STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465163	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandstone North Park	350 South 400 East Bountiful, UT 84010

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - 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** 30563 Based on observation, interview and record review it was determined, for 1 of 33 sampled residents, that the facility did not treat each resident with respect and dignity and provide care in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life. Specifically, a resident was not allowed to go to his room and was placed under a call light panel that was beeping intermittently. Resident identifiers: 25. Findings include: Resident 25 was admitted to the facility on [DATE] with diagnoses which included dementia, history of falling, cervicalgia, and muscle weakness. On 1/27/25 at 11:05 AM, a continual observation was made of resident 25 sitting at the nurses station under the call light alarm system that was alarming intermittently. At 11:09 AM, resident 25 stated he needed to use the bathroom and was wheeling himself toward his room. At 11:11 AM, resident 25 stated he was going to the bathroom. The Activities Director (AD) walked past resident 25. At 11:12 AM, Certified Nursing Assistant (CNA) 5 was observed to ask resident 25 if he needed assistance and helped him to the bathroom. On 1/28/25 at 3:00 PM, an observation was made of resident 25 asking Licensed Practical Nurse (LPN) 1 to be let into his room. LPN 1 was observed telling resident 25 that he could not go into his room. (continued on next page)

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

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F 0550 Level of Harm - Actual harm Residents Affected - Few	On 2/5/25 at 10:20 AM, a continual observation was made of resident 25. Resident 25 was observed under the call light system at the nurses station with a beeping sound. Resident 25 was observed with a drink and a magazine on a bedside table. At 10:48 AM, resident 25 was observed to look at the call light system alarming and removed his hearing aides. There were no staff at the nurses station. At 11:03 AM, resident 25 was wheeling away from the nurses station and asked LPN 1 if he could go into his room. At 11:05 AM, an observation was made of resident 25 trying to open the door to his room. At 11:10 AM, resident 25 was sitting in hallway outside of his room. At 11:20 AM, resident 25 was observed outside his room with House Keeper (HK) 1. Resident 25 was pointing at the door to his room. HK 1 was observed to wheel resident 25 back to the nurses station under the alarming call light panel. Resident 25 stated to HK 1 he did not want to go there and stated he never asked to go there. HK 1 stated OK, one moment and left resident. HK 1 walked to the housekeeping cart and wheeled the cart down the hallway. Resident 25 was observed to be wheeling himself towards his room and asking HK 1 if he could go to his room. HK 1 was observed to put her hand up like a stop sign and stated ok. Resident 25 was wheeling himself toward his room and asked another staff member if he could go into his room. The staff member told him to ask his nurse and pointed toward the nurses station. At 11:23 AM, he waved toward HK 1 and stated Hey. HK 1 did not respond. At 11:24 AM, LPN 1 walked by resident 25 outside his room reaching for the door handle. LPN 1 stated, It's for your safety. At 11:26 AM, a CNA was observed to wheel resident 25 away from his room and under the call light panel which was alarming. Resident 25 wheeled himself toward his room. At 11:27 AM, resident 25 asked a surveyor if they were able to open his room. LPN 1 stated he was not allowed to go in his room, so staff tried to re-direct him. LPN 1 stated staff tried to re-direct him because he was not safe in his room. At 11:28 AM, LPN 1 asked resident 25 if he needed to use the bathroom. Resident 25 stated yes, he needed to use the rest room. At 11:28 AM, resident 25 was taken to his room and assisted into the bathroom. On 2/5/25 at 11:31 AM, an interview was conducted with HK 1. HK 1 stated resident 25 needed to stay at the nurses station so he can be watched by a CNA. HK 1 stated a CNA had to be with him if he went into his room. HK 1 stated It's no good if he is in his room. HK 1 stated resident 25 had to stay at the front at the nurses station. HK 1 stated if resident 25 kept trying to get into his room, she let the CNA's know. On 2/5/25 at 2:19 PM, an observation was made of resident 25 sitting under the call light panel while the call light system was alarming. On 2/6/25 at 8:47 AM, an observation was made of resident 25 by the nurses station under the call light panel. Resident 25 was observed sitting under the call light panel with a bedside table. On the bedside table there was a nutritional drink, cereal and a mug. Resident 25 was observed to be wiping the table. CNA 5 was observed to put a towel over resident 25's legs and offered to get him a new applesauce. The call light panel was alarming intermittently. Resident 25's medical record was reviewed 1/27/25 though 2/6/25. A quarterly MDS dated [DATE] revealed resident 25 had a Brief Interview of Mental Status (BIMS) score of 4 out of 12 which indicated severe cognitive impairment. (continued on next page)

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F 0550 Level of Harm - Actual harm Residents Affected - Few	On 2/5/25 at 3:56 PM, an interview was conducted with resident 25 and his family member. Resident 25 stated they have stupid rules. Resident 25's family member stated staff closed the door to his room because he was not allowed in his room alone because he could fall down. Resident 25's family member stated that staff took resident 25 to the nursing desk to watch him all the time. Resident 25's family member stated when she was here he was able to go anywhere in the facility including his room. Resident 25's family member stated there were a couple of staff members who had a cocky attitude and said things like I can't help you now, I'm busy. Resident 25's family member stated a lot of staff did not understand how to be polite to residents. Resident 25 stated being locked out of his room, made him feel terrible. Resident 25's family member stated resident 25 should be able to go into his room and staff should check on him. Resident 25's family member stated staff tell her that he's into things and having falls in his room, but he was also falling by the nurses station. Resident 25's family member stated it felt like no one was really that concerned about resident 25, the facility was understaffed and that was why resident 25 was put at the nurses station. Resident 25's family member stated if resident 25 had hearing aides adjusted then he heard the beeping at the nurses station. Resident 25's family member stated resident 25 had told her that he did not like to be at the nurses station. Resident 25's family member stated resident 25 was placed at the nurses station to make things easier for staff. Resident 25's family member stated staff were over worked and short tempered because they had a lot to do. On 2/6/25 at 8:54 AM, an interview was conducted with CNA 5. CNA 5 stated resident 25 could not be left alone, so a staff member always had an eye on him. CNA 5 stated when resident 25 was at the nurses station, he always had a staff members eyes on him. CNA 5 stated resident 25 had an alarm under him and he could not go in his room alone. CNA 5 stated resident 25 thought there was a piano in his room. CNA 5 stated if resident 25 wanted to go in his room, then she had to go in there with. CNA 5 stated resident 25 had not complained about the call light panel alarming because he was hard of hearing. CNA 5 stated being under the call light panel, sheWould imagine that would be annoying. On 2/6/25 at 8:56 AM, an interview was conducted with Licensed Practical Nurse (LPN) 2. LPN 2 stated resident 25 was a fall risk big time, so he was at the nurses station. LPN 2 stated if there was an activity resident 25 was taken to the activity. LPN 2 stated resident 25 usually slept in and then sat at the nurses station to eat breakfast. LPN 2 stated resident 25 asked to go to his room and staff usually told him they were making his bed and cleaning his room. LPN 2 stated she liked to watch resident 25 at all times and paid attention to where he was. LPN 2 stated CNAs made sure to know where resident 25 was at all times also. LPN 2 stated resident 25 was hard of hearing, so she did not think he could hear the call light system beeping above him at the nurses station. LPN 2 stated there was no specific reason resident 25 was placed under the call light system. LPN 2 stated she had not noticed increased agitation to resident 25 when call lights were alarming. At 9:02 AM, an observation was made with LPN 2. The call light system was alarming. Resident 25 was observed to stop a staff member as they walked by when the system was alarming. (continued on next page)

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F 0550 Level of Harm - Actual harm Residents Affected - Few	On 2/6/25 at 11:47 AM, an interview was conducted with the DON. The DON stated one of the fall interventions was to increase supervision while resident 25 was in his wheelchair. The DON stated when resident 25 was unsupervised in his room and he fell . The DON stated resident 25 being at the nurses station under the alarming call light system was a supervision thing. The DON stated resident 25 fell asleep at the nurses station and then when staff took him to his room he woke up. The DON stated resident 25 asked staff to open his door but he only asked when he was wheeling himself to his room. The DON stated when resident 25 was asking to go to his room, staff were to ask him what he was trying to do. The DON stated if resident 25 tried to reach for his door handle of his room, his chair alarm went off. The DON stated staff should be assisting resident 25 with what he needed, like ask him if he wanted to go to bed or the restroom. The DON stated he had not noticed resident 25 was under the alarming call light system. 50200

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48709 Based on observation, interview, and record review, it was determined for 1 of 33 sampled residents that the facility failed to ensure the right to self-administer medications if the interdisciplinary team (IDT) had determined that this practice was clinically appropriate. Specifically, one resident who had not been determined by the IDT to be appropriate and safe for self-administration had a medication at the bedside. Resident identifier: 35. Findings include: On 1/27/25 at 10:27 AM, an interview and concurrent observation were made in resident 35's room. A fluticasone propionate inhaler was observed to be on the resident's bedside table. Resident 35 stated she also had an emergency inhaler in her purse that she keeps in her drawer next to her bed. Resident 35 stated the nurse would leave her morning medications on her bedside table while she slept and that she took about 10 pills in the morning. Resident 35 stated she loved taking her medications that way because she could only take one pill at a time. Resident 35's medical record was reviewed 1/27/25 through 2/6/25. Resident 35 was admitted to the facility on [DATE] with diagnoses which included wedge compression fracture of fifth lumbar vertebra, spinal stenosis, radiculopathy, aortocoronary bypass graft, type 2 diabetes mellitus, and hypertension. The Quarterly Minimum Data Set, dated dated dated [DATE] indicated a Brief Interview for Mental Status (BIMS) score of 13, which indicated an intact cognition. A Nursing Note dated 1/28/25 at 7:49 AM indicated, MD [medical doctor] gave order may leave medications at bedside, for trial period. Pt [patient] made aware. A NSG (Nursing)-Self-Administration Of Medication evaluation was dated 1/28/25 at 8:00 AM indicated resident was capable of self-administering medications. A care plan Focus indicated, [resident 35] prefers to administer her own medications. Date Initiated: 01/29/2025. The Goal indicated, [Resident 35] will continue to take medications as directed. Date Initiated: 01/29/2025. The Interventions indicated, Nurse will assist resident with preparing medication and monitor resident at bedside for safety. Date Initiated: 01/30/2025 RN [registered nurse] LPN [licensed practical nurse]. The nurse will administer medications to the resident at scheduled times so that [resident 35] can take them at the time of her choosing. Date Initiated: 01/29/2025. On 2/6/25 at 1:32 PM, an interview was conducted with LPN 2. LPN 2 stated a resident needed to have an evaluation, doctor's order, and care plan in place before a medicated inhaler could be left in their room. No physician orders or IDT notes prior to 1/28/25 were provided.

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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** 43212 Based on observation, interview and record review it was determined, for 1 of 33 sampled residents, that the facility did not provide each resident with reasonable accommodation of resident needs and preferences. Specifically, a resident had a physician order to be evaluated for a tilt wheelchair that was not addressed for 5 months. Resident identifier: 34. Findings include: Resident 34 was admitted to the facility on [DATE] with diagnoses that included non-traumatic intracerebral hemorrhage, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, hereditary and idiopathic neuropathy, obstructive sleep apnea, prediabetes, and depressive episodes. On 1/27/25 at 11:13 AM, an interview was conducted with resident 34 who stated he had fallen from his bed and injured his shoulder. Resident 34 stated he had suffered a stroke prior to admission. Resident 34 stated had left sided deficits and was not receiving therapy services due to insurance issues. [Note: Resident 34 was not observed out of bed or in a wheelchair throughout the survey period.] Resident 34's medical records were reviewed between 1/27/25 and 2/6/25. A Minimum Data Set (MDS) Admission assessment dated [DATE] revealed resident 34 had a Brief Interview for Mental Status (BIMS) score of 13, indicating he was cognitively intact. The admission assessment also revealed resident 34 was dependent for mobility. Physician orders included : a. On 8/29/24, PT/OT (Physical Therapy/Occupational Therapy) to evaluate & treat for custom wheelchair. b. On 8/29/24, resident will need a tilt and space wheelchair for life for improved mobility, independence and quality of life. Resident 34's care plan dated 8/13/24 revealed, [Resident 34] has limit/impaired physical mobility r/t [related to] left sided hemiparesis secondary to a stroke. The goal was, [Resident 34] will remain free of complications related to immobility, including contractures, thrombus formation, skin-breakdown, fall related injury through the next review date. Interventions dated 8/20/24 and revised on 11/5/24 revealed use of reclining geri chair or tilt in space wheelchair when out of bed, resident 34 was unable to sit up in a regular wheelchair. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A hospital Physical Therapy progress note dated 7/29/24 revealed, .Do not leave patient in chair at this time. Use hoyer lift for all transfers. Close supervision at all times when sitting in chair. He has very poor control of trunk .Impairments: .Neurologic: motor control; Coordination/Proprioception deficits; Hemispatial neglect; Midline awareness; Hemiparesis; Lateropulsion .Recommendation: .New equipment Recommended (PT) [physical therapy]: Tilt in space WC [wheelchair] . On 1/30/25, a provider note for necessity revealed, .Face to face visit with [resident 34], . [Resident 34] has had a stroke resulting in left sided hemiparesis. [Resident 34] has severely impaired [sic] mobility. He is not able to stand or walk. He has impiarded [sic] sitting balance. [Resident 34] is in need of a tilt in space wheelchair. This will provide him with mobility and also with comfort and safety while sitting in it due to impaired sitting balance. A wheelchair will improve his quality of life. On 1/30/25, a Wheelchair Initial Evaluation Form revealed, Member information: [Resident 34] .Diagnosis: hemiplegia and hemiparesis following cerebral infarction, Hereditary and idiopathic neuropathy .Provider information: Date of wheelchair evaluation: 1/30/25; Date of physician's order: [blank] Evaluation form identified the following as necessity for resident 34: a. Tilt in space wheelchair with recline: Necessary to allow for changes in position periodically to avoid pain skin breakdown. Pt is unable to independently weight shift has current stage 2 pressure ulcer on buttocks and is in wheelchair for prolonged periods of time, needs to open up hip angle. b. Deep contour positioning backrest: Necessary to provide positioning assist for reduce trunk strength and stability. Pt is unable to sit unsupported, indicating he requires external support. c. Cushioned headrest-Headrest to support his head when the chair is in the tilted position. d. W/c [wheelchair] manual swingaway- Headrest- Hardware to attach to headrest which is removable for better access to pt by staff members when performing transfers. e. Solid seat pan- Necessary to provide pt with even weight distribution throughout buttocks for optimal comfort to decrease chance of pressure areas. f. Skin protect/position seat cushion-Necessary to prevent skin breakdown with prolonged sitting. Pt is dependent for weight shifts, has history of skin breakdown . [It should be noted that a 5 month period elapsed between the initial order for a tilt in space wheelchair evaluation and the time the evaluation was provided.] On 2/6/25 at 1:58 PM, an interview was conducted with the Director of Nursing who stated the Director of Rehab [DOR] was the person who coordinated evaluations for special wheelchairs. On 2/6/25 at 2:10 PM, an attempt to reach the DOR was made. A message was left on the DOR voicemail. The DOR did not return the phone call.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48709 Based on interview and record review it was determined, that for 7 of 33 sampled residents, that the facility failed to initiate and ensure prompt efforts to resolve grievances. Specifically, one resident's grievance was not documented, grievances took 30 or more days to resolve for two residents, and the grievances about staff was not thoroughly followed up on. Resident identifiers: 11, 14, 24, 27, 29, 32, and 34. Findings include: 1. Resident 27 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, end stage renal disease, and hypertension. On 1/27/25 at 1:46 PM, an interview was conducted with resident 27. Resident 27 stated around his birthday in November, he gave a pair of new Nike shoes to a Certified Nurse Assistant (CNA) and asked her to break them in for him. Resident 27 stated the CNA took the shoes and they disappeared. Resident 27 stated he told staff when it happened. On 2/5/25 at 2:17 PM, an interview was conducted with the Administrator. The Administrator stated that resident 27's shoes went missing in the last week of November, but that he was not made aware of them until the last week of December and it took him one week to investigate. The Administrator stated that the resident did not want to file a grievance, so he did not fill out a grievance form for him. The Administrator stated he did not have documentation regarding the missing shoes. 30563 2. Resident 29 was admitted to the facility on [DATE] which included chronic respiratory failure with hypoxia, congestive heart failure, pain in right knee, fibromyaglia, major depressive disorder, spinal stenosis, muscle weakness. On 1/27/25 at 9:45 AM, an interview was conducted with resident 29. Resident 29 stated she had missing items in laundry and staff told her they were looking for them. Resident 29 stated she filed a grievance about a nurse last week but had not heard anything back. Resident 29 stated she did not get her medication on time and was upset. Resident 29 stated that the nurse was an agency nurse so they moved her to another hallway. Resident 29 stated she was worried about the residents on that hallway getting their medication on time. On 1/28/25 at 4:01 PM, an interview was conducted with resident 29. Resident 29 stated she had pink sheets that were lost and the facility replaced them today. Resident 29 stated the sheets were really nice. A review of the grievance binder revealed a form titled Grievance/Concern Report dated 12/17/24 for resident 29. Resident 29 was missing a pink sheet. Laundry unable to find missing item. Sheet was not found in her room. The form was signed by Administrator on 1/28/25. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 29's medical record was reviewed on 1/27/25 through 2/6/25. A quarterly Minimum Data Set, dated dated dated [DATE] revealed resident 29 had a Brief Interview of mental Status of 15 which indicated cognitively intact. On 1/28/25 at 9:15 AM, an interview was conducted with the Administrator. The Administrator stated the Social Services Director (SSD) was in charge of grievances. On 2/5/25 at 1:30 PM, a phone interview was conducted the SSD. The SSD stated she was the Resident Advocate (RA) but no longer worked at the facility. The SSD stated that she filled out the grievance for resident 29 and the Administrator was new so she put the grievance on his desk. The SSD stated she asked about the grievance in the QAPI (Quality Assurance and Performance Improvement) meeting. The SSD stated it took longer than usual to replace the sheets. The SSD stated she wanted grievances resolved within 5 to 7 days. 50200 A review of the facility's grievances revealed: a. On 10/1/24 a grievance was filed by residents 32 and 34. Resident 32 and 34 reported a CNA left them waiting for an extended period of time to receive cares and to get ready for bed. It was reported the CNA helped resident 34 after 20 minutes and then left the room and did not assist resident 32. It was reported the CNA returned to assist resident 32 after a period greater than 20 minutes. It was reported the CNA told residents 32 and 34 that they were impatient and ungrateful. The resolution to this grievance was to have the CNA no longer work with residents 32 and 34. b. On 10/10/24 a grievance was filed by resident 32. Resident 32 reported he asked an agency CNA to help him with a brief change. Resident 32 reported he was informed by the CNA he would be assisted after dinner trays were collected. Resident 32 reported that he asked again 15-20 minutes later. Resident 32 reported he overheard two CNA's talking about him in the CNA break room. The immediate corrective action that was taken was to educate staff and agency. The resolution to this grievance was to educate staff. c. On 11/19/24 a grievance was filed by resident 24. Resident 24 reported resident 11 was having trouble with a CNA who was refusing to help resident 11. Resident 24 reported that resident 11 told him that the CNA refused to get him in his chair and would get him out of bed when he did not want to get out. The immediate corrective action of this grievance was to educate the CNA on resident rights. The resolution to the grievance was to educate staff. d. On 12/3/24 a grievance was filed by resident 32. Resident 32 reported it took 45 minutes for his call light to be answered. Resident 32 reported a CNA came in and informed resident 32 that they were in the middle of rounds and couldn't change his brief. Resident 32 reported the CNA returned an hour later and he informed them that he had been sitting in his bowel movement the entire time. The immediate corrective action to this grievance was to educate the CNA's. The resolution to this grievance was that all CNA's were educated on changing residents timely and per request. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	e. On 12/17/24 a grievance was filed by resident 11. Resident 11 reported that a CNA had an attitude while caring for him during a brief change. Resident 11 reported he told the CNA to find another job or lose the attitude. The immediate corrective action of this grievance was to provide education to the CNA. The resolution for this grievance was CNA education on having a better attitude. f. On 1/20/25 a grievance was filed by resident 14. Resident 14 stated she and resident 11 were having problems with a CNA. Resident 14 reported they would ask the CNA to get resident 11 up in his chair and the CNA would tell them she was too busy. The immediate corrective action done by the facility was to speak with the CNA and provide education. A verbal education was provided to the CNA about being more aware. On 2/5/25 at 2:07 PM, an interview was conducted with the Administrator. The Administrator stated there were grievance forms that were filled out by residents, family or staff. The Administrator stated the grievance officer was the previous SSD and there was a new one that started on 2/5/25. The Administrator stated grievances should be resolved quickly and should be resolved by the next QAPI meeting which was scheduled monthly. The Administrator stated he started halfway through December and was not prepared to do QAPI for December, so it was postponed to January. The Administrator stated he reviewed the grievances when he started. The Administrator stated there were a lot of it was missing items which had been replaced. The Administrator stated most of the grievances were minor issues. The Administrator stated he saw a lot of grievances about staff treatment of residents and the SSD brought those up in the QAPI meeting in January 2025. The Administrator stated there were 2 Certified Nursing Assistant who were written up for their attitudes. The Administrator stated there was a grievance for resident 29 on 1/20/25 that revealed she was concerned about late medications. The Administrator stated if he remembered right, the agency nurse was overwhelmed with 2 hallways, so they decided she was not a good fit and moved her to another hallway which had the same amount of residents but was one hallway. The Administrator stated he did not look into other residents medications being administered late. The Administrator stated residents spoke up, if medications were late, so he felt like they were getting medications on time. The Administrator stated he had not followed up with the agency nurse to see if the new hallway work load was doable. The Administrator stated he ordered a pink sheet for resident 19 and it never came, so he decided to buy one at a local store. The Administrator stated the facility got her one that was more expensive. The Administrator stated they looked through laundry to try the sheet but did not find it. The Administrator stated he was pretty sure they ordered it, but was unable to provide a confirmation of when the sheet was ordered. A review of the facility's grievance policy revealed: POLICY: Residents have the right to file grievances related to care, services, or other aspects of life in the facility. The facility will assist residents, their representatives (sponsors), other interested family members, or resident advocates file grievances when such requests are made and will investigate and take actions, as needed, to address such grievances. GUIDELINES: 1. Any resident, his or her representative (sponsor), family member, or appointed advocate may file a grievance with the facility concerning treatment, medical care, behavior of other residents, staff members, theft of property, or other aspects of life in the facility without fear of discrimination, threat or reprisal in any form. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Upon admission, residents are provided with written information on how to file a grievance. A copy of the grievance procedure is posted and available upon request. 3. Grievances may be submitted orally or in writing. No specific form or format is required to file a written grievance. However, a form is available if the resident/representative prefers. Grievances may be submitted anonymously. 4. Residents may file a complaint with the local Ombudsman office, Quality Improvement Organization, the State survey and certification agency, or other protection or advocacy system. Contact information for such agencies is posted in the facility. 5. The Administrator is the Grievance Officer. The Grievance Officer, with the assistance of social services, has the responsibility to oversee the grievance process, receive and track grievances through to their conclusion, lead any necessary investigations, maintain confidentiality, issue written grievance decisions and coordinate with state or federal officials, as necessary. 6. If a staff member overhears receives a grievance voiced by a resident, a resident's representative (sponsor), or another interested family member of a resident concerning the resident's medical care, treatment, food, clothing, or behavior of other residents, etc., the staff member will provide information as to how to file a written or verbal grievance with the facility. 7. Staff will immediately report to the Grievance Officer any grievance that alleges violations related to potential neglect, abuse, injuries of unknown source, and/or misappropriation of resident property. 8. The Grievance Officer will take immediate action to prevent further potential violations of any resident right while a grievance is investigated. 9. The resident, or person filling the grievance on behalf of the resident, will be informed of the findings of the investigation and the actions that will be taken to correct any identified problems. The Grievance Officer and or the designee, will make such reports available within seven (7) business days** of the filing of the grievance with the facility. A summary report of the investigation will be available to the resident. A confidential file will be maintained on grievance decisions and investigations for three years. ** In crisis situations, such as the COVID-19 Pandemic, some grievance resolutions may delayed [sic] if the grievance is due to restrictions or limitations caused by the crisis.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50200 Based on interview and record review, it was determined that the facility did not prevent misappropriation of a resident's medications for 1 of 33 sampled residents. Specifically, a cognitively impaired resident had missing fentanyl patches on numerous occasions. Resident identifier: 8 Findings included: Resident 8 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included multiple sclerosis, cervicalgia, major depressive disorder, muscle weakness, and type 2 diabetes. Resident 8's medical record was reviewed 1/27/25 through 2/6/25. A review of resident 8's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 1. A score of 0-7 would indicate severe cognitive impairment. Resident 8's orders were reviewed and documented the following fentanyl patch orders: a. A physician order with a start date of 6/24/24 documented, fentaNYL Transdermal Patch 72 hour 50 MCG/HR [microgram/hour]. Apply 50 mcg transdermally every 72 hours for pain *remove old patch and place on new* and remove per schedule b. An order with a start date of 10/1/24 documented, Check fentnyl [sic] patch placement q [every] 2 hours to ensure proper placement. If missing investigate and management [sic]. A review of resident 8's progress notes revealed: a. On 8/5/24 at 12:31 PM, an orders administration note for the fentanyl patch revealed not found. b. On 8/20/24 at 12:36 PM, an orders administration note for the fentanyl patch revealed not found. c. On 8/26/24 at 12:21 PM, an orders administration note for the fentanyl patch revealed not found. d. On 9/11/24 at 10:58 AM, a nursing note documented, This nurse checked lidocaine placement on right arm. It was on his right arm when this nurse checked when giving morning medication. This nurse went to go check placement while using skin prep on right heel, and the lidocaine patch was gone. This nurse and a CNA [certified nurse aide] checked all around his bed and in the sheets but could not find the patch. The resident denied knowing where it went. e. On 9/12/24 at 12:49 PM, a nursing note documented, Correction: The patch was a fentanyl patch. DON [Director of Nursing] aware. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	f. On 10/19/24 at 2:00 PM, a nursing note documented, This nurse went into residents room at 1pm [sic] to change the fentanyl patch. The patch was gone off of his left thigh where it had previously been. I checked the residents fentanyl patch between 11:30-11:45 for the 12 round and the patch was on the left thigh. This nurse checked the residents bed, the sheets, all over residents body with permission from resident to do so, under the bed, in the trash cans, in the resident bedding, and in the big yellow trash bin. This nurse did not find the fentanyl patch. This nurse asked the CNA's when they changed him, they said they changed him before lunch. This nurse asked the CNA's if they noticed the patch missing, they did not notice. The housekeepers who cleaned the room stated they only noticed milk and a chocolate boost on the floor. The resident had a red mark in the area on the left thigh where the patch had been. Oncall [sic] unit manager notified. New patch placed on resident with 3 tegaderms to keep in place on right thigh. g. On 12/11/24 at 3:36 AM, an orders administration note for the fentanyl patch revealed not in place. h. On 12/23/24 at 7:32 AM, an orders administration note for the fentanyl patch revealed pain patch not found NM [nurse manager] notified. Searched room and bedding and body. i. On 12/23/24 at 3:27 PM, an orders administration for the fentanyl patch revealed fentanyl patch was found earlier on bed, management is aware of this. MD [medical doctor] was notified and management/MD working on issue and on prophylactic action for future. resident denies pain at this time and has no s/s [signs and symptoms] related to pain. j. On 1/8/25 at 11:07 PM, a nursing note documented, This nurse checked for a fentanyl patch at 2000 [8:00 PM] and 2100 [9:00 PM]. Unable to find on L [left] thigh where previously documented it was placed. Searched with other RN [registered nurse] and still could not find anywhere. DON notified and narc [narcotic] book reviewed. Patch was taken off 1/7 but never readministered per narc book. Count still correct. DON given order for RN to place patch now and update MAR [medication administration record]. [It should be noted, according to the MAR, the fentanyl patch was checked every 2 hours on 1/8/25 and documented as in place on resident 8's left thigh.] k. On 1/13/25 at 8:35 PM an orders administration note for the fentanyl patch revealed bed searched cannot locate and not on pts [patients] body. l. On 1/14/25 at 1:05 PM, a nursing note documented, New orders received to discontinue fentanyl patches and start MS [morphine sulfate] Contin 30 mg [milligram] po [by mouth] TID [three times a day]. Also to add oxycodone 10 mg po q12h [hour] prn [as needed] for breakthrough pain. Daughter notified of changes. A review of resident 8's physician progress notes revealed the following: a. A provider progress note dated 10/28/24 documented, Chief Complaint: Follow up on possible medication diversion .Assessment/Plan: .-Chronic pain syndrome .-fentanyl path [sic] 50mcg q 3 days topical, monitor . (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. A provider progress note dated 1/14/25 documented, Chief Complaint: Difficulty with pain management medications .Interval History: [resident 8] has been having continual problems with being able to keep his fentanyl patch in place, it typically comes off with 1-1/2 days of putting it on, crating problems both for diversion and also for pain control . Review of the narcotic record log entries with the corresponding MAR for fentanyl patches 50 mcg every 72 hours revealed the following: a. On 8/20/24 the medication was signed out of the narcotic log at 1:36 (unknown if this was AM or PM) and the MAR documented an administration time of 12:36 PM. b. On 9/7/24 the medication was signed out of the narcotic log at 1400 (2:00 PM) and the MAR documented an administration time of 1300 (1:00 PM). c. On 9/19/24 the medication was signed out of the narcotic log at 1150 (11:50 AM) and the MAR documented an administration time of 1204 (12:04 PM). d. On 10/25/24 the medication was signed out of the narcotic log at 1400 (2:00 PM) and the MAR documented and administration time of 1508 (3:08 PM). e. On 11/3/24 the medication was signed out of the narcotic log at 1130 (11:30 AM) and the MAR documented and administration time of 1202 (12:02 PM). f. On 11/6/24 the medication was signed out of the narcotic log at 1330 (1:30 PM) and the MAR documented and administration time of 1344 (1:44 PM). g. On 11/21/24 the medication was signed out of the narcotic log at 1323 (1:23 PM) and the MAR documented and administration time of 1258 (12:58 PM). h. On 11/27/24 the medication was signed out of the narcotic log at 1330 (1:30 PM) and the MAR documented and administration time of 1440 (2:40 PM). i. On 12/26 the medication was signed out of the narcotic log at 1700 (5:00 PM) and the MAR documented and administration time of 1613 (4:13 PM). j. On 1/7/25 the medication was signed out of the narcotic log at 1830 (6:30 PM) and the MAR documented and administration time of 2013 (8:13 PM). k. On 1/8/25 the medication was signed out of the narcotic log at 2132 (9:32 PM) and the MAR documented and administration time of 2143 (9:43 PM). It should be noted the facility did not provide the narcotic log book for fentanyl patches for 12/1/24-12/17/24. It should be noted on 11/24/24, 12/26/24, and 1/4/25 only one nurse initials were signed in the narcotic log book with the removal of a fentanyl patch. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/29/25 at 9:25 AM, a phone interview was conducted with Registered Nurse (RN) 2. RN 2 stated resident 8's fentanyl patches had gone missing on several occasions. RN 2 stated that staff should change the fentanyl patches every 3 days and the facility had never provided any education about them. RN 2 stated she arrived at work one day and discovered a new order to check the fentanyl patches every two hours. RN 2 stated that when resident 8's fentanyl patches went missing, he did not receive a replacement patch and suffered from severe chronic pain. RN 2 stated that resident 8 became combative with staff when he was in pain. RN 2 stated that she had worked a shift when a fentanyl patch went missing. Upon discovering the missing patch, RN 2 texted the DON to report the issue. The DON responded, instructing her to call the on-call provider. RN 2 stated that the facility provided no education on disposing of used fentanyl patches and that a witness was required for disposal. On 1/30/25 at 11:00 AM an interview was conducted with Licensed Practical Nurse (LPN) 2. LPN 2 stated that resident 8 experienced significant pain, became very irritable, and would fight with staff as a result. LPN 2 stated that resident 8 was prescribed fentanyl patches for pain, but the patches often went missing. LPN 2 stated to secure them, the nursing staff applied Tegaderm over the patches, but they still disappeared. LPN 2 stated that the staff searched resident 8 and the bedding but never found the missing patches. LPN 2 stated that when this happened, she had to monitor resident 8's pain and behavior, as his pain would increase. On 1/30/25 at 11:08 AM, an interview was conducted with RN 1. RN 1 stated resident 8 had back problems that caused him significant pain. RN 1 stated the nursing staff tried applying the fentanyl patches to different areas and covered them with Tegaderm to secure them. RN 1 stated that she recalled working when a patch went missing, and it was never found. On 2/4/25 at 12:32 PM, an interview was conducted with the DON. The DON stated resident 8 displayed some physical aggression and did not like to be bothered. The DON stated that resident 8 was prescribed fentanyl patches and scheduled oxycodone. The DON stated that because resident 8 had little body fat, the patch frequently came off. The DON stated that missing fentanyl patches had only occurred a few times in the past few months and that staff had been able to locate each missing patch. The DON stated that he spoke with the medical director about the patches coming off and requested a switch to oral medications. On 2/5/25 at 9:24 AM, an interview was conducted with the Unit Manager (UM). The UM stated resident 8 did have an order for fentanyl patches and staff tried different places to apply them. The UM stated an order was placed for frequent checks to ensure the patch was still on. The UM stated if staff could not find the patch they were instructed to alert her and the DON. The UM stated she personally could not account if all the fentanyl patches that went missing were ever located. The UM stated the clinical team discussed the missing fentanyl patches to see if it there was a trend with certain times of the day or certain staff when the fentanyl patches would come up missing. On 2/5/25 at 1:42 PM, a follow up interview was conducted with the DON. The DON stated the fentanyl patches went missing a total of four times between 8/26/24-10/19/24, with the patch on 10/19/24 being the only one not located. The DON stated on 2/5/25, he contacted one of the nurses who had documented a missing fentanyl patch in August to determine if the patch was ever found. The DON stated there was no documentation confirming if it was located. The DON stated that the facility implemented checks every two hours to ensure the fentanyl patches remained in place and expected nurses to investigate and document if a fentanyl patch went missing and was found. The DON stated that disposing of fentanyl patches required two nurse signatures on the narcotics log. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[It should be noted that the DON did not address any missing fentanyl patches after 10/19/24.]

