STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475040	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Green Mountain Nursing and Rehabilitation	475 Ethan Allen Avenue Colchester, VT 05446

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 46442 Based on observation and interview the facility failed to provide the residents with a home-like environment during meals. Findings include: On 3/25/24 at 12:35 pm, an observation of the lunch meal in the main resident dining room revealed 6 of 12 residents had their meal delivered on paper plates, this included 2 residents who had puree diets, a puree diet is food that is blended to a soft almost liquid like consistency. Regarding the residents that had the pureed diet, the plates were noted to be wet appearing as the liquid from the food was making the plate soft, effecting the strength of the plate. It was observed that the other residents in the dining room had regular plates. An interview on 3/25/24 at 12:30 pm with the Registered Dietitian (RD) revealed that the facility has had a shortage of plates for about a month and some residents have been using paper plates during that time. An interview on 3/25/24 at 4:40pm with the facility administrator revealed that the administrator went into the storage area that morning and found 2 cases of regular plates. S/he confirmed that the facility had been using paper plates for the past month and the plates had not been found until today.

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46442 Based on observation, interview, and record review the facility failed to notify the resident and resident representative of a transfer to the hospital and the reason for transfer to the hospital in writing for 4 of 27 residents sampled (Resident #21, Resident #39, Resident #52, and Resident #167). Findings include: 1. Per record review Resident #21 was discharged to the hospital on 12/5/23 and was readmitted to the facility on [DATE]. S/he was again discharged to the hospital on 1/29/24 and readmitted on [DATE]. There is no documentation in the electronic medical record or the paper medical record that Resident # 21 or his/her representative received a discharge/transfer notice. Per an interview on 3/26/24 at 12:43 pm the Registered Nurse (RN) Unit Manager (UM) confirmed that there is no documentation that supports that a discharge/transfer notice was given to Resident # 21 or the resident representative on either of the two discharges dates to the hospital. 40258 2. Per record review Resident #39 was sent to the hospital on 3/24/24 for evaluation and treatment due to sudden onset of pain. There is no documentation in the electronic medical record or the paper medical record that Resident #39 or his/her representative was provided a transfer/discharge notice. Per an interview on 3/27/24 at approximately 2:15 PM the Registered Nurse (RN) Unit Manager (UM) confirmed that there is no documentation that supports that the written notification of transfer to the hospital was given to Resident #39 or the resident representative. 3. Per record review Resident #52 was sent to the hospital on 12/28/23 for evaluation and treatment due to a fall. There is no documentation in the electronic medical record or the paper medical record that Resident #52 or his/her representative was given transfer/discharge notice. Per interview on 3/27/24 at approximately 2:15 PM the Registered Nurse (RN) Unit Manager (UM) confirmed that there is no documentation that supports that a discharge/transfer notice was given to Resident #52 or the resident representative. 44192 4. Per interview on 3/25/24 at approximately 1:30 PM, Resident #167 stated that they have been transferred to the hospital twice since their initial admission to the facility on [DATE], and they do not recall ever having been given a notice of transfer prior to transfer or discussing one with staff. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Per record review, Resident #167 transferred to the hospital for evaluation of medical symptoms on 2/28/24 and 3/15/24. Both transfers resulted in hospital admissions. There was no evidence in the record that a transfer notice was ever provided to Resident #167 for either transfer. Per interview on 3/26/24 at approximately 12:45 PM, the Social Worker stated that nurses are expected to provide transfer notices to the resident/representative prior to transfer. Per interview on 3/26/24 at approximately 1:00 PM, Resident #167's nurse confirmed that they also could not locate any evidence of a transfer notice being completed for either of Resident #167's transfers out of the facility. Per interview on 3/26/24 at approximately 1:10 PM, the Unit Manager stated that there are blank copies of transfer notices in every resident's paper chart to use in the event of a transfer. Upon inspection of the blank transfer notices, it was discovered that the Administrator's signature is pre-signed on all of the copies. The Unit Manager confirmed that this is the case, even though the Administrator is not the person who is responsible for providing/discussing the transfer notices with the resident/representative. Per interview on 3/26/24 at approximately 1:30 PM, the Administrator confirmed that the facility's current practice for transfer notices does not meet the regulation.

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Many	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46442 Based on interview and record review, the facility failed to ensure that residents or resident representatives received written notification of the facility bed hold policy on residents' discharge to the hospital for 4 of 27 residents sampled. (Resident #21, Resident #39, Resident #52, and Resident #167). Findings include: 1. Per record review Resident #21 was discharged to the hospital on 12/5/23 and was readmitted to the facility on [DATE]. S/he was again discharged to the hospital on 1/29/24 and readmitted on [DATE]. There is no documentation in the electronic medical record or the paper medical record that the bed hold policy was given to the resident or the resident's representative. Per an interview on 3/26/24 at 12:43 pm with the Registered Nurse (RN) Unit Manager (UM) confirms that there is no documentation that supports that the written notification of the bed hold policy was given to Resident # 21 or the resident representative on either of the two discharges to the hospital. 40258 2. Per record review Resident #39 was sent to the hospital on 3/24/24 for evaluation and treatment due to sudden onset of pain. There is no documentation in the electronic medical record or the paper medical record that a bed hold policy was given to Resident #39 or their representative. Per interview on 3/27/24 at approximately 2:15 PM the Registered Nurse (RN) Unit Manager (UM) confirmed that there is no documentation that supports that the written notification of the bed hold policy was given to Resident #39 or their representative. 3. Per record review Resident #52 was sent to the hospital on 12/28/23 for evaluation and treatment due to a fall. There is no documentation in the electronic medical record or the paper medical record that a bed hold policy was provided to Resident #52 or their representive. Per interview on 3/27/24 at approximately 2:15 PM the Registered Nurse (RN) Unit Manager (UM) confirmed that the written notification of the bed hold policy was not provided to Resident #52 or their representive. 44192 4. Per interview on 3/25/24 at approximately 1:30 PM, Resident #167 stated that they have been transferred to the hospital twice since their initial admission to the facility on [DATE], and they do not recall ever having been given a bed hold notice prior to transfer or discussing one with staff. They said that having their bed held for them upon return was always a concern for them. (continued on next page)

