STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465180	A. Building B. Wing	05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southern Utah Veterans Home - Ivins	160 North 200 East Ivins, UT 84738

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview it was determined, for 1 of 35 sampled residents, that the facility did not ensure that the resident had the right to self determination through support of the resident's choice. Specifically, a resident had their aerosolized can of deodorant removed from their possession. Resident identifier: 39. Findings included: Resident 39 was admitted to the facility on [DATE] with diagnoses which consisted of type II diabetes mellitus, chronic obstructive pulmonary disease, emphysema, cervicalgia, hypertension, low back pain, and pulmonary hypertension. On 5/12/25 at 3:31 PM, an interview was conducted with resident 39. Resident 39 stated that the facility took his deodorant and told him he could not have it because it was a metal can. Resident 39 stated that they just took it from him because of the state survey inspection, but they were never worried about it before. Resident 39 stated that it upset him. Resident 39 stated that the Resident Advocate (RA) took it and said he would give it to the nurse and he needed to ask for it to use. Resident 39 stated that the RA asked if he could look in his room, but that he felt like he could not say no to the request. On 5/15/25 at 8:27 AM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated that there was no reason for resident 39 to not have his deodorant in his room. RN 1 stated that resident 39 was capable of self care and did not need assistance with applying his deodorant. RN 1 stated that she was not aware of the deodorant being removed from resident 39's room. RN 1 inspected the medication cart and did not locate resident 39's deodorant inside it. On 5/15/25 at 1:37 PM, an interview was conducted with the RA. The RA stated that he removed resident 39's deodorant from his room. The RA stated that he was told that anything pressurized needed to be kept at the nurse's station.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined, for 1 of 35 sampled residents, that the facility did not immediately consult with the resident's physician when there was a significant change in the resident's physical status or a need to alter treatment. Specifically, a resident had complaints of uncontrolled pain and the physician was not notified. Resident identifier: 75. Findings included: Resident 75 was admitted to the facility on [DATE] with diagnoses which included encounter for palliative care, dementia, cognitive communication deficit, traumatic brain injury, post-traumatic stress disorder, cervical disc disorder, radiculopathy, hemiplegia and hemiparesis right side, and a history of falls. On 5/13/25 at 9:17 AM, an interview was conducted with resident 75. Resident 75 complained of pain in his right shoulder and neck. Resident 75 stated that he had 5 shoulder operations and it was aching him like crazy. Resident 75 stated that he had an Oxycodone this morning but it had worn off and his current pain score was an 8 out of 10, with 10 being the worst pain possible. Resident 75's medical records were reviewed. Review of resident 75's physician orders revealed the following: a. On 4/24/25, an order was initiated for Oxycodone Oral Tablet 5 milligram, give 1 tablet by mouth every 6 hours as needed for pain. b. On 10/25/24 an order was initiated for Acetaminophen Oral Tablet 500 mg, give 1 tablet by mouth every 6 hours as needed for pain or fever. Review of resident 75's May 2025 Medication Administration Record revealed the following: a. On 5/8/25 at 7:06 PM, Tylenol 500 mg was documented as administered for a pain score of 5/10. The administration was documented as ineffective. No documentation could be found that the provider was notified of the ineffective pain medication. b. On 5/13/25 at 6:44 AM, Oxycodone 5 mg was documented as administered for a pain score of 8/10. The administration was documented as ineffective. No documentation could be found that the provider was notified of the ineffective pain medication. On 8/29/24, resident 75 had a care plan initiated for pain management related to radiculopathy of lumbar regions, cervical disc disorder with myelopathy, and osteoarthritis. An intervention identified on the care plan was to notify the physician if interventions were unsuccessful or if current complaint was a significant change from past experience of pain. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/14/25 at 9:27 AM, an interview was conducted with Registered Nurse (RN) 2. RN 2 stated that resident 75 complained of pain in the right shoulder. RN 2 stated when the resident had complaints of pain she administered pain medication upon request. RN 2 stated that after administration of the pain medication she would follow-up with the resident to see if the medication was effective at relieving the resident's pain. RN 2 stated if the medication was reported as not effective she would notify the supervisor who would then notify the physician. RN 2 stated that documentation of provider notification could be found in the medication administration notes. On 5/14/25 at 1:50 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that staff should re-assess a resident's pain after medication or non-pharmacological interventions were provided. The DON stated that if the pain medication was ineffective at controlling the resident's pain, then they should notify the physician. The DON stated that the licensed nurse or the nurse supervisor would notify the provider. The DON stated that the nurse should document that the physician was notified in the progress notes. The DON stated that he did not see that the provider was notified of either ineffective doses of pain medication. The DON stated that he did not see that the resident was administered any additional doses of pain medication for either dates with ineffective pain management. On 5/15/25 at 1:57 PM, an interview was conducted with resident 75's hospice nurse, RN 3. RN 3 stated that he was notified of resident 75's uncontrolled pain in the last 2 days. RN 3 stated that he was informed of resident 75's uncontrolled pain on 5/13/25 with the administration of Oxycodone. RN 3 stated that he evaluated resident 75 today and the plan was to discontinue the Oxycodone and start the resident on Morphine. RN 3 stated that if resident 75 complained of ineffective pain relief with the Tylenol administration then he would have given the Oxycodone as well.