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43212 Based on interview and record review it was determined, for 2 of 33 sampled residents, that the facility failed to notify the resident and the resident's representative of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand and failed to send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. Specifically, one resident was not notified of the reason for transfer in writing. In addition, the Office of the State Long-Term Care Ombudsman was not notified when residents were transferred or discharged from the facility. Resident identifiers: 8 and 32. Findings include: 1. Resident 32 was admitted to the facility on [DATE] with diagnoses that included end stage renal disease, acquired absence of left leg below the knee, dysphagia, sleep related hypoventilation, cirrhosis of the liver, osteomyelitis of the lumbar spine. Resident 32's medical records were reviewed between 1/27/25 and 2/6/25. On 7/12/24 at 5:18 AM, a nursing progress note revealed, Resident chose to sleep out in the court yard all night in his wheelchair. On 7/12/24 at 10:10 AM, a nursing progress note revealed, This nurse was asked to assess resident. Resident siting [sic] wheelchair by nurses station, has cool compress to forehead, back of neck and lower abdomen. Vital signs BP [blood pressure] 166/73, Temp [temperature] 95.6, HR [heart rate] 86, RR [respiration rate] 18, SPO2 [oxygen saturation] 90% on RA [room air], BS [blood sugar] 108. Floor nurse has been offering and encouraging fluids with success. Resident alert to self, hand grasps equal with decreased strength, unable to hold upper extremities up on own. Bilateral extremities warm to touch, head and neck cool with cool compress intact. Pupils 3 mm [millimeters] round with sluggish reaction. Resident does not follow commands, lethargic. MD [medical doctor] notified, spoke to NP [nurse practitioner] on the phone and new orders to continue to encourage oral hydration and cool patient. Resident vomiting x3 small episodes @ [at] 1020 [10:20 AM] of dark yellow bile. MD new orders for IV [intravenous] 500 mg [milligrams] NS [normal saline] Bolus then follow with 250 ml [milliliters]/hr [hour] x 2 hours. 22 gauge IV placed in RAC [right antecubital] and fluids started. On 7/12/24 at 1:51 PM, a nursing progress note revealed, Pt [patient] was found outside sleeping in heat. Pt was slow to respond, altered mental status. NP notified and orders were to give IV normal saline for dehydration. NP assessed pt and felt pt needed to go to ER [emergency room] to be evaluated. Pt's [family member] was notified. Pt was transferred to [hospital] by ambulance. On 7/12/24 at 11:00 PM, a nursing progress note revealed, Per [hospital] resident has been admitted for encephalopathy. House MD notified. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/15/24 at 5:31 PM, a nursing progress note revealed, Resident readmitted from [hospital] via stretcher. Confused and very agitated. MD notified of order review. Refusing all PO4 [potassium] binders stated 'I'm not eating anything.' Refused amputee brace on. Stated 'i didn't have to wear it at the hospital and i'm not putting it on.' Resident reassured and tried calming technique worked for a while until this nurse left. Started yelling out my name. Went back in and did ADL's [activities of daily living] for distractions. Still working on agitation at this time. On 1/30/25 at 11:07 AM, an interview was conducted with resident 32 who stated he fell asleep outside in July. Resident 32 stated he did not know if he intended to sleep outside. Resident 32 stated management did not know and he did not tell anyone. Resident 32 stated he did not remember talking to anyone during the night and he was out of it. Resident 32 stated he did not have much recollection of the event. Resident 32 stated he did not know if it was hot. Resident 32 stated he did come back inside the facility, but did not know what time. Resident 32 stated he went to the hospital for 2-3 days and was told this information by staff. On 1/30/25 at 3:31 PM, an interview was conducted with the Director of Nursing (DON). The DON stated resident 32 had requested to sleep outside. The DON stated staff went and asked resident 32 to come inside and resident 32 stated he wanted to sleep outside. The DON stated the next day staff told him resident 32 was lethargic. On 2/4/25 at 10:41 AM, an interview was conducted with the Lead CNA (certified nurse aide) who stated resident 32 was pretty independent and liked to go outside. The lead CNA stated resident 32 did not want to come inside and was angry he was being taken to the hospital. On 2/4/25 at 1:40 PM, an interview was conducted with Registered Nurse (RN) 3 who stated resident 32 told her he was going to sleep outside. RN 3 stated they tried to tell him not to. RN 3 stated, [resident 32] does what [resident 32] wants. On 2/6/25 at 12:35 PM, an interview was conducted with the DON who stated if a resident had to go to the hospital an order would be obtained from the physician, EMS [emergency medical services] would be contacted and the staff would contact the resident's family. The DON stated the resident was not provided information about why they were going to the hospital and the room bed hold policy was signed by the resident on admission and in the admission packet. 50200 2. Resident 8 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included, multiple sclerosis, cervicalgia, major depressive disorder, muscle weakness, and type 2 diabetes. A review of resident 8's progress notes revealed the following: (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. On 1/20/25 at 11:37 AM, a nursing note documented, contacted [medical group] with updates about [resident 8]; his left arm iv infiltrated and had to be stopped. i attempted to start a new one on his right arm with no success. he wont [sic] keep his o2 [oxygen] mask on and is hypoxic with sats [saturations] ranging from 75-83. we contacted his daughtervia [sic] 3way [sic] call to update her on his condition and made a collective decision to have him sent to hospital dt [due to] respiratory distress. i called 911 then paramedics showed up around 1030 [10:30 AM] and transported him to [local hospital] b. On 1/20/25 at 6:00 PM, a nursing note documented, This nurse spoke with daughter, resident has been admitted to [local hospital] ICU [intensive care unit] with PNA [pneumonia]. MD notified. c. On 1/29/25 at 1:58 PM, a nursing note documented, resident arrived on a stretcher in a van with driver et [and] daughter. placed in room [ROOM NUMBER]. resident transferred to his bed with 4 person assist. placed on 2 liters of oxygen per NC [nasal cannula]. no distress noted or reported. On 2/5/25 at 8:43 AM, an interview was conducted with the Administrator. The Administrator stated he would only submit reports to the the Ombudsman if a resident was discharged back into the community. The Administrator stated he did not know he was supposed to report residents that were discharged to a hospital. 48709 On 2/5/25 at 08:28 AM, an email was received from the Administrator. The email indicated, We were unable to verify ombudsman notification because we couldn't access the old administrator's email, so I attached the December log and resent the January DC [discharge] Log just to ensure that we have updated our ombudsman. On 2/6/24 at 11:00 AM, a telephone interview was conducted with the State Long-Term Care Ombudsman. The State Long-Term Care Ombudsman stated they had not received any notifications of transfers or discharges from the facility.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43212 Based on observation, interview, and record review, for 5 of 33 sampled residents, the facility did not develop and implement a comprehensive person-centered care plan consistent with the resident's rights that included measurable objectives and timeframes to meet a resident's medical, nursing, and psychosocial needs that were identified in the comprehensive assessment. Specifically, resident care plans were not followed, care plans did not include use of oxygen, fall interventions were not implemented after each fall and smoking was not included in the care plan. Resident identifiers: 12, 18, 32, 34, and 293. Findings include: 1. Resident 12 was admitted to the facility on [DATE] with diagnoses that included schizophrenia, chronic obstructive pulmonary disease, type 2 diabetes, follicular lymphoma, panlobular emphysema, and lymphocytopenia. On 1/27/25 at 10:55 AM, an observation was made of resident 12 in his room. Resident 12 was taking cigarettes out of his night stand in preparation to go and smoke. An interview was conducted with resident 12. Resident 12 stated he was allowed to keep his smoking materials in his room and he kept his lighter in the pocket of his jacket that he wore all the time. Resident 12's left hand was observed to have a tremor during the interview. On 1/28/25 at 11:46 AM, an observation was made of resident 12 smoking a cigarette in the smoking area. Resident 12's right had was shaking significantly as he was holding the cigarette. Ash was observed to be falling on the resident. Resident 12's plaid pajama bottoms were observed to have a small hole on one of the legs. An interview was conducted with resident 12 who stated he did not need to be using a smoking apron. On 1/28/25 at 12:28 PM, an observation was made of resident 12 smoking a cigarette in the smoking area. Resident 12 was holding his cigarette in his left hand, and his left hand was observed to have a jerking motion as he lifted the cigarette to his mouth and back down again. On 1/28/26 at 12:30 PM, an observation was made of resident 12 who dropped his cigarette on to the ground. Resident 12 leaned over and picked up the cigarette and continued smoking it. Resident 12's medical records were reviewed between 1/27/25 and 2/6/25. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 12's care plan revealed, [Resident 12] is a smoker and chooses to smoke while at the facility. Date initiated: 1/23/24, Revision on: 1/23/24. The goal was, [Resident 12] will not suffer injury from unsafe smoking practices through the review date. Date initiated: 1/24/24, Revision on 8/12/24, Target date: 1/29/25. Interventions included, Cigarettes (or other smoking materials) should be stored in a locked box by the nurses station. [Resident 12] has the key to his box. Encourage compliance. Date initiated: 1/24/24, Revision on: 1/27/25; Instruct resident about the facility policy on smoking: locations, times, safety concerns. Date initiated: 1/24/24; Notify charge nurse immediately if it is suspected resident has violated facility smoking policy. Date initiated: 1/24/24; Observe clothing and skin for signs of cigarette burns. Notify LN [licensed nurse] immediately if present. Date initiated: 1/24/24; The resident can smoke UNSUPERVISED. Date initiated: 1/24/24. On 1/28/25 at 3:11 PM, an interview was conducted with Licensed Practical Nurse (LPN) 1 who stated he completed smoking assessments on residents when they were admitted to the facility. LPN 1 stated he had a score that he used when evaluating residents for smoking to determine if they could smoke independently or not. LPN 1 stated he had not noticed anything, except one of resident 12's hands had limited movement when assessing resident 12, that he would consider unsafe for him to smoke independently. LPN 1 stated if there was information that was concerning he would notify the Certified Nursing Assistant (CNA) lead so she could let the CNA's know. LPN 1 stated his communication with CNA's was verbal. It should be noted that LPN 1 reviewed the smoking assessment he completed on 1/21/25 and stated there was no score on the assessment. On 1/28/25 at 3:25 PM, an interview was conducted with the Director of Nursing (DON) who stated the Unit Manager (UM) was typically the person who completed smoking assessments on the residents and she would be the person to ask about how the smoking screening determined the resident's ability to smoke independently. The DON stated smoking assessments were done quarterly so there may not be many times to see how resident 12 was smoking. The DON stated resident 12 had a lock box on the wall by the nurses station and that was where he kept his smoking materials. The DON stated he did not have any concerns about resident 12 smoking unsupervised or unsafely. The DON stated resident 12 was a fast smoker. The DON stated if he witnessed resident 12 dropping ash on himself he would not consider him safe to smoke independently. On 1/28/25 at 4:04 PM, an additional interview was conducted with the DON who stated he had observed resident 12 with a burn hole in his pants and involuntary movement. The DON stated resident 12 was being placed on supervised smoking going forward. The DON stated he had not witnessed involuntary movements or burn holes in resident 12's clothing until today. On 1/28/25 at 4:40 PM, an additional interview was conducted with LPN 1 who stated the process for determining if a resident was safe to smoke was to make sure the resident had a smoking assessment. If they did not, he would complete one. LPN 1 stated he used his professional judgement when completing resident 12's smoking assessment. LPN 1 stated if anything seemed hazardous he would determine the resident was not safe to smoke independently. LPN 1 stated if residents were dropping stuff he would determine that smoking devices were needed. LPN 1 stated the reason he completed the smoking assessment on resident 12 was it popped up in resident 12's medical chart that day. LPN 1 stated he did not observe resident 12 when completing his smoking assessment and filling out the screening form. LPN 1 stated there was a lock box near the nurses station where residents kept their smoking materials. LPN 1 stated resident 12's smoking materials were in the narcotics drawer and had his name on them. LPN 1 stated he thought resident 12's smoking materials were in his lock box before being put in the narcotics drawer. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/28/25 at 4:59 PM, an interview was conducted with the Administrator (ADM) who stated all residents who smoked were independent. The ADM stated if a smoking resident was showing signs of doing something that would make them unsafe they should bring it up with the DON. The ADM stated actions that would be considered unsafe would be not being able to hold a cigarette, not being stable to hold a cigarette, cognitive impairment, inability to make choices, inability to perform Activities of Daily Living (ADL)'s and take care of themselves, or needing extra assistance. The ADM stated he did not know if staff members went out to the smoking area to ensure residents were smoking safely. The ADM stated he was unsure where residents were keeping their smoking materials. The ADM stated residents could request a smoking apron if they wanted one, but most residents did not want to use a smoking apron, they just go out and smoke. The ADM stated when a resident was admitted with a history of smoking, staff would go over the smoking policy with the resident. The ADM stated he did not know resident 12 very well and had not observed any type of uncontrolled movement when talking with resident 12. The ADM stated he did not know if there was a particular staff member who completed the smoking assessments. On 1/28/25 at 5:08 PM, an interview was conducted with the DON who stated staff were aware of which residents smoked by looking at the resident's KARDEX, and the care plan. The DON stated smoking assessments were completed on every resident whether or not they were smokers. On 1/29/25 at 9:00 AM, an interview was conducted with CNA 3 who stated she had not noticed resident 12 to have any involuntary movements. CNA 3 stated she had not observed any burn holes on resident 12's clothing. CNA 3 stated resident 12 was a partial to substantial assist depending on the day or time of day. CNA 3 stated resident 12 would ask for help if he needed anything. CNA 3 stated a resident holding a cigarette for too long or burning themselves would be considered a concern. CNA 3 stated if she observed a safety concern while a resident was smoking she would notify the nurse and go and supervise the resident or have another staff member supervise the resident. 2. Resident 32 was admitted to the facility on [DATE], and readmitted on [DATE] with diagnoses that included end stage renal disease, acquired absence of left leg below knee, sleep related hypoventilation, type 2 diabetes, osteomyelitis of vertebra, cirrhosis of liver, congestive heart failure, and major depressive disorder. On 1/27/25 at 1:43 PM, an interview was conducted with resident 32 who stated he used oxygen only at night. Resident 32's medical records were reviewed between 1/27/25 and 2/6/25. Resident 32's physician orders were reviewed. It should be noted that resident 32's orders did not contain orders for oxygen use. Resident 32's care plan was reviewed. It should be noted that resident 32's care plan did not include the use of oxygen. A provider progress note dated 12/19/24 revealed, .Having nocturnal hypoxemia with significant desats [desaturation], stable overall and sleeping well, per report he has had a history of OSA [obstructive sleep apnea] in the past. Continue nighttime oxygen and monitor; refer to sleep clinic for evaluation. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/4/25 at 8:32 AM, an interview was conducted with CNA 4 who stated resident 32 wore oxygen most of the time. CNA 4 stated resident 32 took his oxygen off sometimes and did not wear it when in his wheelchair. CNA 4 stated resident 32 wore his oxygen while at dialysis and throughout the night. On 2/4/25 at 11:04 AM, an interview was conducted with Registered Nurse (RN) 4. RN 4 stated sometimes orders would say PRN [as needed], or it could say when to use oxygen or to use it continuously. On 2/5/25 at 3:03 PM, an interview was conducted with the DON who stated resident 32 had been discharged and readmitted a few times. On 2/5/25 at 3:29 PM, an interview was conducted with Regional Nurse Consultant (RNC) 2 who stated she did not see any orders for oxygen when resident 32 was readmitted on [DATE]. 3. Resident 34 was admitted to the facility on [DATE] with diagnoses that included non-traumatic intracerebral hemorrhage, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, hereditary and idiopathic neuropathy, obstructive sleep apnea, prediabetes, and depressive episodes. On 1/27/25 at 11:17 AM, an interview was conducted with resident 34 who stated he wore oxygen all the time. Resident 34 was not wearing his oxygen. Resident 34 stated he was not wearing his oxygen because he could not find it. Resident 34 stated he had not called for assistance to find is nasal cannula yet. It was observed that resident 34 was laying on top of his oxygen tubing. Resident 34's medical records were reviewed between 1/27/25 and 2/6/25. Resident 34's physician orders were reviewed on 1/28/25. It should be noted no oxygen orders were found in resident 34's current physician orders. Resident 34's care plan was reviewed on 1/29/25. It should be noted that no care area was found to address resident 34's use of oxygen. An admission Minimum Data Set (MDS) dated [DATE] revealed, oxygen therapy, response Yes. A provider admission progress note dated 8/2/24 revealed, . He did not wear oxygen prior to hospitalization . Family report he was diagnosed with OSA [obstructive sleep apnea] in the hospital and did wear a CPAP [continuous positive air pressure] in hospital. Continue oxygen especially at night . Obstructive sleep apnea (adult) (pediatric) CPAP in hospital-use oxygen 2 L [liters] via NC [nasal cannula] keep O2 [oxygen] sats [saturation] above 92%. On 2/4/25 at 8:32 AM, an interview was conducted with CNA 4 who stated resident 34 used oxygen all the time. CNA 4 stated staff had to go in frequently because resident 34 would take his oxygen off. On 2/4/25 at 2:45 PM, an interview was conducted with the DON who stated he was not sure if resident 34 had been on oxygen since he was admitted . The DON stated resident 34 frequently took his oxygen off. The DON looked at resident 34's physician orders and stated he did not see any discharge orders for oxygen from the hospital. 48709 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Resident 18 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included displaced dens fracture, end stage renal disease, dementia, hypertension, and type 2 diabetes mellitus. Resident 18's medical record was reviewed 1/27/25 through 2/6/25. A Quarterly MDS dated [DATE] indicated a Brief Interview for Mental Status (BIMS) score of 2. A BIMS score between 0-7 indicated severe cognitive impairment. A Nursing Note dated 9/18/24 at 5:39 PM indicated, pt [patient] FOF [found on floor] on her fall mat by CNA [Certified Nurse Assistant] at 400 [4:00 AM] . There was no updated intervention made to the care plan. A Nursing Note dated 10/6/24 at 3:30 AM indicated, While rounding on the resident the resident was found on the floor next to her bed. There was no updated intervention made to the care plan. A Nursing Note dated 1/3/25 at 4:06 PM indicated, Pt found by CNA @15:45 [at 3:45 PM] on the floor next to her bed. Pt reported trying to get up to go to the bathroom but slide [sic] out of bed . The care plan Intervention initiated on 1/3/25 indicated, Education to be provided about alarm use. A Nursing Note dated 1/6/25 at 4:10 PM indicated, Pt fof next to bed on fall matt laying on right side mostly face down, bed was in lowest position, pull tab alarm in place and functioning. Alarm still attached to Pt and repositioning bar on bed. Head to toe assessment done, Pt has small skin tear to right forearm. Cleansed and dressed. Pt c/o [complains of] pain to both hands. Aid translated that pt stated she was sitting on edge of bed trying to reach wheelchair and fell off because bed is too small. Neuro checks started. MD [Medical Doctor], DON [Director of Nursing] and son notified. A Nursing Noted dated 1/7/25 at 3:47 PM indicated, RN [Registered Nurse] called [Hospital name redacted] ER [emergency room] to check on pt status ER RN [sic] that pt has been transferred to [Hospital name redacted] and admitted for a 'broken back due to the fall' . An Emergency Provider Report document dated 1/6/25 at 10:05 PM indicated, .Patient does have baseline dementia, but states that she fell , and hit her head. She had some pain diffusely in the left hand, predominantly in the fingers. She complains of a skin tear on her left forearm .She denies any other pain or injury elsewhere . It further indicated resident had a CT (Computerized Tomography) of the neck which revealed, 1. ACUTE nondisplaced type III dens fracture. The document further indicated that resident 18 was transferred to a second hospital after the fracture was identified on 1/7/25 at 12:00 AM for possible surgery. A Nursing Admission note dated 1/8/25 at 5:15 PM, indicated resident 18 was transferred back to the facility. The care plan Interventions initiated on 1/8/25 indicated, Personal alarm to be used when resident is in wheelchair/dialysis chair and Pressure alarm to be used when resident is in bed. It should be noted that these interventions were previously documented as being implemented in an incident report and nursing notes as early as 9/18/24. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An Incident Report for an Un-witnessed Fall dated 9/18/24 at 4:00 AM indicated a Predisposing Environmental Factor was, Alarm- present, not sounding. A Nursing Note dated 10/29/24 at 9:18 AM indicated, Pt being monitored post recent fall. Neuro checks continue to be WNL [within normal limits] per Pt baseline. No new injuries noted. Pt in bed, bed in lowest position, fall mat in place, bed alarm in place and functioning. Call light within reach. Staff checking on Pt often. A Nursing Note dated 1/15/25 at 6:33 PM indicated, .This nurse and the CNA ensured residents bed was at lowest position, call light was on resident, and fall alarm was attached to resident. CNA came out of the residents room and stated a nurse was needed. This nurse went to assess. Resident was sitting on the ground with back against the bed. The resident stated she was trying to go to the bathroom. Resident assisted back into the bed. Resident was wearing non skid socks, bed was in lowest position, fall alarm working properly, and fall mat beside residents bed. Head to toe assessment done with no injuries noted. Resident denied any pain. Resident denied hitting her head. Neuros started. Provider notified and emergency contact notified. There was no updated intervention made to the care plan. An Incident Report for an Un-witnessed Fall dated 1/15/25 at 6:00 PM indicated, .Pt to be moved to a busier hall to increase sight on pt. On 2/6/25 at 8:50 AM, an interview was conducted with the Administrator. The Administrator stated that resident 18 was moved to a new room that was closer to the nurse's station and in a busier hallway with stronger staff presence on 1/20/25 and that she had not fallen since her move. On 2/6/25 at 11:21 AM, an interview was conducted with the DON. The DON stated the intervention implemented after her 1/3/25 fall was to remind staff about the fall alarm. The DON stated the fall alarm did not prevent falls. The DON stated the intervention implemented after her 1/6/25 fall, which resulted in a dens fracture, was that she was sent to the hospital. The DON stated that when she was readmitted on [DATE], the plan was to move her down to the 300 hall, but that she still had all the fall interventions in place until she was moved. The DON stated they were just waiting to move her because they could not find a room. On 2/6/25 at 1:28 PM, an interview was conducted with Licensed Practical Nurse (LPN) 2. LPN 2 stated she was not sure when the last fall resident 18 had was but that she was moved to the 300 hall to be closer with more staff traffic and that she had not had a fall since she was moved. 50200 5. Resident 293 was admitted to the facility on [DATE] with diagnoses which included displaced intertrochanteric fracture of left femur, other toxic encephalopathy, major depressive disorder, tobacco use, muscle weakness, and need for assistance with personal care. Resident 293's medical record was reviewed 1/27/25-2/6/25. A review of resident 293's nursing admission evaluation dated 1/15/25, documented that resident 293 used tobacco, alcohol, or drugs and was a current smoker. It should be noted that a smoking evaluation was not performed on resident 293. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/27/25 at 9:50 AM, an interview was conducted with resident 293. Resident 293 stated he was a smoker and smoked around 2-3 cigarettes a day. Resident 293's care plan was reviewed and revealed there were no care plans developed for smoking or the use of cigarettes. On 1/28/25 at 3:01 PM, an interview was conducted with Certified Nurse Aide (CNA) 2. CNA 2 stated resident 293 would smoke outside with his son. On 2/04/25 at 2:17 PM, an interview was conducted with the MDS Coordinator. The MDS Coordinator stated she would adjust care plans daily based on orders and evaluations. The MDS Coordinator stated she would start a care plan for new resident admissions within 48 hours.