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Many	Per record review, Resident #167 transferred to the hospital for evaluation of medical symptoms on 2/28/24 and 3/15/24. Both transfers resulted in hospital admissions. There was no evidence in the record that a bed hold notice was provided to Resident #167 for either transfer. Per interview on 3/26/24 at approximately 12:45 PM, the Social Worker stated that nurses are expected to provide bed hold notices to the resident/representative prior to transfer. Per interview on 3/26/24 at approximately 1:00 PM, Resident #167's nurse confirmed that they also could not locate any evidence of a bed hold notice being completed for either of Resident #167's transfers out of the facility. Per interview on 3/26/24 at approximately 1:30 PM, the Administrator confirmed that the facility's current practice for bed hold notices does not meet the regulation.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48017 Based on observations, interviews, and record reviews, the facility failed to develop a comprehensive care plan that is person-centered and developed to meet the residents' preferences and goals for 1 of 23 residents in the sample (Resident #30). Findings include: 1. Resident #30 was admitted to the facility on [DATE] with diagnoses that include depression, demoralization, and apathy. Per interview on 3/25/2024 at approximately 2:00 PM with a family member of Resident #3, they revealed that they are concerned about how often the resident refuses care. This includes refusing to have a dressing changed on a wound on top of their head. When Resident #30 was at home, the family would reapproach until they could provide care, change the dressing and assist with bathing and dressing. Per observation on 3/26/24 at approximately 9:40 AM, Resident #30 was sitting in a recliner in his/her room. A Licensed Nursing Assistant (LNA) asked Resident #30 if they could assist resident with morning care. Resident #30 did not respond to several requests and pushed the LNA's hand away. An interview with the LNA a few minutes later, she/he stated we just know to reapproach at another time and that this resident refuses most care daily; it often takes several attempts before care of any care is received. Per observation on 3/27/24 at approximately 10:00 AM, Resident #30 did not respond to the wound care practitioner requesting to change his/her wound dressing. The wound care nurse stated this is often the case, and I know from experience to come back later, explaining that some days it took three or four attempts. A record review reveals that Resident #30's care plan does not contain any goals or interventions regarding refusal of care or reapproaching resident later. A policy titled Care Plans, Comprehensive Person-Centered with an adoption date of 3/21, page 1, # 7 states, The comprehensive, person-centered care plan: a. Includes measurable objectives and timeframes. b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including: c. (1) services that would otherwise be provided for the above but are not provided due to the resident exercising his or her rights, including the right to refuse treatment. #13 on page 2 states, The resident has the right to refuse to participate in the development of his/her care plan and medical nursing treatments. Such refusals are documented in the resident's clinical record in accordance with established policies. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Per interview with the DON on 3/27/2024 at approximately 3:20 PM, s/he confirmed that Resident #30's care plan did not include documentation addressing his/her refusal of care.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50336 Based on observation, interview, and record review, the facility failed to ensure that a resident's care plan was reviewed and revised for 2 of 27 residents sampled (Residents #6 and #1). Findings include: 1.Per record review Resident # 6 admitted to the facility in 2023 with diagnoses that include heart failure, rheumatic heart disease, chronic respiratory failure oxygen dependent, and receiving anticoagulants. On 12/30/23 Resident #6 fell on to the right side of his/her chest striking it off the footboard. Post fall documentation completed on 12/30/23 by a license nurse noted a small bruise to the right side of chest with no other injury. Physician orders on 12/30/2023 at 11:54 am identified Resident # 6 as being in severe right rib pain related to fall. Per [NAME] Mountain Nursing and Rehabilitation policy last reviewed 01/2021 Comprehensive Care Plan: assessments of residents are ongoing and comprehensive care plans are revised as information about the resident's condition changes. Interdisciplinary team reviews and updates the care plan for the following reasons. A significant change in resident status, when the desired outcome is not met, and when the resident has been readmitted after hospitalization . Review of Resident #6's care plan revealed that the comprehensive care plan was not updated or revised timely to address the fall or the severe right rib pain, and none of the interventions listed in the above policy were implemented in the plan of care until 01/23/2024 An interview with the director of nursing on 3/28/24 at 138 PM confirmed that the care plan had not been updated for Resident # 6 until 01/23/24, 24 days after the fall and sustained injury. The Director of nursing confirmed that all residents comprehensive care plans should be updated when changes in resident's condition occur. 2. Per record review, Resident # 1 was admitted to facility on 6/14/2012 with diagnoses of Lou Gehrigsdisease (ALS), paraplegia, expressive aphasia (the lack of ability to communicate using voice), and dysphagia (difficulty swallowing due to disease or other injury). Resident #1 is dependent for all his/her care, and has contractures of both his hands that limit use. Resident #1 requires assistance for mobility and all transfers. On 05/25/2023 Resident #1 was transferred to the hospital with an infection and admitted until 06/05/2024. A Physician's Transition of Care Report dated 06/05/2023 reveals that Resident #1 was admitted to the University of [NAME] Medical Center related to sepsis, (an infection in the blood) on 05/25/23. During Resident # 1's hospital stay a G-tube was inserted to be used for all medications and nutrition. Hospital discharge orders written on 06/05/2024 reflect all medications and nutrition to be given through the g-tube. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Per [NAME] Mountain Nursing and Rehabilitation policy last reviewed September 2022, Gastrostomy and jejunostomy sites will have a physician order to care for the site, care plan will be reviewed and updated for any special needs of the resident. Documentation of the g-tube site will include, when care was performed, how the resident tolerated care of the site, and assessment of the area. Documentation of the care will be completed by the licensed nursing staff and include date, time, and signature. According to the facility's policy Comprehensive Care Plan last updated 01/2021 assessments of residents are ongoing and comprehensive care plans are revised as information about the resident's condition changes. Interdisciplinary team reviews and updates the care plan for the following reasons. A significant change in resident status, when the desired outcome is not met, and when the resident has been readmitted after hospitalization . Review of Resident#1's care plan revealed no evidence that a comprehensive plan was developed for Resident #1's G-tube, and none of the interventions listed in the policies were implemented in the plan of care. Director of Nursing confirmed during interview on 3/28/2024 at 2:30 PM all Resident's comprehensive care plans should be updated at the time there is a change in resident's condition.