndrome injury. At the time of injury, the resident reported some pain but was unable to state what happened in the van. The summary of interviews documented that Nurse Assistant (NA) 2 had reported that he had wheeled the resident out to the transport vehicle where the CNA Coordinator (CNAC) strapped the patient in with all four straps and seat belt. NA 2 stated that he had never done anything with transportation prior. The summary of interviews documented that the CNAC stated that when she came to a stop and looked back, she saw that the resident was no longer sitting upright. The CNAC stated that she came to a stop, turned on her hazards, exited the vehicle, and waved down help. The CNAC stated that she put down the ramp with the patient. The CNAC stated that she did not receive training on how to use the van prior to transporting resident 96. The investigation documented under the summary that the CNAC was scheduled to be trained to assist in covering for the normal transport driver. The day the CNAC was scheduled to be trained she was sent home due to having COVID. The Previous Transport Driver (PTD) confirmed that the CNAC had participated in a previous transport by watching and sitting at an appointment with a patient. The report documented that the CNAC had placed the safety straps on the wheelchair wheels and not the wheelchair frame. The report documented that they assumed that the patient pushed on the [NAME] in front of him and tipped backward as a result of the strap placement. The conclusion of the facility investigation documented that the incident was a result of improper placement of safety straps on the wheelchair wheels and not the wheelchair frames. The root cause identified was insufficient training in transportation. The facility provided a driving in-service on [DATE]. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 2:37 PM, an interview was conducted with the CNAC. The CNAC stated that she was the driver of the vehicle at the time of the accident with resident 96. The CNAC stated that she had only transported for the facility twice, and once with resident 96. The CNAC stated that she had not been given training on how to transport residents, had never ridden with another driver, and was not shown how to properly secure someone down inside the van. The CNAC stated that she secured resident 96's wheelchair wheels down with the straps and placed the seatbelt over resident 96. The CNAC stated that she thought she had secured resident 96 correctly. The CNAC stated that she placed the straps from the floor of the van and hooked them to the wheels of the wheelchair on both sides, four straps in total. The CNAC stated that she did not connect the straps to the frame of the wheelchair. The CNAC stated that she was told after the accident that this was not how it was supposed to be done. The CNAC stated that she checked the resident in the rearview mirror during the transport and talked to him. The CNAC stated that she had just made it to the freeway entrance when she looked back and noticed that resident 96 had fallen backwards. He was folded in half like a taco. The CNAC stated that she pulled over and stopped the vehicle. The CNAC stated that she found resident 96 folded up against the drop gate. The CNAC stated that before she let the drop gate down, she removed her hoodie and placed it under resident 96's neck to support it. The CNAC stated that resident 96's legs were positioned up towards his chest and torso, and his head was folded down towards his chest. The CNAC stated that as she lowered the gate, she placed her hoodie for support so his neck would not hyperextend. The CNAC stated that resident 96 was able to answer questions, and said his head hurt. The CNAC stated that resident 96 had a small scrap on the back right side of his head from contact with the drop gate. The CNAC stated that when EMS arrived, they moved resident 96 without placing a c-collar on the resident first. The CNAC stated that EMS undid the seatbelt, moved the chair to a seated position, and backed him out of the van. The CNAC stated that resident 96 began to convulse, and he had no history of a seizure disorder prior. The CNAC stated that the ADM and Previous Director of Nursing (PDON) arrived at the scene and started drilling her. The CNAC stated that she was suspended for abuse and returned to work 5 days later. The CNAC stated that the facility substantiated the allegation of abuse, and that the facility was at cause because she had never received proper training. The CNAC stated that the next day they started training everyone in the facility on how to transport someone. The CNAC stated that she refused to sign the in-service training log because the training was conducted during her suspension period. The CNAC stated that she was suspended on Sunday and the incident occurred on Friday. The CNAC stated that she worked remotely on Saturday and Sunday and then she was on suspension for a week. The CNAC stated that resident 96 had returned to the facility and she had told the PDON that she was uncomfortable working with resident 96 again. The CNAC stated that she did not want to lose her license. The CNAC stated that resident 96's family had come to the facility and said they were upset that she was still working at the facility. The CNAC stated that she did not mind training the staff on how to care for resident 96. The CNAC stated that she showed staff from a distance how to clean the c-collar, and how to safely transfer resident 96. The CNAC stated that for resident 96 they could not use a hoyer lift for transfers because this was contraindicated with a spinal cord injury. The CNAC stated that she did not participate in resident 96 care for quite some time after the incident. The CNAC stated she had noticed before resident 96 passed away he was unkept, his beard and nails were long. The CNAC stated that she clipped his nails and then asked the PDON if the hair school could give him a haircut. The CNAC stated that the PDON stated it was safe to remove the c-collar for care. The CNAC stated that she thought the resident was going to have his c-collar removed the following day at a scheduled doctor's appointment. It should be noted that the transportation schedule did not document that resident 96 was scheduled for any appointments on [DATE], which would have been the following day. The CNAC stated that she was never asked not to have contact with resident 96, that it was a personal preference. The CNAC stated that resident 96 passed away that day, and he was not on hospice and it was not expected. The CNAC stated that she assisted resident 96 during his hair cut. The CNAC stated that resident 96's c-collar was removed for the haircut, and she held his head still, with no sudden movements and no flexion or extension of the neck. The CNAC stated that NA 3 and NA 5 had assisted resident 96 with a shower. The CNAC stated that she believed resident 96's c-collar was removed for the shower under the direction of the PDON. The CNAC stated that NA 3 and NA 5 were both new aides that time. The CNAC stated that the PDON called her at approximately 5:15 PM, on the day that

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 8:38 AM, an interview was conducted with the DON. The DON stated that if a resident had a c-collar applied she would expect to see an order for it and monitoring. The DON stated that documentation of the monitoring could be in the TAR or in a progress note. The DON confirmed that the October TAR documented that the c-collar order was discontinued on [DATE]. The DON stated that she would interpret the nurse note on [DATE] as discontinue the c-collar in 12 weeks from [DATE]. On [DATE] at 2:12 PM, a follow-up interview was conducted with the DON. The DON stated that the order for the c-collar should not have been discontinued and the c-collar was to stay on at all times. The DON stated that the PDON stated that the c-collar had stayed on resident 96 up until his death. The DON stated that if you had a spinal injury, it might be necessary to have the c-collar at all times, and it would stabilize the neck. The DON stated that the provider should supervise any removal of the collar. The DON stated that if the c-collar was removed it would be possible to re-injury the injury you were trying to fix. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 2:22 PM, an interview was conducted with NA 3. NA 3 stated that she had provided care for resident 96. NA 3 stated that she was not sure why resident 96 wore a neck brace. NA 3 stated that she showered resident 96 one time with the assistance of the CNAC on the day that he passed away. The shower was provided in the communal shower room. NA 3 stated that the residents were doing their monthly haircuts and resident 96 had a haircut and his beard shaved. NA 3 stated that afterwards she informed the CNAC that it was resident 96's scheduled shower day. NA 3 stated that this was the first time she had provided resident 96 with a shower, and the CNAC said since resident 96 was already up she would assist NA 3 with the shower. NA 3 stated that they washed resident 96's hair, beard, chest, and feet. NA 3 stated that while they were performing the shower resident 96 was having a bowel movement. NA 3 stated that the CNAC told her that when resident 96 received a shower they took his c-collar off, and that the CNAC was the person who removed the collar. NA 3 stated that the CNAC was helping her with the shower by holding the shower head and rinsing resident 96 off. NA 3 stated that she was washing resident 96 while the CNAC was holding the shower head. NA 3 stated that she washed resident 96's chest and neck. NA 3 stated that resident 96 was sitting in a shower chair during the shower. NA 3 stated that they washed the front, sides and back of resident 96's neck. NA 3 stated that while the CNAC was holding the shower head she was guiding NA 3, saying that as long as she was washing the neck gently and the neck and spine were aligned it would be okay. NA 3 stated that they made sure that resident 96 was not moving around. NA 3 stated that NA 5, PDON and the CNAC were all present during resident 96's shower. NA 3 stated that she was training NA 5 and asked the CNAC how to shower resident 96. NA 3 stated that the CNAC had the PDON come assist with transferring resident 96 onto and then off the shower chair. NA 3 stated that once resident 96 was transferred only she, NA 5 and the CNAC were present. NA 3 stated that she did not recall if the PDON was present when they removed the neck collar. NA 3 stated that at that point in time she had only worked at the facility for ,d+[DATE] months, and she was training NA 5. NA 3 stated that NA 5 only observed during the shower. NA 3 stated that resident 96 wore his c-collar during the transfers and it was only removed during the shower. NA 3 stated that resident 96 was good at sitting up straight, and he was not leaning. NA 3 stated that no one was holding or stabilizing resident 96's head once the c-collar was removed, and the c-collar was off for approximately 20 minutes for the duration of the shower. NA 3 stated that the CNAC switched positions, and she held the shower head while the CNAC washed resident 96's genitals. NA 3 stated resident 96 did not have to shift positions to have his genitals cleaned as the shower chair had a hole in the seat. NA 3 stated that she asked the CNAC how to put the neck brace back on, and the CNAC placed the c-collar back on resident 96. NA 3 stated that the c-collar had two parts to it, a front and a back. NA 3 stated that the CNAC first placed the front on to make sure the neck was visible, and the sides were placed near his collar bones. NA 3 stated that the back piece had two Velcro tabs that strapped around to the front to make sure it stayed in place. NA 3 stated that she asked the CNAC how she knew the difference between the back and the front piece, and she told her that the back piece should be longer than the front. NA 3 stated that the c-collar was solid and did not have a whole in the front piece to visualize the neck. NA 3 stated that she could not tell the difference between the front and back piece, had never worked with a neck brace before, and wanted to know what to do if she came across it again. NA 3 stated that she did not confirm with the nurse prior to removing the neck brace. NA 3 stated that the CNAC said that they would just quickly give him a shower without it. NA 3 stated that after they reapplied the neck brace, they put a hospital gown on resident 96. NA 3 stated that the CNAC and PDON transferred resident 96 from the shower chair onto the wheelchair and the CNAC told her to put him back into bed. NA 3 stated that she and NA 5 took resident 96 back to his room. NA 3 stated that they tried to transfer resident 96 back to bed, but they could not physically do it. NA 3 stated that she and NA 5 attempted to do the same transfer method as the PDON and CNAC, [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** 46232 Based on observation, interview, and record review it was determined, for 3 of 40 sampled residents, that the facility did not ensure that a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. Specifically, a resident had moisture associated skin damage. This finding was cited at a harm level for resident 6. In addition, another resident sat in a soiled brief for an hour and toileting services were not provided to a resident for 3 hours. Resident Identifiers: 6, 17, and 28. Findings Included: HARM 1. Resident 6 was initially admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnoses that included schizophrenia, type 2 diabetes mellitus, major depressive disorder, generalized anxiety disorder, dementia, repeated falls, vitamin b12 deficiency, extrapyramidal and movement disorder, and overactive bladder. On 2/6/24 at 9:29 AM, an interview was conducted with resident 6. Resident 6 stated recently they were not given a brief change the entire night and there had been numerous times where they were left in a brief for a long time. Resident 6 stated sometimes they were left in a dirty brief for more hours than they appreciated. Resident 6 complained about the redness on their bottom. On 2/21/24 at 9:16 AM, an observation was made of Certified Nursing Assistant (CNA) 2 assisting resident 6 with a brief change. The CNA 2 was observed to ask resident 6 if they were wet and then proceed to check resident 6's brief. Resident 6's brief was removed and resident 6's buttocks area was observed to be erythematous with red dots of varying sizes present. The CNA 2 was observed to wipe resident 6 clean and then applied barrier ointment to resident 6's posterior. The CNA 2 stated they also tried to keep resident 6's diaper semi loose to prevent further skin irritation. On 12/27/23, a Quarterly Minimum Data Set (MDS) assessment documented resident 6's bowel and bladder function as incontinent. Resident 6 was also documented to have moisture associated skin damage (MASD) as a skin condition. Resident 6's care plan was reviewed and documented the following care areas associated with incontinence: a. A care plan focus area, initiated on 11/7/23, documented resident 6 was at risk for skin break related to incontinence and a history of MASD to peri-area. Documented intervention included but not limited to weekly skin checks. b. A care plan focus area, initiated on 11/20/23, documented resident 6 had an alteration in bowel and bladder elimination due to incontinence and it stated resident 6 required assistance with toileting care. Documented interventions included but not limited to changing resident 6's disposable brief every shift and during rounds as needed. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	c. A care plan focus area, initiated on 2/18/24 documented, resident 6 had MASD to their bottom related to incontinence. Documented interventions included but not limited to keeping the skin clean and dry and checking for incontinence frequently. Resident 6's physician orders were reviewed and documented the following orders in regard to resident 6's skin condition: a. An order with a start date of 1/8/24 stated as followed, Calmoseptine External Ointment 0.44-20.6 % (Menthol-Zinc Oxide). Apply to coccyx fissure topically every shift for MASD May D/C [discontinue] once resolved. This order was discontinued on 2/27/24. b. An order with a start date of 2/1/24 stated as followed, Nystatin External Powder 100000 UNIT/GM [gram] (Nystatin (Topical). Apply to under breast, groin topically every shift for yeast, redness. c. An order with a start date of 2/19/24 stated as followed, WOUND CARE - MASD breakdown to crack of buttocks Cleanse with wound cleanser and pat dry. Apply medihoney sheet (cut to fit) to wound bed and cover with silicone foam dressing. Change daily and as needed for soiling/dislodgement. On 11/21/23, a weekly skin review/assessment documented, Patient is incontinent of bowel and bladder. She does try and use the restroom but constantly has soiled briefs. She has slight redness in groin area, using Nystatin to help. She has no other skin breakdown. Skin warm, dry and intact. On 11/28/23, weekly skin review/assessment documented, Patient is incontinent of bowel and bladder. She does try and use the restroom but constantly has soiled briefs and needs assistance to get changed. She has slight redness in groin area, using Nystatin to help. She has no other skin breakdown. Skin clear, warm, dry and intact. Will continue to monitor. On 12/31/23, a weekly skin review/assessment documented, Resident continues to have some redness and applied nystatin to groin, [NAME] and buttock and encouraged resident to take scheduled showers. On 1/7/24, a weekly skin review/assessment documented, Resident continues with treatment of rash to groin, [NAME] and buttock folds. Nystatin applied with brief changes. On 1/8/24 at 11:06 AM, a nurse note stated, Aide came to LN [licensed nurse] and stated that when they went to go and change pt [patient] brief, that they noticed pt had an open area. LN went in and assessed; pt has some redness noted to their coccyx area, with open fissure noted. LN communicated with management and received instruction to go ahead and apply calmoseptine r/t [related to] MASD and use Q [every] Shift, until resolved. On 1/14/24, a weekly skin review/assessment documented as followed, No skin issues skin is clean dry and intact barrier cream being used because of incontinences, WCTM [will continue to monitor]. On 2/4/24, a weekly skin review/assessment documented, Resident continues with treatment for redness under breasts, [NAME] and groin skin is pink and dry flaking around the edges. On 2/11/24, a weekly skin review/assessment documented, Resident continues with treatment for redness under breasts, [NAME] and groin skin is more inflammed [sic] and dry flaking around the edges. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	On 2/18/24 at 11:23 AM, a nurse note stated, MASD noted in buttocks along the crack skin has broken down - area cleansed and dressing applied. MD [medical doctor] and administration notified to add to wound rounds. new orders for daily dressing changes. On 2/18/24, a weekly skin review/assessment documented the following, Resident continues with nystatin under both breasts (both very red and starting to breakdown, bilateral [NAME] (light pink areas on each side). MASD noted in buttocks along the crack skin has broken down - dressing applied. On 2/21/24 at 8:32 AM, an interview was conducted with Nursing Assistant (NA) 4. The NA 4 stated resident 6 was able to reposition themselves in bed and used a brief. The NA 4 stated resident 6 was a heavy wetter and was able to notify staff when they needed a brief change. The NA 4 stated staff attempted to check on resident 6 between every 1-2 hours. The NA stated when they did their rounding, there was a high probability that resident 6 needed to be changed. The NA stated resident 6 had a bad rash on their butt and described it as red, patchy, and peeling like dry skin. On 2/21/24 at 8:40 AM, an interview was conducted with Certified Nursing Assistant (CNA) 5. The CNA 5 stated resident 6 did very minimal to help with their cares. The CNA 5 states resident 6 was able to reposition themselves in bed and was able to help turn themselves with brief changes. The CNA 5 stated resident 6 was incontinent but was able to notify staff when they needed a brief change and became impatient if not changed quick enough. The CNA 5 stated resident 6 had a rash on their bottom and believed it was either due to a reaction to the brief or because of resident 6's excessive sweat. The CNA 5 described resident 6 had a rash with red dots on their bottom and stated that ointment was applied with every brief change to help the rash. On 2/21/24 at 9:06 AM, an interview was conducted with CNA 2. The CNA 2 stated resident 6 had a hard time communicating their needs and stated resident 6 sometimes yelled and screamed to get staff's attention. The CNA 2 stated resident 6 had some mental delays and behaved like a child. The CNA 2 stated resident 6's briefs were changed at least every 2 hours. The CNA 2 stated resident 6 had been told to go in their brief since they were heavy to get up. The CNA 2 stated resident 6 was able to call when they needed a brief change. The CNA 2 stated resident 6 had sensitive skin which had lead to their current skin problems. The CNA 2 stated resident 6's skin around their bottom was irritated like when a baby had diaper rash. The CNA 2 stated they applied cream with every brief change to prevent it from getting worse. The CNA 2 stated resident 6 had a history of this and this irritation was new. The CNA 2 stated the type of rash resident 6 had occurred more frequently on light colored skin since that skin was more sensitive. On 2/21/24 at 10:44 AM, an interview was conducted with the Director of Nursing (DON). The DON stated they were unsure if resident 6 was able to make their needs known to staff and expected staff to check on resident 6 frequently. The DON stated they expected the CNAs to go in and check on resident 6 at least every two hours and that included incontinence care if needed. The DON stated if a resident was left in a soiled brief multiple times for a prolonged period, it affected the resident's skin integrity. The DON stated the outcome of compromised skin integrity included MASD which led to further skin break down and wounds if not treated appropriately. The DON stated staff had to be diligent on checking incontinent residents and applying barrier cream to prevent MASD. The DON stated resident 6 had MASD and was being followed by the wound care provider due to this. 22992 (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	POTENTIAL FOR HARM 2. Resident 17 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease; dementia, moderate, with other behavioral disturbance; and diabetes. Resident 17's medical record was reviewed from 2/5/24 through 2/22/24. Resident 17's quarterly MDS assessment dated [DATE] indicated that resident 17 was frequently incontinent of urine and bowel. Resident 17's care plans were reviewed and revealed the following: a. On 10/21/22, a care plan was developed indicating that the resident has bowel and bladder incontinence and needs assistance with toileting cares r/t (related to) cognitive deficits. The interventions included to change resident 17's disposable briefs every shift and as needed, and check routinely during rounds and as required for incontinence. b. On 1/4/23, a care plan was developed indicating that the resident was at risk for skin breakdown related to incontinence, diabetes, and history of yeast infections and moisture associated skin damage. The interventions included to change reposition frequently as tolerated. c. On 10/11/22, a care plan was developed indicating that the resident had an ADL self-care performance deficit. Interventions listed indicated that the resident required partial/moderate assistance by one staff for toileting. A review of resident 17's Toilet Use Task in the electronic medical record on 2/14/24 indicated that during the previous 30 days the resident required varying degrees of assistance for toileting, including supervision, limited assistance, extensive assistance and total dependence. The Toilet Use Task information also indicated that the resident was only being assisted with toileting between one and three times a day. On 2/7/24, a continuous observation was made of resident 17, and revealed the following: a. At 9:45 AM, the resident was observed to be seated at a dining room table with other residents. b. At 10:15 AM, a strong smell of feces was noticeable in the dining room in the area where resident 17 was seated. c. At approximately 11:00 AM, the Activities Director (AD) asked a staff member to help resident 17 freshen up. d. At 11:59 AM, nearly one hour later, a staff member entered the dining room and walked with resident 17 to her room. e. At 12:02 PM, CNA 6 was observed to be wiping off the chair where resident 17 had been seated, using disinfectant wipes. CNA 6 stated that the other staff member had taken resident 17 to change her brief. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	f. At approximately 12:15 PM, resident 17 was observed to enter the dining room wearing a different shirt and pants. On 2/7/24 at 10:39 AM, an interview was conducted with CNA 4. CNA 4 stated that residents should be checked on and changed if needed every 2 hours. CNA 4 stated that staff did not document in the electronic medial record when brief changes were completed. 3. Resident 28 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included dementia, subarachnoid hemorrhage, muscle weakness, and generalized anxiety disorder. Resident 28's medical record was reviewed from 2/5/24 through 2/22/24. Resident 28's admission MDS assessment dated [DATE] indicated that resident 28 was frequently incontinent of bowel, and occasionally incontinent of urine, and required partial to moderate assistance with toileting hygiene. The MDS also indicated that resident 28 required substantial to maximum assistance to come to a standing position from sitting in a chair. Resident 28's care plans were reviewed and revealed the following: a. On 6/27/23, a care plan was developed that indicated resident 28 was at risk for skin breakdown related to incontinence, impaired mobility and cognitive impairment. b. On 7/19/23, a care plan was developed that indicated resident 28 required substantial/maximum assistance of staff for transfers and toileting. c. On 7/17/23, a care plan was developed that indicate resident 28 was at risk for pressure ulcer development related to cognitive impairment, impaired mobility, incontinence, impaired communication and malnutrition. The interventions on the care plan did not include any information regarding repositioning of the resident. On 2/7/24, a continuous observation was made of resident 28 and revealed the following: a. At 9:45 AM, resident 28 was observed to be seated in her wheelchair in the dining room. b. Between approximately 10:00 AM and 11:00 AM, resident 28 was observed to participate in an activity. c. At 12:10 PM, resident 28 was served lunch. d. At 12:31 PM, nearly three hours after the observation was initiated, resident 28 was wheeled out of the dining room. At no time during the 3 hour observation, was resident 28 repositioned or approached by staff regarding toileting. On 2/7/24 at 12:33 PM, an interview was conducted with Nursing Assistant (NA) 4. NA 4 stated that resident 28 was taken out of the dining room and to the shower room for toileting.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46232 Based on interview and record review, the facility did not ensure that 1 of 40 sampled residents maintained acceptable parameters of nutritional status, such as usual body weight or desirable body weight range. Specifically, a resident was not provided their ordered supplement for 3 days. Resident identifier: 33. Findings Include: Resident 33 was initially admitted to the facility on [DATE] and readmitted with the following diagnoses that included severe protein calorie malnutrition, alcoholic cirrhosis of liver without ascites, dementia, opioid dependence, esophageal obstruction, gastrointestinal hemorrhage, generalized anxiety disorder, and alcohol dependence. Resident 33's medical record was reviewed on 2/6/24 through 2/22/24. On 2/6/24, resident 33's documented weight was 86 pounds. A nutrition care plan initiated on 10/22/23 documented resident 33 had Potential for/actual alteration in nutrition related to cachexia, hospital diagnosis of severe malnutrition, hx [history] of esophageal strictures, alcohol dependence with cirrhosis [sic], hx of gastric tube for nutrition . It stated resident 33 had a history of inadequate intake due to a low BMI [body mass index] and one of the interventions listed included to provide/serve diet and supplements as ordered. On 10/25/23, an admission nutritional assessment documented, Other dxs [diagnoses] include esophageal stricture, severe malnutrition, hx of alcohol use & current smoker .Intake meets estimated needs, however, considering BMI, she will benefit from increased nutrient needs. One of the recommendations made by the Registered Dietician (RD) included Medpass 60 milliliters (mls) to be given twice a day. On 1/17/24, a nutritional assessment documented, Intake meets estimated needs but considering malnutrition dx [diagnosis] and low BMI, she will benefit from increased nutrition provision. One of the recommendations made by the RD included a House Supplement 120 mls to be given twice a day. A physician order with a start date of 1/19/24 and end date of 1/30/24 stated, House supplement. Two times a day for low weight. GIVE 120ml [milliliter] twice daily. [This was restarted on 1/30/24 till current.] On 1/28/24 at 9:48 AM, an orders administration note documented, House Supplement two times a day for low weight GIVE 120ml twice daily. medication unavailable. On 1/28/24 at 4:58 PM, an orders administration note documented, House Supplement two times a day for low weight GIVE 120ml twice daily. Unavailable. On 1/29/24 at 11:29 AM, an orders administration note documented, House Supplement two times a day for low weight GIVE 120ml twice daily. not available. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/29/24 at 1:37 PM, an orders administration note documented, House Supplement two times a day for low weight GIVE 120ml twice daily. N/A [not applicable]. On 1/30/24 at 8:31 AM, an orders administration note documented, House Supplement two times a day for low weight GIVE 120ml twice daily. No Med Pass, Boost or Mighty Shakes available. On 1/30/24 at 1:48 PM, an orders administration note documented, House Supplement two times a day for low weight GIVE 120ml twice daily. No supplements available. It should be noted that resident 33 had an order for supplements since their admission to the facility due to a low BMI. On 2/20/24 at 12:49 PM, an interview was conducted with Registered Nurse (RN) 2. RN 2 stated resident 33 was a frail and tiny resident and needed all the nutrition they were able to get. RN 2 stated resident 33 did not eat most of their food and preferred to just eat snacks. RN 2 stated resident 33 received a supplement such as medpass or boost. RN 2 stated supplements were offered on a schedule since it was ordered by the physician, and it needed to be documented like a medication. RN 2 stated the supplements provided extra nutrition and were high in vitamins, calories, and proteins. RN 2 stated the supplements were used to help maintain and build body mass. RN 2 stated there had been times when they had run out of supplements and residents had to miss a couple of doses. RN 2 stated it was frustrating when a resident missed doses of their ordered supplements since some residents worked hard to gain weight or maintain their weight. RN 2 expressed concern for when some residents missed a dose and stated sometimes that was their only nutrition and it could have detrimental consequences for those residents. RN 2 stated the loss of a few calories for resident 33 affected their nutritional status. On 02/20/24 at 2:17 PM, a phone interview was conducted with the RD. The RD stated when a resident was admitted to the facility they did a nutritional evaluation and made recommendations and put interventions based on the findings. The RD stated resident 33 admitted with a low BMI and even though resident 33 had been meeting their caloric needs, they suggested adding medpass as a supplement. The RD stated the medpass was to encourage resident 33 to gain weight due to a low BMI. The RD stated resident 33's BMI had gone from 14 to 15.8 which suggested that the interventions in place were helping resident 33 maintain/gain weight. On 2/20/24 at 3:12 PM, an interview was conducted with the Director of Nursing (DON). The DON stated there was a time when medpass was on back ordered but they had other supplements available for residents. The DON stated supplements were ordered for a variety of reasons such as wound healing and nutritional means. The DON stated resident 33 had supplements ordered to help with caloric intake. The DON stated if the supplements were ordered then they expected them to be given as ordered.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46232 Based on observation and interview, it was determined for 1 of 40 sampled residents that the facility did not ensure intravenous (IV) therapy was administered consistent with professional standards of practice as well as implement prevention of infection at the IV site to the extent possible. Specifically, a resident was observed to have IV fluid lying on a flat surface while being administered and no alcohol caps were observed on the IV hub. Resident Identifier: 26 Findings Include: Resident 26 was admitted to the facility on [DATE] with the following diagnoses of osteomyelitis of right ankle and foot, generalized muscle weakness, polyneuropathy, type 2 diabetes mellitus with foot ulcer, non-pressure chronic ulcer of other part of right foot with bone involvement without evidence of necrosis, and necrotizing fasciitis. On 2/5/24 at 10:41 AM, an observation was made of resident 26's dual lumen peripherally inserted central catheter (PICC) line. One of the ports was observed to have been hooked up to a 500-milliliter bag of sodium chloride fluid which was laying on the bed next to resident 26. The other port was observed to not be covered. An interview was conducted with resident 26. Resident 26 stated the nurse had just connected the IV fluids to the PICC line about 10 minutes ago. Resident 26 stated it was not their job to tell the nurse how to administer the fluids. Resident 26 stated the nurse should have been aware to put the fluids on the pole they had in the corner of the room. Resident 26 stated they were not getting any of the fluids since it was lying next to him. Resident 26 expressed frustration related to the infection control process of their PICC line. Resident 26 stated that sometimes nurses used their PICC line without gloves and without wiping the port clean. On 2/8/24 at 2:39 PM, an observation was made of Registered Nurse (RN) 3. RN 3 was observed to have applied gloves and clean resident 26's PICC line port prior to use. An interview was conducted with RN 3 about resident 26's PICC line. RN 3 stated resident 26 required the PICC due to the intravenous (IV) antibiotics they need for an infection on resident 26's right foot. RN 3 stated the PICC line went into resident 26's subclavian vein which was in the heart. RN 3 stated they needed to disinfect the port prior to each use due to the port being exposed to the environment. RN 3 stated sometimes there were caps that could be put on the PICC line port to keep it clean, but the pharmacy had not sent any. The RN 3 stated they flushed resident 26's PICC line prior to every use to ensure the line was patent. The RN 3 stated resident 26's antibiotics were not hung on the pole since they were delivered in a pressurized ball that delivered the medication over a certain rate. The RN 3 stated a bag of IV fluids needed to be hung on a pole or have some kind of pump or flow regulator for the fluid to drip down since it was not pressurized. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/20/24 at 1:12 PM, an interview was conducted with RN 2. RN 2 stated resident 26 had a double lumen PICC that went right to the top of his heart. RN 2 stated the red port was mainly used for blood draws and the blue port was to administer medication. RN 2 stated both ports were flushed to prevent them from clotting off. RN 2 stated to prevent PICC line infections, they scrubbed the port with alcohol, waited for it to dry, and then used a sterile syringe. RN 2 stated they had used caps in the past but currently there was no need since it did not make a difference in preventing PICC line infections. RN 2 stated the caps caused more problems then what they were useful for. RN 2 stated residents were at risk for bed sores in those areas and there was no reason to introduce more problems. RN 2 stated there were studies that showed the same number of patients were getting infections were if they used caps or not on the PICC line port. RN 2 stated infections occurred when the port was not cleaned with an alcohol swab for 10 seconds and bacteria was introduced inside the body. RN 2 stated the alcohol killed any germs that were located on the port. RN 2 stated once the PICC line had been cleaned, they used a sterile syringe on the port to prevent any cross contamination. RN 2 stated resident 26 received two different types of antibiotics in a pressurized ball system which allowed it to be administered at a predetermined rate. RN 2 stated any IV medication in a bag needed to be put on the pole for the fluid to drip in. On 2/20/24 at 2:02 PM, an interview was conducted with the Director of Nursing (DON). The DON stated resident 26 had a PICC line in place for IV antibiotics. The DON stated they noticed resident 26's IV fluid was not on a hook that day and educated the resident on why the fluid needed to stay on the pole. The DON stated since the IV fluid had not been on the pole, that meant the medication had not been infused. The DON stated the nurse was the one responsible to ensure the IV medication was given as ordered and using the appropriate equipment needed to administer the medication. A case study by The American Jornual of Infection Control published on 9/15/22 was referenced. A case study titled: Antiseptic barrier caps to prevent central line-associated bloodstream infections: A systemic review and meta-analysis; was reviewed and summarized why patients benefited from antiseptic barrier caps. It documented a frequent complication of a central venous catheter was the source of contamination at the hub due to micro-organisms colonizing and forming a biofilm and being spread into the bloodstream due to inadequate disinfection techniques which resulted in an increased risk for an acquired central line associated bloodstream infection (CLABSIs). The case study stated, Antiseptic barrier caps have been developed to decrease CLABSIs by reducing the effect of variations in scrubbing duration and techniques . The cap is screwed directly onto the needle-less connector and continuously bathes the access point in an antimicrobial agent and can be left in place between infusions, providing improved disinfection and preventing touch or airborne pathogens from invading the hub.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47432 Based on observation, interview, and record review, it was determined that for 1 of 40 sampled residents, that the facility did not ensure that a resident who needed respiratory care was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the the resident's goals and preferences. Specifically, the facility did not have physician's orders in place for a resident's oxygen tubing to be changed or documentation that the resident's oxygen tubing had been changed. Resident identifier: 7. Findings include: Resident 7 was originally admitted [DATE], readmitted [DATE], with diagnoses including chronic respiratory failure unspecified whether with hypoxia or hypercapnia, morbid (severe) obesity with alveolar hypoventilation, chronic obstructive pulmonary disease unspecified, interstitial pulmonary disease unspecified, and dependence on supplemental oxygen. On 2/5/24 at 10:25 AM, an observation was made of Resident 7 in his room. It was noted that the resident was using an oxygen concentrator and was receiving 4 liters per minute of oxygen via a nasal cannula. The oxygen tubing was not dated. On 2/20/24, Resident 7's medical record was reviewed. The following physician's orders were noted with start dates of 9/18/23: a. Oxygen (O2) per nasal cannula at 2 Liters/minute as needed. Goal to maintain oxygen saturations (Sats) greater than (>) 90%. Check O2 sat every shift. b. Monitor shortness of breath (SOB) or Difficulty Breathing: (1) SOB with Exertion (2) Sitting at Rest (3) Laying Flat. c. Check O2 Sats every shift. There were no orders for Resident 7's oxygen tubing to be changed. On 2/20/24, Resident 7's Treatment Administration Record (TAR) was reviewed for the months of September 2023 through February 2024. There was no documentation of oxygen tubing changes in the TAR. On 2/20/24 at 1:10 PM, an interview was conducted with Nursing Assistant (NA) 1. NA 1 stated that Certified Nursing Assistants were responsible for changing oxygen tubing. NA 1 stated that she was unsure when oxygen tubing was changed, but that she thought it happened after each shift change. On 2/8/24 at 10:18 AM, an interview was conducted with the Certified Nursing Assistant Coordinator (CNAC). The CNAC stated she changed Resident 7's oxygen tubing weekly. The CNAC stated that she labels the oxygen tubing with the date that it was changed. The CNAC stated that Resident 7 often refused his cannula tubing to be changed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/20/24 at 1:15 PM, an interview was conducted with Registered Nurse (RN) 3. RN 3 stated that oxygen tubing was changed once a week every Sunday. RN 3 stated that the nurse on duty each Sunday was responsible for changing the oxygen tubing. RN 3 stated that she was unsure where the oxygen tubing change would be documented if there was not an order for the tubing to be changed in the resident's chart. On 2/20/24 at 2:37 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that the CNAC was responsible for oxygen tubing changes, or the DON's responsibility if there was no CNAC. The DON stated that oxygen tubing should be changed weekly. The DON stated that Resident 7's oxygen tubing had last been changed two weeks ago and that the date it was changed should be marked on the tubing with a piece of tape. The DON stated that she was unsure if the tubing changes would be documented elsewhere. The DON stated that the company policy was to change oxygen tubing each week. On 2/20/24 at 3:02 PM, a copy of the company oxygen tubing policy was requested from the DON. On 2/20/24 at 3:39 PM, an additional interview was conducted with the DON. The DON stated that the company does not have a policy for oxygen tubing changes.

