STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495112	A. Building B. Wing	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Guggenheimer Health and Rehab Center	1902 Grace Street Lynchburg, VA 24504

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21875 Based on observation, resident interview, and clinical record review, the facility staff failed to provide respect for privacy for one of twenty-nine residents in the survey sample (Resident #44). The findings include: Facility staff entered Resident #44's room and private space without knocking or requesting verbal permission to enter. Resident #44 (R44) was admitted to the facility with diagnoses that included peripheral vascular disease, hypertension, and carotid stenosis. The minimum data set (MDS) dated [DATE] assessed R44 with moderately impaired cognitive skills. On 9/30/24 at 11:11 a.m., R44 was interviewed in his room about quality of life/care in the facility. During this interview, a staff person entered the room without knocking or giving any verbal announcement prior to entering the room. The employee went to R44's roommate, pulled the center curtain and did not acknowledge or address R44 in any manner. R44 stated at this time, This goes on all the time. R44 stated staff members frequently entered his room without knocking or asking if it was ok to enter. R44 stated staff members frequently just come in and tell you what they are going do. R44 stated he felt this was disrespectful and that staff should ask and/or address him verbally prior to entering the room. On 9/30/24 at 11:13 a.m., during R44's interview, registered nurse (RN) #2 entered R44's room without any prior announcement or knock. RN #2 proceeded to R44's roommate and administered medications. On 9/30/24 at 12:30 p.m., RN #2 was observed entering R44's room without knocking or addressing the resident prior to entering. R44 was on the bed. RN #2 went to R44's bedside and stated she was there to look at his bed rail. On 10/1/24 at 2:26 p.m., the licensed practical nurse unit manager (LPN #1) was interviewed about how staff were expected to enter resident rooms with respect for privacy. LPN #1 stated staff members were expected to knock prior to entering resident rooms, acknowledge residents and get their ok before entering. LPN #1 stated staff members were expected to provide respect for residents' personal room/space. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/1/24 at 3:10 p.m., the director of nursing (DON) was interviewed about staff entering R44's room without knocking or any prior announcement. The DON stated staff members should be knocking, announcing themselves and asking residents if their entrance was okay. This finding was reviewed with the administrator, DON and regional nurse consultants during a meeting on 10/1/24 at 4:20 p.m. with no further information provided prior to the end of the survey.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 49456 Based on staff interview, facility documentation review and clinical record review, the facility staff failed to complete a SNF ABN (Skilled Nursing Facility Advance Beneficiary Notice) for 2 residents in a survey sample of 3 residents (Resident #316, Resident #317, Resident # 318) reviewed for Beneficiary Notifications. The findings included: For Resident #317 and Resident #318, the facility staff failed to provide a SNF ABN notice prior to skilled care services ending. As a result of this deficient practice Resident #317 and Resident #318 were not afforded the opportunity to continue skilled care services and have Medicare decide about coverage of such services, known as a demand bill, nor the option for services to continue and the resident be financially responsible. Resident #316 was issued a NOMIC on 4/29/24 but service ended on 4/3/24, so the notice was not given in a timely manner. On 10/1/24 a clinical record was reviewed. The clinical record revealed no evidence of an ABN (Advanced Beneficiary Notice) being issued. The progress notes made no reference with regards to an ABN. On 10/1/24 a clinical review was conducted. Resident # 317 was on skilled services from 3/7/24 through 4/3/24 and remained a resident of the facility following skilled services ending. Resident #316 was on skilled services from 1/4/24 through 2/6/24 and remained a resident of the facility. This surveyor requested all beneficiary notices the residents were issued and were only provided the NOMNC. On 10/01/24 1:27 p.m. an interview was conducted with the social service director. The Social Service Director stated, that ABN's were not being completed prior to me coming here and I received an email with the new ABN form a week ago and that is when I realized ABN's was supposed to be completed. She stated she was aware of the purpose and importance of the ABN's. CMS identifies when the ABN is required to be issued in their document titled Form Instructions Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNFABN) read, Medicare requires SNFs to issue the SNFABN to Original Medicare, also called fee-for-service (FFS), beneficiaries prior to providing care that Medicare usually covers, but may not pay for in this instance because the care is: Not medically reasonable and necessary; or Considered custodial. The SNF/ABN provides information to the beneficiary so that s/he can decide whether or not to get the care that may not be paid for by Medicare and assume financial responsibility. SNFs must use the SNFABN when applicable for SNF Prospective Payment System services (Medicare Part A). SNFs will continue to use the ABN Form CMS-R-131 when applicable for Medicare Part B items and services. Accessed online at: https://www.cms.gov/search/cms?keys=ABN (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/2/24, during an end of day meeting the facility Administrator, Director of Nursing and Corporate staff were made aware of the above concern. No further information was provided.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 49456 Based on observations, staff interviews and resident interviews, the facility staff failed to uphold the resident's right to privacy with regards to mail and failed to provide timely mail delivery for residents on 3 of 3 units. The findings included: The facility staff failed to deliver mail opened and does not deliver/distribute any mail on Saturdays. On 10/1/2024 at 2:30 p.m. a resident council meeting was conducted with the surveyor and six residents, (R#41, R#43, R#46, R#47, R#56, R#59). Of the six residents, two were from each of the resident units. Residents expressed concerns that mail is opened when they receive it and 4 confirmed, it is particularly with bills. They don't get mail on Saturdays, despite an activity assistant is working every other Saturday. Residents expressed concerns about not receiving packages in a timely manner. R#56 had a package delivered on Monday 9/30/24, that his sister had tracked the package, and he hasn't received it on 10/1/24. R#59 stated that the mail had recently just started being delivered opened to their rooms. The residents stated that the activity director was the one that delivers the mail to their rooms. On 10/01/24 at 3:22 p.m. an interview was conducted with the activity director. The activity director was not aware of opened mail being delivered to the residents. The activity director stated that the package for R#56 that was delivered yesterday, she would try to locate the package and deliver it to the resident. The activity director stated that, I am not here on Saturday to deliver the mail and my assistant works every other Saturday but does not deliver the mail. On 10/1/24 at 4:30 an end of day meeting was conducted. The above concerns were discussed, and the administrator stated, that they would work on putting a system in place for the delivery of mail on Saturday's and that packages are sometimes delivered to the back loading dock, and it just depends on what company is delivering the package to where it goes. We will try to locate the package. On 10/2/24 at 9:15 a.m. an interview was conducted with the business office manager. The business office manager said she has no idea why residents mail would be opened and was not aware of the mail being opened. She stated that the resident or their responsible party will request for her to open the mail if it is a bill, and we need to pay the bill. She stated that mail comes at times with just the facility name on it and we do not know who's mail it was until it was opened. On 10/2/224 at 9:30 a.m. an interview was conducted with the receptionist. The receptionist stated that mail is delivered to the lobby mailbox, and she will deliver the mail if the activity director is unable. She stated, if the mail is addressed to the facility, we will open the mail because we don't know who the mail belongs to, and I don't remember any mail being opened (referring to mail addressed to residents). There is no receptionist here on the weekends and I am not sure if activities work the weekends. The receptionist stated, the postal service delivers the mail down at the entrance to the unit one nursing unit on Saturday's and I pick it up on Monday mornings and deliver the mail then. