STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A064	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Creek Rehabilitation and Nursing	876 West 700 South Salt Lake City, UT 84104

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 47432 Based on observation and interview, it was determined that for 3 of 28 sampled residents, that the facility did not treat each resident with respect and dignity. Specifically, staff at the facility were observed standing next to residents while assisting them with eating, staff were observed using labels instead of resident names when addressing residents, residents were not served meals at the same time, and residents did not receive necessary assistance during dining. Resident identifiers: 11, 18, and 19. Findings included: 1. On 9/22/24 at 12:32 PM, an observation was made of the lunch time dining service. Nursing Assistant (NA) 2 was observed to assist Resident 19 with eating her meal. NA 2 was standing next to Resident 19 while assisting her with eating. 2. On 9/23/24 at 8:09 AM, an observation was made of the breakfast time dining service. The facility had already started to serve meals by the time the observation had started. At 8:17 AM, all residents had been served their meals except for Resident 11. At 8:23 AM, Resident 11 finally received his meal after staff tracked it down from the cart used to deliver meals to residents who eat in their rooms. On 9/25/24 at 10:02 AM, an interview was conducted with NA 1. NA 1 stated that when assisting residents with feedings, staff should sit next to residents to promote dignity. NA 1 stated that the assistance each resident requires varies. NA 1 stated that some residents just need to be coached while others may need to be fed manually. 38031 3. Resident 18 was admitted to the facility on [DATE] with diagnoses which consisted of asthma, dementia, hypertension, hyperlipidemia, insomnia, overactive bladder, gastro-esophageal reflux disease, hypokalemia, malignant neoplasm, chronic pain, unspecified protein-calorie malnutrition, anxiety disorder, and major depressive disorder. Resident 18's medical records were reviewed. Resident 18's diet order was for a no added salt diet, regular texture, regular consistency. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/27/24, the Minimum Data Set (MDS) Assessment documented that resident 18 required supervision or touching assistance for eating. On 8/29/24, resident 18's nutritional assessment documented that resident 18 required setup help and supervision for dining. On 9/22/24 at 12:41 PM, an observation was made of resident 18 during the lunch meal service. Resident 18 was observed lifting her fork to her mouth two times without any food on the utensil. Nurse Assistant (NA) 1 was observed to load resident 18's fork with mashed potatoes and beef and attempted to feed the resident while standing at the resident's side. The aide offered the resident a bite of food but did not take the utensil fully to resident 18's mouth. Flies were observed to be hovering and then landing on resident 18's head during the meal. On 10/01/24 at 12:52 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that the aides should be seated with the resident when assisting with dining. The DON stated that the aides should load the utensil for the resident, cue the resident to eat, or provide total assistance with feeding the resident.

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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** 38031 Based on interview and record review it was determined, for 2 of 28 sampled residents, that the facility did not immediately consult with the resident's physician and notify when there was an accident involving the resident which resulted in injury; a significant change in the resident's physical, mental, or psychosocial status; or a need to alter treatment, or a decision to transfer or discharge the resident from the facility. Specifically, a resident had an injury of unknown origin identified and the physician was not notified. Additionally, the physician was not notified when a resident refused blood draws for laboratory orders. Resident identifiers: 14 and 18. Findings included: 1. Resident 18 was admitted to the facility on [DATE] with diagnoses which consisted of asthma, dementia, hypertension, hyperlipidemia, insomnia, overactive bladder, gastro-esophageal reflux disease, hypokalemia, malignant neoplasm, chronic pain, unspecified protein-calorie malnutrition, anxiety disorder, and major depressive disorder. Resident 18's medical records were reviewed. On 9/4/24 at 7:06 AM, resident 18's nurse note documented, CNAs [Certified Nurse Assistant(s)] found a bruise on the resident's upper thigh area. This appears to be a new bruise. Resident doesn't know how it happened. On 9/9/24, a skin assessment documented no new skin integrity problems. It should be noted that no documentation could be found of an assessment of the identified bruise. Resident 18's care plan for at risk for skin breakdown was initiated on 8/21/24. The care plan goal was that resident 18 would not develop a pressure injury. Interventions identified were do not massage bony prominence and implement weekly skin checks. It should be noted that the care plan did not have interventions related to monitoring, reporting or treating altered skin conditions. On 10/01/24 at 11:39 AM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated that if she identified a newly developed bruise on a resident she would notify the provider, notify the Director of Nursing (DON), document in a progress note and monitor the skin. On 10/01/24 at 11:48 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that CNAs should notify the nurse of any new skin conditions such as a bruise. The DON stated that the licensed nurse needed to assess the skin to see if it was suspicious before reporting it as abuse. The DON stated that the nurse should notify the provider as a non-urgent symptom to review and there was a list in the provider communication book for issues that needed attention by the provider. The DON stated that the licensed nurse sometimes documented in a progress note, but they were not consistently doing that. The DON stated that the licensed nurse should document a progress note that stated the provider was notified of the condition. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident 14 was admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses which included cerebral infarction, hemiplegia and hemiparesis, cognitive communication deficit, chronic obstructive pulmonary disease, pain, major depressive disorder, dementia, insomnia, cervical disc degeneration, spondylosis with myelopathy, alcoholic polyneuropathy, hypertension, osteoarthritis, radiculopathy, cirrhosis of liver, hyperlipidemia, nicotine dependence, alcohol abuse, cannabis abuse, suicide attempt, suicidal ideations, ventral hernia, trochanteric bursitis of left hip, and lesion of ulnar nerve. Resident 14's medical records were reviewed. Resident 14's physician orders revealed the following: a. On 1/18/24, an order for a B-type natriuretic peptide (BNP) and and basic metabolic panel (BMP) was ordered. The order was documented as completed in resident 14's electronic medical records (eMR). b. On 2/22/24, an order for a complete blood count (CBC), a comprehensive metabolic panel (CMP), a thyroid-stimulating hormone (TSH) with reflex thyroxine (T4), a BNP, and a magnesium level (Mg) was ordered. The order was documented as completed in resident 14's eMR. It should be noted that no results could be found for either laboratory order. Review of resident 14's progress notes revealed no documentation of the laboratory results or physician notification. On 10/01/24 at 11:01 AM, an interview was conducted with the DON. The DON stated that on 1/18/24 and 2/22/24 resident 14 refused the lab draw but they did not have documentation of that. The DON stated that the refusal for the blood draws should have been documented in a progress note. The DON stated that the licensed nurse should have notified the physician of resident 14's refusal for the blood draws, and that the refusal and physician notification should have been documented in a progress note.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47432 Based on observation and interview, it was determined that the facility did not provide a safe, clean, comfortable, and homelike environment. Specifically, resident restrooms were found to be dirty and there were strong odors of urine in facility restrooms Findings Included: On 10/02/24 at 11:42 AM, an observation was made of the restroom located in room [ROOM NUMBER]. There was a stain surrounding the base of the toilet. On 10/02/24 at 11:45 AM, an observation was made of the restroom located in room [ROOM NUMBER]. There was a strong odor of urine. On 10/02/24 at 11:58 AM, an interview was conducted with the Housekeeper. The Housekeeper stated that the restroom in room [ROOM NUMBER] always smells like mold and mildew. The Housekeeper stated that she tries to get rid of the odor in the restrooms by scrubbing the toilet and shower with disinfectant. The Housekeeper stated that the odor in the restrooms goes away after she cleans the restrooms. The Housekeeper stated that the odor in the restroom is absent for a while after cleaning, but eventually it comes back. The Housekeeper stated that she believes the odor comes from residents urinating outside of the toilet bowl. [Note: The observation of odors in the facility's restrooms occurred after the housekeeper had finished cleaning restrooms for the day.] The Housekeeper stated that she is unable to get to all of her housekeeping duties completed such as washing and cleaning the curtains because the facility reduced the hours of the other housekeeper that works part time in the evenings from 4:00 PM to 8:00 PM. The Housekeeper stated that the last time she was able to wash the curtains was over a month ago. The Housekeeper stated that the part time housekeeper used to work Sunday through Thursday, but now only works Sunday through Wednesday. On 10/02/24 at 11:34 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that he was unaware of how often resident rooms are cleaned, but that the facility has two housekeepers, one during the day and one during the evening.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38031 Based on interview and record review it was determined, for 9 out of 28 sampled residents, that the facility did not ensure that the resident had the right to be free from abuse, neglect, misappropriation of resident property and exploitation. Specifically, the facility did not protect residents from abuse following an incident of sexual abuse by a Certified Nurse Assistant (CNA), an incident of verbal abuse by a CNA, multiple incidents of physical abuse following residents to resident altercations, and two incidents of sexual abuse from other residents. Resident identifiers: 2, 7, 9, 14, 22, 85, 86, 91, and 92. Findings included: 1. Resident 7 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which consisted of presence of right and left artificial shoulder joint, chronic obstructive pulmonary disease, hypertensive heart disease, pulmonary hypertension, chronic pain syndrome, ventricular premature depolarization, insomnia, nonrheumatic mitral valve insufficiency, history of myocardial infarction, dysphagia, overactive bladder, lesion of ulnar nerve, hypertension, lymphedema, osteoporosis, and hyperlipidemia. On 9/22/24 at 10:15 AM, an interview was conducted with resident 7. Resident 7 stated that CNA 3 was a wonderful aide, he was jovial, he was lovely. Resident 7 stated that one day while talking to CNA 3 he had mentioned that he was going to Kauai, and he told her that he would take her with him. Resident 7 stated that she was not sure how it happened, but CNA 3 said that it would be better if she went as his wife. Resident 7 stated that CNA 3 had told her that he really cared for her. Resident 7 stated that it then felt like manipulation when CNA 3 had asked her to take a photo of her bare breast. Resident 7 stated that she told CNA 3 no and that it was not appropriate. Resident 7 stated that CNA 3 then told her that he must have an obedient wife. Resident 7 stated that she thought it was a ridiculous request and she felt uncomfortable. Resident 7 stated that after CNA 3 was terminated he sent threatening texts to her. Resident 7 stated that the texts said that he could not get a job, that she had ruined his life, and that he was so good to her. Resident 7 stated that she later learned from another aide that CNA 3 was married and had children. Resident 7 stated that she confronted CNA 3 via text, and he replied something nasty and that was the last of it. Resident 7 stated that she showed the text to one of the important people here and then he got fired. Resident 7 stated that CNA 3 was inappropriate, and that was the reason he lost his job and not her. Resident 7 stated She did nothing inappropriate. When you're a married man you don't ask another woman to be your wife. Obviously he has some mental issues and I don't know where he is now. Resident 7 stated that she texted CNA 3 and asked him if he asked her to be his wife so he could get American citizenship and he replied no. Resident 7 stated that she wished he had continued to be a good CNA and that he was a lot of fun. Resident 7 stated that this occurred approximately 6-8 months ago, and she no longer had contact with CNA 3. Resident 7 stated that CNA 3 had called her a silly woman with delusions and denied that it had occurred. Resident 7 stated that was when she handed the text over to the facility staff. Resident 7 stated that she did not have the text messages any longer and that she may have gotten a new phone since this occurred. Resident 7's medical records were reviewed. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/14/24, resident 7's Quarterly Minimum Data Set (MDS) Assessment documented that the resident had a Brief Interview for Mental Status (BIMS) score of 15, which would indicate that resident 7 was cognitively intact. On 3/18/24 at 6:11 PM, resident 7's Social Service Note documented, LCSW [Licensed Clinical Social Worker] met with [resident 7] to assess potential indicators of psychosocial distress. [Resident 7] appears friendly, attentive, communicative, well groomed, and happy. She exhibits speech that is normal in rate, volume, and articulation and is coherent and spontaneous. Language skills are intact. Mood presents as normal with no signs of either depression or mood elevation. Affect is appropriate, full range, and congruent with mood. Associations are intact. There were no signs of psychotic symptoms. She denies having suicidal ideas. Homicidal ideas or intentions are denied. Cognitive functioning and fund of knowledge are intact and age appropriate. Short- and long- term memory are intact. This patient is fully oriented. Vocabulary and fund of knowledge indicate cognitive functioning in the normal range. There are no signs of anxiety. There are no signs of hyperactive or attentional difficulties. [Resident 7's] behavior was cooperative and attentive with no gross behavioral abnormalities. When asked about the situation regarding the texts between her and an employee [resident 7] stated 'we were supposed to get married. I don't know why he would ask for pictures. That's not right' and 'he told me he wanted an obedient wife, and I told him children are obedient'. [Resident 7] expressed that 'now he is going to lose his CNA license and I didn't want that to happen.' When LCSW asked her how she was feeling she stated, 'I wish it could go back to how it was before, he was fun and we're not going to talk anymore, he said goodbye'. [Resident 7] was offered mental health services and declined stating 'I'm tired of talking about it.' Screening for s/sxs [signs and symptoms] abuse was negative. Based on review of resident's medical chart, assessments. staff observations, and clinical interview, resident does not appear to be experiencing psychosocial distress. The facility notification to the State Survey Agency (SSA), form 358, documented an allegation of sexual abuse by CNA 3 towards resident 7. The form documented that the Resident Advocate (RA) became aware of the incident on 3/18/24 at 9:22 AM. The details of the incident documented inappropriate phone correspondence between staff and a resident of a sexual nature. The form documented that the incident occurred on 3/14/24. Review of the facility investigation, form 359, revealed an interview that was conducted with resident 7. The interview summary documented, 'He was always very playful and fun with me. He never made any inappropriate comments until he asked to communicate with me through email. I told him that I don't use email well, and we exchanged phone numbers instead. Very early in the conversation, he suddenly said that he wanted me to be his wife. I enjoyed the conversation. Then he started asking me to send him nude photos of my breasts. I was surprised and a little annoyed by that. I told him that he can take them himself the next time he's at work (3/21).' DON [Director of Nursing] offered to assist her with blocking the perpetrator's number and she declined. The next day, upon learning of the investigation, perpetrator sent several frustrated messages to the resident, as divulged by her when DON met with her for the day. Resident expressed that she is not upset by the content of the messages, and when DON again offered to assist her to block the number, she again declined. Resident was not observed displaying any symptoms of distress, physical or psychological harm. She indicated that the two of them had never had any sort of inappropriate physical contact, and a complete skin check revealed no abnormalities. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The summary of interviews also documented, No witnesses present with this incident, though the staff member that the resident divulged to read the text messages. The information obtained is quotations from the perpetrator's text messages to the victim: 'Good morning, [resident 7]! I need to get some sleep after my night shift. After that, I will start sending you messages on your cell phone and your email about our future trip to the islands with the aim of your recovery. Have a wonderful day!' '[Resident 7], I just sent a test message to your email. (Kissing emoji)' (The email simply said 'Hello [name omitted], this is a test email' 'Hey [name omitted]! I am so sorry, but I am very busy with my extra work. Don't worry, I am continuing to communicate with you and would like to hug you in a private place. I didn't use a car because public transport in Salt Lake City is perfect. But I understand your desire to make with me always. Would you like to be my wife?' 'Thanks for your amazing messages! But I would like to ask you a simple question: Would you like to be my wife? (Heart emoji)' 'If you are ready to be my wife, then send me a photo fo (sic) your bare breasts. I love you and much!! (Face and heart emoji)' 'Sorry, but you can't see your photo (Heart-eyes emoji)' 'I need an obedient wife, so try to send me your special photo' 'My spoken English is imperfect, so let's correspond .' '[name omitted], do you really love me?' The conclusion of the facility investigation verified the allegation of sexual abuse. The corrective action implemented by the facility was termination of CNA 3. The entry gate code was changed to ensure that CNA 3 had no ability to enter the facility grounds. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/30/24 at 2:59 PM, an interview was conducted with the RA. The RA stated that she became aware that resident 7 and CNA 3 had a relationship. The RA stated that it was texting, and she had viewed those text messages. The RA stated that she had taken photos of the text communication between CNA 3 and resident 7 but did not know if she still had those copies. The RA read the text messages that were documented in the facility abuse investigation, form 359, and stated that it was accurate. The RA stated that when she first spoke to resident 7 regarding this incident resident 7 was hinting about it to her. The RA stated that resident 7 seemed happy about the relationship because she thought she had found love. The RA stated that she persuaded resident 7 to show her the text communication with CNA 3. The RA stated that after reading the text messages she explained to resident 7 why it was wrong. The RA stated that she told resident 7 that CNA 3 had professional obligations and could not have relations with any resident, and that it was inappropriate and against the law. The RA stated that resident 7 had reported that nothing physical had happened. The RA stated that resident 7 did not seem upset about the request for nude photos but did state that it was inappropriate. The RA stated that resident 7 had replied that was not who she was, when CNA 3 stated he needed an obedient wife. The RA stated that she reported the incident to the DON immediately. On 10/01/24 at 3:00 PM, an interview was conducted with the Administrator (ADM). The ADM stated that he and the previous ADM conducted the investigation. The ADM stated that CNA 3 had begun texting resident 7. The ADM stated that resident 7 had the right to a romantic relationship but the staff could not have a romantic relationship with residents. The ADM stated that the RA had informed the ADM of the incident. The ADM stated that the RA had informed them of the text messages between resident 7 and CNA 3. The ADM stated that the messages were making resident 7 uncomfortable. The ADM stated it seemed like it was romantic and it went wrong. The ADM stated that he informed CNA 3 by the phone communication app that he was suspended. The ADM stated that they did not speak to CNA 3 and he seemed to avoid all conversation with the facility. The ADM stated that they attempted several times to call CNA 3 but was never able to communicate with him. The ADM stated that they changed the security code to the gate, they communicated with the staff through whats app that CNA 3 was not allowed back in the facility. The ADM stated that when he spoke to resident 7 she was embarrassed about the whole situation. The ADM stated that resident 7 had a good conversation with the RA and DON. The ADM stated We wanted to protect her but wanted to respect her rights. The ADM stated that they asked resident 7 if she wanted to continue talking to CNA 3 after he was terminated or if she wanted them to block his number. The ADM stated that resident 7 did not want to talk to CNA 3 anymore, did not want to respond to his texts, but did not want to block him. The ADM stated that he had viewed the photos of the text messages that the RA had taken. The ADM stated that the text messages included CNA 3 requesting photos of resident 7's bare breasts. The ADM stated that any sort of communication like that was an instant termination. The ADM stated that afterwards they tried to determine if there were any other residents that were involved with CNA 3. The ADM stated that they interviewed 5 other cognitively intact women and asked them if they had ever had any text communication with staff or any request for inappropriate photos from staff. The ADM stated that determined that there were no other incidents of sexual abuse. The ADM stated that they provided staff education after the incident that included professional relationships and what was considered inappropriate. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/01/24 at 3:16 PM, an interview was conducted with the DON. The DON stated that they discovered through the RA a relationship between resident 7 and CNA 3. The DON stated that resident 7 had some text messages in which CNA 3 had requested a photo of resident 7's breasts. The DON stated that CNA 3 had texted that he wanted resident 7 to be an obedient wife and it chapped her. The DON stated that resident 7 was a strong willed individual. The DON stated She did not feel victimized, she felt annoyed, and she would not be obedient. The DON stated that resident 7's response to the photo request was come take it yourself. The DON stated that resident 7 did not send a picture, and did not want to be caught up in a photograph. The DON stated that resident 7 was more annoyed by the request. The DON stated that they informed resident 7 of the seriousness and extent of violation that was in healthcare. The DON stated that resident 7 understood and she expressed some sadness because she wanted to be loved. It made her sad. Not because it happened but because it wasn't going to continue. The DON stated that CNA 3 was terminated the same day. The DON stated that he performed a full body skin check on resident 7, and there was no new skin issues. The DON stated that resident 7 adamantly denied anything physical had happened. The DON stated that the incident had occurred the night before. The DON stated resident 7 stated He was playful, flirty and fun and she like it. The DON stated that CNA 3 had tried to initiate email communication, but that resident 7 did not know how to do that. The DON stated that he talked to resident 7 about her emotional status and offered behavioral health services. The DON stated that the LCSW visited resident 7 and assessed her. The DON stated that resident 7 refused to block CNA 3's phone number. She thought it was resolved and he wouldn't continue. The DON stated that resident 7 continued to engage her normal way, but was sad that she did not have that relationship. The DON stated that after CNA 3 was terminated he sent some nasty messages to resident 7, something along the lines of your actions cost me my job. The DON stated that afterwards they initiated an ability to consent by the provider and resident 7 was deemed capable of consenting. The DON stated that even if resident 7 was capable it was not appropriate with a CNA. The DON stated that he called CNA 3 and left a voicemail stating that he was suspended. The DON stated that CNA 3 never called back or texted. The DON stated that corporate human resources called about the termination. The DON stated that they changed the gate code and notified the police department of the incident. The DON stated that they conducted a facility wide sweep to see if any other female residents had any contact with a staff member in an uncomfortable or sexual manner. The DON stated that all responses were negative. The DON stated that they did abuse training and appropriate communication forms afterwards. 2. a. Resident 22 was admitted to the facility on [DATE] with diagnoses which included frontotemporal neurocognitive disorder, unspecified mood disorder, impulse disorder, insomnia, disinhibited attachment disorder, asthma, anxiety disorder, chronic respiratory failure, and hepatic encephalopathy. Resident 9 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included epidural hemorrhage, stable burst fracture of T11-T12, type 2 diabetes mellitus, chronic obstructive pulmonary disease, morbid obesity, contusion of abdominal wall, hypertensive heart disease with heart failure, schizoaffective disorder, post-traumatic stress disorder, spondylolisthesis, insomnia, chronic pain, hypothyroidism, anxiety disorder, spinal stenosis cervical region, osteoarthritis, overactive bladder, history of suicidal behavior, and repeated falls. Resident 22's medical records were reviewed. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/25/24, resident 22's MDS Assessment documented that a BIMS could not be conducted because resident 22 was rarely or never understood. The assessment documented that resident 22 Mood Interview was not conducted because resident 22 was rarely or never understood. The Assessment documented that resident 22 did not have hallucinations or delusions, and did not have any physical or verbal behavioral symptoms directed toward others. On 6/21/24 at 11:29 PM, resident 22's Social Service Note documented, LCSW met with resident to assess for potential indicators of psychosocial distress. [Resident 22] appears anxious, distracted, minimally communicative, and casually groomed, which is consistent with her typical daily baseline. She exhibits speech that is fast in rate, normal in volume, is coherent at times and is repetitive. There were no signs of psychotic symptoms. Vocabulary and fund of knowledge indicate cognitive functioning in the below normal range. Insight and judgement into problems appears low. [Resident 22] behavior was uncooperative, and she repeated 'I'm good', and 'goodbye. goodbye'. [Resident 22] also 'fist-bumped' LCSW for the second time as she walked away. Based on a review of resident's medical chart, assessments. staff observations, and clinical interview, her behaviors appear to be within her baseline, and it does not appear that she is experiencing psychosocial harm. On 6/27/24, resident 22's skin assessment documented no new skin problems. It should be noted that no documentation could be found that resident 22's skin was assessed after the incident with resident 9 on 6/21/24. On 6/21/24 at 4:47 PM, resident 9's Nurses Note documented, Resident reported to one of the aides that she jabbed another resident with a pen last night 'hard enough to leave a mark' because she is 'fucking psychotic and manic' (referring to herself). Skin check revealed no significant injury on the other resident. On 6/21/24 at 9:50 PM, resident 9's hospital behavioral health intake notes documented that another resident with dementia came into her room, touched her things and resident 9 stabbed her with a pencil. Per pt [patient], she was trying to write 'stop it' on the resident's arm. Pt told staff, 'I'm fucking psychotic and manic.'. The facility notification to the SSA, form 358, documented an allegation of physical abuse by resident 9 towards resident 22. On 6/21/24 At 1530 [3:30 PM] [CNA 2] was toileting [resident 9]. While washing her hands, [resident 9] stated that she is manic bipolar and that today she 'got so psycho' that she stabbed [resident 22] with a pen for toughing (sic) her things. At 1535 [3:35 PM] [CNA 2] informed [name omitted] (Operations Manager) of what she was told. [ADM] told [CNA 2] to tell the DON [name omitted] and to have [resident 22] get a skin check. They found a pen mark with a skin abrasion at 1538 [3:38 PM]. The form documented that resident 22 sustained a skin abrasion to her left forearm. Review of the facility investigation, form 359, revealed, There were no witnesses to the altercation, but our CNA [name omitted] was providing cares when [resident 9] stated that she was experiencing a manic episode and that she had stabbed [resident 22] with a pen which she attributed to her manic episode. Skin assessment was done with [resident 22] to confirm the story and an abrasion was found and the abrasion did match a scratch with a pen due to the ink line still on the skin. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The conclusion of the facility investigation verified the allegation of physical abuse. The corrective action implemented by the facility was a Stop sign installed on resident 9's door to prevent resident 22 from wandering into the room. The systemic changes identified were to in-service the staff to re-direct resident 22 when wandering and resident 9 was referred to physical therapy to help channel excess energy of mania. On 9/24/24 at 1:49 PM, an interview was conducted with the DON. The DON stated that he had read the note that resident 9 had not received her Latuda. The DON stated that he called the pharmacy and balled them out. The DON stated that when he identified that the medication was out of stock, he called the pharmacy and they did not provide a good explanation, and that the general explanation was due to a dose change. The DON stated that if a resident was not provided their ordered psychotropic medications, it could cause an exacerbation of their psychiatric illness. The DON stated that resident 9 had an episode of aggression towards resident 22. The DON stated that resident 22 had wandered into resident 9's room and reached for something. The DON stated that resident 9 shouted and jabbed at resident 22. The DON stated that this resulted in a drawing mark on resident 22 but no broken skin. It should be noted that this contradicted form 358 and form 359 that documented an abrasion to resident 9's left forearm. The DON stated that resident 9 was blue sheeted and sent to the hospital for evaluation. The DON stated that resident 9 returned with a diagnosis of a urinary tract infection. The DON stated that interventions after the incident were to place a stop sign so that resident 22 would not wander into resident 9's room. The DON stated that resident 22 was fixated on food and would wander during mealtimes in search of food. The DON stated that staff were instructed to redirect resident 22 during meals. On 9/25/24 at 1:52 PM, an interview was conducted with CNA 2. CNA 2 stated that resident 9 had reported an incident between her and resident 22. CNA 2 stated that resident 9 had been coloring and writing letters. CNA 2 stated that resident 22 frequently takes other residents belongings. CNA 2 stated that resident 9 reported that resident 22 attempted to take her belongings and she stabbed her with a pen. CNA 2 stated that resident 9 was upset that resident 22 took her stuff, and knew she should not have done what she did. CNA 2 stated she asked resident 9 if she had hurt resident 22 and she replied, I don't think so. CNA 2 stated that she finished resident 9's care and reported the incident to the ADM. CNA 2 stated that she checked resident 22's hand and it had an ink mark but no broken skin. CNA 2 stated that resident 22 did not appear in any distress and was lying in bed when she observed the skin. [Cross-refer to F755] 2. b. On 5/3/24 at 10:28 am, the facility reported to the SSA that on 5/3/24 at 8:05 am, a CNA was observed repeatedly yelling Goodbye in an aggressive and mocking tone towards the resident 22 while passing out breakfast trays in the dining room. The facility notification to the SSA, form 358, documented an allegation of verbal abuse by CNA 4 towards resident 22. The form documented the details of the incident as, [RA] observed the CNA [name omitted] yelling 'Goodbye' repeatedly in an aggravating and mocking tone to the resident while [name omitted] was passing breakfast trays. Another CNA, [name omitted] walked the resident away from the dining room. The RA reported the incident to the DON who informed the ADM. The form documented that the immediate steps taken were suspension of the CNA 4. The RA then spoke to resident 22 who was given a fist bump, a hug, and told [RA] 'I'm good, I'm fine.'. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility investigation, form 359, documented a summary of the interview with resident 22. Per resident's cognitive and communicative baseline, she does not elaborate deeply into the event or how she's feeling. Her responses are curt, largely consisting of 'I'm good, see you later'. Then a fist bump to the RA, which is a baseline pleasantry exchanged with staff. On 5/3/24, a facility interview with CNA 5 documented, I heard someone shouting 'Goodbye, goodbye' repeatedly and responded to the area to find the perpetrator shouting at the victim because she was looking for food. On her [CNA 4] way out I heard her [CNA 4] threating (sic) that 'They better pay me my money or I am going to come back and shoot this place up' in front of [ADM] office. On 5/3/24, a facility interview with Registered Nurse (RN) 3 documented, I heard [CNA 4] shouting and found her saying 'Goodbye' loudly at the resident because she was out looking for the breakfast tray. On her way out I heard her talking back to us but couldn't hear what she said because I was helping another resident. On 5/3/24, a facility interview with the RA documented, I was sitting in my office and heard what sounded like a staff member shouting 'Goodbye' very loudly and seemingly in a mocking way. I responded to find her shouting it toward a resident's face as the resident was searching for snacks on the breakfast tray, which is a behavior of hers. [CNA 4] has a tendency to be abrupt when redirecting resident behaviors, but has never shown a tendency towards mocking or shouting at residents in the past. I went to [resident 22's] room after to see how she was doing and she told me that she was ok and that she was good. She even gave me a hug and a fist bump. The form 359 documented that resident 22 had a medical history of frontotemporal neurocognitive disorder, impulse control disorder, disinhibited attachment disorder, and behaviors related to binge eating from other resident trays while trays are being passed, resulting in a necessity of redirection. Resident 22 had a BIMS of 0. When staff attempt redirection, she will often say 'I'm good, goodbye', which is assumed by the investigators to be where the repeatedly shouted 'Goodbye' stems from. Resident responds well to calm verbal redirection the majority of the time. The conclusion of the facility investigation was verified the allegation of verbal abuse and documented, Incident of abuse verified in this circumstance due to the incident being witnessed by other staff, though resident observes no signs of mental or physical harm and continues to function at her physical and psychosocial baseline. On 9/30/24 at 3:20 PM, a telephone interview was conducted with CNA 5. CNA 5 stated that resident 22 had a behavior of seeking food, and that staff were to get her something to eat and then redirect her. CNA 5 stated that she observed CNA 4 scream at resident 22 in her face and then dragged her back to her room. CNA 5 was read her original statement from the facility investigation and CNA 5 confirmed the accuracy of that statement. CNA 5 stated that CNA 4 had said goodbye to resident 22 and then told her that she did not need to eat. CNA 5 stated that the RA was in her office at the desk and heard what was said by CNA 4. CNA 5 stated that the incident occurred in the TV room. CNA 5 stated that the facility sent CNA 4 home after the incident. CNA 5 stated that she heard CNA 4 state that she was going to blow up the place when she was on her way out the door. CNA 5 stated that CNA 4 made this comment next to the ADM office and that the ADM had also heard the threat. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/30/24 at 2:45 PM, an interview was conducted with the RA. The RA stated that she heard from her office the altercation between CNA 4 and resident 22. The RA stated that resident 22 had come out looking for food and CNA 4 was shouting goodbye repeatedly at her. The RA stated that this was during a meal pass in the dining room area. The RA stated that this was said in a raised voice. The RA stated that when she came out of her office, she observed resident 22 walking back to her room. The RA stated that form 359 had a discrepancy in the summary, not sure why it was worded that way. The RA stated that the ADM interviewed her for the investigation. The RA stated that she could not verify the accuracy of the interview summary that was documented by the ADM. The RA stated that she did not recall stating that CNA 4 had a tendency to be abrupt when redirecting resident behaviors. The RA stated that she could have said that CNA 4 has never shown a tendency towards mocking or shouting at residents in the past. The RA stated that she did not witness CNA 4 in resident 22's face shouting, but instead heard the altercation from her office that was located next to where the incident occurred. The RA stated that if you told resident 22 to go back to her room, she would respond by saying goodbye. The RA stated that was why she described CNA 4's comments as mocking towards resident 22. The RA stated that CNA 4 was her sister but she was not her immediate supervisor. The RA stated that she was not present when CNA 4 made the statement when exiting the building. The RA stated that she was aware of the statement though. On 10/1/24 at 10:07 AM, an interview was conducted with the ADM. The ADM stated that when he was first informed of any allegation of abuse he would immediately check for resident safety. The ADM stated that as soon as the resident was deemed safe, he would gather information regarding the incident. The ADM stated that he would gather the details and interview any person who could to corroborate the story. The ADM stated that once he obtained a rough timeline of events then he would determine if a staff member needed to be suspended. The ADM stated that the nurse would assess the resident for any injuries. The ADM stated that he would then report the incident to the SSA, Adult Protective Services, and the ombudsman within 2 hours. The ADM stated that during the investigation he would try to determine if this was a systemic problem verses a one time occurrence. The ADM stated that he gathered information by asking the person reporting to tell him all the details, and then he would follow-up with any other witnesses. The ADM stated that he took notes on the interviews and then summarized in the form 359. The ADM stated that he shredded his notes after he summarized the interviews. The ADM stated that he would also have the interviewee write a statement in their own words and sign it. The ADM stated that he was new at the time of the incident between CNA 4 and resident 22. The ADM stated that he was on the way to the facility when the DON called him and notified him. The ADM stated that the RA had overheard CNA 4 yell at resident 22 in a mocking tone. The ADM stated that CNA 5 stepped in to help separate resident 22 and CNA 4. The ADM stated that they immediately suspended CNA 4. The ADM stated that he told CNA 4 that she was suspended immediately because there was an abuse allegation. The ADM stated that he explained to CNA 4 that if the allegation was not substantiated then she would be paid for the days she was suspended, but if it was substantiated then there was no pay. The ADM stated that CNA 4 responded like a teenager would with disrespect and said, fine I guess. The ADM stated that he asked CNA 4 to grab her things and clock out and they would do the process and keep her informed. The ADM stated that CNA 4 made some negative comments on her way out the door, they better pay me my money or I'm going to come back and shoot this place up. The ADM stated that this was said directly in front of his office window. The ADM stated that he was so shocked by the comment that he had to confirm with CNA 5 and RN 3 what w [TRUNCATED]