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46135 Based on interview, record review, and facility policy, the facility failed to prepare a discharge summary that included a final summary of the resident's status and a post discharge plan of care for 1 applicable resident (Resident #64) and did not have a system in place to prepare a discharge summary that included all the required elements for any resident with the potential for discharge, putting residents with the potential for discharge at risk for more than minimal harm. Findings include: Facility policy titled Discharge Summary and Plan, adopted on 9/2022, states that when a resident's discharge is anticipated, a post-discharge plan and a discharge summary will be developed, provided to the resident, and filed in the resident's medical record. The policy indicates that the discharge summary should include a summary of the resident's status at the time of discharge by including a description of the resident's: a. current diagnosis; b. medical history; d. current laboratory, radiology, consultation, and diagnostic test results; physical and mental functional status; ability to perform activities of daily living including bathing, dressing and grooming, toilet use, eating, and using speech, language, and other communication systems, and the ability to form relationships, make health care decisions, and participate in activities; sensory and physical impairments; nutritional status and requirements including weight and height, nutritional intake, and eating habits, and preferences; special treatments or procedures; mental and psychosocial status; discharge potential; dental condition; activities potential, rehabilitation potential, and cognitive statusc. The post discharge plan should include: a description of the resident's stated discharge goals; the degree of caregiver/support person availability, capacity and capability to preform required care; how the IDT will support the resident or representative in the transition to post-discharge care; what factors make the resident vulnerable to preventable readmission; and how those factors get addressed. Per record review, Resident #64 was admitted to the facility on [DATE] for therapy related to a fractured femur and discharged home on 12/31/2023. A request was made to the Resident Family Service Coordinator (RFSC) on 3/27/2024 to provide this surveyor with Resident #64's discharge summary and post-discharge plan. On 3/27/2024 at approximately 2:00 PM, the RFSC and this surveyor reviewed a document titled GMNH Discharge Instructions, located in Resident #64's paper chart, a progress note titled Discharge Summary, located in Resident #64's electronic health record, and the facility Discharge Summary and Plan policy. Review of the Discharge Instructions form for Resident #64, dated as reviewed on 12/31/2023, shows that most of the required elements of the discharge summary and the post-discharge plan listed above are not included. S/He stated that the discharging resident does not receive a separate discharge summary and post-discharge plan. The RFSC explained that the Discharge Instructions form is what a resident receives on discharge, in addition to a medication list; they do not give the resident a copy of the progress note. S/He indicated that s/he had not seen the discharge summary and discharge plan policy before and was not aware that the discharge summary and discharge plan required so many components. S/He confirmed that the Discharge Instructions form Resident #64 received did not include all the required elements as stated in the facility policy. S/He explained that the Discharge Instructions form is what they use for all residents discharging and confirmed that the form does not contain the required elements as stated in the facility policy.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 40258 Based on interview and record review the facility failed to ensure that 1 of 23 residents sampled (Resident #29) did not recieve a medication that is listed in their medical record as a known drug allergy. Per record review Resident #29 has Tramadol listed as an allergy. A physicians order dated 3/23/2024 reflects Tramadol 25 mg give 1 tablet by mouth every 8 hours as needed for pain related to low back pain. Review of Resident #29's Medication Administration Record (MAR) reveals that on 3/23/24 Resident #29 receaved a dose of Tramadol 25mg for pain rated as 5 on a 10 pain scale. Per interview on 3/28/24 at 4:15 PM the Director of Nursing (DON) confirmed that Resident #29 had an order for and was administered Tramadol with a listed known allergy.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46135 Based on interview and record review, the facility failed to provide pressure ulcer treatment consistent with professional standards of practice for 1 applicable resident with a pressure ulcer (Resident #2) as evidenced by the facility not providing weekly wound assessments, not providing pressure ulcer treatment, not providing daily monitoring of pressure ulcers, and not creating a care plan that reflected the resident's actual pressure ulcer. As a result, Resident #2's pressure ulcer worsened, became infected, and caused him/her pain. Findings include: Resident #2 was admitted to the facility on [DATE] and has diagnoses that include Alzheimer's disease, muscle weakness, heart failure, and major depressive disorder. Per Resident #2's Minimum Data Set (MDS; a comprehensive assessment used as a care-planning tool) dated 2/17/24, s/he is occasionally incontinent, has a BIMS of 2 (brief interview for mental status; a cognitive assessment score indicating severe cognitive impairment), requires staff assistance for mobility, and is at risk of developing pressure ulcers. Resident #2's care plan, initiated on 12/6/23, states [Resident #2] is currently w/o pressure ulcers but remains at risk due to incontinence of urine although [s/he] is mobile with assistance, with an intervention to Assess [Resident #2's] skin weekly and PRN [as needed]. Report to MD any changes and TX [treatment] as ordered, initiated on 12/06/2023. A weekly wound assessment dated [DATE] reveals that Resident #2 has a newly identified stage 2 (partial thickness loss) left gluteal pressure ulcer, identified by nursing staff on 4/3/24, measuring 1 x 0.8 x 0.1 cm and described as facility acquired. The following treatment recommendations were made: Recommend Cleanse, Apply skin prep to periwound [area around wound], medihoney [wound gel] and border foam over area, QOD [every other day]. Increase brief changes and frequent position changes per facility protocol. Cushion in wheelchair/seat. Professional standards for pressure ulcer prevention and management reveal that a thorough wound assessment should be completed at least weekly*; wounds and/or dressings should be monitored regularly to ensure they are clean, dry, and intact and worsening the wound or new signs of infection should be reported to the health care provider **; and care plans should be revised for newly existing pressure injuries and interventions should include wound assessments, treatment orders, treatment evaluation plans, and other interventions based on risk factors, positioning, and support surfaces***. Review of Resident #2's care plan reveals that their care plan was not updated to reflect the left gluteal pressure ulcer until 5/27/24, 56 days after the wound was identified. The care plan did not include interventions for weekly wound assessments, wound treatment orders, or frequent monitoring of wounds and/or dressings. Resident #2's care plan was not revised to reflect the recommendations to increase the frequency of brief changes and position changes as recommended by the wound provider on 4/2/24; brief use and position changing interventions were last created on 12/6/23. Resident #2's care plan did not include interventions for a wheelchair/seat cushion. Physician orders reveal that Resident #2 did not have orders to treat their pressure ulcer wound until 4/8/24, 6 days after the wound was identified. Per review on Resident #2's Treatment Administration Record (TAR) for May 2024, Resident #2 did not receive treatment for their pressure ulcer wound on 5/7/24, 5/11/24, 5/15/24, 5/19/24, 