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45490 Based on observation, interview and record review it was determined, for 2 of 40 sampled residents, that the facility did not ensure that pain management was provided to residents who required such services. Specifically, two residents complained of uncontrolled pain and the pain medication follow up was documented as ineffective pain control, and the physician was not notified in a timely manner. A resident was also observed to vocalize pain during a wound treatment and was not provided pain medication prior to the treatment as was care planned, this will be sited at a harm level. Resident identifiers: 29 and 90. Finding Included: HARM 1. Resident 90 was admitted to the facility on [DATE] with diagnosis which included cellulitis of right lower limb, cellulitis of left lower limb, chronic venous hypertension with inflammation of left lower extremity, chronic venous hypertension with inflammation of right lower extremity, non-pressure chronic ulcer of unspecified part of left lower leg with fat layer exposed, non-pressure chronic ulcer of unspecified part of right lower leg with fat layer exposed, pain in unspecified limb, pain in unspecified foot, peripheral vascular diseases, diabetes type 2, and need for assistance with personal care. On 2/06/24 at 10:43 AM, an interview was conducted with resident 90. She stated that she tells the staff she was in pain from her legs to her feet. She stated that her pain was often at a 10 and that it was currently at a 10 and staff had not given her any pain medications that morning. She stated that when she tells staff she was in pain the staff will say they will get her something but never come back, and that it takes a lot of time to get somebody to help. Resident 90's medical record was reviewed from 2/12/24 thru 2/22/24. On 2/4/24, an admission Minimum Data Set (MDS) assessment was conducted. The functional ability of the MDS documented resident 90's functional limitation range of motion impairment for the upper extremity (shoulder, elbow, wrist, hand) and lower extremity (hip, knee, ankle, foot) was impairment on both sides. Resident 90 required substantial/maximal assistance with mobility, upper and lower body dressing, toileting, and shower/bathe. On 2/5/24, an admission MDS assessment for pain was conducted. The pain interview documented, pain frequency as almost constantly. Resident 90 was asked, Please rate your pain over the last 5 days on a zero to ten scale, with zero being no pain and ten as the worst pain you can imagine. The response was 10. Resident 90's care plan dated 2/3/24 indicated that the resident was at risk for pain related to wounds to bilateral lower extremities with infection. The interventions documented were the following: (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	a. Administer analgesia per orders. Observe for efficacy and side effects. Give 1/2 (half) hour before treatments or care. b. Evaluate the effectiveness of pain interventions. Review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition. c. Monitor/record/report to nurse resident complaints of pain or requests for pain treatment. d. Resident 90's pain was aggravated by walking, movement, and wound treatment for foot wounds. e. Resident 90's pain was alleviated by pain meds, rest, and elevated legs. On 2/3/24, resident 90's physician orders revealed that resident 90 had the following orders: a. Oxycodone Hydrochloride (HCl) Oral Tablet 5 milligram (mg). Give 1 tablet by mouth every 6 hours as needed for Pain. b. Acetaminophen Oral Tablet 500 mg. Give 1 tablet by mouth every 6 hours as needed for Pain. On 2/4/24 at 2:22 PM, a pain level score was documented as 10 out of 10 (using a numerical scale from 0-10, 10 being the worst). On 2/4/24 at 2:22 PM, an administration note documented resident 90 received Oxycodone 5 mg for pain. On 2/4/24 at 5:06 PM, an administration note documented, oxyCODONE HCl Oral Tablet 5 MG[Miligrams] . Administration was: Ineffective. Follow-up Pain Scale was: 9. On 2/4/24 at 8:03 PM, an administration note documented Oxycodone was given for pain, resident reports pain 10/10. On 2/5/24 at 10:20 AM, a pain level score was documented as 8 out of 10. On 2/5/24 at 10:20 AM, an administration not documented resident 90 was given Oxycodone 5 mg for pain. On 2/5/2024 at 1:29 PM, an administration note documented, oxyCODONE HCl Oral Tablet 5 MG . Administration was: Ineffective. Follow-up Pain Scale was: 6. On 2/6/24 at 6:15 PM, an administration note documented resident 90 received Oxycodone 5 MG, pt [patient] c/o [complained of] px [pain] 8/10. On 2/6/24 at 9:10 PM, an administration note documented, oxyCODONE HCl Oral Tablet 5 MG . Administration was: Effective. Follow-up Pain Scale was: 3. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	On 2/7/24 at 3:19 PM, a nurses note documented, the nurse spoke with the physician about resident experiencing pain but not asking for pain medication. PCP [primary care physician] ordered to schedule 5 mg Oxycodone BID [twice a day] to help with pain management . On 2/7/24 at 7:00 PM, a physicians order documented, oxyCODONE HCl Oral Tablet 5 MG (Oxycodone HCl). Give 1 tablet by mouth two times a day for Pain. [It should be noted that a physician was not contacted for 3 days regarding resident 90's documented uncontrolled pain and ineffective pain score after receiving medication.] On 2/14/24 at 10:34 AM, an observation was made of resident 90's receiving bilateral leg wound care. Resident 90 was observed to have her wound dressings already removed by the Wound Care Nurse Practitioner (WCNP). Resident 90 was observed to have her eyes tightly closed and eyebrows furrowed. The WCNP lifted each leg to observe the wounds, resident 90 stated ouch. At 10:46 AM, Registered Nurse (RN) 2 and RN 3 entered the room and stated they were giving resident 90 medication for pain. At 10:47 AM, WCNP and RN 3 lifted resident 90's left leg and continued wound care, while resident 90 cried out in pain stating ouch and crying. RN 2 stated resident 90 could hold her hand squeeze as hard as you need, I can take it. At 10:50 AM, Resident 90 cried louder stating, All of it hurts, the WCNP pressed on her heel and she cried out in pain, the WCNP asked the resident to state where she was feeling pain and where the WCNP was touching, resident 90 stated again, it all hurts, my heel. The WCNP stated she was sorry. At 10:52 AM, the WCNP began cleaning her wounds with gauze and wound cleanser, while the resident continued to have eyes shut tightly and crying while stating ouch multiple times. RN 2 stated for resident 90 to just squeeze her hand and that she could handle it. At 10:58 AM, resident 90's left leg was being wiped with gauze and wound cleanser, with each wipe of the gauze on the skin she would say ouch. At 11:03 AM, resident 90's legs were being wrapped in the outer layer of the wound dressing, she appeared calm, her eyes were no longer closed tightly and her eyebrows were not furrowed. [It should be noted that resident 90 did not receive pain medication a half hour prior to wound care and that it took approximately 30 minutes for her to look calm. It should be noted that after approximately 30 minutes the first 30 minutes of wound care included cleaning and directly touching the wounds and after the cleansing wound care consisted of wrapping resident 90's legs and no longer directly wiping the open wounds.] On 2/14/2024 at 10:45 AM, a physicians order documented, oxyCODONE HCl Oral Tablet 5 MG (Oxycodone HCl). Give 5 mg by mouth every 24 hours as needed for pain with wound care. On 2/14/24 at 12:43 PM, an interview was conducted with RN 3. RN 3 stated when a resident received Oxycodone for pain, that it took about a half hour up to one hour for the pain relief to take effect. RN 3 stated that if a resident was receiving wound care that caused them pain, the resident should receive the medication before wound care so that it could help with and lessen pain during wound care. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	On 2/14/24 at 1:54 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that pain scores were considered one of the resident vitals and that if they were out of control the expectation was that staff would call the physician immediately to report if it was not being controlled with their current medication regimen. The DON stated that if a resident was taking oral Oxycodone for pain, it takes 15 to 30 minutes for it to become effective. The DON stated that if someone was getting wound care that was painful, she would expect the resident to receive the medication at least 15 minutes prior to wound care because the pain would be considerably less. The DON stated that if the resident did not receive pain medication prior to wound care, the resident would not have pain relief during wound care for the time it would take to become effective. She stated that resident 90 should have gotten the pain medication earlier, but that the nurses were busy and can only go so quickly. She stated that a wound care can be delayed or rescheduled in order for the resident to receive pain medication. The DON stated that during wound care when resident 90 was crying the WCNP did tell the resident they could stop wound care, but that the process of giving pain medication prior to wound care was to prevent pain during wound care, that ideally we do not inflict pain on the resident. 38031 2. Resident 29 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included a traumatic brain injury (TBI), hemiplegia and hemiparesis, major depressive disorder, panic disorder, anxiety disorder, low back pain, hepatitis C, seizures, insomnia, migraine, schizoaffective disorder, and history of suicidal behavior. 02/6/24 at 9:22 AM, an interview was conducted with resident 29. Resident 29 stated that he had pain in back and head. Resident 29 stated that he received Oxycodone for the pain, but it did not help. Resident 29 stated that his current pain level was 9/10. Resident 29 stated that he would like the pain to be non-existent, but he had to live with the pain. On 2/06/24, resident 29's medical records were reviewed. On 9/28/23, resident 29 had an order for Oxycodone Capsule 5 milligram (mg), give 1 capsule by mouth every 4 hours as needed for moderate to severe pain initiated. Resident 29's January 2024 Medication Administration Record (MAR) was reviewed. The Oxycodone 5 mg was documented as administered 22 times for reported pain scores of 2 through 9. On 1/26/24 at 7:56 PM, the Oxycodone 5 mg was administered for complaints of a headache. Resident 29 reported an initial pain score of 9/10. On 1/26/24 at 10:10 PM, resident 29's Oxycodone follow-up administration assessment was documented as Ineffective with a follow-up score of 7/10. No documentation could be found that the provider was notified of the ineffective pain control and no additional pain medication was administered. On 1/27/24 at 6:33 PM, the Oxycodone 5 mg was administered for complaints of bladder pain. Resident 29 reported an initial pain score of 9/10. On 1/27/24 at 8:22 PM, resident 29's Oxycodone follow-up administration assessment was documented as Ineffective with a follow-up score of 9/10. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	No documentation could be found that the provider was notified of the ineffective pain control and no additional pain medication was administered. On 12/21/23, resident 29's care plan for at risk for pain related to history of craniotomy, trauma and chronic migraines was initiated. Interventions identified included to anticipate the resident's need for pain relief and respond immediately to any complaints of pain; evaluate the effectiveness of pain interventions; review pain interventions for alleviation of symptoms, dosing schedules and resident satisfaction with results; monitor for side effects of pain medication and report occurrences to the physician; monitor/record/report any signs and symptoms of non-verbal pain; monitor/record/report to nurse loss of appetite, refusal to eat and weight loss; monitor/record/report to nurse resident complaints of pain or requests for pain treatment; and notify physician if interventions are unsuccessful or if current complaint was a significant change from past experience of pain. Review of the facility policy for Administering Pain Medications documented that pain management was defined as the process of alleviating the resident's pain based on his or her clinical condition and established treatment goals. The policy stated that staff were to document the effectiveness of non-pharmacological interventions. The policy stated that staff were to re-evaluate the resident's level of pain 30-60 minutes after administering pain medication. The policy stated that staff should report information in accordance with facility policy and professional standards of practice. The policy was last revised in January 2024. On 2/12/24 at 12:37 PM, an interview was conducted with Registered Nurse (RN) 2. RN 2 stated resident 29 did not report pain. RN 2 stated that resident 29 would say that he had bladder pain and needed to urinate and wanted to be catheterized. RN 2 stated that resident 29 goes to the bathroom [ROOM NUMBER] times a day and his bladder was never full. RN 2 stated that resident 29 had as needed pain medication. RN 2 stated that he did not get the pain medication unless he asked for it. RN 2 stated that they would obtain a pain score and location of the pain prior to the medication administration and then they would evaluate the effectiveness 30 minutes after administration. RN 2 stated that if the pain medication was not effective, they should contact the physician. RN 2 stated that the notification to the physician would be documented in a progress note. On 2/13/24 at 7:56 AM, an interview was conducted with the Director of Nursing (DON). The DON stated for uncontrolled pain or pain that was not alleviated with pain medication the nurse should notify the physician. The DON stated the expectation for unresolved pain was to follow-up with physician immediately, and document in the nursing note that the physician was notified.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22992 Based on interview, observation and record review, 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. Specifically, multiple residents voiced concern about the staffing level both individually and in a group setting, showers were not provided as scheduled, pain medication was not provided timely, incontinence care was not provided timely, and a nurse left the facility to retrieve the keys to the medication cart from the Director of Nursing. Resident identifiers: 1, 4 6, 7, 8, 16, 30, 31, and. Findings included: 1. On 2/5/24 at 1:47 PM, an interview was conducted with resident 31. Resident 31 stated that approximately one month prior, she was left in the shower for 10 to 15 minutes alone. She stated that she had the emergency light on because she needed to go to the bathroom, but because no one came, she attempted to get to the toilet, but slipped on the wet floor, went down on her knees, and ultimately defecated on herself. The resident stated that this was embarrassing for her. 2. On 2/6/24 at 10:37 AM, an interview was conducted with resident 30. Resident 30 stated that the facility was badly understaffed. 3. On 2/5/24 at 12:11 PM, an interview was conducted with resident 1. Resident 1 stated that there was never enough staff, that's why they have agency. Resident 1 stated that during the night shift he has had to wait a long time for assistance. Resident 1 stated that on one occasion, his bowel movement was coming and he needed to be positioned on his side and he had to scream for help. 4. On 2/5/24 an interview was conducted with resident 16. Resident 16 stated that the facility was understaffed, and that there were long call light times, and showers get missed. 5. On 2/5/4 at 11:13 AM, an interview was conducted with resident 8. Resident 8 stated that she often did not receive showers as scheduled. Resident 8 stated that there was not enough staff here. At night there's only one nurse, and sometimes there's just 2 aides. 6. The resident council notes for the previous 14 months were reviewed and revealed the following concerns voiced by the residents: a. On 1/25/23: i. Agency staff don't always understand specific needs. High turn over rate. Affecting care. b. On 2/24/23: i. Water jugs. (switch off.) instead of being picked up and waiting. Just switch them off. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ii. Dietary: . Portions are too small, need another set of hands. c. On 3/31/23: i. Water (takes hours). [Note: There was no specific information regarding what this concern referred to.] ii. Call lights are not being answered (1 hr (hour) [and] 45 minutes went by). iii. Medications are late iv. A lot of slacking, there should always be someone on the floor. v. Staff is slacking, every day can't be an emergency. Wait time is too long. They have to do what they have to do. I'm going backwards in my disability not getting the assistance I need. d. On 4/25/23: i. Water is still not being distributed (not being passed out). ii. CNA's are not answering call lights in appropriate timing. iii. Nurses are no where to be found (solution would be to hire another nurse. iv. CNA's only doing their section whey they can help. (Help where you can.) (Spend more time charting.) e. On 5/30/23 i. Residents state that nurses need to pay better attention to them. ii. Issues: Residents need to receive care within a timely matter. iii. Nursing: need to be more attentive to residents [and] their needs. iv. Problems - Nurses don't pay attention to the people they need to pay attention to. Someone will be yelling to get nurse's attention and it takes forever to get attention and help they need. They need to be taken care of . Call lights not being answered. v. [Resident name] is served is food, but no one is available to help him for at least a half hour. Food is always cold. f. On 6/13/23: i. Call lights not being answered promptly .CNA's need to do their job ii. Water mugs have not been consistently going out the last few days. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	g. On 7/27/23: i. Snacks not being passed out in evenings. h. On 8/8/23: i. Nursing: Working their tails off . Sad they lost hope. CNA's - short-handed. i. On 9/12/23: i. Nurses [and] CNA's . need to be more on top of it - waiting a long time answer residents. j. On 10/11/23: i. CNA's - call lights are taking 45 minutes - 1 hour. ii. New Business: .More access to ice - resident waited an hour. iii. Issues: not getting water daily - 4/5 days no hydration cup. k. No resident council notes for November 2023 were provided by the facility. l. On 1/9/24: i. Nursing: . Residents don't feel heard by CNAs. ii. Some residents feel neglect. [Note: There was no other specific information as to what the resident council discussed with regard to possible neglect.] 45490 7. Resident 90 was admitted to the facility on [DATE] with diagnosis which included cellulitis of right lower limb, cellulitis of left lower limb, chronic venous hypertension with inflammation of left lower extremity, chronic venous hypertension with inflammation of right lower extremity, non-pressure chronic ulcer of unspecified part of left lower leg with fat layer exposed, non-pressure chronic ulcer of unspecified part of right lower leg with fat layer exposed, pain in unspecified limb, pain in unspecified foot, peripheral vascular diseases, diabetes type 2, and need for assistance with personal care. On 2/6/24 at 10:43 AM, an interview was conducted with resident 90. She stated that she tells the staff she was in pain from her legs to her feet. She stated that her pain was often at a 10 and that it was currently at a 10 and staff had not given her any pain medications that morning. She stated that when she tells staff she was in pain the staff will say they will get her something but never come back, and that it takes a lot of time to get somebody to help. Resident 90's medical record was reviewed from 2/12/24 thru 2/22/24. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/4/24 an admission Minimum Data Set (MDS) assessment was conducted. The functional ability of the MDS documented resident 90's functional limitation range of motion impairment for the upper extremity (shoulder, elbow, wrist, hand) and lower extremity (hip, knee, ankle, foot) was impairment on both sides. Resident 90 required substantial/maximal assistance with mobility, upper and lower body dressing, toileting, and shower/bathe. On 2/5/24 an admission MDS assessment for pain was conducted. The pain interview documented, pain frequency as almost constantly. Resident 90 was asked, Please rate your pain over the last 5 days on a zero to ten scale, with zero being no pain and ten as the worst pain you can imagine. The response was 10. Resident 90's care plan dated 2/3/24 indicated that the resident was at risk for pain related to wounds to bilateral lower extremities with infection. The interventions documented were the following: a. Administer analgesia a per orders. Observe for efficacy and side effects. Give 1/2 (half) hour before treatments or care. b. Evaluate the effectiveness of pain interventions. Review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition. c. Monitor/record/report to nurse resident complaints of pain or requests for pain treatment. d. Resident 90's pain is aggravated by walking, movement, and wound treatment as has foot wounds. e. Resident 90's pain is alleviated by pain meds, rest, elevated legs. On 2/3/24 resident 90's physician orders revealed that resident 90 had the following orders: a. oxyCODONE Hydrochloride (HCl) Oral Tablet 5 milligram (MG) (Oxycodone HCl). Give 1 tablet by mouth every 6 hours as needed for Pain. b. Acetaminophen Oral Tablet 500 MG (Acetaminophen). Give 1 tablet by mouth every 6 hours as needed for Pain. On 2/4/24 at 2:22 PM, a pain level score was documented as 10 out of 10 (using a numerical scale from 0-10, 10 being the worst). On 2/4/24 at 2:22 PM, an administration note documented resident 90 received Oxycodone 5 MG for pain. On 2/4/24 at 5:06 PM, an administration note documented, oxyCODONE HCl Oral Tablet 5 MG[Miligrams] . Administration was: Ineffective. Follow-up Pain Scale was: 9. On 2/4/24 at 8:03 PM, an administration note documented Oxycodone was given for pain, resident reports pain 10/10. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/5/24 at 10:20 AM, a pain level score was documented as 8 out of 10. On 2/5/24 at 10:20 AM an administration not documented resident 90 was given Oxycodone 5 MG for pain. On 2/5/2024 at 1:29 PM, an administration note documented, oxyCODONE HCl Oral Tablet 5 MG . Administration was: Ineffective. Follow-up Pain Scale was: 6. On 2/6/24 at 6:15 PM, an administration note documented resident 90 received Oxycodone 5 MG, pt [patient] c/o [complained of] px [pain] 8/10. On 2/6/24 at 9:10 PM, an administration note documented, oxyCODONE HCl Oral Tablet 5 MG . Administration was: Effective. Follow-up Pain Scale was: 3. On 2/7/24 at 3:19 PM, a nurses note documented, the nurse spoke with the physician about resident experiencing pain but not asking for pain medication. PCP [primary care physician] ordered to schedule 5 mg Oxycodone BID [twice a day] to help with pain management . On 2/7/24 at 7:00 Pm a physicians order documented, oxyCODONE HCl Oral Tablet 5 MG (Oxycodone HCl). Give 1 tablet by mouth two times a day for Pain [It should be noted that a physician was not contacted for 3 days regarding resident 90's documented uncontrolled pain and ineffective pain score after receiving medication.] On 2/14/24 at 10:34 AM, an observation was made of resident 90's receiving bilateral leg wound care. Resident 90 was observed to have her wound dressings already removed by the Wound Care Nurse Practitioner (WCNP). Resident 90 was observed to have her eyes tightly closed and eyebrows furrowed. The WCNP lifted each leg to observe the wounds, resident 90 stated ouch. At 10:46 AM, RN 2 and RN 3 entered the room and stated they were giving resident 90 medication for pain. At 10:47 AM WCNP and RN 3 lifted resident 90's left leg and continued wound care, while resident 90 cried out in pain stating ouch and crying. RN 2 stated resident 90 could hold her hand squeeze as hard as you need, I can take it. At 10:50 AM, Resident 90 cried louder stating, All of it hurts, the WCNP pressed on her heel and she cried out in pain, the WCNP asked the resident to state where she was feeling pain and where the WCNP was touching, resident 90 stated again, it all hurts, my heel. The WCNP stated she was sorry. At 10:52 AM, the WCNP began cleaning her wounds with gauze and wound cleanser, while the resident continues to have eyes shut tightly and crying while stating ouch multiple times. RN 2 stated for resident 90 to just squeeze her hand and that she could handle it. At 10:58 AM resident 90's left leg was being wiped with gauze and wound cleanser, with each wipe of the gauze on the skin she would say ouch. At 11:03 AM resident 90's legs were being wrapped in the outer layer of the wound dressing, she appeared calm, her eyes were no longer closed tightly and her eyebrows were not furrowed. [It should be noted that resident 90 did not receive pain medication a half hour prior to wound care and that it took approximately 30 minutes for her to look calm. It should be noted that after approximately 30 minutes the first 30 minutes of wound care include cleaning and directly touching the wounds and after the cleansing wound care consisted of wrapping resident 90's legs and no longer directly wiping the open wounds.] (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/14/2024 at 10:45 AM, a physicians order documented, oxyCODONE HCl Oral Tablet 5 MG (Oxycodone HCl). Give 5 mg by mouth every 24 hours as needed for pain with wound care. On 2/14/24 at 1:54 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that pain scores are considered on of the resident vitals and that if they are out of control the expectation is that staff would call the physician immediately to report if it is not being controlled with their current medication regimen. The DON stated that if a resident is taking oral Oxycodone for pain, it takes 15 to 30 minutes for it to become effective. The DON stated that if someone is getting wound care that is painful, she would expect the resident to receive the medication at least 15 minutes prior to wound care because the pain would be considerably less. The DON stated that if the resident did not receive pain medication prior to wound care, the resident would not have pain relief during wound care for the time it would take to become effective. She stated that resident 90 should have gotten the pain medication earlier, but that the nurses were busy and can only go so quickly. She stated that a wound care can be delayed or rescheduled in order for the resident to receive pain medication. The DON stated that during wound care when resident 90 was crying the WCNP did tell the resident they could stop wound care, but that the process of giving pain medication prior to wound care is to prevent pain during wound care, that ideally we do not inflict pain on the resident. [Cross refer to F697] 46232 8. Resident 6 was initially admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnosis that included schizophrenia, type 2 diabetes mellitus, major depressive disorder, generalized anxiety disorder, dementia, repeated falls, vitamin b12 def, extrapyramidal and movement disorder, and overactive bladder. On 2/6/24 at 9:29 AM, an interview was conducted with resident 6. Resident 6 stated recently they were not given a brief change the entire night and there had been numerous times where they were left in a brief for a long time. Resident 6 stated sometimes they were left in a dirty brief for more hours than they appreciated. Resident 6 complained about the redness on their bottom. On 2/21/24 at 9:16 AM, an observation was made of Certified Nursing Assistant (CNA) 2 assisting resident 6 with a brief change. The CNA 2 was observed to ask resident 6 if they were wet and then proceed to check resident 6's brief. Resident 6's brief was removed and resident 6's buttocks area was observed to be erythematous with red dots of varying sizes present. The CNA 2 was observed to wipe resident 6 clean and then applied barrier ointment to resident 6's posterior. The CNA 2 stated they also tried to keep resident 6's diaper semi loose to prevent further skin irritation. On 12/27/23, a Quarterly Minimum Data Set (MDS) documented resident 6's bowel and bladder function as incontinent. Resident 6 was also documented to have moisture associated skin damage (MASD) as a skin condition. Resident 6's care plan was reviewed and documented the following care areas associated with incontinence: (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. A care plan focus area, initiated on 11/7/23 documented resident 6 was at risk for skin break related to incontinence and a history of MASD to peri-area. Documented intervention included but not limited to weekly skin checks. b. A care plan focus area, initiated on 11/20/23 documented resident 6 had an alteration in bowel and bladder elimination due to incontinence and it stated resident 6 required assistance with toileting care. Documented interventions included but not limited to changing resident 6's disposable brief every shift and during rounds as needed. c. A care plan focus area, initiated on 2/18/24 documented resident 6 had MASD to their bottom related to incontinence. Documented interventions included but not limited to keeping the skin clean and dry and checking for incontinence frequently. Resident 6's physician orders were reviewed and documented the following orders in regard to resident 6's skin condition: a. An order with a start date of 1/8/24 stated as followed, Calmoseptine External Ointment 0.44-20.6 % (Menthol-Zinc Oxide). Apply to coccyx fissure topically every shift for MASD May D/C [discontinue] once resolved. This order was discontinued on 2/27/24. b. An order with a start date of 2/1/24 stated as followed, Nystatin External Powder 100000 UNIT/GM [gram] (Nystatin (Topical). Apply to under breast, groin topically every shift for yeast, redness. c. An order with a start date of 2/19/24 stated as followed, WOUND CARE - MASD breakdown to crack of buttocks Cleanse with wound cleanser and pat dry. Apply medihoney sheet (cut to fit) to wound bed and cover with silicone foam dressing. Change daily and as needed for soiling/dislodgement. On 11/21/23, a weekly skin review/assessment documented, Patient is incontinent of bowel and bladder. She does try and use the restroom but constantly has soiled briefs. She has slight redness in groin area, using Nystatin to help. She has no other skin breakdown. Skin warm, dry and intact. On 11/28/23, weekly skin review/assessment documented, Patient is incontinent of bowel and bladder. She does try and use the restroom but constantly has soiled briefs and needs assistance to get changed. She has slight redness in groin area, using Nystatin to help. She has no other skin breakdown. Skin clear, warm, dry and intact. Will continue to monitor. On 12/31/23, a weekly skin review/assessment documented, Resident continues to have some redness and applied nystatin to groin, [NAME] and buttock and encouraged resident to take scheduled showers. On 1/7/24, a weekly skin review/assessment documented, Resident continues with treatment of rash to groin, [NAME] and buttock folds. Nystatin applied with brief changes. On 1/8/24 at 11:06 AM, a nurse note stated, Aide came to LN [licensed nurse] and stated that when they went to go and change pt [patient] brief, that they noticed pt had an open area. LN went in and assessed; pt has some redness noted to their coccyx area, with open fissure noted. LN communicated with management and received instruction to go ahead and apply calmoseptine r/t [related to] MASD and use Q [every] Shift, until resolved. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/14/24, a weekly skin review/assessment documented as followed, No skin issues skin is clean dry and intact barrier cream being used because of incontinences, WCTM [will continue to monitor]. On 2/4/24, a weekly skin review/assessment documented, Resident continues with treatment for redness under breasts, [NAME] and groin skin is pink and dry flaking around the edges. On 2/11/24, a weekly skin review/assessment documented, Resident continues with treatment for redness under breasts, [NAME] and groin skin is more inflammed [sic] and dry flaking around the edges. On 2/18/24 at 11:23 AM, a nurse note stated, MASD noted in buttocks along the crack skin has broken down - area cleansed and dressing applied. MD [medical doctor] and administration notified to add to wound rounds. new orders for daily dressing changes. On 2/18/24, a weekly skin review/assessment documented the following, Resident continues with nystatin under both breasts (both very red and starting to breakdown, bilateral [NAME] (light pink areas on each side). MASD noted in buttocks along the crack skin has broken down - dressing applied. On 2/21/24 at 8:32 AM, an interview was conducted with Nursing Assistant (NA) 4. The NA 4 stated resident 6 was able to reposition themselves in bed and used a brief. The NA 4 stated resident 6 was a heavy wetter and was able to notify staff when they needed a brief change. The NA 4 stated staff attempted to check on resident 6 between every 1-2 hours. The NA stated when they did their rounding, there was a high probability that resident 6 needed to be changed. The NA stated resident 6 had a bad rash on their butt and described it as red, patchy, and peeling like dry skin. On 2/21/24 at 8:40 AM, an interview was conducted with Certified Nursing Assistant (CNA) 5. The CNA 5 stated resident 6 did very minimal to help with their cares. The CNA 5 states resident 6 was able to reposition themselves in bed and was able to help turn themselves with brief changes. The CNA 5 stated resident 6 was incontinent but was able to notify staff when they needed a brief change and became impatient if not changed quick enough. The CNA 5 stated resident 6 had a rash on their bottom and believed it was either due to a reaction to the brief or because of resident 6's excessive sweat. The CNA 5 described resident 6 had a rash with red dots on their bottom and stated that ointment was applied with every brief change to help the rash. On 2/21/24 at 9:06 AM an interview was conducted with CNA 2. The CNA 2 stated resident 6 had a hard time communicating their needs and stated resident 6 sometimes yelled and screamed to get staff's attention. The CNA 2 stated resident 6 had some mental delays and behaved like a child. The CNA 2 stated resident 6's briefs were changed at least every 2 hours. The CNA 2 stated resident 6 had been told to go in their brief since they are heavy to get up. The CNA 2 stated resident 6 was able to call when they needed a brief change. The CNA 2 stated resident 6 had sensitive skin which has lead to their current skin problems. The CNA 2 stated resident 6's skin around their bottom was irritated like when a baby had diaper rash. The CNA 2 stated they applied cream with every brief change to prevent it from getting worse. The CNA 2 stated resident 6 had a history of this and this irritation was new. The CNA 2 stated the type of rash resident 6 had occurred more frequently on light colored skin since that skin was more sensitive. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/21/24 at 10:44 AM, an interview was conducted with the Director of Nursing (DON). The DON stated they were unsure if resident 6 was able to make their needs known to staff and expected staff to check on resident 6 frequently. The DON stated they expected the CNAs to go in and check on resident 6 at least every two hours and that included incontinence care if needed. The DON stated if a resident was left in a soiled brief multiple times for a prolonged period, it affected the resident's skin integrity. The DON stated the outcome of compromised skin integrity included MASD which led to further skin break down and wounds if not treated appropriately. The DON stated staff had to be diligent on checking incontinent residents and applying barrier cream to prevent MASD. The DON stated resident 6 had MASD and was being followed by the wound care provider due to this. [Cross refer to F690] 38031 9. Resident 7 was admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease, morbid obesity, alcoholic cirrhosis, hepatic failure, type II diabetes mellitus with polyneuropathy, portal hypertension, narcolepsy, major depressive disorder, obstructive sleep apnea, personality disorder, bipolar II disorder, alcoholic dependence, restless leg syndrome, male erectile dysfunction, hypertension, heart failure, anxiety disorder, hyperlipidemia, hyperaldosteronism, and osteoarthritis. On 2/05/24 at 10:21 AM, an interview was conducted with resident 7. Resident 7 stated that his scheduled shower days were Wednesday and Saturday. Resident 7 stated that the last month they had been following the schedule, but prior to that he was not provided showers. Resident 7 stated that he needed assistance with washing his genitals and back and needed his oxygen while showering. On 2/16/24, the Quarterly Minimum Data Set (MDS) assessment documented a Brief Interview for Mental Status (BIMS) score of 15, which would indicate that resident 7 was cognitively intact. The assessment documented that resident 7 required substantial maximal assistance for bathing and the helper did more than half the effort. On 2/20/24, resident 7's bathing tasks documented the bathing schedule was Wednesday and Saturday morning, and the last 30 days documented no showers were provided. On 12/6/23, resident 7's skin check/shower sheet documented that a shower was provided. No other shower sheets were noted. Resident 7's progress notes revealed the following: a. On 9/20/23 at 1:58 PM, the admission note documented, refused shower from hospice. He said he will do it tomorrow. poor hygiene noted. b. On 9/21/23 at 2:57 PM, the Nurses Note documented, He was assisted in the shower by hospice cna today. He refused shower yesterday. and he got upset when the nurse asked him to shower today. After the shower today, he refused to wear clean pants. He still wants to wear dirty pants. hospice nurse notified. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. On 9/21/23 at 5:00 PM, the Admission: 72 Hour Charting note documented, required 1 person extensive with shower, dressing. pull up use for incontinent of bowel. refused to change his pants even he has stool on after the shower. d. On 11/22/23 at 2:14 PM, the Nurses Note documented, RNC [regional nurse consultant] and Administrator went to speak with this resident regarding his care concerns. resident expressed he does not want 2 staff for his cares including showers and housekeeping to clean. He often refuses when attempts are made to clean his room and it has a foul odor and belongings everywhere which he will not allow to be cleaned up. He did report that he was showered yesterday. e. On 11/29/23 at 5:11 AM, the Nurses Note documented, Resident came out of his room demanding a shower, although he was not on the list for showers. Resident is to shower on Saturdays. Resident proceeded to yell at staff and scratched a CNA [certified nurse assistant]. Nurse informed the DON [Director of Nursing] and was instructed to call 911 for a police report. Nurse encouraged resident to be polite, respectful and patient. Resident continued to yell and argue with the staff. Police came to facility and completed a police report. f. On 12/10/23 at 1:18 AM, the Nurses Note documented, no issues with behaviors although patient claims to have asked for a shower and didn't receive one. g. On 12/10/23 at 11:47 AM, the Nurses Note documented, Resident has been calm and cooperative with cares. Took meds as prescribed minus lactulose. Resident still looking for armodafinil prescription that hasn't been filled. He claims he wasn't showered yesterday, nurse asked CNAs to please accommodate him today. h. On 1/31/24 at 10:47 AM, the Social Service Note documented, He was excited to be having pizza for dinner and then have a shower. He states he has no other concerns at this time. i. On 2/1/24 at 3:16 PM, the Nurses Note documented, Patient has not been abusive to this nurse or residents but earlier he was demanding to have a shower when he refused his shower yesterday, He kept telling his aid that he was busy. j. On 2/1/24 at 3:23 PM, the Nurses Note documented, When the patient was demanding a shower the aid explained to him that it was not his shower day and that it was 12 oclock and lunch was being served and he needed to get the lunch trays out. the resident started yelling and said that he is a priority patient, and needed a shower. The patient went to his room. The aid that tried to shower him yesterday said that he would try and get him in the shower today. On 9/18/23, resident 7 had a care plan initiated for had a Activities of Daily Living (ADL) self-care performance deficit. Interventions identified included Cares with Pairs: Assist of 2 with cares when in room related to behaviors; adjust ADL assistance per level of need at time of care; and required limited/ partial/ moderate assist of 2 due to behaviors for bathing/showering; (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/08/24 at 10:18 AM, an interview was conducted with the CNA Coordinator (CNAC). The CNAC stated that the shower sheet was posted in a binder so that the aides could see who was scheduled for a shower that day. The CNAC stated that they were struggling with showers due to staff turn over. The CNAC stated that the shower sheet should be uploaded into the resident's electronic medical records. The CNAC stated that if a resident wanted more showers they were allowed, but first they would complete that days scheduled showers. The CNAC stated that if a resident refused a shower the aides were to fill out the refusal sheet and take it to the nurse to sign. The CNAC stated that resident 7 needed 2 staff to provide cares for moody and aggressive behaviors. The CNAC stated that resident 7 needed assistance with showers. On 2/20/24 at 1:06 PM, an interview was conducted with Nursing Assistant (NA) 1. NA 1 stated that resident 7 required a two person assist for transferring and a one person assist for showers. NA 1 stated that they documented showers in the shower sheet and in the electronic medical records. On 2/20/24 at 1:11 PM, and interview was conducted with NA 2. NA 2 stated that they documented the showers on the shower sheet and any refusals. On 2/20/24 at 1:16 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that she was not seeing any shower sheets for resident 7. [Cross refer to F676] 10. Resident 4 was admitted to the facility on [DATE] with diagnoses which included mononeuropathy, chronic respiratory failure, type II diabetes mellitus, morbid obesity, chronic obstructive pulmonary disease, non-pressure ulcer of left calf, schizoaffective disorder, epilepsy, hypothyroidism, peripheral vascular disease, varicose veins, hypertension, bilateral osteoarthritis of hip, intervertebral disc disorder, edema, chronic pain syndrome, tremor, overactive bladder, hyperlipidemia, viral hepatitis C, insomnia, sleep apnea, post traumatic stress disorder, anxiety disorder, bipolar disorder, borderline personality disorder, and major depressive disorder. On 2/12/24 at 12:43 PM, an interview was conducted with resident 4. Resident 4 stated that on Saturday night at approximately 11:00 PM the nurse left for 45 minutes because he locked the keys inside the medication cart and had to drive to the Director of Nursing (DON) house to get a second set of keys. Resident 4 stated that the residents were left with only one aide for an hour. Resident 4 stated that the nurse on shift was Registered Nurse (RN) 4. On 2/12/24 12:49 PM, an interview was conducted with the DON. The DON stated that she got a call after 10:00 PM on Saturday night from RN 4. The DON stated that RN 4 had reported that he had locked the keys to the medication cart inside the cart and there were no spare keys. The DON stated that she called the pharmacy to see if they had any spare keys inside the Pixus and they did not. The DON stated that they were in the process of obtaining a spare key to have in a lock box in the medication room. The DON stated that the aide on shift came to her home to get her office keys and then RN 4 was able to get into her desk to obtain the spare medication cart keys. The DON stated that she did not know who the aide was that came and picked up the keys. The DON stated that she placed her office key under her front door mat for them to retrieve. The DON stated that the nurse should not have left the facility and it should have been the aide to come and pick up the spare key. The DON stated that she would verify with RN 4 who came to pick up the key. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/12/24 at 1:49 PM, a telephone interview was conducted with Nurse Assistant (NA) 7. NA 7 confirmed that she worked on Saturday night and RN 4 locked the keys in one of the carts. NA 7 stated that RN 4 left the facility and went to the DON's house to get a spare key. NA 7 stated that there were no issues with the resident while the licensed nurse was gone from the facility. 11. On 2/21/24 at 7: [TRUNCATED]