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38031 Based on interview and record review it was determined, for 1 of 28 resident's sampled, that the facility did not implement written policies and procedures that ensure reporting of all alleged violations to the Administrator, State Survey Agency (SSA), and Adult Protective Services (APS). Specifically, an allegation of verbal abuse by a facility Certified Nurse Assistant (CNA) towards the resident was not reported to Adult Protective Services. Resident identifier 22. Findings included: Resident 22 was admitted to the facility on [DATE] with diagnoses which included frontotemporal neurocognitive disorder, unspecified mood disorder, impulse disorder, insomnia, disinhibited attachment disorder, asthma, anxiety disorder, chronic respiratory failure, and hepatic encephalopathy. The facility notification to the SSA, form 358, documented an allegation of verbal abuse by CNA 4 towards resident 22. The form documented the details of the incident as, [RA] observed the CNA [name omitted] yelling 'Goodbye' repeatedly in an aggravating and mocking tone to the resident while [name omitted] was passing breakfast trays. Review of the facility abuse investigation revealed no documentation that demonstrated that APS was notified of the incident. On 10/01/24 at 10:07 AM, an interview was conducted with the ADM. The ADM stated that when he was first informed of any allegation of abuse he would immediately check for resident safety. The ADM stated that as soon as the resident was deemed safe he would gather information regarding the incident. The ADM stated that he would gather the details and interview any person who could corroborate the story. The ADM stated that once he obtained a rough timeline of events then he would determine if a staff member needed to be suspended. The ADM stated that they nurse would assess the resident for any injuries. The ADM stated that he would then report the incident to the SSA, Adult Protective Services, and the ombudsman within 2 hours. The facility policy for Resident Abuse Procedural Summary documented that the supervisor will be responsible for taking immediate actions to report the abuse to the appropriate individuals. The Administrator and Director of Nursing will be responsible for reporting the concerns, as required by law, and conducting the investigation. The policy further stated that all employees would be given specific example and measurable limits as to when reporting was required and they could be found contained within the Abuse Policy. The facility policy for Abuse, Neglect, Exploitation and Misappropriation Prevention Program documented that allegations of abuse would be reported within timeframes required by federal requirements. The policy was last revised in April 2024. [Cross-refer F600]

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38031 Based on interview and record review it was determined, for 2 out of 28 sampled resident, that the facility did not ensure that all alleged violations involving abuse or injuries of unknown source were reported immediately, but not later than 2 hours after the allegation was made, to the State Survey Agency (SSA) and Adult Protective Services (APS). Specifically, a resident had a newly identified bruise that was not reported to the SSA and an incident of verbal abuse by a Certified Nurse Assistant (CNA) towards a resident was not reported to APS. Resident identifiers 18 and 22. Findings included: 1. Resident 18 was admitted to the facility on [DATE] with diagnoses which consisted of asthma, dementia, hypertension, hyperlipidemia, insomnia, overactive bladder, gastro-esophageal reflux disease, hypokalemia, malignant neoplasm, chronic pain, unspecified protein-calorie malnutrition, anxiety disorder, and major depressive disorder. Resident 18's medical records were reviewed. On 8/27/24, resident 18's Admission Minimum Data Set (MDS) Assessment documented a Brief Interview for Mental Status (BIMS) score of 1/15, which would indicate a severe cognitive impairment. On 9/2/24, resident 18's Montreal Cognitive Assessment (MOCA) score was a 2/30, which would indicate a severe cognitive impairment. On 9/4/24 at 7:06 AM, resident 18's nurse note documented, CNAs [Certified Nurse Assistant(s)] found a bruise on the resident's upper thigh area. This appears to be a new bruise. Resident doesn't know how it happened. On 9/9/24, a skin assessment documented no new skin integrity problems. It should be noted that no documentation could be found of an assessment of the identified bruise. Resident 18's care plan for at risk for skin breakdown was initiated on 8/21/24. The care plan goal was that resident 18 would not develop a pressure injury. Interventions identified were do not massage bony prominence and implement weekly skin checks. It should be noted that the care plan did not have interventions related to monitoring, reporting or treating altered skin conditions. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/01/24 at 11:39 AM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated that if she identified a newly developed bruise on a resident she would notify the provider, notify the Director of Nursing (DON), document in a progress note and monitor the skin. RN 1 stated that she would document an event note to alert other staff and would pass off the information in shift report. RN 1 stated that areas of the body that were suspicious for bruising would be private areas, inner thighs, breast, butt, vagina, back of arm, or face. RN 1 stated that if she identified a new bruise she would document characteristics of the bruise such shape like finger prints, and coloring to date the bruise. RN 1 stated she would also document the exact location on the thigh to indicate if it was the outer or inner thigh. RN 1 stated that she felt like the exact location made a difference in investigating the bruise, especially if the resident was not cognitively aware to describe how it happened, the more details the better. On 10/01/24 at 11:48 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that CNAs should notify the nurse of any new skin conditions such as a bruise. The DON stated that the licensed nurse needed to assess the skin to see if it was suspicious before reporting it as abuse. The DON stated that the nurse should notify the provider as a non-urgent symptom to review and there was a list in the provider communication book for issues that needed attention by the provider. The DON stated that the licensed nurse sometimes documented in a progress note, but they were not consistently doing that. The DON stated that the licensed nurse should document a progress note that stated the provider was notified of the condition. The DON stated that a bruise would be considered suspicious if the size was large, was located in areas of the genitals or anus, and if it appeared like fingerprints or if the resident reported an allegation of abuse. The DON stated that if the resident was not able to report what caused the injury the staff should also consider observations and resident behaviors that may be at cause. The DON was informed of the nurse note identifying a new bruise on resident 18. The DON asked if the bruise was located on the lateral or medial aspect of the thigh. The DON stated that for the lateral aspect of the thigh he would still expect the nursing staff to assess for suspicious circumstances. The DON stated that if the bruise was located on the medial aspect of the thigh it would be considered suspicious and the Administrator (ADM), DON and provider should be notified. The DON stated that if the bruise was located on the inner thigh it could be a possible indicator of abuse. The DON stated that if it was an indicator of abuse, or an injury of unknown origin it should have been notified to the SSA. The DON stated that the note did not contain the precise location or characteristics of the bruise and the licensed nurse should have done a better note. The facility policy on Identifying Types of Abuse documented Possible indicators of physical abuse include an injury that is suspicious because the source of the injury is not observed, the extent or location of the injury is unusual, or because of the number of injuries either at the single point in time or over time. The policy further documented possible examples of injuries that could indicate physical abuse were bruises, including those found in unusual locations such as the head, neck, lateral locations on the arms, or posterior torso and trunk, or bruises in shapes (e.g., finger imprints); The policy was last revised in September 2024. 2. Resident 22 was admitted to the facility on [DATE] with diagnoses which included frontotemporal neurocognitive disorder, unspecified mood disorder, impulse disorder, insomnia, disinhibited attachment disorder, asthma, anxiety disorder, chronic respiratory failure, and hepatic encephalopathy. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility notification to the SSA, form 358, documented an allegation of verbal abuse by CNA 4 towards resident 22. The form documented the details of the incident as, [RA] observed the CNA [name omitted] yelling 'Goodbye' repeatedly in an aggravating and mocking tone to the resident while [name omitted] was passing breakfast trays. Review of the facility abuse investigation revealed no documentation that demonstrated that APS was notified of the incident. On 10/01/24 at 10:07 AM, an interview was conducted with the ADM. The ADM stated that when he was first informed of any allegation of abuse he would immediately check for resident safety. The ADM stated that as soon as the resident was deemed safe he would gather information regarding the incident. The ADM stated that he would gather the details and interview any person who could corroborate the story. The ADM stated that once he obtained a rough timeline of events then he would determine if a staff member needed to be suspended. The ADM stated that the nurse would assess the resident for any injuries. The ADM stated that he would then report the incident to the SSA, Adult Protective Services, and the ombudsman within 2 hours. The facility policy for Resident Abuse Procedural Summary documented that the supervisor will be responsible for taking immediate actions to report the abuse to the appropriate individuals. The Administrator and Director of Nursing will be responsible for reporting the concerns, as required by law, and conducting the investigation. The policy further stated that all employees would be given specific example and measurable limits as to when reporting was required and they could be found contained within the Abuse Policy. The facility policy for Abuse, Neglect, Exploitation and Misappropriation Prevention Program documented that allegations of abuse would be reported within timeframes required by federal requirements. The policy was last revised in April 2024. [Cross-refer F600] 47432

