STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475020	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Berlin Health & Rehab Ctr	98 Hospitality Drive Barre, VT 05641

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 51154 Per observation, interview, and record review, the facility failed to determine whether it is clinically appropriate for residents to self-administer medications for one sampled resident (Resident #364). This is a repeat deficiency for this facility, with violations cited during the previous two recertification surveys, dated 08/19/24 and 03/01/24. Findings include: Per observation on 2/4/25 at 9:18 AM, Resident #364 was seen sitting in bed with three pills on his/her lap. S/he was asking for more water. Per interview with LPN [Licensed Practical Nurse] #1 on 2/4/25 at 9:18 AM, it was confirmed that LPN #1 left the pills at the resident's bed side. Per record review, the medications left at the bedside were Docusate 100 mg tablet [a medication used for constipation], Metformin 500 milligram tablet [a medication used for Diabetes] and Bupropion ER 150 milligram tablet [a medication used to treat depression]. Per record review, Resident #364 did not have Docusate 100 milligram tablets on his/her MAR [Medication Administration Record]. Per the facility's Medication Administration policy [last revised 9/24] states, Review MAR to identify medication to be administered. 2. Compare medication source (bubble pack, vial, etc.) with MAR to verify resident name, medication name, form, dose, route, and time. a. Refer to drug reference material if unfamiliar with the medication, including its mechanism of action or common side effects. b. Administer within 60 minutes prior to or after scheduled time unless otherwise ordered by physician. c. If other than PO route, administer in accordance with facility policy for the relevant route of administration . Observe resident consumption of medication. Per interview with the DON [Director Nursing] on 2/5/25 at 9:45 AM, the DON confirmed Resident #364 has not had an assessment for self-administration of medications and cannot self-administer medications.

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 43524 Based on interview, and record review, it was determined that the facility failed to provide resident choices specific to aspects of their life that were important to them for 1 resident in a standard survey sample of 20 residents. (Resident #563). Findings include: Per interview on 2/5/25 at approximately 12:00 PM, Resident #563 stated she/he was recently admitted to this facility. She/he stated they came in on a Friday, 1/31/25, and spent the whole weekend in bed. Resident #563 stated they did ask staff to please get them up and was told by staff that until they (the resident) is assessed by PT (physical therapy) staff are not allowed to get them out of bed. The resident stated they had to use a bedpan because staff were not allowed to help the resident to the bathroom and she/he was upset about being there for rehab but not being able to get out of bed for 2 days. Per interview on 2/5/25 at approximately 12:40 PM, Resident #563's spouse met surveyor outside resident's room to discuss her/his concerns. They stated that their spouse was admitted on Friday, 1/31/25 for rehabilitation after a short stay in the hospital. She/he stated they accompanied their spouse to this facility for admission. She/he stated no one took their phone number during the admission process and that later that night she/he called to check-in and see how their spouse was doing and the phone just rang and rang. Their son and daughter also tried to reach someone that night and no one answered. She/he stated that eventually after many attempts and almost calling the police to do a welfare check, she/he was able to reach someone. She/he stated when she/he left after the admission there were no staff to be found to give their phone number to and no one asked during the admission process. They stated they did not want to get anyone in trouble and was not trying to cause trouble they just want their spouse to get better and get the therapy or treatment needed so they can come home. She/he stated, there does seem to be a short staffing issue here. Per interview on 2/5/25 at approximately 1:00 PM, the facility's DON (Director of Nursing) confirmed that Resident #563 was admitted on Friday, 1/31/25, and she/he was aware that the resident was not assessed by PT until later the following week which resulted in her/him being required to stay in bed over the weekend. The DON stated the current policy states that until a resident is assessed by PT and their level of supervision, if any, is needed, newly admitted residents do not transfer out of bed. She/he stated that this is being reviewed and changes forthcoming. Review of the facility policy titled, Resident Rights, date reviewed/revised: 10/2024, states under subtitle, Resident Rights, section #5, Self-Determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to: a. The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. The resident has the right to make choices about aspects of his or her life in the facility that are significant to 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** 46135 Based on interview and record review, the facility failed to ensure that a physician was notified of symptoms requiring an as needed medication whose prescription had expired for one of 20 sampled residents (Resident #25). Findings include: In an interview on [DATE] at 11:00 AM, Resident #25 stated that they had not been given an PRN [as needed] dose of anxiety medication that they had requested on [DATE] in the AM. Resident #25 stated that they were told that the prescription had expired during the week and that the prescriber had gone home for the weekend and there was nothing the nurse on duty could do to remedy this issue. Resident #25 revealed that they had requested their PRN anxiety medication several times on both [DATE] and [DATE]. Resident #25 stated they were told by the nurse on duty [DATE] and by the nurse on duty [DATE] that Resident #25 would have to wait until Monday [DATE] for the prescriber to come back in to renew the prescription. Resident #25 said this caused them to have even more anxiety, and that they had a very uncomfortable and stressful weekend due to not being able to receive their anxiety medication. In an interview with Resident #25 on [DATE] at 4:00 PM they said that they did not end up receiving their PRN anxiety medication until 1:20 PM on [DATE]. Record review showed that no nursing notes were entered regarding Resident #25's request for this anxiety medication or any reasons why they could not receive the dose. Record review also showed no attempt to contact the on-call physician to renew the Resident's prescription. The most recent order for Resident #25's PRN anxiety medication was dated [DATE] - [DATE]. Resident #25's most recent order read Clonazepam 0. 5mg-give one tablet by mouth every 12 hours as needed for anxiety for two weeks. This order is consistently reordered going back through medication orders back to November of 2024. Medication administration records dating back through [DATE] show that Resident #25 requested this medication several times per week on average. In an interview with the Director of Nursing [DON] on [DATE] at 2:00 PM, the DON stated that nursing staff have access to an on-call physician 24 hours a day, 7 days a week and a nurse should have called the on-call physician to have Resident #25's prescription renewed when they noticed Resident #25 didn't have a prescription.