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No more information was provided.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 41449 Based on observation, resident interview, staff interview, and facility documentation review, the facility staff failed to maintain a homelike environment for two residents (resident #70-R70 and resident #78-R78) in a survey sample of 29 residents. The findings included: 1. For R70, whose ceiling was leaking the facility staff failed to make timely repairs to maintain a homelike environment. On 9/30/24 at 11:29 a.m., R70 was visited in her room. R70 was non-verbal but was able to communicate by shaking her head to indicate yes and no. During the interview, R70 pointed to a trashcan that had been placed on top of the air conditioning (ac)/heat unit in the room at the window. The surveyor observed that underneath the trash can was towels that appeared to have been there for an extended period and chips of plaster/sheet rock were on the towel, ac unit, and floor. The trash can had water in it measuring about 1- 1 1/2 inches deep and a black substance was floating on top of the water. When asked about the duration of the leak, R70 indicated it had been like that for months. On 10/1/24, a review of the maintenance work orders revealed that multiple maintenance work orders had been entered and noted as completed with regards to the ceiling. Maintenance work orders were entered on the following dates for the past three months reviewed: 8/15/24, 8/30/24, 9/22/24, 9/23/24, and 9/25/24. Each of the work orders were noted as completed and comments read as follows: this is previous moisture causing discoloration, this occurs intermittently during a hard blowing rain from the southwest. Building windows need professional resealing, coming from 315, water coming from 315 ac, and coming from 315. On 10/1/24 at approximately 12 noon, an interview was conducted with certified nursing assistant #9 (CNA#9). CNA #9 reported that R70's ceiling had been leaking for quite a while and she had put in a maintenance work order. When asked what was being done, CNA #9 said she was not aware, but they [maintenance] were the ones that put the trash can there to catch the water. On 10/1/24 at 4:34 pm, during an end of day meeting held with the facility administrator, director of nursing and corporate staff was made aware of the above findings to include the trash can with standing water and a black substance floating in the water. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/2/24 at 8:35 a.m., an interview was conducted with the facility's maintenance director. The maintenance director was asked about R70's ceiling leaking. The maintenance director said, he didn't know anything about it. The maintenance director accompanied the surveyor to R70's room. The room remained the same as it had been observed on 9/30/24, with the trash can, towels and water in the trash can with a black substance floating in the water. The maintenance director said, it depends on the direction of the rain, we had one side of the building re-sealed around the windows but if we get a blowing rain there is going to be drips that propagate. The stated the problem was definitely coming from the window. When asked if they had done anything to contract with someone or make arrangements to have the re-sealing done, he indicated nothing had been done yet because they were waiting on a renovation that was being discussed. 2. For resident #78- R78, the facility staff failed to provide a homelike environment by failing to provide a closet with doors and make timely corrections when notified it was in need of repair. On 9/30/24 at approximately 2 p.m., during an interview with R78, he reported his closet was broken. The surveyor observed that the door for the closet was completely off and leaning against the wall behind the head of the bed. When asked how long it had been like this, the resident said about two months. On 10/1/24 at 8:38 a.m., R78 was visited in his room again by the surveyor. The closet door was noted to be in the same position as the day prior. On 10/1/24 at approximately 9:05 a.m., the maintenance assistant was seen in the hallway and interviewed. When asked about R78's closet door he stated he was not aware what was going on but had only been employed for two weeks. The maintenance assistant was taken to R78's room and shown the closet door was not on the closet but was leaned against the wall. The maintenance assistant stated he would repair it immediately. On 10/1/24, review of the maintenance work orders revealed that on 7/9/24, a work order had been entered that read, re-hang wardrobe cabinet door that noted R78's room. The work order was noted as completed on 8/9/24 by the maintenance director and read, re-attached. The facility policy titled, Maintenance Work Orders was reviewed. The policy read, 1. In order to establish a priority of maintenance service, work orders will be filled out and forwarded to the Maintenance Director/designee. 2. Staff will be educated on the process of completing a work order. 3. Work orders may be communicated to the Maintenance Department manually or electronically. 4. If an emergency work order is requested, the requesting person will notify the Maintenance Department of the urgency of the request and where possible priority will be made in making necessary repairs. 5. Completed work orders will be maintained in the Maintenance Department. On 10/1/24 at 4:34 pm, during an end of day meeting held with the facility administrator, director of nursing and corporate staff, they were made aware of the above finding. No additional information was provided.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41449 Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to accurately complete a pre-admission screening and resident review (PASARR) to identify if a level II evaluation was warranted for one resident (resident #90-R90) in a survey sample of 29 residents. The findings included: For R90, who had multiple diagnosis of mental illness, the facility staff failed to accurately complete a level I PASARR, to determine if a more in-depth, level II assessment was warranted. On 10/1/24, a clinical record review was conducted of R90's chart. This review revealed that R90 was admitted to the facility on [DATE], and had diagnosis which included, but were not limited to post-traumatic stress disorder, major depressive disorder- recurrent, unspecified psychosis not due to a substance or known physiological condition, paranoid schizophrenia, paranoid personality disorder, and schizophrenia unspecified. Review of the level I PASARR completed 4/21/23, revealed that question 2. which asked, Does the individual have a current serious mental illness? was marked no. The assessment was completed by Other Employee #13 (OE #13), who was an admissions coordinator. On 10/01/24 at 2:51 p.m., an interview was conducted with OE #13. OE #13 confirmed that she does complete the level I PASARR. When asked what the purpose of the form is, OE #13 said, to screen if a patient needs nursing home level of care and also to screen for a level II PASARR. When asked what instances would qualify a person for a level II PASARR, OE #13 said, mental illness before age of 18. OE #13 was asked to access R90's PASARR and explain why question #2 had been answered no. OE #13 said, I believe with him, because he was able to live on his own and manage that was the reason why he would not be eligible. He lived alone and he did not need assistance doing the ADLs at home and management of finances and things like that. OE #13 was then asked to review R90's diagnosis and was why question 2a was not answered. Question 2a read, Is this major mental disorder diagnosable under DSM (e.g., schizophrenia, mood, paranoid, panic, or other serious anxiety disorder; somatoform disorder; personality disorder; other psychotic disorder; or other mental disorder that may lead to a chronic disability)? OE #13 said, I may have missed that, I was thinking he didn't need a level II. When asked by the surveyor, how she came to that conclusion if the question wasn't answered, OE #13 said, right, I got you. When asked who trained OE #13 on completion of the PASARR, she said, no one. When asked if this was a task she learned on her own, OE #13 said, yes ma'am.