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38031 Based on interview and record review it was determined, for 3 of 28 sampled residents, that the facility in response to allegations of abuse did not prevent further potential abuse while the investigation was in progress. Specifically, the facility did not put effective measures in place to ensure that abuse did not occur and corrective measure that were identified were not implemented. Resident identifier, 14, 85, and 86. Findings included: 1. a. Resident 86 was admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses which consisted of atrial fibrillation, type I diabetes mellitus, acute respiratory failure, bipolar disorder, hepatic failure, hypertensive heart disease, anxiety disorder, post-traumatic stress disorder, dementia, hepatic encephalopathy, hyperlipidemia, essential tremor, pain, insomnia, major depressive disorder, benign prostatic hyperplasia, osteoarthritis, and age-related cognitive decline. Resident 14 was admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses which included cerebral infarction, hemiplegia and hemiparesis, cognitive communication deficit, chronic obstructive pulmonary disease, pain, major depressive disorder, dementia, insomnia, cervical disc degeneration, spondylosis with myelopathy, alcoholic polyneuropathy, hypertension, osteoarthritis, radiculopathy, cirrhosis of liver, hyperlipidemia, nicotine dependence, alcohol abuse, cannabis abuse, suicide attempt, suicidal ideations, ventral hernia, trochanteric bursitis of left hip, and lesion of ulnar nerve. The facility notification to the SSA, form 358, documented an allegation of physical abuse between resident 14 and resident 86. On 9/5/23 at 7:15 PM, the form documented that facility staff became aware of the incident. It is alleged that [resident 86] and [resident 14] were arguing over [resident 14's] radio and both residents were found on the floor. The form documented that the residents were separated and resident 86 was removed to another room. The form documented that resident 14 had a small cut on the top of his left hand and resident 86 had a small cut on his right elbow and his lip. The form 359 documented the corrective actions taken were a room change for resident 86, alert charting, skin assessments, and 15-minute checks on both residents for 24 hours. Med review was requested. It should be noted that no documentation could be found that 15-minute safety checks were completed for resident 86 or resident 14 after the incident occurred. 1. b. Resident 85 was admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses which included Alzheimer's disease, pseudobulbar affect, anxiety disorder, anemia, dementia with anxiety and mood disorder, and major depressive disorder. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility notification to the SSA, form 358, documented an allegation of sexual abuse by resident 86 towards resident 85. The form documented that Licensed Practical Nurse (LPN) 1 witnessed resident 86 seated on the couch next to resident 85. Its reported that [resident 86] was seen with his hand down the front of his pants and his other hand moving up the female residents leg and briefly making contact with her genital area. The residents were quickly separated, and [resident 86] was taken to his apartment. [Resident 85] was assessed and was unable to give any verbal feedback due to significant cognitive deficits, but was not showing signs of distress, pain or discomfort outside of her baseline. The corrective actions documented on form 359 were that resident 86 was placed on 15-minute checks to reduce the risk of continued incidents. [Resident 86's] provider ordered Depo-Provera, in order to reduce continued behaviors of a sexual nature Resident 86's medical records were reviewed. Resident 86's progress notes documented the following: a. On 9/14/23 at 5:07 PM, the Order Note documented, On 9/14, resident's POA [Power of Attorney][name omitted] was contacted following event with a female resident of the community. The provider ordered Depo-Provera in response to the event, and this order was discussed in detail with POA. POA had no concerns with this medication, and provided consent to DON to administer the medication. b. On 9/16/23 at 10:55 AM, the Orders - Administration Note documented that the Depo-Provera Intramuscular injection was unavailable from the pharmacy. Review of resident 86's 15-minute check logs revealed that the visual checks were initiated on 9/15/24 at 12:15 AM and entries continued until 10:00 AM. No documentation was entered on the log from 10:15 AM to 9:45 PM on 9/15/24. On 9/16/24, the 15 minute check log had missing entries from 6:15 AM to 1:45 PM. On 9/17/24, the 15 minute check log had missing entries from 4:00 PM to midnight. It should be noted that no other documentation of 15-minute checks was found. On 10/02/24 at 11:11 AM, an interview was conducted with the DON. The DON stated that to his knowledge resident 86 did not have a history of sexually inappropriate behaviors. The DON stated that resident 86's family member reported a past incident of sexual behavior with the onset of dementia, but nothing at the facility that he was aware of. The DON stated that the provider ordered Depo Provera in response to the incident. The DON stated that they tried to keep the residents separated, and ensure they were not in the common area at the same time. The DON stated 15-minute checks were not typically used as an intervention. The DON stated that with the facility demographic it was difficult to maintain 15-minute checks when you had another 10+ behavioral residents. The DON stated that the staff should have been consistent with the 15-minute checks and filling out the form completely. On 10/03/24 at 9:55 AM, an interview was conducted with the ADM. The ADM stated that 15-minute checks were a poor intervention in the facility. The ADM stated that 15-minute checks were basically a 1:1 staffing situation. The ADM stated that the immediate intervention was to identify what they could do to keep resident 86 and resident 85 separated. The ADM stated that he would expect to see the interventions documented in the facility investigation under corrective measures. The ADM stated that if they could not take measure to keep residents safe then he had to take drastic measures and transfer residents out. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[Cross-refer F600] 47432