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 51189 Based on interview and record review, the facility failed to develop and implement comprehensive care plans for 2 of 2 sampled residents (Resident #27 and Resident #35) related to palliative care; and failed to implement care plan interventions related to supervision for 1 of 20 sampled residents (Resident #363). This is a repeat deficiency for this facility, with violations cited during the previous two recertification surveys, dated 08/19/24 and 03/01/24. Findings include: 1. Per record review, a Medication Regimen Review (MRR) dated 9/16/24 for Resident #27 stated Currently receiving cyclobenzaprine [used to treat pain and stiffness due to muscle spasms] as a standing order. Long term use not recommended due to high risk of anticholinergic side effects including drowsiness, dizziness, and dry mouth. Please evaluate continued need and consider taper to PRN [as needed] for 1 week then discontinue, if appropriate. The Nurse Practitioner disagreed, writing Palliative care patient as the reason. Per record review, Resident #27's Care Plan does not include any focus or interventions for palliative care. 2. Per record review, two MRRs, dated 4/17/24 and 6/12/24, for Resident #35 stated Currently receiving methocarbamol [used to treat muscle spasms and pain] without a stop date. Long term use not recommended due to high risk of side effects including drowsiness, dizziness and dry mouth. Please evaluate. Consider add [sic] stop date now, if appropriate. The Nurse Practitioner disagreed, writing Palliative care patient as the reason. Per record review, Resident #35's Care Plan does not include any focus or interventions for palliative care. The Facility policy titled Providing End of Life Care, revised on 8/24, defines palliative care as patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. The policy states The facility will complete a comprehensive assessment to provide direction for the development of the resident's care plan to address choices and preferences of the resident. During an interview at 11:18 AM on 2/6/25, the Director of Nursing confirmed that any patient deemed palliative care should be care planned for palliative care. S/he also confirmed that neither Resident #27 nor Resident #35 were care planned for palliative care. During an interview at 11:46 AM on 2/6/25 with the Licensed Practical Nurse assigned to Resident #35 and Resident #27, s/he confirmed that neither resident was care planned for palliative care. During an interview at 1:47 PM on 2/6/25 with the Nurse Practitioner, s/he confirmed that that neither Resident #27 nor Resident #35 were care planned for palliative care. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Per record review of the facility's internal investigation report for a resident-to-resident altercation on 1/21/25 states, The nurse on the cart was performing rounds at approx. [approximately] 0118 on 1/21/25, passing by [Resident #48]'s room when [Resident #363] was noted standing over [Resident #48] hitting [him/her] on the upper extremities and pulling [his/her] blanket off while [Resident #48] was sleeping. [Resident #363] was removed from the room and placed on a 1:1 [one to one] .IDT [interdisciplinary team] met and was able to move the resident's roommate to another room. Once this was completed at approx. [approximately] 1500 on 1/21/25 [Resident #363] was changed to Q15 checks [visible checks every fifteen minutes]. Per record review of Resident #363's care plan states, Resident on 1:1 following resident to resident altercation - resolved and placed on Q15min checks when resident's room status became private. Per record review of Resident #363's 15-minute check sheet, there is incomplete documentation on 1/23/25, 1/25/25, 1/26/25, 2/2/25, 2/3/25, and 2/4/25. Per interview on 2/5/25 at 10:20 AM, the LPN assigned to work with Resident #363 confirmed that s/he was unaware Resident #363 was on fifteen minute checks. Per interview on 2/5/25 at 10:26 AM, the LNA assigned to work with Resident #363 confirmed s/he did not know Resident #363 was on fifteen minute checks. S/he stated s/he would know in nursing report hand-off that a resident was on fifteen minute checks.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 51586 Based on observation, interview, and record review, the facility failed to ensure one of 20 sampled residents (Resident #25) was provided necessary assistance to carry out activities of daily living related to grooming and personal hygiene. Findings include: Per observation on 2/3/25 at 11:00 AM, Resident #25's fingernails were approximately 1/2 inch long with a dirt like substance under each nail, except for the right pointer finger where the nail appeared to have broken off with small amounts of a red/brown blood like stain on the tip of the finger. Per interview with Resident #25 on 2/3/25 at 11:03 AM, Resident #25 stated that they are unable to cut their own fingernails and has asked the staff to help cut them. Resident #25 also stated it's very obvious that they need cutting, it was the first thing you noticed when you [surveyor] walked in here. Resident #25 revealed the last day or two they had caught their fingernail on their blanket and accidentally ripped the tip off causing a small amount of pain and bleeding. When asked if any staff provided care for this incident, Resident #25 stated that no one had even noticed. Per record review, Resident #25's care plan states Provide resident total assist (dependent) of 1 for personal hygiene (grooming). Date Initiated: 11/23/2024. Record review showed there is no evidence in Resident #25's medical record that they were provided fingernail care from 1/3/25 to 2/3/25.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. 51189 Based on observation, interview, and record review, the facility failed to provide an ongoing activities program to support residents in their choice of group, individual, and independent activities to meet the interests of and support the well-being of each resident as evidenced by a lack of engaging activities both in and out of resident rooms for 6 of 20 sampled residents (Residents #2, #19, #26, #35, #53 and # 563). Findings include: 1. Per observation, no group activities were seen during the four days this survey was conducted, 02/03/25 through 02/06/25. Residents were, however, observed sitting and moving freely in hallways and public spaces. Observations on Unit A included two residents sitting side by side (not social distancing) in the hallway for the majority of the survey. Observation on 2/3/25 of Unit B revealed many residents sitting in the general milieu in wheelchairs, on the couch and in chairs. Some were conversing, others were visiting with family members, some had food and drink and others were sitting alone, There were no activities going on at this time. There was no social distancing occurring on this unit during the entire survey from 2/3/25 through 2/6/25. Per interview on 2/3/25 at approximately 11:00 AM, an LNA stated that activities are on hold because there is active Covid in the building. 2. Per observation on 2/3/25 at 10:45 AM, 11:30 AM, 1:00 PM, and 2:20 PM, Resident #2 was noted to be in bed with no activities occurring at these times. Resident #2 was not interviewable. Per interview on 2/3/25 at 2:25 PM, the Medication Technician stated she/he had not been out of bed all day and because of Covid there were currently no activities scheduled. Review of Resident #2's care plan goal initiated on 08/01/2024 stated, The Recreation Department does a check in daily, delivers a daily chronicle with a schedule of activities for the day attached. (Proper name omitted) is encouraged to attend. There were no activity logs available to review for this resident. Per observation on 2/4/25 at 9:30 AM, 11:00 AM, and 2:50 PM, Resident #2 was noted to be in bed with no activities occurring at these times. Interview on 2/4/25 at 3:00 PM, an LNA who had just begun her/his shift stated due to Covid activities are not taking place. She/he stated they were not aware if this resident had been offered any bedside activity option. She/he stated that the facility only had 1 activities person and she/he had just started. 3. During an interview, on 02/03/25 at 12:22 PM, Resident #19 said there have been no activities for a while but rumor has it a new activities director has been hired. S/he states that s/he just sits in his/her room and watches TV for entertainment. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Per record review, Resident #19 has a care plan, dated 04/01/24, that states I like to participate in BINGO and musical events with groups of people. His/her care plan also states that s/he is a risk for distressed/ fluctuating mood with an intervention of Encourage [Resident #19's] participation in activity preferences. 4. During an interview on 02/04/25 at 10:19 AM, Resident #35 said there have been no organized activities recently, only self entertainment such as coloring, puzzles, and TV. S/he has asked staff several times, but has received no answer as to when group activities will restart. Per record review, Resident #35 has a care plan, dated 04/02/24, that states I like to participate in BINGO, arts and crafts and resident council with groups of people. 5. Per interview on 2/4/25 at approximately 11:30 AM, Resident #26 stated the only activities that are offered are BINGO but that hasn't happened in a long time. She/he stated they really like music and other things but nothing is really offered. The residents care plan was updated on 2/3/25 and listed the following information for activities, The Recreation Department provides daily room visit, delivers a daily chronicle to the room, with a schedule of activities for the day attached. Resident is encouraged to attend. Since the start of this survey on 2/3/25, there have been no activities taking place and the Activities Director has not been by to see the resident, and s/he has not been provided with any list of activities. There have been no activities taking place on the B Wing unit during this survey. There were no activity logs available to review for this resident. 6. Per interview on 2/4/25 at approximately 2:15 PM, Resident #53 stated she/he stays in their room all the time. When asked about activities she/he laughed and asked, what activities? There haven't been activities for a long time. The person that use to do the activities was pulled out to be the bus driver. They have no activities. Review of the residents current care plan revealed an activities care plan initiated on 02/05/2025 stated, While in the facility, resident/patient states that it is important that s/he has the opportunity to engage in daily routines that are meaningful relative to their preferences. There were no activity logs available to review for this resident. 7. Per interview on 2/4/25 at approximately 3:00 PM, Resident #563 stated she/he hasn't been at the facility very long and they plan on going home. When asked about what activities are offered that she/he likes, they stated that there have been no activities since she/he was admitted and they are not aware of activities being an option. There were no activity logs available to review for this resident. The Activities Calendars for December 2024, January 2025 and February 2025 state Independent Activities on every Saturday and Sunday, and there were no scheduled activities after 4 PM. Per review of activity logs, there were no December 2024 Daily Activity Logs for Residents #2, #26, #35, #53 and #563. There were no January 2025 or February 2025 Daily Activity Logs for Residents #19, #2, #26, #35, #53 and #563. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Activities Director on 02/05/25 at 03:10 PM, s/he stated that group activities were on hold due to a Covid outbreak in the facility, although residents were seen sitting together and moving freely in hallways and common areas. S/he confirmed that there are no planned group activities on evenings or weekends. S/he confirmed that s/he has not reviewed the Activities Assessments of all the residents and that s/he does not know what all the Residents' needs and preferences are. S/he confirmed that s/he is unable to produce Daily Activity Logs for all the residents. S/he confirmed that there are not enough activities for dementia residents. S/he also confirmed that she is the only person on the Activities Staff, and that the Facility needs more Activities Staff. Observation from the start of this recertification survey on 2/3/25 to the exit on 2/6/25 revealed group activities taking place. 43524

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. 51586 Based on observation, interview, and record review, the facility failed to ensure that one of 20 sampled residents (Resident #20) received proper treatment and assistive devices to maintain hearing abilities. Findings include: In an attempted interview with Resident #20 on 2/4/25 at 10:00 AM this surveyor was unable to communicate with the resident. Resident #20 was pointing at their ears and stated they could not hear. This surveyor approached very close to the resident and spoke in a very loud clear voice and Resident #20 stated they were still unable to hear. Resident #20 then stated their hearing aids were dead. Based on record review, Resident #20's has the following physician order apply hearing aids to both ears every AM. Resident #20's care plan reads, resident is hard of hearing and resident has hearing aids to assist with hearing. Resident #20's care plan also includes interventions that cannot be performed without the ability to hear and communicate such as maintain communication that is consistent, open, and respectful and listen to resident without judgment or guilt. On 2/5/25 at 11:40 AM, this surveyor attempted to interview Resident #20 again, but again they were unable to hear. Resident #20 stated that their hearing aids were still on the charging dock. Resident #20 stated that the staff always forget to help them with their hearing aids. Resident #20 also stated that they are completely unable to communicate with staff in anyway without their hearing aids. Per observation on 2/6/25 at 12:00 PM, Resident #20 was once again in bed without their hearing aids.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51154 Based on interview and record review, the facility failed to ensure that 7 residents [Resident #363, Resident #463, Resident #57, Resident #52, Resident #312, Resident #8, and Resident #64] of 14 sampled residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. Findings include: 1. Per interview with the Unit Manager on 2/5/25 at 10:09 AM, Resident #363 was identified as being on fifteen-minute checks. The Unit Manager discussed that the resident has past trauma. Per record review of Resident #364's care plan states, [Resident #363] is at risks for or is experiencing adjustment issues related to: Change in customary lifestyle and routineness and/or difficulty accepting placement in center, loss of status and/or freedom associated with transition .[Resident #363] reports past experience of trauma as evidenced by: being held in concentration [NAME] growing up. Per record review of the facility's Trauma Informed Care policy [last revised 10/2024] states, The facility will use a multi-pronged approach to identifying a resident's history of trauma, as well as his or her cultural preferences. This will include asking the resident about triggers that may be stressors or may prompt recall of a previous traumatic event, as well as screening and assessment tools such as the Resident Assessment Instrument (RAI), Admission Assessment, the history and physical, the social history/assessment, and others . The facility will collaborate with resident trauma survivors, and as appropriate, the resident's family, friends, the primary care physician, and any other health care professionals (such as psychologists and mental health professionals) to develop and implement individualized care plan interventions .The facility will identify triggers which may re-traumatize residents with a history of trauma. Trigger-specific interventions will identify ways to decrease the resident's exposure to triggers which re-traumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident, and will be added to the residents care plan . Per interview with the Social Worker on 2/5/25 at 12:27 PM, the Social Worker confirmed Resident #363 had experienced trauma. The Social Worker confirmed that Resident #363's care did not include information on trauma or triggers. ' 2. Per record review, Resident #463, Resident #57, Resident #52, Resident #312, and Resident #8, and Resident #564 did not have complete assessments for trauma in their medical records. Per interview on 2/5/25 at 1:14 PM, the Social Service Director confirmed that Resident #463, Resident #57, Resident #52, Resident #312, Resident #8, and Resident #564 did not have a trauma informed care assessment. S/he said that s/he is not caught up for all the trauma assessments. S/he does not have an assessment tool to assess triggers for trauma (the tool that she uses does not ask that question/assess). (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	46135