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on interview and record review, it was determined, the facility did not inform each resident periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/Medicaid or by the facility's per diem rate. Specifically, for 1 out of 3 sampled residents, a resident was not issued a Notice of Medicare Non-coverage (NOMNC) when the Medicare part A services were terminated. Resident identifier: 74. Findings include: The facility provided a list of residents who had been discharged from Medicare covered Part A stay with days remaining. Resident 74 was on the list with a discharged date from Part A of 12/7/24 and he remained in the facility. Resident 74's medical record was reviewed. A NOMNC was not located in resident 74's medical record. On 5/14/25 at 8:37 AM, an interview was conducted with Medical Records. Medical Records stated the NOMNC's were provided by the Social Services Department. Medical Records stated that she uploaded any signed NOMNC's that were received into the residents medical record. Medical Records was unable to locate a NOMNC for resident 74. On 05/14/25 at 8:45 AM, an interview was conducted with Licensed Clinical Social Worker (LCSW) 1. LCSW 1 stated the social services department issues the NOMNC's to residents. LCSW 1 stated residents were notified 48 hours before their last covered Medicare day. On 5/14/25 at 8:58 AM, an interview was conducted with the Resident Advocate (RA). The RA stated a NOMNC was not issued because resident 74 changed payers. The RA stated this change did not effect resident 74's out of pocket expense. The RA stated resident 74 should have been issued a NOMNC.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, for 2 of 35 sampled residents, the facility did not ensure an assessment accurately reflected the resident's status. Specifically, a resident who was discharged home was coded as being admitted to an acute hospital. In addition, another resident with a Preadmission Screening Resident Review (PASRR) level II was not coded as having one. Resident identifiers: 22 and 104. Findings include: 1. Resident 22 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included encounter for palliative care, Parkinson's disease, and dysphagia. A significant change Minimum Data Set (MDS) dated [DATE] revealed resident 22 was not currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. A review of resident 22's medical record revealed a PASRR level II dated 8/7/24. On 5/14/25 at 9:01 AM, an interview was conducted with Licensed Clinical Social Worker (LCSW) 1. LCSW 1 stated resident 22 had a PASRR level II related to serious mental illness, post-traumatic stress disorder, and major depressive disorder. On 5/14/25 at 9:24 AM, an interview was conducted with MDS coordinator 1. MDS Coordinator 1 stated resident 22 had a PASRR level II and the MDS was marked incorrectly. 2. Resident 104 was admitted to the facility on [DATE] with diagnoses which included dementia, pacemaker, post-traumatic stress disorder, and chronic kidney disease. A discharge MDS dated [DATE] revealed resident 104 had been discharged to a short-term general hospital. A progress note dated 2/18/25 at 12:36 PM revealed resident 104 discharged home on hospice. On 5/14/25 at 9:21 AM, an interview was conducted with MDS coordinator 1. MDS coordinator stated resident 104's discharge location was coded wrong and needed to be modified.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined, for 1 of 35 sampled residents, that the facility did not develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and timeframe's to meet the resident's medical, nursing, and psychosocial needs that were identified in the comprehensive assessment. Specifically, the resident's care plan did not address the resident's wrist splint. Resident identifier: 8. Findings included: Resident 8 was admitted to the facility on [DATE] and was re-admitted on [DATE] with diagnoses which included encounter for palliative care, hemiplegia and hemiparesis of the left side following a cerebral infarction, and vascular dementia. On 5/12/25 at 2:45 PM, an interview was conducted with resident 8. Resident 8 stated that he had limited movement in his left hand and arm. An observation was made of resident 8's left hand and wrist. The left wrist was observed contracted. Resident 8 stated that he had a brace for the left wrist and was to wear it in the afternoon and evening. Resident 8 stated that he stopped wearing the brace because the Certified Nurse Assistants (CNA's) had a tough time putting it on him. Resident 8 stated that the last time he wore the wrist brace was approximately 2 weeks ago. Resident 8 stated that he did not refuse the brace. Resident 8's medical records were reviewed. No documentation could be found of orders for the wrist splint. On 4/3/25, the hospice provider documented, Left hand contracted with little movement, significant weakness to his left leg with left foot drop. Resident 8's care plan was reviewed. No focus care area or interventions were identified for resident 8's left hand/wrist splint. On 5/14/25 at 11:47 AM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated that resident 8 had a brace for his left hand and wrist. RN 1 confirmed that resident 8 did not have orders for the brace. RN 1 stated that the hospice nurse manager brought the brace for resident 8. RN 1 stated that they occasionally put the brace on resident 8 and they just tried to maintain his comfort. On 5/15/25 at 1:05 PM, an interview was conducted with the Director of Nursing (DON). The DON confirmed that the wrist splint was not on the care plan. The DON stated that the care plan should outline all of the cares that the resident was receiving.