\ OE #13 was asked, what is the importance of determining if a person needs a level II PASARR? OE #13 stated, so we know if they have a serious mental illness if this is an appropriate level of care for that patient. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/1/24 at 3:30 p.m., OE #13 approached the surveyor and reported she had looked at R90's admission history and physical and didn't note those diagnosis. When asked if the PASARR was updated when those diagnosis were added, OE #13 said, probably not, because I was not aware those diagnosis were added. OE #13 reported that once a resident is in the facility she is no longer involved. On the afternoon of 10/1/24, OE #13 provided the surveyor with the facility policy with regards to PASARR screenings and excerpts of R90's clinical record. The record included a psychiatry note dated 3/31/23, which indicated R90 has a history of . psychosis . On 10/1/24 at approximately 3:45 p.m., the facility's director of nursing (DON) was identified as having entered R90's diagnosis into the clinical record. She was asked to provide evidence of where the diagnosis were obtained from. On 10/2/24, the DON provided the surveyor with a document that was titled, Past Diagnosis and Procedures which had the diagnosis of schizophrenia NOS [not otherwise specified] and had a date of 5/2/2005. A progress note dated 4/25/23, written by the nurse practitioner listed the diagnosis of schizophrenia and depression as an indication for medications ordered. Also provide was a Client Medication Report that noted on 3/25/23, a medication Perphenazine which noted the reason as paranoia. The facility policy titled, Long-Term Services and Supports (LTSS) Screening, Preadmission Screening and Resident Review (PASRR) Policy was reviewed. The policy read in part, . The organization observes preadmission screening requirements to ensure that . people with known or suspected mental illness, intellectual disabilities, and/or related conditions are not inappropriately institutionalized or marginalized; to make sure that every individual receives the services and supports that will optimize their success in the least restrictive setting . On 10/2/24, during an end of day meeting, the facility administrator, director of nursing and corporate staff was made aware of the above findings. No additional information was provided.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41449 Based on observation, resident interview, staff interview, and facility documentation review, the facility staff failed to develop a comprehensive care plan for one resident (resident #5- R5) in a survey sample of 29 residents. The findings included: For R5, who was edentulous, due to broken and ill-fitting dentures, the facility staff failed to address oral status in the comprehensive care plan. On 9/30/24 at 2:57 p.m., R5 was visited in his room. The surveyor noted while talking to the resident that he appeared edentulous. When asked, R5 reported he had dentures, but they broke and said, I bit into something a while back and it put a hole in one of them [referring to dentures]. R5 went on to say that he had gone to a dentist, had dentures made and was supposed to just pick them up but didn't go. He said he guesses he would have to get new ones made again since it has been so long. On 9/30/24-10/1/24, a clinical record review was conducted. This review revealed a progress note from the nurse practitioner dated 5/23/24, that read in part, . Chief Complaint/Nature of Presenting Problem: Broken dentures . seen today for complaints of improperly fitting dentures. He has not been wearing his dentures because he does not like the way they fit and states they are uncomfortable and rub on his gums . Plan: Refer to Affordable Dentures to adjust fitting of current dentures. Continue all medications as prescribed. Monitor for acute changes. The surveyor was unable to find any additional information or documentation that R5 had ever gone for a dental consult. According to the minimum data set (MDS) assessment listing, an annual/comprehensive assessment was conducted for R5 on June 5, 2024. During this assessment, the CAA (care area assessment) triggered for nutritional status and dental care. According to the CAA for dental care, it read in part, .will Dental Care - Functional Status be addressed in the care plan? Yes . Review of R5's care plan revealed no information with regards to his dental status. On 10/2/24 at 11:45 a.m., an interview was conducted with registered nurse #6 (RN #6), who was the unit manager for the second floor. When asked about care plans, RN #6 said, they are a general picture of the care the patient is supposed to be getting. On 10/2/24 in the afternoon, an interview was conducted with RN #1, the care plan coordinator, in the presence of the director of nursing. RN #1 explained that the care plan is developed to reflect the care the patient requires and receives. RN #1 explained that all staff use the care plan to know what care is ordered for the patient. RN #1 also confirmed that the facility does follow the RAI (resident assessment instrument). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Care Planning- Comprehensive Person-Centered was conducted. The policy read in part, . Comprehensive care plan means an interdisciplinary communication tool developed after completion of a comprehensive MDS and review of the Care Area Assessments (CAAs) . 13. The comprehensive care plan will: a. incorporate identified program areas; b. incorporate risk factors associated with identified problems; . f. identify the professional [NAME] that are responsible for each element of care . 14. Areas of concern that are triggered during the resident assessment are evaluated using specific assessment tools (including Care Area Assessments) before interventions are added to the care plan . According to the Centers for Medicare & Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User ' s Manual, Version 1.18.11, effective October 2023, gives guidance to the facilities. It read in part, . 4.4 What Does the CAA Process Involve? Facilities use the findings from the comprehensive assessment to develop an individualized care plan to meet each resident's needs (42 CFR 483.20(d)). The CAA process discussed in this manual refers to identifying and clarifying areas of concern that are triggered based on how specific MDS items are coded on the MDS. The process focuses on evaluating these triggered care areas using the CAAs but does not provide exact detail on how to select pertinent interventions for care planning. Interventions must be individualized and based on applying effective problem solving and decision-making approaches to all of the information available for each resident . The dental care CAA addresses a resident ' s risk of oral disease, discomfort, and complications. When this CAA is triggered, nursing home staff should follow their facility ' s chosen protocol or policy for performing the CAA. This CAA is triggered when a resident has indicators of an oral/dental issue and/or condition. The information gleaned from the assessment should be used to identify the oral/dental issues and/or conditions and to identify any related possible causes and/or contributing risk factors. The next step is to develop an individualized care plan based directly on these conclusions. The focus of the care plan should be to address the underlying cause or causes of the resident's issues and/or conditions . On 10/2/24, during the end of day meeting held with the facility administrator, director of nursing and corporate staff, they were made aware of the above findings. No additional information was provided.