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51586 Based on observation, interview, and record review, the facility failed to provide sufficient staffing to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This has the potential to impact all residents. This is a repeat deficiency for this facility, with violations cited during the previous recertification survey, dated 08/19/24. Findings include: 1. In an interview on 2/3/25 at 11:00 AM, Resident #25 stated that when they request as needed medications or personal care, the wait time is often over one hour, or the staff member forgets to return at all. Resident #25 said this sometimes leaves me laying in bed in pain waiting for medication, or just feeling forgotten about. Resident #25 also said that the wait time and staffing issues are noticeably worse on the weekends. Per observation and interview on 2/6/25 at approximately 11:00 AM, a Unit B's medication cart computer showed 8 residents highlighted in red. The LPN working this cart explained that the red indicates that an order is due and is over an hour late. She explained that of the 8 residents marked in red, 1 resident was just administered medications which were over an hour late, and 5 residents are still due for medication administration that was scheduled to be administered an hour or more earlier. She stated that she is late administering medications every day because the unit is short staffed and she has to help with things like passing trays and feeding residents, rather than administering medications. Record review of a document titled [NAME] Health and Rehab Medication Admin Audit Report from the dates 1/23/25-2/6/25 revealed that there were 384 pages of medications given late during that 15 day period (medications were considered late when they were administered over one hour after the time they were ordered by the prescriber). Each page of the report contained about 8-10 late medications, totaling approximently 3,400 late medications in 15 days for 64 residents. The facility had a census of 66 at the start of the recertification survey on 2/3/25. 51189 2. During an interview on 02/04/25 at 10:40 AM, Resident #35 said It is very important to me to be up in my wheelchair in the evening but the staff fights me as s/he requires a Hoyer lift for transfers and staff tell him/her it takes too much time. S/he said staff tell him/her that if s/he wants to lie down in the afternoon, s/he will not be gotten up again in the evening. S/he also said insufficient staffing is worse in the evenings and on weekends. Per record review, Resident #35 has a care plan, dated 01/28/23, that states [Resident #35] requires assistance for ADL care in bathing, grooming, personal hygiene, dressing eating, transfer, locomotion and toileting. Resident #35 also has a Care Plan Intervention that states It is important to me to choose my bedtime. I prefer to go to bed between 8:30 and 9:30 PM. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. During an interview on 02/03/25 at 10:30 AM, Resident #14 said the Facility is often short staffed and that s/he sometimes has to wait for activities of daily living (ADL) assistance. Per record review, Resident #14 has a care plan dated 11/03/22, that states [Resident #14] requires assistance/is dependent for ADL care related to limited mobility and incontinence. 4. During an interview on 2/3/25 at 11:58 AM, Resident #8 said the Facility is always short staffed on Sundays, and that s/he must wait a long time for someone to answer his/her call light. Per record review, Resident #8 has a care plan, dated 01/03/25, that states [Resident #8] requires assistance for ADL care in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion and toileting 5. During an interview on 2/3/24 at 2:22 PM, Resident #19 said there is Very low weekend staffing. Per record review, Resident #19 has a care plan, dated 09/17/22, that states [Resident #19] requires assistance/is dependent for ADL care in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, and toileting. 6. Per interview on 2/5/25 at approximately 12:40 PM, Resident #563's spouse stated that their spouse was admitted on Friday, 1/31/25 for rehabilitation after a short stay in the hospital. She/he stated they accompanied their spouse to this facility for admission. She/he stated no one took their phone number during the admission process and that later that night she/he called to check-in and see how their spouse was doing and the phone just rang and rang. Their son and daughter also tried to reach someone that night and no one answered. She/he stated that eventually after many attempts and almost calling the police to do a welfare check, she/he was able to reach someone. She/he stated when she/he left after the admission there were no staff to be found to give their phone number to and no one asked during the admission process. She/he stated, there does seem to be a short staffing issue here. 46135

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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. 46135 Based on observation, interview, and record review the facility failed to ensure medication error rates were not 5% or greater. The total error rate for all observations was calculated at 43%. There were 30 medication administration opportunities observed resulting in 13 errors for 1 of 7 sampled residents (Resident #12) due to the late administration of 12 medications, not following administration recommendations, and not administering an as needed (PRN) medication. Findings include: Per observation on 2/6/25 at 10:18 AM, a Licensed Practical Nurse (LPN) began the process of administering medications to Resident #12. When the LPN opened the Medication Administration Record (MAR) for Resident #12 on their computer, the resident's medications were highlighted in red. Listed below are the Physician orders for the medications listed on the MAR and the time when they were observed administered. The following medications were administered to Resident #12 at 10:23 AM: Apixaban Oral Tablet 5 MG (Apixaban) Give 1 tablet by mouth two times a day for A-fib [Atrial fibrillation; heart rhythm disorder], scheduled to be administered at 9:00 AM. carBAMazepine Oral Tablet 200 MG (Carbamazepine) Give 1 tablet by mouth three times a day for tremors, scheduled to be administered at 9:00 AM. Cholecalciferol Tablet 1000 UNIT Give 2 tablet by mouth one time a day for Supplement, scheduled to be administered at 9:00 AM. Sodium Chloride Oral Tablet (Sodium Chloride) Give 1000 mg by mouth one time a day for Hyponatremia [low sodium], scheduled to be administered at 9:00 AM. Fluticasone Furoate-Vilanterol Inhalation Aerosol Powder Breath Activated 100-25 MCG/ACT (Fluticasone Furoate-Vilanterol) 1 puff inhaled orally one time a day for COPD [Chronic obstructive pulmonary disease; causes airflow obstruction and breathing difficulties] RINSE MOUTH AFTER USE, scheduled to be administered at 9:00 AM. Potassium Chloride ER Oral Tablet Extended Release 20 MEQ (Potassium Chloride) Give 1 tablet by mouth one time a day for low Potassium, scheduled to be administered at 9:00 AM. Benztropine Mesylate Tablet 1 MG (Benztropine Mesylate) Give 1 tablet by mouth two times a day for tremors and stiffness of the muscles, scheduled to be administered at 9:00 AM. Gabapentin Oral Capsule 100 MG (Gabapentin) Give 1 capsule by mouth three times a day for pain, scheduled to be administered at 9:00 AM. Sertraline HCl Oral Tablet 25 MG (Sertraline HCl) Give 3 tablets by mouth one time a day for depression, scheduled to be administered at 8:00 AM. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During this medication administration, the LPN did not follow the administration recommendations. She did not ask Resident #12 to rinse his/her mouth after using the inhaler and Resident #12 was not observed to do on his/her own. The following medications were administered to Resident #12 at 10:47 AM Aspirin 81 Oral Tablet Delayed Release (Aspirin) Give 1 tablet by mouth one time a day for Heart Failure, scheduled to be administered at 9:00 AM. Finasteride Oral Tablet 5 MG (Finasteride) Give 1 tablet by mouth one time a day for BPH [Benign prostatic hyperplasia; enlarged prostate gland], scheduled to be administered at 9:00 AM. While receiving the above two medications, Resident #12 asked for Milk of Magnesia. The following medication was not administered as of 12:44 PM on 2/6/25, Milk of Magnesia Oral Suspension 400 MG/5ML (Magnesium Hydroxide) Give 30 ml by mouth every 24 hours as needed for constipation. The following medication was administered to Resident #12 at 10:54 AM Amiodarone HCl Oral Tablet 200 MG (Amiodarone HCl) Give 1 tablet by mouth one time a day for Heart Failure, scheduled to be administered at 9:00 AM Per observation and interview on 2/6/25 at approximately 11:00 AM, a Unit B's medication cart computer showed 8 residents highlighted in red. The LPN working this cart explained that the red indicates that an order is due and is over an hour late. She explained that of the 8 residents marked in red, 5 residents are due for medication administration that was scheduled to be administered an hour or more earlier. She stated that she is late administering medications every day because the unit is short staffed and she has to help with things like passing trays and feeding residents, rather than administering medications. Facility policy Medication Errors, last reviewed/revised 9/2024, reads, The facility will consider factors indicating errors in medication administration, including, but not limited to, the following: a. Medication administered not in accordance with the prescriber's order. Examples include, but not limited to: i. Incorrect dose, route of administration, dosage form, time of administration; ii. Medication omission; iii. Incorrect medication. b. Medication administered not in accordance with the manufacturer's specifications (not recommendations) regarding the preparation and administration of the medication or biological. Examples include, but not limited to: i. Failure to shake well; (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ii. Crushing do not crush medications; iii. Administering medications without adequate fluids, without food or antacids. c. Medication administered not in accordance with professional standards and principles. Per interview on 2/06/25 at 2:43 PM, the Director of Nursing confirmed that not administering a PRN medication when asked for was a medication error.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 51154 Based on observation, interview, record review, the facility failed to ensure medications were properly stored for 1 of 7 sampled residents (Resident #364). This is a repeat deficiency for this facility, with violations cited during the previous two recertification surveys, dated 08/19/24 and 03/01/24 Findings include: Per observation on 2/4/25 at 9:18 AM, Resident #364 was seen sitting in bed unsupervised with three pills on his/her lap. S/he was asking for more water. Per record review, the medications left at the bedside were Docusate 100 mg tablet [a medication used for constipation], Metformin 500 milligram tablet [a medication used for Diabetes] and Bupropion ER 150 milligram tablet [a medication used to treat depression]. Per record review, Resident #364 did not have Docusate 100 milligram tablets on his/her MAR [Medication Administration Record]. Per interview with LPN [Licensed Practical Nurse] #1 on 2/4/25 at 9:18 AM it was confirmed that the LPN left the pills at the residents' bed side. The LPN confirmed on 2/4/24 at 9:24 AM that the medications were left on the Resident's lap and should not have been.

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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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or obtain dental services for each resident. 51189 Based on observation, interview, and record review, the facility failed to provide or obtain from an outside resource routine and emergency dental services to meet the needs of each resident for 3 of 20 sampled residents (Residents #19, #46, and #463). This is a repeat deficiency for this facility, with violations cited during the previous recertification surveys dated 08/19/2024. Findings include: The Facility's Dental Services Policy revised 10/24, states It is the policy of this facility to assist residents in obtaining routine (to the extent covered under the State plan) and emergency dental care. The Dental Policy includes the following definitions: Routine dental services means an annual inspection of the oral cavity for signs of disease, diagnosis of dental disease, dental radiographs as needed, dental cleaning, fillings (new and repairs), minor partial or full denture adjustments, smoothing of broken teeth, and limited prosthodontic procedures, e.g., taking impressions for dentures and fitting dentures. Emergency dental services includes services needed to treat an episode of acute pain in teeth, gums, or palate; broken, or otherwise damaged teeth, or any other problem of the oral cavity that required immediate attention by a dentist. For residents with lost or damaged dentures, the facility will refer the resident for dental services. a. Direct care staff are responsible for notifying supervisors or Social Services Director of the loss or damage of dentures during the shift that the loss or damage was noticed, or as soon as practicable. b. The Social Services Director, or designee, shall make appointments and arrange transportation. c. The Nursing Department shall assist the Social Services Department in making appointments as needed. d. The resident and/or resident representative shall be kept informed of all arrangements. 1. During an interview on 02/03/25 at 12:22 PM, Resident #19 stated his/her dentures don't fit well, cut him/her, and hurt him/her. S/he has complained to staff, but states nothing has been done for months. Per record review, Resident #19 has a Care Plan, dated 09/17/22, that states [Resident #19] is at risk for oral health or dental care problems, with an intervention to Obtain dental referral as needed. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Per record review, a Care Plan Meeting note dated 01/07/25 states, [Resident #19] is having problems with [his/her] dentures and would like to see the dentist. Per record review, on 02/05/25 at 1:42 PM, the Facility Dental Appointment logbook shows an appointment for Resident #19 scheduled for 12/13/24, but the visit did not occur. The logbook does not list a reason as to why the visit did not occur. 