5/21/24, and 5/23/24 as ordered by the physician. (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 0686 Level of Harm - Actual harm Residents Affected - Few	There was no evidence in Resident #2's TAR or in progress notes that their wound and/or dressing was monitored daily for complications. Per record review, wound assessments were not completed weekly for Resident #2. Wound assessments were only completed every other week on 4/17/24, 5/1/24, 5/15/24, and 5/29/24. On 5/15/24, the wound was similar in size to the initial assessment, measuring 0.5 x 0.5 x 0.1 cm. A Physician note dated 5/28/24 reveals that Resident #2 is seen for a chief complaint of left gluteal pressure injury. [His/Her] clinical exam today reveals a stage III [full-thickness tissue loss] pressure injury with infection, approximately 3 cm x 3 cm x 1 cm deep. The following physician order was started on 5/28/24 Cephalexin Oral Suspension Reconstituted 250 MG/5ML (Cephalexin) Give 10 ml orally two times a day for wound care until 06/04/2024. A weekly wound assessment dated [DATE] reveals the left gluteal pressure wound measures 3 x 2 x 1.5 cm and Resident #2's pain is a 6 on a scale of 1-10. At this visit, the wound was debrided (surgically remove damaged tissue) which caused Resident #2 to report an increased pain of 8 on a scale of 1-10. Per interview on 6/11/24 at 3:46 PM, the Assistant Director of Nursing (ADON) confirmed that Resident #2 did not have weekly wound assessment, was missing wound treatments in May, and did not have an update to their care plan to reflect their actual wound and care needs, including daily monitoring of the wound and/or dressing, until 5/27/24 and should have. *https://learning.lww.com/files/BacktotheBasicsWoundAssessmentManagementandDocumentation-1662480009184.pdf ** https://www.ncbi.nlm.nih.gov/books/NBK593201/ *** https://www.hhs.texas.gov/sites/default/files/documents/pi-care-plan-highlights.pdf

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46135 Based upon interview and record review, the facility failed to ensure residents received adequate supervision and interventions implemented to remain as free of accident hazards as is possible for 2 residents [Res.#1 and #3] of 4 sampled residents. Findings include: 1.) Per record review, Res.#1 is an [AGE] year-old with diagnoses including Alzheimer's dementia and a fall with fracture of the right hip, for which [h/she] was operated on and then sent to the facility here on 5/9/24. Per record review, two days after admission the resident suffered a fall on 5/11/24. Per record review, a fall note was recorded on 5/12/24 regarding the fall on 5/11/24. The note lists patient tried to go to the bathroom, slipped and fell , found next to bed, no injuries. Nursing Notes dated 5/12/24 at 12:09 PM record the resident was medicated with a narcotic pain reliever administered due to severe pain, crying, yelling out in pain. The fall note on 5/12/24 includes additional fall prevention precautions to be added per center protocol. The facility's Falls - Clinical Protocol policy and procedure, under Treatment/Management, reads the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling. [GMNH Operational Policies & Procedures-Adoption date: 10/23] An interview was conducted with the Assistant Director of Nursing [ADON] on 6/11/24 at 3:44 PM. The ADON confirmed that Res.#1's care plan listed a fall on 5/11/24, the resident suffered severe pain, but the care plan was not revised with any new interventions to prevent future falls or injury. Further review of Res.#1's medical record reveals at 1:27 AM on 6/8/24 Nursing Notes record the resident was complaining of 'left flank pain' and medicated with a narcotic pain reliever. At 7:59 AM, the resident again was complaining of left rib pain and given the narcotic pain reliever again, along with a muscle relaxer for complaint of spasms in [h/her] back and rib area. Nursing Notes record Resident was complaining of left rib pain, [s/he] rated [h/her] pain 10 out of 10. Nursing Notes dated 6/8/24 at 11:27 AM record Family was here to visit and was asking about pain in the rib area. Informed the family that [h/she] did attempt to get out of bed during the night, but staff was able to stop [h/her] from falling. Explained to the family that I would speak with the [Physician] on Monday [6/10/24, 3 days after the fall]. [Per review of the facility's 'Falls and Fall Risk, Managing' policy, under 'Definition': An episode where a resident lost his/her balance and would have fallen, if not for another person or if he or she had not caught him/herself, is considered a fall.] [GMNH Operational Policies & Procedures-Adoption date 10/2017] (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Nursing Notes dated 6/7/24, the day of the fall, reveal no mention of Res.#1 falling or being assisted by staff. In the facility's Policy and Procedure Manual regarding falls under Procedure the policy reads: In the event a resident fall, the following measures will be instituted: -Implement intervention(s) as appropriate to prevent re-occurrence. -Document in the medical record. Documentation should include the following: a. Date and time of the fall b. Location of the fall c. Whether the fall was witnessed or unwitnessed. d. The resident's response to the fall. e. Results of the physical evaluation of the resident. f. How the resident was assisted from the floor and where the resident was assisted to. g. What immediate intervention(s) were put into place to prevent re-occurrence. h. Date and time of notifications to physician and family/representative. [GMNH Operational Policies & Procedures Adoption date: 12/2022] Review of the facility's Policy and Procedures Manual regarding falls includes the policy Evaluating Falls and Their Causes. The policy instructs to Complete an incident report for resident falls in the electronic medical record. The incident report form should be completed by the nurse on duty during the shift of the incident. Under 'Performing a Post-Fall Evaluation', the policy points to completion of a falls risk evaluation and Appropriate interventions taken to prevent future falls. [GMNH Operational Policies & Procedures-Adoption date: 1/2020] 3 days after Res.#1's fall on 6/7/24, Nursing Notes on 6/10/24 record LNA [Licensed Nurses Aide] updated writer as to incident on 6/7-6/8 night shift. Resident with near fall and staff able to prevent fall (per Nurses Note). Noted to have red/yellow bruise to left lower rib area. Complained of pain this shift with movement and gentle palpation to area. MD [Physician] in and updated. In to assess at this time. MD to call family and discuss potential of mobile x-ray of area. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of physician notes dated 6/10/24 record the resident suffered a fall on 6/7/24, with left sided chest wall pain reported on 6/8/24, and along with increasing pain on 6/10/24, ecchymosis at that area [the escape of blood into the tissues from ruptured blood vessels] *. The physician noted post fall with at least left lateral chest wall contusion [medical term for a bruise. It is the result of a direct blow or an impact, such as a fall]**. Differential [A differential diagnosis is a process wherein a doctor differentiates between two or more conditions that could be behind a person's symptoms]*** includes intercostal strain, partial or complete rib fracture. ['intercostal strain' is an injury affecting the muscles between two or more ribs]**** An interview was conducted with the Assistant Director of Nursing [ADON] on 6/11/24 at 3:44 PM. The ADON confirmed the facility's Falls - Clinical Protocol policy and procedure, under Monitoring and Follow-Up records Delayed complications such as late fractures and major bruising may occur hours or several days after a fall and Frail elderly individuals are often at greater risk for serious adverse consequences of falls. Under Treatment/Management the policy reads the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling. [GMNH Operational Policies & Procedures-Adoption date: 10/23] The ADON confirmed that Res.