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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** 48709 Based on interview and record review, it was determined that for 1 of 33 sampled residents, the facility failed to review and revise the comprehensive care plan and did not involve the resident and the resident's representative. Specifically, one resident's comprehensive care plan was not reviewed and revised by an interdisciplinary team (IDT) for seven months. Resident identifier: 31. Findings include: On 1/30/25 at 10:28 AM, a concurrent interview was conducted with resident 31 and her family member. Resident 31 stated she had not heard of a care plan. The resident's family member stated they attended a care plan meeting when the resident was first admitted in May, but had never been invited to any following care plan meetings because the facility did not do them. Resident 31's medical record was reviewed 1/27/25 through 2/6/25. Resident 31 was admitted to the facility on [DATE] with diagnoses which included malignant neoplasm of cerebellum, unspecified mood [affective] disorder, disorders of bladder, major depressive disorder, anxiety disorder, neuralgia and neuritis, systemic lupus erythematosus, and hypertension. A Quarterly Minimum Data Set (MDS) dated [DATE] indicated a Brief Interview for Mental Status (BIMS) score of 14. A BIMS score of 13 to 15 indicated cognition was intact. On 2/5/25 at 9:03 AM, an interview was conducted with the MDS Coordinator. The MDS Coordinator stated a quarterly IDT meeting with the resident and their family was conducted, more if needed. The MDS Coordinator stated she had not had an IDT meeting with resident 13 or her family and that Social Services could have held them. The MDS Coordinator stated it did not look like there were any IDT meetings documented in the medical record, except for the admission IDT Care Plan Conference. On 2/5/25 at 1:28 PM, an interview was conducted with the Social Services Director/Resident Advocate (SSD/RA). The SSD/RA stated that completing the quarterly IDT meetings were a hit and miss. The SSD/RA stated that the electronic medical record program stopped populating when the quarterly IDT meetings were to happen and that she notified administration. The SSD/RA stated she could not recall if resident 31 had quarterly IDT care plan meetings. No IDT care plan meeting documentation was provided.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30563 Based on interview and record review it was determined, for 2 of 33 residents sampled, that the facility did not ensure residents were given the appropriate treatment and services to maintain or improve their ability to carry out the activities of daily living. Specifically, residents were not provided bathing/shower. Resident identifier: 6 and 293. Findings included: 1. Resident 6 was admitted to the facility on [DATE] with diagnoses which included type 2 diabetes mellitus with hyperglycemia, muscle weakness, major depressive disorder, anxiety disorder and scoliosis. On 1/27/25 at 11:27 AM, an interview was conducted with resident 6. Resident 6 stated staff did not wake him up for showers. Resident 6 stated he sometimes refused to be bathed. Resident 6 stated he should have been showered twice a week on Wednesday and Saturday. On 2/6/25 at 9:04 AM, a follow up interview was conducted with resident 6. Resident 6 stated staff had been waking him up for showers for the last week. Resident 6 stated that he felt like he was a car in a car wash when he was showered because they showered him so quickly. Resident 6 stated he liked to scrub the top of his body but staff just washed him quickly. Resident 6 stated staff were always in a big hurry. Resident 6 stated it did not make him feel good when staff hurried him. Resident 6 stated he did not dare ask for more time in the shower because staff were in such a hurry. Resident 6 stated he had been sick in December 2024 so he refused some showers. Resident 6's medical record was reviewed 1/27/25 through 2/6/25. A quarterly Minimum Data Set (MDS) dated [DATE] revealed resident 6 refused showers so there was no information on what type of assistance the resident needed. The Brief Interview of Mental Status (BIMS) score was 15 which indicated resident 6 was cognitively intact. The tasks section of resident 6's medical record revealed in the past 30 days, resident 6 was showered on 1/11/25, 1/18/25, 1/29/25, 2/1/25. Staff had not documented that resident 6 had refused. A care plan dated 11/13/23 and updated on 12/27/24 revealed [Resident 6] has generalized weakness. He has decreased strength, endurance and mobility. He has an ADL [activities of daily living] self-care performance deficit. [Resident 6] sometimes will do less for himself than he is capable of. The goal developed was [Resident 6] will continue to actively participate in upper body dressing and feeding self through next review. Some of the interventions included Bathing/Showering: The resident requires substantial assist to provide bath/shower and as necessary. A Social Services and Annual Note dated 12/13/24 at 3:39 PM revealed .Per observation and interaction, resident refuses his showers, getting out of bed, and tele health appointments due to anxiety, bowels, or pain. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There were no shower sheets provided for the last 30 days. On 1/28/25 at 3:23 PM, an interview was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 stated there was a list in the break room with each residents shower days. CNA 1 stated CNA's on day shift provided 2 residents showers and the evening shift provided 1 resident a shower. CNA 1 stated all residents were scheduled for showers twice per week. CNA 1 stated if a resident refused a shower then she offered them one the next day. CNA 1 sated if a resident said no, then she will say okay because she did not want to force them. CNA 1 stated staff can not force residents to shower. CNA 1 stated if a resident had a shower scheduled on Wednesday but refused then they had to wait till the next shower day. CNA 1 stated there was a paper titled Shower Sheet that had a section for the CNA, nurse and resident to sign if the resident refused. On 1/28/25 at 3:48 PM, an interview was conducted with CNA 2. CNA 2 stated there was a paper in the break room with the resident's showers that needed to be completed each day. CNA 2 stated when residents were admitted , the resident was able to decide how often they want to be showered. CNA 2 stated if a resident refused showers then she went back and asked them later. CNA 2 stated a Shower Sheet was filled out after the shower was completed or if a shower was refused. CNA 2 stated the Nurse, CNA and resident signed the sheet if a resident refused the shower. CNA 2 stated the shower sheets were provided to the lead CNA after they were filled out by the CNA. On 1/28/25 at 4:11 PM, an interview was conducted with the Lead CNA. The Lead CNA stated resident 3 was showered on Mondays and Wednesdays. The Lead CNA stated if a resident refused a shower, then the resident signed a Shower Sheet along with the nurse and CNA. The Lead CNA stated Shower Sheets were completed after each shower and then provided to her or the medical records staff member. The Lead CNA stated the shower sheets were then put into a file on her computer and not into the residents medical record. On 2/4/25 at 12:52 PM, an interview was conducted with the Director of Nursing (DON). The DON stated every resident was assigned 2 showers per week. The DON stated residents were able to shower more often, if they requested. The DON stated the day after admission, a resident was showered. The DON stated after that residents shower days were assigned. The DON stated there was a shower sheet that was completed by the CNA's. The DON stated there was an assignment sheet in the break room for CNA's to know who to shower each day. The DON stated CNA's documented showers and refusals in the tasks section and on a Shower Sheet. The DON stated the Shower Sheet went to the Lead CNA and were uploaded into a file on her computer. The DON stated if a resident refused a shower then they needed to sign the Shower Sheet. 50200 2. Resident 293 was admitted to the facility on [DATE] with diagnoses which included displaced intertrochanteric fracture of left femur, other toxic encephalopathy, major depressive disorder, muscle weakness, and need for assistance with personal care. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/27/25 at 10:24 AM, an observation and interview were conducted with resident 293. Resident 293 was observed to be wearing a hospital gown and had a hospital identification bracelet on his right arm with a date of service of 1/14/25. Resident 293 stated he had not received a shower since he arrived at the facility and had to give himself a whores bath. Resident 293 stated a whores bath consisted of him washing his armpits and genitals with some bottled water he had. Resident 293 stated he had tipped over his urinal the night before and had soaked himself and his bed sheets with urine and needed a bath. Resident 293's medical record was reviewed 1/27/25 through 2/6/25. Resident 293 was scheduled to receive showers on Mondays and Thursdays. A review of resident 293's admission MDS completed on 1/27/25, revealed that resident 293 was a substantial/maximal assistance with showering. The tasks section of resident 293's medical record revealed he received a shower on 1/27/25 at 12:35 PM. A review of resident 293's shower sheets revealed the following: a. On 1/16/25 a shower was refused b. On 1/20/25 there was no shower sheet for this date c. On 1/23/25 a shower sheet documented that resident 293 received a shower the previous morning. There was no documentation to confirm this. d. On 1/27/25 a shower was completed There was no other documentation to confirm any additional showers were completed for resident 293. On 1/28/25 at 3:48 PM, an interview was conducted with the Lead CNA. The Lead CNA resident 293 had a shower on 1/27/25. The Lead CNA stated resident 293 was scheduled for showers on Mondays and Thursdays. The Lead CNA stated resident 293 was not on the shower schedule for 1/20/25 and she did not know why. The Lead CNA stated she did not have any other shower sheets which documented resident 293 had received or refused a shower, but would look through her stack of papers and provide them if located. On 2/03/25 at 12:58 PM, an interview was conducted with CNA 3. CNA 3 stated she was unsure how the shower days got scheduled. CNA 3 stated if a resident refused a shower than she would have the nurse go and talk with the resident. CNA 3 stated if the resident continued to refuse than the resident, the nurse, and the CNA would all sign the refusal sheet. On 2/4/25 at 3:39 PM, an interview was conducted with the Regional Nurse Consultant (RNC) 1. The RNC 1 stated the facility did not have any documentation that supported resident 293 was receiving showers.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30563 Based on observation, interview and record review it was determined, for 1 of 33 sampled resident, that the facility did not provide necessary services to maintain personal hygiene for a resident who was unable to carry out activities of daily living. Specifically, a resident was not offered showers regularly. Resident identifier: 3. Findings include: Resident 3 was admitted to the facility on [DATE] with diagnoses which included infection and inflammatory reaction due to other cardiac and vascular devices, Methicillin-resistant Staphylococcus aureus, surgical after care following surgery on the circulatory system, end stage renal disease with dialysis anemia, diabetes mellitus and Alzheimer's disease. On 1/27/25 at 2:47 PM, an interview was conducted with resident 3. Resident 3 stated she got showers once a week but would like them twice a week. Resident 3's medical record was reviewed 1/27/25 through 2/6/25. A Minimum Data Set (MDS) dated [DATE] revealed resident 3 required extensive 1 person physical assist with bed mobility, extensive 2 or more person for transfers, supervision for eating and extensive 1 person assist for toilet use. Resident 3 had a Brief Interview of Mental Status (BIMS) score of 5 which indicated severe cognitive impairment. A care plan dated 7/3/23 and revised on 5/21/24 revealed [Resident 3] has impaired cognition and weakness. She has an ADL self-care performance deficit. The goal was [Resident 3] will maintain current level of ADL function through the review date. One intervention included Bathing/Showering: The resident needs substantial assist to provide bath/shower and as necessary; The Certified Nursing Assistant (CNA) documentation in the tasks section titled GG revealed resident 3 was dependent with set up assistance for showers/bathing. Resident 3 had documented showers on 12/4/24, 12/13/24, 12/20/24, and 12/27/24 for December 2024. Resident 3 was documented to have received a showered on 1/1/25, 1/8/25, 1/11/25, 1/15/25, 1/18/25, 1/22/25 and 1/24/25 for January 2025. The Lead CNA provided forms titled Shower Sheet revealed resident 3 was showered on 12/4/24 and 12/18/24. There was a Shower Sheet for 12/21/24 which revealed resident 3 was in the hospital. Resident 3 refused a shower on 1/4/25, 1/8/25 and 1/22/25. Resident 3 was showered on 1/11/25, 1/15/25 and 1/18/25. The forms were not in resident 3's medical record. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/28/25 at 3:23 PM, an interview was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 stated there was a list in the break room with each resident's shower days. CNA 1 stated CNA's on day shift provided 2 residents showers and the evening shift provided 1 shower. CNA 1 stated all residents were scheduled for showers twice per week. CNA 1 stated if a resident refused a shower then she offered one the next day. CNA 1 stated if a resident said no, then she will say okay because she did not want to force them. CNA 1 stated staff can not force residents to shower. CNA 1 stated if a resident had a shower scheduled on Wednesday but refused then they had to wait till the next shower day. CNA 1 stated resident 3 was scheduled to be showered on Wednesday and Saturday. CNA 1 stated there was a paper titled Shower Sheet that had a section for the CNA, nurse and resident to sign if the resident refused. On 1/28/25 at 3:48 PM, an interview was conducted with CNA 2. CNA 2 stated there was a paper in the break room with the resident's showers that needed to be completed each day. CNA 2 stated when residents were admitted , the resident was able to decide how often they want to be showered. CNA 2 stated she was not sure how often resident 3 was scheduled for showers. CNA 2 stated if a resident refused showers then she went back and asked them later. CNA 2 stated a Shower Sheet was filled out after the shower was completed or if a shower was refused. CNA 2 stated the Nurse, CNA and resident signed the sheet if a resident refused the shower. CNA 2 stated the shower sheets were provided to the lead CNA after they were filled out by the CNA. CNA 2 stated she did not usually shower resident 3. CNA 2 stated sometimes resident 3 refused a shower because she did not want to get out of bed or was too tired after dialysis. On 1/28/25 at 4:11 PM, an interview was conducted with the Lead CNA. The Lead CNA stated resident 3 was showered on Mondays and Wednesdays. The Lead CNA stated if a resident refused a shower, then the resident signed a Shower Sheet along with the nurse and CNA. The Lead CNA stated Shower Sheets were completed after each shower and then provided to her or the medical records staff member. The Lead CNA stated the shower sheets were then put into a file on her computer. The Lead CNA stated she would have to look for the resident 3's Shower Sheets. On 2/4/25 at 12:52 PM, an interview was conducted with the Director of Nursing (DON). The DON stated every resident was assigned 2 showers per week. The DON stated residents were able to shower more often. The DON stated the day after admission, a resident was showered. The DON stated after that residents shower days were assigned. The DON stated there was a shower sheet that was completed by CNA's. The DON stated there was an assignment sheet in the break room for CNA's to know who to shower each day. The DON stated CNA's documented showers and refusals in the tasks section and on a Shower Sheet. The DON stated the Shower Sheet went to the Lead CNA and were uploaded into a file on her computer. The DON stated if a resident refused a shower then they needed to sign the Shower Sheet.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30563 Based on observation, interview, and record review, it was determined, for 2 of 33 sampled resident, that the facility failed to ensure a resident with limited range of motion received appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Specifically, residents were not provided restorative nursing services to maintain and/or improve their level of function. Resident identifiers: 6 and 31. Findings include: 1. Resident 6 was admitted to the facility on [DATE] with diagnoses which included type 2 diabetes mellitus with hyperglycemia, muscle weakness, major depressive disorder, anxiety disorder and scoliosis. Resident 6's medical record was reviewed 1/27/25 through 2/6/25. A Physical Therapy Evaluation and Plan of Treatment dated 11/13/24 through 12/14/24 revealed the patients goal was to be able to get out of bed and walk with less assistance. Resident 6 demonstrated good rehab potential as evidenced by motivation to participate and motivated to return to prior level of living. The current referral reason was that resident 6 had a decline in his function, especially his left knee and ankle. Resident 6 recently had cortisone injection in his left knee. A Physical Therapy Discharge Summary signed 12/26/24 with the last date of treatment of 11/22/24 revealed discharge recommendations were home exercise program and 24 hour care. It should be noted there was no information on what the home exercise program was. A form titled Restorative notes were provided on 2/6/25. The form for January 2025 revealed resident 6's program was ROM [range of motion] ambulation. Resident 6 refused January 6-12 and January 13-19. Resident 6 was able to walk with gait belt and help with Restorative Therapy Aide (RTA) January 20-26 and January 27- February 2. Resident 6's February 2025 Restorative notes revealed for resident 6 Refused didn't feel well for February 3-9. It should be noted resident 6 refused on a future date. The form did not reveal how many times a week or how long the resident was provided services. On 2/6/25 at 10:14 AM, an interview was conducted with the Director of Rehab (DOR). The DOR stated therapy was provided to residents who had physician's orders. The DOR stated that he provided vague discharge recommendation because there was no Restorative Nursing Program at the facility since the RNA retired. The DOR stated that resident 6 needed restorative nursing program and would probably be walking if he had the program consistently. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/6/25 at 4:04 PM, an interview was conducted with the Regional Nurse Consultant (RNC) 1. RNC 1 stated the Lead CNA did the RNA program. RNC 1 stated that resident 6 usually refused to do the restorative program. RNC 1 stated she was unable to say what the RNA program provided and not sure why the Lead CNA documented resident 6 refused 2/3/25 through 2/9/23 and it was 2/6/25. 48709 2. Resident 31 was admitted to the facility on [DATE] with diagnoses which included malignant neoplasm of cerebellum, unspecified mood [affective] disorder, disorders of bladder, major depressive disorder, anxiety disorder, neuralgia and neuritis, systemic lupus erythematosus and hypertension. On 1/27/25 at 9:34 AM, an interview was conducted with resident 31's family member. Resident 31's family member stated the facility did not do any kind of physical or occupational therapy with resident 31 and that resident 31, begs to walk. On 1/30/25 at 10:28 AM, an interview was conducted with resident 31. Resident 31 stated they started trying to get her to walk. Resident 31 stated she used her walker with Lead CNA and was very happy about that. Resident 31's medical record was reviewed 1/27/25 through 2/6/25. A Quarterly Minimum Data Set (MDS) dated [DATE] indicated a Brief Interview for Mental Status (BIMS) score of 14. A BIMS score of 13 to 15 indicated cognition was intact. It further indicated resident 31 had no impairment of the upper and lower extremities, used a manual wheelchair, and required partial/moderate assistance to stand from a sitting position. It further indicated, I. Walk 10 feet: Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space, and that resident 31 required supervision or touching assistance to complete the task. The Nursing Restorative Initial Review dated 12/20/24 at 10:13 AM indicated, A. Limited Physical Mobility Restorative Tasks Focus: The resident has limit/impaired physical mobility r/t [related to] .Goal: [resident 31] will maintain current level of mobility .Intervention: NURSING REHAB/RESTORATIVE: Walking Program. It further indicated, 1. Reason For Referral: Resident would like to maintain her ability to ambulate. Staff to assist resident with ambulation. A Nursing Restorative Monthly Review dated 1/22/25 at 9:01 AM indicated, Current goals of Program 1: Ambulation program: resident would like to maintain her ability to ambulate and that the resident demonstrated progress or maintained status with Program 1. It further indicated, Program 1 Progress . Resident ambulates with assist from staff. She uses a walker. It further indicated, Continue Present Goals/Plan. A Restorative notes document dated January 2025 indicated, Program Ambulation January 6-12 was able to walk with gait belt using walker and help w/ RTA [Restorative Therapy Assistant] January 13-19 was able to walk with gait belt and help with RTA and using walker January 20-26 Refused didn't feel good January 27-[DATE] was able to walk with gait belt and help from RTA, using walker. A Restorative notes document dated February 2025 indicated, Program Ambulation February 3-9 was able to walk with gait belt and help with RTA and using walker. It should be noted that this document was provided to State Survey Agency on 2/6/25. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The care plan dated 5/21/24 revealed, [Resident 31] has impaired balance and is at risk for decreased mobility. The goal was [Resident 31] will maintain current level of mobility. An intervention dated 6/17/24 revealed CNA LPN RN NURSING REHAB/RESTORATIVE: Walking Program. On 2/4/25 at 1:12 PM, an interview was conducted with Lead CNA. Lead CNA stated resident 31 was started on the walking program about three weeks ago and had not been on the walking program previously. Lead CNA stated resident 31 would like to be able to walk so she can go to the bathroom on her own and walk at her daughter's wedding. Lead CNA stated she will walk with resident 31 in between her tasks, when I have time and that she did not think anyone else walked with resident 31 on days she did not work. Lead CNA stated resident 31's walking ability had increased since she had started on the walking program. On 2/6/25 at 9:51 AM, an interview was conducted with DOR. The DOR stated resident 31 had visual impairments so staff needed to work with her on her right side and resident 31's memory was not fantastic. The DOR stated he would educate the RNA and then they should have trained other staff. The DOR stated he gave her some pointers after she had a fall. The DOR stated RNA services were recommended in May and the facility would determine how often that would have occurred. The DOR stated her functional status had remained the same since her admission.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43212 Based on observation, interview and record review it was determined, for 9 of 33 sampled residents, that the facility did not ensure that each resident's environment remained as free from accident hazards as was possible and each resident received adequate supervision and assistive devices to prevent accidents. Specifically, the facility failed to accurately assess resident's for safe smoking and failed to supervise residents to ensure they demonstrated safe smoking practices according to the facility smoking policy. These deficient practices were found to have occurred at the Immediate Jeopardy (IJ) level. Additionally, interventions were not put in place after a resident had a major fall with injury and another resident sustained falls with repeat interventions. Resident identifiers: 5, 12, 18, 23, 25, 27, 30, 34 and 293. Findings include: NOTICE On January 29, 2025 at 1:30 PM, an IJ was identified when the facility failed to implement the Centers for Medicare & 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 residents were evaluated for smoking safety, that interventions were identified, and that monitoring for safe smoking was implemented. Notice of IJ was given to the facility Administrator (ADM), Director of Nursing (DON), and the Regional Nurse Consultant (RNC), and they were informed of the findings of IJ pertaining to F689. On 1/29/25, the facility provided the following written abatement plan for the removal of the IJ effective on 1/29/25 at 4:30 PM. [Name of facility] is providing the following information to demonstrate that the immediacy of the cited deficiency F689 has been removed. Summary of Action Taken: Resident 12: -Resident had a skin assessment-no injury noted -Attending physician was notified - Resident was reassessed for smoking safety by the RNC/Nurse Manager, which included a return demonstration of smoking safety -Care plan reviewed and updated to supervised smoking and a smoking apron (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-Resident room was checked for smoking material-any smoking material found was removed and will be stored by nursing -Resident was educated on the Smoking Policy, which included storage of smoking material Resident 293: -Resident was reassessed for smoking safety by the RNC/Nurse Manager, which included return demonstration of smoking safety -Care plan was developed based on smoking safety screen -Resident room was checked for smoking material-any smoking material found was removed and will be stored by nursing -Resident was educated on the Smoking Policy, which included storage of smoking material Resident 23: -Resident was reassessed for smoking safety by the RNC/Nurse Manager, which included a return demonstration of smoking safety -Care plan was reviewed and updated based on smoking safety screen -Resident room was checked for smoking material-any smoking material found was removed and will be stored by nursing -Resident was educated on the Smoking Policy, which included storage of smoking material Resident 5: -Resident was reassessed for smoking safety by the RNC/Nurse Manager, which included a return demonstration of smoking safety -Care plan was reviewed and updated based on smoking safety screen -Resident room was checked for smoking material-any smoking material found was removed and will be stored by nursing -Resident was educated on the Smoking Policy, which included storage of smoking material Other Residents at Potential Risk: -All residents that smoke were reassessed for smoking safety by the RNC and/or nurse manager, which included a return demonstration of smoking safety -Care plans were reviewed and updated as applicable (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-All residents that smoke were assessed for smoking injuries -The smoking list was updated to reflect all smokers and level of supervision -Resident rooms were checked for smoking material-any smoking material found was removed and to be stored by nursing -Residents that smoke were reeducated on the smoking policy and storage of smoking material -All residents who smoke will be assessed for smoking safety upon admission/readmission, quarterly and with a change of condition, this assessment will include a return demonstration of smoking safety -Resident will be education upon admission/readmission of the facility's smoking policy and storage of smoking material Systemic Changes and Education: -Administrator, DON, and RNC reviewed smoking policy -Administrator, DON were educated by RNC regarding smoking policy -Specifically on smoking supervision, updated smoking list and level of supervision and storage of smoking material -Administrator, DON/designee will complete Smoking education with all staff, including agency -Specifically on smoking supervision, updated smoking list and level of supervision and storage of smoking material -All current staff, including agency have been educated -All staff, including agency will be educated prior to the start of their next shift -Administrator/DON/designee will complete education with facility nurses on how to complete a Smoking Screen specifically that the assessment includes a return demonstration of smoking safety Monitoring and Quality Improvement Measure: -The administrator/designee will conduct 5 random resident observations on resident that smoke weekly x 4 weeks and then monthly thereafter x3 months to ensure the Smoking Policy have been followed specifically on smoking supervision, updated smoking list and level of supervision and storage of smoking material -The DON/designee will review smoking screen assessments weekly x 4 weeks and then monthly thereafter x3 months to ensure the assessment matches the resident -Medical Director was informed of the incident and QAA Review & Recommendations (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-Results will be reported to the QAA committee for monitoring and follow-up -The Administrator is responsible for substantial compliance of this Plan of Action The facility alleges the immediacy with the deficient practice has been removed on January 29, 2025 by 4:30 PM. The survey staff confirmed the removal of the IJ on 1/30/25 at 8:53 AM. IMMEDIATE JEOPARDY On 1/27/25, the facility provided a list of residents that were currently smoking. The list included residents: 5, 12, 23, 27, 30, and 34. According to the list resident 34 needed assistance getting outside and the others were independent with smoking. 1. Resident 12 was admitted to the facility on [DATE] with diagnoses that included schizophrenia, chronic obstructive pulmonary disease, type 2 diabetes, follicular lymphoma, panlobular emphysema, and lymphocytopenia. On 1/27/25 at 10:55 AM, an observation was made of resident 12 in his room. Resident 12 was taking cigarettes out of his night stand in preparation to go and smoke. An interview was conducted with resident 12. Resident 12 stated he was allowed to keep his smoking materials in his room and he kept his lighter in the pocket of his jacket that he wore all the time. Resident 12's left hand was observed to be moving during the interview. On 1/28/25 at 11:46 AM, an observation was made of resident 12 smoking a cigarette outside near the designated smoking area. Resident 12 was observed smoking independently with no adaptive or protective equipment. Resident 12 was observed to have the cigarette in his right hand. Resident 12 was observed to have abrupt, jerking movements with his right hand. Resident 12 was observed to have a burn hole in his pants. Ash was observed to be falling on the resident's lap. Resident 12's plaid pajama bottoms were observed to have a small hole on one of the legs. An interview was conducted with resident 12 who stated he did not need to be using a smoking apron. At 12:28 PM, resident 12 was smoking a cigarette in the smoking area. Resident 12 was holding his cigarette in his left hand, and his left hand was observed to have a abrupt movements with his left arm as he lifted the cigarette to his mouth and back down again. At 12:30 PM, Resident 12 was observed to dropped his cigarette on to the ground. Resident 12 leaned over and picked up the cigarette and continued smoking it. On 1/28/25 at 5:14 PM, an observation was made of resident 12. Resident 12 was observed to be in the smoking area with Licensed Practical Nurse (LPN) 1. Resident 12 was observed to be smoking apron or assistive devices. Resident 12's medical record was reviewed between 1/27/25 and 2/6/25. On 1/21/25, a smoking assessment was completed by LPN 1. (continued on next page)