2. An interview was conducted with Resident #46's Family Representative on 2/3/25 at 12:28 PM. The Family Representative stated [S/he] needs to see the dentist. [S/he] lost [her/his] upper denture at this facility in December 2024. The family representative also stated, [S/he] can eat without [her/his denture] .I help to feed [her/him] when I am here .We would like [her/him] to have an upper denture. Per record review of Resident #46's orders, there is an order dated 11/26/23 that states, Dental, ophthalmology, podiatry, physiatry, psych. Obtain consult as needed/indicated and treatment for patient health and comfort. Per record review of Resident #46's progress notes, there is a progress note dated 12/10/24 that states, Note: Resident dentures were put on for breakfast sitting in [his/her] room in the wheelchair, LNA [Licensed Nursing Assistant] brought resident out to the common area and noted [his/her teeth] were not in [his/her] mouth, asking resident what did [s/he] do with them [S/he] just steer[sic] at me, went into resident search under bed closet, draws, trash, no found in laundry or kitchen anywhere, I made [his/her family representative] aware and [other family representative] both was present in facility, they search [sic] the room where not found. [Family representative] spoke with the social worker, I this nurse putin [sic] the recommendation in dental book, DON [Director of Nursing] was made awae[sic]. 3. During an interview on 2/3/25 at 2:00 PM, Resident #463 stated that shortly after their admission on 1/17/25, his/her dentures went missing. The resident stated that the staff looked all around the room and inquired both with the kitchen staff and the laundry staff, but their dentures were never found. Record review of electronic medical records titled progress notes, assessments, care plan, and documents for Resident #463, who is on medicaid, from the date of admission (1/17/25) through 2/6/25 show that the facility did not make any attempts to refer Resident #463 for dental services of any kind. Further record review of paper documents on site titled Dental Book also showed no documentation of any attempt to schedule dental services for Resident #463. In an interview on 2/3/25 at 2:30 PM, a Licensed Nurse on the unit stated they were aware that Resident #463's dentures went missing and that they had inquired with the kitchen staff and the laundry staff but no dentures had been found. During an interview on 02/05/25 at 1:45 PM, the Director of Nursing (DON) confirmed the Facility has not had a contract with a dentist since approximately 11/22/24. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/05/25 at 2:00 PM, the Facility Administrator confirmed s/he was aware the Facility did not have access to contracted dental services but was unaware that several residents are currently presenting with dental service needs. The Administrator also confirmed that they are aware that the facility is responsible for sending the patient to an outside dental provider when no services are available within the facility. 51154

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50431 Based on observation and , it was determined that the facility failed to store food in accordance with professional standards for food service safety and failed to maintain a sanitary kitchen. Findings include: Per observation of the kitchen on [DATE] at 10:34 AM, there were food debris on the steam table. There were cobwebs on the coffee pot and carafe storage rack. There were food debris on the stainless-steel covers located on the steam table. An area on the inside of the microwave door appeared to have been burned off. There were food debris on the inside of the microwave and food debris under the microwave on the counter. Per observation there were water marks and food debris on all the stainless-steel counters. There were food debris under the stove burners and around the grill top. Food debris were on the clean plate holding device. The floor of the kitchen had visible remnants of food under all the stainless-steel working surfaces and in front of the stove and the grill. Per observation of the kitchen's dry storage area, the following items were found to be expired: There is one plastic container of turmeric with an expiration date of [DATE]. There is one plastic container of ground ginger, with an expiration date of [DATE]. There is one plastic container of ground allspice, with an expiration date of [DATE]. There is one plastic container of dried chives, with an expiration date of [DATE]. There are two plastic pitchers of juice on the shelf in the cooler, with an expiration date of [DATE]. An interview was conducted with the Dietary Manager on [DATE] at 10:40 AM. The Dietary Manager confirmed that the turmeric, allspice, ginger, and chives were expired.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51586 Based on observation, interview, and record review the facility failed to ensure safe and sanitary storage, handling, and consumption of one of 20 sampled residents (Resident #4). Findings include: In an interview on [DATE] at 2:38 PM Resident #4 stated that they do not eat any of the food that the facility provides. Resident #4 said The food here is garbage, it is inedible. Resident #4 explained that every 10 days they have a friend take them to the store and they purchase all their own food using personal funds. Resident #4 stated that they keep some of the food in their own room and items that require refrigeration are stored in a refrigerator on the unit in a locked room. Resident #4 said that they give food requiring refrigeration to the staff on unit and the staff puts the food in the refrigerator. Per interview on [DATE] 1:00 PM Resident #4 stated that someone had thrown out all their food from the unit refrigerator without notifying them. Resident #4 stated that most of this food was in unopened packages and was not close to expiration date. Resident #4 was distressed and said I do not have anyone to take me to get more food for another week. What am I going to eat? On [DATE], this surveyor observed that the unit fridge was empty and no resident food policy was posted on the refrigerator door. Record review of a document titled Food and Nutrition Services Policy and Procedures, last revised on [DATE], reads food items that require refrigeration must be labeled with patient's/resident's name and date the food was brought in and that food will be held in the refrigerator for three days following the date on the label and will be discarded by staff upon notification to patient/resident. In an interview with the District Manager on [DATE], the District Manager stated that the kitchen staff discarded all the food in the refrigerator on resident #4's unit because none of it was labeled. When asked who is responsible for labeling food put into that refrigerator the district manager stated that the staff on the unit and not the resident is responsible for properly labeling food in the unit refrigerator. The District Manager confirmed that no residents had been informed of the food being thrown out. The District Manager also stated that unopened foods that are labeled are held in the unit fridge until 3 days after the expiration date typically and not just 3 days after the date they are received. The District Manager confirmed that the food should have been labeled by staff and should not have been thrown out if it was not opened and not expired.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. 51586 Based on interview and record review the facility failed to conduct and document a facility wide assessment. This has the potential to impact all residents. Findings include: Per the Division of Licensing and Protection, the facility changed ownership on 12/16/2024. During the recertification entrance conference on 2/3/25 at 10:28 AM, the Director of Nursing (DON) was asked to provide a copy of their Facility Assessment. Later, when the DON provided the facility assessment, it had not been documented as reviewed by anyone. The DON explained that it has not been reviewed by the leadership team yet. In an interview on 2/6/25 at 11:00 AM with the Regional Director of Clinical Operations [RDCO], The RDCO stated that the facility assessment was still a work in progress and had not been actually implemented yet. This surveyor questioned the RDCO about a document mentioned in the draft of the facility assessment that was provided to this surveyor titled staff development and training plan and the RDCO stated that the document had not been created yet. In an interview with the Facility Administrator on 2/3/25 at 2:00 PM the Facility Administrator stated that their expectation was that the previous Facility Administrator would have completed the facility assessment. He confirmed that he had not reviewed the facility assessment as of yet andthere was a plan to do so the following week. Record review showed that the facility assessment draft provided for this current survey was not dated or signed by anyone. Record review also showed that the facility assessment referred to a document that did not yet exist and was unfinished.