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38031 Based on interview and record review it was determined, for 4 out of 28 sampled residents, that the facility did not ensure that when the facility transferred or discharged a resident that the transfer or discharge was documented in the resident's medical record and that all the information was communicated to the receiving provider. The information provided to the receiving provider should include contact information of the practitioner responsible for the care of the resident; resident representative information; Advanced Directive information; all special instructions or precautions for ongoing care; comprehensive care plan goals; and all other necessary information to ensure a safe and effective transition of care. Specifically, residents were transferred to the hospital and no documentation could be found to demonstrate what information was communicated to the receiving provider. Resident identifiers 8, 9, 14, and 19. Findings included: 1. Resident 9 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included epidural hemorrhage, stable burst fracture of T11-T12, type 2 diabetes mellitus, chronic obstructive pulmonary disease, morbid obesity, contusion of abdominal wall, hypertensive heart disease with heart failure, schizoaffective disorder, post-traumatic stress disorder, spondylolisthesis, insomnia, chronic pain, hypothyroidism, anxiety disorder, spinal stenosis cervical region, osteoarthritis, overactive bladder, history of suicidal behavior, and repeated falls. Resident 9's medical records were reviewed. On 9/19/2024 at 4:41 PM, resident 9's nurse note documented, Resident was sent to the hospital via gold cross because of hypotension, lethargic and bradycardic. On 9/23/24 at 9:16 AM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated that she would document a resident change in condition, everything she did for the resident, and if the resident was transferred to the hospital in a progress note. RN 1 stated that the progress notes would detail the time of transfer, circumstance or details of event, and where they transferred to. RN 1 stated she would send the resident face sheet and medication list with the resident to the hospital. RN 1 stated that they do not send a copy of the resident's Physician Order for Life Sustaining Treatment (POLST) to the hospital. RN 1 reviewed a random resident's face sheet and confirmed that the POLST or Advanced Directives were not listed on the form. RN 1 stated that she would also document in the progress note what was sent with the resident to the hospital. On 9/23/24 at 7:55 PM, a telephone interview was conducted with the RN 3. RN 3 stated that resident 9 was drowsy in the morning when she administered her medication. RN 3 stated that later in the day resident 9's vital signs changed and she had a low blood pressure and a low heart rate. RN 3 stated that she informed the Director of Nursing (DON) and the decision was made to send resident 9 to the emergency department. RN 3 stated that she gave the paramedics a copy of resident 9's medication list and face sheet. RN 3 stated that the paramedics shocked resident 9 before they transported her to the emergency room . (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/24/24 at 1:49 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that resident 9 had a change in condition in the afternoon on Thursday. The DON stated that Nursing Assistant (NA) 1 brought it to his attention. The DON stated he asked for a full set of vital signs and resident 9 had a heart rate in the high 30's and a blood pressure around 60/40. The DON stated that when the paramedics arrived they took resident 9's vital signs again. The DON stated that the paramedics asked him for a copy of resident 9's POLST form because they were going to start pacing her. It should be noted that no documentation could be found of the transfer paperwork for resident 9 or what information was sent to the receiving provider. 2. Resident 14 was admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses which included cerebral infarction, hemiplegia and hemiparesis, cognitive communication deficit, chronic obstructive pulmonary disease, pain, major depressive disorder, dementia, insomnia, cervical disc degeneration, spondylosis with myelopathy, alcoholic polyneuropathy, hypertension, osteoarthritis, radiculopathy, cirrhosis of liver, hyperlipidemia, nicotine dependence, alcohol abuse, cannabis abuse, suicide attempt, suicidal ideations, ventral hernia, trochanteric bursitis of left hip, and lesion of ulnar nerve. Resident 14's medical records were reviewed. On 3/7/24 at 2:27 PM, resident 14's nurse note documented, Resident is at hospital for trying to hurt himself. It should be noted that no documentation could be found of the transfer paperwork for resident 14 or what information was sent to the receiving provider. 50200 3. Resident 8 was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses which included, but not limited to, metabolic encephalopathy, diabetes mellitus, chronic obstructive pulmonary disease, chronic respiratory failure with hypercapnia, pulmonary hypertension, paranoid schizophrenia, and anxiety disorder. Resident 8's medical record was reviewed on 9/22/24. A review of the progress notes documented the following: a. On 1/7/24 at 3:56 AM, Nurses Note Note Text: Resident was re-admited [sic] to facility after being at the hospital. She has been hit and miss with keeping her NC [nasal cannula] on for additional oxygen. She doesn't like wearing it, and will sit in the hallway without it, or sit outside. Resident has not had a fall, [NAME] [sic] she exhibiting involuntary arm movements like before her hospital visit. She is compliant with taking her medications and with her ADLs. [activities of daily living] (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. On 1/15/24 at 2:36 AM, Nurses Note Note Text: Late entry for 1-14-2024 @ 1855 [6:55 PM]: Re-admit from [name of hospital] hospital. Arrived back to facility at 1855 in ambulance. DX [diagnosis]; Acute on 1)chronic respiratory failure with hypoxia and hypercapnia 2)Pneumonia. Ambulated from ambulance into facility with assistance from CNA [certified nursing aide] staff. Alert and oriented X3 [times 3] with verbal and nonverbal behavior congruent. New order for BS [blood sugar] checks to be done before and after meals QD [daily]. New order for DME [durable medical equipment] Compressor and for Nebulizer. Order faxed to [name of DME company] medical for DME equipment. VS [vital signs]: Temp [temperature] 97.9, B/P [blood pressure]138/74, Resp [respirations] 20, SPO2 [oxygen saturation] 90% on 3L [liters], Pulse 94. Lungs sounds diminished in all lobes. Wet cough noted with no sputum expelled. c. On 2/22/24 at 2:34 AM, Nurses Note Note Text: [resident 8] voiced she came back to [name of facility] from the hospital today at 4PM. Voiced she is happy to be back and that she missed her friends here. She is alert and oriented X3 and compliant with all meds and cares. Took all HS [bedtime] meds whole with water without any problems. SPO2 90% on 3.5L O2 [oxygen]. Assisted her to call her husband at 2000 [8:00 PM]. She is in bed sleeping without any signs or symptoms of distress. d. On 3/25/24 at 10:44 AM, Nurses Note Note Text: Resident sent to hospital for low 02 saturation. e. On 5/12/24 at 3:56 AM, Incident Note Note Text: At 0250 [2:50 AM], resident was yelling for help, while outside. Staff found the resident away from her walker and lying on the ground. I just fell she told the staff. She also stated, I have too much oxygen. Staff checked and resident's O2 level was 35%. A fewminutes [sic] passed and it jumped to 40%. The resident was helped up to her walker, then walked to her room. Assessment and first set of Neuros were to be started. Resident was placed on 4L of oxygen and only came up to 67%. She was able to answer simple Yes or No questions clearly. However, if she began to explain something, her words became slurred. Staff reported that she had become agitated and raised her fist to staff when told she couldn't go out to smoke. No wounds were visible and resident denied pain. DON [director of nursing] and Administrator were notified at 0257 [2:57 AM]. Because of her low oxygen level and resident's orientation continuing to change when asked questions, 911 was called and she was taken to the [name of hospital] hospital. f. On 6/26/24 at 8:08 AM, Nurses Note Note Text: Resident was sent to the hospital. Resident was lathargic [sic], weak and dizzy, she couldn't stand with out assistance. Residents vitals were (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b/p- 74/43 T-101.2 HR- 104 O2- 66% Resident was sent to the [name of hospital] g. On 7/7/24 4:10 PM, Nurses Note Note Text: CNA notified me that [resident 8] fell on her face outside on the pavement. When this nurse went outside [resident 8] was laying in supine position. She had blood on the R [right] side of her face and inside her mouth. Noted abrasions to her face, blood in hair and in her mouth and throat. Head to toe assessment done. No hip fx [fracture] upon assessment. Head to toe assessment. Neuro check WNL [within normal limits] , VS:B/P 155/85, Resp, 20, Pulse 88, SPO2 88%. 911 called. Notified DON and guardian [name redacted]. MD [medical doctor] notified. Ambulance took [resident 8] to [name of hospital] hospital. h. On 7/15/24 11:11 PM, Nurses Note Note Text: Resident was struggling to oxygenate, causing ALOC [altered level of consciousness] and confusion, she was cyanotic, very lethargic and weak, unable to sit up long enough to take meds. She agreed to be transported to [name of hospital] for evaluation. Guardian and husband were notified. I called for anupdate [sic], and she has been admitted to [name of hospital] Shock/Trauma unit. Personnel on the unit were unavailable to answer the phone for a status update. Will follow up. i. On 9/28/24 at 9:27 AM Nurses Note Note Text: Resident was sent to the hospital. This morning her oxygen was 60% on 5L. She was not being compliant with keeping her Nasal cannula on. When I ask, she said I am breathing and keep walking. On call NP [nurse practitioner] [name redacted] Notified about patient conditions at 7:39 Am and agree to send her to the hospital. Resident guardian was notified. A hospital history and physical report dated 1/10/24 documented, .Patient comes with no documentation from her care facility, attempted to call with no answer/continuous ringing .unable to obtain further information Review of resident 8's electronic medical record revealed no documentation of a transfer/discharge assessment or paperwork that might have accompanied the resident to the hospital. 4. Resident 19 was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses which included, but not limited to, Alzheimer's Disease, dementia, type 2 diabetes mellitus, bipolar disorder, anxiety disorder, hyperkalemia, peripheral vascular disease, and gastro-esophageal reflux disease without esophagitis. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 19's medical record was reviewed on 9/22/24. A review of the progress notes documented the following: a. On 9/4/at 3:21 AM, Orders - General Note from eRecord Note Text: Resident returned from the [name of hospital] ER [emergency room] department at 0245 [2:45 AM]. She had requested to go to the hospital because she was feeling sick. not feeling well. ER department performed the following tests CT [computed tomography] of her brain/head CT maxillofacial w/o [with out] contrast CT spine cervical w/o contrast CBC [complete blood count] w/ auto Diff CMP [comprehensive metabolic panel] Lipase level Urinalysis w/ microscope Everything was found to be unremarkable, except the urinalysis. A urinary tract infection was found, and resident was given a Rocephin shot. The ER sent a script for Keflex 500 mg three times a day for 7 days. Resident was placed in her bed and is sleeping. b. On 9/7/24 at 8:30 AM, Nurses Note Note Text: Patient was transported by EMS [emergency medical services] to [name of hospital] ER. She was drooling while she was waiting which is her primary complaint that her throat is sore enough that she can't swallow. was unable to take her pills due to this. Family, on call provider and DON alerted. Review of resident 19's electronic medical record revealed no documentation of a transfer/discharge assessment or paperwork that might have accompanied the resident to the hospital. On 10/01/24 at 12:57 PM, an interview was conducted with Registered Nurse [RN] 1. RN 1 stated that a face sheet, medication list, and POLST [Physician Orders for Life Sustaining Treatment] form should accompany a resident to the hospital. RN 1 stated that this information was given to the EMTs [emergency medical technicians]. RN 1 stated that the documents needed to be printed and sent with EMS. RN 1 stated that a progress note should be made and the DON should be notified. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/02/24 at 11:32 AM, an interview was conducted with the DON. The DON stated that it should be documented in the progress noted that a resident went to the hospital. The DON stated there was something called e-interact that wasn't done as much as he would like the nurses to do to document that the resident had been transferred to the hospital. The DON stated that the progress notes should document the situation as to why the resident needed to go to the hospital, that the provider, DON, and responsible party should have been notified. The DON stated that the resident's medication list and POLST form should accompany the resident to the hospital.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38031 Based on interview and record review it was determined, for 1 of 28 sampled residents, that the facility did not ensure that recommendations from the pre-admission screening and resident review (PASRR) level II determination and evaluation were implemented and included in the resident assessment, care planning and transitions of care. Specifically, a residents PASRR level II recommendations for specialized services for mental illness was not implemented. Resident identifier 14. Findings included: Resident 14 was admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses which included cerebral infarction, hemiplegia and hemiparesis, cognitive communication deficit, chronic obstructive pulmonary disease, pain, major depressive disorder, dementia, insomnia, cervical disc degeneration, spondylosis with myelopathy, alcoholic polyneuropathy, hypertension, osteoarthritis, radiculopathy, cirrhosis of liver, hyperlipidemia, nicotine dependence, alcohol abuse, cannabis abuse, suicide attempt, suicidal ideations, ventral hernia, trochanteric bursitis of left hip, and lesion of ulnar nerve. Resident 14's medical records were reviewed. Resident 14's progress notes revealed the following: a. On 3/7/24 at 2:27 PM, the nurse note documented, Resident is at hospital for trying to hurt himself. b. On 5/31/24 at 3:08 PM, the resident advocate note documented, [Resident 14] has began Mental health therapy with [name omitted] therapy. On 12/29/21, the PASRR level II evaluation documented that in 2018 the resident began to experience increasing depressive symptoms due to his memory loss and due to fears of being put out on the street as he did not have a place to live. He was having suicidal thoughts and eventually cut on both of his wrists; hospital records state that pt reported 'so rather than living on the street, I decided to end it'. After cutting his wrists he fell and hit his head and ribs as well. Pt [patient] was taken to the ER [emergency room] at [hospital name omitted] and had his wrists bandaged, and due to his severe depression he was admitted to [hospital name omitted] for psychiatric evaluation and stabilization. The assessment documented that the resident may be a substantial danger to himself or others. The assessment documented the recommendations as Pt would likely benefit from counseling services to learn ways to cope with his psychiatric sxs [signs and symptoms]. On 5/25/23, resident 14's care plan for meets PASRR level II determination was initiated. The goal was that resident 14 would receive specialized services as recommended by the PASRR level II evaluation. On 5/27/24, an intervention was initiated for PASRR Recommendations for specialized services treatment: Pt would likely benefit from counseling services to learn ways to cope with his psychiatric sxs. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/2/24 at 1:14 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that resident 14 was blue sheeted to the hospital a couple of months back. The DON stated that something upset resident 14 and he believed it had to do with the resident being out of cigarettes. The DON stated that resident 14 walked away and said might as well get a body bag. The DON stated that he went and talked to resident 14 and he was holding a butter knife. He looked like he was about to cut himself, one arm extended like he was going to cut himself. The DON asked resident 14 to give him the knife and he did. The DON stated that he asked resident 14 if he was actively suicidal and he responded yes. The DON stated that he asked if he had a plan and resident 14 replied what do you think?. The DON stated that resident 14 did not want to go to the hospital so the provider blue sheeted him. The DON stated that resident 14 did not have a psychosocial assessment after the incident. The DON stated that resident 14 reported to the hospital that he was doing the suicidal ideation behavior in an attempt to obtain cigarettes and that was why they did not admit resident 14 to psychiatric unit. The DON stated that the provider ordered Abilify for resident 14 after his re-admission. The DON stated he could not recall if resident 14 was evaluated by a Social Service Worker (SSW) after his re-admission. The DON stated that a SSW should evaluate a resident after any suicidal ideations or suicidal attempts. The DON stated that resident 14 was receiving behavioral health services but did not know when those services began. On 10/02/24 at 1:37 PM, a telephone interview was conducted with Registered Nurse (RN) 3. RN 3 stated that resident 14 was very depressed, and was trying to hurt himself. RN 3 stated that she was not aware of what happened to initiate the depression. RN 3 stated that resident 14 did not have therapy services prior to being sent to the hospital for suicidal ideations in March 2024. RN 3 stated that she thought resident 14 had therapy since the suicidal ideations but does not know who provided it or the frequency of the visits.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38031 Based on interview and record review it was determined, for 2 out of 28 sampled residents, that the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Specifically, the facility failed to promptly identify, monitor, and intervene for an acute change in condition after two residents sustained a fall. Additionally, one resident did not have neurological assessments completed status post fall, and the other resident did not have timely intervention after changes were identified on the neurological assessment. One resident was admitted to the hospital with sinus arrest and the other resident was admitted to the hospital with a subdural hematoma and brain compression. These identified deficient practices were found to have occurred at the Immediate Jeopardy (IJ) level. Resident identifiers: 9 and 87. NOTICE On 9/25/24 at 3:30 PM, an Immediate Jeopardy was identified when the facility failed to implement Centers for Medicare and Medicaid Services (CMS) recommended practices to ensure that residents received treatment and care in accordance with professional standards of practice and to identify and intervene for an acute change in resident's condition. Specifically, the facility failed to ensure that monitoring and interventions were provided timely following the resident's fall and decline in condition. Notice of the IJ was given verbally and in writing to the Administrator (ADM), ADM 2, Director of Nursing (DON), Resident Advocate (RA), Corporate Licensed Clinical Social Worker (CLCSW) and the Corporate Resource Nurse (CRN) and they were informed of the findings of IJ pertaining to F684 for resident 9 and resident 87. On 9/30/24, the Administrator provided the following revised abatement plan for the removal of the Immediate Jeopardy effective 9/30/24 at 10:40 PM. Immediate action: Resident 9 is not in the facility; therefore an individualized plan of action is not possible. Facilities Plan to ensure compliance quickly: Identification of affected residents: A facility audit of all residents was completed by the Director of Nursing/Designee on 9/25/24 to identify residents who were having signs/symptoms of a change of condition. Residents who were identified as having a change from their normal baseline were addressed per facility protocol. This assessment was conducted by Registered Nurses who are familiar with the resident baseline. Systemic Changes: 1) An Ad-Hoc QAPI (Quality Assurance and Performance Improvement) was conducted on 9/24/2024 when quality of care concerns was brought up to the facility. Facility interventions were implemented: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	a. Licensed Nursing and CNA's (Certified Nurse Assistants) trained on 9/25/24 by the Director of Nursing regarding identifying changes of condition in residents and the appropriate action to take if a change is identified. This includes initiating emergency transport to the hospital, notification of physician, responsible party and Director of Nursing. b. Education was initiated for the facility nursing staff on 9/24/24 regarding Facility Change of Condition Policy - which was an up-to-date and applicable policy to the current functions of the facility - as well as normal vital sign ranges, neuro (neurological) checks, and timely interventions for abnormal assessments which include notification to Physician and initiating emergency medical treatment. This training outlined that neurological check procedures should be initiated following unwitnessed falls as well as witnessed falls with the resident striking their head during the fall. This training to clinical staff was validated by completion of a post-training test to assess understanding, and was completed by all clinical staff on 9/25/2024. c. Training provided to Licensed Nursing staff that emphasized urgency of intervention and procedure for notification of providers, seeking guidance from providers, and what to do should a provider not be able to be reached. Verbiage used in consideration of this subject stressed that an emergent change of condition does not warrant delaying emergency medical intervention via ambulance in order to seek a verbal order from a provider; standing order in place for a provider to be called no more than two times without answering before the nurse seeks emergency intervention for the resident without an order from said provider. For other changes of condition, it indicates that the nurse call - rather than text - a provider to seek further advice. The on-call provider schedule is available to nursing staff at the nurse's station. d. Licensed Nurse staff of facility received training on neurological status checks, including indications, completion and interpretation. Licensed Nurses educated on critical changes that warrant immediate, emergent intervention that must be initiated by the assessing nurse, including seeking immediate emergency care, proper notification of responsible party and physician, as well as proper documentation. Licensed nurses' understanding of this material was validated by completion of a post-training test that included, but were not limited to, question(s) referencing the responsibility of nurses - rather than CNAs -- to initiate and complete these examinations, scenario(s) in which the nurse would have to choose a course of action to assure the safety of a resident with abnormally-presenting neurological status, scenario(s) displaying symptoms and asking the nurse to determine which symptoms constitute a normal neuro status finding versus an abnormal finding, question(s) regarding typically-presenting vital sign trends with increasing intracranial pressure (Cushing's Triad) and the urgency of intervention should such vital signs present, question(s) regarding procedure for completing a neurological assessment, question(s) regarding scenarios under which a resident would be at increased risk of intracranial bleeding, and question(s) regarding interpretation of abnormal vital signs not necessarily associated with changing neurological status and how to respond appropriately. Director of Nursing made himself available for questions from Licensed Nursing staff regarding the source material after the initial training, and all nurses demonstrated understanding of the education. This training was completed by all Licensed Nursing staff before midnight on 9/25/2024. e. On 9/30/2024, the training confirmation examinations mentioned above were sent to management within the staffing agencies that the facility uses for emergency clinical staffing with the written understanding that all agency healthcare staff will need to complete prior to the beginning of their shift at the facility. All agency staff that had worked from 9/26 to 9/30 completed the examination(s) on 9/30/24. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	f. The night of 9/25, a resident was witnessed vomiting her medications after they were administered. The nurse confronted the resident and asked if they were ill, which she refuted. The documented note in question dictates this interaction as follows, (RESIDENT) took her evening medications whole with milk. She had swallowed them all then about 10 min later she was in the bathroom gagging over the toilet. Noted white emesis in the toilet. (RESIDENT) said she wasn't sick and then she said don't tell [name removed] (DON). The nurse chose not to notify the provider of this behavior, believing it to be a baseline behavior of her medication refusals, as she frequently and adamantly refuses her medications and has induced vomiting after swallowing her medications in the past as a behavior. Because this behavior did not represent a change of condition as was outlined in the policy or training provided -- either in significant behavioral change or refusal of medications or treatments twice consecutively -- the nurse determined this did not meet criteria as a change of condition, and thus did not follow report protocol. Additional resources to enforce understanding of situations that may warrant a change of condition requiring an immediate report provided to the nursing staff on 9/30/24. g. Staff who did not receive training by end of day 9/30/24 will receive this training prior to their next shift and will not be allowed to provide direct resident care until they have completed the training, and this training will be implemented during onboarding of newly-hired nursing staff. 2) The Director of Nursing/Designee will communicate with the clinical staff from each shift to review if any changes of condition(s) were identified. If any changes occur, the Director of Nursing will review the situation(s) to verify that residents received care per facility protocols. This practice will occur until the Immediate Jeopardy conditions are abated. 3) Any identified trends will be reviewed by the QAPI Committee for further interventions. On 10/1/24 at 12:13 PM, while completing the recertification survey, surveyors conducted an onsite revisit to verify that the Immediate Jeopardy had been removed. The surveyors determined that the Immediate Jeopardy was removed as alleged on 9/30/24 at 10:40 PM. Findings included: IMMEDIATE JEOPARDY 1. Resident 9 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included epidural hemorrhage, stable burst fracture of Thoracic (T)11-T12 vertebra, type II diabetes mellitus, chronic obstructive pulmonary disease, morbid obesity, contusion of abdominal wall, hypertensive heart disease with heart failure, schizoaffective disorder, post-traumatic stress disorder, spondylolisthesis, insomnia, chronic pain, hypothyroidism, anxiety disorder, spinal stenosis cervical region, osteoarthritis, overactive bladder, history of suicidal behavior, and repeated falls. On 9/22/24 at 11:06 AM, an interview was attempted with resident 9. Resident 9 was not available for an interview due to current hospitalization . Resident 9's medical records were reviewed. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 9/19/24 at 4:41 PM, a nursing progress note documented, Resident was sent to the hospital via gold cross because of hypotension, lethargic and bradycardic. It should be noted that no additional documentation could be found of resident 9's assessment for the change in condition. On 9/20/24 at 2:35 PM, a nursing progress note document, DON [Director of Nursing] contacted [name of local hospital] for update on resident. Case manager indicated that resident admitted for Sinus arrest, and that she recovered her cardiac status quickly with IV (intravenous) fluid resuscitation. Case manager indicated an unclear cause for the sudden change in cardiac status, but that resident's lactate levels were elevated and may have contributed. Resident will be hospitalized through the weekend and may be ready for discharge early next week. On 9/18/24 at 4:15 AM, an incident report documented that resident 9 was found on the floor in the bathroom next to the toilet. The incident description documented, A different resident called CNA [Certified Nurse Assistant] and indicated that they heard a 'bump' on the other side of the shared bathroom door. Staff responded and found resident sitting up against the door on the ground, next to the toilet. She indicated that she did not hit her head. Voicemail left for primary contact. Resident Description: 'I couldn't hold my weight and slid off the toilet'. The report documented that the physician was notified on 9/18/24 at 9:22 AM. It should be noted that the physician notification occurred 5 hours after the initial fall. Additionally, the incident report was authored by the DON and not the licensed nurse on shift at the time of the incident. On 7/21/23, the Quarterly Minimum Data Set (MDS) Assessment documented a Brief Interview for Mental Status (BIMS) score of 15, which would indicate that the resident was cognitively intact. The assessment documented that resident 9 required a 2-person extensive assistance for bed mobility, transfer, dressing, toilet use, and personal hygiene. The assessment further documented that resident 9 was not steady moving from seated to standing position and used a wheelchair for a mobility device. No documentation could be found of neurological assessments that were conducted after resident 9's unwitnessed fall on 9/18/24. On 9/7/24 at 7:28 AM, resident 9's last recorded blood pressure reading was 132/80. It should be noted that no other blood pressure readings were documented after this. On 9/18/24 at 7:09 AM, resident 9's heart rate (HR) was documented at 108 beats per minute (bpm). This was elevated from the previous reading on 9/7/24 at 7:28 AM when the HR was 68 bpm. It should be noted that no other HR readings were documented after 9/18/24. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 9/23/24 at 7:55 PM, a telephone interview was conducted with Registered Nurse (RN) 3. RN 3 stated that she worked the day shift on 9/19/24. RN 3 stated that resident 9 was drowsy during her shift on 9/19/24. RN 3 stated that she gave resident 9 her morning medication in the dining room with breakfast. RN 3 stated that after she gave the medication, resident 9 went back to her room and slept. RN 3 stated that she asked the CNA to take resident 9's vital signs (VS) and her blood pressure (BP) and heart rate were low. RN 3 was unable to recall what the blood pressure and heart rate readings were. RN 3 stated that she informed the DON and was instructed to send the resident to the emergency department. RN 3 stated that when the paramedics arrived resident 9's HR was 30 and they shocked the resident. RN 3 stated that she informed the Nurse Practitioner (NP) and she gave orders to transport the resident to the emergency department (ED). RN 3 stated that she did not document that she spoke to the NP. RN 3 stated that she was nervous and forgot to document that she notified the NP. RN 3 stated that she started the VS due to resident 9's drowsiness, and also completed a full neurological (neuro) check. RN 3 stated that she documented the neurological assessment on a flow sheet. It should be noted that no documentation could be found of the neurological flow sheet. RN 3 stated that resident 9 was not on neuro checks before she started declining that day. RN 3 stated that she was not aware of resident 9 having a recent fall, and no one had informed her in report when she arrived on shift on 9/19/24. RN 3 stated that if the resident had a fall it should have been reported to her and she should have had neurological checks ongoing. On 9/20/24 at 12:52 AM, a Medical Intensive Care Unit (MICU) attending physician documented, It is unclear how long she was down and who exactly called EMS [emergency medical services]. On arrival to the ED she was initially bradycardic with rates in the 30's due to complete heart block. Cardiology was consulted and she was started on transcutaneous pacing. Labs resulted and she was found to have hyperkalemia with a K [potassium] of 6.6 and AKI [acute kidney injury] with BUN [blood urea nitrogen]/Cr [creatinine] of 104/5.29 Facility where she resides was contacted and reportedly patient fell from toilet on the morning of 9/17 and had been lethargic since then. The MICU note further documented, She fell two days ago, unclear if she hit her head or not and had decreased PO [by mouth] intake since then and increasing lethargy. It is possible that she developed AKI due to decreased intake which resulted in hyperkalemia and CHB [complete heart block] with bradycardia. An alternative possibility is that she developed intermittent heart block and bradycardia which led to her fall, pre-renal AKI and resultant hyperkalemia. The resident was intubated for airway protection and had subsequently been extubated. The MICU note documented under assessment and plan for polypharmacy, Likely multifactorial with potential causes including multiple centrally acting medications (oxycodone, mirabegron, lurasidone, clonazepam, cyclobenzaprine, gabapentin, lamotrigine, haloperidol) i/s/o [equal, like or similar] AKI, metabolic encephalopathy (BUN 104) on admission), and recent fall. Fall from toilet two days ago, pt [patient] reports hitting her head. The history of present illness documented, EMS was called because [resident 9] had fallen off the toilet two days ago and was altered and confused. On arrival she had a HR of 35 and a pressure of 47/? States she hit her head when she fell , but unable to provide more information about the fall. She is having neck pain and back pain, neck pain is new and back pain is chronic and at baseline. Pt had difficulty answering questions. Called [name of facility] for more information; pt fell of (sic) toilet 2 days ago, unclear if pt had headstrike. Called EMS today because pt was more lethargic and BP was low. Facility states she reports being tired, having decreased PO water intake. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 9/23/24 at 9:16 AM, an interview was conducted with RN 1. RN 1 stated that for a change in condition she would check the vital signs, notify the DON and provider, and go from there. RN 1 stated that she would assess the resident and document the assessment in the progress note, along with everything that she did for the resident and if she had to call EMS. RN 1 stated that the progress note would detail the time of transfer and circumstance or details of event. RN 1 stated that resident 9 was transferred to the hospital due to hypotension and bradycardia. On 9/23/24 at 10:16 AM, an interview was conducted with CNA 1. CNA 1 stated that resident 9 needed more assistance in the morning with transfers and bed mobility due to leg pain. CNA 1 stated resident 9 could stand and transfer to a wheelchair (w/c) independently. CNA 1 stated she was told in report that resident 9 had fallen and hit her head and that was why she was currently in the hospital. CNA 1 stated that for falls they did neuro checks and that the aide could fill out the entire assessment. CNA 1 stated that the assessment included vital signs, pupil response, grasp, and say or repeat anything. On 9/23/24 at 10:37 AM, an interview was conducted with CNA 7. CNA 7 stated that she was present when resident 9 was transferred to the hospital. CNA 7 stated that one of the aides was monitoring resident 9 and her HR was dropping. CNA 7 stated that she was informed that 2 days prior to resident 9's transfer to the hospital she had a fall on night shift. CNA 7 stated that resident 9 had fallen onto the floor from the toilet. CNA 7 stated that resident 9 required minimum assistance with toileting for cleaning and brief placement. CNA 7 stated that resident 9 was independent with transferring to the toilet, but it depended on the day and how she was feeling. On 9/23/24 at 1:56 PM, an interview was conducted with the DON. The DON stated a neurological assessments should be done with any unwitnessed falls or falls with injury to head. The DON stated neuro checks were done every (Q)15 minutes for 1 hour (hr), every 30 minutes for 1 hr, every hour times 4 hrs, then every 4 hrs times 24 hrs. The DON stated that the Neurological flowsheet documented VS, Level of Consciousness (LOC), movement, hand grasp, pupil, and speech response. The DON stated that the licensed nurses conducted the neuro checks and the aides could be delegated the VS. The DON stated that the aides cannot do the neurological assessment because they were not trained. The DON stated that the expectation was that the neuro checks should be filled out completely unless the resident was sent to the hospital. The DON stated that incidents reports were completed for falls, medication errors, suspicious injuries of unknown origin, and resident to resident altercation. On 9/24/24 at 1:19 PM, an interview was conducted with CNA 8. CNA 8 stated that she worked with resident 9 on 9/18/24 and she was mostly tired and in bed that day. CNA 8 stated that night shift reported resident 9 had a fall in the bathroom. CNA 8 stated that resident 9 was talking normally, she was awake and then asleep, but she was arousable. CNA 8 stated that she did not recall a neuro check sheet for resident 9, Don't think there was one. CNA 8 stated that neuro checks were done if a fall was unwitnessed or if the resident fell and hit their head. CNA 8 stated that she took resident 9's VS that morning, but could not recall what they were. CNA 8 stated that she documented VS in the electronic medical records and also wrote them down on a sheet of paper. CNA 8 stated that she took resident 9's oxygen saturation and heart rate the morning of 9/18/24, and her heart rate was 108. CNA 8 stated that if the resident was hypertensive with a blood pressure of greater than 120/60 she would inform the nurse. CNA 8 stated that a normal HR was 60-80 bpm. CNA 8 stated that she was not sure if she should have informed the nurse about resident 9's HR. CNA 8 stated that she only reported to the nurse if the resident had a low oxygen or a high or low blood pressure. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 9/24/24 at 1:49 PM, a follow up interview was conducted with the DON. The DON stated that for unwitnessed falls the staff should respond and verify the resident safety, assess for injury and initiate neuro checks. The DON stated that some nurses chose to document a progress note, but all the information was entered in an incident report. The DON stated that falls should be reported to the oncoming shift for continuity of care. The DON stated that any changes in behavior, dramatic shift of VS outside of normal range, change in LOC, or change in pupil should be reported to the provider. The DON stated that the most recent fall for resident 9 was in the bathroom on the toilet when she attempted a self transfer and fell backwards. The DON stated that no staff were present and she was found on the floor. The DON confirmed that the neurological assessment was not started and should have been completed. The DON stated that resident 9 had a change in condition on 9/19/24 in the early afternoon and she was not presenting the same way that she does. The DON stated that when they conducted VS the HR was in the 30s and the blood pressure was low at around 60/40. The DON stated that the nurse reported that resident 9 was lethargic and confused. The DON stated that the EMTs administered two injectable medications and they were going to start to pace resident 9. The DON stated that he was not aware that the EMT's shocked resident 9. On 9/25/24 at 9:52 AM, an interview was conducted with Nurse Assistant (NA) 1. NA 1 stated that she was not present during the fall but reported resident 9's change in condition. NA 1 stated that she worked the 6:00 AM to 6:00 PM shift on Thursday 9/19/24. NA 1 stated that she was informed in report that resident 9 had a fall. NA 1 stated that she noticed that resident 9 was different than usual. NA 1 stated that resident 9 loved to feed the birds and NA 1 would often take the resident outside to do this. NA 1 stated that resident 9 did not want to do this that day. NA 1 stated that resident 9 could not stay awake longer than 5 minutes and was having random jerks that she had never had before. NA 1 stated that when resident 9 would rouse she would be loopy and would say random things that did not make sense. NA 1 stated that she noticed the changes within the first hour of her shift. NA 1 stated that resident 9 also typically ate and drank a lot and she did not want anything to eat or drink that day. NA 1 stated that resident 9 did not eat her breakfast that morning and could not stay awake long enough to eat. NA 1 stated that she reported these changes to the nurse. NA 1 stated that when she did not receive a response from the nurse she reported the change in condition to the Administrator (ADM). NA 1 stated, I don't think she was okay, she was acting different. NA 1 stated that she informed the ADM that the nurse was not listening to her and not responding. NA 1 stated that she took resident 9's VS every 30 minutes and documented them on a neuro flow sheet. NA 1 stated that she began monitoring resident 9's VS at approximately 7:30 AM to 8:00 AM. NA 1 stated that she documented the VS on a neuro sheet. NA 1 stated that resident 9's blood pressure and heart rate were dropping and every 30 minutes it went down. NA 1 stated that she checked the VS with different equipment, in both arms and with the arm positioned at heart level. NA 1 stated that the readings were all low and that was when she notified the RN. NA 1 stated that the RN checked resident 9's VS and the HR was reading 50 and kept dropping. NA 1 stated that was when they notified EMS. NA 1 stated that when EMS arrived they were in resident 9's room for a long time. NA 1 stated that resident 9 was transported to the hospital between 11:00 AM and 12:00 PM. NA 1 stated that she informed resident 9 that they were sending her to the hospital because her blood pressure was low and the resident responded, I don't want to die. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 9/25/24 at 10:18 AM, a follow-up interview was conducted with the DON. The DON again confirmed that the neurological assessments were not initiated after resident 9's fall. The DON stated We dropped the ball on those. The DON stated that he was not present at 4:15 AM on 9/18/24 after resident 9's fall, but confirmed that he authored the incident report. The DON stated that the details on the incident report were obtained from the staff on shift, both licensed nurses and aides. The DON stated that the procedure was that the nurse was supposed to fill out the incident report, but the nurse on shift that day, RN 2, failed to complete it. The DON stated that was why he filled the report out after the fact. The DON stated that he recognized that RN 2 failed to follow the policy for a resident change in condition and that education had been provided to RN 2 back in October 2023 for the same reason after resident 87 had a fall. 50200 2. Resident 87 was admitted to the facility on [DATE] with diagnoses which included diffuse traumatic brain injury, vascular dementia, traumatic hemorrhage of cerebrum atrial flutter, atrial fibrillation, anxiety disorder, generalized muscle weakness, other lack of coordination, cognitive communication deficit, other toxic encephalopathy, unsteadiness on feet, essential hypertension, hyperlipidemia, hypermagnesemia, hypomagnesemia, insomnia, other symptoms and signs involving cognitive functions and awareness, other reduced mobility, and long term (current) use of anticoagulants. On 10/5/23 at 7:50 PM, a nursing progress note documented, CNA brought to nurses attention that patient had a fall from wheelchair. Head to toe assessment completed. Upon assessment, superficial laceration noted on top of scalp and abrasions on his back. Steri strips placed on laceration. Patient assisted back into wheel chair and brought to nurses station for more frequent checks. Neuro status at baseline. Patient alert and oriented, speech clear, PERRLA [pupils are equal, round, reactive to light, and accommodation]. Passive and active range of motion at baseline. Friend [name redacted] notified who informed nurse that patient has hx [history] of brain bleeds. DON notified. Called LM [left message] for Dr. [name redacted] informing him of the above and to call back if any further orders. Passed onto NOC [night] nurse, [name redacted] of this information and to follow up with patient. Nurse stated understanding. On 10/6/23 at 1:39 AM, a nursing progress note documented, Resident continues at baseline. Neuro checks continued. Night medication was given. Resident refused to remain in bed, fearing the possibility of more falls, resident was placed in recliner in dayroom. VSS. [vital signs stable] Resident fell asleep. On 10/6/23 at 1:54 AM, a nursing progress note documented, Resident is in the recliner, sleeping. He doesn't look or sound well. Vitals are B/P 155/81, pulse 129, Temp. (temperature) 98.2, oxygenation 94%, Respirations are 24. His mouth is dry, because of open mouth breathing, and his eyes look slightly milky. The DON, MDs, have been alerted through [name of messaging system]. The Medical director was notified. Voice mail left. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Creek Rehabilitation and Nursing	876 West 700 South Salt Lake City, UT 84104