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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** 38031 Based on interview and record review it was determined, for 1 out of 40 sampled residents, that the facility failed to have sufficient nursing staff with the appropriate competencies and skill 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. Specifically, a resident was transported via the facility van and the wheelchair was not secured properly inside the vehicle which resulted in the resident falling backwards causing hyperextension of his neck. The resident was diagnosed with central cord syndrome and edema at the level of C6 and C7 of his cervical spine. Upon return to the facility the resident's cervical collar was removed by Certified Nursing Assistant(s) (CNA) during grooming and bathing cares. After the resident's shower, the CNAs attempted to transfer the resident to bed unsuccessfully and the resident was assisted to the floor. These identified deficient practices were found to have occurred at the Immediate Jeopardy (IJ) Level. Additionally, staff reported that orientation training to newly hired Nurse Assistants and Certified Nurse Assistants was not performed and Nurse Assistants were in charge of training new hires. Resident identifier: 96. NOTICE On [DATE] at 4:00 PM, an Immediate Jeopardy was identified when the facility failed to implement Centers for Medicare and Medicaid Services (CMS) recommended practices to identify hazard(s) and risk(s): evaluate and analyze the hazard(s) and risk(s); implement interventions to reduce hazard(s) and risk(s); and monitor for effectiveness and modify the interventions when necessary. Specifically, the facility failed to ensure that staff transporting residents and their equipment were trained on how to secure residents properly to prevent falls or injury; that residents with medical devices or fixtures surgically placed, or otherwise applied to, or adjacent to their person were reviewed to validate monitoring orders, care planning, and appropriate staff training were in place; and that resident's mobility and transfer status including type of transfers and number of staff to perform were assessed and care planned. Notice of the IJ was given verbally and in writing to the Chief Nursing Officer (CNO), Regional [NAME] President (RVP), Administrator (ADM), Administrator in Training (AIT), Director of Nursing (DON), and the Corporate Resource Nurse (CRN) and they were informed of the findings of IJ pertaining to F726 for resident 96. On [DATE], the Administrator provided the following revised abatement plan for the removal of the Immediate Jeopardy effective [DATE] at 11:59 PM. F689/F726: Free of Accident/Hazards & Competent Nursing Staff. Resident #96 is no longer a resident of this facility; therefore, an individualized plan of action is not possible. The Certified Nursing Assistant Coordinator's employment with the facility was self-terminated on [DATE]. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Director of Nursing who was at the facility in [DATE] is no longer an employee of this facility. Abatement Plan. Accident/Hazards Prevention The Director of Nursing/Designee to do an audit of all residents on [DATE] to identify residents with medical devices or fixtures surgically placed, or otherwise applied to, or adjacent to their person. Identified devices reviewed to validate monitoring orders, care planning, and appropriate staff training are in place. The Director of Rehab/Designee to complete an assessment of all resident's transfer status, including type of transfer and number of staff to perform safely. Care Plans Reviewed and Updated as indicated to reflect current needs. The Director of Nursing/Designee to provide training on safe transfers and accident/hazards prevention to Facility Nurses and Nursing Assistants on [DATE]. Training to include proper transfer techniques utilized in the facility, the prohibition of using towel transfers, and where to find information in the care plan regarding individualized requirements for transfers. This training will be validated by a post-test to validate understanding of the material and Physical Therapist to complete return demonstration of transfer techniques with staff. The Director of Nursing to provide training on [DATE] to all Facility Nurses and Nursing Assistants on the definition of a fall and what documentation must be completed when a fall occurs. This training will be validated by a post-test to validate understanding of the material. Transportation The Administrator reviewed all individuals who perform transport duties and validated they have received training including securement of wheelchairs, securement of ambulatory residents, and securement of equipment in the transport van. A return demonstration checklist will be completed with transportation staff prior to their next transport. Any future staff member(s) providing transport services are to receive this training prior to beginning transport duties. Existing drivers to receive refresher training annually and as needed. Staffing Training/Orientation The Chief Nursing Officer (CNO)/designee will provide education to the Inter-disciplinary team (IDT) on [DATE] about company policy on orientation and training to staff who provide direct patient care to residents of the facility and how to properly transfer residents. The Director of Nursing/Designee to review employees who have been hired in the past three months to verify orientation training has been completed on [DATE]. Any employee who does not have the orientation completed will meet with the Director of Nursing/Designee prior to the start of their next shift to create a plan to complete their training and review key interventions to keep residents safe. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Agency The Director of Nursing/Designee to create a summary of this training and put this in the agency binder, to provide agency staff resources to prevent accident/hazards. Training Timeline All Staff will receive training by Director of Nursing/Designee prior to their next working shift. Monitoring The Director of Nursing/Designee to do interview with Charge Nurse(s) for each shift and review expectations for accident/hazards prevention and reporting until the IJ abatement is completed. The facility to review the 24-hour report in daily (M-F) stand-up meetings, and as needed to validate that any accidents/hazards were followed up with in accordance with professional accepted standards of care. This audit to continue ongoing. On [DATE], while completing the recertification survey, surveyors conducted an onsite revisit to verify that the Immediate Jeopardy had been removed. The surveyors determined that the Immediate Jeopardy was removed as alleged on [DATE]. Findings included: IMMEDIATE JEOPARDY 1. Resident 96 was admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses which included central cord syndrome at C6, acute respiratory failure, type II diabetes mellitus, polyneuropathy, hepatic failure, pneumonia, lack of coordination, reduced mobility, muscle weakness, dysphagia, contusion of right wrist, cervicalgia, Parkinson's Disease, dementia, pressure ulcer of sacrum, atrial fibrillation, chronic kidney disease, hypertension and hyperlipidemia. On [DATE], resident 96's Admission Assessment documented that resident 96 required extensive assistance for bed mobility, transfers, dressing, toilet use, and personal hygiene. The assessment documented that resident 96 was alert and oriented to person and situation, had poor memory and could not recall place and time. Resident 96 was assessed as requiring extensive assistance for locomotion on and off the unit and a wheelchair was used as a mobility device. On [DATE], the Morse fall scale documented a score of 65, which would indicate high risk for falls. The assessment documented that resident 96 had fallen before. The assessment documented that resident 96's gait was weak and he overestimated or forgets his limits with his ability to ambulate safely. On [DATE], resident 96's Minimum Data Set (MDS) Assessment documented that resident 96 required a one-person extensive assist for bed mobility, transfers, and toilet use. The assessment documented a Brief Interview for Mental Status (BIMS) score of 3, which would indicate a severe cognitive impairment. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 4:40 PM, an order for C-Collar to be worn AT ALL TIMES, please check to make sure that collar is on resident was initiated for resident 96. The order indicated that it was indefinite with no end date. The [DATE] Treatment Administration Record (TAR) revealed the order for the C-collar to be worn AT ALL TIMES. The order was discontinued on [DATE]. The November and [DATE] TAR did not have any orders monitoring for the c-collar. Resident 96's progress notes and incident reports revealed the following: a. On [DATE] at 1:53 PM, the Incident Note documented, I received a phone call today from the CNA [Certified Nurse Assistant] Coordinator, who was providing transportation for this resident to an appointment at the [name of hospital omitted], the CNA Coordinator stated that when coming to a stop, the wheelchair became dislodged and tipped backwards, CNA Coordinator immediately stopped vehicle and called for assistance from EMS [emergency medical services], the Administrator and I arrived at the scene at about 14:20 [1:20 PM], the resident was complaining of head and neck pain, EMS was treating him, the police officer and the EMS workers all stated that the resident was still strapped into the wheelchair with the seatbelts (EMS reported that there was tension in the belts still), resident was transferred via EMS to [local area hospital] for evaluation, provider notified, family notified. On [DATE] at 1:53 PM, the incident report further documented that resident 96 was very agitated, clutching his head while leaned over, unable to provide description of what occurred (resident has dementia). Resident 96 Pain Assessment in Advanced Dementia (PAINAD) score was assessed as a 9, which would indicate severe pain. The report documented that resident 96 required extensive assistance with transfers. The report further documented, resident possibly secured improperly, improper instruction given to CNA Coordinator about how to strap patient down properly in wheelchair. b. On [DATE] at 6:16 PM, the Incident Note documented, I have called [local hospital] for update: no fractures, some weakness on left side, they will do MRI [Magnetic Resonance Imaging] to rule out any damage to brain, they will call and update me when information is available. I called family of resident to update them on situation. They will continue to await any call on an update on his condition. c. On [DATE] at 10:23 PM, the Nurses Note documented, Hospital called facility and stating they are going to admit him and continue to monitor overnight. d. On [DATE] at 1:04 PM, the Nurses Note documented, Central cord syndrome found on MRI, resident currently in ICU [Intensive Care Unit] r/t [related to] he was having a difficult time maintaining his blood pressure, he is currently not on any supplemental blood pressure medication and the nurse stated that he will soon be ready to transfer either to a step down unit or back to facility, I gave them my name and phone number as a contact for [resident 96], will call again tomorrow for a new update. e. On [DATE] at 4:26 PM, the MDS Note documented, [Resident 96] readmitted from hospital on [DATE] on Medicare part A services with dx [diagnosis] of central cord syndrome at C6 level. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	f. On [DATE] at 9:26 AM, the Incident Note documented, Investigation completed. Facility will be completing training on all drivers and 2 sets of trained eyes will verify proper strap placement on transports. Interventions put in place. MD [Medical Director] to follow up. g. On [DATE] at 8:44 AM, the Nurses Note documented, Resident had episode of syncope this morning, NP [Nurse Practitioner] orders vital signs to be taken BID [two times a day]. It should be noted that no other documentation could be found for the syncopal episode. h. On [DATE] at 5:37 AM, the Incident Note documented, Resident was up in chair in dining room for dinner, CNA noticed and reported to nurse that resident did not look well. VS [vital signs]: BP [blood pressure]:, d+[DATE], P [pulse]: 62, o2[oxygen saturation]: 74%, R [right] pupil enlarged, L [left] pupil smaller, A&O [alert and oriented] x1. CNA transferred resident to bed, Nurse administered oxygen at 3L [liters], and raised head of bed. Vitals taken every 10 min [minutes] until stable and o2 at 85%. Nurse informed MD and DON, per MD, transfer to hospital. EMT [Emergency Medical Technician] arrived at 1900 [7:00 PM] and transferred resident to [local hospital]. DON notified family. On [DATE] at 5:37 AM, the incident note further documented that the predisposing physiological factors were drowsy, hypotensive, recent change in condition, and weakness/fainted. i. On [DATE] at 11:13 AM, the Nurses Note documented, I spoke to nurse at [local hospital] today. Resident is on diltalazem (sic) drip, insulin drip. He is normo-tensive. Now on 13L high flow oxygen, lung sounds are diminished. No discharge date set yet. I informed provider and family. j. On [DATE] at 1:44 PM, the incident report documented, resident was about to slide out of his chair. so the nurse tried to help him up but he slid down more and more and the nurse assisted him to the floor and asked for more help to assist him back to the chair. no apparent injury, no head hitting. He denied of pain. The report documented that the therapy staff assisted the resident back to the chair and 4 staff members were needed for the transfer. k. On [DATE] at 9:37 AM, the Interdisciplinary Team (IDT) Event Review documented, IDT fall review: root cause is found to be this resident's change in condition after accident that resulted in central cord syndrome, intervention: new wheelchair is in process of being purchased, resident will also be moved to room [ROOM NUMBER] to be closer to nurse station, current wheelchair has been modified by physical therapy to help prevent further falls, all other least restrictive interventions in place, will continue with plan of care. l. On [DATE] at 10:00 AM, the IDT Event Review documented, Follow up [DATE] incident: [Resident 96] has been moved to room [ROOM NUMBER] for increased monitoring. Therapy is getting tilt-in-space wheelchair. m. On [DATE] at 3:20 PM, the Nurses Note documented, MD in to visit per MD if we don't already have a end date neck brace lets do end date to come off after 12 weeks x-ray cervical spine 2 view 1 week prior to that. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	n. On [DATE] at 5:14 PM, the Nurses Note documented, Resident had hair cut today, then shower this afternoon. Within minutes after laying him back down he stopped breathing. The nurses performed assessment on him, he had no pulse and was not breathing. DNR [Do Not Resuscitate]. Family notified, MD notified. On [DATE], the Hospital History & Physical documented the chief complaint as a fall. An MRI of the cervical spine documented the impression as Focal edema within the spinal cord at and below the level of the C6/C7 disc space which may be secondary to contusion from adjacent osteophytes at C6/C7. The MRI further documented, Diffuse edema within the paravertebral soft issue from the occiput through the craniocervical junction and a Small amount of fluid in the C6/C7 disc space. Findings could be secondary to hyperextension injury. The Medical Decision Making documented that the MRI revealed a central cord syndrome with cord edema at C,d+[DATE] level secondary to adjacent osteophytes. The resident was admitted to ICU so that the mean arterial pressure could be monitored and kept at greater than 85 millimeters of mercury (mmHg). The resident was transitioned from a hard collar into an Aspen collar. The assessment documented that the resident suffered a hyperextension injury of the C-spine when he toppled in his wheelchair in a transport vehicle, and this resulted in central cord syndrome involving C6/C7. On [DATE], the Hospital Discharge Summary documented that resident 96 was to follow-up with a neurosurgeon in four weeks with a repeat CT of the cervical spine. On [DATE], the Record of Death documented that resident 96 had expired. Resident 96's Care Plans revealed the following: a. A care area for central cord syndrome r/t trauma related to motor vehicle incident that was initiated on [DATE]. The interventions identified included: Discuss with resident/resident and family any concerns, fears, issues regarding diagnosis or treatments; Ensure that c-collar is in place every shift; Give medications as ordered. Monitor/document for side effects and effectiveness; and Physical Therapy (PT), Occupational Therapy (OT), Speech Therapy (ST) to evaluate and treat as ordered. b. A care area for Activities of Daily Living (ADL) selfcare performance deficit r/t Confusion, Dementia, Fatigue, Impaired balance, BUE [bilateral upper extremity] tremors, recent motor vehicle incident with injury to neck and right wrist, pain. The interventions identified included: Resident has a neck brace and right wrist restriction due to pain and injury, use caution and assist with ADLs; scheduled every 2 hour turning to keep resident off of his tailbone (coccyx); Adjust ADL assistance per level of need at time of care; The resident required substantial/maximum assistance of 1 staff for bathing/showering, bed mobility, dressing, personal hygiene, and toileting; The resident required substantial/maximum assistance of 1 staff for 1:1 dining assistance and the resident was at risk for choking and aspiration; The resident required substantial/maximum assistance of 2 staff for transfers; and PT/OT evaluation and treatment as per MD orders. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 1:50 PM, the facility investigation documented that the resident was involved in an accident while being transported in the facility van. The initial report documented that the resident fell back in the transport vehicle on his way to an appointment. The facility's final investigation documented that the resident outcome to the incident was a Central Cord Syndrome injury. At the time of injury, the resident reported some pain but was unable to state what happened in the van. The summary of interviews documented that Nurse Assistant (NA) 2 had reported that he had wheeled the resident out to the transport vehicle where the CNA Coordinator (CNAC) strapped the patient in with all four straps and seat belt. NA 2 stated that he had never done anything with transportation prior. The summary of interviews documented that the CNAC stated that when she came to a stop and looked back, she saw that the resident was no longer sitting upright. The CNAC stated that she came to a stop, turned on her hazards, exited the vehicle, and waved down help. The CNAC stated that she put down the ramp with the patient. The CNAC stated that she did not receive training on how to use the van prior to transporting resident 96. The investigation documented under the summary that the CNAC was scheduled to be trained to assist in covering for the normal transport driver. The day the CNAC was scheduled to be trained she was sent home due to having COVID. The Previous Transport Driver (PTD) confirmed that the CNAC had participated in a previous transport by watching and sitting at an appointment with a patient. The report documented that the CNAC had placed the safety straps on the wheelchair wheels and not the wheelchair frame. The report documented that they assumed that the patient pushed on the [NAME] in front of him and tipped backward as a result of the strap placement. The conclusion of the facility investigation documented that the incident was a result of improper placement of safety straps on the wheelchair wheels and not the wheelchair frames. The root cause identified was insufficient training in transportation. The facility provided a driving in-service on [DATE]. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 2:37 PM, an interview was conducted with the CNAC. The CNAC stated that she was the driver of the vehicle at the time of the accident with resident 96. The CNAC stated that she had only transported for the facility twice, and once with resident 96. The CNAC stated that she had not been given training on how to transport residents, had never ridden with another driver, and was not shown how to properly secure someone down inside the van. The CNAC stated that she secured resident 96's wheelchair wheels down with the straps and placed the seatbelt over resident 96. The CNAC stated that she thought she had secured resident 96 correctly. The CNAC stated that she placed the straps from the floor of the van and hooked them to the wheels of the wheelchair on both sides, four straps in total. The CNAC stated that she did not connect the straps to the frame of the wheelchair. The CNAC stated that she was told after the accident that this was not how it was supposed to be done. The CNAC stated that she checked the resident in the rearview mirror during the transport and talked to him. The CNAC stated that she had just made it to the freeway entrance when she looked back and noticed that resident 96 had fallen backwards. He was folded in half like a taco. The CNAC stated that she pulled over and stopped the vehicle. The CNAC stated that she found resident 96 folded up against the drop gate. The CNAC stated that before she let the drop gate down, she removed her hoodie and placed it under resident 96's neck to support it. The CNAC stated that resident 96's legs were positioned up towards his chest and torso, and his head was folded down towards his chest. The CNAC stated that as she lowered the gate, she placed her hoodie for support so his neck would not hyperextend. The CNAC stated that resident 96 was able to answer questions, and said his head hurt. The CNAC stated that resident 96 had a small scrap on the back right side of his head from contact with the drop gate. The CNAC stated that when EMS arrived, they moved resident 96 without placing a c-collar on the resident first. The CNAC stated that EMS undid the seatbelt, moved the chair to a seated position, and backed him out of the van. The CNAC stated that resident 96 began to convulse, and he had no history of a seizure disorder prior. The CNAC stated that the ADM and Previous Director of Nursing (PDON) arrived at the scene and started drilling her. The CNAC stated that she was suspended for abuse and returned to work 5 days later. The CNAC stated that the facility substantiated the allegation of abuse, and that the facility was at cause because she had never received proper training. The CNAC stated that the next day they started training everyone in the facility on how to transport someone. The CNAC stated that she refused to sign the in-service training log because the training was conducted during her suspension period. The CNAC stated that she was suspended on Sunday and the incident occurred on Friday. The CNAC stated that she worked remotely on Saturday and Sunday and then she was on suspension for a week. The CNAC stated that resident 96 had returned to the facility and she had told the PDON that she was uncomfortable working with resident 96 again. The CNAC stated that she did not want to lose her license. The CNAC stated that resident 96's family had come to the facility and said they were upset that she was still working at the facility. The CNAC stated that she did not mind training the staff on how to care for resident 96. The CNAC stated that she showed staff from a distance how to clean the c-collar, and how to safely transfer resident 96. The CNAC stated that for resident 96 they could not use a hoyer lift for transfers because this was contraindicated with a spinal cord injury. The CNAC stated that she did not participate in resident 96 care for quite some time after the incident. The CNAC stated she had noticed before resident 96 passed away he was unkept, his beard and nails were long. The CNAC stated that she clipped his nails and then asked the PDON if the hair school could give him a haircut. The CNAC stated that the PDON stated it was safe to remove the c-collar for care. The CNAC stated that she thought the resident was going to have his c-collar removed the following day at a scheduled doctor's appointment. It should be noted that the transportation schedule did not document that resident 96 was scheduled for any appointments on [DATE], which would have been the following day. The CNAC stated that she was never asked not to have contact with resident 96, that it was a personal preference. The CNAC stated that resident 96 passed away that day, and he was not on hospice and it was not expected. The CNAC stated that she assisted resident 96 during his hair cut. The CNAC stated that resident 96's c-collar was removed for the haircut, and she held his head still, with no sudden movements and no flexion or extension of the neck. The CNAC stated that NA 3 and NA 5 had assisted resident 96 with a shower. The CNAC stated that she believed resident 96's c-collar was removed for the shower under the direction of the PDON. The CNAC stated that NA 3 and NA 5 were both new aides that time. The CNAC stated that the PDON called her at approximately 5:15 PM, on the day that