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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** Based on observation, interview, and record review, for 1 of 35 sampled residents, the facility did not provide appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living (ADL). Specifically, a resident was not provided oral hygiene to prevent tooth decay. Resident identifier: 22. Findings include: Resident 22 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included encounter for palliative care, Parkinson's disease, and dysphagia. On 5/12/15 at 3:29 PM, an interview was conducted with resident 22's family member. The family member stated resident 22 did not get his teeth brushed regularly. The family member stated resident 22 had a cavity and needed a new crown from not receiving oral hygiene. The family member stated when she kissed him, she would know if his teeth had been brushed that day. On 5/12/15 at 3:29 PM, an observation was made of a sign on resident 22's door. The sign revealed, Attention [name of facility] Staff, please follow these instructions for [resident 22] . Teeth Brushing Please help me brush my teeth every morning after breakfast and every evening after dinner. I struggle to do a good job on my own. Resident 22's medical record was reviewed. A quarterly Minimum Data Set (MDS) dated [DATE] revealed resident 22 required supervision or touching assistance with oral hygiene. A care plan dated 9/20/23 revealed resident 22 had an ADL self-care performance deficit related to muscle weakness, limited mobility, Parkinson's Disease, and history of falls. The goal was that resident 22 would maintain current level of functioning through the review date. One of the interventions was Personal Hygiene/Oral Care: [resident 22] requires supervision/touch assist of (1) staff for personal hygiene and oral care. A dental hygienist note dated 4/17/25 revealed resident 22 was packing food at 14/15. Plaque was generalized, light, food debris. A dental visit note dated 5/6/25 revealed, Heavy amounts of debris stuck in upper and lower vestibules causing gum inflammation and tooth decay. The note further revealed resident 22 was scheduled for dental work to be done on 5/14/25 at 9:30 AM. According to the oral hygiene Certified Nursing Assistant (CNA) documentation from 4/15/25 through 5/13/25, resident 22 was provided supervision to dependent assistance. Resident 22 was provided oral care 1 time on 4/16/25 at 10:05 AM, 4/19/25 at 1:17 PM, 5/3/25 at 11:31 AM, 5/6/25 at 8:41 AM, and 5/11/25 at 10:26 AM. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/14/25 at 1:12 PM, an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated there were physician's orders to have oral hygiene. LPN 1 stated the CNA's were in charge of brushing resident 22's teeth. On 5/14/25 at 1:14 PM, an interview was conducted with CNA 1. CNA 1 stated oral hygiene should be provided in the morning and at night. CNA 1 stated oral hygiene was usually done before breakfast but if the resident preferred, it could be done after breakfast. CNA 1 stated some of the residents were able to provide their own oral care and only need set up assistance. CNA 1 stated oral hygiene should be documented every shift. CNA 1 stated resident 22 should be receiving oral hygiene twice daily but according to the CNA documentation there were days he only had it done once and she did not know why. On 5/14/25 at 2:08 PM, an interview was conducted with Assistant Director of Nursing (ADON) 1. ADON 1 stated there was a task section for the CNA's to document oral hygiene and if a resident refused then the CNA should let the nurse know. ADON 1 stated oral hygiene should be done 2 to 3 times per day for aspiration precautions. ADON 1 stated there were a lot of residents that were resistive to oral care. ADON 1 stated there was a 4-step action plan that Licensed Clinical Social Worker (LCSW) 1 was working on regarding oral hygiene. On 5/14/25 at 2:34 PM, an interview was conducted with LCSW 1 and Director of Nursing (DON). LCSW 1 stated there was a 4-step action plan regarding getting dental services for residents, but the action plan was not for providing daily oral hygiene. The DON stated there were ongoing discussions with the hygienist at the facility and had her do an in-service about better oral care for residents. The DON stated the hygienist did a presentation for nurses and CNAs on 3/20/25. The DON stated oral hygiene was to be documented in the CNA documentation. The DON stated oral hygiene should be offered twice daily and if a resident refused it should be documented in the CNA documentation. The DON stated oral hygiene should be done twice daily. The DON stated he did not have information on why resident 22 had a sign hanging outside his room to have oral hygiene done or why it was not documented twice daily by the CNA's.

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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** Based on observation, interview, and record review it was determined, for 1 out of 35 sampled residents, that the facility did not ensure that a resident who had limited range of motion received the appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Specifically, a resident had a hand/wrist splint that was not being applied consistently and the resident did not have any physician orders for the application of the medical device. Resident identifier: 8. Findings included: Resident 8 was admitted to the facility on [DATE] and was re-admitted on [DATE] with diagnoses which included encounter for palliative care, hemiplegia and hemiparesis of the left side following a cerebral infarction, and vascular dementia. On 5/12/25 at 2:45 PM, an interview was conducted with resident 8. Resident 8 stated that he had limited movement in his left hand and arm. An observation was made of resident 8's left hand and wrist. The left wrist was observed contracted. Resident 8 stated that he had a brace for the left wrist and was supposed to wear it in the afternoon and evening. Resident 8 stated that he stopped wearing the brace because the Certified Nurse Assistants (CNAs) had a tough time putting it on him. Resident 8 stated that the last time he wore the wrist brace was approximately 2 weeks ago. Resident 8 stated that he did not refuse the brace. Resident 8's medical records were reviewed. No documentation could be found of orders for the hand/wrist splint. On 4/3/25, the hospice provider documented, Left hand contracted with little movement, significant weakness to his left leg with left foot drop. Resident 8's care plan was reviewed. No focus care area or interventions were identified for resident 8's left hand/wrist splint. On 5/14/25 at 11:37 AM, an interview was conducted with CNA 2 and CNA 3. CNA 3 stated that resident 8 had a brace for his left lower leg. CNA 2 stated that the brace was for his ankle/foot and was worn inside his shoe. Both CNA 2 and CNA 3 stated that resident 8 did not have a brace for his wrist and they had never applied one to his left wrist. On 5/14/25 at 11:47 AM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated that resident 8 had a brace for his left hand and wrist. RN 1 confirmed that resident 8 did not have orders for the brace. RN 1 stated that the hospice nurse manager brought the brace for resident 8. RN 1 stated that they occasionally put the brace on resident 8 and they just tried to maintain his comfort. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/15/25 at 9:47 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that there should be orders for a splint or brace. The DON stated that sometimes there was a prescription for the use of the device or if it was being discontinued. The DON stated that they would need to get the order from the hospice provider for resident 8's left wrist/hand splint. The DON stated that the licensed nurse should have notified the hospice nurse to obtain an order for the medical device. The DON stated that most of the time the nursing supervisor was responsible for double checking the hospice orders and entering them into the electronic medical record. On 5/15/25 at 1:05 PM, a follow-up interview was conducted with the DON. The DON confirmed that the wrist splint was not on resident 8's care plan. The DON stated that the care plan outlined all of the cares that the resident was receiving. The DON stated that he asked the hospice provider for the splint order. The DON stated that he was not sure how long resident 8 had been using a splint without a physician order. The DON stated that resident 8's hospice provider was going to order the splint per the resident request and comfort.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined, for 1 out of 35 sampled residents, that the facility did not ensure that the resident environment remained as free of accident hazards as was possible and that each resident received adequate supervision and assistance devices to prevent accidents. Specifically, a resident who was identified as a two-person assist for bed mobility and incontinence care sustained a fall during a one-person assist for incontinence care. Resident identifier 8. Findings included: Resident 8 was admitted to the facility on [DATE] and was re-admitted on [DATE] with diagnoses which included encounter for palliative care, hemiplegia and hemiparesis of the left side following a cerebral infarction, vascular dementia, pain in right shoulder, contusion of right shoulder, complete rotator cuff tear of right shoulder, and unspecified fracture of left humerus. On 5/12/25 at 2:31 PM, an interview was conducted with resident 8. Resident 8 stated he fell out of bed one time and hit his head and elbow. Resident 8 stated that his left wrist was now giving him trouble. Resident 8 stated that he had his elbow looked at after the fall but not the wrist. Resident 8 stated that they now had two staff assist him when providing care, one staff located on each side of the bed. Fall mats were observed on both sides of the bed. On 12/10/24 at 5:12 PM, the facility Form 358 documented to the State Survey Agency (SSA) that resident 8 had a fall from the bed during a brief change. [Resident 8] pulled himself over, and this caused him to fall out of the bed. It is unclear if the C.N.A. [Certified Nurse Assistant] should have had someone there in the room to help her. On 12/13/24 at 3:09 PM, the facility Form 359 documented that the CNA 4, who was providing incontinence care to resident 8 at the time of the fall, stated that it was not uncommon to provide bed mobility assistance to the resident by herself. On 12/16/24 at 6:00 PM, CNA 4's witness statement documented, I was changing him alone. I've changed him alone before. He can say if he feels uncomfortable or wants someone else to help. I am aware of the Kardex but I was not aware that it says he needs two people to help him while he's in bed. On this particular time he pushed the call light and told me he had a bowel movement and needed help. I got the supplies ready. I had him turn to his left side. He asked 'is there anything I can do to help?' I reached to grab wipes and the next thing I knew he was flipping out of the bed. I tried to stop him by grabbing onto his leg. I even ran to the other side to try and catch him but he was already on the floor. Resident 8's medical records were reviewed. (continued on next page)

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Southern Utah Veterans Home - Ivins	160 North 200 East Ivins, UT 84738

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/10/24 at 1:30 PM, resident 8's Interdisciplinary Team (IDT) Note documented, on 12/9/24 at approximately 1920 [7:20 PM]. Resident was being assisted for toileting need and resident cares while in bed. Resident asked to help more when he grabbed on to the mattress to turn and position himself a little further to the left side. Resident pulled too far, and it caused him to roll off the bed. Resident immediately assessed for pain and injuries. Skin tears obtained and redness to. Pain 6/10 treated with PRN [as needed] pain medications and non-pharmacological intervention like rest and repositioning. These were effective. Hospice notified. X-ray ordered to extremity due to some increased pain. No visual deficits of the extremity noted. Neuro checks initiated and no deficits identified. vitals taken and WNL [within normal limits] for resident. 72-hour post fall assessment and environmental safety check initiated. new intervention to include 1/4 side rail for repositioning and increase in resident participation on cares. On 12/10/24, resident 8 had a right elbow x-ray completed. The impression was no evidence of fracture or acute abnormality. On 12/5/23, resident 8 had a care plan for Activities of Daily Living (ADLs) initiated. The care plan documented that resident 8 required a substantial maximal assist of (2) staff for bed mobility and a substantial maximal assist of (2) staff for toilet use. On 5/14/25 at 11:37 AM, an interview was conducted with CNA 2 and CNA 3. CNA 3 stated that resident 8 was dependent for transfers with a Hoyer lift and was a substantial max assist for bed mobility. CNA 3 stated that they did most of the work when assisting resident 8 because he had left sided paralysis. CNA 3 stated that resident 8 was a two-person assist for any type of movement. CNA 2 stated that as long as she had been working at the facility (3 months) resident 8 was a dependent two-person assist for toileting. CNA 2 stated that resident 8 did not have enough upper body strength to sit on the toilet without toppling over. On 5/14/25 at 11:47 AM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated that resident 8 required a two-person assist for care since approximately spring of 2024. RN 1 stated that resident 8 had a fall one time while being assisted with toileting and a brief change. RN 1 stated that resident 8 rolled by himself and rolled off the bed. RN 1 stated that after the fall, a side rail was placed on the bed to help with positioning. RN 1 stated that the fall happened at nighttime and they had only one CNA at night. RN 1 stated that after the