#1's care plan listed falls on 5/11/24 with severe pain and on 6/7/24 with a possible rib fracture and there were no new interventions added to prevent future falls after either of the falls. The ADON also confirmed that the facility's Evaluating Falls and Their Causes policy, includes Complete an incident report for resident falls in the electronic medical record. The incident report form should be completed by the nurse on duty during the shift of the incident. Under 'Performing a Post-Fall Evaluation', the policy points to completion of a falls risk evaluation. [GMNH Operational Policies & Procedures-Adoption date: 1/2020] The ADON confirmed no Fall Risk Evaluation was completed after the falls on 5/11/24 and 6/7/24, and no incident report completed after the fall on 6/7/24. The ADON also confirmed under the facility's falls' Procedure the policy includes: In the event a resident fall, the following measures will be instituted: -Implement intervention(s) as appropriate to prevent re-occurrence. -Document in the medical record. Documentation should include the following: What immediate intervention(s) were put into place to prevent re-occurrence. Date and time of notifications to physician and family/representative. [GMNH Operational Policies & Procedures Adoption date: 12/2022] (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The ADON confirmed the Physician Note dated 6/10/24 reported Res.#1 suffered a fall on 6/7/24 with left sided chest wall pain, ecchymosis, left lateral chest wall contusion, and possible intercostal strain, partial or complete rib fracture. The ADON confirmed the resident suffered pain and injury from the fall, and that there is no documentation that Res.#1 was assessed immediately after the fall, that the Physician was notified, or that any new interventions were implemented to prevent future falls and injury. *(https://www.merriamwebster.com/dictionary/ecchymosis) **(https://myhealth.[NAME].ca/health/AfterCareInformation) ***(Differential diagnosis: Definition, examples, and more (medicalnewstoday.com) ****(Intercostal muscle strain: Signs, treatments, and remedies (medicalnewstoday.com) 2.) Resident #3 was admitted to the facility on [DATE] and has diagnoses that include Alzheimer's disease, major depressive disorder, abnormalities of gait and mobility, muscle weakness, and cognitive communication deficit. Per resident #3's care plan, initiated on 12/7/2023, Resident #3 is dependent on staff for all activities of daily living, is on routine pain medication, and is incontinent of urine. A post fall Physician note dated 5/17/24 reveals that Resident #3 suffered from an unwitnessed fall on 5/17/24 and appears to have a right frontal scalp contusion. Further review of Resident #3's care plan reveals that s/he did not have a care plan that addressed his her/risk for falls. A care plan for falls was not initiated until 5/17/24. Per interview on 6/11/24 at 3:31 PM, the ADON confirmed that Resident #3 did not have a care plan for falls prior to his/her fall on 5/17/24 and should have.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 44192 Per observation, interview, and record review, the facility failed to ensure that residents with urinary catheters received appropriate treatment and services to prevent urinary tract infections for one of four sampled residents (Resident #14). Findings include: 1. Per Record review on 3/26/24 reveals resident # 14 has a diagnosis of Flaccid Neuropathic Bladder (this is when the bladder does not contract to empty and therefore requires a catheter to empty the bladder). Resident #14 has orders for an indeweling foley catheter (an indwelling foley catheter is a tube that is maintained in the bladder to constantly drain urine). It is connected to a collection bag that requires frequent emptying. Per further review of the resident diagnosis list s/he has diagnosis of Urinary Tract infections and Infection and Inflammatory Reaction due to Indwelling Urethral catheter. An observation occurred on 3/26/24 at 1:05 pm of a Licensed Nurse Aide (LNA) changing resident #14 foley bag (the bag used to drain the bladder while the resident is in bed) to a leg bag (a drainage bag that is strapped to the resident's leg while the resident is out of bed). The LNA failed to adhere to infection control standards, and the below facility policy/procedure, putting the resident at risk for infection. (See citation at F880). A review of the facility policy Urinary Leg Drainage Bags reveals under section Steps in the Procedure 2. Wash and dry your hands. Apply Clean gloves. #3 Clean the catheter/bag junction with alcohol wipe before disconnecting. #7 Carefully remove cover over connection tip on the leg bag. #8 Connect the catheter to the leg bag with out touching the terminal end of the catheter tubing. Further review of facility policy Emptying a Urinary Collection Bag reveals under section General Guidelines #8 Keep the collection bag below the level of the residents bladder. Per an interview with the Director of Nursing on 3/26/24 at 3:30 pm, s/he indicated that the above policies should be followed while providing urinary catheter care.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 44192 Based on staff interview and record review, the facility failed to ensure that residents maintain acceptable parameters of nutritional status as evidenced by lack of weight monitoring for one of four sampled residents (Resident #16) and a lack of follow up on a significant weight loss for one of four sampled residents (Resident #56). Findings include: 1. Per record review, Resident #16 has a diagnosis of Congestive Heart Failure (a condition in which the heart pumps blood less efficiently, which can lead to fluid overload in the body). Resident #16's record did not contain an order for regular weights. The last documented weight for resident #16 was from 12/20/23. Per order review, Resident #16 was ordered for weights to be obtained monthly until discontinued on 2/23/24. Per a nutritional services order note from 2/23/24 at 6:58 PM, the note states, provider has approved discontinuation of monthly weight monitoring due to resident refusal. There is no documentation from any provider regarding discontinuation of weights for Resident #16. Per the Treatment Administration Record, Resident #16 refused monthly weights regularly. The reason given for refusals is that Resident #16 does not want to get out of bed to have weights obtained. Per review of Resident #16's care plan, a care plan focus for nutrition has the interventions obtain weights as ordered and notify registered dietitian, family, and physician of significant weight changes, both initiated on 6/29/23. Per the care plan, Resident #16 also has chewing difficulties requiring a motified textured diet. There is no evidence anywhere in the record of any efforts by the facility to assess Resident #16's weight refusals or explore ways to increase Resident #16's compliance with obtaining weights prior to discontinuation. Additionally, Resident #16 has a code status of full code and is not on comfort care. Per interview on 3/26/24 at approximately 4:15 PM, the Dietitian confirmed that there was a conversation between them and Resident #16's provider regarding the discontinuation of weights, but that this cannot be verified through provider documentation in the record. The dietitian stated that Resident #16 does not like to get out of bed, which is the main barrier to obtaining weights. The dietitian confirmed that they are not aware of any assessments or interventions done to explore ways to increase Resident #16's compliance with having weights obtained prior to the discontinuation of weights. The dietitian stated that they are also limited in their interventions for supplementing the resident's diet in the event of weight loss, as the family has refused meal supplementation for Resident #16 in the past. 