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 8:38 AM, an interview was conducted with the DON. The DON stated that if a resident had a c-collar applied she would expect to see an order for it and monitoring. The DON stated that documentation of the monitoring could be in the TAR or in a progress note. The DON confirmed that the October TAR documented that the c-collar order was discontinued on [DATE]. The DON stated that she would interpret the nurse note on [DATE] as discontinue the c-collar in 12 weeks from [DATE]. On [DATE] at 2:12 PM, a follow-up interview was conducted with the DON. The DON stated that the order for the c-collar should not have been discontinued and the c-collar was to stay on at all times. The DON stated that the PDON stated that the c-collar had stayed on resident 96 up until his death. The DON stated that if you had a spinal injury, it might be necessary to have the c-collar at all times, and it would stabilize the neck. The DON stated that the provider should supervise any removal of the collar. The DON stated that if the c-collar was removed it would be possible to re-injury the injury you were trying to fix. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 2:22 PM, an interview was conducted with NA 3. NA 3 stated that she had provided care for resident 96. NA 3 stated that she was not sure why resident 96 wore a neck brace. NA 3 stated that she showered resident 96 one time with the assistance of the CNAC on the day that he passed away. The shower was provided in the communal shower room. NA 3 stated that the residents were doing their monthly haircuts, and resident 96 had a haircut and his beard shaved. NA 3 stated that afterwards she informed the CNAC that it was resident 96's scheduled shower day. NA 3 stated that this was the first time she had provided resident 96 with a shower, and the CNAC said since resident 96 was already up she would assist NA 3 with the shower. NA 3 stated that they washed resident 96's hair, beard, chest, and feet. NA 3 stated that while they were performing the shower resident 96 was having a bowel movement. NA 3 stated that the CNAC told her that when resident 96 received a shower they took his c-collar off, and that the CNAC was the person who removed the collar. NA 3 stated that the CNAC was helping her with the shower by holding the shower head and rinsing resident 96 off. NA 3 stated that she was washing resident 96 while the CNAC was holding the shower head. NA 3 stated that she washed resident 96's chest and neck. NA 3 stated that resident 96 was sitting in a shower chair during the shower. NA 3 stated that they washed the front, sides and back of resident 96's neck. NA 3 stated that while the CNAC was holding the shower head she was guiding NA 3, saying that if she was washing the neck gently and the neck and spine were aligned it would be okay. NA 3 stated that they made sure that resident 96 was not moving around. NA 3 stated that NA 5, PDON and the CNAC were all present during resident 96's shower. NA 3 stated that she was training NA 5 and asked the CNAC how to shower resident 96. NA 3 stated that the CNAC had the PDON come assist with transferring resident 96 onto and then off the shower chair. NA 3 stated that once resident 96 was transferred only she, NA 5 and the CNAC were present. NA 3 stated that she did not recall if the PDON was present when they removed the neck collar. NA 3 stated that at that point in time she had only worked at the facility for ,d+[DATE] months, and she was training NA 5. NA 3 stated that NA 5 only observed during the shower. NA 3 stated that resident 96 wore his c-collar during the transfers and it was only removed during the shower. NA 3 stated that resident 96 was good at sitting up straight, and he was not leaning. NA 3 stated that no one was holding or stabilizing resident 96's head once the c-collar was removed, and the c-collar was off for approximately 20 minutes for the duration of the shower. NA 3 stated that the CNAC switched positions, and she held the shower head while the CNAC washed resident 96's genitals. NA 3 stated resident 96 did not have to shift positions to have his genitals cleaned as the shower chair had a hole in the seat. NA 3 stated that she asked the CNAC how to put the neck brace back on, and the CNAC placed the c-collar back on resident 96. NA 3 stated that the c-collar had two parts to it, a front and a back. NA 3 stated that the CNAC first placed the front on to make sure the neck was visible, and the sides were placed near his collar bones. NA 3 stated that the back piece had two Velcro tabs that strapped around to the front to make sure it stayed in place. NA 3 stated that she asked the CNAC how she knew the difference between the back and the front piece, and she told her that the back piece should be longer than the front. NA 3 stated that the c-collar was solid and did not have a whole in the front piece to visualize the neck. NA 3 stated that she could not tell the difference between the front and back piece, had never worked with a neck brace before, and wanted to know what to do if she came across it again. NA 3 stated that she did not confirm with the nurse prior to removing the neck brace. NA 3 stated that the CNAC said that they would just quickly give him a shower without it. NA 3 stated that after they reapplied the neck brace, they put a hospital gown on resident 96. NA 3 stated that the CNAC and PDON transferred resident 96 from the shower chair onto the wheelchair and the CNAC told her to put him back into bed. NA 3 stated that she and NA 5 took resident 96 back to his room. NA 3 stated that they tried to transfer resident 96 back to bed, but they could not physically do it. NA 3 stated that she and NA 5 attempted to do the same transfer method as the PDON and CNAC, the towel transfer. NA 3 stated that this transfer method had a towel under the resident's knees and the staff arm under the resident armpit, and as you hold the towel you shift the resident's weight to transfer them. NA 3 described the towel transfer method as standing at the residents' side facing him with the arm closest to the resident placed under his arm and the arm further away was crossed and holding the towel. NA 3 stated that when you transferred the resident the staff arms slightly uncross, enough to move the resident legs. NA 3 stated that this method caused the aide to twist her upper back during the transfers. NA 3 stated that she and NA 5 could lift resident 96. NA 3 stated that resident 96' [TRUNCATED]