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 10/6/23 at 3:03 PM, a nursing progress note documented, Resident with a notable medical history of atrial fibrillation, atrial flutter, hypertension, traumatic brain injury, traumatic hemorrhage of cerebrum, and vascular dementia moved into the community from a sister community at approximately 1300 [1:00 PM] via wheelchair. Resident had been assessed the day prior by DON, RNC [Regional Nurse Consultant] and Admin [Administrator], and found to be a pleasant, conversational but slightly confused individual with slightly impaired gait, but good balance once walking and able to ambulate long distances with standby assistance. Resident was on a 1:1 at the sister facility due to an elopement attempt, prompting the necessity to relocate him to a secured facility. When resident arrived at the community, he began observing behaviors outside of his reported baseline; shouting at staff, making incoherent angry comments, kicking off the wall as staff were assisting him with ambulation via wheelchair, becoming agitated and attempting to stand but having very poor balance and needing redirected back into his wheelchair. At approximately 1500 [3:00 PM], resident was in the hallway when he attempted to stand himself up, resulting in him falling backward against the wall, scraping his back as he slid down and creating an abrasion on the top of his scalp from where it made contact with thewall [sic]. The scrape on his back was superficial and required no intervention, though the abrasion to the top of his head was cleaned and steri-strips were applied. Resident was immediately assessed and found to be without major injury. Resident was found [NAME] [sic] hypertensive at 157/82 and tachycardic at 109, all other vitals unremarkable. Neuro checks remained unremarkable, though his agitation continued. At 2200 [10:00 PM], resident was assisted to bed, but he continuously attempted to stand back up from bed. Staff asked if he would prefer to be in the common area to minimize his agitation, which he agreed, and staff assisted him into a chair in the common area to avoid isolation. At approximately 0200 [2:00 AM], the nurse performed another neuro check on the resident and found him to be hypertensive at 155/81, tachycardic at 129, and his respiratory rate was 24, utilizing accessory muscles for respirations, though his oxygen saturation was 94% and had an appropriate temperature, also noting that the resident takes Eliquis. Nurse reached out to providers for guidance, but received no response from them. At 0558 [5:58 AM], the nurse reached out to the DON, indicating at the last neuro check at 0545 [5:45 AM], it appeared that resident's pupils were not symmetrical. DON immediately contacted theprovider [sic], who provided an order to send the resident to [name redacted] via ambulance. 911 was called, and EMS left with the resident at approximately 0655 [6:55 AM]. On 10/6/23, the hospital history and physical documented the resident .presented via EMS for altered mental status change with Glasgow Coma Score [GCS] of 3, and approximately 8 falls over the course of the last 24 hours . On 10/6/23, the hospital assessment and plan documented, a. subdural hematoma b. brain compression c. required emergent intubation . On 10/6/23 a CT [cat scan] Spine Cervical without contrast revealed: a. Large mixed attenuation left subdural hematoma resulting in approximately 2.2 cm [centimeters] of rightward midline shift and left-sided uncal herniation. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	b. Dilation of the occipital and temporal horns of the right lateral ventricle with surrounding transependymal edema, suggestive of entrapment. c. Additional intraventricular blood products in the fourth ventricle. d. No acute fracture or malalignment of the cervical spine. On 10/5/23 at 2:37 PM, the incident report documented, CNA brought to nurses attention that patient fell out of wheelchair. On 10/5/23 at 4:00 PM, neuro checks were begun on the patient. The neuro sh [TRUNCATED]

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38031 Based on interview and record review it was determined, for 1 of 28 sampled residents, that the facility failed to ensure that the resident had adequate supervision and assistance devices to prevent accidents. Specifically, a resident was not secured inside the facility vehicle during transport and fell out of her wheelchair. The fall resulted in the resident sustaining a Thoracic (T)11-T12 fracture and a contusion of the abdominal wall. Based on the facility's investigation and corresponding corrective measures, this was cited at past non-compliance with a correction date of 8/1/23. Resident identifier: 9. Findings included: Resident 9 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included epidural hemorrhage, stable burst fracture of Thoracic (T)11-T12 vertebra, type II diabetes mellitus, chronic obstructive pulmonary disease, morbid obesity, contusion of abdominal wall, hypertensive heart disease with heart failure, schizoaffective disorder, post-traumatic stress disorder, spondylolisthesis, insomnia, chronic pain, hypothyroidism, anxiety disorder, spinal stenosis cervical region, osteoarthritis, overactive bladder, history of suicidal behavior, and repeated falls. On 9/22/24 at 11:06 AM, an interview was attempted with resident 9. Resident 9 was not available for an interview due to a current hospitalization . Resident 9's medical records were reviewed. On 7/21/23, resident 9's Quarterly Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 15, which would indicate that the resident was cognitively intact. The assessment documented that resident 9 required a 2 person extensive assistance for bed mobility, transfer, dressing, toilet use, and personal hygiene. The assessment documented that resident 9 was not steady moving from seated to standing position and used a wheelchair for a mobility device. Resident 9's progress notes revealed the following: a. On 7/31/23 at 12:27 PM, the Nurses Note documented, Family and provider were made aware of incident and transfer to hospital on 7/31/23 around 1500 [3:00 PM] by shift nurse. b. On 7/31/23 at 2:45 PM, the Nurses Note documented, [Resident 9] had a fall in the transport van on her way back from the [name omitted] hospital. [Resident 9] hit her head and was also complaining of back pain, staff decided to call the [name omitted] ambulance for her and have her taken to the hospital. c. On 8/1/23 at 12:39 PM, the Social Service Note documented, Called [name of hospital] to check on resident. Was informed that resident was at hospital but then was transferred to [name omitted] ER [emergency room] dept. at 11:04 pm. Spoke with ER nurse who says they are waiting on bed to admit her. Waiting on Case management call to request medical records. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	d. On 8/5/23 at 4:18 AM, the Nurses Note documented, [Resident 9] returned to [name of facility] by [ambulance service]. via stretcher. She is wearing her Back brace as ordered. A&Ox3 [alert and oriented times 3]. Resp [respirations] even and unlabored. Heart regular rate and rhythm. Main concern is her lower back pain. She is incontinent of urine and extensive assist with brief changes. Limited assist with bed mobility. Reoriented her to her call light and room. Orders have been verified. She did have some nausea this evening . zofran given with good effect. She slept through the night at her normal baseline. e. On 8/6/23 at 9:10 AM, the MDS (Minimum Data Set) progress note documented, MDS note for 8/6/23 ARD [assessment reference date]: Res [resident] returned for (sic) hospital stay 7/31-8/4/23 after having being tipped forward in an unrestrained wheelchair in a moving transport vehicle. She sustained multiple spinal injuries including but not limited to a T12 burst fx [fracture], small epidural hematoma, spinal stenosis in cervical/lumbar regions. She also was noted to have an abdominal hematoma and a left diffuse adrenal enlargement. She returned w/ [with] TLSO [thoracolumbar sacral orthosis] brace and orders for PT/OT [physical therapy/occupational therapy]. She is alert and oriented to person place time and situation. She still requires extensive assist of 2 for all LLADLs [Activities of Daily Living] dressing and bathing, extensive assist of 1 for feeding upon return d/t [due to] mobility limitations while in brace. She still requires extensive assist with wheelchair mobility/locomotion on/off unit. Continues on O2 [oxygen] and CPAP [continuous positive airway pressure] w/ SOB [shortness of breath] on exertion. Hearing is adequate w/o [without] aids and vision is corrected lenses worn. On 7/31/23 at 2:57 PM, resident 9's incident report documented that resident 9 had a fall in the transport van while on her way back to the facility from an appointment. Resident 9 reported, I fell in the van hit my head and my back hurts. The report documented a vertebrae fracture as the injury type. The report documented under other information that the seatbelt did not secure. On 7/31/23, the hospital history and physical documented . the resident presented after her transport vehicle stopped suddenly while transporting her in her wheelchair, causing her to roll forward and fall out of her wheelchair. She was unfortunately not secured during transport and buckled forward. She reports hearing crunching and then reports severe low back pain. The resident was initially taken to another hospital where she was found to have an L [Lumbar]1 coronal split fracture as well as signs of possible bowel contusion. The Hospital Course documented the following: #T12 burst fracture with retropulsion and epidural hematoma #Lumbar spondylosis with anterolistesis of L3-L4 and moderate spinal canal stenosis Patient presented with back pain after wheelchair incident in which she was unrestrained in the back of a van and hit the van wall. In the setting of chronic back pain, she was reporting acute worsening of back pain. CT [Computed Tomography] T/L [Thoracic/Lumbar] Spine upon arrival was significant for coronally oriented fracture of T12 without retropulsion. There is widening of the bilateral T12-L1 facet joints suggestive of capsular injury and mild hyperdensity along the ventral epidural space a the L1 level may represent small volume epidural hematoma. The neurosurgical consult recommended a TLSO brace in place and to wear when HOB [head of bed] > [greater] 30 , out of bed or upright. Don/doff when sitting is ok. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility investigation documented that resident 9 had a fall during transportation that resulted in a fracture. The immediate steps taken were to have an off-site transportation company provide services until further safety training could be conducted. The facility investigation documented that resident 9 was picked up from a pulmonology appointment and the transportation driver, who was also the Therapeutic Recreation Specialist (TRS), secured her into the van in her wheelchair. While driving downhill resident 9 fell forward out her wheelchair. The summary of interviews documented, Upon investigation of this incident, we are reasonably relating the fall to the seatbelt not being fully latched. The wheelchair was still secured to the floor when she fell out of it. On 8/1/23, a Quality Assurance Committee Template Tool documented the identified problem as making sure residents and staff are safe when transporting. The corrective measures implemented were to test all seat belts to ensure safety equipment is working. check the lights and hazards. continue to monitor routine maintenance. The section for evaluation on the tool documented check marks next to seat belts, hazards, lights, and no lights on vehicle dashboard. On 8/1/23, an education acknowledgement form was signed by the TRS. The reason for the education documented, Understand the motor vehicle policy. The summary of the education documented, Finding out the safety equipment works, be careful when driving. The form documented that the expectations moving forward were, Review safety equipment before departing in the vehicle. The form was signed by the TRS. On 8/1/23, the TRS disciplinary form documented that the staff member had violated the company policy and the action taken was a final written warning. The explanation of the infractions documented, Understanding the motor vehicle policy specifically failed number six and seven. The form was signed by the TRS. Review of the Motor Vehicle Policy documented the following: 6. An employee who drives any car for facility business purposes must exercise due diligence in so doing. The employee must comply with all traffic laws. Such failure to comply with traffic laws could result in disciplinary action. 7. Employees and their passengers who are driving/riding in a car on facility business purposes must wear seat belts at all times in which the car is being operated. The policy was last revised in January 2008. On 8/1/23, a Performance Improvement Plan was initiated for the TRS. The corrective action documented that verbal/counseling was provided. The job standards that required improvement documented the policy of the motor vehicles. The specific improvement needed was checking all safety equipment before departing in the vehicle. The steps identified to achieve the improvement were training and referral back to the policy as needed. The plan documented that the consequence for not meeting the performance standard was termination. The plan was signed by the TRS. On 1/18/21, the TRS signed a copy of the Driver Safety Policy. The policy covered Basic Vehicle Operation Guidelines which documented, Always use seat belts. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 9/23/24 at 12:00 PM, an interview was conducted with the TRS. The TRS stated that he did a lot of the driving at the facility. The TRS stated that the training he was provided to be the transportation driver included inspecting the vehicle for tire air pressure and ensuring the tires were in good working condition, inspecting the windows, inspecting the locks and ensuring that the resident was seat belted in the vehicle. The TRS stated that it was a requirement that the driver be at least [AGE] years old. The TRS stated that he also had his Commercial Drivers License and use to drive the paratransit bus at the facility. The TRS stated that he had worked at the facility for a long time and had many training's on driver safety. The TRS stated that the training would be documented in the training log. The TRS stated that recently they implemented an additional measure of having a second person verify the safety checks were completed prior to transportation. The TRS stated that the process for securing a resident in a wheelchair inside the vehicle was to ensure that the 4 straps and the lap belt were secured. The TRS stated that the 4 straps were attached to the floor of the van and each strap was secured to the wheelchair frame on either side of the wheels in the front and back of the chair. The TRS stated that the straps were pulled tight to ensure that the chair did not move and that the straps were never attached to the wheels because the chair could then roll. The TRS stated that the floor straps were a ratchet that could be tightened. The TRS stated that the lap belt was positioned over the resident lap and was pulled tight. The TRS stated that he drove resident 9 on the date of the incident. The TRS stated that he was driving away from the hospital and when he came to a stop resident 9 fell out of the wheelchair. The TRS stated that she fell forward towards the front driver seat, impacted the drivers seat, and then fell to the floor. The TRS stated that the 4 floor straps were secured to the wheelchair, but the lap belt was not secured. The TRS stated that resident 9 was not seat belted at the time of the accident. The TRS stated that the van was modified and used to have rows of seats that were removed. The TRS stated that when those seats were in place the vehicle had shoulder seat belt straps that were connected to the sides of the vehicle. The TRS stated that those old seat belts were still present in the vehicle but did not connect to anything as the old seats had been removed. The TRS stated that he attempted to secure the old shoulder strap to the buckle but it would not clip in. The TRS stated that he was shown after the accident that the seatbelt did function. The TRS stated that at the time of the accident he did not see the lap belt. The TRS stated that after the accident he gave all this information to the insurance company. The TRS was asked why he departed the facility without securing a seat belt for resident 9. The TRS responded that it was the way he had done it for a long time and he was told that it was the straps securing the wheelchair that needed to be used. The TRS stated that after the accident it might have been the Maintenance Director that showed him the functioning lap belt. An immediate observation was made of the facility transportation vehicle with the TRS. The vehicle was observed with the wheelchair ramp located at the back of the van. The wheelchair floor straps were located in the back of the van where a previous third row of seats would have been located. The TRS confirmed that it was quite a distance that resident 9 came forward and hit the driver's chair. The TRS stated that after resident 9 fell he pulled the vehicle over and checked on the resident. The TRS stated he called the facility and asked them to call the paramedics. The TRS stated that the paramedics transferred the resident from the floor of the vehicle to the ambulance, and that he did not move resident 9. The TRS stated that after the accident the facility implemented more training. The TRS stated that now the Administrator (ADM) and the Resident Advocate (RA) were also trained as backup drivers. The TRS stated that the RA scheduled the resident appointments and then notified him. The TRS stated that if he was not available to drive he would let the RA know. The TRS stated that he had one resident that had weekly appointments scheduled, and on average he had at least 2 resident appointments per week. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 9/23/24 at 12:58 PM, an interview was conducted with the RA. The RA stated that she was in charge of scheduling resident appointments and she notified the TRS of those appointments daily in the morning meeting. The RA stated that the ADM also drove residents if the TRS was not available. The RA stated that she had been trained to drive residents to appointment's but had not done it yet. The RA stated that if the facility could not transport a resident they contracted with an outside company for those services. The RA stated that after resident 9's accident the resident had requested that all her transportation needs be provided by the contracted company. On 9/23/24 at 1:12 PM, an interview was conducted with the ADM. The ADM stated that when he was first hired he was provided training on driving residents in the transportation van. The ADM stated that to drive the facility vehicle they had to be on the companies insurance, have had the driver training, and reviewed the company policy. The ADM stated that the TRS did a good job and helped with the transportation training. The ADM stated that the process for securing a resident in the van was to secure the wheelchair by centering it in the back of the van, hook all straps on the frame, and tighten them up. The ADM stated that they secured the seatbelt under the handle bar of the wheelchair and ensured that it was tight enough that the resident would not slide down. The ADM stated that he transported residents once a week if the TRS was not available. The ADM stated that all current drivers had training. The ADM stated that the TRS had one other incident with the van other than the accident with resident 9. The ADM stated that last week the TRS accidentally left the van door open while backing out and scratched the paint. The ADM stated that no residents were in the vehicle at the time. The ADM stated that the accident with resident 9, the TRS was confused that the seatbelt was not working. The ADM stated that the TRS secured the wheelchair but not resident 9 and the resident fell forward and hit her head on the seat. On 9/24/24 at 1:49 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that he had started working at the facility shortly after the transportation accident with resident 9. The DON stated that resident 9 was incorrectly secured and she slid out of the wheelchair. The DON stated that after the accident the changes that were made was an in depth training of the TRS by someone in corporate. On 9/25/24 at 8:37 AM, an observation was made of the TRS demonstrating how he secured a wheelchair in the vehicle for transportation. The ADM was the resident in the demonstration. The TRS stated that after he checked the van he would unlock the back door and lower the wheelchair ramp. The TRS placed the wheelchair on the ramp and locked the brakes on the wheelchair. The ramp was raised and the resident was pushed into the vehicle. The TRS secured two floor straps to the left side of the wheelchair frame, and ratcheted it down. The TRS then secured right side of the wheelchair with two floor straps to the bottom of the wheelchair frame. The TRS buckled the seat belt and secured the strap under the arm rests of the wheelchair. The TRS stated that some residents would request that the the seatbelt be loosened, and he would inform them that it needed to be secured firmly. The TRS stated that he made sure that the seatbelt was flush against the abdomen of the resident. The wheelchair was observed stationary and not movable when pulled or pushed on. All straps were secured tight.