48017 2. Per record review, Resident # 56 has been in the facility since 11/25/22. S/he has the following diagnoses: metabolic encephalopathy (a condition in which brain function is disturbed either temporarily or permanently due to different diseases or toxins in the body) and Diabetes. Further record review indicates the following entries: an 18-lb. weight loss, which is 14.6 % of his/her weight in the last 180 days. 9/7/2023 - 122.7 Lbs (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/23/2023- 116.7 Lbs. 11/1/2023 - 113.6 Lbs. 1/2/2024 - 109.9 Lbs. 2/3/2024 - 104.5 Lbs. 3/10/2024 - 99.6 Lbs. 3/26/2024 - 99.6 Lbs. Further record review indicates an entry dated 3/26/24 in the medical record titled Weight Change Warning. A weight of 104.5 Lbs. is entered, and states, documented PO [by mouth] intake is often less than 50%. Continues to take Mighty Shake (a dietary supplement for maintaining weight and nutrition) sometimes. The entry is signed by the Registered Dietician (RD). A nursing note dated 2/6/24: MD is aware of weight decline and in agreement with weights weekly. A review of Resident 56's care plan reveals no documentation of weight loss or interventions to monitor and prevent it. A policy titled Weight Assessment and Intervention with an adoption date of 9/22 under #5 states: The threshold for significant unplanned and undesired weight loss will be based on the following criteria: 6 months-10% weight loss is significant; greater than 10% is severe. The treatment team evaluates undesirable weight loss; care planning for weight loss or impaired nutrition is a multidisciplinary effort and includes the physician, nursing staff, dietitian, consultant pharmacist, and the resident; individualized care plans shall address, to the extent possible, the identified causes of weight loss, goals and benchmarks for improvement and time frames and parameter for monitoring and reassessment. Per observation 3/26/24 at approximately 9:10 AM resident #56 was observed sleeping, sitting up with an untouched tray containing breakfast. Per an interview with an LNA on 3/26/24 at aproximately 11AM, s/he had removed untouched tray and offered a mighty shake (supplement). S/he reported the resident consumed 50% of it. An interview with the unit manager on 3/26/24 at approximately 4:46 PM was conducted, where s/he indicated the nursing staff keeps track of Resident # 56's carbohydrate count for Insulin administration. She states, The Director of Nursing (DON) runs the weight loss team, we tell [him/her] if we notice a resident is losing weight. Per interview with the DON on 3/27/24 at approximately 10:20 AM, s/he confirmed that the weight loss team consisted of the DON and the RD, and both are aware of the 14% weight loss. S/he confirmed Resident #56 had documented weight loss, a nutrition assessment had not been perfomed and the resident's care plan did not contain interventions for weight loss.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50336 Based on interview and record review the facility failed to provide care and treatment of a gastrostomy tube (g-tube; a tube inserted directly into the stomach that can deliver nutrition, hydration, and/or medications) consistent with professional standards for 1 of 24 residents in the sample (Resident #1). Findings include: Per record review, a hospital Transition of Care note dated 6/05/2023 reveals that Resident #1 returned to the facility on [DATE] following a hospital stay that required the placement of a g-tube. Per review of Resident #1's medical record, Resident #1 did not have a care plan related to g-tube site care, physician orders to care for the site, documentation of g-tube site care, documentation of a g-tube site assessment, or documentation of how s/he tolerated site care for over 9 months (6/5/2023 through 3/25/2024). Per facility policy Gastrostomy and Jejunostomy Site Care last reviewed in September 2022, states the purpose of this policy/procedure are to promote cleanliness and to protect the gastronomy of jejunostomy site from irritation, breakdown and infection. Per policy the following is required physician order to care for the site, care plan will be reviewed and updated for any special needs of the resident. Documentation of the g-tube site will include, when care was performed, how the resident tolerated care of the site, and assessment of the area. Documentation of the care will be completed by the license nursing staff and include date, time, and signature. Per a 11/18/2023 nursing progress note, Resident #1 suffered complications related to the g-tube breaking during medication administration and was sent to the emergency room for g-tube repair. Per the hospital discharge summary dated 11/19/2023 Resident #1 returned to the facility on [DATE] with the repaired G-tube. There is no evidence that the facility contacted the provider to obtain orders related to the care and monitoring of the g-tube after return from the hospital on 11/19/23. Per interview on 3/27/2024 at 2:00 pm a Licensed Practical Nurse (LPN) confirmed that Resident #1 did not have physician orders for g-tube care prior to 3/26/2024.The LPN stated that if ordered, the documentation and evaluation of G-tube would be on the treatment administration record (TAR). Confirmation was made that an order should be in place at start of care of resident with g-tube. Orders to include evaluation and care for the g-tube site and area. LPN confirms procedure would be to contact provider and obtain orders for Resident # 1's care of G-tube. There is no evidence that the facility contacted provider to obtain orders prior to 03/26/2024.

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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. 50336 Based on interview and record review, the facility failed to ensure that monthly pharmacist drug regimen reviews, recommendations, and attending physician responses are completed and documented in the resident record for 1 of 5 sampled residents. Findings include: Per record review, a pharmacy recommendation dated 10/24/23 for Resident #6 states Obtain lab work digoxin level every 6 months most recent per record 3/09/2023. Per review of Resident #6's medical record, there was no documented evidence in the record that the physician reviewed the 10/24/23 Pharmacy Recommendations for Resident # 6 taking medication Digoxin. Digoxin can become toxic, which will be evident in the blood. During an interview on 3/28/24 at 2:00 pm the Director of Nursing (DON) confirmed that there was no evidence that the physician reviewed or addressed the recommendations. The DON confirmed that the blood work was not done until 12/20/23 for Resident #6.

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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. 50336 Based on interview and record review, the facility failed to ensure that residents who use psychotropic drugs receive gradual dose reductions (GDR), unless clinically contraindicated, for 1 of 5 sampled residents (Resident #6). Findings include: Per record review, Resident # 6 has a diagnosis of depression with the following Physician order. Citalopram 40 miligrams (mg) once a day to be given by mouth., written 04/04/2023.(Citalopram is a psychotropic medication used to treat depression). Per record review, on 10/24/23 pharmacist medication regimen review recommends a GDR for Citalopram, from 40 mg to 30 mg. There is no evidence that a physician reviewed the pharmacist recommendation prior to 12/15/2023 or that a GDR was attempted or the physician provided clinical rational as to why a GDR was not attempted prior to 12/15/2023. Review of Resident #6's Medication Administration Record reveals that Resident #6 received Citalopram 40 mg daily from 10/24/23 through 12/15/2023. Per interview on 3/28/2024 at 2:00 pm, the Director of Nursing confirmed that a physician did not review the pharmacy recommendations made for Resident #6 on 10/24/2023 or attempt a GDR for Resident #6 until 12/15/2023.