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. 22992 Based on interview and record review, the facility used individuals working in the facility as a nurse aide for more than 4 months, on a full-time basis. Specifically, three Nursing Assistants were providing resident cares despite working at the facility for more than 120 days and not being certified. Findings include: On 2/13/24, the files of 3 Nursing Assistants (NAs) were reviewed and revealed the following: a. NA 2 had a hire date listed as 9/25/23. b. NA 3 had a hire date listed as 9/1/23. c. NA 7 had a hire date listed as 8/7/23. The facility staff schedule for the week of 2/4/24 through 2/10/24 was reviewed. NA 2, NA 3 and NA 7 were all scheduled and assigned a section of the facility to provide cares for residents during that week. On 2/7/24 at 9:55 AM, an interview was conducted with Nurse Assistant (NA) 2. NA 2 stated that he had worked at the facility for 2 months and he was working on getting his certificate. On 2/14/24 at 2:22 PM, an interview was conducted with NA 3. NA 3 stated that she had not taken the test to become certified yet. NA 3 stated that she was training other NAs and Certified Nursing Assistants (CNAs) at the facility. On 2/7/24 at 11:45 AM, an interview was conducted with NA 4. NA 4 stated that she was a new hire and planned to work at the facility for 30 days and then the facility would start her certification class work. NA 4 stated that she would be obtaining her certification through a separate program. NA 4 stated that she trained for a few days with the staff at the facility and they showed her how to do everything. On 2/13/24 at 10:50 AM, the Business Office Manager (BOM) was interviewed. The BOM confirmed that NA 2, NA 3, and NA 7 had been working at the facility for longer than 120 days. The BOM stated that NA 2 was finishing his clinical's and then taking his test. The BOM stated that per corporate policy, staff members who had not been employed at the facility for 60 days as an NA were not enrolled in school to become certified. (continued on next page)

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/13/24 at 12:05 PM, an interview was conducted with the facility Administrator (ADM). The ADM stated that because of the high turnover rate of staff, NAs were not enrolled in a certification program until they had been employed for at least 60 days. The ADM confirmed that NA 2, NA 3 and NA 7 had been working at the facility providing cares for residents for longer than 120 days. The ADM stated that it was the Certified Nursing Assistant Coordinator (CNAC) who was responsible for ensuring NAs were certified before they worked at the facility for 120 days. 38031

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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** 38031 Based on interview and record review it was determined, for 1 of 40 sampled residents, that the facility did not ensure that the resident received the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Specifically, a resident with suicidal ideation, suicidal attempt, and homicidal ideation was assessed as requiring mental health services and those services were not provided. The deficient practice identified was cited at a harm Level. Resident identifier: 29. Findings include: Resident 29 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included a traumatic brain injury (TBI), hemiplegia and hemiparesis, major depressive disorder, panic disorder, anxiety disorder, low back pain, hepatitis C, seizures, hyperlipidemia, overactive bladder, benign prostatic hyperplasia, insomnia, migraine, schizoaffective disorder, lymphangioma, history of transient ischemic attack, and history of suicidal behavior. On 2/06/24 at 9:24 AM, an interview was conducted with resident 29. Resident 29 stated that he recalled previously sharpening a butter knife with the intent to stick his old roommate under the arm. Resident 29 stated that his old roommate, resident 99, was having sex with his old girlfriend and because of this he was going to stab resident 99. Resident 29 stated that resident 4 witnessed him sharpening the knife and asked him not to do it. Resident 29 stated that resident 4 liked resident 99 and did not want to see him hurt. Resident 29 stated that he never tried to hurt resident 99. Resident 29 stated that he never spoke to anyone at the facility about the incident and never spoke to the nurse about it. On 2/06/24 at 10:55 AM, an interview was conducted with resident 4. Resident 4 stated that she vaguely recalled another resident sharpening a knife. Resident 4 stated that she took the knife away and gave it to the nurse. On 6/22/23, resident 29's Patient Health Questionnaire (PHQ)-9 depression assessment documented a score of 17, which indicated moderately severe depression. On 9/21/23, resident 29's PHQ-9 depression assessment documented a score of 11, which indicated moderate depression. On 10/4/23, resident 29's PHQ-9 depression assessment documented a score of 7, which indicated mild depression. On 8/14/23, resident 29's Brief Interview for Mental Status (BIMS) assessment documented a score of 9, which indicated a moderate cognitive impairment. On 10/9/23, resident 29's BIMS assessment documented a score of 11, which indicated a moderate cognitive impairment. (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	On 6/27/23, resident 29's PASRR Level II documented the resident's past medical history of a TBI due to assault that resulted in a craniotomy. Resident 29 then sustained a car accident that affected the right hemisphere with paralysis of the left upper extremity. On 4/28/23, resident 29 was hospitalized with increased extracranial fluid and periorbital cellulitis with Methicillin-resistant Staphylococcus aureus (MRSA) bacteremia. Resident 29's history of psychiatric symptoms documented a history of depression and anxiety dating back to childhood. Resident 29 reported that his mother was abusive and neglectful and she forced him to go with a man who was a pedophile for money. Resident 29 endorsed a history of depressed mood, anhedonia, problems with sleep, problems with concentration, feeling of worthlessness and history of suicidal ideation. Resident 29 stated, I am depressed and I'm anxious and I have panic attacks. I feel like I'm absolutely no good. Resident 29 reported that he was hospitalized multiple times for mental health and attempted suicide at least twice. Resident 29 reported worsening of depression since accident and stated, I just wish life would be over. I just want to give this body back. Resident 29 stated he was depressed and very anxious. The assessment documented resident 29's mental illness diagnoses as major depressive disorder, panic disorder, and anxiety disorder. The assessment recommendations for specialized services for mental illness treatment were individual counseling and review of psychotropic medications. On 9/21/23, resident 29's PASRR level II documented the current psychiatric functioning was that resident 29 was struggling with feeling he needed to use the bathroom constantly and not being able to urinate. Resident 29 reported that this made him extremely anxious and he perseverated about this all the time. Resident 29 reported that his depression was less and he felt he was doing okay. The assessment recommendations for specialized services for mental illness treatment were individual counseling and review of psychotropic medications. Review of resident 29's physician orders revealed the following: a. On 5/10/23, an order was initiated for Clonazepam 1 milligram (mg) Oral Tablet, give 1 tablet by mouth as needed for Anxiety two times daily as needed. b. On 10/19/23, an order was initiated for Duloxetine Hydrochloride (HCL) Oral Capsule Delayed Release Particles 30 mg, give 30 mg by mouth one time a day related to major depressive disorder. c. On 1/30/24, an order was initiated for Duloxetine HCl Oral Capsule Delayed Release Particles 30 mg, give 30 mg by mouth one time a day related to major depressive disorder. d. On 5/10/23, an order was initiated for Escitalopram Oxalate Tablet 20 MG, give 1 tablet by mouth one time a day for depression. e. On 5/23/23, an order was initiated for Escitalopram Oxalate Oral Tablet, give 40 mg by mouth one time a day related to depression. f. On 1/30/24, an order was initiated for Escitalopram Oxalate Oral Tablet, give 40 mg by mouth one time a day for depression. g. On 5/19/23, an order was initiated for Hydroxyzine HCl Tablet 25 mg, give 1 tablet by mouth every 6 hours as needed for itching. (continued on next page)

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Meadow Brook Rehabilitation and Nursing	433 East 2700 South Salt Lake City, UT 84115