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43524 Based on observation, interview, and review of policies and procedures, it was determined that the facility failed to maintain facility-wide systems for the prevention, identification, and control of infection and communicable disease of residents, staff and visitors through surveillance, staff training and following established policies and procedures related to changing oxygen tubing, hand washing, cleaning and disinfection of reusable equipment, proper use and disposal of PPE (personal protective equipment), and facility cleanliness. Findings include: 1. Per observation on 2/3/25 at approximately 11:30 AM, the Unit Manager was observed in the general milieu without a mask in place. Review of facility policy and procedure titled, Transmission-Based (Isolation) Precautions, date implemented: 5/2022, date reviewed/revised: 07/2024, under subtitle, Policy Explanation and Compliance Guidelines, #11. Droplet Precautions and 12. Airborne Precaution, state,states, a. Intended to prevent transmission of pathogens spread through close respiratory or mucous membrane contact with respiratory secretions (i.e. respiratory droplets that are generated by a resident who is coughing, sneezing, or talking). b. A private room is preferential, but if not available, the resident can be cohorted with a resident with the same infectious agent. c. If a resident who requires droplet precautions has to share a room with a resident who does not have the same infection, the facility will make a decision regarding resident placement on a case-by-case basis after considering infection risks to other residents in the room and available alternatives. d. Draw curtain between beds in multi-bed rooms when one resident is infected with a pathogen that is transmitted by the droplet route. Maintain at least 3 feet of separation between beds. e. Healthcare personnel will wear a facemask for close contact with an infectious resident. f. Based upon the pathogen or clinical syndrome, if there is risk of exposure of mucous membranes or substantial spraying of respiratory secretions is anticipated, gloves and gown as well as goggles (or face shield) should be worn. g. Residents on Droplet Precautions who must be transported outside of the room should wear a facemask if tolerated, and follow respiratory hygiene/cough etiquette as described in the facility's Standard Precautions Infection Control Policy. 2. Airborne Precautions- (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	a. Airborne Precautions prevent transmission of pathogens that remain infectious over long distances when suspended in the air. b. The preferred placement for patients who require Airborne Precautions is in an airborne infection isolation room (AIIR). c. This facility does not have an airborne infection isolation room; therefore, residents who have confirmed infection requiring airborne precautions will be transferred to an acute care hospital that has an available AIIR. d. If unable to transfer resident to an AIIR room, as in the case of COVID-19 infection, the facility will follow CDC guidance as to cohorting, private room accommodation and/or designated units and staff will wear a fit-tested N95 or higher-level respirator and other appropriate PPE while delivering care to the resident. Interview on 2/3/25 at approximately 11:32 AM with the Unit Manager of B wing confirmed there were residents on this unit with active Covid. This Surveyor asked what the direction was for masking this unit, the Unit Manager stated they were not sure as the information about masking had not been made clear. She/he was asked what their expectation was for their staff working on this unit specific to masking and she/he stated they would expect staff to wear masks but she/he wasn't sure if masking was required in the hallways or just in resident rooms and would need to get clarification. Per observation on 2/3/25 at approximately 11:45 AM, a staff member was noted to be carrying 2 clear plastic bags with gloved hands in the hallway. The staff member was observed entering the dirty utility room, where she/he placed each bag in a different bin. She/he removed their gloves and threw them in the trash in the dirty utility room then exited the dirty utility room without performing hand hygiene. The staff member was identified as an LNA (Licensed Nursing Assistant) through interview with her/him on 2/3/25 at approximately 11:47 AM. She/he stated that they always wear gloves to transport dirty linens and trash to the dirty utility but I usually do hand hygiene after I remove my gloves but I must have forgot. Per interview on 2/3/25 with the Unit Manager regarding hand hygiene when donning (putting on) and doffing (taking off) gloves, she/he stated first off staff are not supposed to be wearing gloves in the hallway for any reason but when bringing bags of trash, they could take a clean glove and fold it over and use it to grab the bag. Per observation on 2/3/25 at approximately 12:30 PM, an LNA was observed walking down the B wing hallway with her/his mask under their chin. Per interview on 2/3/25 at approximately 12:31 PM the LNA was asked if there was a masking policy in the building. She/he stated there was but she/he gets hot and I can't breath so I take the mask down for a minute. Per interview on 2/3/25 with the Unit Manager regarding observations of staff not wearing the masks appropriately on the unit, she/he confirmed that this was an issue despite all the reminders and training she/he had provided. She/he asked which staff and then stated she/he has been spoken to numerous times. This same LNA was observed again at approximately 12:48 PM with her/his mask under their nose and upon seeing surveyors moved the mask to the appropriate position over her/his nose. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Per observation on 2/3/25 at approximately 1:10 PM a staff, who was later identified as an LNA was observed wearing her/his mask under her/his nose. Interview on 2/3/25 at approximately 1:12 PM with the Unit Manager regarding the above observation, she/he stated and that's the other one that I'm constantly speaking to about their mask. Per observation on 2/4/25 at approximately 9:31 AM. an LNA was observed wearing her/his mask under their nose while on B Unit. Per interview with the LNA on 2/4/25 at approximately 9:33 AM, she/he confirmed she/he was not wearing mask appropriately and at that time put it in proper placement. She/he confirmed receiving instruction on the proper use of PPE. Per observation on 2/4/25 at approximately 9:45 AM, an LNA was observed not wearing her/his mask correctly coming out of room [ROOM NUMBER] with her/his mask under her/his nose. Per observation on 2/4/25 at approximately 10:00 AM, the facility's NP (Nurse Practitioner) was performing an assessment on Resident #12 in room [ROOM NUMBER]. Outside of this room was a precaution cart and precautions sign to the right of the door. It was noted that the NP was using a reusable stethoscope to assess Resident #12. After using the stethoscope on Resident #12, without cleaning it, she/he placed the stethoscope over her/his neck where it hung in place. She/he removed their PPE and exited the room at approximately 10:10 AM, she/he used hand sanitizer from a hall wall dispenser and cleaned her/his hands and stethoscope. She/he put on new PPE and at approximately 10:13 AM she/he re-entered room [ROOM NUMBER] and performed an assessment