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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. 46442 Based on observation and staff interviews and record review, the facility failed to consistently store food in accordance with professional standards for food service safety. Findings include. On 3/25/24 at 11:05 am an initial tour of the facility kitchen was conducted; the Dietary Manager and Registered Dietitian (RD) were present during this tour. During an observation of a refrigerator/freezer in the kitchen, the following was observed: 1. A package of donuts with no date and no label. 2. A package of English muffins, with no date and no label. 3. A container with what appeared to be mixed iced tea with no date with no date and no label on the container. 4. What appeared to be 4 baked cake layers, frozen with no dates, and no labels. 5. A bag plastic bag with what appeared to be hash browns that had no label and no date. 6. A plastic bag of what appeared to be pepperoni with no date and no label. 7. A plain plastic bag with no label and no date that appeared to be fish. 8. A steel pan covered with tin foil that had a tear in the tin exposing the food in the container, the foil was labeled beef teriyaki no date was noted. 9. 10 individual serving-size containers with a white substance in them that the Kitchen manager stated was Mayonnaise there were no dates or labels on these containers. 10. A small container of what appeared to be pickles with no date or label. 11. In a different freezer unit, there was a metal pan covered with alumni foil labeled kielbasa cabbage There was a break in the foil that exposed the food, and another metal pan was underneath, with the foil that was covering the food in that pan pushed down, exposing the food to the bottom of the top pan. 12. In a dry food storage area there was a large bag labeled dry pancake mix that had no date on it as to when it was opened. When asked about the missing open date, the dietary manager wrote today's date on it, and s/he was asked if the bag was in fact opened today s/he stated I don't know when it was opened. The top of the opened bag was folded down but was not secured shut. 13. In another dry storage area there were 2 racks of what appeared to be muffins covered with plastic wrap, both with no label or dates. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 3/28/24, a review of refrigerator temperatures revealed the following: 1. In August 2023, the milk cooler was recorded at 50 degrees (F) on 8/1, 8/2, 8/3, 8/4, 8/5 and 8/6. 2. During November 2023 the Milk cooler has recorded temperatures between 60 degrees (F) and 80 degrees (F) from November 5th through to November 21st On 03/28/24 at 12:26 PM interview with the kitchen manager reveals that during the episodes in August and November when the milk cooler was out of the acceptable temperature range, the milk was removed and stored in the cave refrigerator. S/he further explained that this is a refrigerator that is kept unplugged and empty in the basement, however, the dietary manager revealed that when the milk was put in this refrigerator the temperature of the refrigerator was not taken at any time while the milk was being stored there in August or November. An interview on 3/28/24 with the Maintenance Supervisor reveals that s/he does recall both of the times the milk cooler was down, s/he reveals that the milk was taken out of the milk cooler and brought to the refrigerator in the basement the cooler was taken out of service and was fixed by a vendor.

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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. 46135 Based on interview and record review, the facility failed to ensure that records are complete, accurately documented, readily accessible, and systematically organized related to physician notes for 2 of 23 sampled residents (Residents #63, # 56), laboratory results for 1 of 23 sampled residents (Resident #63), medication reviews for 1 of 5 sampled residents (Resident #35), and care plan revision notes for 3 of 23 sampled residents (Residents #35, #52, and #39). Findings include: 1. Per review of 1/11/2024 nursing progress notes, Resident #63 was showing respiratory symptoms on 1/11/2024 and staff notified the physician. Resident #63 was seen by a physician that day and confirmed him/her to be positive for RSV and ordered a chest x-ray to be complete. A 1/12/2024 nursing progress note reveals that Resident #63 passed away the following day. A review of both Resident #63's electronic medical record and the paper chart does not contain the 1/11/2024 physician visit note or the 1/12/2024 x-ray results. On 3/27/2024 at 11 AM, the Administrator confirmed that the 1/11/2024 physician note and the 1/12/2024 x-ray results were not in Resident #63's medical record. 48017 2. Per record review, Resident #56 has resided at the facility since 11/25/22. A review of the electronic medical record (EMR) and Resident #56's paper chart indicated no evidence of provider visits after September 5, 2023. Per an interview with the Unit Manager on 3/26/24 at approximately 2:20 PM, s/he indicated the facility had been in the process of transferring the paper charts to an electronic health record (EMR) since April 2023. S/he indicated that when there was time, s/he would access Resident #56's provider notes from the provider's EMR and place them in the paper chart; s/he did not know how the facility was managing the transfer of resident information from the paper chart to the EMR. 3. Per record review, 25 documents containing provider information, dated 9/11, 9/12, 9/13, 9/21, 10/20. 10/21, 10/26, 11/7, 11/9, 11/15, 11/20, 11/24, 11/29, 12/2, 12/27,12/29/23,1/3, 1/11, 1/19, 2/21, 2/27, and 3/5/24 were missing from both the paper chart and the EMR. Per interview on 3/26/24 at approximately 3 PM, a Licensed Practical Nurse (LPN) functioning as the evening charge nurse reported s/he did not have access to Prism, preventing access to Resident records. Per interview on 3/27/24 at approximately 1:00 PM, the Unit Manager confirmed that the facility was not maintaining medical records in a systemically organized manner that was readily accessible. 40258 3. Per record review Resident #35's monthly Consultant Pharmacist's Medication Regimen Review recommendations for September and October of 2023 were not available in the medical record. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/27/24 at approximately 3:00 PM the Director of Nursing (DON) confirmed that the September and October 2023 Consultant Pharmacist's Medication Regimen Review recommendations were not available in the medical record. The DON printed the recommendations during this interview and provided them to this surveyor. 4. Per record review Resident #52 last had a care plan meeting documented on 11/1/23. A Resident Care Plan / Review - Sign Sheet dated 11/1/2023 reflects that members of the Interdisciplinary team (IDT) met to review Resident #52's care plan on 11/1/23. There was no documented evidence in the record that Resident #52's care plan had been reviewed and revised by the IDT in February 2024 as required. Per record review Resident #39 last had a care plan meeting documented on 11/8/23. A Resident Care Plan / Review - Sign Sheet dated 11/8/2023 reflects that members of the Interdisciplinary team (IDT) met to review Resident #39's care plan on 11/8/23. There was no documented evidence in the record that Resident #39's care plan had been reviewed and revised by the IDT in February 2024 as required. Per record review Resident #35 last had a care plan meeting documented on 11/8/23. A Resident Care Plan / Review - Sign Sheet dated 11/8/2023 reflects that members of the Interdisciplinary team (IDT) met to review Resident #35's care plan on 11/8/23. There was no documented evidence in the record that Resident #35's care plan had been reviewed and revised by the IDT in February 2024 as required. During an interview on 3/28/24 at 4:15 PM the Director of Nursing (DON) confirmed that the last Resident Care Plan Sign Sheets in the record were documented in November of 2023 and that there was no documented evidence in the record that a care plan meeting where the IDT met to review and revise the care plans for Residents #52, #39, and #35 happened in February of 2024 as required.