fall, the care plan was changed to show that resident 8 had to have two-person assist for cares. RN 1 stated that prior to the fall, the care plan stated that resident 8 only required a one-person assist for toileting. It should be noted that resident 8's care plan documented a substantial maximal assist of (2) staff for bed mobility and toilet use since 12/5/23. On 5/15/25 at 8:19 AM, an interview was conducted with CNA 5. CNA 5 stated that all the resident specific assistive needs were located on the Kardex and would be passed off in report. CNA 5 stated that resident 8 was a total assistance for all ADL's. CNA 5 stated that interventions to prevent falls for resident 8 were monitoring and when he was in his wheelchair he needed to be assisted to all activities. On 5/15/25 at 8:31 AM, an interview was conducted with CNA 6. CNA 6 stated that fall interventions for resident 8 were ensuring the bed was lowered to the ground, frequent checks, encourage call light use, and repositioning the resident with pillows. CNA 6 stated that resident 8 was dependent two-person assist for most ADL's including bed mobility and toileting. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/15/25 at 10:24 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that the CNA should have followed what resident 8's care plan said for the number of staff required for assistance. The DON stated that sometimes the residents get impatient and do not want to wait until other help arrived. The DON stated that the staff should be following the recommendations for assistance that was on the Kardex.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** On 5/20/25 at 9:50 AM, a follow-up interview was conducted with Director of Nursing (DON). The DON stated hopefully staff were able to anticipate resident's pain. The DON stated the expectation was for staff to assess the general criteria of pain like where, how bad, and if it had happened before, and then complete a full assessment if it was not identified before. The DON stated nurses provided interventions and contacted the physician for pain medication. The DON stated if the interventions were not effective, staff should notify the provider for additional assistance. The DON stated resident 78 had multiple medications available and resident 78 was discussed in their clinical meeting. The DON stated the physicians were usually in the building so staff were able to report pain to them verbally. The DON stated sometimes staff did not document contacting the physician, but it was done. On 5/20/25 at 10:28 AM, an interview was conducted with the DON. The DON stated according to resident 78's Medication Administration Record, he received an uptake in non-pharmacological interventions starting 4/11/25. The DON stated resident 78 had Biofreeze ordered 4/13/25 at 2:17 PM to be applied through out the day. The DON stated the Physician's Assistant (PA) note revealed no pain during his reduction on 4/23/25. The DON stated resident 78 had a dental procedure on 4/11/25 so that was why there was an increase in non-pharmacological interventions. The DON stated on 4/15/25 that there was an ineffective pain relief documented with no follow up information, except that non-pharmacological interventions were tried. On 5/20/25 at 9:10 AM, an interview was conducted with the Physician Assistant (PA). The PA stated he was notified of right shoulder pain for resident 78. The PA stated resident 78 reported he had the shoulder pain for about 8 months. The PA stated he did not suspect dementia at the time, but now was suspecting he had increased dementia. The PA stated after the initial evaluation he ordered an x-ray on 4/14/25. The PA stated during his exam the shoulder looked normal. The PA stated the x-ray revealed an anterior dislocation so a sling was ordered for a few days. The PA stated he performed a reduction to put the shoulder back into place. The PA stated resident 78 refused to wear the sling and his shoulder continued to dislocate. The PA stated he was unable to reduce the shoulder until 4/23/25 because he was busy with other things. The PA stated he assumed that pain was relieved when the shoulder was reduced because the resident asked for it to be put back into place. Based on interview and record review it was determined, for 2 of 35 sampled residents, that the facility did not ensure that pain management was provided to residents who required such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. Specifically, two residents had reports of uncontrolled pain management that was not addressed timely. Resident identifiers: 75 and 78. Findings included: 1. Resident 75 was admitted to the facility on [DATE] with diagnoses which included encounter for palliative care, dementia, cognitive communication deficit, traumatic brain injury, post-traumatic stress disorder, cervical disc disorder, radiculopathy, hemiplegia and hemiparesis right side, and a history of falls. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/13/25 at 9:17 AM, an interview was conducted with resident 75. Resident 75 complained of pain in his right shoulder and neck. Resident 75 stated that he had 5 shoulder operations and it was aching him like crazy. Resident 75 stated that he had an Oxycodone this morning but it had worn off and his current pain score was an 8 out of 10, with 10 being the worst pain possible. Resident 75's medical records were reviewed. Review of resident 75's physician orders revealed the following: a. On 4/24/25, an order was initiated for Oxycodone Oral Tablet 5 milligram (mg), give 1 tablet by mouth every 6 hours as needed for for pain. b. On 10/25/24, an order was initiated for Acetaminophen Oral Tablet 500 mg, give 1 tablet by mouth every 6 hours as needed for pain or fever. c. On 8/29/24, an order was initiated for Question resident about presence of pain or burning including pressure points. Monitor for pain using 0-10 scale. 0 for no pain, 10 for worst pain possible. If resident is not able to answer, use PAINAD [Pain Assessment in Advanced Dementia] scale. d. On 8/29/25, an order was initiated for Record non-pharmacological pain: 1=repositioning/limb, elevation 2=reassurance/emotional support 3=distraction/diversionary activities 4=ROM [Range of Motion]/ambulation/stretching 5=rest period/quiet environment 6=deep breathing/relaxation exercises 7=massage/therapeutic touch 8=application of ice/heat pack 9=laughter/socialization; 10=Aroma therapy 11=NO PAIN PRESENT every shift for pain record non pharmacological code and number of episodes. Review of resident 75's May 2025 Medication Administration Record (MAR) and Treatment Administration Record (TAR) revealed the following: a. On 5/8/25 at 7:06 PM, Tylenol 500 mg was documented as administered for a pain score of 5/10. The administration was documented as ineffective. The TAR documented no pain was present on the non-pharmacological pain monitoring. No documentation could be found that the provider was notified of the ineffective pain medication. b. On 5/13/25 at 6:44 AM, Oxycodone 5 mg was documented as administered for a pain score of 8/10. The administration was documented as ineffective. The TAR documented the non-pharmacological pain interventions offered were repositioning, reassurance, distraction, and rest. No documentation could be found that the provider was notified of the ineffective pain medication. On 8/29/24, resident 75 had a care plan initiated for pain management related to radiculopathy of lumbar regions, cervical disc disorder with myelopathy, and osteoarthritis. Interventions identified on the care plan were: administer medications as ordered, anticipate the resident's need for pain relief and respond immediately, monitor for cause of pain episode, and notify the physician if interventions were unsuccessful or if current complaint was a significant change from past experience of pain. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/14/25 at 9:27 AM, an interview was conducted with Registered Nurse (RN) 2. RN 2 stated that resident 75 complained of pain in the right shoulder. RN 2 stated when the resident had complaints of pain she administered pain medication upon request. RN 2 stated that after administration of the pain medication she would follow-up with the resident to see if the medication was effective at relieving the resident's pain. RN 2 stated if the medication was reported as not effective she would notify the supervisor who would then notify the physician. RN 2 stated that documentation of provider notification could be found in the medication administration notes. On 5/14/25 at 1:50 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that staff should re-assess a resident's pain after medication or non-pharmacological interventions were provided. The DON stated that if the pain medication was ineffective at controlling the resident's pain, they should notify the physician. The DON stated that the licensed nurse or the nurse supervisor would notify the provider. The DON stated that the nurse should document that the physician was notified in the progress notes. The DON stated that he did not see that the provider was notified of either ineffective doses of pain medication. The DON stated that he did not see that the resident was administered any additional doses of pain medication for either dates with ineffective pain management. On 5/15/25 at 1:57 PM, an interview was conducted with resident 75's hospice nurse, RN 3. RN 3 stated that he was notified of resident 75's uncontrolled pain in the last 2 days. RN 3 stated that he was informed of resident 75's uncontrolled pain on 5/13/25 with the administration of Oxycodone. RN 3 stated that he evaluated resident 75 today and the plan was to discontinue the Oxycodone and start the resident on Morphine. RN 3 stated that if resident 75 complained of ineffective pain relief with the Tylenol administration then he would have given the Oxycodone as well. 2. Resident 78 was admitted to the facility on [DATE] with diagnoses which included hemiplegia and hemiparesis of right dominant side, aphasia, insomnia, major depressive disorder, cerebral infarction, hernia, duodenal ulcer, type II diabetes mellitus, and postprocedural pain. On 5/13/25 at 9:56 AM, an interview was conducted with resident 78. Resident 78 complained of pain in the right shoulder and stated that it hurt when the arm was moved around. Resident 78 stated that he received medication for the pain and it helped a little bit. Review of resident 78's physician orders revealed the following: a. On 4/15/25, an order was initiated for a sling to the right shoulder every shift for pain. b. On 4/13/25, an order was intimated for Biofreeze Cool The Pain External Gel 4 % (Menthol (Topical Analgesic)) Apply to right shoulder topically every 6 hours as needed for PAIN. c. On 2/19/25, an order was initiated for Hydrocodone-Acetaminophen Oral Tablet 5-325 milligram mg, give 1 tablet by mouth every 4 hours as needed for pain 5-10. Not to exceed more than 3000 mg of Tylenol from all sources in 24 hours. d. On 1/15/24, an order was initiated for Tylenol Oral Tablet, give 500 mg by mouth every 6 hours as needed for pain. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	e. On 12/12/23, an order was initiated for Record non-pharmacological pain: 1=repositioning/limb, elevation 2=reassurance/emotional support 3=distraction/diversionary activities 4=ROM/ambulation/stretching 5=rest period/quiet environment 6=deep breathing/relaxation exercises 7=massage/therapeutic touch 8=application of ice/heat pack 9=laughter/socialization; 10=Aroma therapy 11=NO PAIN PRESENT every shift for pain record non pharmacological code and number of episodes. f. On 12/12/23, an order was initiated for Question resident about presence of pain or burning including pressure points. Monitor for pain using 0-10 scale. 0 for no pain, 10 for worst pain possible. If resident is not able to answer, use PAINAD scale. Review of resident 78's April 2025 MAR and TAR revealed the following: a. On 4/13/25 at 12:33 PM, the Hydrocodone was administered for a pain score of 8/10 and was documented ineffective. No additional Tylenol or Biofreeze was documented as administered for the continued pain. The TAR documented the non-pharmacological pain interventions offered were repositioning, reassurance, distraction, and rest. No documentation could be found that the provider was notified of the ineffective pain medication. b. On 4/15/25 at 8:43 AM, the Hydrocodone was administered for a pain score of 5/10 and was documented ineffective. No additional Tylenol or Biofreeze was documented as administered for the continued pain. The TAR documented the non-pharmacological pain interventions offered were repositioning, reassurance, distraction, and rest. No documentation could be found that the provider was notified of the ineffective pain medication. Resident 78's progress notes revealed the following: a. On 4/13/25 at 4:03 PM, the Nursing Note documented, Resident centered rounding was preformed [sic] every 2 hours and as needed for care and comfort. Resident was medication compliant. Resident had complaints of right shoulder pain and was given PRN [as needed] Hydrocodone. Resident is now in his bed resting with the door shut. Resident was left with call light, remote, and water mug within reach. b. On 4/14/25 at 2:25 PM, the Nursing Note documented, Notified provider of the residents complaints of increased pain to the right shoulder. New order to obtain an x ray to the right shoulder. c. On 4/15/2025 at 11:27 AM, the Nursing Note documented, Results to the right shoulder X Ray were reviewed by provider with a new order for a sling to the right arm and pt [patient] eval [evaluation] and tx [treat] as able Impression: 1. Mild inferior subluxation of the humeral head which may represent inferior dislocation, hemarthrosis, inferior labral injury or capsular laxity. Correlate clinically 2. No definite radiographic evidence of acute fracture, If there are persistent symptoms f/u [follow-up] exam may be obtained as clinically warranted. 