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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** 41449 Based on observation, resident interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to review and revise the care plan for five residents (Resident #78, Resident #70, Resident #83, Resident #15, and Resident #106), in a survey sample of 29 residents. The findings included: 1. For Resident #78 (R78), who had a hernia and was scheduled for surgical repair, the care plan was not revised to reflect the hernia being present nor pre-operative instructions/care that the facility needed to provide. On 10/1/24 at 8:34 a.m., R78 was interviewed in his room. R78 reported that he had a knot in his lower abdomen/groin and was scheduled to have surgery. On 10/1/24 and 10/2/24, a clinical record review was conducted. There was no documentation within the progress notes with regards to an upcoming surgery. However, in the miscellaneous tab of the clinical record was a document titled, Doctor Order Sheet, which was uploaded into R78's chart on 9/16/24. The document itself was dated 9/11/24, and read in part, Patient is scheduled to have robotic right inguinal hernia repair possible bilateral with Dr. [name redacted] on [DATE] . According to R78's care plan, there was no documentation regarding the hernia, scheduled surgery or pre-operative measures the facility needed to follow prior to surgery for R78. On 10/2/24 at 11 a.m., an interview was conducted with the facility's nurse practitioner (NP). The NP reported that she was aware of the upcoming scheduled surgery. On 10/2/24 at 11:45 a.m., an interview was conducted with registered nurse #6 (RN #6), who was the unit manager. The unit manager was asked about R78. RN #6 was aware of R78's hernia and scheduled surgery. On 10/2/24 in the afternoon, an interview was conducted with registered nurse #1 (RN #1), who was the care plan coordinator. When asked about R78's hernia and scheduled surgery not being reflected on the care plan, RN #1 stated, I was not aware he was scheduled for surgery. 2. For Resident #70 (R70), who no longer used a white board to communicate, the facility staff failed to revise the care plan to reflect this change. On 9/30/24 at 11:29 a.m., R70 was visited in her room and was noted to be alert but non-verbal. When asked questions, R70 would shake their head yes or no. No communication book or board was observed in the room. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/30/24, at approximately 1:30 p.m., a nurse and certified nursing assistant #11 were both asked how they communicate with R70. Licensed practical nurse #5 and CNA #11 both stated that R70 would nod yes and no, in response to simple questions. On 10/1/24, a clinical record review was conducted. According to R70's care plan with a revision date of 1/20/23, R70 had a communication deficit, but . communicates with a white board . On 10/2/24 at 8:23 a.m., R70 was visited in her room again. Observations again revealed no white board being present. When asked about having a white board to write out responses, R70 shook head, indicating No. When asked about having one previously, R70 shook head, indicating No. When asked about ever using a white board, R70 shook head, indicating No. On 10/2/24 at 8:26 a.m., an interview was conducted with CNA #9. CNA #9 reported that R70 . used to have a white board but when her mother bought her the laptop, we use that to communicate. She types things out. CNA #9 revealed that R70 has had the computer for many months. On 10/2/24 in the afternoon, an interview was conducted with registered nurse #1 (RN #1), who was the care plan coordinator. When asked about R70's white board and it not being present, RN #1 stated, I've used the white board. When asked how long ago, RN #1 stated it had been several months ago. 3. For Resident #83 (R83), who sustained a laceration to his lower leg that required treatment and antibiotics, the facility staff failed to review and revise the care plan. On 9/30/24 at 10:34 a.m., R83 was interviewed in his room. R83 reported that he had hit his leg on a drawer, which caused a large gash on his leg. R83 stated that he thought they were going to have to send him out for sutures, since they don't do that at the facility. R83 said, They are dressing it daily, but it has been going on for several weeks. On 10/1/24, a review of R83's clinical record was conducted. According to a progress note by the wound care specialist, R83 sustained the laceration/skin tear on 9/1/24, which measured 5 cm length x 3.4 cm width x 0.2 depth and was noted to have heavy blood-tinged drainage and swelling encircling wound. The note read in part, This wound is expected to have delayed healing. According to R83's physician orders and medication administration record, the antibiotic Cephalexin was ordered three times daily for seven days from 9/17/24-9/24/24, for the treatment of a wound infection. According to R83's care plan, there was no evidence of the skin tear, wound treatment orders, antibiotic therapy, or any other interventions/goals pertaining to the skin tear noted on the care plan. On 10/2/24 in the afternoon, an interview was conducted with registered nurse #1 (RN #1), who was the care plan coordinator. When asked about R83's skin tear not being noted on the care plan, RN #1 didn't respond. 4. For Resident #15, who developed a stage III pressure ulcer, the facility staff failed to revise the care plan to indicate the presence of and the treatment of the wound and failed to revise the care plan when hospice services were discontinued on 11/24/23. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy titled, Care Planning- Comprehensive Person-Centered was conducted. The policy read in part, . Comprehensive care plan means an interdisciplinary communication tool developed after completion of a comprehensive MDS and review of the Care Area Assessments (CAAs) . 13. The comprehensive care plan will: a. incorporate identified program areas; b. incorporate risk factors associated with identified problems; . f. identify the professional services that are responsible for each element of care . 14. Areas of concern that are triggered during the resident assessment are evaluated using specific assessment tools (including Care Area Assessments) before interventions are added to the care plan . On 10/2/24, during an end of day meeting the facility administrator, director of nursing and corporate staff was made aware of the above findings. No additional information was provided. 21875 The findings include: 5. Resident #106's plan of care was not revised to include problems or interventions in place regarding poor nutritional status and weight loss. Resident #106 (R106) was admitted to the facility with diagnoses that included osteomyelitis, schizophrenia, diabetes, chronic kidney disease, peripheral vascular disease, protein-calorie malnutrition, adult failure-to-thrive, above-knee amputation, prostate cancer, atrial fibrillation and anemia. The minimum data set (MDS) dated [DATE] assessed R106 with short and long-term memory problems and severely impaired cognitive skills. R106's clinical record documented the resident was assessed with poor intake and low body weight upon admission to the facility. R106 was ordered and administered Boost supplement twice per day staring in May 2024 and a pureed textured diet. Prostat supplement was added twice per day in June 2024. R106 experienced a significant weight loss in August 2024 and Medpass supplement was added twice per day. R106's therapeutic diet was changed on 9/4/24 to a liberalized pureed diet to improve intake. R106's plan of care (revised 9/12/24) documented the resident had dysphagia and body mass index less than 25. Interventions to maintain adequate nutrition and stable weight included dental consult if needed, determine likes/dislikes, diet as ordered, oral care and weight monitoring. R106's plan of care made no mention the resident had experienced significant weight loss and had not been revised to include the liberalized pureed diet or the multiple supplements provided. On 10/2/24 at 8:47 a.m., the licensed practical nurse unit manager (LPN #1) was interviewed about R106's plan of care. LPN #1 stated she initiated the baseline care plan and the MDS coordinator was responsible for care plan revisions/updates. On 10/2/24 at 9:48 a.m., the registered nurse (RN #1) responsible for MDS and care plans was interviewed about R106. RN #1 reviewed R106's plan of care and stated she did not see anything about weight loss or the dietary interventions. RN #1 stated the dietitian was responsible for updating the nutrition portion of the care plan. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/2/24 at 10:43 a.m., the registered dietitian (RD - other staff #4) was interviewed about R106. The RD stated the resident was on Boost supplement, Medpass and Prostat to address nutrition issues. The RD stated providers had reviewed and adjusted medications in addition to liberalizing the therapeutic diet. The RD stated she did not know why the weight loss and interventions had not been added to the plan of care. The RD stated she did not update care plans in the electronic health record, and she thought MDS was responsible for care plans. On 10/2/24 at 2:44 p.m., the MDS coordinator (RN #1) was interviewed again. RN #1 stated R106's plan of care had not been revised with nutrition interventions. This finding was reviewed with the administrator, director of nursing and regional nurse consultants during a meeting on 10/2/24 at 6:20 p.m. with no further information provided prior to the end of the survey.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21875 Based on observation, resident interview, staff interview, facility document review and clinical record review, the facility staff failed to follow professional standards of care for three of twenty-nine residents in the survey sample (Residents #53, #68 and #166). The findings include: 1. Resident #166's medication Advair diskus (fluticasone-salmeterol) was left at the bedside after administration of the medication. Resident #166 (R166) was admitted to the facility with diagnoses that included COPD (chronic obstructive pulmonary disease), respiratory failure, diabetes, urinary tract infection, asthma, anemia, and rheumatoid arthritis. The minimum data set (MDS) dated [DATE] assessed R166 with moderately impaired cognitive skills. On 9/30/24 at 10:42 a.m., R166 was observed in bed. The medication Advair diskus breath activated inhaler device was observed on R166's over-bed table. R166 was interviewed at this time about the Advair. R166 stated the nurse administered the medication last evening (9/29/24) and left the medication on her table. R166 stated she did not self-administer medications, and the Advair had been there since last evening. R166's clinical record documented a physician's order dated 9/13/24 for Advair diskus aerosol powder breath activated 500-50 micrograms/dose with instructions for one inhalation every 12 hours for treatment of COPD. R166's medication administration record documented the Advair was last administered at 9:00 p.m. on 9/29/24. On 9/30/24 at 10:51 a.m., registered nurse (RN #2) caring for R166 was interviewed about the Advair. Accompanied by RN #1, the Advair diskus was observed on R166's over-bed table. RN #1 stated the evening nurse must have left the Advair on the table after administration. RN #2 stated she had looked for the Advair in the medication cart and could not locate the medicine. RN #2 stated R166 did not self-administer medications. RN #2 stated, It [Advair] must have been left there by another shift. On 10/1/24 at 1:27 p.m., the licensed practical nurse unit manager (LPN #1) was interviewed about R166's Advair left at the bedside. LPN #1 stated R166 had not been assessed for self-administration of medications. LPN #1 stated the nurse should have administered the medication and returned the Advair to the medication cart for proper storage. The facility's policy titled Medication Storage (undated) documented, The facility shall store all drugs and biologicals in a safe, secure, and orderly manner .Drugs shall be stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing systems . This finding was reviewed with the administrator, director of nursing and regional nurse consultants during a meeting on 10/2/24 at 6:20 p.m. with no further information presented prior to the end of the survey. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28106 2. The facility failed to timely assess resident #53 (R53) after a fall. The Findings Include: Diagnoses for R53 included; Dementia, Alzheimer's disease, and fracture of right clavicle. The most current MDS (minimum data set) was an significant change assessment with an ARD (assessment reference date) of 7/19/24. R53 was assessed with a cognitive score of 3 indicating severely impaired cognitively. R53 self ambulates without physical assistance or use of devices. On 10/1/24 R53's clinical record was reviewed. A progress note dated 7/6/24 read: C.n.a. [certified nursing assistant] reported that pt. [patient] had a fall on 7/4/24 and hit her head and was c/o [complaining of] pain to her rt. [right] leg this afternoon. C.n.a. stated agency nurse should have reported the fall. Nothing was documented in chart of the fall. Notified NP [nurse practitioner] will be up to assess pt. family notified. A nurse practitioners documentation assessment note dated 7/6/24 indicated that R53 was not able to elaborate on the details of the fall and was not sure if R53 had hit her head, however did appear to be having some right hip discomfort with movement, had no obvious visible injuries, vital signs and neuro checks were stable and an x-ray pf right hip was ordered. The x-ray did not indicate fracture. A follow up nurse practitioners note dated 7/8/24 indicated x-rays of the right hip pain was unremarkable but now has presented with some right neck and shoulder bruising which is tender to palpate and an x-ray of the right shoulder was ordered. The right shoulder x-ray showed fracture of the distal clavicle without displacement, the age of the fracture was indeterminate. On 10/1/24 at 4:40 p.m. the above information was presented to the administrator and director of nursing (DON). The DON verbalized an investigation was completed regarding the fracture and would look into a possible fall on 7/4/24. On 10/02/24 at 9:52 a.m. the DON verbalized that R53 had fallen on 7/1/24 and was documented and did not evidence a fall had occurred on 7/4/24 based on incident reports and communication logs. It was explained to the DON that according to nurse progress notes and nurse practitioner progress notes R53 had a fall on or around 7/4/24. The DON verbalized not being aware of this fall and if a fall occurred it should have been documented. On 10/02/24 at 11:25 a.m. the nurse practitioner (other staff, OS #1) was interviewed. OS #1 verbalized being notified that R53 a had a fall that occurred a day or two ago and R53 was not at her baseline. OS #1 verbalized R53 did not complain of pain but when assessing her it was noted to have some discomfort to the right hip area so an x-ray was completed and did not indicate fracture. Then two days later R53 was reassessed and seemed to have discomfort when palpating the right shoulder, an x-ray was obtained and showed a clavicle fracture. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/02/24 at 4:33 p.m. certified nursing assistant (CNA #5, person that reported the fall to the nurse) was interviewed. CNA #5 said that R53 had fallen on 7/4/24 near to the end of the daylight shift and remembers because it was a holiday. CNA #5 said that R53's assigned CNA had called out to her (CNA #5) because R53 had fallen in her room and needed help. CNA #5 verbalized that an agency nurse was assigned to R53 that day and when R53 fell the agency nurse, R53's assigned CNA, and herself (CNA #5) went back to help R53 get into bed. CNA #5 said that she had told the agency nurse that the fall needs to be reported and assessed. Two days later R53 was acting a little differently and seemed to be favoring her right leg, so when she reported it to the nurse, the nurse reviewed the medical chart and found that the fall that occurred on 7/4/24 had not been reported. The agency nurse or the nurse notifying the nurse practitioner was unable to be contacted. A facility policy titled Assessing Falls and Their Causes was presented and read in part After a Fall: If a resident has just fallen [.] evaluate for possible injuries to the head, neck, spine,and extremities. Notify a license nurse to evaluate the resident for potential injury. Obtain and record vital signs as soon as it is safe to do so . On 10/02/24 at 6:23 p.m. the above finding was presented to the administrator, DON and nurse consultant. No other information was presented prior to exit conference on 10/2/24. 41449 3. For resident #68- R68, the facility staff failed to follow professional standards of practice during medication administration by leaving lactulose medication and not observing the resident take the medication. On 9/30/24 at 10:22 a.m., R68 was in her room, sitting in the wheelchair eating breakfast. On the over bed table was a medication cup of amber colored liquid. The resident was asked what was in the cup and R68 said it was her medication to make me go poop. Upon the surveyor exiting the room, licensed practical nurse #5 (LPN #5) was a few doors down outside of another resident's room. When asked about the cup of medication at R68's bedside, LPN #5 stated it was Lactulose and aid, she likes to sip on it, I was going to go back and check on her. When asked if R68 had been assessed to self-administer medications, LPN #5 said no. On 10/1/24, a clinical record review was conducted of R68's chart. According to the physician orders, care plan, and assessments, there was no indication that R68 had been assessed for the ability to self-administer medications. On 10/1/24 at 3:46 p.m., an interview was conducted with the director of nursing. When asked about medication administration practices she indicated that staff are to watch resident's consume medication and not leave it in the room. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49456 Based on observation, staff interviews, resident interviews, clinical record review and facility documentation review the facility staff failed to provide activity of daily living (ADL) care for three residents (Resident #13 (R13), Resident #43 (R43) and Resident #56 (R56)) of 29 residents in the survey sample. The findings included: 1. The facility staff failed to provide showers for one resident (R13). R13 was admitted to the facility on [DATE]. Diagnoses for R13 included but are not limited to periprosthetic fracture around internal prosthetic right hip joint, subsequent encounter. R13's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 9/6/24 coded R13 with no cognitive impairment. In addition, the Minimum Data Set coded R13 requiring maximal assistance on staff, for Activities of Daily Living care. On 9/30/24 at 10:00 a.m. a tour of the unit one nursing unit was conducted. R13 was observed in her room and sitting in her wheelchair. Her hair was oily in appearance and lower extremities had some dry skin noted. R13's bed was observed unmade and only had the fitted sheet on the bed. On 9/30/24 10:45 a.m. an interview was conducted with R13. R13 stated, the staff has given me one bath since I have been here and the rest of the time, I bathe myself the best I can. I have not had a shower since I have been here and staff is short especially on weekends and my bed has been like it is right now since Friday, unmade. On 9/30/24 12:34 p.m. an interview was conducted with CNA#2. CNA#2 said that we have a shower system. The residents are supposed to get a shower two times weekly. The shower list is divided between the first shift and second shift. The residents bed linen should be changed on shower days. If showers are refused, we are to report to the nurse. We are short staffed all the time and the residents are aware when we are short staffed. On 10/01/24 8:34 a.m. an interview was conducted with the unit manager LPN#1. LPN#1 stated, the showers should be given daily no matter the staffing. On 10/2/24 at 10:30 a.m. a clinical record review was conducted. The ADL documentation was reviewed, and it showed that a shower had been given on 9/5/24, 9/12/24 and 9/19/24. On 9/26/24 there was no documentation and on 9/30/24 NA [not applicable] was documented. The regional nurse consultant stated, NA means it didn't happen and the blank area's we cannot say it did or didn't happen. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/2/24 at 11:25 a.m. an interview was conducted with CNA#4. CNA#4 was the author of the showers documented on 9/5/24, 9/12/24, and 9/19/24. CNA#4 stated, I have never given this resident [R13] a shower because she is a second shift shower. The surveyor showed CNA#4 the ADL sheet with the documentation of three showers, that was documented by CNA#4. CNA#4 stated, that is wrong, I did it wrong because I have never showered her because she is a second shift shower. CNA#4 was very adamant about the fact she had never given R13 a shower since she had been at the facility. For 29 days R13 has not had a shower, since her admission. 2. The facility staff failed to get R43 out of bed daily. R43 was admitted to the facility on [DATE]. Diagnoses for R43 included but are not limited spinal stenosis and muscle weakness. R43's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 2/4/24 coded R43 with moderate cognitive impairment. In addition, the Minimum Data Set coded R43 is dependent on staff, for Activities of Daily Living care. On 9/30/24 at 10:30 a.m. an observation was conducted. During the tour of unit one R43 was observed in his room laying in the bed. On 9/30/24 at 3:00 p.m. an observation was conducted and R43 was observed in his room and laying in the bed. On 10/01/24 at 1:55 p.m. an interview was conducted with the unit one's manager, LPN#1. LPN#1 stated, we try to get him [R43] up daily but there are times we cannot I will be honest it's due to not enough staff when we cannot get him up. On 10/1/24 at 2:30 p.m. an interview with R43 was conducted. R43 stated, we have problems getting up every day and it's when they have no staff and I require a Hoyer lift and need 2 people and when they don't have enough staff we don't get up. On 10/2/24 at 9:45 a.m. an interview was conducted with the social service director. The social service director said that the activity director brought to my attention about a month ago that R43 wanted to attend activities daily, but staff refuses to get him up. The social service director said she sent an email with this concern to the director of nursing, activities director and the social worker for unit one. On 10/2/24 at 2:30 p.m. an interview was conducted with the activity's director. The activities director said that she goes and ask the staff to get him up to come to activities and most of the time the staff will. She said sometimes that R43 will decline to get up out of bed and at times there is two aides on the floor and he's not out of bed. On 10/2/24 a clinical record review was conducted. The ADL record showed that R43 remained in bed for 23 days in the month of September. The documentation noted NA on the 23 days by the facility staff. The regional nurse consultant stated, NA means it didn't happen. 3. The facility staff failed to get R56 out of bed daily. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R56 was admitted to the facility on [DATE]. Diagnoses for R56 included but are not limited age-related physical debility and muscle weakness. R56's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 9/19/24 coded R56 with no cognitive impairment. In addition, the Minimum Data Set coded R56 requires maximal assistance from staff, for Activities of Daily Living care. On 9/30/24 at 10:30 a.m. an observation was conducted. During the tour of unit one R56 was observed in his room laying in the bed. On 9/30/24 at 4:30 p.m. an interview was conducted with R56. R56 stated, I like to get out of bed daily and I seem to only get up at the most 4 times weekly, due to lack of staff. On 10/01/24 at 1:55 p.m. an interview was conducted with the unit one's manager, LPN#1. LPN#1 stated, we try to get him [R56] up daily but there are times we cannot I will be honest it's due to not enough staff when we cannot get him up. On 10/1/24 at 2:30 R56 voiced a concern during resident council meeting about not being able to get out of bed daily. R56 stated, my preference is to get up daily but if the staff is short, I remain in the bed. On 10/2/24 a clinical record review was conducted. The ADL record showed that R56 remained in bed for 17 days in the month of September. The documentation noted NA [not applicable] on the 17 days by the facility staff. The regional nurse consultant stated, NA means it didn't happen. On 10/2/24, during an end of day meeting the facility Administrator, Director of Nursing and Corporate staff were made aware of the above concerns. No further information was provided.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21875 Based on observation, staff interview and clinical record review, the facility staff failed to follow physician orders for seven of twenty-nine residents in the survey sample (Residents #20, #24, #56, #70, #27, #76 and #78). The findings include: 1. Resident #24 did not have weights obtained as ordered by the physician. Resident #24 (R24) was admitted to the facility with diagnoses that included osteomyelitis, chronic pressure ulcers, quadriplegia, heart failure, atrial fibrillation, methicillin resistant staphylococcus aureus and neurogenic bladder. The minimum data set (MDS) dated [DATE] assessed R24 as cognitively intact. R24's clinical record documented a physician's order dated 9/9/24 for daily weights for three days, weekly weight for four weeks then monthly weights. R24's clinical record documented a weight on 9/15/24. There was no other weight documented until 9/30/24. On 10/1/24 at 1:42 p.m., the licensed practical nurse unit manager (LPN #1) was interviewed about R24's weights not obtained as ordered. LPN #1 stated R24's weights were supposed to be obtained as ordered. LPN #1 stated the order for weights was listed on the resident's medication administration record so that nurses were aware of the needed weights. LPN #1 stated that nurses were expected to be sure the weights were obtained as ordered and that aides usually weighed residents. LPN #1 stated this order was standard for most new admissions and that all residents were supposed to be weighed at least monthly. This finding was reviewed with the administrator, director of nursing and regional nurse consultants during a meeting on 10/1/24 at 4:20 p.m. with no other information presented prior to the end of the survey. 2. Resident #76 was not administered the medications enoxaparin sodium, metoprolol, hydrocodone-acetaminophen and calcitonin nasal spray as ordered by the physician. Resident #76 (R76) was admitted to the facility with diagnoses that included hip fracture, coronary artery disease, Alzheimer's, psychosis, mood disturbance, anxiety, atrial fibrillation, and hypertension. The minimum data set (MDS) dated [DATE] assessed R76 with severely impaired cognitive skills. R76's clinical record documented the following physician orders. 9/9/24 - metoprolol tartrate 25 mg (milligrams) two times per day for treatment of coronary artery disease. 9/10/24 - enoxaparin sodium injection prefilled syringe 40 mg/0.4 milliliters - inject 1 syringe daily for 25 days for prophylaxis. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9/10/24 - calcitonin nasal solution 200 units/spray - one spray each day for history of compression fractures. 9/16/24 - hydrocodone-acetaminophen 5-325 mg - 1/2 tablet two times per day for pain management. R76's medication administration record (MAR) documented these medications were not administered as follows. Metoprolol tartrate 25 mg was not administered on 9/23/24, 9/26/24 (two doses), 9/27/24, 9/28/24 and 9/29/24. Enoxaparin sodium 40 mg/0.4 ml injection was not administered on 9/12/24. Calcitonin nasal spray was not administered on 9/27/24 and 9/28/24. Hydrocodone-acetaminophen 5-325 mg was not administered on 9/16/24, 9/17/24 (two doses), and 9/18/24 (two doses). Nursing notes documented these medications were not administered because the medications were on order or not in med cart. On 10/2/24 at 8:54 a.m., the licensed practical nurse unit manager (LPN #1) was interviewed about R76's missed medications. LPN #1 stated the metoprolol, enoxaparin injection and hydrocodone-acetaminophen were available in the Omnicell back-up supply and should have been accessed by the nurse for administration. LPN #1 stated the calcitonin spray was not kept in the back-up supply and was most likely not reordered timely from pharmacy. LPN #1 stated nurses were expected to enter a refill order when approximately five doses of a medication remained. LPN #1 stated some nurses order medications too early and others did not order quick enough to maintain a supply in the cart. LPN #1 stated she was not aware R76 had missed medications. LPN #1 stated there was always a nurse or supervisor in the building with access to the Omnicell back-up medicines. LPN #1 stated the hydrocodone-acetaminophen required a script for refills or Omnicell access but that there was a nurse practitioner available 24/7 for scripts. The facility's policy titled Medication and Treatment Orders (undated) documented, .Drugs and biologicals that are required to be refilled will be reordered from the issuing pharmacy in a timely manner prior to the last dosage being administered to ensure that refills are readily available . The facility's policy titled General Guidelines for Medication Administration (revised 8/2020) documented, . Medications are administered as prescribed in accordance with good nursing principles and practices .The facility has sufficient staff and a medication distribution system to ensure safe administration of medications without unnecessary interruptions .Medications are administered in accordance with written orders of the provider . These findings were reviewed with the administrator, director of nursing and regional nurse consultants during a meeting on 10/2/24 at 6:20 p.m. with no further information presented prior to the end of the survey. 41449 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3a. For resident #78-R78, the facility staff failed to carry out a physician order to hold Coumadin, (an anticoagulant), which resulted in the resident having to have his surgery for hernia repair to be postponed. On 10/1/24 at 8:34 a.m., R78 was visited in his room. R78 reported that he had a knot in his lower abdomen/groin and was scheduled to have surgery. On 10/1/24 and 10/2/24, a clinical record review was conducted. There was no documentation within the progress notes with regards to an upcoming surgery. However, in the miscellaneous tab of the clinical record was a document titled, Doctor Order Sheet which was uploaded into R78's chart on 9/16/24. The document itself was dated 9/11/24, and read in part, Patient is scheduled to have robotic right inguinal hernia repair possible bilateral with Dr. [name redacted] on [DATE] and will need to hold his warfarin 5 days prior per verbal order by Dr. [name redacted] . Review of the physician orders revealed no order to hold R78's Coumadin. According to the medication administration record (MAR), R78 was administered the dose of coumadin daily through 10/1/24. On 10/2/24 at 11 a.m., an interview was conducted with the facility's nurse practitioner (NP). The NP reported she was aware of the upcoming surgery scheduled but was not aware that the blood thinner had not been held as ordered. The NP said, We will have to contact the surgery center. On 10/2/24 at approximately 11:30 a.m., the facility administrator and corporate staff were made aware of the above findings. On 10/2/24 at approximately 11:40 a.m., the facility's corporate nurse consultant