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F 0740 Level of Harm - Actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38031 Based on interview and record review it was determined, for 1 of 28 sampled residents, that the facility did not ensure that each resident received the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Specifically, a resident with a history of suicidal ideations (SI) was hospitalized for a suicidal attempt and did not have behavioral health services provided for more than 2 months after the hospitalization . Resident identifier 14. Findings included: Resident 14 was admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses which included cerebral infarction, hemiplegia and hemiparesis, cognitive communication deficit, chronic obstructive pulmonary disease, pain, major depressive disorder, dementia, insomnia, cervical disc degeneration, spondylosis with myelopathy, alcoholic polyneuropathy, hypertension, osteoarthritis, radiculopathy, cirrhosis of liver, hyperlipidemia, nicotine dependence, alcohol abuse, cannabis abuse, suicide attempt, suicidal ideations, ventral hernia, trochanteric bursitis of left hip, and lesion of ulnar nerve. Resident 14's medical records were reviewed. Resident 14's physician orders revealed the following: a. Aripiprazole Tablet 2 milligram (mg), give 1 tablet by mouth one time a day for supplemental treatment for major depressive disorder. The order was initiated on 3/8/24. b. Duloxetine Hydrochloride Capsule Delayed Release Particles, give 120 mg by mouth one time a day related to major depressive disorder. The order was initiated on 12/19/22. c. Escitalopram Oxalate Tablet, give 20 mg by mouth one time a day related to major depressive disorder. The order was initiated on 11/13/2023. Resident 14's progress notes revealed the following: a. On 3/7/24 at 2:27 PM, the nurse note documented, Resident is at hospital for trying to hurt himself. b. On 3/9/24 at 9:20 AM, the nurse note documented, Resident state that he is having suicidal thought but dont have any plan. He refused to go hospital. Thank you DON [Director of Nursing] notified. c. On 5/31/24 at 3:08 PM, the resident advocate note documented, [Resident 14] has began Mental health therapy with [name omitted] therapy. It should be noted that more than 2 months had passed since resident 14 was hospitalized for SI to when behavioral health services were implemented. (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	d. On 6/4/24 at 2:04 PM, the Social Services Assessment documented, Social Services has reviewed resident's psychosocial needs and created initial care plan. On 12/29/21, the Pre-Admission Screening and Resident Review (PASRR) Level II evaluation documented that in 2018 the resident began to experience increasing depressive symptoms due to his memory loss and due to fears of being put out on the street as he did not have a place to live. He was having suicidal thoughts and eventually cut on both of his wrists; hospital records state that pt reported 'so rather than living on the street, I decided to end it'. After cutting his wrists he fell and hit his head and ribs as well. Pt [patient] was taken to the ER [emergency room] at [hospital name omitted] and had his wrists bandaged, and due to his severe depression he was admitted to [hospital name omitted] for psychiatric evaluation and stabilization. The assessment documented that the resident may be a substantial danger to himself or others. The assessment documented the recommendations as Pt would likely benefit from counseling services to learn ways to cope with his psychiatric sxs [signs and symptoms]. On 5/25/23, resident 14's care plan for meets PASRR Level II determination was initiated. The goal was that resident 14 would receive specialized services as recommended by the PASRR Level II evaluation. On 5/25/23, interventions initiated included: Assist case worker with obtaining any needed information; Coordinate services with habilitative coordinator; Invite the habilitative coordinator to the quarterly care plan meeting; and Report any need to re-evaluate for specialized services. On 5/27/24, an intervention was initiated for PASRR Recommendations for specialized services treatment: Pt would likely benefit from counseling services to learn ways to cope with his psychiatric sxs. and PASRR Recommendations for services to be provided by facility: Medical Management, Assistance with ADL?S [Activities of Daily Living], Therapies for rehabilitation/to improve memory, support from SNF [skilled nursing facility] staff. On 5/29/24, an intervention was initiated for a Gradual Dose Reduction (GDR) contraindication given the patients significant depressive symptoms. On 1/1/23, resident 14's care plan for at risk for suicidal impulsive/ideations of self harm related to depression was initiated. The goal was that resident 14 would remain safe from self harm. Interventions identified on the care plan were: allow time for expression of feelings; provide empathy, encouragement and reassurance; encourage participation in activity preferences; ensure medications were swallowed after administration; familiarize resident with own belongings and surroundings; monitor and report to the charge nurse, nursing supervisor, and physician any behavior changes; and immediately report to nurse and provider any verbalizations of hurting self. (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	On 3/7/24, resident 14's hospital history of present illness documented that resident 14 was seen for suicidal thoughts. Patient reports that just he has declined to the point where he just feels like there is no reason to live anymore and was talking about cutting his wrist to end his life. Patient is not actually hurt himself at this point but just more in the thought process The physical exam documented that resident 14 had a flat affect, stated SI and that had a sense of hopelessness at this time that his life is not worth living due to the fact that he is staying any (sic) rehab facility and has no family or friends as well as his health is deteriorating to the point where he is not functional The report documented that resident 14 was evaluated by a psychiatric crisis counselor. Patient did have some issues with the facility and was acting out this morning due to anger due to restrictions of his smoking and the crisis worker felt that patient is not truly suicidal but just more acting out due to worsening dementia and other concerns with the facility. The hospital discharge note documented that resident 14 was transferred back to the facility to discuss with the provider the possibility of increasing his dose of antidepressant medication as well as incorporating counseling to help alleviate some of his suicidal thought and end-stage concerns. Patient will follow through on safety plan that was established by him and the crisis worker. On 6/5/24, the behavioral health provider progress note documented that resident 14 reported passive SI at intake, today adheres to same passive SI without intent or thought of planning. Safety plan documented, attempted to create a safety plan due to the shift in emotional lavility today, however pt [patient] adamantly refused to safety plan. Staff were notified of the presence of SI and the pt to safety plan. They were given recommendations based of protective factors identified during last weeks assessment. He reported that I wish I would die because I don't want to be here anymore. When asked whether he had any plans to harm himself or others he replied no I can't do anything here when therapist tried to draw out more information he became more labile and so therapist opted to end the session and discuss the situation with the staff at the facility. He was given a SafeUt card with 988 information if he wanted to talk later on with someone. On 10/2/24 at 1:14 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that resident 14 was blue sheeted a couple of months back. The DON stated that something upset resident 14 and he believed it had to do with the resident being out of cigarettes. The DON stated that resident 14 walked away and said might as well get a body bag. The DON stated that he went and talked to resident 14 and he was holding a butter knife. He looked like he was about to cut himself, one arm extended like he was going to cut himself. The DON asked resident 14 to give him the knife and he did. The DON stated that he asked resident 14 if he was actively suicidal and he responded yes. The DON stated that he asked if he had a plan and resident 14 replied what do you think?. The DON stated that resident 14 did not want to go to the hospital so the provider blue sheeted him. The DON stated that resident 14 did not have a psychosocial assessment after the incident. The DON stated that resident 14 reported to the hospital that he was doing the SI behavior in an attempt to obtain cigarettes and that was why they did not admit resident 14. The DON stated that the provider ordered Abilify for resident 14 after his re-admission. The DON stated he could not recall if resident 14 was evaluated by a Social Service Worker (SSW) after his re-admission. The DON stated that a SSW should evaluate a resident after any suicidal ideations or suicidal attempts. The DON stated that resident 14 was receiving behavioral health services but did not know when those services began. (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	On 10/02/24 at 1:37 PM, a telephone interview was conducted with Registered Nurse (RN) 3. RN 3 stated that resident 14 was very depressed, and was trying to hurt himself. RN 3 stated that she was not aware of what happened to initiate the depression. RN 3 stated that resident 14 did not have therapy services prior to being sent to the hospital for SI in March 2024. RN 3 stated that she thought resident 14 had therapy since the SI and hospitalization , but does not know who provided it or the frequency of the visits. On 10/02/24 at 1:57 PM, an interview was conducted with Certified Nurse Assistant (CNA) 6. CNA 6 stated that resident 14 did not have any behaviors that she was aware of and she was not aware of a history of SI. On 10/02/24 at 1:59 PM, an interview was conducted with RN 1. RN 1 stated that resident 14 did not have any behaviors that came to mind. RN 1 stated that she felt like since she had been at the facility there had been some talk of behaviors for resident 14 but she could not recall what was said. RN 1 stated that resident 14 did not have a safety plan that she was aware of. On 10/02/24 at 2:00 PM, an interview was conducted with CNA 1. CNA 1 stated that resident 14 had behaviors of yelling or screaming at the staff. On 10/02/24 at 2:05 PM, an observation was made of resident 14's room. The room contained the following items that could be used for self harm: a fork on the bedside table; a candle in glass jar; push pins in wall holding up the calendar; pens on the table; multiple cords; and a nasal cannula.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38031 Based on interview and record review it was determined, for 1 of 28 sampled residents, that the facility did not provide routine and emergency drugs and biological to its residents. Specifically, a resident was not provided their psychotropic medications for multiple days due to unavailability from the pharmacy. Resident identifier: 9. Findings included: Resident 9 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included epidural hemorrhage, stable burst fracture of T11-T12, type 2 diabetes mellitus, chronic obstructive pulmonary disease, morbid obesity, contusion of abdominal wall, hypertensive heart disease with heart failure, schizoaffective disorder, post-traumatic stress disorder, spondylolisthesis, insomnia, chronic pain, hypothyroidism, anxiety disorder, spinal stenosis cervical region, osteoarthritis, overactive bladder, history of suicidal behavior, and repeated falls. Resident 9's medical records were reviewed. Resident 9's progress notes revealed the following: a. On 6/4/24 at 7:15 AM, the Orders - Administration Note documented, Lurasidone HCl [hydrochloride] Oral Tablet 120 MG [milligram] Give 120 mg by mouth one time a day for give with food related to SCHIZOAFFECTIVE DISORDER, BIPOLAR TYPE. The note further documented that the medication was on order from the pharmacy. b. On 6/5/24 at 8:21 AM, the Orders - Administration Note documented, Lurasidone HCl Oral Tablet 120 MG Give 120 mg by mouth one time a day for give with food related to SCHIZOAFFECTIVE DISORDER, BIPOLAR TYPE. The note further documented med [medication] on order not availbale (sic) from the pharmacy. c. On 6/10/24 at 11:10 AM, the Orders - Administration Note documented, Lurasidone HCl Oral Tablet 120 MG Give 120 mg by mouth one time a day for give with food related to SCHIZOAFFECTIVE DISORDER, BIPOLAR TYPE. The note further documented Med not available from the pharmacy. d. On 6/10/24 at 6:16 PM, the Orders - Administration Note documented, Haloperidol Oral Tablet 10 MG Give 10 mg by mouth two times a day related to SCHIZOAFFECTIVE DISORDER, BIPOLAR TYPE. The note further documented medication n/a [not available] for dispense from the pharmacy. e. On 6/14/24 at 10:40 AM, the Nurses Note documented, Resident meloxicam and lurasidone will be deliver by this evening as per pharmacy. when I contact them this morning. f. On 6/18/24 at 10:26 AM, the Orders - Administration Note documented, Escitalopram Oxalate Oral Tablet 10 MG Give 1 tablet by mouth one time a day related to GENERALIZED ANXIETY DISORDER. The note further documented med n/a for dispense will f/u [follow-up] c [with] rx [pharmacy]. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	g. On 6/21/24 at 4:47 PM, the Nurses Note documented, Resident reported to one of the aides that she jabbed another resident with a pen last night 'hard enough to leave a mark' because she is 'fucking psychotic and manic' (referring to herself). Review of the June 2024 Medication Administration Record (MAR) revealed that resident 9's Lurasidone 120 mg was documented as not administered with a code of 9 (see progress note) on 6/4/24, 6/5/24, and 6/10/24. The MAR also documented that resident 9's Escitalopram 10 mg was not administered on 6/18/24 with a code of 9, and the Haloperidol 10 mg was not administered on 6/10/24 with a code of 9. On 6/21/24 at 9:50 PM, the hospital behavioral health intake note documented that another resident with dementia came into her room, touched her things and resident 9 stabbed her with a pencil. Per pt [patient], she was trying to write 'stop it' on the residents arm. Pt told staff, 'I'm fucking psychotic and manic.' Pt stated that facility was unable to get Latuda for a week and a half and restarted four days ago. The note further documented that the resident denied any aggression but did note increased irritability d/t [due to] being off her Latuda. Which isn't my fault, the care facility is supposed to take care of shit like that. That's why people are admitted to that kind of facility Patient reports that while she is still irritable, she is feeling better and far less irritable than she was a week ago. 'I just told them that woman pisses me off and make me want to stab her. There's a lot of shit I want to do and don't do, I'm civilized, but I can still get pissed. When you are off your medication and someone is intentionally pushing your buttons, eventually you will say something and that's all I did. On 9/24/24 at 8:26 AM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated that the process for reordering medication was to pull the sticker off the blister pack and place on a reorder sheet, and that reorder sheet was filled out daily. RN 1 stated that she would also verify in the medication cart if the resident had any additional blister packs that may have been overlooked. RN 1 stated that if a medication was low they would reorder when there were 8-10 pills remaining. RN 1 stated that the pharmacy would take usually 2 days to fill any requested medications unless they were having issues with authorization from the insurance. RN 1 stated that the Latuda was not available in the facility Nexsys system but that Haldol was. RN 1 stated that she documented in the MAR if a medication was not available and was on order from the pharmacy. RN 1 stated that she also called the pharmacy but they were not the best at responding and delivering timely. RN 1 stated that she could recall waiting at least 3 days for medication to be delivered in the past. RN 1 confirmed that she documented that the Latuda was not available on 6/4/24 and 6/5/24. RN 1 stated that n/a in the MAR meant not available. RN 1 stated that resident 9 became manic when she was not provided her antipsychotic medication as prescribed. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/24/24 at 1:49 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that the process for ordering medication from the pharmacy was to peel the reorder sticker and fax it to the pharmacy daily when that medication had 7 days remaining in the current blister pack. The DON stated that medication deliveries were not consistent, but generally they were delivered by the next day. The DON stated that if a medication was unavailable the staff should look in the Nexsys system, contact the pharmacy for timeframe of delivery, reach out to the provider to notify them, and generally a hold order would be placed until they become available again. The DON stated that the nurses should document this in a progress note. The DON stated that if a resident was not provided their ordered psychotropic medications it could cause an exacerbation of their psychiatric illness. The DON stated that he had read the note that resident 9 had not received their Latuda. The DON stated that he called the pharmacy and balled them out. The DON stated that when he identified that the medication was out of stock he called the pharmacy and they did not provide a good explanation, and that the general explanation was due to a dose change. It should be noted that the June MAR documented that the Lurasidone 120 mg dose was started on 8/5/23 and was discontinued on 6/26/24 and a dose change had not been ordered at the time the medication was unavailable from the pharmacy.