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F 0740 Level of Harm - Actual harm Residents Affected - Few	h. On 9/12/23, an order was initiated for Hydroxyzine HCl Oral Tablet, give 25 milligram by mouth every 6 hours as needed for itching, agitation or anxiety for 30 Days. i. On 9/21/23, an order was initiated for Mirtazapine Oral Tablet, give 15 mg by mouth one time a day for depression for 30 Days. j. On 9/28/23, an order was initiated for Mirtazapine Oral Tablet, give 15 mg by mouth one time a day for depression for 30 Days. Resident 29's September 2023 Medication Administration Record (MAR) revealed the following: a. The Hydroxyzine 25 mg every 6 hours as needed was documented as administered with effectiveness on 9/14/23 at 11:29 AM, on 9/19/23 at 12:17 AM, on 9/22/23 at 11:21 AM, and on 9/23/23 at 7:56 AM. b. The behavior monitoring for the antianxiety medication for verbalization of anxiety had 28 episodes documented. c. The behavior monitoring for the antidepressant medication for negative statements to self and verbalized sadness had 6 episodes documented. Resident 29's progress notes revealed the following: a. On 9/14/23 at 2:56 PM, the Nurses Note documented, Resident was depressed about his ex-girlfriend. Stated that she was here this am and left and he need to tell her to bring him money. then worry about her getting into his money. He told [name omitted] in activities that he wanted to cut his wrist or kill himself. MD [Medical Director] notified. new order to transfer resident to ER [emergency room] for eval. [evaluation] paramedic came and transported him to [local hospital name omitted] hospital at 14:56 [2:56 PM]. b. On 9/18/23 at 4:31 PM, the Interdisciplinary Team (IDT) Event Review note documented, resident sent to [local area hospital] for psych eval., returned today, mirtazapine started by [local area hospital] for increase in depression, all other least restrictive interventions in place, will continue to monitor. c. On 9/20/23 at 4:49 AM. the 72 Hour Event Charting note documented, Type of Event: Resident returned to facility on Monday after hospitalization for suicide threats. Interventions: Provided positive talk and encouragement, medication administration, and validation of feelings. Resident Reaction to Interventions: Resident compliant and expressive regarding his feelings of his current situation. Pain Management: Denied s/s [signs and symptoms] of pain, Improvement/Decline: Same, Notification(s): None d. On 9/20/23 at 2:03 PM, the Admission: 72 Hour Charting note documented, Primary Diagnosis: readmission for suicidal ideation. Focused Assessment: alert and oriented x [times] 3. stayed to himself sleeping and resting most of the day. required waking him up for meals and medications. verbalized needs when asked question. Adjustment to Admission: adjust well , ambulated to the bathroom. Pain Management: denied of pain this shift. Mental Status/Behavior: calm to self , quiet to self. Improvement/Decline: steady (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	e. On 9/21/23 at 10:33 AM, the Social Service Note documented, [Resident 20] returned to the facility after going to hospital for suicidal comments and stating that he has a plan. He will be referred to [contracted behavioral health service] today. f. On 9/21/23 at 2:41 PM, the Admission: 72 Hour Charting note documented, Primary Diagnosis: suicidal ideation. Focused Assessment: alert and oriented x 3. He keep quiet in the room. appear tired. He keep stating that he cannot urinate. but found him in the bathroom urinate (sic) in toilet and still said he cannot urinate. water is pushed and then straight catheter him later. 30 cc [cubic centimeters] of urine came out. resident constantly use the bathroom. He went to f/u [follow-up] appt [appointment] with [name of provider omitted] today. ua [urinalysis] sample obtained and sent to the lab to rule out infection. Adjustment to Admission: compliant with medications. Pain Management: denied of pain. rest comfortably in bed. Mental Status/Behavior: quiet and sleep in bed mostly today. Improvement/Decline: stable g. On 9/22/23 at 1:42 PM, the Admission: 72 Hour Charting note documented, Primary Diagnosis: DIFFUSE TRAUMATIC BRAIN INJURY WITH LOSS OF CONSCIOUSNESS OF UNSPECIFIED DURATION, SUBSEQUENT ENCOUNTER. Focused Assessment: Due to SI [suicidal ideation] pt [patient] was transferred to psych [psychiatric] hospital for stabilization of mood. Pt readmitted on ce stable to. Admission: Adjusting well. No mention of any SI/depression at this time. Pt is out on the floor appropriately socializing. Pain Management: No c/o [complaints of] pain at this time. Mental Status/Behavior: Pt perseverates on needing to/unable to void/BM's [bowel movement]. Medication given as needed. Improvement/Decline: Pt's depression has improved. h. On 9/23/23 at 2:30 PM, the Social Service Note documented, Late Entry: Note Text: Clinical Status: [Resident 29] presents as stable. No psychiatric complaints are today expressed. Recent History: [Resident 29] described recent but not current thoughts of suicide. He today described brief, fleeting thoughts of suicide leading up to his recent hospitalization . He denied suicidal ideas or intentions following his return from the hospital. Denial is convincing. Mental Status Exam: [Resident 29] appears calm, attentive, communicative, casually groomed, and relaxed. He exhibits speech that is normal in rate, volume, and articulation and is coherent and spontaneous. Language skills are intact. Mood presents as normal with no signs of either depression or mood elevation. Affect is appropriate, full range, and congruent with mood. Associations are intact. There were no signs of psychotic symptoms this session. He denies having suicidal ideas. Homicidal ideas or intentions are denied. Cognitive functioning and fund of knowledge are intact and age appropriate. Short- and long-term memory are intact, as is ability to abstract and do arithmetic calculations. Vocabulary and fund of knowledge indicate cognitive functioning in the normal range. Insight into problems appears fair. Judgment appears fair. There are no signs of anxiety. There are no signs of hyperactive or attentional [sic] difficulties. [Resident 29] behavior in the session was cooperative and attentive with no gross behavioral abnormalities. Current risk appears to be LOW after returning from brief hospitalization . Resident currently denies any intent to carry out active self-harm while here under our care and supervision. Has committed to seek help and ask staff for support if risk elevates. i. On 9/24/23 at 2:50 PM, the Nurses Note documented, Nurses haven't been able to contact resident or get a hold of [name omitted] whom he was with. [Local] police dept called to do a well check on resident since he doesn't have his medications with him. They reported back that [resident 29] is fine and that he reports he is not returning to the facility. He expressed that he does want his belongings back, so we are working on that arrangement so he can get his medications and sign the necessary documentation. (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	j. On 10/1/23 at 8:40 AM, the Nurses Note documented, Patient was angry in the middle o [sic] the night Had a fight with his girl friend [sic] and then he wanted to leave the facility and he started ramming his wheelchair into the front door. So this nurse went and got him and brought him down to the nurses station and talked with him for a bit. He wants his family in [name of stated omitted]. Patient returned to his room and was not seen for a bit. k. On 10/19/23 at 5:41 PM, the Psychotropic Note documented, Psychotropic meeting today, resident went to hospital last month for SI and was started on mirtazapine, however he continues to exhibit depressive symptoms, will start duloxetine 30 mg [milligrams]PO [by mouth] daily; provider agrees. Resident agrees with this plan. l. On 11/19/23 at 1:53 PM, the Nurses Note documented, It was brought to this nurses attention that resident was outside sharpening a butter knife to use to stab another resident. m. On 1/19/24 at 4:10 PM, the Social Service Note documented, Resident's referral re-submitted to [contracted behavioral health provider] for counseling. n. On 1/23/24 at 2:08 PM, the Social Service Note documented, Resident referred to [contracted behavioral health provider] program for (counseling and medication management). On 9/14/23 at 2:56 PM, the incident report documented, Resident made statements to several staff members today about wanting to kill himself, he told [name omitted] in Activities that he had attempted suicide this morning via cutting his wrists but was not successful. The resident stated, I just want to die. Immediate action taken was the resident was transferred to the hospital for a psychiatric evaluation. The report documented that the MD was informed on 9/14/23 at 3:03 PM. It should be noted that no documentation could be found of a facility investigation into the incident with the knife as documented in the nurse note on 11/19/23 On 5/10/23, the hospital History & Physical (H & P) documented, Suicidal ideation- may have been associated with his medical illness, and will need crisis eval at the time of discharge. On 9/14/23, the hospital H & P documented, Patient reports he has had chronic suicidality this year, he just finally voiced it today. His ex-girlfriend came to visit him today and did not say goodbye. He had a plan to cut his wrist with a butter knife he had access to. He reports he tried to do this but was unsuccessful. Does not have access to guns. Patient currently feels suicidal, hopeless. Says he can not continue living with chronic pain. Says he has a history of schizoaffective bipolar disorder, not currently on meds. Was formally on Ativan for anxiety but not currently. Denies HI [homicidal ideation] or AVH [auditory verbal hallucinations]. Has a history of previous mental health hospitalization and previous suicide attempts. Denies drug or alcohol use Says he would be willing to go back on psychiatric medication. The Specialized Rehabilitation Services (SRS) and Social Work Consultation notes documented under observations, findings, and recommendations the following: a. May 2023- Resident needs a social service care plan for depression and LTC [long term care] or Discharge (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	On 8/2/23, resident 29 had a care plan initiated for patient meets PASRR Level II level of determination secondary to major depression, generalized anxiety disorder, and panic disorder. The care plan documented that resident 29 had a history of recurrent depression, anhedonia, problems with sleep and appetite, fatigue, concentration, history of suicidal ideation and attempts. The care plan further documented that resident 29 had difficulty controlling worry, had a history of panic where he feels abrupt surge of fear, trembling, shaking, abdominal distress, fear of dying, feelings of light-headedness, numbness, tingling. Interventions identified included would receive appropriate specialized services as indicated on the PASRR Level II; refer to mental health Services as needed; arrange for PASRR re-evaluation if there was a significant change in status that results in new evidence of possible mental disorder, intellectual disability and/or related condition; coordinate and/or inform the appropriate agency to conduct the PASRR evaluation and obtain results if it was learned that Resident's/Patients PASRR was not completed or was incorrect; recommendation for specialized services for mental illness was mental health services needed including individual counseling and a review of his psychotropic medications; recommendations for services to be provided by the facility for physical therapy (PT), occupational therapy (OT), medication management and assist with activities of daily living (ADLs); and monitor for increase in symptoms of depression. On 9/15/23, resident 29 had a care plan initiated for at risk for suicidal impulsive/ideation's of self-harm related to psychiatric disorder and a history of suicidal statements. Interventions identified included to send to emergency department for suicidal ideation; medication changes made; allow time for expression of feelings; provide empathy, encouragement, and reassurance; encourage resident participation in activity preferences; ensure medications are swallowed after administering; keep resident representative(s) involved with status of resident condition and plan; listen to resident and try to calm; monitor and report to the Charge Nurse, Nursing Supervisor, and Physician/NP [nurse practitioner] any behavior changes (e.g., appetite/expression, excessive crying, etc.); SUICIDAL IDEATION RESPONSE: A staff member will remain with the resident until the Licensed Staff member arrives to assess the resident; SUICIDAL IDEATION RESPONSE: After performing a suicide assessment, the Licensed Staff member shall notify the resident's Attending MD and responsible party; SUICIDAL IDEATION RESPONSE: Immediately report to the Charge Nurse, Nursing Supervisor, and Physician/NP if resident verbalizes thoughts of hurting themselves; SUICIDAL IDEATION RESPONSE: Nursing personnel and other staff involved in caring for the resident shall be informed of the suicidal ideation and instructed to report changes in the resident's behavior immediately; and SUICIDAL IDEATION RESPONSE: Provide increased supervision of resident until the danger of imminent harm has passed or a transfer occurs. On 2/8/24 at 10:18 AM, an interview was conducted with the Certified Nurse Assistant Coordinator (CNAC). The CNAC stated that the facility provided behavioral training which covered de-escalation techniques for the residents. The CNAC stated that the techniques were resident specific and she along with the previous Director of Nursing (DON) would identify interventions and care plan them together. The CNAC stated that they had a Resident Advocate (RA) that had been at the facility for about a month. The CNAC stated that prior to that they had been without a social service worker for approximately 3 months. The CNAC stated that they had a local behavioral health provider that came to the facility to provide mental health services. The CNAC stated that they came to the facility weekly and as needed. The CNAC stated that resident 29's behavior was urination behaviors, believing he has to urinate all the time. (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	On 2/12/24 at 9:06 AM, an interview was conducted with Nursing Assistant (NA) 1. NA 1 stated that resident 29 did not have any behaviors that she was aware of. NA 1 stated that on one occasion she witnessed resident 29 yelling from the bathroom. NA 1 stated that resident 29 stayed in his room a lot, and maybe was depressed. NA 1 stated that resident 29 did not have any restrictions that she was aware of. On 2/12/24 at 9:47 AM, a follow-up interview was conducted with the CNAC. The CNAC stated that resident 29 did not have any violent behaviors that she was aware of. The CNAC stated that resident 29 liked to sleep a lot. The CNAC stated that resident 29 reported sad thoughts and that he had some issues with his ex-girlfriend. The CNAC stated that resident 29 was suicidal a few months ago and it had to do with his girlfriend. The CNAC stated that resident 29 gets down when he was lonely. The CNAC stated that resident 29 needed to feel more valued as an individual. He may be a little depressed, a lot of the residents feel that way when they don't have 1:1. The CNAC stated that resident 29 reported to one of the employees, I'm down, I want to die. The CNAC stated that they took this statement seriously. He needed a bit more help. The CNAC stated that they transferred resident 29 to the hospital. On 2/12/24 at 11:57 AM, an interview was conducted with the Resident Advocate (RA). The RA stated that the Minimum Data Set (MDS) Coordinator was arranging the residents referrals to the contracted behavioral health provider but now they were training her on how to do it. The RA stated that a couple of weeks ago the MDS Coordinator provided her a list of residents that needed referrals to the behavioral health provider. The RA stated that the Director of Nursing (DON) stated that they were no longer using the previous contracted behavioral health provider and would need to send the referrals to the new mental health provider. The RA stated that she was still waiting for the new provider information. The RA stated that the facility had not had a social service worker (SSW) for awhile prior to her arrival on 12/19/23. On 2/12/24 at 1:12 PM, an interview was conducted with the MDS Coordinator. The MDS Coordinator stated that she was in charge of referrals to behavioral health services for the time period between when the previous RA (PRA) left and when the new Resident Advocate arrived. The MDS Coordinator stated it was not clear that she should have been doing referrals, and she did not make any new referrals during this time. The MDS Coordinator stated that if the resident was receiving mental health services then the notes would be located in the electronic medical records under miscellaneous. (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	On 2/12/24 at 2:00 PM, an interview was conducted with the Corporate Social Service Worker (CSSW). The CSSW stated that the Social Worker Consultant that documented the SRS notes did not come to the facility and see the residents, but instead conducted a chart review. The CSSW stated that the facility contracted with a behavioral health provider for mental health services, but they were in the process of obtaining a new contracted provider. The CSSW stated that residents were also able to use their own provider if they already had one. The CSSW stated that if the residents had not been seen by the contracted provider then they had not been seen for mental health services. The CSSW stated that they had identified that there was a need for residents to be connected with behavioral health services. The CSSW stated that for a lot of the residents they could not find documentation that mental health services had been provided. The CSSW stated that they reviewed all the residents two weeks ago and made a bunch of referrals. The CSSW stated that when they received a PASRR in the admission process that identified a mental illness they should be asking the resident about behavioral health services and if they have a provider. If the resident was open to services the CSSW stated that someone in the facility should be coordinating those services. The CSSW stated that the referrals and coordination of care should be documented in the resident progress notes. The CSSW stated that resident 29 would like to have counseling. The CSSW stated that resident 29 was sent to the hospital in September 2023 for suicidal ideation and the PRA was supposed to have made a referral for mental health services. The CSSW stated that her understanding was that it was a suicidal ideation and not a suicidal attempt. The CSSW stated that resident 29's care plan should address the suicidal ideation, PASRR and recommendations and any mental health issues. The CSSW stated that interventions to prevent future attempts should address removing any sharp objects from the room, monitoring for access to those objects and re-assessing upon return to the facility to determine safety needs. The CSSW stated that the monitoring should occur until the MD made a determination to discontinue. The CSSW stated that the staff should also be monitoring for the resident's access to any sharp objects and they should be putting in a progress note or alert charting for the monitoring. The CSSW stated it should also be in the Kardex as well. The CSSW stated that staff should be able to tell her that they were monitoring resident 29 for this and if he had any restrictions. The CSSW stated that it would be concerning if resident 29 had repeat access to sharp objects again. On 2/12/24 at 2:52 PM, a follow-up interview was conducted with the CSSW. The CSSW stated that resident 29 was referred to the contracted behavioral health provider on 1/19/24 and again on 1/23/24. The CSSW stated that resident 29 was not referred for mental health services prior to this. On 2/13/24 at 8:18 AM, an interview was conducted with Registered Nurse (RN) 2 and RN 3. RN 2 stated that the Director of Nursing (DON) updated the resident's care plan. RN 2 stated that they could view the care plan and they informed the DON of any new interventions that they had identified. RN 3 stated that the aides had a Kardex that would inform them of the identified interventions for the residents. (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	On 2/13/24 at 8:20 AM, an interview was conducted with the DON. The DON stated that the MDS Coordinator updated the resident care plans, and the information was communicated in the morning stand up meetings. The DON stated that if the nurses notified her of any new care plan interventions or care areas she would discuss it in the morning meeting. The DON stated that they did not have a behavioral group. The DON stated that the facility used a psychiatric NP in the past. The DON stated that she felt like they needed a psychiatrist involved with the care to resolve any behavioral health plans. The DON stated that they had been consulting with a contracted behavioral health service. The DON stated that resident 29 needed behavioral health services as soon as possible. Just because he hasn't had any recent issues doesn't mean he doesn't need one. The DON stated that she would send a referral to the contracted behavioral health service today for resident 29. The DON stated that the new behavioral health group was not yet implemented but that they had planned to transition to new providers. On 2/13/24 at 8:39 AM, a follow-up interview was conducted with the MDS Coordinator. The MDS Coordinator stated that they identified care plan interventions through the IDT meetings and morning standup meeting. The MDS Coordinator stated that she and the DON went through the 72 hour report, checked the resident dashboard for medication changes, and each department would discuss issues with resident care. The MDS Coordinator stated that she was currently handling the PASRR Level II evaluation referrals. The MDS Coordinator stated that resident 29's current PASRR care plan was initiated on 12/21/23 and the SI care plan was initiated on 12/21/23. The MDS Coordinator stated that resident 29 was readmitted to the facility on [DATE]. The MDS Coordinator stated that they would have had to redo the PASRR if resident 29 was discharged to the community for greater than 2 days. The MDS Coordinator stated that they received resident 29's PASRR letter of determination on 9/28/23 and he was reassessed.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38031 Based on interview and record review it was determined, for 2 out of 40 sampled residents, that the facility did not provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Specifically, the facility did not submit and follow-up on the application process for the New Choice Waiver (NCW) program that provided support services to enable residents to reside in their own home or other community-based settings. Resident identifiers: 4 and 31. Findings included: 1. Resident 4 was admitted to the facility on [DATE] with diagnoses which included mononeuropathy, chronic respiratory failure, type II diabetes mellitus, morbid obesity, chronic obstructive pulmonary disease, non-pressure ulcer of left calf, schizoaffective disorder, epilepsy, hypothyroidism, peripheral vascular disease, varicose veins, hypertension, bilateral osteoarthritis of hip, intervertebral disc disorder, edema, chronic pain syndrome, tremor, overactive bladder, hyperlipidemia, viral hepatitis C, insomnia, sleep apnea, post traumatic stress disorder, anxiety disorder, bipolar disorder, borderline personality disorder, and major depressive disorder. On 2/6/24 at 10:46 AM, an interview was conducted with resident 4. Resident 4 stated that she wanted to discharge with NCW, but the facility did not submit the paperwork and she was denied. Resident 4 stated she asked the Resident Advocate (RA) for a new application and she said she would lay it on her bed, this was on Friday. Resident 4 stated that on Monday she asked again and it still was not given to her. On 10/14/23, resident 4's Annual Minimum Data Set (MDS) assessment documented that the Brief Interview for Mental Status score was 15, which would indicate that the resident was cognitively intact. Resident 4's progress notes revealed the following: a. On 11/2/23 at 11:21 AM, the Social Service Note documented, New Choice Waiver requested additional paperwork for processing. A new H&P [history and physical] might need to be done by facility Dr [doctor], waiting to her back from NCW. Paperwork was submitted. b. On 2/12/24 at 3:35 PM, the Social Service Note documented, Resident would like to apply for New Choices Waiver. Application submitted with supporting documents (continued on next page)

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Meadow Brook Rehabilitation and Nursing	433 East 2700 South Salt Lake City, UT 84115

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/12/24 at 11:12 AM, an interview was conducted with the RA. The RA stated that she started at the facility on 12/19/23. The RA stated that the previous social worker handled all the NCW applications but she was going to be taking on that responsibility now. The RA stated that she was not sure of the application process for the NCW and she would find out more from the Corporate Social Service Worker (CSSW). The RA stated that she was not exactly sure who handled the NCW application prior to her as the facility did not have a SSW for awhile and there was no one here when she arrived. The RA stated that a couple of the residents had asked about their NCW status. The RA stated that the CSSW had just showed her how to access the NCW login. The RA stated that resident 4's application was returned and because it had been so long it needed to be re-submitted again. The RA stated that resident 4 had stated that she wanted to fill out the paperwork and have the facility fax it back to them. The RA stated that she did not know how the previous social worker was tracking the NCW applications prior to her. On 2/13/24 at 11:31 AM, a follow-up interview was conducted with the RA. The RA stated that resident 4's NCW application was submitted on 11/22/23 and the NCW program had requested additional information. The RA stated that on 12/22/23 the application was closed because the facility did not submit the additional information that was requested. The RA stated that she just barely got login access to the NCW. The RA stated that the login page did not reflect where the residents were in the application process. The RA stated that the website would say accepted but that only meant that the application was accepted and not that they had been accepted to the program. 2. Resident 31 was admitted to the facility on [DATE] with diagnoses which included hemiplegia and hemiparesis following a cerebral infarction, type II diabetes mellitus, asthma, morbid obesity, generalized anxiety disorder, major depressive disorder, insomnia, hypertension, pseudobulbar affect, hyperlipidemia, nondisplaced fracture of proximal phalanx of left great toe, and chondromalacia left knee. On 2/05/24 at 1:58 PM, an interview was conducted with resident 31. Resident 31 stated that she told management that she wanted to get her own place, but no one had helped her. Resident 31 stated that in November she signed up for the NCW and was assigned a case worker. Resident 31 stated that the facility did not turn in all the required paperwork. On 9/28/23, resident 31's Quarterly MDS assessment documented a BIMS score of 14, which would indicate that resident 31 was cognitively intact. Resident 31's progress notes documented the following: a. On 9/22/23 at 10:14 AM, the Social Service Note documented, NCW waiver sent off today. b. On 10/24/23 at 1:40 PM, the Social Service Note documented, New Choice Waiver website stated that the Resident had been approved. Will follow up with NCW office to find out what the next step for her is at this point. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. On 10/26/23 at 2:53 PM, the Social Service Note documented, Resident remains a valued LTC [long term care] resident of the facility. Resident continues to show signs of little to no cognitive impairment. Resident is oriented to person, place , and time. Resident denies any mood concerns at this time. She tends to be very pleasant upon contact and is a active member of the community. She tends not to participate in most of the scheduled activities but appears to socialize with other residents. She was recently approved for NCW and will start the process of transitioning to a ALF [assisted living facility]. In November 2023 and December 2023 the Specialized Rehabilitation Service (SRS) and Social Work Consultation Services note documented for resident 31, Recent progress notes indicate resident will be moving to an ALF, let's update her care plans to reflect this. It should be noted that no documentation could be found that a care plan was initiated for resident 31's anticipated discharge to the ALF. On 2/13/24 at 11:10 AM, an interview was conducted with the RA. The RA stated she did not know why the resident who had been approved for NCW was still at the facility. Stated she would have to check with the CSSW about this. 02/13/24 11:31 AM, a follow-up interview was conducted with the RA. The RA stated that resident 31 was denied for the NCW program on 10/12/23. The RA stated that resident 31 did not meet the level of care for Activities of Daily Living (ADLs) or cognitive function. The RA stated she did not know why the progress notes said resident 31 was accepted. The RA stated that maybe they thought the website meant they were accepted for the program and not that the application was accepted. The RA stated that if anything had changed in resident 31's level of care requirements then they could reapply for the program anytime.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46232 Based on interview and record review it was determined for 1 of 40 sampled residents, the facility did not ensure that each resident was free from unnecessary drugs. An unnecessary drug was any drug when used in excessive dose; excessive duration; without adequate monitoring; without adequate indication for its use; or in the presence of adverse consequences which indicated the dose should have been reduced or discontinued. Specifically, a resident's blood pressure was not monitored before being administered pain medication as ordered by the physician. Resident Identifier: 16. Findings Included: Resident 16 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE] with the following diagnoses that included type 2 diabetes mellitus, stage 4 pressure ulcer of sacral region and stage 4 pressure sore of left heel, generalized anxiety disorder, post-traumatic stress disorder, personal history of adult physical and sexual abuse, suicidal ideation, vitamin D deficiency, moderate protein calorie malnutrition, hypomagnesemia, and hypothyroidism. Resident 16's medical record was reviewed on 2/6 through 2/14. A care plan focus area initiated on 2/23/23, documented resident 16 was on pain medication therapy. The listed interventions included administering the pain medication as ordered by the doctor and monitoring for respiratory depression and other adverse side effects such as sedation, dizziness, and altered mental status. A physician order with a start date of 9/7/23 documented, oxyCODONE HCL [hydrochloride] Oral Tablet 5 MG [milligram]. Give 10 mg by mouth every 6 hours as needed for pain. Please check blood pressure before administering this medication!! Resident 16's Medication Administration Record (MAR) was reviewed from February 1 to February 7, 2024. The MAR documented resident 16 had received their oxycodone 19 times in the last 7 days. Resident 16's oxycodone administration times documented the following: a. On February 1, oxycodone 10 mg was administered at 7:40 AM, at 1:59 PM, and at 9:43 PM. [note: there were no documented blood pressure readings 1 hour (hr) prior to the medication administration on this day.] b. On February 2, oxycodone 10 mg was administered at 7:29 AM, at 2:23 PM, and at 6:45 PM. [note: there was only one documented vital sign 1 hr prior to the medication administration on this day.] c. On February 3, oxycodone 10 mg was administered at 6:39 AM and at 12:42 PM. [note: there were no documented blood pressure readings 1 hr prior to the medication administration on this day.] d. On February 4, oxycodone 10 mg was administered at 1:17 AM, at 7:51 AM, at 1:51 PM, and at 7:42 PM. [note: there was only one documented vital sign 1 hr prior to the medication administration on this day.] (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	e. On February 5, oxycodone 10 mg was administered at 1:33 AM, at 11:45 AM, and at 7:11 PM. [note: there were no documented blood pressure readings 1 hr prior to the medication administration on this day.] f. On February 6, oxycodone 10 mg was administered at 3:28 AM and at 12:35 PM. [note: there were no documented blood pressure readings 1 hr prior to the medication administration on this day.] g. On February 7, oxycodone 10 mg was administered at 9:24 AM and at 7 PM. [note: there was only one documented vital 1 hr prior to the medication administration on this day.] Resident 16's vitals were reviewed from February 1 to February 7. Resident 16 had 14 documented vitals in the last 7 days but only 3 of the documented vitals were obtained 1 hour prior to the oxycodone administration. It should be noted a comparison between the documented MAR times and vital times revealed resident 16 was administered their oxycodone 16 times without having a blood pressure checked 1 hour prior. On 2/20/24 at 1:26 PM, an interview was conducted with Registered Nurse (RN) 1. The RN 1 stated vitals were obtained twice a day depending on the resident. The RN 1 stated there were certain medications that a resident's vitals needed to be checked more often such as blood pressure medications. The RN 1 stated the certified nursing assistants (CNAs) tried to get vitals before the medication pass. The RN 1 stated their charting system alerted them if a medication required a vital check prior to administration. The RN 1 stated once the vital had been documented, the system alerted them if the medication could be given. The RN 1 stated if they followed the doctor's orders as instructed. The RN 1 stated resident 16 had a history of low blood pressure and if given the pain medication with another medication it bottomed her out. The RN 1 stated a resident could be hospitalized due to a low blood pressure. The RN 1 stated if a resident had a blood pressure 100/60 or lower then they worried about medication side effects. On 2/20/24 at 3:05 PM, an interview was conducted with the Director of Nursing (DON). The DON stated if there were directions included in the orders, then they expected the nurse to follow them. The DON stated resident 16 oxycodone order indicated a blood pressure check prior to administration. The DON stated it was always best practice to have supplementary documentation included with the order, so the nurses were prompted to obtain the additional information needed prior to the medication administration. The DON stated there was no supplementary documentation included with resident 16 oxycodone order which meant the nurses were not made aware to check resident 16 blood pressure. The DON stated those directions were put in place by the provider to avoid resident 16 from becoming hypotensive and dizzy if their blood pressure was on the lower side prior to the medication administration.