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Sandstone North Park	350 South 400 East Bountiful, UT 84010

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident 12's care plan initiated on 1/23/24 revealed, [Resident 12] is a smoker and chooses to smoke while at the facility. The goal was, [Resident 12] will not suffer injury from unsafe smoking practices through the review date. Interventions initiated on 1/24/24 included, Cigarettes (or other smoking materials) should be stored in a locked box by the nurses station. [Resident 12] has the key to his box. Encourage compliance.; Instruct resident about the facility policy on smoking: locations, times, safety concerns; Notify charge nurse immediately if it is suspected resident has violated facility smoking policy; Observe clothing and skin for signs of cigarette burns. Notify LN [Licensed Nurse] immediately if present; and The resident can smoke UNSUPERVISED. On 1/28/25 at 3:11 PM, an interview was conducted with LPN 1 who stated he completed smoking assessments on residents when they were admitted to the facility. LPN 1 stated he had a score that he used when evaluating resident for smoking to determine if they could smoke independently or not. LPN 1 stated he had not noticed anything about resident 12 that he would consider unsafe to smoke independently. LPN 1 stated if there was information that was concerning he would notify the Lead Certified Nursing Assistant (CNA) so she could let the CNA's know. LPN 1 stated his communication with CNA's was verbal. It should be noted that LPN 1 reviewed the smoking assessment he completed on 1/21/25 and stated there was no score on the assessment. On 1/30/25 at 9:27 AM, an interview was conducted with resident 12 who stated he had been educated about the smoking policy by administration earlier that morning and was now wearing a smoking apron while smoking. 2. Resident 34 was admitted to the facility on [DATE] with diagnoses that included non-traumatic intracerebral hemorrhage, hemiplegia and hemiparesis, heredity and idiopathic neuropathy, homonymous bilateral field deficits, reduced mobility, depressive episodes, chronic kidney disease, and pre-diabetes. On 1/27/25 at 11:13 AM, an interview was conducted with with resident 34 who stated he was not smoking. Resident 34's medical records were reviewed between 1/17/25 and 2/6/25. An admission Minimum Data Set (MDS) assessment dated [DATE] revealed resident 34 had a Brief Interview for Mental Status (BIMS) score of 13 indicating resident 34 was cognitively intact. Additionally, the MDS admission assessment included, Current Tobacco Use: NO. It should be noted an admission smoking assessment could not be found in resident 34's medical record. Resident 34's care plan dated 9/2/24 revealed, [Resident 34] is a smoker and chooses to smoke while at the facility. The goal was, [Resident 34] will not suffer injury from unsafe smoking/vaping practices through the review date and [resident 34] will not smoke without supervision through the review date. Interventions included, Cigarettes (or other smoking materials) to be stored at the nurses desk; Instruct resident about the facility policy on smoking: locations, times, safety concerns; [Resident 34] needs to be supervised (by staff or family) when he goes outside to smoke. He needs staff to push him outside; and Observe clothing and skin for signs of cigarette burns. Notify LN immediately if present. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 8/2/24, a provider progress note revealed, Chief complaint: Admit .Social History: .From chart: Substance abuse, tobacco use, requesting nicotine patch 7 mg [milligrams] daily. On 1/7/25, a provider progress note revealed, Chief complaint: Fall .Social History: .From chart: Substance abuse, tobacco use, requesting nicotine patch 7 mg daily. 3. Resident 5 was admitted to the facility on [DATE] with diagnoses which included, paraplegia, pressure ulcers of the right and left buttocks, pressure ulcer of sacral region, type 2 diabetes, and unspecified symptoms and signs involving cognitive functions and awareness. Resident 5's medical record was reviewed 1/27/25-2/6/25. On 1/8/25, a smoking evaluation was completed on resident 5. The smoking evaluation revealed the following: a. The resident had a history of hiding their smoking materials or activities from staff. b. The resident had a history of noncompliance with the facilities smoking policy. c. The resident was unable to retrieve a cigarette if it were dropped. d. The resident used medications that could cause drowsiness. It should be noted that approximately 21 days had passed after admission before resident 5 was assessed for smoking safety and did not reveal if resident 5 required supervision while smoking or could be an independent smoker Resident 5's care plan initiated on 1/8/25 revealed that resident 5's smoking supplies should be stored in a lock box near the nurse's station. Resident 5 had a key to the lock box and compliance should be encouraged. On 1/28/25 at 12:31 PM, an observation was made of resident 5 and resident 23 outside in the resident smoking area. Resident 5 was observed to light a cigarette in her mouth and then pass the lit cigarette to resident 23 who then placed the cigarette into her mouth. Resident 5 and resident 23 were observed to continue to smoke the lit cigarette by passing it back and forth between them. On 1/28/25 at 4:00 PM, an interview was conducted with resident 5. Resident 5 stated she was able to keep her cigarettes and lighter in her room and did not ask staff for them. 4. Resident 293 was admitted to the facility on [DATE] with diagnoses which included displaced intertrochanteric fracture of left femur, other toxic encephalopathy, major depressive disorder, tobacco use, muscle weakness, and need for assistance with personal care. Resident 293's medical record was reviewed 1/27/25-2/6/25. A review of resident 293's nursing admission evaluation dated 1/15/25, documented that resident 293 used tobacco, alcohol, or drugs and was a current smoker. It should be noted a smoking evaluation was not performed on resident 293. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 1/27/25 at 9:50 AM, an interview was conducted with resident 293. Resident 293 stated he was a smoker and smoked around 2-3 cigarettes a day. On 1/28/25 at 3:01 PM, an interview was conducted with CNA 2. CNA 2 stated resident 293 would smoke outside with his son. CNA 2 stated residents were free to smoke whenever they wanted to. CNA 2 stated cigarettes and lighters could be kept in the resident's rooms. 5. Resident 23 was admitted to the facility on [DATE] with diagnoses which included bipolar disorder with psychotic features, dementia, convulsions, cognitive communication deficit, muscle weakness and need for assistance with personal care. An MDS dated [DATE] revealed resident 23 had a BIMS score of 10 which indicated moderate cognitive impairment. A smoking screening evaluation dated 1/1/25 revealed resident 23 had problems with communicating effectively with others, was unable to use a fire extinguisher to extinguish a fire as a result of smoking, and used medications that could cause drowsiness. It was determined, however, that resident 23 was able to smoke unsupervised and staff should notify the charge nurse immediately if it was suspected the resident had violated facility smoking policy. A care plan initiated 1/18/23 and updated on 9/16/24 documented that resident 23 was a smoker and stated at that time she wanted to quit smoking and use Nicotine patches but always went back to smoking. The goal was that resident 23 would not suffer injury from unsafe smoking practices through the review date. The care plan indicated that resident 23's smoking supplies should be stored in a lock box near the nurses station and resident 23 had the key. The care plan further revealed resident 23 could smoke unsupervised. Another care plan dated 1/31/24 revealed that resident 23 asked other residents for cigarettes. The goal was resident 23 would smoke her own cigarettes. Interventions included recreation staff had offered to buy cigarettes for resident 23 on scheduled shopping trips and she was reminded it was not appropriate for her to ask others for her cigarettes. A Social Services Quarterly & Annual Note dated 4/2/24 at 12:13 PM revealed resident 23's BIMS was 9. The note further revealed . Resident often asks other smokers for cigarettes and at times gets upset when the other resident is unable to give her a cigarette. Other residents have mentioned that she will beg them for their cigarettes and tell them they are lucky they can afford them. On 1/28/25 at 3:12 PM, an interview was conducted with CNA 1. CNA 1 stated residents could go out on their own to smoke and did not need staff to accompany them. CNA 1 stated staff could watch the residents smoking through the window in the family room. CNA 1 stated residents should keep their smoking supplies in the locked boxes near the nurses station. CNA 1 stated nurses would gather the resident's smoking supplies and lock them in the locked boxes. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 1/28/25 at 3:25 PM, an interview was conducted with the DON who stated the Unit Manager (UM) was typically the person who completed smoking assessments on the residents and she would be the person to ask about how the smoking screening determined the resident's ability to smoke independently. The DON stated the smoking assessments were only done quarterly. The DON stated resident 12 had a lock box on the wall by the nurses station and that was where he kept his smoking materials. The DON stated he did not have any concerns about resident 12 smoking unsupervised or unsafely. The DON stated resident 12 was a fast smoker. The DON stated if he witnessed resident 12 dropping ash on himself he would not consider him safe to smoke independently. On 1/28/25 at 3:27 PM, an interview was conducted with CNA 1. CNA 1 stated there used to be set times for smoking, but now residents were able to smoke when they wanted to. CNA 1 stated there was a smoke shack that residents smoked under and staff were able to see them. CNA 1 stated resident 34 required supervision when smoking. CNA 1 stated staff had to go outside to the smoke shack with him while he smoked. CNA 1 stated no residents needed any smoking equipment or devices. CNA 1 stated if she was seeing a resident that was unsafe smoking, she would tell her supervisor nurse or the DON. CNA 1 stated she would write up a statement about it. CNA 1 stated there were no observations of burn holes in anyone's clothing. CNA 1 stated residents were very careful and no one had burned clothing because the residents who smoke were really with it. On 1/28/25 at 4:04 PM, an additional interview was conducted with the DON who stated he had observed resident 12 with a burn hole in his pants and involuntary movement. The DON stated resident 12 was being placed on supervised smoking going forward. The DON stated he had not witnessed involuntary movements or burn holes in resident 12's clothing until today. On 1/28/25 at 4:37 PM, an interview was conducted with RN 4. RN 4 stated residents were screened for their smoking abilities upon admission. RN 4 stated she was unaware of any supervised smokers in the facility. RN 4 stated none of the residents in the facility showed a need to use a smoking apron or other device. RN 4 stated resident 5 was fine to smoke independently. RN 4 stated she was unaware that resident 293 smoked. RN 4 stated she did not monitor the residents while they smoked. RN 4 stated the residents should put their smoking supplies in the locked boxes. RN 4 stated she was unaware of any residents that share cigarettes or did not follow the smoking policy. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 1/28/25 at 4:40 PM, an follow up interview was conducted with the DON. The DON stated if resident wanted to smoke, then nurses completed a smoking evaluation. The DON stated the evaluation included how many times a day a resident smokes, what time of day, cognitive loss, visual deficits, problems with communication, dexterity problems, disposing of ashes and cigarette, hiding smoking material, history of non-compliance, smoking in non-designated area, able to pick up, extinguish a fire, use supplemental oxygen, no tremors, drowsiness, burns, and can the resident light his or her own cigarettes. The DON stated based on evaluation resident 12 seemed to be able to smoke independently. The DON stated all smokers were A&O x 3-4 (alert and oriented to person, place, time and situation). The DON stated residents were also able to light and extinguish cigarettes. The DON stated if there were physical signs of burns, which was pointed out today, then the resident was put on a supervised smoking schedule. The DON stated resident 12 moved his hand fast when he was smoking and moved it away from his body so there was no concern with him burning himself. The DON stated after staff assessed resident 12, he now needed a smoking apron. The DON stated resident 12 was alert and oriented x 3-4 with some forgetfulness. The DON stated resident 5, resident 30, resident 27, and resident 12 smoked. The DON stated he was not sure if resident 23 was currently smoking. The DON stated she had a history of smoking but thought she was on a nicotine patch and had stopped smoking. The DON stated if resident 23 started smoking again then staff needed to know. The DON stated resident 23 probably started smoking when resident 5 returned to the facility. The DON stated the Unit Manager should be aware of who was smoking. The DON stated nurses needed to go out and physically watch each resident smoke when completing the smoking evaluation.The DON stated CNA's would know who smoked by the Kardex system. The DON stated all residents could keep their lighters and cigarettes. The DON stated there was a lock box by the nurses station to store smoking materials. The DON stated residents who smoked had access to the lockers. The DON stated resident 12 had a key to the locker for his smoking material. The DON stated all residents should be storing their smoking materials in the lockers. On 1/28/25 at 4:40 PM, a follow up interview was conducted with LPN 1 who stated the process for determining if a resident was safe to smoke was to make sure the resident had a smoking assessment. LPN 1 stated if they did not, he would complete one. LPN 1 stated he used his professional judgement when completing resident 12's smoking assessment. LPN 1 stated if anything seemed hazardous he would determine the resident was not safe to smoke independently. LPN 1 stated if residents were dropping stuff he would determine that smoking devices were needed. LPN 1 stated the reason he completed the smoking assessment on resident 12 was it popped up in resident 12's medical chart that day. LPN 1 stated he did not observe resident 12 when completing his smoking assessment and filling out the screening form. LPN 1 stated there was a lock box near the nurses station where residents kept their smoking materials. LPN 1 stated resident 12's smoking materials were in the narcotics drawer and had his name on them. LPN 1 stated he thought resident 12's smoking materials were in his lock box before being put in the narcotics drawer. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 1/28/25 at 4:59 PM, an interview was conducted with the Administrator (ADM) who stated all residents who smoked were independent. The ADM stated if a smoking resident was showing signs of doing something that would make them unsafe they should bring it up with the DON. The ADM stated actions that would be considered unsafe would be not being able to hold a cigarette, not being stable to hold a cigarette, cognitive impairment, inability to make choices, inability to perform Activities of Daily Living (ADL)'s and take care of themselves, or needing extra assistance. The ADM stated he did not know if staff members went out to the smoking area to ensure residents were smoking safely. The ADM stated he was unsure where residents were keeping their smoking materials. The ADM stated residents could request a smoking apron if they wanted one, but most residents did not want to use a smoking apron, they just go out and smoke. The ADM stated when a resident was admitted with a history of smoking, staff went over the smoking policy with the resident. The ADM stated he did not know resident 12 very well and had not observed any type of uncontrolled movement when talking with resident 12. The ADM stated he did not know if there was a particular staff member who completed the smoking assessments. On 1/28/25 at 5:08 PM, an interview was conducted with the DON who stated staff were aware of which residents smoked by looking at the resident's KARDEX, and the care plan. The DON stated smoking assessments were completed on every resident whether or not they were smokers. On 1/29/25 at 9:00 AM, an interview was conducted with CNA 3 who stated she had not noticed resident 12 to have any involuntary movements. CNA 3 stated she had not observed any burn holes on resident 12's clothing. CNA 3 stated resident 12 was a partial to substantial assist depending on the day or time of day. CNA 3 stated resident 12 would ask for help if he needed anything. CNA 3 stated a resident holding a cigarette for too long or burning themselves would be a concern. CNA 3 stated if she observed a safety concern while a resident was smoking she would notify the nurse and go and supervise the resident or have another staff member supervise the resident. On 1/29/25 at 9:11 AM, an interview was conducted with the Unit Manager (UM) who stated she was the staff member who usually completed the smoking screens. The UM stated when completing the screenings she would watch the resident smoke to ensure they could light the cigarette safely, put it out safely, smoke safely in the designated area. The UM stated she looked for tremors and involuntary movements when conducting the assessments. The UM stated smoking evaluations were completed on admission, quarterly and annually. The UM stated the current smoking evaluation did not have an area to mark if the resident was not a smoker. The UM stated residents were keeping their smoking materials on their person, however the facility changed that yesterday. The UM stated now all residents are keeping their smoking materials at the nurse's station. The UM stated a staff member had to go out with residents who required supervision, and it could be a floor staff member, a clinical staff member or someone from the management team. The UM stated smoking times were posted at the nurse's station and in the CNA break room. On 1/29/25 at 11:12 AM, an interview was conducted with LPN 2. LPN 2 stated resident 23 was a smoker and did not require supervision. LPN 2 stated smoking materials were stored at the nurses station somewhere. LPN 2 stated resident 23 would not be able to keep her smoking material. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 1/29/25 at 11:14 AM, an interview was conducted with RN 1. RN 1 stated resident 23 smoked and was able to unsupervised. RN 1 stated since last night all smoking materials were kept at the nurses station. RN 1 stated prior to last night residents were able to keep their smoking material including resident 23. RN 1 stated there were lock boxes at the nurses station for resident to keep their smoking material but residents kept losing their keys. The smoking policy and procedures revised on 3/2019 provided upon entrance was reviewed and revealed the following: Physical Environment Smoking- Supervised Smokers . Purpose: To provide a safe environment for residents. Policy: The facility shall establish and maintain safe practices in an effort to keep residents safe while smoking. Guidelines: 1. Smoking will occur in designated areas only. The designated smoking area will be placed in a location compliant with local and state specific regulations. 2. The facility will furnish the designated smoking area with a fire extinguisher and proper receptacle for extinguishing smoking materials. Smoking blankets or aprons will be furnished for residents who are assessed to require a smoking blanket or apron. 3. Residents who wish to smoke will be assessed for smoking safety by nursing. 4. Smoking assessments will be completed on admission, quarterly, with significant change of condition and as needed for residents who wish to smoke. Smoking assessment will include a return demonstration of ability to safely manage smoking paraphernalia. 5. Residents who smoke will be supervised by staff members while smoking. Smoking will occur at designated smoking times. 6. Smoking paraphernalia will be managed by nursing staff and will be made available at designated smoking times. 7. Residents requiring continuous oxygen administration will require supervision while smoking and will smoke during desgnated smoking times. Oxygen tanks and concentrators will be placed outside of desginated smoking areas. 8. Pipes, cigars, electronic cigarettes and vapes are considered smoking paraphernalia and their usage is subject to theses same guidelines. 48709 Falls (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	1. Resident 18 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included displaced dens fracture, end stage renal disease, dementia, hypertension, and type 2 diabetes mellitus. On 1/28/25 at 2:17 PM, an observation was made of resident 18 in her room sleeping in bed wearing a neck collar, the bed was in a low position, a fall mat was on the right side of the bed with her wheelchair positioned on the fall mat, and there was no call light observed within reach of the resident. On 1/28/25 at 2:24 PM, an interview was conducted with CNA 2 in resident 18's room. CNA 2 stated resident 18's call light was hanging up on the wall and that she was a fall risk. CNA 2 stated resident 18 needed assistance to get up. During the interview, the resident was observed to be attempting to get out of bed on the left side of the bed where there was no fall mat. Resident 18's medical record was reviewed 1/27/25 through 2/6/25. A Quarterly MDS dated [DATE] indicated a BIMS score of 2. A BIMS score between 0-7 indicated severe cognitive impairment. A Nursing Note dated 9/18/24 at 5:39 PM indicated, pt [patient] FOF [found on floor] on her fall mat by CNA at 400 [4:00 AM] . There was no updated intervention made to the care plan. A Nursing Note dated 10/6/24 at 3:30 AM indicated, While rounding on the resident the resident was found on the floor next to her bed. There was no updated intervention made to the care plan. A Nursing Note dated 1/3/25 at 4:06 PM indicated, Pt found by CNA @15:45 [at 3:45 PM] on the floor next to her bed. Pt reported trying to get up to go to the bathroom but slide [sic] out of bed . The care plan Intervention initiated on 1/3/25 indicated, Education to be provided about alarm use. A Nursing Note dated 1/6/25 at 4:10 PM indicated, Pt fof next to bed on fall matt laying on right side mostly face down, bed was in lowest position, pull tab alarm in place and functioning. Alarm still attached to Pt and repositioning bar on bed. Head to toe assessment done, Pt has small skin tear to right forearm. Cleansed and dressed. Pt c/o [complains of] pain to both hands. Aid [NAME] [TRUNCATED]