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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** 50200 Based on interview and record review, it was determined that for 2 out of 28 sampled residents, the facility did not ensure that resident's drug regimen was free from unnecessary drugs. An unnecessary drug was any drug when used in excessive dose; or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Specifically, the facility did not monitor the blood sugars of a resident receiving insulin, did not administer a resident's thyroid medication, address a resident's continued pain, or use non-pharmacological pain interventions. Resident identifiers: 9, 32. Findings included: 1. Resident 32 was admitted to the facility on [DATE] with diagnoses which included type 2 diabetes mellitus, essential hypertension, hemiplegia and hemiparesis following a cerebral infarction, hyperlipidemia, and chronic obstructive pulmonary disease. Resident 32's medical record was reviewed on 9/22/24. Resident 32's physician orders revealed the following: a. Resident 32's physician's orders dated 6/25/24, documented Insulin Glargine 20 units subcutaneous one time a day. b. Resident 32's physician's orders dated 6/18/24, documented HumaLOG Solution 100 UNIT/ML [milliliter] inject as per sliding scale. This medication was discontinued on 7/22/24. c. Resident 32's physician's orders dated 6/9/24, documented Monitor BG [blood glucose] Q [every] AM [morning]. This order was discontinued on 7/22/24. d. Resident 32's physician' orders dated 9/20/24, documented Daily BG one time a day for 10 days with an end date of 10/1/24. A review of resident 32's Medication Administration Record [MAR] revealed that no blood glucose levels were taken on 6/9/24, 6/10/24, 6/11/24, and 6/12/24. No blood glucose levels were reported from 7/23/24-8/31/24. On 6/27/24 at 1:19 PM, a physician admission history and physical documented, .She is in her bed. says she hates having her fingers poked and wonders when we can stop. She started on jardiance this week and understands that we will lower her insulin slowly. Discussed her care plan and health history. Asked about CGM [continuous glucose monitor] when roommate [sic] mentioned it. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/23/24 at 9:50 AM, an interview was conducted with Registered Nurse [RN] 1. RN 1 stated that nurses perform the blood glucose checks on the residents. RN 1 stated that any resident that was prescribed insulin should have their blood glucose levels monitored at least daily, but preferably before every meal. RN 1 stated that if a resident received insulin once a day then the blood glucose level should still be taken. RN 1 stated that an order was required before a blood glucose can be taken and the results were documented in the MAR. On 10/1/24 at 08:31 AM, an interview was conducted with the Director of Nursing [DON]. The DON stated that the facility monitored residents that received insulin based on the medical providers recommendations and the nurses obtained the blood glucose. The DON stated that some residents did not like getting the finger sticks that were required when a blood glucose was obtained. The DON stated that he was unsure if there would be an order for no finger sticks in a resident's medical record. The DON stated that it would be up to the doctor to decide if a blood glucose level was needed. The DON stated that this information would be documented in a physician note at the very least, but preferably would be documented in a progress note. The DON stated he would check the resident's medical chart for documentation or orders for no finger sticks for the resident. No follow up information was provided by the DON. 38031 2. Resident 9 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included epidural hemorrhage, stable burst fracture of T11-T12, type 2 diabetes mellitus, chronic obstructive pulmonary disease, morbid obesity, contusion of abdominal wall, hypertensive heart disease with heart failure, schizoaffective disorder, post-traumatic stress disorder, spondylolisthesis, insomnia, chronic pain, hypothyroidism, anxiety disorder, spinal stenosis cervical region, osteoarthritis, overactive bladder, history of suicidal behavior, and repeated falls. Resident 9's medical records were reviewed. Resident 9's September 2024 Medication Administration Record (MAR) revealed the following: a. On 8/5/23, an order was initiated for Levo-T Oral Tablet 100 MCG [micrograms] (Levothyroxine Sodium) Give 100 mcg by mouth one time a day related to HYPOTHYROIDISM, UNSPECIFIED. The order was discontinued on 9/22/24. On 9/18/24, the Levothyroxine was not documented as administered. b. On 12/11/23, an order was initiated for OxyCODONE HCl [hydrochloride] Capsule 5 MG [milligram] Give 1 capsule by mouth every 6 hours as needed for moderate to severe pain. The order was discontinued on 9/22/24. On 9/13/24 at 6:28 PM, the Oxycodone 5 MG was documented as ineffective. On 9/13/24 at 10:09 PM, the Orders - Administration Note documented that the Oxycodone 5 mg was ineffective and the follow-up pain score was a 7 out of 10, with 10 being the worst possible pain. No documentation could be found to indicate that the resident 9's pain was addressed after the oxycodone was documented as ineffective. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Additionally, no documentation could be found on the Treatment Administration Record (TAR) to indicate that non-pharmacological interventions were being monitored or implemented for resident 9's pain. On 9/23/24 at 9:47 AM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated that for ineffective pain control she would notify the Director of Nursing (DON) and the provider to see if they could increase the pain medication or administer any additional pain medication. RN 1 stated that it would be documented in a progress note and she would expect to see something documented that other interventions or attempts were made to control the resident's pain. On 10/01/24 at 8:20 AM, an interview was conducted with the DON. The DON stated that the licensed nurse should call the provider if pain medication was documented as ineffective and seek further instruction. The DON stated that the nurse should document in a progress note that the provider was notified. The DON stated that on 9/18/24 the Levothyroxine was not documented as administered, and without it being documented you would not know if the medication was actually administered.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38031 Based on interview and record review it was determined, for 1 of 28 sampled residents, that the facility did not ensure that the resident's drug regimen was free from unnecessary psychotropic drugs. An unnecessary drug was any drug when used in excessive dose; or for excessive duration; or without adequate monitoring; or without adequate indications for its use. Specifically, a resident's psychotropic medications were not monitored for behavioral episodes, non-pharmacological interventions, and adverse side effects of the medications. Resident identifier: 9. Findings included: Resident 9 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included epidural hemorrhage, stable burst fracture of T11-T12, type 2 diabetes mellitus, chronic obstructive pulmonary disease, morbid obesity, contusion of abdominal wall, hypertensive heart disease with heart failure, schizoaffective disorder, post-traumatic stress disorder, spondylolisthesis, insomnia, chronic pain, hypothyroidism, anxiety disorder, spinal stenosis cervical region, osteoarthritis, overactive bladder, history of suicidal behavior, and repeated falls. Resident 9's medical records were reviewed. Resident 9's September 2024 Medication Administration Record (MAR) revealed the following: a. On 5/11/24, an order was initiated for Escitalopram Oxalate Oral Tablet 10 MG [milligram] (Escitalopram Oxalate) Give 1 tablet by mouth one time a day related to GENERALIZED ANXIETY DISORDER. b. On 6/27/24, an order was initiated for Lurasidone HCl [hydrochloride] Oral Tablet (Lurasidone HCl) Give 160 mg by mouth one time a day related to SCHIZOAFFECTIVE DISORDER, BIPOLAR TYPE. c. On 8/8/23, an order was initiated for clonazePAM Oral Tablet 0.5 MG (Clonazepam) Give 0.5 mg by mouth two times a day related to GENERALIZED ANXIETY DISORDER. d. On 8/8/23, an order was initiated for Haloperidol Oral Tablet 10 MG (Haloperidol) Give 10 mg by mouth two times a day related to SCHIZOAFFECTIVE DISORDER, BIPOLAR TYPE. e. On 1/16/24, an order was initiated for BEHAVIOR Antipsychotic medication: Hallucinations/Delusions every shift for Behavior Monitoring. No documentation could be found to indicate that monitoring was conducted for adverse side effects of the antianxiety and antipsychotic medications, or any monitoring for episodes of anxiety. Additionally, no documentation was found of non-pharmacological interventions that were provided prior to the administration of the antianxiety and antipsychotic medications. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/01/24 at 8:20 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that the licensed nurse should monitor for adverse side effects of the psychotropic medications, effectiveness of medications, and any episodes of behavior. The DON stated that the nurses were typically really good at monitoring in the Treatment Administration Record (TAR).

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50200 Based on observation, interview, and record review, it was determined for 2 out of 28 sample residents, that the facility did not ensure that it was free of medication error rates of five percent or greater. Observations of 27 medication opportunities, on 9/24/24, revealed two medication errors which resulted in a 7.41% medication error rate. Specifically, wrong doses of medications were given. Resident identifiers: 12, 31. Findings included: 1. Resident 12 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included, but were not limited to, traumatic subarachnoid hemorrhage, cerebral infarction, chronic obstructive pulmonary disease, temporal sclerosis, dementia, paranoid schizophrenia, anxiety disorder, and major depressive disorder. On 9/24/24 at 7:15 AM, Registered Nurse (RN) 1 was observed to spill the medication cup across the medication cart that contained resident 12's medications. One tablet of Haloperidol remained in the medication cup. RN 1 replaced two tablets of Haloperidol 1 milligram (mg) and Aripiprazole 30 mg. It was observed that there was an incorrect dosage of Haloperidol in the medication cup. On 9/24/24 07:19 AM, RN 1 was observed to enter resident 12's room when the surveyor stopped RN 1 and asked RN 1 if the medications were correct that she was about to administer to resident 12. RN 1 removed one of the Haloperidol tablets from the cup with a gloved hand and disposed of the medication in a sharps container. RN 1 stated she did not realize that there were 3 tablets in the cup. RN 1 stated she would have given the medication if the surveyor had not intervened. RN 1 stated that in her opinion giving 3 mg of Haloperidol would not have done anything to the resident because the resident took so much medication already. RN 1 stated that she did not know the side effects, signs of overdose, or adverse reactions of Haloperidol. Resident 12's medical record was reviewed for the reconciliation of medication on 9/24/24. According to Physician's orders, resident 12 was to receive Haloperidol Tablet 1 MG: 2 tablets by mouth two times a day. 2. Resident 31 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, bipolar disorder, chronic obstructive pulmonary disease, venous insufficiency, generalized anxiety disorder, post-traumatic stress disorder, diarrhea, gastro-esophageal reflux disease, and obsessive-compulsive disorder. On 9/24/24 at 7:07 AM, RN 1 was observed to prepare and administer medications to resident 31. RN 1 administered one tablet of Loperamide 2 mg to resident 31. Resident 31's medical was reviewed for the reconciliation of medication on 9/24/24. According to Physician's orders, resident 31 was to receive Loperamide HCl Oral Tablet 2 mg: 2 tablets by mouth three times a day (TID) for diarrhea. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/24/24 at 7:46 AM, an interview was conducted with RN 1. RN 1 stated that she always double checks the medication cup before she gave residents their medications to prevent errors. RN 1 stated that she checked the medication card and the milligrams of all medications. RN 1 stated that if she gave a wrong dose of medication she would notify the Director of Nursing (DON), notify the provider, monitor the resident, notify the family and follow whatever instructions the provider would want them to do. On 10/1/24 at 9:00 AM, an interview was conducted with the DON. The DON stated that medication errors are classified as the wrong dose, wrong resident, wrong medication, and the wrong route. The DON stated that for all medication errors, once it was identified the nurse should contact the provider first and seek instruction. The DON stated if it was a less urgent medication error then the nurse should just monitor the resident. The DON stated that for all errors alert charting should be started and an incident report completed, but that was not always done.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50200 Based on observation and interview it was determined that the facility did not ensure safe and secure storage of drugs and biologicals in accordance with accepted professional principles; or included the appropriate accessory and cautionary instructions, and the expiration date on the medication. Specifically, in the medication refrigerator, one multi-dose vial was not labeled with an opened date, insulin pens did not have names or dates, one insulin pen was expired with an open date of [DATE], and a Prevnar 13 dose was expired and available to use. Findings included: On [DATE] at 7:35 AM, the medication refrigerator was inspected. A multi-dose vial of Tuberculin was observed open and available for use and an open date was not marked on the vial. A Prevnar 13 vaccine with an expiration date of [DATE] was available for use. A Tresiba insulin pen was observed to have been used with no opened date. A Lantus insulin pen was observed to be available for use with an open date of [DATE]. A Lantus insulin pen was observed to be opened and used with no open date. An aspart insulin flex pen was observed to have been opened and used with no name or open date on it. An insulin glargine pen was observed to be opened and used with no name on it. On [DATE] at 07:36 AM, an interview was conducted with RN 1. RN 1 stated she thought insulin pens were good for 30 days once they were used or at least by the expiration date listed on the pen. RN 1 stated that if she could not read the name or the date on the insulin pen then the pen should be discarded in the sharps container. RN 1 stated that she was unable to see names listed on some of the insulin pens or any opened dates. On [DATE] at 9:00 AM, an interview was conducted with the Director of Nursing (DON). The DON was informed of the expired medication, the medications that were not labeled with expiration dates/opened dates, and the medication not labeled with the resident identifiable information. The DON stated that all medications should be labeled with the resident's name. The DON stated that insulin stored in the refrigerator should be labeled with an open date and the resident's name. The DON stated that once insulin was opened it was good for 30 days. The DON stated that there should not be anything else stored in the refrigerator but medications.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47432 Based on record review and interview, it was determined that for 2 of 28 sample residents, that the facility did not provide or obtain laboratory services to meet the needs of its residents. Specifically, there were at least two instances where the facility did not obtain International Normalized Ratio (INR) labs for a resident despite there being physician orders for the labs to be obtained every 4 weeks and one instance where the facility did not obtain a Basic Metabolic Panel (BMP) for another resident despite there being physician orders for the BMP to be drawn. Resident identifiers: 31 and 9. Findings Included: Resident 31 was admitted [DATE] with diagnoses including bipolar disorder, chronic obstructive pulmonary disease, other asthma, venous insufficiency, generalized anxiety disorder, post-traumatic stress disorder, unspecified combined systolic and diastolic heart failure, peripheral vascular disease, unspecified cirrhosis of liver, obsessive-compulsive disorder, and chronic embolism and thrombosis of unspecified deep veins of right lower extremity. Resident 31's medical record was reviewed. The following Physician's orders were reviewed: Draw INR once every 4 weeks on Thursdays. INR results for the dates of 4/12/24, 7/12/24, 8/27/24, 9/12/24, and 9/19/24 were uploaded into Resident 31's medical record. INR results for the months of May and June were not found in Resident 31's medical record. On 6/10/24, a pharmacy consultant review for the month of May 2024 documented, Nursing-I did not find routine monthly monitoring of PT[prothrombin]/INR values to follow warfarin treatment. He has fluctuating weight and medications which may alter warfarin effectiveness. Recommendation: Check and record PT/INR value at least monthly. On 8/9/24, a pharmacy consultant review for the month of July 2024 documented, .[Resident 31's] PT/INR has been subtherapeutic the last two labs found (April and July). Goal INR is 2-2.5 to provide protection against clotting. Recommendations: 1. Monitor PT/INR at least once a month . On 10/03/24 at 10:35 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that he had reviewed the orders for Resident 31's INR to be checked in May and June of 2024. The DON stated that it was likely that the phlebotomist contracted to work for the facility never obtained the labs for the months of May and June 2024. 38031 (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident 9 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included epidural hemorrhage, stable burst fracture of T11-T12, type 2 diabetes mellitus, chronic obstructive pulmonary disease, morbid obesity, contusion of abdominal wall, hypertensive heart disease with heart failure, schizoaffective disorder, post-traumatic stress disorder, spondylolisthesis, insomnia, chronic pain, hypothyroidism, anxiety disorder, spinal stenosis cervical region, osteoarthritis, overactive bladder, history of suicidal behavior, and repeated falls. Resident 9's medical records were reviewed. On 8/13/24, resident 9's physician ordered a Basic Metabolic Panel (BMP). No documentation could be found in resident 9's electronic medical records of the BMP results. On 9/23/24 at 1:56 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that the BMP that was ordered on 8/13/24 was missed and not obtained. On 9/25/24 at 9:20 AM, a follow-up interview was conducted with the DON. The DON stated that lab orders were placed by him and he followed-up with the providers. The DON stated that the laboratory process was that the order requisition was placed in the computer system and a resident face sheet was placed in a binder for the phlebotomist. The DON stated that the order requisition did not have a carbon copy for the facility records. The DON stated that the lab placed the results in the portal and it notified him automatically when the results were ready. The DON stated that the lab would call him directly if the labs had critical high or low values. The DON stated that once the provider reviewed the report they would sign the report and then it was scanned into the resident's medical records. The DON stated that he was the only staff that had access to the portal with the laboratory results. The DON stated that the results were also faxed to the facility at the same time they were uploaded into the portal. The DON stated that part of the process was making sure that the nurses were documenting in a progress note that the labs were being done. The DON stated that all labs should have the date and signature of the provider once they have been reviewed.

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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 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38031 Based on interview and record review it was determined, for 1 of 28 sampled residents, that the facility did not promptly notify the ordering physician of laboratory results that fall outside of clinical reference ranges, and only obtain laboratory services when ordered by a physician. Specifically, a resident's Basic Metabolic Panel (BMP) and lipid panel had results out of range and the provider was not notified and a BMP and lipid panel were obtained without a physician order. Resident identifier 14. Findings included: Resident 14 was admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses which included cerebral infarction, hemiplegia and hemiparesis, cognitive communication deficit, chronic obstructive pulmonary disease, pain, major depressive disorder, dementia, insomnia, cervical disc degeneration, spondylosis with myelopathy, alcoholic polyneuropathy, hypertension, osteoarthritis, radiculopathy, cirrhosis of liver, hyperlipidemia, nicotine dependence, alcohol abuse, cannabis abuse, suicide attempt, suicidal ideations, ventral hernia, trochanteric bursitis of left hip, and lesion of ulnar nerve. Resident 14's medical records were reviewed. On 1/30/24, resident 14 had laboratory results for a BMP and lipid panel. It should be noted that no documentation could be found of a physician order for the laboratory services. On 1/30/24, resident 14's BMP and lipid panel results documented abnormal ranges for Potassium at 5.3 high (H), Chloride at 101 low (L), and total Cholesterol at 112 L. It should be noted that no documentation was found to indicate that resident 14's physician was notified of the results. Additionally, the lab result did not contain any signatures or dates by the provider. On 2/6/24, resident 14's physician ordered a BMP one time only for sodium level. On 2/6/24, resident 14's BMP results documented abnormal ranges for Sodium at 135 L, Potassium at 5.1 H, Chloride at 99 L, and Creatinine at 0.74 L. It should be noted that no documentation was found to indicate that resident 14's physician was notified of the results. Additionally, the lab result did not contain any signatures or dates by the provider. (continued on next page)

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/25/24 at 9:20 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that lab orders were placed by him and he followed-up with the providers. The DON stated that the laboratory process was that the order requisition was placed in the computer system and a resident face sheet was placed in a binder for the phlebotomist. The DON stated that the order requisition did not have a carbon copy for the facility records. The DON stated that the lab placed the results in the portal and it notified him automatically when the results were ready. The DON stated that the lab would call him directly if the labs had critical high or low values. The DON stated that once the provider reviewed the report they would sign the report and then it was scanned into the resident's medical records. The DON stated that he was the only staff that had access to the portal with the laboratory results. The DON stated that the results were also faxed to the facility at the same time they were uploaded into the portal. The DON stated that part of the process was making sure that the nurses were documenting in a progress note that the labs were being done. The DON stated that all labs should have the date and signature of the provider once they have been reviewed. On 10/01/24 at 11:01 AM, a follow-up interview was conducted with the DON. The DON stated that they did not have an order for the labs that were obtained on 1/30/24.