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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** 45490 Based on interview and record review it was determined, for 3 of 40 sampled residents, that residents who have not used psychotropic (anti-psychotics; anti depressants; anti-anxiety; and hypnotics) drugs were not given these drugs unless the medication was necessary to treat a specific condition as diagnosed and documented in the clinical record. Additionally, the facility did not ensure that a resident who used psychotropic drugs received gradual dose reductions (GDR), and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Specifically, residents that used psychotropic medication did not receive gradual dose reductions as required, and a resident with orders to document sleeping patterns was not being monitored, after being prescribed a medication for insomnia. Resident identifiers: 2, 7, and 31. Findings included: 1. Resident 2 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included bipolar disorder, schizophrenia, generalized anxiety, major depressive disorder, delusional disorder, catatonic disorder, and dementia. Resident 2's medical record was reviewed on 2/12/24 through 2/21/24. A care plan dated 8/15/23 with a revision dated 1/12/24, documented resident 2 meets PASRR (Preadmission Screening and Resident Review) II Level of determination secondary to serious mental illness diagnosis. Gradual dose reductions: Dose reductions should be approached with caution & not without the oversight of a physician or psychiatrist. On 2/13/24 at 10:23 AM, a review of the facilities psychotropic binder was conducted. A document titled psychotropic medication monthly review stated a GDR was due for the following medications: Aracept, mirtazapine, ativan, gabapentin, seroquel, duloxetine. The document indicated a change was clinically contraindicated and documented there were no new recommendations. The document stated that the MD [medical director] agrees with recommendations, the document had an area for the MD signature. The document did not have an MD signature. On 2/12/24 at 12:50 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that a GDR review was done every 90 days and the purpose was to discuss every psychotropic medication a resident was taking and the last GDR date. The DON stated that the pharmacist, the DON and primary care physician were present at the meetings, and would sign off any changes being made to any of the medications. The DON stated that the MD's signature should be on the GDR sheet for the review, if the physician signature was not on the form then it would not be anywhere else. The DON stated that there would be no way of knowing if the physician was present or not with out their signature. 38031 (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident 31 was admitted to the facility on [DATE] with diagnoses which included hemiplegia and hemiparesis following a cerebral infarction, type II diabetes mellitus, asthma, morbid obesity, generalized anxiety disorder, major depressive disorder, insomnia, hypertension, pseudobulbar affect, hyperlipidemia, nondisplaced fracture of proximal phalanx of left great toe, and chondromalacia left knee. Resident 31's physician orders revealed the following: a. On 6/21/23, an order was initiated for Clonazepam Oral Tablet 0.5 milligram (mg), give 0.5 mg by mouth two times a day for anxiety. The order was discontinued on 1/30/24. b. On 1/30/24, an order was initiated for Clonazepam Oral Tablet 0.5 milligram (mg), give 0.5 mg by mouth two times a day for anxiety. c. On 6/21/23, an order was initiated for Escitalopram Oxalate Oral Tablet, give 20 mg by mouth one time a day for depression. The order was discontinued on 1/30/24. d. On 1/31/24, an order was initiated for Escitalopram Oxalate Oral Tablet, give 20 mg by mouth one time a day for depression. e. On 11/10/23, an order was initiated for Trazodone, give 50 mg by mouth one time a day related to major depressive disorder. The order was discontinued on 1/30/24. f. On 1/31/24, an order was initiated for Trazodone, give 50 mg by mouth one time a day related to major depressive disorder. g. On 6/21/23, an order was initiated for Trazodone, give 100 mg by mouth one time a day for insomnia. The order was discontinued on 1/30/24. h. On 1/30/24, an order was initiated for Trazodone, give 100 mg by mouth one time a day for insomnia. On 9/29/23, a psychotropic review of Trazodone, Clonazepam, and Escitalopram was conducted. The review documented that a Gradual Dose Reduction (GDR) was due. The new recommendation was to start Dextromethorphan 20 mg by mouth daily for 7 days then increase to 40 mg daily. It should be noted that no changes or GDR was made to the Trazodone, Clonazepam, and Escitalopram. On 11/16/23, the psychotropic review of Trazodone, Clonazepam, and Escitalopram was conducted. The review documented that a Gradual Dose Reduction (GDR) was due. Target symptoms/behaviors were increased lability, crying, and acting out. New symptoms identified were crying and aggression. The new recommendation was to decrease Dextromethorphan to 20 mg daily and to obtain a prior authorization and start Neudexta. It should be noted that no changes or GDR was made to the Trazodone, Clonazepam, and Escitalopram. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/12/24 at 10:06 AM, an interview was conducted with the Director of Nursing. The DON stated that resident 31's Trazodone 50 mg was administrated in the morning and was for depression and the Trazodone 100 mg was administered at night for insomnia. The DON stated that she did not have any attempted GDR nor documentation of a contraindication for a GDR for the Trazodone, Clonazepam and Escitalopram. 47432 3. Resident 7 was originally admitted on [DATE] and readmitted on [DATE] with diagnoses including narcolepsy without cataplexy, major depressive disorder recurrent moderate, personality disorder unspecified, bipolar II disorder, and generalized anxiety disorder. Resident 7's medical record was reviewed on 2/20/24. Resident 7's most recent Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 14, which indicated no cognitive impairment. A physician's order dated 9/18/23 revealed,traZODone HCl [hydrochloride] Oral Tablet (Trazodone HCl) Give 400 mg by mouth one time a day for insomnia. A physician's order dated 11/23/23 revealed, Chart hours of sleep every morning and at bedtime. A care plan dated 9/18/23 revealed a focus area of,Potential for adverse side effects d/t [due to] uses antidepressant medication r/t [related to] Depression, INsomnia [sic]. The goal documented for this focus area was [Resident 7] will be free from discomfort or adverse reactions related to antidepressant therapy through the review date. The interventions for this care area were documented as: a. Administer ANTIDEPRESSANT medications as ordered by physician. Monitor/document side effects and effectiveness Q-SHIFT [each shift]. b. Monitor for target behavior sx [symptoms]: negative statements to self, verbalizes sadness. c. Monitor/document/report PRN [as needed] adverse reactions to ANTIDEPRESSANT [sic] therapy: change in behavior/mood/cognition; hallucinations/delusions; social isolation, suicidal thoughts, withdrawal; decline in ADL [activities of daily living] ability, continence, no voiding; constipation, fecal impaction, diarrhea; gait changes, rigid muscles, balance probs [problems], movement problems, tremors, muscle cramps, falls; dizziness/vertigo; fatigue, insomnia; appetite loss, wt [weight] loss, n/v [nausea/vomiting], dry mouth, dry eyes. d. Psychotropic Review per IDT [interdisciplinary team] at least quarterly and PRN [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	A care plan dated 9/30/23 revealed a focus area of, Potential for/actual alteration in mood r/t Major Depressive Disorder, Generalized ANxiety [sic] Disorder, Insomnia, stimulant use, phq9 [patient health questionnaire 9] score indicating moderate depression, PL2 findings, H/o [history of] abuse Refuses MD prescribed Seroquel and Lithium 11/10/2023 for new diagnosis of BIPOLAR DISORDER, CURRENT EPISODE MIDED [sic], MODERATE. The goal documented for this focus area was, [Resident 7] will have less than daily symptoms of depression, anxiety or sad mood by/through review date. The interventions for this care area were documented as: a. Administer medications as ordered. Monitor/document for side effects and effectiveness. b. Arrange for psych consult, follow up as indicated. c. Monitor/document/report PRN [as needed] any s/sx [signs/symptoms] of depression, including: hopelessness, anxiety, sadness, insomnia, anorexia, verbalizing, negative statements, repetitive anxious or health-related complaints, tearfulness. Resident 7's September 2023 through February 2024 Medication Administration Record (MAR) and Treatment Administration Record (TAR) were reviewed. The MAR revealed that Resident 7 received Trazodone daily from 9/18/23 through 2/19/24. The TAR revealed that Resident 7's hours of sleep (HS) were not being monitored for the medication given 9/18/23 through 2/19/24. On 2/21/24 at 10:08 AM, an interview was conducted with Registered Nurse (RN) 3. RN 3 stated that she had seen orders for hours of sleep to be monitored for residents taking Trazodone before. RN 3 stated that she was not sure if hours of sleep should be monitored for Resident 7. On 2/21/24 at 10:53 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that she expected residents with orders for Trazodone for insomnia to have their hours of sleep monitored. The DON stated that the nurse who originally entered the order for Resident 7's hours of sleep to be monitored did not enter the order correctly and that it was not showing up in the electronic medical record for floor nurses to document.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38031 Based on interview and record review it was determined, for 1 of 40 sampled residents, that the facility did not ensure that residents were free from any significant medication errors. Specifically, a resident's Trulicity medication was omitted for two consecutive weeks due to unavailability from the pharmacy. Resident identifier: 31. Findings included: Resident 31 was admitted to the facility on [DATE] with diagnoses which included hemiplegia and hemiparesis, type II diabetes mellitus, asthma, morbid obesity, anxiety disorder, major depressive disorder, insomnia, hypertension, pseudobulbar affect, hyperlipidemia, nondisplaced fracture of proximal phalanx left great toe, chondromalacia left knee, and dementia. On 2/10/24 resident 31's medical records were reviewed. On 11/3/23, resident 31 had an order initiated for Trulicity Subcutaneous Solution Pen-injector 0.75 milligram (mg)/0.5 milliliter (ml), Inject 0.75 mg subcutaneously one time a day every Friday related to type II diabetes mellitus. On 1/12/24 at 12:55 PM, the Orders - Administration Note documented that the Trulicity was not administered due to Pharmacy is to deliver today. On 1/12/24, the January Medication Administration Record (MAR) documented that the medication was not administered. On 1/19/24 at 5:14 PM, the Orders - Administration Note documented that the Trulicity was not administered due to waiting on pharmacy. On 1/19/24, the January Medication Administration Record (MAR) documented that the medication was not administered. It should be noted that no documentation could be found that the physician was notified that the Trulicity was not administered. On 2/12/24 at 7:44 AM, an interview was conducted with RN 2. RN 2 stated that the pharmacy usually had any medications delivered to the facility within in a day. RN 2 stated that the new pharmacy was taken longer, a couple of days, but they were getting better at having medications like antibiotics available. RN 2 stated if a medication was not available she would notify the DON and she would then notify the physician. RN 2 stated that the DON had been handling a lot of issues with the new pharmacy. RN 2 stated that if the medication was not available or if it was an insurance coverage issue the DON handled it. RN 2 stated that for a medication like Trulicity she would contact the DON or notify the physician. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/12/24 at 10:06 AM, an interview was conducted with the DON. The DON stated that if a medication was not available she would immediate let the pharmacy know and then pull from the Pixus overstock. The DON stated that they did not have Trulicity available in the Pixus. The DON stated that staff should notify her and she would notify the pharmacy immediately. The DON stated that any insulin should be at the facility within hours. The DON stated that staff should have notified the interim DON so that they could notify the Medical Director (MD) and get a new order or attempt to get the medication in the facility. The DON stated that staff should notify the MD immediately of something critical like insulin and then document the MD notification in a progress note.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 38031 Based on observation, interview and record review it was determined that the facility did not ensure that all drugs and biologicals were stored and labeled in accordance with accepted professional principles, under proper temperature controls and cautionary instructions, and the expiration date when applicable. Specifically, the temperature in both medication fridges was not within a safe temperature range for medication storage, medications did not have resident information, and medication was available for use past the expiration date. Resident identifiers: 6, 9, 14, 21, 26, 28, 31, and 33. Findings included: On 2/21/24 at 9:35 AM, an observation was made of the facility medication refrigerators. Two mini fridges were observed at the nurse's station located under the desk. The first fridge temperature gauge measured 49 degree Fahrenheit (F). The first fridge was observed with a large block of ice in the freezer section of the fridge that was partially melted and was obstructing the door from closing properly. The locked medication box was located on the shelf directly below the block of ice. The lock box was not accessible and could not be removed from the shelf as the ice was blocking it. The following items were located in the first refrigerator: a. A Tresiba flex touch pen was observed frozen to the side of the block of ice. b. A box of Biscodyl suppositories was placed on the shelf directly below the block of ice and was located in a puddle of melted water. Water was observed dripping from the block of ice directly onto the boxed medication. The label on the box identified that the medication belonged to resident 33. c. A box labeled Cathflo Activase 2 milligram (mg). No resident information was located on the package. d. A Humira Pen 40 mg/0.8 milliliters (ml) pen for resident 6. e. A Prevnar 20-valent multi-use vial. f. A Respiratory Syncytial Virus (RSV) vaccine multi-use vial. g. Trulicity 1.5 mg/0.5 ml, 10 pens for resident 31. h. Lorazepam 2 mg/ml, 80 syringes for resident 14. i. Lorazepam 2 mg/ml, 19 syringes for resident 21. j. Lorazepam 2 mg/ml oral concentration for resident 28. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	k. Risperdal consta 50 mg, 2 vials for resident 6. An immediate interview was conducted with Registered Nurse (RN) 2. RN 2 pulled the box of Tresiba flex touch pen from the block of ice tearing the box in the process. RN 2 stated that the medication belonged to resident 9. RN 2 stated that she did not know who the Cathflo Acitvase 2 mg was for, I don't even know what it is. The Cathflo had an expiration date of September 2023. The second fridge temperature gauge measured 27.7 F. The following items were located in the second fridge: a. Meropenem 1gram (gr)/100 ml, 5 medicine balls for resident 26. b. Vancomycin 800 mg/120 ml, 6 medicine balls for resident 26. c. Tuberculin purified protein derivative (PPD), 7 multi-use vials. An interview was conducted with RN 3. RN 3 stated that the Cathflo was used to unclogged a peripherally inserted central catheter (PICC) line. RN 3 stated that she does not know what to do about the block of ice. RN 3 stated that she did not know how to get the ice out and they had no where to transfer the medication to. RN 3 stated she thinks that the ice developed when the power was going out frequently over the last week. RN 3 stated that she would reorder the Biscodyl suppository. RN 2 stated, at least it will get fixed now. On 2/21/24 at 9:56 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that she did not know what the Cathflo was for. The DON stated that she was going to get one of the corporate supervisors to come look at the medication fridge, and she was going to get a new fridge for the medication. On 2/21/24 at 10:05 AM, an interview was conducted with the DON and the Chief Nursing Officer (CNO). The CNO stated that the first fridge was at room temperature. The DON stated that she was on the phone with the facility pharmacist. The Pharmacist stated that the Biscodyl and insulin was safe to save, and the Trulicity could be stored up to room temp for 14 days. The pharmacist stated he would have to check to see if it was still safe to administer the Meropenem and Vancomycin. The CNO attempted to pry the locked medication box free from under the block of ice and was not successful. The CNO stated he was not sure what medication was in the locked box. The facility policy and procedure for Storage of Medications documented under interpretation and implementation that 1. Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light and humidity controls. 4. Drug containers that have missing, incomplete, improper, or incorrect labels are returned to the pharmacy for proper labeling before storing. 5. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed. The policy was last revised in January 2024.

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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 1 of 40 sampled residents, that the facility did not provide or obtain laboratory services to meet the needs of the residents. Specifically, a resident had orders for labs that were not obtained by the facility. Resident identifier: 31. Findings included: Resident 31 was admitted to the facility on [DATE] with diagnoses which included hemiplegia and hemiparesis following a cerebral infarction, type II diabetes mellitus, asthma, morbid obesity, generalized anxiety disorder, major depressive disorder, insomnia, hypertension, pseudobulbar affect, hyperlipidemia, nondisplaced fracture of proximal phalanx of left great toe, and chondromalacia left knee. On 2/10/24 resident 31's medical records were reviewed. Resident 31's physician laboratory orders revealed the following: a. On 1/19/24, an order was initiated to obtain a Hemoglobin A1c (HbA1c) and a Glomerular Filtration Rate (GFR). b. On 2/1/24, an order was initiated to obtain a HbA1C and a Basic Metabolic Panel (BMP). Review of resident 31's laboratory results revealed no documentation of the physician ordered labs on 1/19/24 and 2/1/24. On 2/12/24 at 10:06 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that she checked resident 31's medical records and called the laboratory for the lab results. The DON stated that she could not find any lab results for the HbA1c and GFR on 1/19/24 and the HbA1c and the BMP on 2/1/24.

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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** 22992 Based on interview and record review, the facility did not provide food that was palatable for 10 of 40 residents. Specifically, residents voiced concerns regarding the food quality in individual interviews, as well as resident council minutes. Resident identifiers: 1, 4, 8, 21, 26, 30, 31, 33, 34 and 36. Findings included: 1. On 2/5/24 at 11:13 AM, an interview was conducted with resident 8. Resident 8 stated that the food is fair. I don't care for it. Sometimes its warm, but not always. 2. On 2/5/24 at 10:09 AM, an interview was conducted with resident 34. Resident 34 stated that the food is not very good. 3. On 2/6/24 at 10:36 AM, an interview was conducted with resident 21. Resident 21 stated that the food was edible, but that's all . we all get the same slop. Resident 21 stated that he felt he had lost weight due to the poor quality of the food. 38031 4. On 2/5/24 at 1:43 PM, an interview was conducted with resident 31. Resident 31 stated that the food was nasty. Sometimes it was good depending on who cooked. Resident 31 stated that the food was the same every week, and they served hot dogs all the time. Resident 31 stated that she gets tired of the same food, and had a can of Chef Boyardee ravioli in her closet. Resident 31 stated that sometimes the hot food was served cold. Resident 31 stated that she had lost weight, but she did not mind because she felt she needed to. Resident 31 stated that the snacks were always peanut butter and jelly sandwiches, a cheese and ham sandwich, or fish crackers. Resident 31 stated that she would like cheese or fresh fruit, and rarely had yogurt or a banana. 5. On 2/5/24 at 9:49 AM, an interview was conducted with resident 36. Resident 36 stated that snacks were peanut better and jelly sandwich or a bologna and cheese sandwich every day. Resident 36 stated that he asked for double portions for his food otherwise he would not get enough to eat. 6. On 2/6/24 at 10:53 AM, an interview was conducted with resident 4. Resident 4 stated that she was served cold eggs everyday and it was a small portion size. Resident 4 stated that the food was disgusting and bland. 7. On 2/5/24 at 12:16 PM, an interview was conducted with resident 1. Resident 1 stated that the food sucked, and the product was not good quality. Resident 1 stated that the food was comparable to TV dinners. Resident 1 stated that the food was bland and he had to over salt his food. 46232 (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8. On 2/5/24 at 10:35 AM, an interview was conducted with resident 26. Resident 26 stated they have asked for extra portions but do not get them. Resident 26 stated they were diabetic and wished to eat a variety of healthy foods such as broccoli, cucumbers, and lettuce and had been told by the kitchen they did not have those vegetables. Resident 26 stated a salad only consisted of spinach and tomatoes. On 2/12/24 at 12:46 PM, a follow up interview was conducted with resident 26. Resident 26 stated that over the weekend he was served a salad that consisted solely of tomato and lettuce. Resident 26 showed a photo of the salad that he had taken with his cell phone camera. The photo showed a salad that solely consisted of lettuce and diced tomatoes. 9. On 2/5/24 at 11:14 AM, an interview was conducted with resident 33. Resident 33 stated the food could be better. Resident 33 stated they were not served enough portions, so they ate baby food to supplement for the lack of food. Resident 33 stated they had been hospitalized due to an eating problem and they wanted to stay on top of what they ate to avoid going to the hospital again. 10. On 2/6/24 at 8:44 AM, an interview was conducted with resident 30. Resident 30 stated they were on a specific diet and sometimes they had to eat hamburgers 3 times a week. Resident 30 stated sometimes the food was bland and cold and they were often served the same thing. Resident 30 stated it would be nice if they changed out the menu. 47432 11. The resident council notes for the previous 14 months were reviewed and revealed the following concerns voiced by the residents: a. On 1/25/23: i. Dietary: I like him [name of staff member] he's doing better. Tray transfer needs to be thought over, need to use second cart so dirt/grime does not get on the bottom trays. Larger portions. b. On 2/24/23: i. Water jugs. (switch off.) instead of being picked up and waiting. Just switch them off. ii. Dietary: . Portions are too small, need another set of hands. c. On 3/31/23: i. Water (takes hours). [Note: There was no specific information regarding what this concern referred to.] ii. Dietary: Food portions are small. Reassess drinks (many are not receiving milk.) Tickets are not being followed. Food is cold. They need to learn portion control. Bring out alternative menus to fill out. d. On 4/25/23: (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	i. Water is still not being distributed (not being passed out). ii. Dietary: Not being served enough food (reach out to corporate to fix portions or double up portions.) Need to serve mechanical soft food. e. On 5/30/23 i. Residents want more ice cream! They also want their ice cream to not be melted by the time they are ready to eat it - Arrives directly with the meal. ii. Dietary: Food is often late 15 - 45 minutes better portions - they want. iii. [Resident name] is served is food, but no one is available to help him for at least a half hour. Food is always cold. f. On 6/13/23: i. Dietary: food is cold. ii. Water mugs have not been consistently going out the last few days. g. On 7/27/23: i.Snacks not being passed out in evenings. ii: Dietary: Food could be better. h. On 8/8/23: i. Dietary: Cold food. Portions are too small. High turnover. Too salty .Chicken is not cooked all the way. Still pink in the middle. Worried that food is cold in kitchen before it comes out. i. On 9/12/23: i. [Name of resident] - wants to meet with dietician (sic) about high protein diet - wants protein drinks - not allowed to have them of (sic) the facility. Been told several [NAME] (sic) to remove from building. j. On 10/11/23: i. Dietary: cold food, [name of resident] receiving food she doesn't want . bland food, want more seasoning - veggies too mush or too hard. Never medium. This month a Resident Council Departmental Response Form was attached to the resident council notes. In response to the dietary concerns, the interventions included Will have department head pull a test tray regularly to ensure consistency of food. k. No resident council notes for November 2023 were provided by the facility. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	l. On 1/9/24: i. Dietary: . Feels like the same thing all the time. Portions are small. Not a lot of care put into it. Worn out menu. Food not up to par. Dining room not clean. Stuff runs out. Meals not Complete. Kitchen is just sad! This month a Resident Council Departmental Response Form was attached to the resident council notes. In response to the dietary concerns, the interventions included Audited meal service on portion sizes with cook, RD (Registered Dietitian) and l. Admin (Administrator) pruchesed (sic) condiment holders for tables. [Note: Not all of the concerns voiced by the residents were addressed on the response form.] m. On 2/6/24: i. Dietary: . Like kitchen staff. Do not like food. Portions are small. Stay on top of stuff you run out off (sic). There was no Resident Council Departmental Response Form connected with the February 2024 resident council notes. It should be noted that dietary concerns were identified by residents in 13 of the 14 months of resident council notes reviewed. On 2/12/24 at 12:39 PM, an interview was conducted with the Dietary Manager (DM). The DM stated that when receives complaints about the food served from an individual resident, he will meet with the individual resident, talk to them, and put relevant notes in their dietary profile or care plan. The DM stated that if there are complaints from resident council about the food served, he will then come up with a correction and interview members of the resident council after the correction has been implemented. The DM stated that if residents file a grievance, he will address the grievance and file the resolution in the grievance log.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47432 Based on observation, interview, and record review, it was determined that the facility did not store, prepare, distribute, and serve food in accordance with professional standards for food safety. Specifically, the kitchen was not clean or sanitary and resident meal trays were subject to physical contamination while being served. Findings Included: On 2/12/24 at 11:33 AM, a walk through of the facility kitchen was conducted. Hotel pans were stored on visibly soiled white painted shelves. There were metal colanders stored on top of the ice machine. There was a carafe stored upside down on a chipped laminate shelf. The carafe was not dry, and a watery pink liquid was dripping from the carafe into the chips on the laminate shelf. Inside of the shelf was made of particle board. The chips in the laminate indicate that the storage space cannot be fully sanitized. The laminate counter where the coffee machine was stored was covered with multiple coffee stains. A window air conditioning unit was observed to be blowing cold air across two trays with uncovered cake slices on the trays. A vent on the wall in the dry storage was visibly covered in dust. There were crumbs of food on the bottom shelves of two of the refrigerators in the dry storage area of the kitchen. Cleaning chemicals were stored in the dry storage area. On 2/12/24 at 12:34 PM, the February 2024 Kitchen cleaning schedule was reviewed. The cleaning schedule was documented as completed on February 1st, 12th, 13th, and 14th. On 2/12/24 at 11:58 AM, an observation was made of the tray cart used to pass meal trays to residents. The tray cart was covered with a plastic cover. The plastic cover was visibly soiled. The bottom of the plastic cover touched the two trays on the bottom rung of the cart. On 2/12/24 at 12:43 PM, an interview was conducted with the Dietary Manager (DM). The DM stated that the plastic cart covers should be cleaned after each meal served. The DM stated that shelves used to store utensils should be cleaned every other day. On 2/12/24 at 12:07 PM, an observation was made of Nursing Assistant (NA) 4 passing meal trays to residents during lunch mealtime. As CNA 4 removed a tray from the meal cart, the plastic covering of the meal cart brushed across and made contact with an uncovered slice of cake on the meal tray. On 2/14/24 at 3:11 PM, an interview was conducted with Nursing Assistant (NA) 3. NA 3 stated that it was not acceptable for the plastic covering on the tray cart to brush across uncovered food on resident meal trays. On 2/13/244 at 3:27 PM, an interview was conducted with the Certified Nursing Assistant Coordinator (CNAC). The CNAC stated that it was not acceptable for the plastic covering on the tray cart to brush across uncovered food on resident meal trays when serving meals to residents.