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50200 Based on observation, interview and record the review it was determined, for 4 of 33 sample residents, that the facility failed to ensure that residents who were incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to maintain or restore continence to the extent possible. Specifically, 2 residents had a delay in treatment for urinary tract infections (UTI) with 1 requiring another medication to manage symptoms. In addition, 2 residents were not placed on a bowel and bladder training program despite staff assessment of appropriateness. Resident identifiers: 6, 25, 31, and 35. Findings include: HARM 1. Resident 35 was admitted to the facility on [DATE] with diagnoses which included wedge compression fracture of fifth lumbar vertebra, spinal stenosis, radiculopathy, aortocoronary bypass graft, type 2 diabetes mellitus, and hypertension. A review of resident 35's progress notes revealed: a. On 10/24/24 at 4:36 PM, a nursing note documented, pt [patient] reports [NAME] [sic] on urination. provider notified. new order received to collect UA [urinalysis] with c&s [culture and sensitivity]. pt is her own POA [power of attorney] and notified of new order. pt verbalizes agreement and understanding. b. On 10/28/24 at 10:32 PM, a nursing note documented, preliminary UA results received. result positive. awaiting culture results. placed in dr's [doctor's] folder. c. On 10/29/24 at 12:22 PM, a nursing note documented, Results received from UA collected 10/24. NP [nurse practitioner] [name redacted] gave order for Pyridium 100 mg [milligrams] po [by mouth] TID [three times a day] x [times] 3 days. Waiting for c&s. Pt made aware d. On 10/31/24 at 1:31 PM, a nursing note documented, MD [medical doctor] new orders for Nitrofurantoin 100mg [sic] 1 po BID [two times a day] x 3 days for UTI [urinary tract infection]. Patient notified. Orders noted. e. On 11/1/24 at 9:15 PM, a nursing note documented, The resident is on alert charting for UTI taking PO macrobid. The resident is still c/o [complaining of] burning when urinating . f. On 11/2/24 at 9:09 AM, a nursing note documented, pt continues on PO ABX [antibiotic] therapy for UTI. pt. reports some urinary symptoms remain, but that burning has lessened since starting ABX therapy. g. On 11/3/24 at 9:54 PM, a nursing note documented, .The resident is c/o pain/burning when urinating. Provider notified . (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	h. On 11/4/24 at 12:12 AM, a nursing note documented, Urine culture results collected on 10/24/24 at 1730 [5:30 PM] Result: aerococcus species . Susceptible to: ceftriaxone, linezolid, PCN [penicillin] ,vanco [vancomycin], No interpretation to: daptomycin, doxycycline. Intermediate to: levofloxacin. provider notified i. On 11/6/24 at 6:25 PM, a nursing note documented, new order received from provider: amoxicillin 500 mg po TID X 3 days. pt is her own POA and notified of new order. pt verbalizes agreement and understanding. It should be noted that Nitrofurantoin was not an antibiotic susceptible to treat resident 38's urinary tract infection. On 2/4/25 at 1:02 PM, an interview was conducted with the Unit Manager (UM). The UM stated she was the Infection Preventionist for the facility. The UM stated resident 38 had chronic UTI's and the doctor wanted to wait for the culture results before starting antibiotics. The UM stated that urine culture results took 2 to 5 days. The UM stated if results were not back from the lab in that timeframe she would contact the lab and document in the resident's medical record. The UM stated resident 38 continued to have urinary symptoms and was given pyridium on 10/29/24. The UM stated she did not call the lab to get urine culture results for resident 38 and the facility did not receive the results until 11/3/24. On 2/5/25 at 11:29 AM, an interview was conducted with Regional Nurse Consultant (RNC) 1. RNC 1 stated urine cultures took a minimum of 48 hours to grow bacteria. RNC 1 stated if a resident continued to have urinary symptoms she would expect the nursing staff to communicate with the physician and get orders. On 2/5/25 at 1:37 PM, an interview was conducted with RNC 2. RNC 2 stated the nurse practitioner was notified of resident 38's urinary pain on 10/24/24. RNC 2 stated resident 38 was reassessed on 10/29/24 and continued to have urinary pain so pyridium was prescribed. RNC 2 stated the urine culture took longer than usual, and staff was expected to contact the lab to determine the cause of the delay. RNC 2 stated there was no documentation to verify if the lab was contacted or not. 30563 Potential for Harm 2. Resident 6 was admitted to the facility on [DATE] with diagnoses which included type 2 diabetes mellitus, urine retention, major depressive disorder, generalized anxiety, and muscle weakness. Resident 6's medical record was reviewed on 1/27/25 through 2/6/25. A care plan revealed that resident 6 was incontinent with bladder. The goal was that resident 6 will be free from complications related to incontinence. The interventions were to check for incontinence at regular intervals and assist with urinal use at residents request. A nursing progress note dated 12/19/24 at 3:18 PM, revealed, Resident c/o burning while urinating. [name removed] NP in facility and gave orders to obtain a UA with C&S . (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	A physician's order dated 12/19/24, revealed to obtain UA with C&S one time only for burning with urination. A nursing progress note dated 12/27/24 at 1:23 PM, revealed, Residents UA with C&S test results did not come back from 12/18 [24] collection. This nurse called on call [name removed] NP [name removed]. [name removed] NP gave orders to collect another UA with C&S. Resident notified. A physician's order dated 12/27/24, revealed to obtain UA with C&S one time only for increased white blood cells. The results for the UA ordered on 12/19/24, revealed there was escherichia coli and the final report was completed on 12/24/24. The laboratory form was signed by the physician on 12/31/24. It was noted by RN 1 on 12/27/24. A nursing progress note dated 12/27/24 at 3:12 PM, revealed that laboratory provided results and the NP ordered to start on Bactrim twice daily for 7 days. On 2/5/25 at 9:46 AM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated if a resident complained of signs and symptoms of a UTI, she contacted the physician. RN 1 stated laboratory results were documented in the Medication Administration Record (MAR). RN 1 stated if the nurse prior to her obtained labs for a resident, then she would watch for the results from the laboratory. RN 1 stated UA results were sent to the facility quickly and the culture took about 3 days. RN 1 stated the results were faxed to the facility. RN 1 stated sometimes nurses needed to call the lab, and have the results faxed. RN 1 stated she did not know what happened with resident 6's UA results. On 2/5/25 at 9:53 AM, an interview was conducted with the Director of Nursing (DON). The DON stated if a resident had signs and symptoms of a UTI, the physician was contacted for orders. The DON stated if the physician ordered a UA then an order was placed in the medical record and the nurse obtained a sample. The DON stated the lab then picked up the sample. The DON stated usually results were faxed to the facility. The DON stated he was able to log into the laboratory portal for the results. The DON stated labs were also available to nurses through the residents medical record. 3. Resident 25 was admitted to the facility on [DATE] with diagnoses which included dementia, cervicalgia, need for assistance with personal cares, and anxiety. On 1/27/25 at 11:05 AM, an observation was made of resident 25 at the nurses station. Resident 25's room was observed to have a strong urine odor. Resident 25 was observed to wheel himself to his room in his wheelchair. Resident 25 was asking staff to open the door to his room. On 1/30/25 at 1:28 PM, an observation was made of resident 25's room. The room had a strong urine odor. Resident 25 was not in his room. On 2/3/25 at 1:10 PM, an observation was made of resident 25. Resident 25 was in the hallway asking staff to go into his room. Resident 25 was not taken to the restroom. Resident 25 was observed to ask visitors to open the door to his room. Resident 25 was observed to have a strong urine odor. On 2/5/25 at 10:42 AM, an observation was made of resident 25. Resident 25 was observed at the nurses station with a urine odor. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Resident 25's medical record was reviewed on 1/27/25 through 2/6/25. A nursing bowel and bladder screener dated 5/29/24, revealed resident 25 was a candidate for scheduled toileting (timed voiding) and was not currently on a toileting program. There was no additional information. A care plan dated 5/23/24, revealed [Resident 25] has had occasional bladder incontinence r/t [related to] decreased mobility. The goal was resident 25 would not have increased incontinence through the next review. The interventions included to assist with toileting as the resident requested and as needed, monitor for increased incontinence and use pull-ups. On 1/28/25 at 3:34 PM, an interview was conducted with CNA 1. CNA 1 stated she was not aware of a bowel and bladder retraining program for residents. CNA 1 stated if there was a retraining program there would be a paper behind the residents door with times on it. CNA 1 stated resident 31 was on a retraining program. CNA 1 stated that meant staff took resident 31 to the bathroom at 2:00 PM, between 4:00 and 5:00 PM, after dinner, and then before bed which was 4 times during the evening shift. CNA 1 stated she was not sure if resident 25 was on the same program. CNA 1 stated resident 25 was continent and let staff know when he needed to use the restroom. 48709 4. Resident 31 was admitted to the facility on [DATE] with diagnoses which included malignant neoplasm of cerebellum, unspecified mood [affective] disorder, disorders of bladder, major depressive disorder, anxiety disorder, neuralgia and neuritis, systemic lupus erythematosus and hypertension. On 1/27/25 at 9:34 AM, an interview was conducted with resident 31's family member. Resident 31's family member stated the facility, threw [resident 31] in a brief. The family member stated that resident 31 had to rely on staff to take her to the bathroom and sometimes staff did not answer her call light and she would have to call the family member and then the family member would have to call the nurse's station or go to the facility themselves to help the resident to the bathroom. The family member stated they felt like staff used the brief because they were short-staffed. On 1/30/25 at 10:28 AM, an interview was conducted with resident 31. Resident 31 stated staff would put a brief on her all the time without asking her if that was what she wanted and that she had to start wearing them all of the time during the Covid outbreak. Resident 31 stated she got used to wearing a brief. Resident 31's family member stated she took resident 31 to see a urologist because she was having frequent urination and she did not always have to wear a brief. Resident 31 stated if she could get up on her own, she would not have to wear a brief because I could get to the bathroom and that was why they started working on walking with a walker. Resident 31's medical record was reviewed 1/27/25 through 2/6/25. A Quarterly Minimum Data Set (MDS) dated [DATE] indicated a Brief Interview for Mental Status (BIMS) score of 14. A BIMS score of 13 to 15 indicated cognition was intact. The following NSG-Bowel and Bladder Screener indicated: (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	a. An admitted d 5/20/24 Always voided appropriately without incontinence with assistance of 1 person. Confused, needed prompting and was usually aware of the need to toilet. No current toileting program was currently being used. Candidate for Schedule toileting (timed voiding). b. An other dated 8/18/24 Not always, but at least daily voided appropriately without incontinence with assistance of 1 person. Confused, needed prompting and was usually aware of the need to toilet. No current toileting program was currently being used. Candidate for Schedule toileting (timed voiding). c. An other dated 11/18/24 Not always, but at least daily voided appropriately without incontinence with assistance of 1 person. Forgetful but followed commands and was usually aware of the need to toilet. No current toileting program was currently being used. Candidate for Schedule toileting (timed voiding). A physician's order indicated Tamsulosin HCL Oral Capsule 0.4 MG was started on 10/2/24 at bedtime for urine retention. An Ultrasound Imaging Appointment in [Hospital name redacted] Radiology report, dated 11/15/24 indicated, FINDINGS: Kidneys: Renal echogenicity is normal. There is no hydronephrosis. Bladder: Views of the bladder are unremarkable. The care plan dated 5/17/24 revealed, [Resident 31] has weakness. She has impaired vision on her left side. She has an ADL [activities of daily living] self-care performance deficit. The goal was [Resident 31] will maintain her current functional ability through next review. An intervention dated 5/17/24 was Toilet use: The resident requires partial/moderate assist for toilet use; [Resident 31] has had occasional urinary incontinence; [Resident 31] will have no increased in episodes of urinary incontinence through next review; Assist with toileting at resident request; Monitor for increased incontinence; and Pull-ups. The facility policy, Quality of Care Incontinence Urinary Incontinence, dated 5/4/23, indicated, The facility will consider various modifiable factors when determining ways to assist the resident to acheive his/her highest practicable level of functioning related to bladder incontinence. On 2/4/25 at 1:12 PM, an interview was conducted with the Lead Certified Nurse Assistant (CNA). The Lead CNA stated that the facility had a toileting program in the past, but that they did not have one now. The Lead CNA stated that when a resident was on a toileting program they would have to take them to the restroom every 2 hours. The Lead CNA stated resident 31 needed assistance to get to the bathroom with her walker or wheelchair and that she was aware when she had to void and was assisted to the bathroom upon request. The Lead CNA stated resident 31 wore a pull-up during the day and at night she would be put in a tabbed brief. On 2/4/25 at 3:14 PM, an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated he was assigned to the 300 hallway and that he was not aware of any resident that was on a toileting program. LPN 1 stated he did not receive any education on a toileting program. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	On 2/4/25 at 3:21 PM, an interview was conducted with RN 4. RN 4 stated the facility did not currently have a toileting program. RN 4 stated a toileting program would benefit a resident who was aware of the need to void or someone who needed assistance to get to the restroom. RN 4 stated any nurse can fill out the bowel and bladder evaluation and if a resident was a candidate the nurse should talk to the unit manager. On 2/4/25 at 3:26 PM, an interview was conducted with the UM. The UM stated there were no residents currently on the toileting program. The UM stated the resident did not need to agree to a toileting program and the residents with dementia were the target. The UM stated that if a resident was on the toileting program, staff would take them to the bathroom every 2 to 3 hours. The UM stated the purpose of a toileting program was to help those who may have lost independence of going to the bathroom on their own, to encourage continence, and be able to go home. The UM stated she had never had a resident ask to be put on the toileting program. The UM stated the toileting program would help benefit resident 31 and that she would be a good candidate for the program to help her not decline and improve. The UM stated that if the bowel and bladder evaluation indicated she was a candidate for the program then it should be on the care plan and CNA's would be aware and be documenting that. On 2/5/25 at 9:17 AM, an interview was conducted with RNC 1. RNC 1 stated if a resident was incontinent and if the resident expressed a want to toilet themselves it would be in their care plan. On 2/5/25 at 9:23 AM, an interview was conducted with the DON. The DON stated a bladder and bowel assessment was completed upon admission and nursing would review it. The DON stated if a resident was on a toileting program, it would be on the care plan and Kardex which would allow staff to know they needed assistance with toileting. The DON stated a resident that they were trying to help restore continence would be put on a schedule. The DON stated resident 31 was aware when she needed to use the restroom and would be assisted to the restroom when she called for assistance. The DON stated she wore a brief for accidents. On 2/5/25 at 12:27 PM, an interview was conducted with RNC 2. RNC 2 stated research showed bowel and bladder retraining programs did not work, so facilities did not do them.

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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 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** 30563 Based on interview, and record review, it was determined, for 1 of 33 sampled residents, that the facility failed to ensure parenteral fluids were administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. Specifically, a peripherally inserted central catheter (PICC) line had no physician orders for care for 10 days after the line was placed. Resident identifier: 3. Findings include: Resident 3 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included infection and inflammatory reaction due to other cardiac and vascular devices, methicillin-resistant Staphylococcus aureus (MRSA), end stage renal disease and dialysis. Resident 3's medical record was reviewed 1/27/25 through 2/6/25. A nursing progress note dated 12/28/24 at 5:00 PM revealed, [PICC/Midline placement company] came out to the building an [sic] placed a midline. Resident tolerated procedure with minimal pain. First dose of IV [intravenous] ABX [antibiotic] Vancomycin started. A physician's order dated 1/7/25 at 6:00 PM revealed, PICC/Midline: Flush IV line before and after medication administration every shift. A physician's order dated 1/7/25 at 6:00 PM revealed, PICC/Midline: If no meds/fluids, flush with 5-10ml NS [normal saline] q [every] 12 hours every shift. A Physician's order dated 1/7/25 at 6:00 PM revealed, PICC/Midline: Site observation (redness, warmth, swelling, pain, itching) every shift. A physician's order dated 1/8/25 at 6:00 AM revealed, Central Line/PICC/Midline: Dressing and cap change Weekly & PRN [as needed] every day shift every Wed [Wednesday]. A physician's order dated 1/8/25 at 6:00 AM revealed, PICC/Midline: Change tubing Q day every day shift. A nursing progress note dated 1/20/25 at 10:51 PM, PICC/Midline Site with mild swelling, large amount of dried blood at insertion site and under dressing, insertion site appears red and inflamed Dressing changed performed with sterile technique Concerned midline is infected and/or no longer patent Provider, don, um made will be aware in morning feedback. On 1/29/25 at 9:25 AM, an interview was conducted with Registered Nurse (RN) 2. RN 2 stated she did not know what was going on with resident 3's PICC/Midline flushes, dressing changes and cap changes. RN 2 stated there were no orders for the PICC line for a while after it was placed. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/30/25 at 1:00 PM, an interview was conducted with Licensed Practical Nurse (LPN) 2. LPN 2 stated a resident with a PICC/Midline needed a physician's orders to be flushed before and after medication was administration. LPN 2 stated the PICC/Midline usually had a physician's order to have the dressing changed every 5 to 7 days. LPN 2 stated if a resident was not administered a medication through the PICC/Midline, then the PICC/Midline needed to be flushed every shift. LPN 2 stated there needed to be physician's order to flush the PICC/Midline line. LPN 2 stated as long as the line was there, there needed to be physician's orders to flush and change the dressing. On 1/30/25 at 1:30 PM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated there was an outside source who placed PICC lines after the physician ordered it. RN 1 stated a PICC line needed to be flushed to make sure it was flowing with no blockage. RN 1 stated the nurse needed to assess the PICC site and look for redness or itching. RN 1 stated vital signs should be done every shift which included looking for signs or symptoms of infection. RN 1 stated the dressing to the PICC line needed to be changed weekly or as needed if it was peeling. RN 1 stated she performed a sterile process to change the dressing weekly. RN 1 stated if there was not a physician's order, then the nurse needed to contact the physician. RN 1 stated she would know from nurse to nurse report at the start of her shift if someone had a PICC line and then she would look for physician's orders. On 2/3/25 at 1:31 PM, an interview was conducted with the Director of Nursing (DON) and Regional Nurses Consultant (RNC) 1. The DON stated a PICC/Midline should be flushed before and after medication administered. The DON stated the PICC/Midline needed to be flushed daily if no medication was administered. On 2/4/25 at 9:16 AM, a follow up interview was conducted with RNC 1. RNC 1 stated there were no order to do PICC cares in resident 3's medical record until 1/7/25 and the PICC was placed on 12/28/24. RNC 1 stated PICC cares needed to be done when medication was administered and once per shift. RNC 1 stated the shifts were 12 hours. RNC 1 stated the PICC needed to be flushed with 5-10 milliliters of NS every shift. RNC 1 stated there were no physician's orders on how often, what to do or how to care for the PICC prior to 1/7/25. The facility provided a policy and procedure titled Clinical Services Policy and Guidelines for Implementation which revealed the following: PURPOSE: To assure that residents receive care and services for the provision of parenteral fluids consistent with professional standards of practice, including competent staff, in consideration of the resident's plan of care, accepted infection control practices and monitoring for complications. POLICY: The facility will provide parenteral fluids consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan and the resident's goals and preferences. Accepted infection control practices will be used and the resident will be monitored for complications. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	GUIDELINES: 1. Facility staff will use appropriate hand hygiene while administering and caring for parenteral devices and providing IV services. 2. When placing a venous access device aseptic technique will be used. 3. Appropriate personal protective equipment will be used while inserting, removing or otherwise manipulating venous access devices. 4. Parenteral fluids will be administered according to physician orders. 5. Parenteral therapy will be administered according to the resident-centered care plan, in accordance with the resident's goals, preferences and advance directives, as appropriate.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30563 Based on observation, interview, and record review it was determined for, 5 of 33 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 residents' goals and preferences. Specifically, the facility did not have oxygen orders for residents. In addition the facility did not follow their processes with labeling and dating the oxygen tubing and the humidifier water. Resident identifiers: 11, 14, 29, 32 and 34. Findings Included: 1. Resident 29 was admitted to the facility on [DATE] which included chronic respiratory failure with hypoxia, congestive heart failure and muscle weakness. On 1/27/25 at 9:45 AM, an interview was conducted with resident 29. Resident 29 stated her oxygen tubing was changed when she asked staff to change it. Resident 29 stated if the nasal cannula fell on the floor they provided her new oxygen tubing and nasal cannula. Resident 29 stated the water and the tubing were not changed regularly. Resident 29's oxygen was observed. There were no dates on the oxygen tubing. There was a bag on the concentrator with no date. The water on the concentrator was not dated. The water was almost empty. Resident 29's medical record was reviewed 1/27/25 through 2/6/25. A care plan dated 3/28/23 revealed [Resident 29] has potential for altered respiratory status r/t [related to] hypoxic respiratory failure, sleep apnea. The goal was [Resident 29] will have no unreported s/s [signs and symptoms] respiratory distress through next review. One of the interventions was O2 [oxygen] as ordered; monitor O2 sats as ordered. Resident 29's physician's orders revealed the following: a. On 6/24/24, Oxygen 0-5 liters per nasal cannula or mask to keep sats > [greater than] 90%. Document O2 sats and liters per minute every shift. b. On 6/24/24, Change oxygen tubing, concentrator bottle (if needed) and clean filter every week every day shift every Fri [Friday]. According to the Treatment Administration Record for January 2025 revealed oxygen was changed 1/3/25, 1/10/25, 1/17/25, 1/24/25 and 1/31/25. There was no documentation that the tubing was changed on 1/27/25. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/28/25 at 3:56 PM, an interview was conducted with Certified Nursing Assistant (CNA) 2. CNA 2 stated there were concentrators in each resident room for residents who needed oxygen. CNA 2 stated there were portable oxygen tanks for when residents who left their rooms. CNA 2 stated there was tubing and water for the concentrators. CNA 2 stated the oxygen tubing and water were checked daily. CNA 2 stated the tubing and water were changed weekly. CNA 2 stated when water was empty then staff changed the water container and tubing. CNA 2 stated the tubing was dated on tape and the water container was dated with a black marker. CNA 2 observed resident 29's oxygen was changed on 1/27/25. An observation was made of resident 29's oxygen and there was a piece of tape with the date of 1/27/25, the water container was full with a date of 1/27/25 and a plastic bag was on the oxygen concentrator dated 1/27/25. On 1/28/25 at 3:32 PM, an interview was conducted with CNA 1. CNA 1 stated staff change out the oxygen tubing, nasal cannula and the water containers every Friday. CNA 1 stated the items were dated with tape around the tubing and black marker on the water. CNA 1 stated oxygen supplies were changed weekly to keep them clean from parasites for the resident to be able to breath correctly. CNA 1 stated the respiratory system was very important for elderly who needed oxygen. CNA 1 stated the previous Friday she did not work. On 2/5/25 at 2:30 PM, an interview was conducted with the Director of Nursing (DON). The DON stated oxygen tubing and water container were changed weekly. The DON stated there was a physician's order in each resident's medical record for nurses to sign off after it had been changed. The DON stated each resident with oxygen should have a plastic bag on the concentrator that was dated. The DON stated the tubing and water container needed to have a date written on them. The DON stated he did not know why there was no date on resident 29's oxygen when the order was to be changed every Friday. The DON stated he did not know why the nurse signed off that the oxygen supplies were changed 1/24/25. The DON did not provide additional information why the tubing, bag and water container were not dated. 43212 2. Resident 32 was admitted to the facility on [DATE], and readmitted on [DATE] with diagnoses that included sleep related hypoventilation, and congestive heart failure. On 1/27/25 at 1:43 PM, an interview was conducted with resident 32 who stated he used oxygen only at night. Resident 32 was observed to have an oxygen concentrator with no labeling on the oxygen tubing. Resident 32's medical record was reviewed 1/27/25 through 2/6/25. A quarterly Minimum Data Set (MDS) dated [DATE] revealed, oxygen therapy, response No. Resident 32's physician orders were reviewed. No oxygen orders could be found in resident 32's physician orders. Resident 32's care plan was reviewed. No care area for the use of oxygen could be found in resident 32's care plan. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 32's MAR (Medication Administration Record) and TAR (Treatment Administration Record) for January 2025 was reviewed. No orders were found for use of oxygen. Resident 32's progress notes revealed: On 9/24/24 at 1:33 PM, a LTC [long term care] charting note revealed, .Vitals: Most recent O2 [oxygen] sats-[saturations] O2 90%-9/24/24 3:21 PM Method: Room Air .Respiratory .Does resident use supplemental oxygen: Yes; Route: Nasal Cannula . On 1/7/25 at 11:31 AM, a LTC charting note revealed, Vitals: .Most recent O2 sats-O2 94%-12/16/24 8:57 AM Method: Room Air .Respiratory .Does resident use supplemental oxygen: No . On 1/8/25 at 1:37 AM, an Orders-Administration note revealed, Room Air Trial; Nurse to collect 4 readings 5 min [minutes] apart if patient SPO2 [oxygen saturation of pulse] and document in nursing note every shift for 7 day(s) for 2 Days: 5 min [minutes]: 94%; 10 min: 90%; 15 min: 93%; 20 min: 90%. On 1/9/25 at 10:42 PM, a nursing progress note revealed, Patient O2 sats on room air trial: 96%, 93%, 92%, and 92%. On 1/11/25 at 6:28 PM, a nursing progress note revealed, SPO2 obtained today; 3:07 PM-92; 3:12 PM-90; 3:17 PM-93, 3:22 PM-93. On 1/29/25 at 3:03 AM, a nursing progress note revealed, 2110 [9:10 PM] Pt [patient] reported chills and not feeling right .O2 [oxygen] 94 3 L [liters] NC [nasal cannula] . A provider progress note dated 9/16/24 revealed, .On recent nights, he has had higher oxygen needs, as much as 5 L by NC or mask, otherwise asymptomatic. He states that he had a Dx [diagnosis] of OSA [Obstructive Sleep Apnea] years ago, had not really had any follow-up since then and felt he did not need it, but now he feels that it may be time .Dyspnea, unspecified; oxygen 2L NC PRN [as needed], clear lungs . Having nocturnal hypoxemia with significant desats, stable overall and sleeping well, per report he has had a history of OSA in the past; continue nighttime oxygen and monitor; refer to sleep clinic for evaluation. A provider progress note dated 11/18/24 revealed, .Problem list .Dyspnea; sleep related hypoventilation in conditions classified elsewhere .Assessment/Plan .Having nocturnal hypoxemia with significant desats, stable overall and sleeping well, per report he has had a history of OSA in the past; continue nighttime oxygen and monitor; refer to sleep clinic for evaluation. A provider progress note dated 12/19/24 revealed, .Problem list .Dyspnea; sleep related hypoventilation in conditions classified elsewhere .Assessment/Plan .Having nocturnal hypoxemia with significant desats, stable overall and sleeping well, per report he has had a history of OSA in the past; continue nighttime oxygen and monitor, refer to sleep clinic for evaluation. On 2/4/25 at 8:32 AM, an interview was conducted with CNA 4 who stated resident 32 used oxygen most of the time. CNA 4 stated resident 32 used oxygen when receiving dialysis and throughout the night but did not use it when he was in his wheelchair. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/4/25 at 10:33 AM, an interview was conducted with the Lead CNA who stated resident 32 used 2 liters of oxygen. The Lead CNA stated resident 32 did not use oxygen when in his wheelchair, but did use it while at dialysis and while in bed. On 2/5/25 at 3:29 PM, an interview was conducted with the Regional Nurse Consultant (RNC) 2 who stated a provider note on 9/16/24 documented resident 32 was feeling short of breath. RNC 2 also stated that on 9/16/24 resident 32 had an order for vital signs every 4 hours. RNC 2 stated a physician referral was placed on 9/16/24 for an in lab sleep study test DX [diagnosis]; insomnia, daytime sleepiness, fatigue, hypoxia. RNC 2 stated referrals were placed at 10 different facilities by the transportation manager and none of the facilities would accept the referral. RNC 2 stated a second referral for in home sleep study test DX: Insomnia, daytime sleepiness, fatigue, hypoxia was placed on 11/25/24. RNC 3 stated the test was completed on 1/21/25. The RNC stated the transportation manager did not keep a record of who she contacted for the original sleep study and on what dates. RNC 2 stated resident 32 did not have an oxygen order when he was readmitted on [DATE]. RNC 2 stated resident 32 did not have an oxygen order on his initial admission. The RNC stated that when an order was given for oxygen, the nurse or the nurse manager were responsible to put the order into the resident's medical record. RNC 2 stated the order should include keeping the resident's oxygen saturation above 90%, and can be addended to be more specific. RNC 2 stated oxygen orders should be part of the resident's regular care plan under oxygen or respiratory care. RNC 2 stated the nurse was responsible to verify that the resident received the ordered oxygen and could delegate to the CNA to make sure the oxygen was on the resident if they needed it. RNC 2 stated if a resident refused, the CNA would notify the nurse and the nurse would document the refusal. 3. Resident 34 was admitted to the facility on [DATE] with diagnoses that included obstructive sleep apnea. On 1/27/25 at 11:17 AM, an interview was conducted with resident 34 who stated he used oxygen all the time. An observation was made of the oxygen concentrator. The oxygen tubing was not labeled or dated. Resident 34 was observed not to be wearing his oxygen during the interview. Resident 34 stated he was not wearing it because he could not find it and had not called staff to help him find it. Resident 34 was observed to be laying on top of his oxygen tubing. Resident 34's medical record was reviewed between 1/27/25 and 2/6/25. On 7/31/24, an IP [inpatient] transfer report from the hospital revealed, .Plan .Pulm [pulmonary]: Nocturnal hypoxia; Has required 1-2 L overnight both here and at [hospital] before admission, continue CPAP [Continuous Positive Airway Pressure], inpatient sleep study done, f/u results; Will discuss mask options with RT [respiratory therapist], Long-term Comprehensive Rehabilitation Issues(taken from H & P [history and physical] 7/9/24): Pulmonary: Nocturnal hypoxia, suspected OSA; Patient with several witnessed apneic events at home prior to stroke, intermittently using his father's nocturnal O2. Required noctural O2 while on rehab, improved with CPAP. Additionally, muscle/tissue flaccidity d/t [due to] stroke further predispose to OSA. Supplemental O2 if needed to keep sats >90%, ISS [injury severity score], Appreciate SLP [speech language pathologist] evaluation and recs [recommendations], CPAP at night, Working on sleep study while inpatient .Discharge planning: .Dad reports that pt often suffers from SOB [shortness of breath] prior to admit and uses his dads O2 at home at times . (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 34's physician orders were reviewed. No oxygen orders could be found in resident 34's physician orders. Resident 34's care plan was reviewed. No care area for the use of oxygen could be found in resident 34's care plan. Resident 34's MAR (Medication Administration Record) and TAR (Treatment Administration Record) for January 2025 was reviewed. No orders were found for use of oxygen. Resident 34's progress notes revealed: a. On 7/31/24 at 2:35 PM, a clinical admission note revealed, .O2 92% Method: Room air .Respiratory: Lungs clear throughout bilaterally. No difficulty breathing. No cough noted. No shortness of breath noted . b. On 7/31/24 at 10:20 PM, a Daily Skilled Charting note revealed, O2 sats O2 92% Method: Room Air . Respiratory: Does the resident use supplemental oxygen-Yes .Route: Nasal Cannula; Liter Per Minute (LPM) no response, Frequency: Continuous c. On 1/9/25 at 10:44 PM, a nursing note revealed, Note text: O2 sats on room air trial: 91%, 91%, 89%, and 90%. d. On 1/11/25 at 6:33 PM, a nursing note revealed, Note text: SPO2 obtained: 3:05 pm-93, 3:10 pm-95, 3:15 pm-93, 3:20 pm-95. e. On 1/13/25 at 8:00 AM, a Psych follow-up note revealed, .He is suppose [sic] to be on bipap [bilevel positive airway pressure] per his report. He had a sleep study at the [hospital] while hospitalized , was having some problems prior to stroke. He used pap machine while at [hospital]. He was told they would have a machine here at the facility. He did okay with bipap, had a dry mouth, he thinks that his oxygen machine does not have a strong enough flow, He would like it checked. 12-16-24 reminder to locate sleep study so he can obtain bipap for sleep .He does not have a cpap machine yet .He would like to know if his sleep study from the [hospital] was found and if medical is working toward bipap machine or if this is waiting for insurance to be straightened out. He reports he was treated with bipap at the [hospital] and was told they would have a machine here for him. He thinks he has trouble breathing out and by using oxygen in the day he thinks it helps him feel like he can breath out better .need BIPAP machine and location of sleep study from [hospital] .Obstructive sleep apnea, bipap; Obstructive sleep apnea (adult) (Pediatric). On 8/2/24 a Provider admission note revealed, .He did not wear oxygen prior to hospitalization . Family report he was diagnosed with OSA in the hospital and did wear a cpap in hospital. Continue oxygen especially at night .Obstructive sleep apnea (adult) (pediatric) .Respiratory: Lungs CT, OTHER: 2L via NC . Obstructive sleep apnea (adult) (pediatric); CPAP in hospital; use oxygen 2L via NC keep O2 sats above 92%. On 1/20/25 a provider progress note revealed, .Obstructive sleep apnea (adult) (pediatric); cpap in hospital, use oxygen 2L via NC keep O2 sats above 92%. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/4/25 at 8:32 AM, an interview was conducted with CNA 4 who stated resident 34 used oxygen all the time. CNA 4 stated resident 34 frequently took his oxygen tubing off and staff had to go in and encourage him to put it back on. CNA 4 stated the Lead CNA was responsible for changing the oxygen tubing on the oxygen concentrators. CNA 4 stated the task was performed yesterday. On 2/5/25 at 2:54 PM, an interview was conducted with the DON [Director of Nursing] who stated he did not see any discharge orders from the hospital for resident 34 to have oxygen. The DON reviewed resident 34's medical record and confirmed he did not have orders for oxygen. The DON stated resident 34 did not have orders for oxygen use even though he was getting it sometimes. 4. Resident 11 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included coronary artery disease, congestive heart failure, and respiratory failure. On 1/27/25 at 1:36 PM, resident 11 was observed to be wearing oxygen while laying in bed. The surveyor observed that there was no labeling on the oxygen tubing. Resident 11's medical records were reviewed between 1/27/25 and 2/6/25. A review of resident 11's physician orders revealed: a. On 2/2/25, Obtain O2 sats on room air. Apply O2 to keep sats >90% every shift. b. On 2/25/25, Oxygen: O2 @ 0-5 liters per minute via nasal cannula to keep SPO >90% as needed for O2 stats [sic] ,90%. c. On 2/2/25, Oxygen: weekly change out & cleaning equipment change O2 tubing, bubbler, filter (if soiled), and wipe down concentrator, every day shift every Friday related to ACUTE RESPIRATORY FAILURE WITH HYPOXIA. A review of resident 11's January MAR/TAR revealed on 6/28/24 and discontinued on 2/2/25, Change oxygen tubing, concentrator bottle (if needed) and clean filter every week every day shift every Fri. The TAR revealed oxygen tubing changes and filter changes were not completed on 1/24/25 and 1/31/25. 5. Resident 14 was admitted to the facility on [DATE], and readmitted on [DATE] with diagnoses that included heart failure, chronic obstructive coronary disease, and respiratory failure. On 1/27/25 at 9:56 AM, an interview was conducted with resident 14 who stated she wore oxygen all the time. Resident 14 stated she was not wearing her oxygen at the time because she had just gotten out of the shower. Resident 14 stated she believed the staff changed her oxygen tubing every 3 months. Resident 14's medical records were reviewed between 1/27/25 and 2/6/25. A review of resident 14's physician orders revealed: a. On 2/2/25, Oxygen: weekly change out & cleaning equipment change O2 tubing bubbler, filter (if soiled), and wipe down concentrator, every day shift every Fri related to CHRONIC OBSTRUCTIVE PULMONARY DISEASE, UNSPECIFIED. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. On 2/2/25, Oxygen: O2 @ 0-5 liters per minute via nasal cannula to keep SPO >90% every shift. c. On 2/2/25, Obtain O2 sats on room air. Apply O2 to keep sats >90% every shift. A review of resident 14's January MAR/TAR revealed on 6/24/24 May apply oxygen per nasal cannula or mask titrate to keep sats >90%. Document O2 sats and liters per minute. Notify MD for initiation of use, as needed for O2 sats ,90%. The TAR revealed oxygen was applied on 1/5/25. On 2/4/25 at 10:33 AM, an interview was conducted with the Lead CNA who stated she was the staff member who changed the oxygen tubing and it was changed every Friday. The Lead CNA stated when changing oxygen tubing, she placed tape on the tubing and put the date the tubing was changed. The Lead CNA stated the nurse documented when the oxygen tubing was changed in the computer. On 2/4/25 at 11:04 am, an interview was conducted with RN 4 who stated a physician order was necessary for residents who used oxygen. RN 4 stated the order should include if a nasal cannula or mask should be used and how many liters of oxygen the resident should be using. RN 4 stated sometimes the order stated PRN or continuous to keep saturations above 90%. On 2/5/25 at 2:54 PM, an interview was conducted with the DON who stated the cannulas for each resident were changed weekly. The DON stated there was an order for that and the nurse would document when it was completed. The DON stated the nurse or the nurse manager were responsible for putting oxygen orders in the resident's medical chart.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30563 Based on interview and record review it was determined, for 2 of 33 sampled residents, that the facility did not ensure that residents who required dialysis received such services, consistent with professional standards of practice. Specifically, resident's receiving dialysis were not provided a fluid restriction as ordered from dialysis. Resident identifier 3 and 32. Findings include: 1. Resident 3 was admitted to the facility on [DATE] with diagnoses which included infection and inflammatory reaction due to other cardiac and vascular devices, end stage renal disease with dialysis, Methicillin-resistant Staphylococcus aureus, surgical after care following surgery on the circulatory system, anemia, diabetes mellitus and Alzheimer's disease. Resident 3's medical record was reviewed 1/27/25 through 2/6/25. The current diet order dated 1/10/25 CCD (carbohydrate controlled), renal diet, Regular RG7 (regular) texture, thin consistency, 1 gram sodium. There was no physician's order for a fluid restriction. A care plan dated 7/7/23 and revised on 1/19/24 revealed resident 3 had fluid retention after dialysis and was encouraged to follow her 1 liter fluid restriction. One of the interventions was to remind resident 3 about her fluid restriction as needed. Another care plan dated 7/3/23 and revised on 12/6/23 revealed resident 3 was non compliant with her fluid restriction. There were no interventions on what to do when resident 3 was non-compliant. A Nutritional Evaluation dated 12/16/24 revealed in the assessment section, .Has 1.5 liter/day fluid restriction that she is often non-compliant with. No recommended changes at this time. Will continue to monitor and assist prn [as needed]. A form titled Communication Report from resident 3's dialysis dated 1/17/25 revealed Reinforced low sodium diet & fluid restriction, Pt [patient] acknowledge understanding. A form titled Communication Report from resident 3's dialysis dated 1/22/25 revealed Reinforced diet & Fluid restriction. Pt acknowledged understanding. A form titled Communication Report from resident's dialysis dated 1/24/25 revealed .reinforced diet & fluid restrictions. Pt acknowledged understanding. On 1/29/25 at 9:25 AM, an interview was conducted with Registered Nurse (RN) 2. RN 2 stated residents who needed to be on fluid restrictions were not on fluid restrictions. RN 2 stated nurses did not know how much fluid residents were provided because there was no tracking system. 43212 (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident 32 was admitted to the facility on [DATE], and readmitted on [DATE] with diagnoses that included end stage renal disease, dysphagia, protein calorie malnutrition, type 2 diabetes and cirrhosis of the liver. Resident 32's medical record was reviewed between 1/27/25 and 2/6/25. Physician orders were reviewed. Resident 32's diet order revealed: a. On 8/5/24, Renal diet, Regular RG7 texture, thin consistency; Liberal Renal CCD [controlled carbohydrate]. It should be noted that resident 32 did not have an order for a fluid restriction. b. [Provider] Dialysis to provide in-house dialysis treatment up to 3x a week. Resident 32's care plan dated 7/20/23 revealed, [Resident 32] is receiving dialysis r/t [related to] ESRD [End stage renal disease]. The goal was, [Resident 32] will have not s/s [signs and symptoms] of complications from dialysis through the review date. Interventions included, Monitor/document/report PRN [as needed] new/worsening peripheral edema. Resident 32's progress notes included: a. On 1/15/25 at 1:00 PM, a nursing progress note revealed, resident to dialysis et [sic] back again with suggestion to encourage him to follow fluid restriction. b. On 1/31/25 at 3:40 PM a nursing progress note revealed, .Acknowledges understanding the importance of achieving optimal results by completing treatment and adhering to fluid restriction. Resident 32's dialysis communication notes were reviewed and revealed: a. On 11/25/24, a dialysis communication report revealed, . Reinforced diet & fluid restriction, pt acknowledged understanding. b. On 12/13/24, a dialysis communication report revealed, .Enforced diet and fluid restriction. Pt acknowledged understanding. c. On 12/24/24, a dialysis communication report revealed, . Reinforces diet and fluid restriction. Pt acknowledged understanding. d. On 1/24/25, a dialysis communication report revealed, .Please have him follow fluid restrictions & diet. e. On 1/31/25, a dialysis communication report revealed, .Reinforced diet and fluid restriction. Pt acknowledged understanding. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/3/25 at 12:23 PM, an interview was conducted with the Registered Dietitian (RD) who stated resident 32 sometimes switched back and forth with watching his fluid intake. The RD stated she did not believe resident 32 was on a fluid restriction. The RD stated resident 32 would need a physician order to be on a fluid restriction. The RD stated she communicated with the dialysis RD through email and received a report card on each resident receiving dialysis. The RD stated she had access to all the notes of the dialysis RD, including lab reports and dry weights and did not recall a mention of a fluid restriction. The RD stated resident 32 had discussed his fluid gains with her and she had given him simple tips on how to reduce his fluid intake. The RD stated she had not given resident 32 specific restrictions or anything set in stone. The RD stated resident 32 was monitoring himself as he needed to, and they were not going to tell him he can't drink. The RD stated resident 32's fluid intake was documented in the CNA's Point of Care (POC) tasks. The RD stated, Maybe since there is not an order for it, it is not being implemented. On 2/6/25 at 12:39 PM, an interview was conducted with the Director of Nursing (DON) who stated the dialysis RD would send an email to the DON, the Unit Manager, and the RD to let them know what she wanted regarding a fluid restriction. The DON stated resident 32 had signed a risk/benefit form indicated that he chose not to follow his dietary recommendations and that it should be in his medical record. On 2/6/25 at 3:00 PM, an interview was conducted with the Unit Manager (UM) who stated there were a few residents who were on fluid restrictions, and if resident 32 were on a fluid restriction it would be in the MAR (Medication Administration Record). The UM stated the order would include how much of a fluid restriction for dietary and for nursing for a 24 hour period. The UM stated there should be a box to type in the amount in ml's [milliliters] on the resident's dietary profiles. When asked if resident 3 was on a fluid restriction, the UM stated she thought all the dialysis patients are on fluid restrictions. The UM stated if there was a new order from the dialysis RD, she would get an email or a fax with the new order. The UM stated she had not reviewed every dialysis sheet that came with residents after dialysis. The UM stated she did not think that resident 32 was on a fluid restriction. The UM stated if it was not on the diet order, the nurses would not know about it. The facility dialysis Policy and Guidelines revised on 5/2019 revealed the following: Purpose: To provide residents with hemodialysis or peritoneal dialysis that is consistent with professional standards of practice and consistent with the individuals assessment and goals. Policy: The facility will provide residents, who require dialysis, care and service consistent with professional standards of practice, a comprehensive person-centered care plan and inclusive of the residents' goals and preferences. Guidelines: . 4. The facility and the dialysis center will collaborate to assure that the resident's needs related to dialysis treatments are being met. 9. There will be ongoing communication between the facility and the dialysis center reflected in the medical record. This communication may include but not limited to: . (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	d. Nutritional/fluid management including documentation of weights, resident compliance with food/fluid restrictions or the provision of meals before, during and/or after dialysis and monitoring intake and output measurements as ordered.