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F 0775 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep complete, dated laboratory records in the resident's record. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47432 Based on record review and interview, it was determined that for 1 of 28 sampled residents that the facility did not file in the resident's clinical record laboratory reports that were dated and contained the name and address of the testing laboratory. Specifically, there were two instances where a resident had physicians orders for a residents lithium levels to be checked, but the results of these lithium level checks were not filed or uploaded in the resident's electronic medical record. Resident Identifier: 31. Findings Included: Resident 31 was admitted [DATE] with diagnoses including bipolar disorder, chronic obstructive pulmonary disease, asthma, venous insufficiency, generalized anxiety disorder, post-traumatic stress disorder, unspecified combined systolic and diastolic heart failure, peripheral vascular disease, unspecified cirrhosis of liver, obsessive-compulsive disorder, and chronic embolism and thrombosis of unspecified deep veins of right lower extremity. Resident 31's medical record was reviewed. The following physician orders were reviewed: a. Lithium level one time a day for Monitoring for 1 day. This order was placed on 5/9/24. There were no lab results uploaded in Resident 31's electronic medical record for this order. The facility was able to provide a copy of the lab results upon request. The results came back on 5/10/24 as a 0.8, indicating that Resident 31's lithium levels were within normal limits. b. Re-check lithium 5/30 one time a day for Monitoring for 1 day. This order was placed on 5/30/24. There were no lab results uploaded in Resident 31's electronic medical record for this order. The facility was able to provide a copy of the lab results upon request. The results came back on 5/30/24 as a 1.0, indicating that Resident 31's lithium levels were within normal limits. On 10/03/24 at 10:35 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that the requested lithium labs that were not uploaded into Resident 31's medical record should have been uploaded into Resident 31's medical record.

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F 0779 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep signed and dated reports of x-rays and other diagnostic services in the residents record. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38031 Based on interview and record review it was determined, for 1 out of 28 sampled residents, that the facility did not file in the resident's clinical record signed and dated reports of radiologic and other diagnostic services. Specifically, a resident's 12 lead electrocardiogram (EKG) was not in the medical records. Resident identifier 14. Findings included: Resident 14 was admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses which included cerebral infarction, hemiplegia and hemiparesis, cognitive communication deficit, chronic obstructive pulmonary disease, pain, major depressive disorder, dementia, insomnia, cervical disc degeneration, spondylosis with myelopathy, alcoholic polyneuropathy, hypertension, osteoarthritis, radiculopathy, cirrhosis of liver, hyperlipidemia, nicotine dependence, alcohol abuse, cannabis abuse, suicide attempt, suicidal ideations, ventral hernia, trochanteric bursitis of left hip, and lesion of ulnar nerve. Resident 14's medical records were reviewed. On 3/15/24, resident 14's physician ordered a 12 lead EKG, one time a day for monitoring for 2 days. No documentation could be found in resident 14's medical records of the EKG reports. On 10/01/24 at 11:01 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that the 12 lead EKG report was obtained today. The DON stated that the report was sent to the provider but not to the facility. The DON stated that it would be uploaded into resident 14's records today.

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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 - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 47432 Based on observation, interview, and record review, it was determined that for 2 of 28 sampled residents, that the facility did not ensure that each resident received and the facility provided food prepared by methods that conserve nutritive value, flavor, and appearance; food and drink that was palatable, attractive, and at a safe and appetizing temperature. Specifically, there were resident complaints about the food served at the facility, a test tray was pulled and found to be unappetizing, and there were resident council complaints regarding the food served at the facility. Resident Identifiers: 17 and 30. Findings Included: On 9/22/24 at 12:43 PM, Resident 17 was observed to complain that the lunchtime meal served was too cold during a lunchtime meal observation. At 12:46 PM, Resident 17 further complained that the food served would be good if it was warm. A resident council note dated 9/6/24 documented a resident complaint of pork that was served undercooked and too tough to chew. A resident council note dated 7/17/24 documented a resident complaint of burnt eggs that were frequently served with breakfast meals. On 9/22/24 at 1:26 PM, an interview was conducted with Resident 30. Resident 30 stated that the food served at the facility sucked and that the food was bland. On 9/25/24 at 12:35 PM, a test lunch tray was pulled. The collard greens were found to be soggy and bland. The potatoes had a chunky texture. The corn bread served with the meal was overly salty and was not sweet. The soup served with lunch was overly salty. The apple pie mousse dessert tasted like plain sour yogurt. On 9/25/24 at 1:07 PM, an interview was conducted with the Corporate Dietitian (CD). The CD stated that if residents had food complaints, they could fill out a grievance form. The CD stated that the dietary manager followed up with residents that filed grievances individually and would update their tray tickets.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50200 Based on interview and record review, it was determined that for 1 out of 28 sampled residents, the facility did not maintain medical records on each resident that were complete, accurately documented, readily accessible, and systematically organized and the facility kept confidential all information contained in the resident's records. Specifically, resident's information was left open on a computer screen unsecured on two different occasions while residents were in the vicinity and no documentation of a resident's hospital visit was found in the medical record. Resident identifier: 14. Findings included: On 9/22/24 at 09:40 AM, an observation was made of Registered Nurse [RN] 4 walk away from the medication cart. The computer on top of the medication cart was left open with resident information available to view. An observation was made of residents 10 and 18 around the medication cart. On 9/22/24 at 12:40 PM, an interview was conducted with RN 4. RN 4 stated that any time the medication cart was left unattended the computer and medication cart should be locked. RN 4 stated that she usually locked the computer screen when she left the cart. On 9/24/24 at 07:50 AM, an observation was made of RN 1 leaving the medication cart unattended with the computer open with resident information visible. Residents 10 and 31 were in the hallway next to the medication cart. On 9/25/24 at 1: 22 PM, an interview was conducted with RN 1. RN 1 stated when she left the medication cart she made sure she locked the cart and the computer so that no information was visible to residents. RN 1 stated she tried to always have her computer screen locked when she was not in the area. On 10/1/24 at 9:00 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that the expectation of staff was to keep all identifiable resident information confidential. The DON stated that if a medication cart was left unattended the nurse should lock the computer screen to avoid residents from seeing Health Insurance Portability and Accountability Act (HIPAA) protected information. 38031 2. Resident 14 was admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses which included cerebral infarction, hemiplegia and hemiparesis, cognitive communication deficit, chronic obstructive pulmonary disease, pain, major depressive disorder, dementia, insomnia, cervical disc degeneration, spondylosis with myelopathy, alcoholic polyneuropathy, hypertension, osteoarthritis, radiculopathy, cirrhosis of liver, hyperlipidemia, nicotine dependence, alcohol abuse, cannabis abuse, suicide attempt, suicidal ideations, ventral hernia, trochanteric bursitis of left hip, and lesion of ulnar nerve. Resident 14's medical records were reviewed. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/7/24 at 2:27 PM, resident 14's nurse note documented, Resident is at hospital for trying to hurt himself. No documentation could be found in resident 14's electronic medical records (eMR) of the hospital history and physical or discharge paperwork following his hospitalization on [DATE]. On 10/2/24 at 1:14 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that resident 14 was blue sheeted a couple of months back. The DON stated that something upset resident 14 and he believed it had to do with the resident being out of cigarettes. The DON stated that resident 14 walked away and said might as well get a body bag. The DON stated that he went and talked to resident 14 and he was holding a butter knife. He looked like he was about to cut himself, one arm extended like he was going to cut himself. The DON asked resident 14 to give him the knife and he did. The DON stated that he asked resident 14 if he was actively suicidal and he responded yes. The DON stated that he asked if he had a plan and resident 14 replied what do you think?. The DON stated that resident 14 did not want to go to the hospital so the provider blue sheeted him. The DON stated that they should have resident 14's discharge paperwork, and that the hospital did not admit him. On 10/03/24 at 9:28 AM, a follow-up interview was conducted with the DON. The DON stated that he requested the hospital records for resident 14 and the hospital had replied that he was not seen there. The DON stated that he then called the ambulance service and they had a record of the transport. The DON stated that he would follow-up with the hospital again. On 10/8/24 at 4:18 PM, the facility provided the hospital history and physical (H & P) for resident 14's hospitalization on [DATE]. The DON stated, Here's the H&P for that hospitalization . On review of old messages, I realized a blue sheet wasn't initiated on this resident for this incident. When he made these expressions, the ambulance was contacted without a blue sheet and he agreed to go to the hospital.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 38031 Based on interview and record review it was determined that the facility did not ensure that the quality assessment and assurance committee met at least quarterly to coordinate and evaluate activities under the Quality Assurance and Performance Improvement (QAPI) program. The Quality Assessment and Assurance (QAA) Committee must be composed of, at a minimum: The Director of Nursing (DON); the Medical Director or his/her designee; at least three other members of the facility staff and one must be the Administrator; and the infection preventionist. Specifically, there was no evidence that the Medical Director participated in the quarterly QAPI meetings. Findings included: Review of the QAPI team revealed that the QAA committee members were the Administrator, the DON, Therapeutic Recreation Specialist (TRS), the Resident Advocate (RA), the Maintenance Director, the Business Office Manager, and the Dietary Manager. The QAA committee did not have the Medical Director listed as a participating member. The facility 2024 Quality Assurance and Performance Improvement (QAPI) Plan was reviewed and documented that the QAPI Committee consisted of the Nursing Home Administrator (NHA), the Director of Nursing (DON), the Medical Director, at least two additional staff members (who can be direct care team members), the Infection Preventionist (effective 2019) and other consultants as deemed necessary by the committee. The plan further documented, The Medical Director is accountable for providing leadership for, and is actively involved in the implementation of, the QAPI program. Performance accountabilities for the Medical Director include, but are not limited to, the following: 1. Validating that quality management initiatives pertaining to the delivery and management of care are clinically sound, promote consumer safety, and are based on current best practices. 2. Participating in and providing support to other committees for the development of appropriate assessment and evaluation efforts, intervention strategies, and corrective action plans. 3. Involving providers and representatives of medical delivery systems in reviewing and planning the QAPI program's core activities. On 10/03/24 at 12:39 PM, an interview was conducted with the Administrator (ADM). The ADM stated that the QAA committee met quarterly but also as needed when issues arise. The ADM stated that if they see something that they could improve they document it, make a plan and talk about it as an Interdisciplinary Team (IDT). The ADM stated that the quarterly meetings were attended by the DON, RA, kitchen staff, TRS, and the ADM. The ADM stated that he would provide the Maintenance Director notes of the meeting. The ADM stated that they invited the Medical Director and tried to have him attend depending on his schedule. The ADM stated that they typically just followed-up with notes to the Medical Director. The ADM stated that the Medical Director did not attend the last quarterly meeting in June 2024, and he was not sure if he attended the prior quarterly meeting in March 2024.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 50200 Based on observation and interview it was determined, for 2 out of 28 sampled residents, that the facility did not 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, medications were not administered in a sanitary manner. Resident Identifiers: 12 and 25. Findings included: On 9/24/24 at 7:12 AM, an observation was made of Registered Nurse (RN) 1 during the morning medication pass. RN 1 was observed preparing medications for resident 12. RN 1 did not perform hand hygiene prior to removing the medication from the medication packs. RN 1 was observed to drop medications out of the medication cup onto the medication cart and the floor. RN 1 was observed to scoop up a medication that was half in the medication cup and half on the medication cart. RN 1 was observed to put more medication into the same medication cup and give the medications to resident 12. On 9/24/24 at 7:23 AM, an observation was made of RN 1 during the morning medication pass. RN 1 was observed to drop medication onto the cart and onto the floor. RN 1 was observed to bend down and pick the medication up off the floor, dispose of the medication in the sharps container, and continue to prepare medications for resident 25 without performing hand hygiene. On 9/24/24 at 7:28 AM, an interview was conducted with RN 1. RN 1 stated that she always performed hand hygiene before she began medication pass. RN 1 stated that she sometimes gets distracted by residents that come up to the cart and possibly touches the resident or other things before returning to the medication preparation. RN 1 states that if she dropped medications then she would dispose of them in the sharps container and then continue on with the medication pass. On 10/1/24 at 9:00 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that the expectation for staff was to perform appropriate hand hygiene prior to beginning any tasks that involved resident care. The DON stated that nurses should be using hand sanitizer before preparing medications, going into the resident's room, and upon exiting the resident's room.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50200 Based on interview and record review it was determined, for 1 of 28 sampled residents, that the facility did not establish an infection prevention and control program (IPCP) that included an antibiotic stewardship program that included antibiotic use protocols and a system to monitor antibiotic use. Specifically, a resident was receiving an antibiotic for a urinary tract infection and the facility did not follow up with the hospital for the culture and sensitivity results. Resident identifier: 19. Findings included: Resident 19 was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses which included, but not limited to, Alzheimer's Disease, dementia, type 2 diabetes mellitus, bipolar disorder, anxiety disorder, hyperkalemia, peripheral vascular disease, and gastro-esophageal reflux disease without esophagitis. Resident 19's medical record was reviewed on 9/22/24. Resident 19's progress notes were reviewed and revealed the following: a. On 9/4/24 at 3:21 AM, Orders - General Note from eRecord Note Text: Resident returned from the [hospital name]ER department at 0245 [2:45 AM]. She had requested to go to the hospital because she was feeling sick. not feeling well. ER [emergency room] department performed the following tests CT [computed tomography]of her brain/head CT maxillofacial w/o [with out]contrast CT spine cervical w/o contrast CBC [complete blood count] w/ auto Diff CMP [comprehensive metabolic panel] Lipase level Urinalysis w[with]/ microscope Everything was found to be unremarkable, except the urinalysis. A urinary tract infection was found, and resident was given a Rocephin shot. b. On 9/11/2024 at 2:37 AM, Alert Note (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Note Text: ANTIBIOTICS: Since resident returned from the hospital, she hasn't been taking antibiotics. Staff report no foul-smelling order. Resident not verbalizing pain but scored 4/10 on PAINAD [pain assessment in advanced dementia] scale. On 9/24/24 at 1:52 PM, an interview was conducted with the Director of Nursing [DON]. The DON stated that he got orders from the discharge instructions when a resident returned to the facility from the hospital. The DON stated that he reached out to the hospital for culture results and had not had any luck in getting the records. The DON stated that the resident would have the antibiotics administered for the duration the hospital ordered and alert charting would be put in place to monitor the resident for symptoms. On 10/03/24 at 10:05 AM, a follow up interview was conducted with the DON. The DON stated that he did not receive the culture and sensitivity report from the hospital for resident 19. The DON stated that hospital discharge papers showed that a culture and sensitivity was to be performed for resident 19, but was not verified by the DON. The DON stated he would be contacting the hospital for the records.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38031 Based on interview and record review it was determined that the facility did not ensure that the resident or resident representative had the opportunity to accept or refuse a COVID-19 vaccine, and that the resident's medical record included documentation that indicated that the resident was provided education regarding the benefits and potential risks associated with the vaccine; documentation of each dose administered; and documentation of declinations or contraindications to the vaccine. Specifically, for 4 out of 5 sampled residents, the facility did not have evidence that each resident was provided education about the COVID-19 vaccine, was provided the COVID-19 vaccine, or declined the COVID-19 vaccine. Resident identifiers: 7, 18, 28, and 30. Findings included: 1. Resident 7 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which consisted of presence of right and left artificial shoulder joint, chronic obstructive pulmonary disease, hypertensive heart disease, pulmonary hypertension, chronic pain syndrome, ventricular premature depolarization, insomnia, nonrheumatic mitral valve insufficiency, history of myocardial infarction, dysphagia, overactive bladder, lesion of ulnar nerve, hypertension, lymphedema, osteoporosis, and hyperlipidemia. Resident 7's medical records were reviewed and no documentation could be found of the COVID-19 vaccine education, vaccine administration or vaccine declination. 2. Resident 18 was admitted to the facility on [DATE] with diagnoses which consisted of asthma, dementia, hypertension, hyperlipidemia, insomnia, overactive bladder, gastro-esophageal reflux disease, hypokalemia, malignant neoplasm, chronic pain, unspecified protein-calorie malnutrition, anxiety disorder, and major depressive disorder. Resident 18's medical records were reviewed and no documentation could be found of the COVID-19 vaccine education, vaccine administration or vaccine declination. 3. Resident 28 was admitted to the facility on [DATE] with diagnoses which included aphasia, frontotemporal neurocognitive disorder, insomnia, and dementia. Resident 28's medical records were reviewed and no documentation could be found of the COVID-19 vaccine education, vaccine administration or vaccine declination. 4. Resident 30 was admitted to the facility on [DATE] with diagnoses which included unspecified focal traumatic brain injury, chronic obstructive pulmonary disease, Alzheimer's disease, dementia, hypertension, hyperlipidemia, cognitive communication deficit, chronic pain, and osteoarthritis. Resident 30's medical records were reviewed and no documentation could be found of the COVID-19 vaccine education, vaccine administration or vaccine declination for the current vaccine season. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility Coronavirus Disease (COVID-19) - Vaccination of Residents policy documented that the resident or resident representative had the opportunity to accept or refuse a COVID-19 vaccine and before the vaccine was offered the resident was provided education regarding the benefits, risks, and potential side effects associated with the vaccine. The policy further stated that residents must sign a consent to vaccinate form prior to receiving the vaccine and a vaccine administration record was filed in the resident record. The policy also stated that if a resident did not receive the COVID-19 vaccine due to medical contraindications or refusal the documentation was made in the resident record. The policy was last revised in August 2024. On 10/3/24 at 10:58 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that he was not sure where the documentation was located for the resident COVID-19 immunization records.

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F 0948 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that paid feeding assistants have the training they need. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47432 Based on interview and record review, it was determined that for 1 of 28 sampled residents, that the facility did not ensure that any individual working in this facility working as a paid feeding assistant had completed a State-approved training program for feeding assistants. Specifically, a staff member who was not a Certified Nursing Assistant (CNA), a Licensed Nurse, or a paid feeding assistant assisted a resident with a feeding. Resident Identifier: 28. Findings Included: Resident 28 was admitted [DATE] with diagnoses including aphasia following cerebrovascular disease, other frontotemporal neurocognitive disorder, moderate protein-calorie malnutrition, vitamin B12 deficiency anemia unspecified, and dementia in other diseases classified elsewhere moderate with agitation. Resident 28's medical record was reviewed. Resident 28's CNA documentation in the Point of Care Response History section was reviewed for the dates of 9/4/24 through 10/2/24. There were 4 occurrences where resident 28 was able to eat independently. There were 8 occurrences where resident 28 required supervision while eating. There were 21 occurrences where resident 28 required limited assistance while eating. There were 16 occurrences where resident 28 required extensive assistance while eating. There were 16 occurrences where resident 28 was totally dependent on staff to eat his meals. On 10/2/24 at 11:58 AM, an interview was conducted with Staff 8. Staff 8 stated that on 10/2/24 around 9:30 AM that they had entered resident 28's room and noticed that resident 28 had not received any dining assistance with his breakfast meal. Staff 8 stated that it appeared resident 28 had not eaten any food, so they assisted resident 28 by feeding him his meal. Staff 8 stated that they were not a CNA. Facility entrance documents stated that the facility does not have any paid feeding assistants. On 10/2/24 at 12:53 PM, an interview was attempted with resident 28. Resident 28 was unable to respond to questions asked. On 9/25/24 at 10:02 AM, an interview was conducted with Nursing Assistant (NA) 1. NA 1 stated that staff can check the facility Kardex to find out what dining assistance each resident needed. NA 1 stated that staff can also ask their co-workers what assistance residents needed. NA 1 stated that the kitchen staff sent a meal ticket with each resident's meal that specified any allergies, the diet order, and any assistance needed. On 10/2/24 at 2:13 PM, an interview was conducted with Certified Nursing Assistant 1. CNA 1 stated that resident 28 ate finger foods like sandwiches easily, but struggled with foods that required fine motor control such as soup with a spoon. (continued on next page)

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F 0948 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/2/24 at 12:58 PM, an interview was conducted with CNA 2. CNA 2 stated that resident 28 did well with finger foods and that he could use a spoon. CNA 2 stated that resident 28 did not use his right arm and that she was unsure whether or not that was his dominant hand. CNA 2 stated that resident 28 struggled to eat with his left hand. On 10/3/24 at 10:09 AM, an interview was conducted with the Administrator (ADM). The ADM stated that staff who were not CNA's, Nurses, Speech Therapists, or paid feeding assistants should not be assisting residents with feedings.