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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. 46442 Based on observation, interviews and record review, the facility failed to ensure that staff maintained proper procedures and techniques to ensure infection prevention was maintained during catheter care for 1 of 27 residents sampled. (Resident #14) Record review reveals Resident #14 has a diagnosis of Flaccid Neuropathic Bladder (this is when the bladder does not contract to empty and therefore requires a catheter to empty the bladder). Resident #14 has orders for a foley catheter (a foley catheter is a tube that is maintained in the bladder to constantly drain urine). It is connected to a collection bag that requires frequent emptying. An observation on 3/26/24 at 1:05 pm of a Licensed Nurse Aide (LNA) changing resident #14's foley bag [the bag used to drain the bladder while the resident is in bed] to a leg bag [a drainage bag that is strapped to the resident's leg while the resident is out of bed] revealed the following. 1. Before the start of the procedure there were noted to be two leg bags in the bathroom hanging on a rail, the bags were exposed with no cover, neither bag was labeled or dated and both bags had residual urine in them. They both had no cap on the spout that empties the bags or on the connector that connects the bag to the catheter. 2. Resident #14 was assisted to roll to his/her side while in bed, before the foley bag was emptied. The foley bag that had urine in it was lifted up over the resident and the bag was placed on the opposite side of the bed. This was done a second time when the resident was rolled back to the other side. [Lifting the foley bag above the bladder can cause the urine that is in the tube to backflow into the bladder putting the resident at risk for infection] 3. The LNA placed a container on the floor next to where the foley bag was hanging. The LNA did not place a barrier between the floor and the container, and s/he continued to disconnect the valve to release the urine into the container, Urine was noted to spray onto the floor in multiple places, this was not noted by the LNA, and was not cleaned up. 4. When the LNA was ready to disconnect the connection from the foley bag and the catheter, Resident #14 took hold of the tubing at the connection site and pulled the tubes apart. S/he then bent the end of the catheter over in his/her hand and held the catheter there. The resident had not sanitized his/her hands and was not wearing a glove. 5. The LNA then asked the resident for the end of the catheter so he/she could connect it to the leg bag. The LNA did not clean the end of either tube with alcohol before connecting the two tubes. The resident was not offered hand sanitizer after releasing the catheter tube. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Per an interview with the LNA on 3/26/24 at 2:15 pm s/he confirmed that there should have been a barrier on the floor and that s/he did not notice the urine that sprayed on the floor. S/he confirmed that s/he should have cleaned the catheter off with alcohol when s/he reconnected the bag but stated that there was no alcohol handy to do that. S/he confirmed that the foley bag should be kept at bladder level and not lifted higher. When asked about the resident separating the tubing and holding the catheter end folded over in his hand s/he stated there was not anything she could do about that but confirmed having the resident sanitize his/her hands and or put gloves on would be a good idea. A review of the faciliy policy Urinary Leg Drainage Bags reveals under section Steps in the Proceedure 2. Wash and dry your hands. Apply Clean gloves. #3 Clean the catheter/bag junction with alcohol wipe before disconnecting. #7 Carefully remove cover over connection tip on the leg bag. #8 Connect the catheter to the leg bad with outh touching the terminal end of the catheter tubing. Further review of facility policy Emptying a Urinary Collection Bag reveals under section General Guidlines #8 Keep the collection bag below the level of the residents bladder. Per an interview with the Director of Nursing on 3/26/24 at 3:30 pm, s/he indicated that the expectation would be for staff to follow facility policy and confirmed that the unused catheter leg bags would be rinsed, the ends would be capped, and the bags should be labeled, dated, and should have a clean bag covering them when they are taken off. The DON also confirmed that the LNA should use a barrier between the container and the floor when emptying the bag. S/he confirmed that the connector should be cleansed with an alcohol sponge prior to connection and that the resident should have hand hygiene and a glove to assist with his/her catheter care.

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop, implement, and/or maintain an effective training program for all new and existing staff members. 46135 Based on interview, employee record review, facility assessment, facility policy, and facility onboarding training, the facility failed to implement and maintain an effective training program for all new and existing staff related to QAPI (quality assurance and performance improvement), communication, and emergency preparedness, for 10 of 10 sampled direct care staff, and failed to implement and maintain an effective training program for all new contracted staff for 3 of 3 direct care staff sampled. Findings include: Per facility policy titled In-Service Training, All Staff, last revised 8/2022 states. All staff must participate in initial orientation and annual in-service training. For the purpose of this policy, staff means all new and existing personnel, individuals providing services under contractual agreement, and volunteers. Required training topics include the following: a. effective communication. d. elements and goals of the facility QAPI program. Training requirements are met prior to staff providing services to residents, annually, and as necessary based on the facility assessment. Completed training is documented by the staff development coordinator, or his or her designee and includes: the date and time of training. The topic of the training, the method used for training; a summary of the competency assessment; and the hours of training completed. Review of the facility's Facility assessment dated 2024, included in section staff training/education and competencies, training such as emergency preparedness training should be completed upon new employee orientation and annually. There is an extensive list of all the required training the facility has determined necessary for staff to complete in order to provide competent support and care for the resident population. Per review direct care staff education files, 10 of the 10 sampled staff did not have education related to communication, QAPI, or Emergency Preparedness in their files. 3 of the 10 staff sampled were hired within the past year. These 3 staff did not have evidence of onboarding education in their files [Licensed Nursing Assistant #1 (LNA), LNA #2, and Registered Nurse #1 (RN)]. (continued on next page)

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Per interview on 3/28/24 at 3:15 PM, the Staff Educator, whom is also the Director of Nursing, explained that onboarding education consists of the new staff member reading handouts that are included in their new hire packets. Staff are to read the materials, take a quiz on the materials, and return the quiz to Human Resources, who keeps track of training. S/He indicated that there is no communication training. S/He explains that s/he is not responsible for emergency preparedness and QAPI training and is unsure when these trainings are completed and how they are tracked. The Educator confirmed that contracted staff are supposed to do the education as well. Per interview on 3/28/2024 at 4:20 PM, the Human Resource Specialist explained that new employees are given new hire folders that contain handouts, that serve as the required trainings, and follow up quizzes to these handouts. S/He explained that s/he keeps records of the quizzes but is unsure that the quizzes are reviewed for correction. S/He explained that contracted staff do not return quizzes. S/He indicated that there is no system in place to follow up with employees that have not returned the onboarding quizzes and employees can work their assignments without having evidence of training completed. The Human Resource Specialist confirmed that s/he did not have evidence that LNA #1, LNA #2, or RN#1 had completed any onboarding education and confirmed that they worked assignments without having this education completed. Per review of an employee onboarding packet, there is no evidence of communication training, QAPI training, or emergency preparedness training in the packet.