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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. 22992 Based on observation, interview, and record review, the facility did not establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. Specifically, multiple areas of immediate jeopardy and harm were identified on the recertification survey. Resident identifiers: 3, 6, 17, 19, 21, 28, 29, 31, 34, 39, 90, 91, 92, 93, 94, 96, and 97. Findings include: 1. Based on observation, interview, and record review it was determined, for 10 out of 40 sampled residents, that the facility failed to ensure that the resident environment remained as free of accident hazards as was possible and each resident received adequate supervision and assistance devices to prevent accidents. Specifically, a resident was transported via the facility van and the wheelchair was not secured properly inside the vehicle which resulted in the resident falling backwards causing hyperextension of his neck. The resident was diagnosed with central cord syndrome and edema at the level of C6 and C7 of his cervical spine. Upon return to the facility the resident's cervical collar was removed by Certified Nursing Assistant(s) (CNA) during grooming and bathing cares. After the resident's shower, the CNAs attempted to transfer the resident to bed unsuccessfully and the resident was assisted to the floor. These identified deficient practices were found to have occurred at the Immediate Jeopardy (IJ) Level. Additionally, a resident sustained four falls in the facility with the last one resulting in a fractured hip; a resident tripped over the broken base of a structural column outside the facility and sustained a laceration requiring sutures; and a resident had an unsafe discharge to the community, was found wandering the streets and was subsequently placed on a medical hold in the hospital. These identified deficient practices were found to have occurred at a Harm Level. Lastly, two residents eloped from the facility; a resident struck another resident with a razor cutting them and was not monitored or restricted from further sharp objects after the incident; a resident was provided a germicidal cleaning wipe by another resident and used it to blow and clean their nose; and a resident was hit by the meal cart during delivery service of the meals. Resident identifiers: 3, 6, 19, 31, 34, 91, 92, 93, 94, and 96. [Cross refer to F689] (continued on next page)

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F 0867 Level of Harm - Actual harm Residents Affected - Some	2. Based on interview and record review it was determined, for 1 out of 40 sampled residents, that the facility failed to have sufficient nursing staff with the appropriate competencies and skill 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. Specifically, a resident was transported via the facility van and the wheelchair was not secured properly inside the vehicle which resulted in the resident falling backwards causing hyperextension of his neck. The resident was diagnosed with central cord syndrome and edema at the level of C6 and C7 of his cervical spine. Upon return to the facility the resident's cervical collar was removed by Certified Nursing Assistant(s) (CNA) during grooming and bathing cares. After the resident's shower, the CNAs attempted to transfer the resident to bed unsuccessfully and the resident was assisted to the floor. These identified deficient practices were found to have occurred at the Immediate Jeopardy (IJ) Level. Additionally, staff reported that orientation training to newly hired Nurse Assistants and Certified Nurse Assistants was not performed and Nurse Assistants were in charge of training new hires. Resident identifier: 96. [Cross refer to F726] 3. Based on interview and record review, the facility did not ensure that 1 of 40 sampled residents had the right to refuse medical treatment and formulate an advance directive. Specifically, one resident with an advanced health care directive received treatment that was documented as against the resident's wishes. This resulted in a finding of harm. Resident identifier: 39. [Cross refer to F578] 4. Based on interview and record review, the facility did not provide and document sufficient preparation to 2 of 40 sampled residents to ensure safe and orderly transfer or discharge from the facility. Specifically, one resident with cognitive impairment was discharged to a hotel room, but was subsequently seen at a local emergency room after becoming lost. This resulted in a finding of harm. In addition, one resident left on a leave of absence, and was not oriented for discharge upon return to the facility. Resident identifiers: 94 and 97. [Cross refer to F624] 5. Based on interview and record review it was determined, for 3 of 40 sampled residents, that the facility did not incorporate the recommendations from the pre-admission screening and resident review (PASRR) level II determination and the PASRR evaluation report into the resident assessment, care planning, and transitions of care. Specifically, residents had PASRR level II recommendations for mental health services and none were provided. The deficient practice identified was cited at a HARM Level. Resident identifiers: 21, 29, and 34. [Cross refer to F644] 6. Based on observation, interview, and record review it was determined, for 3 of 40 sampled residents, that the facility did not ensure that a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. Specifically, a resident had moisture associated skin damage. This finding was cited at a harm level for resident 6. In addition, another resident sat in a soiled brief for an hour and toileting services were not provided to a resident for 3 hours. Resident Identifiers: 6, 17, and 28. (continued on next page)

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F 0867 Level of Harm - Actual harm Residents Affected - Some	[Cross refer to F690] 7. Based on observation, interview and record review it was determined, for 2 of 40 sampled residents, that the facility did not ensure that pain management was provided to residents who required such services. Specifically, two residents complained of uncontrolled pain and the pain medication follow up was documented as ineffective pain control, and the physician was not notified in a timely manner. A resident was also observed to vocalize pain during a wound treatment and was not provided pain medication prior to the treatment as was care planned, this will be sited at a harm level. Resident identifiers: 29 and 90. [Cross refer to F697] 8. Based on interview and record review it was determined, for 1 of 40 sampled residents, that the facility did not ensure that the resident received the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Specifically, a resident with suicidal ideation, suicidal attempt, and homicidal ideation was assessed as requiring mental health services and those services were not provided. The deficient practice identified was cited at a harm Level. Resident identifier: 29. [Cross refer to F740] On 2/14/24 at 1:00 PM, an interview was conducted with the facility Administrator (ADM). The ADM stated that she had conducted the first new Quality Assurance (QA) meeting in January of 2024. The ADM stated that prior to January 2024, items in QA were brought up just adhoc, and there weren't consistent items reviewed at each meeting. The ADM stated that as of January 2024, she had completed education with each of the department heads, and reviewed what everyone's responsibilities were. The ADM also stated that QA meetings were now more structured, and that every department head had to do reporting and tracking on specific items.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 45490 Based on interview and record review it was determined that the facility did not establish and maintain an infection prevention and control program to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Specifically, the facility infection control tracking and trending was not complete. Findings included: On 2/12/24 at 1:24 PM, the facility infection control tracking and trending log was requested. A review of the log revealed no mapping, tracking, trending or analysis of the data for June, July, August, and September of 2023. A review of the Infection Prevention policy and procedure documented, goals of the infection prevention and control program which included: A. Decrease the risk of infection to residents and personnel. B. Monitor for occurrence of infection and implement appropriate control measures. C. Identify and correct problems relating to infection prevention and control practices. D. Maintain compliance with state and federal regulations relating to infection prevention and control . There is on-going monitoring for infections among residents, employees . and subsequent documentation of infections that occur . Infection prevention and control is a component of the facility's quality assessment and assurance (QAA) program and infection prevention and control reports are made to the QAA committee. In addition, infection prevention and control rounds/audits are made to assess the level of quality provided and actions for improvement are taken as needed. On 2/12/24 at 1:58 PM, an interview was conducted with the administrator (ADM). The ADM stated that she was unable to locate the infection control information for the months of June through September 2023. On 2/14/24 at 4:41 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that she was unable to locate the files pertaining to those missing months for infection control, and that tracking and trending would be difficult without documentation.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. 45490 Based on interview and record review it was determined that the facility did not ensure that the antibiotic stewardship program included antibiotic use protocols and a system to monitor the antibiotic use. Specifically, the facility infection control tracking and trending was not complete. Findings included: On 2/12/24 at 1:24 PM, the facility infection control tracking and trending log was requested. A review of the log revealed no mapping, tracking, trending or analysis of the data for June, July, August, and September of 2023. A review of the Infection Prevention policy and procedure documented, goals of the infection prevention and control program which included: A. Decrease the risk of infection to residents and personnel. B. Monitor for occurrence of infection and implement appropriate control measures. C. Identify and correct problems relating to infection prevention and control practices. D. Maintain compliance with state and federal regulations relating to infection prevention and control. There is on-going monitoring for infections among residents, employees . and subsequent documentation of infections that occur . Infection prevention and control is a component of the facility's quality assessment and assurance (QAA) program and infection prevention and control reports are made to the QAA committee. In addition, infection prevention and control rounds/audits are made to assess the level of quality provided and actions for improvement are taken as needed. On 2/12/24 at 1:58 PM, an interview was conducted with the administrator (ADM). The ADM stated that she was unable to locate the infection control information for the months of June through September 2023. On 2/14/24 at 4:41 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that she was unable to locate the files pertaining to those missing months for infection control, and that tracking and trending would be difficult without documentation.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. 47432 Based on observation, interview, and record review, it was determined that the facility did not maintain all mechanical, electrical, and patient care equipment in safe operating condition. Specifically, the facility dishwasher spilled water onto the floor whenever a dishwashing cycle was run. Findings included: On 2/12/24 at 12:35 PM, an interview was conducted with the Dietary Manager (DM). The Dietary Manager stated that the dish machine was serviced by Ecolab once a month. On 2/12/24 at 12:36 PM, the facility's mechanical dishwashing machine was tested . While the dishwashing machine was running, water flowed from the bottom of the machine onto the floor. On 2/14/24 at 9:21 AM, an interview was conducted with the Custodial Staff (CS). The CS stated that it was not normal for the dish machine to flood water onto the floor. The CS stated that either he or the facility maintenance staff usually mopped any spills from the machine. The CS stated that there was currently no maintenance staff at the facility. On 2/20/24 at 2:40 PM, an interview was conducted with the Registered Dietitian (RD). The RD stated that she had observations and reports of water coming out of the bottom of the dish machine. The RD stated that the Dietary Manager was aware of it. The RD stated that maintenance was aware of the issue and working on it. On 2/20/24 at 4:28 PM, The RD provided copies of her January 2024, interim, and February 2024 sanitation audits. The interim audit stated that, The drain doesn't drain fast enough to keep up with the dishwasher output. It does all drain down, it just takes a bit of time. Maintenance has snaked the dishwasher drain multiple times. External plumbing service serviced the drain January 2024.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 46232 Based on observation and interviews it was determined, for 2 of 40 sampled residents, that the facility did not adequately equip each resident with a communication system that was relaying calls directly to staff or a centralized work area. Specifically, residents call lights were not functioning properly. Resident identifiers: 26 and 30. Findings Included: On 2/8/24 at 1:52 PM, an observation was made of the maintenance log located next to the nurse's station. The maintenance log dated 2/4/24 documented there was a repair/safety concern that needed to be fixed for room [ROOM NUMBER] b and c. It documented the following issue, Light needs fixed please. Call light stays on. On 2/5/24 at 10:35 AM, an interview was conducted with resident 26 who resided in room [ROOM NUMBER] B. Resident 26 stated the call light had not been working for the last two days. Resident 26 stated their call light outside of the room had been on for the last two days, so staff were unsure when they needed assistance. On 2/6/24 at 8:44 AM, an interview was conducted with resident 30 who resided in room [ROOM NUMBER] C. Resident 30 stated they believed their call light had been working the last couple of days. Resident 30 stated they do not use their call light and instead went into the hallway to find staff for assistance. Resident 30 stated they were unsure why they had the red cowbell. Resident 30 stated staff must have found it under their roommate's bed and assumed it was theirs. Resident 30 stated they were unaware that was an alternative for a call light. On 02/14/24 at 1:33 PM, an interview was conducted with Corporate Maintenance (CM). The CM stated he was temporary and had only been here for 3 days. The CM stated he was responsible for project management and trying to help out the building. The CM stated he came to the building depending on how big the project was. The CM stated they oversaw big projects such as replacing toilets, working on AC units, doing floor repairs and doing a fluff and puff on a new room. The CM stated he did not do the day-to-day maintenance stuff and did not generally look at the maintenance log. The CM stated the administrator oversaw the maintenance log. The CM stated they assumed the administrator would notify them of anything they needed to fix from the maintenance log. The CM stated he did not look at the facility maintenance log unless he was asked to. On 2/14/24 at 3:15 PM, an interview was conducted with Nursing Assistant (NA) 3. The NA 3 stated if the call light system was not working, first they tried to replace the cord. The NA 3 stated on the weekends, staff present tried to fix the call light and if they were unable to then they wrote it down on the maintenance log. The NA 3 stated if the problem occurred on the weekday, they notified the maintenance man or administration. The NA 3 stated residents were provided cow bells if their call light was not working and stated it was not the best solution, but it was better then not having anything. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/20/24 at 1:23 PM, an interview was conducted with the Administrator (ADM). The ADM stated if a resident's call light was not working then residents were provided a cow bell within a short period of time until the call light was fixed. The ADM stated residents thought the cow bells were stupid at first. The ADM stated residents have used the cow bells when they were provided to them as an alternative to get a hold of staff. The ADM stated residents located further down the hall from the nurses' station were harder to hear then the ones located closer to the nurses station. On 2/20/24 at 2:06 PM, an interview was conducted with the Director of Nursing (DON). The DON stated they had a call light system located next to the nurse's station. The DON stated staff were able to look at the system to see who's call light was going off. The DON stated if a call light had issues, they unplugged it to see if it fixed the issue. The DON stated if the call light was not working after unplugging it and plugging it back in then the resident's were given a bell. The DON stated the bell was used to notify staff they needed help. The DON stated residents have expressed their dislike of the cow bells and have raised concerns about them. The DON stated residents have said they did not want to keep continually ringing their bell till someone could answer it. The DON stated they were able to understand how the bell was a dignity problem.

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F 0923 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have enough outside ventilation via a window or mechanical ventilation, or both. 47432 Based on observation and interview, it was determined that the facility did not have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two. Specifically, there were odors throughout the facility. Findings Included: On 2/13/24 at 10:43 AM, an observation was made of the facility shower room. It was noted that there was a strong odor of both feces and urine in the shower room. On 2/12/24 at 11:33 AM, a walk through of the facility kitchen was conducted. A vent on the wall in the dry storage was visibly covered in dust. 46232 On 02/14/24 at 1:33 PM, an interview was conducted with the Corporate Maintenance (CM). The CM stated he was temporary and had only been here for 3 days. The CM stated that he got a text from the admin to replace the toilet and that was why he was here. The CM stated he was responsible for project management and helped with the building. The CM stated he came to the building depending on how big the project was. The CM stated they oversaw big projects such as replacing toilets, working on AC units, doing floor repairs, and doing a fluff and puff on a new room. The CM stated he did not do the day-to-day maintenance stuff and generally did not look maintenance log. The CM visualized the black stuff in the main shower room and stated the black stuff was not mold and it looked more like algae. The CM stated the black stuff could be removed if the area was clean/disinfected. The CM stated the caulking around the toilet was not a requirement. The CM stated the caulking served as a sealant. The CM stated if there was no sealant present then fluid was able to get under the toilet. The CM stated if a resident voided or had diarrhea on the floor and it happened to go under the toilet then he expected a smell to be present underneath it since there was no sealant to prevent the bodily fluid from going underneath and there was no way to clean underneath the toilet. The CM stated depending on the substance spilled on the floor around the toilet, then a smell might have been present. The CM stated the in-house maintenance man was the one responsible for changing the vents. The CM stated if the vent was dusty then they expected there to be a restriction in the airflow due to the dust so it would not work as efficiently.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22992 Based on record review and interview, the facility did not ensure that nursing assistants received training to ensure ongoing competence, and include dementia management training. Findings included: 1. A list of inservices provided to staff for the previous 12 months was requested and revealed the following: a. On [DATE] an inservice was provided on Wandering Residents. However, only 8 staff members' signatures were listed on the signature sheet. b. On [DATE] an inservice was provided on Elopements, garbage bags, CNA duties. However, only 10 staff members' signatures were listed on the signature sheet. c. On [DATE] an inservice was provided on Resident issues, Infection Prevention, PHI (protected health information). However, only 7 staff members' signatures were listed on the signature sheet. d. On [DATE] an inservice was provided on Behavioral interventions, abuse training [and] reporting requirements, dignity and customer service. However, only 13 staff members' signatures were listed on the signature sheet. On [DATE] at 12:05 PM, an interview was conducted with the facility Administrator (ADM). The ADM stated that since she began employment at the facility in [DATE], monthly trainings had been provided to CNAs. When asked how she would ensure that all staff were provided the training, she stated that it would be the Director of Nursing or CNA Coordinator (CNAC). The ADM could not provide documentation any inservices for staff prior to [DATE]. On [DATE] at 3:30 PM, an interview was conducted with the CNAC. When asked about training provided at the facility, the CNAC stated there is no training ever. The CNAC stated that an abuse training had been provided, and a fall training, but no others. The CNAC stated that there had not been a dementia or trauma informed care training provided to staff. 2. On [DATE], the files of 3 Nursing Assistants (NAs) were reviewed and revealed the following: a. NA 1 had a hire date listed as [DATE]. No orientation checklist was included in NA 1's employee file. b. NA 2 had a hire date listed as [DATE]. No orientation checklist was included in NA 2's employee file. c. NA 3 had a hire date listed as [DATE]. No orientation checklist was included in NA 3's employee file. (continued on next page)

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. NA 4 had a hire date listed as [DATE]. No orientation checklist was included in NA 4's employee file. The facility staff schedule for the week of [DATE] through [DATE] was reviewed. NA 1, NA 2, NA 3 and NA 4 were all scheduled and assigned a section of the facility to provide cares for residents during that week. On [DATE] at 9:55 AM, an interview was conducted with Nurse Assistant (NA) 2. NA 2 stated that he had worked at the facility for 2 months and he was working on getting his certificate. On [DATE] at 2:22 PM, an interview was conducted with NA 3. NA 3 stated that she had been employed at the facility for 5 months, but had never completed an orientation packet. NA 3 stated she asked the CNA Coordinator about it and was told, we never got around to doing it. NA 3 stated that she had not taken the test to become certified yet. NA 3 stated that she was training other NAs and Certified Nursing Assistants (CNAs) at the facility. On [DATE] at 11:45 AM, an interview was conducted with NA 4. NA 4 stated that she was a new hire and planned to work at the facility for 30 days and then the facility would start her certification class work. NA 4 stated that she would be obtaining her certification through a separate program. NA 4 stated that she trained for a few days with the staff at the facility and they showed her how to do everything. On [DATE] at 12:05 PM, an interview was conducted with the facility Administrator (ADM). The ADM stated that upon hire, all NAs and CNAs were supposed to be trained using a facility orientation checklist. The ADM provided the orientation checklist for NA 1, however the checklist was not complete. The ADM stated that it was the responsibility of the CNA Coordinator to complete the training, fill out the checklist, and return the checklist to the Business Office Manager. The ADM stated that she could not find an orientation checklist for NA 2 or NA 4. The facility CNA/NA Orientation Checklist was reviewed. The checklist included skills and tasks to be observed and/or completed, such as communication and interpersonal skills; demonstrate knowledge of resident's rights; protect residents' dignity; verbalize knowledge of signs and symptoms of abuse; procedures for responding to and reporting accidents and incidents care of cognitively impaired, verbally aggressive, and/or physically aggressive residents; reporting resident changes in condition, how to provide assistance with activities of daily living; how to perform transfers; how to perform skin care; fall prevention; promoting hydration; responding to resident requests for assistance; use of assistive devices; range of motion; infection control; and care of the deceased .