on Resident #12's roommate. She/he placed their re-usable stethoscope back over her/his neck where it hung. She/he removed all PPE, exited room [ROOM NUMBER], went to precaution cart put on new mask, located the hand sanitizer dispenser on the hall wall and proceeded to clean her/his hands and their re-usable stethoscope. Per interview on 2/4/25 at approximately 10:15 AM, the NP stated she usually cleans her/his stethoscope between residents and after use on a resident with Covid however there was no hand sanitizer in room [ROOM NUMBER] so she/he decided to come out into the hallway to find some. When asked how she/he cleans reusable equipment after use on residents she/he stated that they use alcohol on resident who do not have Covid and bleach wipes on reusable equipment for residents with Covid. When asked what the facility's policy and procedure requires she/he restated the use of alcohol on reusable equipment used on residents who do not have Covid and bleach on reusable equipment used on residents with Covid. When asked if there is a wet contact wait time for hand sanitizer and bleach she/he stated there was but could not state what those times were. Review of the MIFU (Manufacturers Instructions for Use) bleach wipes used in this facility revealed a Wet Contact Time (the amount of time a disinfectant needs to remain wet on a surface to kill germs) of 3 full minutes. Per observation on 2/4/25 at approximately 10:05 AM, an LNA was observed going into a precaution room with just a surgical mask on and no other PPE. Per interview on 2/4/25 at approximately 10:07 AM with the LNA who confirmed she/he had gone into a precaution room with only a surgical mask on and no other PPE, she/he stated they should be wearing full PPE and confirmed that would an N95 mask, face shield, gloves, and a gown. She/he confirmed they were not wearing the correct mask or the other required PPE. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Per observation on 2/5/25 at approximately 9:42 AM, an LNA with a badge that read New Staff was observed wearing her/his mask under their nose. Per interview with this staff on 2/5/25 at approximately 9:43 AM, she/he confirmed she/he was an LNA and a new staff member. She /he stated that the mask should be above the nose. This was again observed on 2/5/25 at 9:54 AM, 10:00 AM, 10:30 AM, and again at 10:45 AM. Additional observations were made of staff not wearing masks properly: On 2/03/25 at 11:09 AM, an LNA was in room [ROOM NUMBER]A providing patient care with her mask below her chin. On 2/03/25 at 11:11 AM, an LNA exited room [ROOM NUMBER] A with her mask not covering her nose or mouth. On 2/03/25 at 11:30 AM, an LNA went in and out of room [ROOM NUMBER] A with her mask below her mouth. On 2/3/25 at 12:28 PM, an LNA was in the Unit A hall with her mask pulled off her face and mouth. On 2/3/25 at 12:41 PM, an LPN and an LNA were standing at the medication cart in the hall with their masks on their chin. On 2/3/25 at 1:01 PM, an LNA was in the Unit A hall with her mask not covering her nose or mouth. On 2/3/25 at 3:00 PM, an LNA came out of room [ROOM NUMBER] with her mask below her chin. On 2/3/25 at 3:01 PM, an LNA was in room [ROOM NUMBER] with her mask below her chin. On 2/3/25 at 3:09 PM, an LNA was in the hall with her mask on her chin. On 2/3/25 at 3:10 PM, an LNA was in the hall with her mask below her chin. On 2/3/25 at 3:12 PM, an LNA, mask below her chin in the hall On 2/3/25 at 5:15 PM, an LNA was standing at the Unit A medication cart without her mask covering her nose and mouth. On 2/3/25 at 5:16 PM, an LNA was passing trays in Unit B without her mask covering her nose and mouth. On 2/4/25 at 9:20 AM, an LNA was in the Unit A hall without her mask covering her nose and mouth. On 2/4/25 at 9:28 AM, the Housekeeping Manager was walking down the hallway on Unit B without his/her mask covering their nose and mouth. On 2/4/25 at 9:30 AM, an LNA was in the Unit A hall with her mask below her mouth. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/4/25 at 10:35 AM, an LNA was in Resident #22's room providing patent care with her mask pulled below her chin. On 2/4/25 at 10:47 AM, 2 LNAs were walking down the Unit A hall without their masks below their mouths. On 2/4/25 at 12:39 PM, a LNA was providing care in room [ROOM NUMBER] with her mask below her mouth. On 2/4/25 at 12:41 PM, a Dietary Staff was bringing the lunch cart onto Unit B without his mask covering his nose and mouth. On 2/4/25 at 12:42 PM, an LNA was in the Unit B hall without her mask covering her nose and mouth. On 2/4/25 at 3:41 PM, an LNA was in the Unit B hall without her mask covering her nose and mouth. On 2/4/25 at 3:22 PM, an LNA was at the Unit B nurse station with her mask pulled down below her chin. On 2/4/25 at 4:20 PM, an LNA, was in the hall without her mask covering her nose and mouth. On 2/5/25 at 9:44 AM, an LNA was in room [ROOM NUMBER] with her mask below her chin while feeding a resident. On 2/5/25 at 9:45 AM, an LNA is in Resident #464's room with her mask not covering her nose or mouth. On 2/5/25 at 9:52 AM, a Licensed Nurse was in room [ROOM NUMBER] mask with her mask not covering her nose. On 2/6/25 at 11:59 AM, an LNA was not wearing her mask at the Unit A nursing station while residents were in close proximity. 2. Per observation on 2/3/25 at approximately 12:15 PM of Resident #12's room revealed an oxygen concentrator and a nebulizer machine both with attached oxygen tubing that was not dated. Per interview on 2/3/25 at approximately 12:20 PM, the Medication Technician working on the unit where Resident #12 resides stated all oxygen tubing is to be changed and dated every week. She/he accompanied this surveyor to Resident #12's room and confirmed the oxygen tubing was not dated. Review of the facility's Oxygen Administration Policy, date implemented: 5/2022; date reviewed/revised: 9/2024 under subtitle reveals, Policy Explanation and Compliance Guidelines, #5. Staff shall perform hand hygiene and don gloves when administering oxygen or when in contact with oxygen equipment. Other infection control measures include: a. Follow manufacturer recommendations for the frequency of cleaning equipment filters. b. Change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	c. Change humidifier bottle when empty, every 72 hours or per facility policy, or as recommended by the manufacturer. Use only sterile water for humidification. d. If applicable, change nebulizer tubing and delivery devices weekly and as needed if it becomes soiled or contaminated. e. Keep delivery devices covered in plastic bag when not in use. Per observation and interview on 2/3/25 at 11:48 AM, an LPN was changing Resident #6's oxygen tubing. The old tubing did not have a date and the LPN confirmed that it should. Per observation on 2/3/25 at 12:15 PM, Resident #464 did not have a date on their oxygen tubing. Per observation on 2/3/25 at 12:19 PM, Resident #33's oxygen tubing is marked with 1/25. Per facility policy, the tubing should have been replaced within 7 days, which would be 2/1/25. Per observation on 02/03/25 at 2:32 PM, and again on 02/04/25 at 4:30 PM, Resident #8's oxygen tubing was dated 1/22, and the cannula portion was on the floor.Per record review, Resident #8 has an order for oxygen tubing to be changed weekly dated 1/29/25. During an interview on 02/04/25 at 4:30 PM, a Licensed Practical Nurse confirmed Resident #8's oxygen tubing was outdated, and on the floor. Per observation on 2/4/25 at 12:04 PM Resident #33, who is recieving oxygen via nasal canula, had oxygen tubing dated 1/3/25. Per record review Resident #33 had an order stating oxygen tubing must be replaced every 7 days. Per observation and interview on 2/4/25 at 4:27 PM, Resident # 22's oxygen tubing is dated 1/22. Per facility policy, the tubing should have been replaced within 7 days, which would be 1/29/25. An LPN confirmed that Resident #22's oxygen tubing was dated 1/22 and should have been changed after 7 days. 46135 51189 51586