3. Mild osteopenia (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. On 4/15/25 at 2:47 PM, the Nursing Note documented, Resident has a right dislocated shoulder. It is important to not put tension or pressure on shoulder at this time. Resident has been ordered to wear a sling. Resident is a x2 assist transfer at this time d/t [due to] shoulder. Slide board effective for transferring. Gait belt also beneficial for transferring. POA [Power of Attorney]/emergency contact was contacted about resident shoulder. Resident has uncontrolled pain at this time. PRN pain pill given and ineffective. Resident centered rounds completed Q2 [every 2] and PRN. Residents' call light left within reach. Resident ate and drank adequately. Resident has been pleasant and cooperative. Nursing staff to continue monitoring resident's shoulder. e. On 4/17/25 at 4:11 PM, the Alert Note documented, Resident has complaints of pain, please assess. f. On 5/9/25 at 1:55 AM, the Nursing Note documented, .Resident has C/O [complaints of] right shoulder pain but has refused pain medication as he says 'doesn't help'. Nonpharmacological interventions used. On 5/15/25 at 8:51 AM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated that resident 78 had complaints of headache and shoulder pain. RN 1 stated that they just did a shoulder manipulation last week for a dislocation. RN 1 stated that it was dislocated during a transfer at the facility and had heard this in shift change report from other nurses and the Certified Nurse Assistants. RN 1 stated that resident 78 had paralysis of the right side and had shoulder pain in the right shoulder. RN 1 stated that when resident 78 was moved in the bed they pulled on his shoulder and when he was transferred from the bed to the wheelchair or to the toilet they pulled on his right shoulder and used a gait belt. RN 1 stated that after an injury they assessed the area for pain and reported it to the supervisor who then reported it to the physician. RN 1 stated that resident 78 had an x-ray and then they ordered a sling for the arm. RN 1 stated that for an injury such as this they should have completed an incident report and the nurse on shift would be responsible for doing this. It should be noted that an incident report was not completed for the injury with a transfer. RN 1 stated that they noticed the injury afterwards because resident 78 complained of pain. RN 1 stated that if the pain medication was ineffective they would report to the supervisor and the physician and non-pharmacological interventions would be provided. On 5/15/25 at 9:56 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that the shoulder injury was located on resident 78's flaccid side. The DON stated resident 78 started to complain of pain after his most recent shoulder dislocation. The DON stated that he could not recall if the injury was caused by a staff transfer. The DON stated that he would have to look at the investigation documentation for details of the incident. On 5/15/25 at 11:54 AM, a follow-up interview was conducted with the DON. The DON stated that they initiated an abuse investigation but did not complete it as they determined that it was not an injury of unknown origin. The DON stated that he talked to the physician and he stated that it was from paralysis on that side. The DON stated that he talked to staff and asked if they did anything different that day and staff replied no. The DON stated he talked to the provider and he stated that it could have happened during a transfer. The DON stated that he did not have detailed staff interview notes but that staff reported nothing new. The DON stated that he did not expand the dates to look for an origin or cause of the injury.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined, for 1 of 35 sampled residents, that the facility did not ensure that the irregularities identified by the pharmacist were acted upon by the attending physician. Specifically, the pharmacist identified that the resident's as needed (PRN) order of Lorazepam exceeded 14 days and did not have a stop date or a rationale to extend the use or duration of treatment and the provider did not act upon the pharmacists recommendations. Resident identifier: 8. Resident 8 was admitted to the facility on [DATE] and was re-admitted on [DATE] with diagnoses which included encounter for palliative care, vascular dementia, cognitive communication deficit, anxiety disorder, post-traumatic stress disorder, and major depressive disorder. Resident 8's medical records were reviewed. Resident 8's Lorazepam orders revealed the following: a. On 1/9/25, an order was initiated for Lorazepam Oral Tablet 0.5 milligram (mg), give 1 tablet by mouth two times a day for chronic anxiety AND give 1 tablet by mouth every 2 hours as needed for restlessness/agitation for 14 Days. The order was discontinued on 4/18/25. b. On 3/22/25, an order was initiated for Lorazepam Oral Tablet 0.5 mg, give 1 tablet by mouth every 2 hours as needed for restlessness. The order was discontinued on 4/4/25. c. On 3/22/25, an order was initiated for Lorazepam Oral Concentrate 2 MG/milliliter (ml), give 0.5 ml by mouth every 2 hours as needed for anxiety/restlessness AND give 1 ml by mouth every 2 hours as needed for anxiety/restlessness. The order was discontinued on 4/4/25. d. On 4/18/25, an order was initiated for Lorazepam Oral Concentrate 2 mg/ml, give 0.5 ml by mouth every 2 hours as needed for anxiety/restlessness, AND give 1 ml by mouth every 2 hours as needed for anxiety/restlessness for 14 Days. The order was discontinued on 5/2/25. e. On 4/19/25, an order was initiated for Lorazepam Oral Concentrate 2 mg/ml, give 0.5 ml orally every 2 hours as needed for agitation/restlessness, AND give 0.75 ml orally every 2 hours as needed for agitation/restlessness, AND give 1 ml orally every 2 hours as needed for agitation/restlessness. The order was discontinued on 5/2/25. f. On 5/9/25, an order was initiated for Lorazepam Oral Concentrate 2 mg/ml, give 0.5 ml by mouth every 2 hours as needed for AGITATION RESTLESSNESS for 14 Days AND Give 1 ml by mouth every 2 hours as needed for AGITATION RESTLESSNESS for 14 Days. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The April 2025 pharmacy consultation report documented, [Resident 8] has a PRN order for an anxiolytic, without a stop date: lorazepam 0.5 mg tab po [by mouth] q2h [every 2 hours] PRN anxiety. Recommendation: Please add a stop date of 14 days. If the medication cannot be discontinued at this time, please document the indication for use, the intended duration of therapy, and the rationale for the extended time period. Rationale for Recommendation: CMS [Centers for Medicare and Medicaid Services] requires that PRN orders for non-antipsychotic psychotropic drugs be limited to 14 days unless the prescriber documents the diagnosed specific condition being treated, the rationale for the extended time period, and the duration for the PRN order. A hand written note was documented on the report that stated, Stop date in place and was signed by the Assistant Director of Nursing (ADON) 2. It should be noted that no documentation was found in resident 8's medical records of a rationale for the extended use of the PRN Lorazepam. On 5/14/25 at 2:01 PM, an interview was conducted with the Director of Nursing (DON). The DON stated both he and the ADON 2 reviewed the psychotropic medication and pharmacy recommendations. The DON stated that they would then follow-up on the recommendations and implement the changes.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465180	A. Building B. Wing	05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southern Utah Veterans Home - Ivins	160 North 200 East Ivins, UT 84738