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F 0742 Level of Harm - Actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48709 Based on observation, interview, and record review, for 1 of 33 sampled residents, it was determined that the facility failed to ensure that a resident who displayed or was diagnosed with mental disorder or psychosocial adjustment difficulty, or who had a history of trauma and/or post-traumatic stress disorder (PTSD) were provided appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being. Specifically, one resident who was diagnosed with mental disorders and post-traumatic stress disorder experienced interactions with staff that caused them undue stress. Resident identifier: 28. Findings include: Resident 28 was admitted to the facility on [DATE] with diagnoses which included spinal stenosis, intervertebral disc degeneration lumbar region, anxiety disorder, major depressive disorder, post-traumatic stress disorder, somatization disorder, and wedge compression fracture of T11-T12 vertebra. On 1/27/25 at 9:45 AM, an interview was conducted with resident 28. Resident 28 stated they felt staff continually harassed and threatened them into moving rooms. Resident 28 stated the previous Administrator would threaten them on a daily basis and they would worry about it all day. Resident 28 stated they had a sensory processing disorder and they could not handle having people come in and out of their room, loud noises, or lots of visitors. Resident 28 stated they experienced a complete autistic meltdown and was in the fetal position and cried when they had a roommate that was loud and always had visitors. Resident 28 stated they were moved to a different room about a year ago and they had cried, begged, and pleaded not to have to move. Resident 28 stated the Administrator and Director of Nursing (DON) came into their room about 2 weeks ago and stated they would have to move rooms or have a roommate and that this caused them stress and trauma and that, I was in a state of constant anxiety. Resident 28 stated they were now working to get approval to have a private room and that their therapist already wrote a detailed letter on why they needed a private room. On 1/28/25 at 5:45 PM, an interview was conducted with resident 28 and her family member. The family member stated that resident 28's needs were not being met by facility staff and it felt like the facility administration was trying to upset her. The family member stated that administration came to resident 28's room and told her she was getting a roommate but she had the weekend before the resident would move in. The family member stated administration told her the roommate was a fall risk and needed to be in a busier hallway. The family member stated administration told her the resident had alarms to keep her from falling. The family member stated she told administration that would not work for resident 28. The family member stated facility staff were not aware of how to care for resident 28 because she required female CNA (Certified Nursing Assistants) to care for her because of her PTSD. The family member stated agency male CNAs had been assigned to care for her and resident 28 had to tell them males were not allowed to care for her. Resident 28 stated when a male staff came into her room it caused her excessive adrenaline which took her days to recover from. Resident 28 stated she had to buy her own Tylenol because she was told by the DON that they only supply a certain type and she needed a specific shape to be able to swallow them. (continued on next page)

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F 0742 Level of Harm - Actual harm Residents Affected - Few	A concurrent observation was made of resident 28's door. The door had six signs taped on the outside of the door, which included: a. PLEASE BE QUIET WHEN IN THIS ROOM, THANKS!! b. IMPORTANT NOTICE BED 'B' ONLY 1) NO VITAL SIGNS UNTIL AFTER BREAKFAST, PLEASE! 2) DO NOT WAKE RESIDENT TO OBTAIN VS [vital signs] @ ANY TIME! c. Please Close Door UNTIL YOU HEAR IT CLICK Thanks! d. ATTENTION STAFF!! Please keep in mind when assigned to this hall re: personal perfume/body spray/lotion, etc. - -There are residents with sensitivities to scents in this hall. - Please do not use air freshener in this hall! e. KEEP DOOR CLOSED Please f. IN THIS ROOM: Put on new gloves in front of resident, please & thank you! On 2/5/25 at 2:38 PM, an interview and observation was made of resident 28. Resident 28 was visibly upset and stated the DON and Unit Manager (UM) came into the resident's room and took away their medications. Resident 28 was observed to lower her bed and pulled out a lock box that was placed under her bed and next to the night stand. Resident 28 stated that someone would have to move her bed and night stand to get to her lock box with medications. Resident 28 stated she administered her own medications because the nurse was always late which caused her to be anxious and feel awful. Resident 28 was observed to have a narcotic count sheet she filled out when she took her medications. Resident 28's medical record was reviewed 1/27/25 through 2/6/25. A Quarterly Minimum Data Set (MDS) Assessment, dated 1/2/25, indicated a Brief Interview for Mental Status (BIMS) score of 15. A BIMS score of 13 to 15 indicated cognition was intact. A Physician/Practitioner Note, dated 1/30/25 at 2:21 PM, indicated, .[Resident 28] has PTSD, anxiety, and major depressive disorder. [Resident 28] states that [Resident 28's] symptoms have been exacerbated by being told that [Resident 28] was going to share a room and possibly change [Resident 28's] current room. [Resident 28] states that [Resident 28's] symptoms have been exacerbated by being told that [Resident 28] is going to share a room and possibly change [Resident 28's] current room. [Resident 28] states that this has made [Resident 28] more depressed and made it more difficult for [Resident 28] to sleep. [Resident 28] complains of increased anxiety and constant worry. [Resident 28] is currently calm and cooperative during this exam .The resident states that [Resident 28] had a hard time switching rooms previously and is worried that switching rooms again or having to have [Resident 28's] roommate will exacerbate things even more . Plan: .At this time the resident would benefit from having [Resident 28's] own private room however encourage the resident to meet with behavioral health to take [sic] about coping mechanisms so that the resident could adjust to changes . A SS [Social Services] Quarterly & Annual Note, dated 10/1/24 at 3:07 PM, indicated, .Pt [patient] will make statements that staff are not being careful enough, trying to cause [resident 28] harm as they 'don't understand my sensory disorder' and even the littlest touch or unintended bump [resident 28] believes will cause [resident 28] permanent harm. (continued on next page)

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F 0742 Level of Harm - Actual harm Residents Affected - Few	The Care Plan indicated, The resident has a mood problem DX of Somatic symptom disorder per PASRR [Preadmission Screening Resident Review] level II. [Resident 28] has voiced multiple concerns about [Resident 28's] care, roommates, interactions with the staff, the environment. [Resident 28] states [Resident 28] has a 'sensory processing disorder' that makes [Resident 28] ultra sensitive to noise, smell, taste, ect. Pt will make statements that staff are not being careful enough, trying to cause [Resident 28] harm as they don't understand my sensory disorder and even the littlest touch or unintended bump [Resident 28] believe will cause [Resident 28] permanent harm. Date Initiated: 04/18/2022 Revision on: 06/11/2024. It further indicated a Goal of, [Resident 28] will have improved mood state e/b [as evidenced by] verbalizes satisfaction with [Resident 28's] stay at the facility through next review. Date Initiated: 04/18/2022 Revision on: 12/30/2024 Target Date: 04/13/2025. Interventions included, Administrator has approved a private room for [Resident 28] unless it is absolutely necessary to put a room mate in [Resident 28's] room. Date Initiated: 04/28/2023 Revision on: 07/19/2023. Assist the resident, family, caregivers to identify strengths, positive coping skills and reinforce these. Date Initiated: 04/18/2022. Remind staff to be very careful and not touch or bump [Resident 28's] bed. Date Initiated: 06/10/2024. [Resident 28] demonstrates a behavior of frequently complaining that staff are not being careful enough, trying to cause [Resident 28] harm as they don't understand my sensory disorder and even the littlest touch or unintended bump [resident 28] believe will cause [Resident 28] permanent harm. Date Initiated: 02/16/2024. [Resident 28] has a reminder sign on [Resident 28's] privacy curtain asking resident's to ask permission to go beyond the curtain. [Resident 28] has requested this sign. Date Initiated: 06/11/2024. [Resident 28] has multiple reminder signs on [resident 28's] door and on [resident 28's] armoire, at [resident 28's] request, all with specific requests. Date Initiated: 01/20/2023 Revision on: 06/11/2024. Staff should not enter [Resident 28's] room unless they hear [resident 28] respond to come in. Date Initiated: 06/10/2024. On 1/29/25 at 9:25 AM, an interview was conducted with RN 2. RN 2 stated resident 28 required a female CNA to care for her and had been scheduled a male CNA which caused her distress. RN 2 stated she cared for resident 28 as a CNA when a male was assigned to her or another CNA assigned to another hall cared for her. RN 2 stated the facility was unable to provide resident 28 with type of Tylenol she was able to swallow so resident 28 had to buy her own. On 2/4/25 at 9:11 AM, an interview was conducted with the Lead Certified Nurse Assistant (CNA). The Lead CNA stated resident 28 did not want any staff in resident 28's room and that resident 28 did not want males to go in resident 28's room because resident 28 had PTSD with males. On 2/4/25 at 3:38 PM, an interview was conducted with CNA 6. CNA 6 stated that resident 28 did not allow her to go in their room and provide cares. On 2/5/25 at 1:16 PM, a telephone interview was conducted with the Resident Advocate (RA). The RA stated a discussion occurred in the morning meeting that a resident needed to moved to the 400 hall and resident 28's room was the only room that had a bed available, so resident 28 was asked to move rooms, but resident 28 absolutely refused to move or have a roommate. The RA stated resident 28 had somatizing disorder and PTSD and feared that any movement or bump would break resident 28's back, so this caused really bad anxiety and fixation on their back being broken. (continued on next page)

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F 0742 Level of Harm - Actual harm Residents Affected - Few	On 2/5/25 at 2:41 PM, an interview was conducted with the DON. The DON stated resident 28's medications were taken out of her room to satisfy a 2-lock rule for narcotics and that he told resident 28 that they were going to hold onto the medications until they bought a locked cabinet, but that they should be returned before the next doses were due. The DON stated resident 28 said that would work for them. The DON stated resident 28 would get panic attacks and sets them back a lot with the smallest changes and that they cannot move their room or put a roommate in with them because of it. The DON stated he knew he would get push back when resident 28 was asked to move but they were trying to do what was best for the other resident. On 2/5/25 at 2:53 PM, an interview was conducted with the Administrator. The Administrator stated he talked to resident 28 about moving rooms or getting a roommate approximately 2 weeks ago but resident 28 did not want to do either option. Resident 28 called the State Ombudsman and the Department of Health and Human Services when this occurred and then he received a phone call from both entities, and he ended up asking a different resident to move from hall 400 to accommodate the facility's need so resident 28 did not need to move rooms or have a roommate. The Administrator stated that was his first interaction with resident 28. The Administrator stated when he talked to resident 28, [resident 28] was not having any of that and that resident 28 was crying and visibly upset. The Administrator stated the staff did warn him that resident 28 was not going to like being asked to do this and that resident 28 was very difficult but staff did not provide any more health information about why resident 28 would react that way. The Administrator stated resident 28 stated that they had mental health issues and did not want to talk to us about it. The Administrator stated resident 28 was upset about this incident for about 1 to 1-1/2 weeks.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30563 Based on interview and record review, it was determined that for 1 of 33 residents, that the facility did not ensure that the resident's drug regimen was adequately monitored. Specifically, a resident was administered a medication used to treat hypertension when the resident's blood pressure was outside of parameters set by a physician's order. Resident Identifier: 3 Findings Include: Resident 3 was admitted to the facility on [DATE] and readmitted after hospital stay on 12/27/24 with diagnoses which included infection and inflammatory reaction due to other cardiac and vascular devices, implants and grafts, Methicillin-resistant Staphylococcus aureus, end stage renal disease, dialysis, surgical after care on circulatory system, diabetes mellitus, Alzheimer's disease, and osteoarthritis. Resident 3's medical record was reviewed 1/27/25 and 2/6/25. A physician's order dated 12/28/24 revealed Metoprolol Succinate ER [extended release] Oral Tablet Extended Release 24 Hour 50 MG [milligrams] (Metoprolol Succinate) Give 1 tablet by mouth one time a day for blood pressure HOLD for sbp [systolic blood pressure] < [less than] 105 or hr [heart rate] <55. The Medication Administration Record (MAR) dated 1/1/25 revealed a blood pressure of 100/59 with a HR of 69. Metoprolol Succinate was administered with blood pressure below parameters. On 2/6/25 at 1:39 PM, an interview was conducted with the Director of Nursing (DON). The DON stated the Metoprolol should have been held with a blood pressure of 100/59.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50200 Based on interview and record review it was determined, for 2 out of 33 sampled residents, that the facility did not ensure that residents who have not used psychotropic drugs were not given these drugs unless the medication was necessary to treat a specific condition as diagnosed and documented in the clinical record and that PRN (as needed) orders for psychotropic drugs were limited to 14 days, except if the physician extends it beyond 14 days and documents their rationale in the medical records and indicated the duration for the PRN order. Specifically, a resident was prescribed an antipsychotic medication without a supporting clinical diagnosis and a resident received PRN anxiety medication for more than 14 days. Resident identifiers: 35 and 38. Findings include: 1. Resident 38 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included urinary tract infection, generalized muscle weakness, difficulty in walking, unspecified dementia, and difficulty in walking. Resident 38's medical record was reviewed 1/27/25-2/6/25. An admission Minimum Data Set (MDS) dated [DATE] revealed resident 38's Brief Interview of Mental Status (BIMS) score was 3. A score of 0-7 indicated severe cognitive impairment. Resident 38's MDS dated [DATE] revealed no psychosis or behavioral symptoms. Resident 38's physician order dated 12/31/24 revealed quetiapine, an antipsychotic, 50 mg (milligrams) at bedtime for a diagnosis of mood. A review of resident 38's psychotropic meeting dated 1/9/25 revealed resident 38 had aggressive behaviors towards staff and others and should continue taking quetiapine. It should be noted the facility did not begin to track for these behaviors until 1/9/25. On 1/28/25 at 2:47 PM, an interview was conducted with Registered Nurse (RN) 4. RN 4 stated resident 38 was very sweet and always grateful for things. RN 4 stated resident 38 did not have any aggressive behaviors. RN 4 stated she was not monitoring resident 38 for any behaviors. On 1/30/25 at 2:52 PM, an interview was conducted with RN 1. RN 1 stated that resident 38 was taking quetiapine for her mood. RN 1 stated resident 38 was a little anxious if she was left alone, but was easily distracted with television if this occurred. RN 1 stated she was not monitoring resident 38 for any behaviors and had not seen any aggressive behaviors from resident 38. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/4/25 at 12:51 PM, an interview was conducted with the Director of Nursing (DON). The DON stated psychotropic medications had the diagnosis on the physician orders. The DON stated psychotropic meetings were held the second Thursday of every month. The DON stated psychotropic meetings were done on admission and then quarterly. The DON stated the only approved diagnoses for the use of antipsychotic medications were Schizophrenia, Bipolar, and Huntington's Disease. On 2/5/25 at 11:37 AM, an interview was conducted with Regional Nurse Consultant (RNC) 1. RNC 1 stated there were certain diagnoses needed in order for a resident to be prescribed an antipsychotic medication. RNC 1 stated psychotropic meetings were held where medications and behaviors were reviewed. RNC 1 stated if a resident came to the facility without an appropriate diagnosis the unit manager would get medical records for the resident to support the usage of psychotropic medications. RNC 1 stated any behaviors the resident was having should be documented in the Treatment Administration Record (TAR) and the nurse would make a progress note in the chart. On 2/5/25 at 01:40 PM, an interview was conducted with RNC 2. RNC 2 stated there were no behaviors documented in progress notes for resident 38. RNC 2 stated best practice would be to monitor for the behaviors and a gradual dose reduction (GDR) of the antipsychotic medication be completed. On 2/5/25 at 1:41 PM, a follow up interview was conducted with the DON. The DON stated resident 38 was being monitored for common behaviors seen in residents that were prescribed antipsychotic medications. The DON stated resident 38 did not have these behaviors. The DON stated resident 38 did not have a diagnosis for the use of antipsychotic medications and the family of resident 38 did not know why she was taking it. 48709 2. Resident 35 was admitted to the facility on [DATE] with diagnoses which included wedge compression fracture of fifth lumbar vertebra, spinal stenosis, radiculopathy, aortocoronary bypass graft, type 2 diabetes mellitus, hypertension, and panic disorder. Resident 35's medical record was reviewed 1/27/25 through 2/6/25. A physician's order dated 9/4/24 at 4:15 PM, indicated, hydroxyzine HCL Oral Tablet (Hydroxyzine HCL) Give 25 mg by mouth every 8 hours as needed for anxiety. It further indicated a discontinued date of 1/16/25. A review of the Medication Administration Record (MAR) for the months of September, October, November, and December 2024 indicated the resident received Hydroxyzine HCL 25mg every 8 hours as needed for anxiety on 9/8/24 at 6:58 PM, 9/20/24 at 10:00 AM, 10/2/24 at 12:33 PM, 10/8/24 at 12:58 AM, 10/15/24 at 12:43 AM, 10/23/24 at 11:15 PM, 10/29/24 at 1:44 AM and 11:00 PM, 11/5/24 at 12:25 AM, 11/6/24 at 1:48 AM, 11/20/24 at 1:19 AM, and 12/15/24 at 12:09 AM. A review of the care plan dated 9/5/24 indicated, [Resident 35] uses PRN [as needed] hydroxyzine to help manager her anxiety. The goal was [Resident 35] will have fewer episodes of verbalized anxiety or noticeable restlessness through next review. Interventions included Administer prn hydroxyzine medications as ordered by physician. Monitor for side effects and effectiveness Q-SHIFT [every shift]; Calm Reassurance; Involvement in decision making as possible; and Maintenance of daily routine and caregivers as possible. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/5/25 at 9:30 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that PRN anti-anxiety medications were to be scheduled for 14 days and that if they were needed for longer than 14 days, then they would review that medication and try to get the medication ordered at scheduled times. The DON stated resident 35's PRN hydroxyzine should have had a 14 day limit.