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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 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. Based on observation, interview, and record review, the facility did not provide food that was palatable, attractive, and served at a safe and appetizing temperature. Specifically, for 9 out of 35 sampled residents, residents complained of food quality, a test tray was not attractive or palatable, and Dining Committee meetings revealed complaints of food. Resident identifiers: 5, 24, 29, 39, 58, 78, 91, 94, and 101. Findings include: 1. On 5/13/25 at 9:17 AM, an interview was conducted with resident 5. Resident 5 stated the food was good and bad. Resident 5 stated the evening meal was awful and hot dogs were served 3 days a week. Resident 5 stated he felt like chicken was served too often. 2. On 5/12/25 at 3:29 PM, an interview was conducted with resident 39. Resident 39 stated that even with his dentures, he had a hard time chewing the meat because it was tough. Resident 39 stated that the food was not good. 3. On 5/13/25 at 9:56 AM, an interview was conducted with resident 78. Resident 78 stated that he did not like the food and it did not taste good. Resident 78 stated that he was a cook and the food was not good. Resident 78 stated that he bought his own food because he did not like the food served at the facility. Resident 78 stated that they served a pizza soup and it was really bad, what the hell? Resident 78 stated that he asked for some cottage cheese and he did not receive it. Resident 78 stated that in one week, he had hot dogs three times and he had not requested them. 4. On 5/12/25 at 3:20 PM, an interview was conducted with resident 94. Resident 94 stated the food had been difficult at the facility for her because she was vegan prior to admission. Resident 94 stated she liked lots of raw fruits and vegetables which she did not get at the facility. Resident 94 stated the vegetables were usually overcooked which took out the nutrients. 5. On 5/12/25 at 3:49 PM, an interview was conducted with resident 24. Resident 24 stated he did not want to answer questions about food and asked to move onto the next question. Resident 24 stated he was married for 73 years and was spoiled with his wife's cooking. 6. On 5/12/25 at 3:56 PM, an interview was conducted with resident 58. Resident 58 stated the food sucks. Resident 58 stated the food did not taste good or look appetizing. Resident 58 stated he ordered breaded shrimp and was served a corn dog instead. Resident 58 stated that was very disappointing. 7. On 5/13/25 at 7:59 AM, an interview was conducted with resident 101. Resident 101 stated the food was served cold. 8. On 5/13/25 at 8:03 AM, an interview was conducted with resident 29. Resident 29 stated the food was okay. Resident 29 stated sometimes the meat was so tough he could not chew it. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9. On 5/14/25 at 9:15 AM, an interview was conducted with resident 91. Resident 91 stated he did not know what breakfast was and it looked like something that came out of the south end. Resident 91 stated it was like, diarrhea. Resident 91 stated he went to Food Council monthly and would talk about that when he went. Resident 91 stated the Food Council was scheduled for Thursday. The menu posted for residents in the 600 hallway dining room was stuffed shells for lunch on 5/14/25. The menu provided by the facility upon entrance for lunch on 5/14/25 was Rancher's Chicken, seasoned rice, spiced beets, and peach pie. A test tray was requested on 5/14/25 at 12:29 PM. There was wild grain rice with a white sauce, a piece of chicken on top of the white sauce with an orange sauce on top. There was a bowl with cubed beets on the plate. There was pie served for dessert from a store bought container. The temperature was 112.7 for the chicken and rice and 108.3 for the beets. The rice was crunchy and undercooked. The chicken was tough and hard to chew with a gravy and southwest sauce on top of the chicken. The gravy and sauce together with the chicken and rice had different flavors which were not palatable. The beets were dull in color. Dining Committee Meeting Minutes revealed the following new business: a. On 11/21/24, burgers were too big (bun too thick) or cold, bacon not cooked enough, sandwiches were still getting buns/bread, food still cold, carrots not being fully cooked, and meatloaf too much gravy. b. On 12/26/24, the veggies were still too hard (cook more), food bland (veggies are worst), bacon not crispy. c. On 1/24/25, the carrots well done and the cream of wheat was lumpy and watery. d. On 2/20/25, the break pudding was dry and tough meats at dinner. e. On 3/20/25, burger dry, cook veggies longer, over cooked meat and pork/beef over cooked, dry carrots not done, and cornbread not cooked. f. On 4/17/25, meats over cooked, corned beef tough, carrots and green beans undercooked, and burgers to [sic] thick/dry. On 5/14/25 at 1:48 PM, an interview was conducted with the facility Registered Dietitian (RD). The RD stated resident's complained of food quality and normally it was the same residents. The RD stated a kitchen staff member was involved in the Interdisciplinary Team (IDT) meetings with residents to hear about food quality. The RD stated residents did not always attend the Dining Committee meeting. The RD stated she sampled a test tray monthly and the last time she did that was in April. The RD stated there was nothing super concerning. The RD stated a few of the sister facilities had a plating competition and the facility won, so she was surprised it did not look appetizing to residents. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/14/25 at 2:27 PM, an interview was conducted with the Dietary Manager (DM). The DM stated there was a monthly Dining Committee meeting for the last 7 years. The DM stated there were surveys done during the IDT meetings regarding temperature of the food and palatability. On 5/14/25 at 2:45 PM, an interview was conducted with the Administrator. The Administrator stated he was not aware of food concerns. The Administrator stated residents could file a grievance if there were concerns with food or there was a QR (Quick Response) code in the dining rooms for residents to voice their complaints. The Administrator stated he was concerned because the facility won a plating competition against sister facilities and residents had not complained about the food.