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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** 30563 Based on observation, interview and record review it was determined, for 2 of 33 sampled residents, that the facility did not ensure that residents were free of any significant medication errors. Specifically, a resident on vancomycin (vanco) was not administered according to pharmacy and physician orders. In addition, laboratory (labs) were not completed according to pharmacy and physician's orders. Another resident was administered medication for low blood pressure and it was not documented as administered. Resident identifier: 3 and 32. Findings include: 1. Resident 3 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included infection and inflammatory reaction due to other cardiac and vascular devices, Methicillin-resistant Staphylococcus aureus (MRSA), and end stage renal disease with dialysis. Resident 3's medical record was reviewed 1/27/25 through 2/6/25. Discharge order from the local hospital dated 12/27/24 revealed resident 3 was admitted on [DATE]. An order revealed Vancomycin for four weeks after each hemodialysis. If there were any questions contact an specific Infectious Disease physician. a. A nursing progress note dated 12/28/24 at 10:46 AM revealed, This nurse called to clarify IV Vancomycin orders. The pharmacist stated the dose to give now: Vancomycin 1.5g IV. The pharmacist also stated to get vancomycin levels before dialysis tomorrow morning. Once the results come back, the pharmacist stated to notify pharmacy for dosing instructions. Resident notified about new orders. A nursing progress note and physician's order on 12/28/24 revealed a PICC or mildline was to be placed. There was no physician's order for Vancomycin to be administered on 12/28/24 and there was no documentation in the December 2024 Medication Administration Record (MAR) that Vancomycin was administered. b. There was a physician's order dated 12/29/24 to obtain a vanco trough level. The level was returned to the facility on [DATE] revealed it was 31.7 The nurse documented in a nursing note that the physician and pharmacy was contact. The nurse documented the pharmacist instructed to hold the dose on 12/29/24 and draw another trough on 12/31/24. c. On 12/31/24 a form titled Notification of Order Change(s) Made revealed the previous order was Vancomycin 1.5grams (gm)/300 milliliters (ml) IV once daily on dialysis days after dialysis. The new order was Vancomycin 1 gm/200ml IV once daily on dialysis days after dialysis over 1 hour. The labs to be draws were vancomycin level 1/3/25 pre dialysis. The form finished with please call pharmacy with results prior to administering dose. The laboratory results dated [DATE] revealed hand written documentation to give 1.5gm/200ml after dialysis, redraw trough on 1/3/25 before dialysis and call pharmacy for dosing. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[It should be noted that the doses were different from the laboratory form and notification of order change. In addition, vancomycin was not administered after dialysis on 1/1/25 and 1/3/25 which was documented on the notification of orders changes made.] A nursing note dated 1/1/25 revealed that IV vancomycin given on 12/31/24. According to the physician's orders and December MAR there was no Vancomycin administered and no documentation of what doses were administered. d. A nursing note dated 1/2/25 revealed called pharmacy to confirm vanco trough timing. Per pharmacist vanco trough was to be drawn 2 hours after dialysis then call pharmacy for dosing. On 1/3/25 a Notification of Order Change(s) Made revealed vancomycin trough on 1/3 resulted in 22.6 and patient did not have dialysis 1/3. The new orders were to hold vancomycin medication and nurse ordered trough before patient next dialysis on 1/6 in the morning. A nurses note dated 1/4/25 revealed Pharmacist called asking about vanco trough from yesterday. The nurse looked through nursing notes and found resident did not go to dialysis yesterday and trough was not drawn. The Pharmacist stated that it was okay for resident to not have IV vancomycin today 1/4/25 and 1/5/24 due to not being able to clear the vanco from not having dialysis. Pharmacist gave order to draw vancomycin trough levels before dialysis on 1/6/25. e. A physician's progress note dated 1/6/25 and signed by the physician on 1/7/25 at 6:15 PM revealed Later in the evening, there was an issue with her vancomycin dosing, unable to ascertain her vancomycin level at the moment but needing a vancomycin dose after dialysis today. She was given 1 g of IV vancomycin based on prior dose of 1.5 g, with emphasis to obtain vancomycin level as soon as possible so as to allow proper dosing. A nursing note dated 1/7/25 at 2:07 AM reveled that there was an order for vanco trough on 1/6. There were no results for the day and the night shift nurse called the physician because the pharmacy would not order a dose without a vanco level. The physician gave an order for a 1 time dose of Vanco 1 gram/200ml normal saline over 1 hour via PICC. The dose was administered at 7:45 PM on 1/6/25. A nursing note dated 1/7/25 at 4:44 PM revealed, vanco trough results were 24.3. The pharmacy recommended to hold vanco 1/8 and redraw on 1/9. A Nurse Practitioner (NP) dated 1/7/25 revealed, [Resident 3] was started on Vanco, 12/20, several days of no dose given related to high vanco trough levels. Recommend 21 days of Vanco. If issues continue with coordinating labs, discussed with nursing changing to oral medication. Her right arm remains with stitches, slightly pink. f. A nursing note dated 1/9/25 at 1:06 PM revealed, this nurse called the lab to receive stat, random vanco level which was 17.8 and pharmacist would figure out the dose and send it to the facility. A nursing note on 1/9/25 revealed the vanco was received from the pharmacy and it was to be administered on 1/10/25 after dialysis. There was a physician's order and it was documented as administered on the January 2025 MAR. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing progress note from 1/11/25, 1/12/25 and 1/12/25 revealed resident finished IV Vanco for sepsis, resident finished regime of IV vanco. A physician's progress note dated 1/13/25 revealed resident was getting ongoing vancomycin and finishing course today. g. An NP progress note dated 1/14/25 revealed, no labs or any vanco over the weekend for unknown reasons. The note further revealed to continue vanco for 2 more weeks per Infectious Disease physician. The physician wanted to have vanco after her dialysis with troughs completed on Friday and Wednesday. Would recommend going to oral antibiotics if this does not get followed. An alert note dated 1/14/25 revealed new order for a random vanco trough. A nursing note dated 1/15/25 at 12:05 AM revealed, resident had finished the course of IV vanco. At 5:04 AM, resident had been off vanco for multiple days. Random vanco level drawn. At 9:03 AM, vanco level was 13.5. The laboratory results for revealed hand written documentation ATTN [attention]: Pharmacist .1/15 call pharm to dose vanco give today after dialysis initialed by the NP. A Notification of Order Change(s) Made dated 1/15/24 revealed new order nurse will infuse Vancomycin IV 1 gram after dialysis today. Nurse ordered a vancomycin level on 1/17 before dialysis. Administered Vanco according to the January 2025 MAR on 1/15/25. h. On 1/17/25 a laboratory form was signed by the physician on 1/20/25. It was hand written MD notified, pharmacy notified vanco dose was to be held. The random level was 21.5 which was high. Nursing progress notes revealed the vancomycin dose were held on 1/17/25, 1/18/25 and 1/19/25. i. On 1/20/25 at 3:33 PM a nurses note revealed, vanco trough draw was 9.6. Pharmacy ordered vancomycin 750/150 ml to be administered. There was no physician's order or documentation in the MAR that the Vancomycin had been administered. j. On 1/22/25 at 10:44 AM a nurses note revealed, vanco level was faxed to pharmacy and NP. Pharmacy was called and lab was reported. Another nurses note dated 1/22/25 at 3:44 PM, revealed the nurse attempted to call the pharmacy 2 or 3 times. Phones were acting weird and unable to get to the pharmacy. The direct line to the pharmacist went straight to voice mail. A nurses note dated 1/23/25 at 10:30 AM that the pharmacy faxed to give IV vanco 750 mg today. The next administered dose was on 1/23/25 which was 750 mg/150ml. There was a laboratory form dated 1/24/25 which was signed by the physician on 1/28/25 with no orders. A nurses note dated 1/25/25 at 9:31 PM revealed, resident finished with IV vancomycin. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/29/25 at 2:08 PM a nurses note revealed the NP ordered to remove the midline. On 1/29/25 at 9:35 AM, an interview was conducted with Registered Nurse (RN) 2. RN 2 stated resident 3's vancomycin dosing and trough were not drawn according to physicians orders. RN 2 stated the physician had to guess what the dosing was because there was not a trough drawn. RN 2 stated the physician had to give random orders for vancomycin and hope for the best. On 1/30/25 at 1:00 PM, an interview was conducted with Licensed Practical Nurse (LPN) 2. LPN 2 stated if a resident was admitted with orders for vancomycin, those orders needed to be put into the resident medical record. LPN 2 stated if a resident was receiving dialysis then a trough level was obtained before dialysis and sent to the laboratory stat. LPN 2 stated the pharmacy and physician got the laboratory results and determined the dose for that day and when to draw the next trough. LPN 2 stated all medications needed to have an order and a progress note. LPN 2 stated there was no concern with resident 3's vancomycin administration or obtaining trough levels. On 1/30/25 at 1:30 PM, an interview was conducted with RN 1. RN 1 stated if a resident was on vancomycin, a trough needed to be obtained after the 4th Vancomycin dose. RN 1 stated the pharmacy dosed vancomycin for resident who were were on dialysis. RN 1 stated based on the trough, the pharmacy determine the dose. RN 1 stated resident 3 was on vancomycin because she had a fistula infection. RN 1 stated resident 3 had surgery to removed the infection and was ordered vancomycin when she returned from the hospital. RN 1 stated resident 3 had troughs drawn early in the morning and usually received the results the same day. RN 1 stated she called the pharmacy with the trough results and the pharmacy provided the dose resident 3 needed. RN 1 stated resident 3 was to be administered vancomycin on her dialysis days. RN 1 stated orders for the Vancomycin were entered into resident 3's medical record and into her MAR to be marked off when it was administered. On 2/3/25 at 10:30 AM, an interview was conducted with Physician 1. Physician 1 stated he was aware resident 3 was receiving vancomycin for an infection. Physician 1 stated vancomycin needed to be administered after dialysis because it was removed by dialysis. Physician 1 stated there were challenges with getting the trough levels lined up correctly. Physician 1 stated at times, he had to make his best estimate on the dose to administer. Physician 1 stated with kidney disease and dialysis it made the dosing for vancomycin easier. Physician 1 stated elevated vancomycin levels could result in kidney damage but since resident 3 was on dialysis it was not a big concern. Physician 1 stated the main thing was to get the infection out of resident 3. Physician 1 stated resident 3's vancomycin should have been administered every other day after dialysis. Physician 1 stated he knew there were some difficulties with the lab but resident 3's dosing should not have been that difficult. Physician 1 stated the dose could have been based on the resident weight. Physician 1 stated the trough needed to be obtained to ensure there was a therapeutic level. Physician 1 stated a normal trough level was 15-20. Physician 1 stated resident 3's vancomycin levels were not toxic. On 2/3/25 at 1:11 PM, an interview was conducted with LPN 1. LPN 1 stated he knew that resident 3 was on vancomycin for a while. LPN 1 stated the vancomycin was administered on dialysis days after dialysis. LPN 1 stated resident 3 had troughs drawn before each dose or at least once per week. LPN 1 stated the nurses received the results and discussed with pharmacy on how much to administer. LPN 1 stated he did not think there were any concerns with obtaining laboratory values for resident 3. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/3/25 at 1:31 PM, an interview was conducted with the Director of Nursing (DON). The DON stated for residents who required Vancomycin, there should be a trough drawn every other dose. The DON stated if a resident was on dialysis, the pharmacy managed their Vancomycin dosing. The DON stated resident 3 was administered the vanco after dialysis and then a trough was drawn before the next dose. The DON stated dosing vanco was more tricky with dialysis. The DON stated the nurse needed to enter physician's orders according to what the pharmacy instructed. The DON stated when Vancomycin was administered there needed to be a signed physician's order and the nurse needed to initial when it was administered in the MAR. The DON stated the physician signed the orders. The DON stated resident 3 came from the hospital with a 21 day vancomycin regimen, so resident 3 should be administered the dose for 21 days based on the trough levels. On 2/4/25 at 9:16 AM, an interview was conducted with Regional Nurse Consultant (RNC) 1. RNC 1 went over the above information with the surveyor. RNC 1 stated hospital orders were 3 weeks to have Vancomycin finished on 1/23/25. RNC 1 stated there were physician's orders on the form titled Notification of Order Change and on the laboratory results form. RNC 1 stated the DON was provided emails from the pharmacy for orders of Vancomycin and troughs. RNC 1 stated there was no physician's order for the Vancomycin administered on 12/28/24. RNC 1 stated on 1/6/25 there was no laboratory results. RNC 1 stated the trough sample not picked up by lab on 1/6/25. RNC 1 stated the sample had been out to long to test so a redraw was done on 1/7/25. RNC 1 stated there was a discussion around 1/10/24 that the Unit Manager (UM) was going to contact the infectious disease (ID) physician regarding discontinuing the Vancomycin. RNC 1 stated there was no documentation regarding if the UM contacted the ID. RNC 1 stated a trough was drawn on 1/13/25 and signed by the physician on 1/14/25. RNC 1 stated there was no documentation the physician was contacted on 1/13/25. RNC 1 stated there was no physician's order for the trough on 1/20/25. RNC 1 stated for the labs on 1/22/24, the phones were having problems so the nurse contacted the DON. RNC 1 stated she was not sure if the DON contacted the physician or the pharmacy. RNC 1 stated that a trough was completed on 1/24/25 and the laboratory form was signed by the physician on 1/28 with no orders. RNC 1 stated after looking through resident 3's medical record regarding Vancomycin she had created a performance improvement plan. On 2/4/25 at 11:58 AM, a follow up interview was conducted with RNC 1. RNC 1 provided the Notification Orders Change Made dated 12/31/24 which revealed a new order to provide Vancomycin on dialysis days after dialysis. RNC 1 stated according to those orders resident 3 should have been administered Vancomycin Monday, Wednesday and Fridays after dialysis and recheck on 1/6/25. RNC 1 stated resident 3 was not administered Vancomycin on 1/1/25 or 1/3/25. 43212 2. Resident 32 was admitted to the facility on [DATE] with diagnoses that included end stage renal disease, acquired absence of left leg below the knee, dysphagia, sleep related hypoventilation, cirrhosis of the liver, osteomyelitis of the lumbar spine. Resident 32's medical record was reviewed between 1/27/25 and 2/6/25. Resident 32's physician orders dated 7/15/24 revealed, Midodrine HCl [hydrochloride] Oral Tablet 5 MG [milligram], Give 5 mg by mouth every 24 hours as needed for low b/p [blood pressure] SBP [systolic blood pressure] less than 130. A review of resident 32's MARs revealed: (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. The December 2024 MAR revealed administration of Midodrine 5 mg on 12/31/24 at 7:44 AM. b. The January 2025 MAR revealed administration of Midodrine 5 mg on 1/3/25 at 7:10 AM, 1/29/25 at 6:17 AM, and 1/31/25 at 9:52 AM. Resident 32's progress notes revealed: a. On 12/31/24 at 7:44 AM, an orders-administration note revealed, Midodrine HCl Oral Tablet 5 mg; Give 5 mg by mouth every 24 hours as needed for low b/p SBP less than 130. Midodrine given per dialysis request. bp 90/60. b. On 1/3/25 at 7:10 AM, an Orders-administration note revealed, Midodrine HCl Oral Tablet 5 mg; Give 5 mg by mouth every 24 hours as needed for low b/p SBP less than 130. c. On 1/20/25 at 4:00 PM, a nursing progress note revealed, Resident is hypotensive during dialysis even with prn [as needed] medications. tolerated HDTX [hemodialysis treatment] with no other complications. d. On 1/29/25 at 6:17 AM, an Orders-administration note revealed, Midodrine HCl Oral Tablet 5 MG; Give 5 mg by mouth every 24 hours as needed for low b/p SBP less than 130. given to dialysis RN [registered nurse] due to low b/p during treatment. Dialysis communication documentation returned with resident 32 revealed: a. On 12/31/24, Patient condition or events during/post dialysis: The patient tolerated HDTX w/o [without] complications. b. On 1/3/25, Patient condition or events during/post dialysis: The patient tolerated HDTX w/o complications. c. On 1/20/25, Pt [patient] is hypotensive during the tx [treatment] even w [with]/taking PRN med [medication] and tolerated HDTX w/o other complication. (systolic BP 90'ish) [It should be noted there was no medication administration documented on resident 32's MAR.] d. On 1/29/25, Pt was hypotensive for 2 hrs [hours] but tolerated HDTX without other complications. (8-10 AM). [Resident 32] was hypotensive even taking PRN med Midodrine. On 1/28/25 at 3:00 PM, an interview was conducted with LPN 1 who stated he did not provide resident 32 with Midodrine every day, only if resident 32's blood pressure dropped during dialysis. LPN 1 stated if resident 32's blood pressure dropped while receiving dialysis, the dialysis nurse called and requested the nurse bring the medication down and administer it. LPN 1 stated after resident 32 finished dialysis, he returned to the resident area with a report stating what his blood pressure was. LPN 1 stated he had not provided Midodrine to resident 32. LPN 1 stated the Certified Nursing Assistants [CNA]s completed vital signs on residents and gave the results to the nurse on duty. LPN 1 stated if there was a question about a blood pressure he would check it himself. LPN 1 stated when, on 1/23/25, resident 32's blood pressure was 110/55 mmHg [millimeters of mercury] and he asked resident 32 how he was feeling before providing the medication. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/28/25 at 3:18 PM, an interview was conducted with the DON who stated resident 32 was a dialysis patient and the order for Midodrine was for dialysis. The DON stated the nurses looked at the resident's dialysis communication form and talked with the resident before providing Midodrine. The DON stated, [resident 32] knows how he feels. The DON stated on non-dialysis days, resident 32's blood pressure was not checked so staff went by how the resident stated they felt. The DON stated the order for Midodrine was not an every day order. The DON stated if the dialysis center requested the Midodrine for resident 32, the nurse would provide it and document it in a progress note. On 2/5/25 at 8:47 AM, an interview was conducted with the Dialysis Registered Nurse [DRN] who stated resident 32's vital signs were kept in her computer system in dialysis. The DRN stated if resident 32's blood pressure was low, she would call upstairs to the nurse on duty and request they bring a Midodrine down to resident 32. The DRN stated the nurses were 100% responsive administering Midodrine when she called and resident 32 was 100% compliant in taking it.

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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** 30563 Based on interview and record review it was determined, for 1 of 33 sampled residents, that the facility did not provide or obtain timely laboratory (lab) services to meet the needs of its residents. Specifically, a resident's vancomycin trough was not obtained timely. Resident identifer: 3. Findings include: Resident 3 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included infection and inflammatory reaction due to other cardiac and vascular devices, Methicillin-resistant Staphylococcus aureus (MRSA), and end stage renal disease with dialysis. Resident 3's medical record was reviewed 1/27/25 through 2/6/25. There was a physician's order dated 1/6/25 for vanco trough level before dialysis. A review of the medical record revealed no vanco trough results. A physician's progress note dated 1/6/25 and signed by the physician on 1/7/25 at 6:15 PM revealed Later in the evening, there was an issue with her vancomycin dosing, unable to ascertain her vancomycin level at the moment but needing a vancomycin dose after dialysis today. She was given 1 g [gram] of IV [intravenous] vancomycin based on prior dose of 1.5 g, with emphasis to obtain vancomycin level as soon as possible so as to allow proper dosing. A nursing note dated 1/7/25 at 2:07 AM reveled that there was an order for vanco trough on 1/6. There were no results for the day and the night shift nurse called the physician because the pharmacy would not order a dose without a vanco level. The physician gave an order for a 1 time dose of Vanco 1 gram/200ml [milliliter] normal saline over 1 hour via PICC. The dose was administered at 7:45 PM on 1/6/25. A nursing note dated 1/7/25 at 4:44 PM revealed, vanco trough results were 24.3. The pharmacy recommended to hold vanco 1/8 and redraw on 1/9. On 1/29/25 at 9:35 AM, an interview was conducted with Registered Nurse (RN) 2. RN 2 stated resident 3's vancomycin dosing and trough levels were not drawn according to physicians orders. On 2/4/25 at 9:16 AM, an interview was conducted with Regional Nurse Consultant (RNC) 1. RNC 1 stated on 1/6/25 there was no laboratory results. RNC 1 stated the trough sample was not picked up by lab on 1/6/25. RNC 1 stated the sample had been out to long to test so a redraw was done on 1/7/25. RNC 1 stated after looking through resident 3's medical record regarding Vancomycin she had created a performance improvement plan.

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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. 43212 Based on observation, interview and record review it was determined, for 5 of 33 sampled resident, the facility did not provide food prepared by methods that conserve flavor and appearance or provide food and drink that was palatable, attractive, and at an appetizing temperature. Specifically, there were multiple complaints from residents about palatable and cold food. There were observations of no plate warmers and there were resident complaints about cold food in the resident council minutes. Resident identifiers: 26, 28, 29, 33 and 34. Findings include: On 1/27/25 at 9:56 AM, an interview was conducted with resident 33 who stated breakfast and lunch were ok, but the dinner meal needed improvement. Resident 33 stated residents were getting a lot of sandwiches and hamburgers. On 1/27/25 at 11:10 AM, an interview was conducted with resident 34 who stated the food was not always good. Resident 34 stated the evening meal was mostly sandwiches. On 1/27/25 at 2:16 PM, an interview was conducted with resident 26. Resident 26 stated the food was not good. Resident 26 stated the scrambled eggs were smashed eggs and he did not like it. On 1/27/25 at 9:45 AM, an interview was conducted with resident 29. Resident 29 stated the food was not warm. Resident 29 was observed to be eating breakfast. There was no warmer under the plate. Resident 29 stated they did not usually send the trays with the warmer. Resident 29 stated the other night she had warm food when her tray was sent with the warmer. Resident 29 stated she was told by kitchen staff that to use the warmers, it would take the facility staff more than 5 hours for each meal. On 1/27/25 at 9:45 AM, an interview was conducted with resident 28. Resident 28 stated the food was delivered cold, often for dinner and on the weekends because the plate warmers were not being used. On 1/28/25 at 3:07 PM, a follow up interview was conducted with resident 28. Resident 28 stated the roasted turkey that was served at lunch was sliced deli meat. Resident 28 stated the pork and beef were so tough, they could not be chewed. Resident 28 stated the meats were over cooked and vegetables were under cooked. On 1/27/25 during the lunch meal service an observation was made of the hallway trays. There were no warmers under the plates on the trays. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/4/25 at 11:37 AM, an observation was made in the kitchen of [NAME] 1 preparing the lunch meal which consisted of meatballs in cream sauce, mashed potatoes with brown gravy, peas and carrots, a slice of bread and a cup of crushed pineapple. An observation was made of a stack of plate warmers on the food preparation table near where the meal was being plated. An interview was conducted with [NAME] 1. [NAME] 1 stated he had already heated up the plate warmers and they were ready to be used for the lunch meal. [NAME] 1 picked up a plate warmer and stated, here, test it. The surveyor touched the plate warmer and it warm to the touch. At 11:51 AM, [NAME] 1 was observed to put a scoop of mashed potatoes on the plate, followed by a small ladle of brown gravy. A scoop of peas and diced carrots was put on the plate, then 3 meatballs with a small amount of cream sauce. A slice of white bread was put on top of the food on the plate. Some plates were covered without a plate warmer on the bottom. Those plates were put on a kitchen rack, other plates were put on a plate warmer, then covered the plates with a dome and put in a meal cart. It was noted that several meals were plated without plate warmers and put on the kitchen rack before meals were placed into the hall carts and sent out. On 2/4/25 at 12:03 PM, the kitchen rack was wheeled into the dining room. On 2/4/25 at approximately 12:05 PM, the first hall cart left the kitchen for the 400 hallway, followed by the 100 hall cart. The 300 hall cart was the last to leave the kitchen. On 2/4/25 at 12:14 PM, a test tray was requested. At 12:15 PM the meal was put onto the 300 hall cart as it left the kitchen. An observation was made that the 100 hall cart had not been picked up when the 300 hall cart left for the hallway. On 2/4/25 at 12:24 PM, the test tray was removed from the 300 hall cart. On 2/4/25 at 12:25 PM, the following observations were made of the lunch meal which had a variation of color on the plate and a nice presentation: a. Meatballs with cream sauce-132.6 degrees Fahrenheit. The meatballs were well seasoned with a pleasing flavor, and were warm to the taste. b. Mashed potatoes with brown gravy-147.4 degrees Fahrenheit. The potatoes were warm to the taste, soft and a pleasant flavor. c. Peas and diced carrots-132.4 degrees Fahrenheit. The vegetables were easy to chew, not over cooked, and not mushy. d. Slice of white bread-was dry and stale to the taste. e. Crushed pineapple-47.8 degrees Fahrenheit. The pineapple tasted like canned pineapple. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/6/25 at 9:14 AM, an interview was conducted with the Dietary Manager (DM) who stated plate warmers were used for all meals unless the meal was a cold meal. The DM stated the plates were stored in the plate warmer between meals, and at approximately 11:20 AM, the cook would start warming up the plate holders for the meal. The DM stated the majority of cold food complaints came from the weekend. The DM stated the cook who worked on the weekends was not using the plate warmers because of laziness. The DM stated he and the Administrator had been checking in on the weekends to ensure the cook was using the plate holders. The DM stated the cook took the temperature of the food right after it came out of the oven and before it went on the steam table. The DM stated as long as the steam table was on, the food should stay hot and could stay there a while. The DM stated he had attended resident council when he was invited. The DM stated if he did not go, the information from the resident council was passed on to him by another staff member. The DM stated after receiving a resident complaint, he would go to visit with the resident. The DM stated he also attended the quarterly meetings with residents to follow-up on any complaints they might have or address any concerns. The DM stated he wanted to make sure the residents were satisfied. The DM stated he also liked to meet with resident's family members as he was able to find things out that the resident might not tell him, such as dislikes or preferences. 50200 A review of the facility's resident council meetings revealed: a. August 2024: .Action Items-Grievances to Follow-Up -cold food-ongoing issue . Dietary: -cold food . b. September 2024: .OLD BUSINESS .cold food-educated weekend staff . Dietary: cold veggies on Sept [September] 25th lunch .Concern/Problem Cold Veggies on Sep [September] 25th lunch in dining room . Resolution ok . c. November 2024: .Action Items-Grievances to Follow-Up .cold food .Dietary: Food cold on weekends + [and] weekdays . d. December 2024: .Action Items- Grievances to Follow-Up .Food temp [temperature] .Dietary: -not reading meal tickets -Food temp- use plate warmers . e. January 2025: .Concern/Problem Report of cold food . 30563 48709

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30563 Based on observation, interview and record review it was determined, for 2 of 33 sampled residents, that the facility did not ensure the facility provided each resident with food prepared in a form designated to meet their individual needs. Specifically, thickened beverages were not prepared according to the recipe. Resident identifiers: 2 and 4. Findings include: 1. Resident 4 was admitted to the facility on [DATE] with diagnoses which included dysphagia, intellectual disabilities and cognitive communication deficit. Resident 4's medical record was reviewed 1/27/25 through 2/6/25. A physician's order dated 6/24/24 revealed regular diet, pureed, nectar/mildly thick consistency. 2. Resident 2 was admitted to the facility on [DATE] with diagnoses which included multiple sclerosis, dysphagia and cognitive communication deficit. Resident 2's medical record was reviewed 1/27/25 through 2/6/25. A physician's order dated 6/24/24 revealed Resident is on thickened liquids two times a day for dysphagia. A physician's order dated 11/27/24 revealed regular pureed texture with nectar/mildly thick consistency. A Speech Language Pathology (SLP) Discharge Summary dated 5/31/21 revealed no information regarding swallowing. Resident 2 was provided cognitive treatments. On 1/27/24 at 11:58 AM, an observation was made of the lunch meal in the dining room. Resident 2 and resident 4 were observed in the dining room. Resident 4 and resident 2 were observed with beverages that were not thick. On 1/27/25 at 12:32 PM, an interview was conducted with the Dietary Manager (DM). The DM stated the Dietary Aides (DA) thickened the liquids the day before. The DM stated the liquids provided to residents for lunch would have been made the night before so they thickened in the refrigerator. An observation was made of DA 1 preparing thickened beverages. DA 1 stated she was not sure how big the cups were and she thought they were 4 ounces (oz). DA 1 was observed to ask DA 2 how big the glasses were and he stated 6 oz. DA 1 was observed to use 1 pump of liquid thickener for the 6 oz. DA 1 was observed to stir the liquid for about 10 seconds, placed a lid on it and wrote an N on it. DA 1 stated she then put the date and drinks into the refrigerator to use the next day. The liquid thickener bottle was observed and revealed the following: (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Slightly thick use 1 pump for 6 oz of liquid b. Mildly thick/nectar use 1 pump for 4 oz of liquid or 2 pumps for 8 oz of liquid c. Honey thick 2 pumps for 4 oz of liquid and 4 pumps for 8 oz of liquid. Follow usage chart. Dispense appropriate amount of [thickener] get into beverage. Stir briskly for 30 seconds. It should be noted the beverages were made slightly thick and were not stirred for 30 seconds. On 2/6/25 at 10:18 AM, an interview was conducted with the Director of Rehab (DOR). The DOR stated resident 4 was never provided SLP services while a resident at the facility. The DOR stated resident 2 was not provided services since 2021 and they were for cognition and not swallowing. On 2/6/25 at 11:58 AM, an interview was conducted with SLP 1. SLP 1 stated mildly and nectar thick liquids were the same. SLP 1 stated residents with dysphagia and ordered mildly thick/nectar thick should be served thicker rather than thinner to prevent aspiration. SLP 1 stated mildly/nectar thick were similar textures to tomato juice. SLP 1 stated the facility staff should be following the instructions on the container. SLP 1 stated the beverage needed to be mixed for one minute before serving. 43212 On 2/6/25 at 9:14 AM, an interview was conducted with the DM who stated the dietary aides had been trained on how to thicken the liquids for those residents who required thickened liquids. The DM stated the bottles of liquid thickener had a list on the bottle of how much of the thickener should go in depending on the quantity of liquid. The DM stated the dietary aide looked at the bottle of thickener before thickening the liquids to make sure the correct amount of thickener was used. The DM stated he did not know if the dietary aides could interpret what the consistency was supposed to look like. The DM stated if liquid was not thickened appropriately, it could result in a choking hazard to the resident or aspiration pneumonia. The DM stated he had not had any residents develop aspiration pneumonia.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43212 Based on observation and interview it was determined the facility did not store, prepare, distribute and serve food in accordance with professional standards for food service safety. Specifically, food items in the reach in refrigerator were open to air and not labeled, food items in the walk in refrigerator were past the use-by date, frozen food in the walk-in freezer were open to air, food items in the kitchen were open to air, and the kitchen was unclean. Additionally, there were no test strips to ensure the sanitation bucket had the correct amount of sanitizer in it and the Dietary Manager (DM) was not wearing a beard guard while in the kitchen. Findings include: On 1/27/25 at 8:42 AM, an initial kitchen walk-through was conducted. The floors under the stove and oven were observed to have crumbs and food particles underneath, the microwave had a brown substance spilled inside, the top of the dish machine had crumbs on it. There was food splatter on the wall behind one of the food preparation tables, a mop head was on the floor under the steam table. The garbage was overflowing near the DM's desk, and there were no paper towels in the dispenser by the sink. On 1/27/25 at 8:50 AM, observations were made in the food storage areas. In the reach-in refrigerator, there was no thermometer to confirm the temperature inside. A container of vegetable base was open and not covered. A dish of shredded cheese, covered in plastic wrap, was not labeled. Six separate cuts of meat were wrapped in plastic wrap but were not labeled and dated. Two packages of white cheese were not labeled, a package of yellow cheese was wrapped in plastic wrap and not labeled, a bag of [NAME]/cheddar cheese mix was open to air and not labeled, a bag containing boiled eggs was not labeled, a container of lemon juice had a use by date of 1/3/25, a container of sweet and sour sauce was open with no lid on it, and a box of green peas was open to air. The reach-in freezer did not have a thermometer in it. The temperature outside the unit read -4 degrees Fahrenheit. On 1/27/25 at 9:05 AM, the DM was observed to check the sanitation bucket. The DM obtained a testing strip and dipped it into the sanitation bucket. After holding in the water for a few seconds, the test strip revealed no result. The DM tried another strip with no result. The strips were for the dish machine. The DM stated the sanitation bucket was changed at 5:30 AM. The DM stated he did not have the correct strips to check the sanitation buckets citing budgetary constraints and not being allowed to order more strips. On 1/27/25 at 9:09 AM, an observation was made of a food storage shelf above a food preparation area. A box of cornbread mix was open to air. A box of cream of wheat was open to air. On 1/27/25 at 9:15 AM, an observation was made in the walk-in freezer. A box of chocolate chips was open to air and a box of frozen ravioli was open to air. In the walk-in refrigerator, 5 gallon jugs of fat free milk were found to be past the use by date of 1/22/25. In the dry storage room, cans of diced pears were not dated. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	It should be noted that temperature logs had been completed for future dates and times for the storage areas in the basement of the building, and there were several days on the dish machine temperature log that had not been completed. On 1/27/25 at 11:25 AM, an observation was made of [NAME] 1. [NAME] 1 was wiping down a food cart with a rag from the sanitation bucket. [NAME] 1 stated he had just put fresh water into the bucket. [NAME] 1 checked the bucket again with the strips from the dish machine and obtained no reading. On 1/27/25 at 11:54 AM, an interview was conducted with the DM who stated [chemical supplier] had not been to the facility for service since November 2024. The DM stated he was very restricted as to what he was allowed to order. The DM stated he gets in trouble when he orders from [chemical supplier]. The DM stated he was required to order supplies from another supplier. The DM stated he had ordered new thermometers for the reach in refrigerator, but had not yet received them. On 1/27/25 at 2:11 PM, an interview was conducted with the DM who stated he conducted his own audits of the kitchen each Monday. The DM stated he threw the milk away from the walk-in refrigerator, and had found the thermometer in the reach in refrigerator which had fallen to the back behind food items. On 2/4/25 at 11:37 AM, a second walk-through was conducted in the kitchen. In the reach-in refrigerator, a box of cookies was open to air. In the reach-in freezer, a box of peas and carrots was open to air. There was no thermometer in the reach-in freezer. On the shelf above one of the food preparation areas, a box of corn bread mix was open to air, a box of cream of wheat was open to air, a box of corn starch was open to air. Food crumbs were observed to be under the oven and stove. On 2/6/26 at 8:57 AM, an observation was made of the food storage areas in the basement. The walk-in freezer was observed to have chocolate chip cookie dough open to air, a box of frozen peas was open to air, a box of frozen broccoli was open to air, a box of dinner rolls was open to air. In the walk-in refrigerator, a large box of zucchini was found to be moldy. On 2/6/25 at 9:14 AM, an interview was conducted with the DM who stated his expectation for food being placed back into the refrigerator or freezer after partial use was that it be labeled and dated. The DM stated he was out a lot for the month of January so he was not checking the storage areas as frequently as he usually did. The DM stated the Regional Dietitian (RD) usually came to do monthly audits in the kitchen, but left last November so there had been no audits completed. The DM stated the consultant RD was the only dietitian he was working with. The DM stated the RD did her first audit on 2/4/25 and had not been informed the regional RD was not with the company. The DM stated he had taken some disciplinary action against the kitchen staff for the lack of meeting expectations to make sure they know what they should be doing and were doing it. The DM stated for the aids, it was likely lack of knowledge, and stated for the cooks, it was laziness. The DM stated kitchen staff should be wearing standard attire in the kitchen which included a hairnet or hat, gloves when washing dishes, and changing gloves between handling different food items. The DM stated any time a staff member went past the yellow line in the kitchen, a hair net was required. The DM stated he still did not have the correct strips to check the sanitation buckets. The DM stated the consequence of not knowing if the sanitation bucket contained the right amount of sanitizer was there was a possibility of food bourne illness and cross contamination. The DM stated food in storage areas that was open to air did not last as long and the quality not as good.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30563 Based on observation, interview and record review it was determined, for 3 of 33 sampled residents, that the facility did not maintain medical records on each resident that was complete; accurately documented; readily accessible; and systematically organized. Specifically, a resident's wound orders were not the same as the wound orders documented by the Wound Physician Assistant, Certified (PA-C) and resident shower sheets were not in their medical records. Resident identifiers: 3, 6, and 293. Findings include: 1. Resident 6 was admitted to the facility on [DATE] with diagnoses which included type 2 diabetes mellitus with hyperglycemia, major depressive disorder, generalized anxiety, scoliosis and chronic pain. On 2/5/25 at 10:51 AM, an observation was made of resident 6's leg with the Wound PA-C and Registered Nurse (RN) 1. There were 2 dressings on his left lower extremity. Resident 6's medical record was reviewed 1/27/25 through 2/6/25. A current physician's order dated 1/24/25 revealed Wound to left lower leg: cleanse w/ [with] wound cleanser, apply collagen to open areas, cover w/ border foam. Change every other day et [and] prn [as needed]. every day shift every other day. According to the January 2025 Treatment Administration Record (TAR) the dressings were changed on 1/24/25, 1/26/25, 1/28/25 and 1/30/25, 2/1/25, 2/3/25, 2/5/25. A progress note from the Wound PA-C revealed on 1/22/25 an order to Remove dressing (if applicable), cleanse wound per standard wound care protocol and apply the following order: Apply to peri-wound: A&D ointment Apply to wound bed: Collagen Cover with: Ca Alg [Calcium Alginate] Secure with rolled gauze Treatment frequency QOD [every other day] and prn if soilked [sic] or dislodged dressing. A progress note from the Wound PA-C revealed on 1/29/25 an order to Remove dressing (if applicable), cleanse wound per standard wound care protocol and apply the following order: Location: Apply to peri-wound: A&D ointment Apply to wound bed: Place collagen and covered Dressing on open wounds. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Apply betadine to scabbeed [sic] areas Cover with: rolled gauze Secure with: N/A [not applicable] Treatment frequency: QOD and PRN if soilked [sic] or dislodged dressing. The Wound Nurse Progress Note dated 1/29/25 revealed the wounds were getting smaller. On 2/5/25 at 9:17 AM, an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated that the Director of Nursing (DON) was the facility wound nurse. LPN 1 stated if he had any questions, then he asked the DON. On 2/5/25 at 9:59 AM, an interview was conducted with the DON. The DON stated there was a wound specialist that came to the facility weekly. On 2/5/25 at 10:01 AM, an interview was conducted with the Wound PA-C. The Wound PA-C came to the facility weekly and looked at the wounds with the nurse or the DON. The Wound PA-C stated she documented on the wound and provided new orders to nurse or DON and then her Medical Assistant sent her notes to the DON. The Wound PA-C stated resident 6 had a venous stasis ulcers on his left lower extremity. The Wound PA-C stated the order she provided on 1/22/24 was Scabbed area with betadine to try and dry up the scabs to fall off. The Wound PA-C stated as the venous stasis ulcer starts to heal, it will start to dry out so she wanted to have A&D ointment on the peri wound. On 2/6/25 at 11:45 AM, an interview was conducted with the DON. The DON stated the physician's order that was on the TAR was not the same order as the Wound PA-C documented. The DON stated the orders needed to match. 2. Resident 3 was admitted to the facility on [DATE] with diagnoses which included infection and inflammatory reaction due to other cardiac and vascular devices, end stage renal disease with dialysis, Methicillin-resistant Staphylococcus aureus, surgical after care following surgery on the circulatory system, diabetes mellitus and Alzheimer's disease. On 1/27/25 at 2:47 PM, an interview was conducted with resident 3. Resident 3 stated she got showers once a week but would like them twice a week. Resident 3's medical record was reviewed 1/27/25 through 2/6/25. The Lead Certified Nursing Assistant (CNA) provided forms titled Shower Sheet revealed resident 3 was showered on 12/4/24 and 12/18/24. There was a Shower Sheet for 12/21/24 which revealed resident 3 was in the hospital. Resident 3 refused a shower on 1/4/25, 1/8/25 and 1/22/25. Resident 3 was showered on 1/11/25, 1/15/25 and 1/18/25. The forms were not in resident 3's medical record. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/28/25 at 4:11 PM, an interview was conducted with the Lead CNA. The Lead CNA stated if a resident refused a shower, then the resident signed a Shower Sheet along with the nurse and CNA. The Lead CNA stated Shower Sheets were completed after each shower and then provided to her or the medical records staff member. The Lead CNA stated the shower sheets were then put into a file on her computer. On 2/4/25 at 12:52 PM, an interview was conducted with the Director of Nursing (DON). The DON stated there was a shower sheet that was completed by CNA's. The DON stated CNA's documented showers and refusals in the tasks section and on a Shower Sheet. The DON stated the Shower Sheet went to the Lead CNA and were uploaded into a file on her computer. The DON stated the Shower Sheets were not added to the resident's medical record. 50200 3. Resident 293 was admitted to the facility on [DATE] with diagnoses which included displaced intertrochanteric fracture of left femur, other toxic encephalopathy, major depressive disorder, muscle weakness, and need for assistance with personal care. On 1/27/25 at 10:24 AM, an observation and interview were conducted with resident 293. Resident 293 was observed to be wearing a hospital gown and had a hospital identification bracelet on his right arm with a date of service of 1/14/25. Resident 293 stated that he had not received a shower since he arrived at the facility and had to give himself a whores bath. Resident 293 stated that a whores bath consisted of him washing his armpits and genitals with some bottled water that he had. Resident 293 stated that he had tipped over his urinal the night before and had soaked himself and his bed sheets with urine. A review of resident 293's medical record was reviewed 1/27/25-2/6/25. Resident 293 was scheduled to receive showers on Mondays and Thursdays. The tasks section of resident 293's medical record revealed that he received a shower on 1/27/25 at 12:35 PM. A review of resident 293's shower sheets revealed the following: a. On 1/16/25 a shower was refused b. On 1/20/25 there was no shower sheet provided c. On 1/23/25 a shower sheet documented that resident 293 received a shower the previous morning. There was no documentation to confirm this. d. On 1/27/25 a shower was completed There was no other documentation to confirm additional showers were provided to resident 293. There were no shower sheets located in resident 293's medical record. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/28/25 at 3:48 PM, an interview was conducted with the Lead CNA. The [NAME] CNA stated resident 293 had a shower on 1/27/25. The Lead CNA stated resident 293 was scheduled for showers on Mondays and Thursdays. The Lead CNA stated she did not have resident 293 on the schedule for a shower on 1/20/25. The Lead CNA stated she did not have any other shower sheets which documented whether resident 293 had received or refused a shower, but would look through her stack of papers and provide them if located. The Lead CNA stated the shower sheets were scanned by medical records into a file.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 30563 Based on interview, observation and record review, the facility did not ensure that policies were established and implemented to ensure that identified quality deficiencies were corrected. Specifically, areas of immediate jeopardy (IJ) and harm were identified and not identified through the Quality Assurance and Performance Improvement (QAPI) process. Findings include: 1. There was noncompliance identified at an IJ level for residents who were not assessed for smoking safety. A resident was observed to have a burn hole in his pants. 2. There was noncompliance identified at a harm level for residents who experienced falls without updated interventions. Resident's sustained a injuries. 3. There was noncompliance identified at a harm level for a resident who was placed under an alarming call light system. The resident was also not allowed to go into his room. 4. There was noncompliance identified at a harm level for a resident who was not provided person centered care for mental disorders. Administration caused unnecessary psychological harm to a resident. 5. There was noncompliance identified at a harm level for a resident who did not receive treatment for a Urinary Tract Infection. In addition, the facility did not have a bowel and bladder retraining program. On 2/6/25 at 3:25 PM, an interview was conducted with the Administrator (ADM). The ADM stated QAPI meetings were done monthly. The ADM stated that there was no December 2024 meeting because he had just started. The ADM stated the last QAPI was January 20 or 21st of 2025. The ADM stated trends were looked at for QAPI to determine what areas needed to be improved. The ADM stated he had not been at the facility long enough to determine trends. The ADM stated each department was in charge of presenting information. The ADM stated if there was a concern, then it was talked about and a power point presentation was developed. The ADM stated the QAPI team then determined what needed to happen before the next meeting. The ADM stated the Regional Nurse Consultant knew how to develop performance improvement plans (PIP) but he did not know how. The ADM stated smoking, bowel and bladder, and caring for residents with behavioral health were not discussed. The ADM stated cold food was discussed and grievances in the meeting. The ADM stated falls were discussed in the meeting as far as how many if if there were repeat falls. The ADM stated he felt like there was a good plan in place for falls.

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Sandstone North Park	350 South 400 East Bountiful, UT 84010

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50200 Based on observation and interview it was determined, for 11 of 33 sampled residents, the facility did not establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Specifically, enhanced barrier precautions (EBP) were not implemented for residents, the infection prevention and control program was not reviewed annually, there was no documentation for the testing of Legionella. Additionally, observations were made of a nurse was observed to handle resident's medications with bare hands and a staff member who did not perfor hand hygiene during meal service. Resident identifiers: 2, 3, 4, 5, 6, 9, 18, 25, 26, 31 and 32. Findings included: EBP 1. Resident 5 was admitted to the facility on [DATE] with diagnoses which included, paraplegia, stage 4 pressure ulcers of the right and left buttocks, stage 4 pressure ulcer of sacral region, type 2 diabetes, and unspecified severe protein-calorie malnutrition. On 1/27/25 at 9:28 AM, an observation was made of resident 5's room. There was no Personal Protective Equipment (PPE) inside or outside of the room and no EBP signage. On 1/28/25 at 12:35 PM, an observation was made of resident 5's room. Resident 5 had a small cart with PPE located directly outside her room and an EBP sign was on the door. A review of resident 5's care plan revealed that resident 5 had chronic wounds, a colostomy, suprapubic catheter, and PEG (percutaneous endoscopic gastrostomy) tube for enteral feeding. On 2/4/25 at 10:16 AM, an interview was conducted with the Unit Manager/Infection Preventionist (UM/IP). The UM stated EBP went into effect for the facility on 1/1/25. The UM stated EBP was used for any residents that had an indwelling device or wounds. The UM stated all residents who required EBP should have orders for EBP. The UM stated EBP was not implemented in the facility prior to last week. On 2/4/25 at 12:46 PM, an interview was conducted with the Director of Nursing (DON). The DON stated EBP was started in the facility last week. The DON stated staff were educated about EBP last week in person and by phone. The DON stated it was the job of the infection preventionist to make sure EBP was done in the facility. 2. Resident 3 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included infection and inflammatory reaction due to other cardiac and vascular devices, Methicillin-resistant Staphylococcus aureus and end stage renal disease. On 1/27/25, 1/28/25, 1/29/25, 1/30/25, 2/3/25 and 2/4/25, observations were made of resident 3's room. There was no signage or EBP outside or inside the room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 3's medical record was reviewed 1/27/25 though 2/6/25. Resident 3 had a physician's order which revealed to monitor dialysis catheter every shift for potential complications and signs and symptoms of infection. Another physician's order revealed to place a PICC (peripherally inserted central catheter) or midline one time for antibiotics on 12/28/24 and it was discontinued on 1/29/25. There were no physician's order for EBP. 3. Resident 6 was admitted to the facility on [DATE] with diagnoses which included type 2 diabetes mellitus with hyperglycemia, vascular wounds, muscle weakness, major depressive disorder and anxiety disorder. On 1/27/25, 1/28/25, 1/29/25, 1/30/25 and 2/3/25 observations were made of resident 3's room. There was no signage or EBP inside or outside resident 3's room. Resident 6's medical record was reviewed 1/27/25 through 2/6/25. A physician's order dated 1/24/25 revealed there was a wound to the left lower leg. A physician's order dated 2/4/25 revealed Isolation: enhanced barrier precautions (wounds to left lower leg). On 1/29/25 at 9:25 AM, an interview was conducted with Registered Nurse (RN) 2. RN 2 stated she went into work on 1/28/25 and there were signs on resident room about EBP for residents with feeding tubes, catheters, and IV's (intravenous therapy). RN 2 stated she was not sure why resident 3 did not have EBP because she had a midline and a dialysis catheter. RN 2 stated CNA's were asking question on what EBP was because staff had not received training. RN 2 stated she was not sure what to do with the EBP because she had not been provided training. On 2/4/25 at 8:08 AM, an interview was conducted with CNA 4. CNA 4 stated there were signs outside the residents door if a resident needed isolation precautions. CNA 4 stated she was not caring for anyone with isolation precautions. CNA 4 stated she was not aware of EBP and did not know what she would need to wear. CNA 4 was taking care of the 300 hallway where resident 3 resided. On 2/3/25 at 3:15 PM, an interview was conducted with the Lead CNA. The Lead CNA stated EBP was required by the state anytime staff were cleaning something that went into a residents body, like a site. The Lead CNA stated resident 5 did her own stuff so no one needed to wear gown or gloves. The Lead CNA stated resident 6 and resident 3 did not have EBP. The Lead CNA stated that resident 6 had wounds on his legs and resident 3 had a surgical wound. On 2/4/25 at 12:48 PM, an interview was conducted with the Director of Nursing (DON). The DON stated resident 3 needed EBP because of her dialysis catheter. The DON stated resident 6 needed to be on EBP because of his wounds. On 2/6/25 at 9:19 AM, an interview was conducted with the UM. The UM stated the infection control and prevention program was not reviewed annually in 2024. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility Infection Prevention and Control policy on EBP adopted 5/1/24 documented: POLICY: It is the policy of this facility to use Enhanced Barrier Precautions (EBP) to expand the use of PPE and to refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of Multi-Drug Resistant Organisms (MDROs) to staff hands and clothing. MDROs may be indirectly transferred from resident to resident during these high-contact care activities. Residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs. The use of gown and gloves for high-contact resident care activities is indicated, when Contact Precautions do not otherwise apply for residents with wounds and/or indwelling medical devices regardless of MDRO colonization as well as for residents with MDRO infection or colonization . Legionella Testing On 2/5/25 at 9:09 AM, an interview was conducted with the Administrator (ADMIN). The ADMIN stated it was the Director of Maintenance (DOM) who was in charge of water management for the facility. On 2/5/25 at 12:20 PM, an interview was conducted with the DOM. The DOM stated he tested the water monthly for the presence of chlorine that would prevent Legionella in the water. The DOM stated he did not have any results, documentation, or logs recording the results of testing that was completed. Medication Administration Observation On 1/28/25 at 7:40 AM, an observation was made of Licensed Practical Nurse (LPN) 1 placing resident 3's medications directly into bare hands before transferring them into a medication cup. On 1/28/25 at 7:55 AM, an observation was made of LPN 1. LPN 1 popped resident 4's divalproex out of blister pack into their bare hand before placing it into a medication cup. While preparing medications to be crushed, LPN 1 removed the divalproex from the medication cup with bare hand, opened capsules, and poured the contents into a Keppra solution medication cup. On 1/28/25 at 8:15 AM, an observation was made of LPN 1. LPN 1 popped resident 26's carbamazepine out of blister pack into bare hand before placing it into a medication cup. The LPN then opened a bottle of acetaminophen, poured the tablets into bare hand, and placed them into the medication cup. On 1/28/25 at 8:25 AM, an observation was made of LPN 1 popping resident 32's omeprazole out of blister pack into bare hand before placing it into a medication cup. On 1/28/25 at 8:44 AM, an observation was made of LPN preparing medications for resident 9 when a gabapentin landed on top of the medication cart. The LPN picked medication up with a bare hand and placed it into the medication cup. 30563 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dining Observation On 1/27/25 at 11:59 AM, a dining observation was made of in the dining room. The Lead CNA was observed to touch resident 18's utensils, then picked up cups, touched the beverage containers, filled up the cups, provided the cups to resident 25 and then touched the seat of a stool and wheeled the stool next to resident 18, then touched resident 18's utensils, then cleaned resident 18's hands with wipes, touched the door handle to the kitchen, obtained a new spoon from the kitchen, touched a residents mug around the rim, fed resident 18 with the spoon, obtained a mug from the kitchen, picked up the beverage containers to fill the mug and gave the mug to a resident. The Lead CNA continued to touch resident's and their wheelchair handles, touched the door knob to the kitchen, touched the rim of a mug with coffee and gave it to resident 31. The Lead CNA was observed to touch resident 25, then the seat of the stool, her cell phone, resident 18's silverware, fed resident 18, touched a cabinet under the radio, touched the door handle to the kitchen, fed resident 18, picked up a cup, touched the beverage containers, filled the cup, gave the cup to another resident, touched the seat of the stool, picked up resident 4's drink by the rim, fed resident 4, touched resident 2's tray, put his napkin in his shirt, arranged his food closer to him and fed resident 18 without hand performing hygiene. 43212 47431

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide behavior health training consistent with the requirements and as determined by a facility assessment. 48709 Based on interviews and record reviews it was determined the facility failed to provide behavioral health training as determined by the facility assessment. Specifically, 4 staff members did not receive behavioral health training. Findings include: A review of the Facility Assessment Sandstone North Park, dated 5/20/24, indicated, a Resident Profile that reflected the facility's resident population included, Psychiatric /mood disorders [with common diagnoses of:] Psychosis (hallucinations, delusion, etc.), alterations in cognition, mental disorder, depression, manic depression, schizophrenia, post-traumatic stress disorder [PTSD], anxiety, behavioral expressions that need intervention. It further indicated, Services and Care We Offer Based on our Residents' Needs .Types of Care: Behavioral health. Specific Care or Practices: Behavioral support, behavioral healthcare needs such as dealing with anxiety, dementia care, memory care, care for depression, trauma/ PTSD, psychiatric diagnoses, intellectual or developmental disabilities. It further indicated, Direct care personnel complete a competency validation process in conjunction with new hire orientation and selected 'Core' competencies are completed annually. Competencies for our facility personnel include but are not limited to and or [Company name redacted] courses: Staff Competencies: Care of Residents with Psychosocial, Mental, and Behavioral Concerns. Including those with Substance Use Disorder, History of Trauma or PTSD. Emphasis on effective communication, meaningful activities, person-centered care approaches and non-pharmacological interventions. A review of Licensed Practical Nurse (LPN) 1, Lead (Certified Nurse Assistant) CNA, CNA 6, and Unit Manager (UM) trainings did not include care of residents with psychosocial, mental, and behavioral concerns; history of trauma or PTSD; or person-centered care approaches and non-pharmacological interventions. On 2/6/25 at 8:50 AM, an interview was conducted with the Administrator. The Administrator stated the facility had a lot of residents that have mental and behavioral health concerns and that staff should be trained on how to handle that type of resident but that he was not sure if staff had been trained. A follow-up interview was conducted with the Administrator at 1:36 PM. The Administrator stated staff are trained for dementia but resident's with behavioral health needs like PTSD, depression or schizophrenia would not be handled the same as a resident with dementia. On 2/6/25, an interview was conducted with the Director of Nursing. The DON stated the Facility Assessment was completed by the DON and the Administrator. The DON stated that there were no residents residing in the facility that had any behavior concerns like aggressive behaviors or combativeness. The DON stated staff completed core training and that corporate decided what training they get. The DON stated training should be based on the Facility Assessment. Cross refer to 742