reported to the survey team that R78's surgery was rescheduled because there was a conflict with the surgery and a dermatology appointment. On 10/2/24 at 11:45 a.m., an interview was conducted with registered nurse #6 (RN #6), who was the unit manager. The unit manager was asked about R78. RN #6 stated that R78 had missed his pre-op appointment on Friday, 9/27/24, but the resident's family was present for the appointment and completed the pre-op. The unit manager went on to say that on Monday, 9/30/24, she had talked with someone at the surgery center, and they asked about the coumadin being held. When RN #6 reported the resident had been receiving the coumadin, they said the doctor wanted to postpone surgery since the order to hold the coumadin had not been carried out. The unit manager went on to say, I think surgery would have been a go had that coumadin been held. His [R78's] son was in my office yesterday and I talked with him, he has another pre-op appointment October 9 and surgery [DATE]. On 10/2/24, during an end of day meeting, the facility administrator, director of nursing and corporate staff was made aware that R78's surgery was postponed due to an order to hold Coumadin not being carried out. No further information was provided. 3b. For R78, who was experiencing constipation, the facility nursing staff administered medication without a physician's order and failed to carry out an order for a fleet's enema timely. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/1/24 at 8:34 a.m., R78 was visited in his room. R78 reported that he had not been to the bathroom in 8 days and they were supposed to be in here at 6:30 this morning to give me something and haven't shown up. On 10/1/24 at 8:43 a.m., an interview was conducted with the licensed practical nurse #4 (LPN #4), who was assigned to R78. When notified the resident was reporting he had not had a bowel movement in eight days and reported they were supposed to administer an enema at 6:30 a.m. LPN #4 stated, it didn't show up for me [the order did not appear for her to administer the enema] and when I finish, I was going to check into it. On 10/1/24 a clinical record review was conducted, and a follow-up review was conducted on 10/2/24. On 10/1/24, the review revealed that there was a progress note written on 9/30/24, by the nurse practitioner (NP). This note read in part, . Per reports he has not had a bm in > 3 days. He is not currently on a bowel regimen. He was administered 2 Senna Plus tabs and Miralax yesterday without results . Plan: Start Miralax 17 gm dissolved in water daily Administer FE [fleets enema] now. Monitor for efficacy . According to the medication administration record, there was no evidence of senna, Miralax or an enema being administered. There were no nursing notes with regards to the resident's report of constipation, administration of any medications, or communication with the medical provider. According to a physician order dated 9/30/24, that read, Fleet Oil Enema, Insert 1 application rectally one time only for constipation. According to the medication administration record, this order was not carried out. On 10/1/24 at 9:39 a.m., LPN #4 reported back to the surveyor and stated, I spoke with the unit manager and she put the order in again and brought some fleets enemas up [referring to bringing them from the central supply room to the unit]. On 10/1/24 at 9:45 a.m., an interview was conducted with the unit manager, who was registered nurse #6. She was asked about R78's order for an enema. She stated, it looks like when the NP put it in, it was timed so when it fell off it wasn't communicated. I went yesterday to central supply and brought 2 up here, the nurse yesterday asked me for them, so I don't know why it wasn't given. On 10/2/24 at 11 a.m., an interview was conducted with the NP who had ordered the enema. When asked about the stool softener and laxative she documented was administered, the NP stated, it's a house order, they can do without calling us. The nurse told me she had given it, we have a communication book at each nursing station, where they write things down. So I ordered an enema. I put the order in and spoke with the nurse and gave a 1-hour window for it to be given. When asked if she was aware, it had not been given, the NP said, no. On 10/2/24, an interview was conducted with the facility administrator, director of nursing, and corporate clinical directors, all who reported the facility does not have standing orders or a bowel regime, the nurses have to the call the provider and get orders prior to administering any medications. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/2/24, a review of the communication book revealed an entry dated 9/29/24, that was regarding R78. The entry read, Pt [patient] reported to this nurse on 9/24 that he hadn't had a bm that shift. I waited til my next day of work to see if pt had stooled and he did not and that was on 9/26. I gave 2 senna and still no BM that shift. 9/28 pt still reported no BM so I gave a cap full of Miralax and 2 senna plus and pt still has not stooled as of 7-3 shift for today 9/29. Pt has not had BM for days. On 10/2/24, an additional clinical record review was conducted, which revealed R78 was administered an enema at 3:30 p.m. on 10/1/24. On 10/2/24 at 8:40 a.m., R78 was interviewed and reported he had two small bowel movements following administration of the enema on 10/1/24. 3c. For R78, the facility staff failed to carry out a physician order and failed to notify the provider it was not carried out, but to the medication not being ordered from the pharmacy. On 10/1/24 at 8:34 a.m., R78 was visited in his room. R78 reported he was being seen by a dermatologist for various skin issues. On 10/1/24, a clinical record review was conducted which revealed a physician order dated 8/2/24, with a start date of 8/5/24, which read, apply 10-15 drops Clobetasol 0.05% scalp solution to flaking on scalp and ears twice daily two times a day for flaking of scalp and ears for 2 Weeks. That order was noted as discontinued. There was another order dated 8/12/24, that read, apply 10-15 drops Clobetasol 0.05% scalp solution to flaking on scalp and ears twice daily two times a day for flaking of scalp and ears for 2 Weeks. Throughout the nursing progress notes were multiple entries with regards to the Clobetasol order dated 8/13/24, 8/14/24, 8/15/24, 8/16/24, 8/17/24, 8/18/24, 8/20/24, 8/21/24, 8/22/24, 8/23/24, and 8/26/24 that read, on order. A progress note entry was made on 8/3/24, by the nurse practitioner that read in part, . [AGE] year-old gentleman with multiple medical problems seen today for follow up on a scalp abrasion. He has been evaluated by facility wound care team and treatments are in place. See wound care notes for details. He is not responding well to current treatments, and he does have pmh [past medical history] skin cancer of his scalp however details are not available for review. He was seen by Dermatology with new orders in place . Plan: . apply 10-15 drops Clobetasol 0.05% scalp solution to flaking on scalp and ears twice daily Monitor for acute changes/healing Follow up with Dermatology as scheduled Continue all medications as prescribed. According to the MAR, the physician order for Clobetasol was never administered. On 10/1/24, during an end of day meeting, the facility administrator, director of nursing and corporate staff was made aware of the above findings. On 10/2/24, it was reported by the facility administration to the survey team that the order for Clobetasol was not entered as a pharmacy order, and therefore the medication was never ordered from the pharmacy, which is why it was never received or administered. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/2/24 at 11 a.m., an interview was conducted with the nurse practitioner. When asked if she was aware that R78 was not administered the Clobetasol as ordered, the NP stated, no. I find out days later they are not getting medications when I go to do a follow-up. The communication really needs to improve. No further information was provided. 4. For resident #70- R70, the facility staff failed to administer insulin as ordered and failed to communicate to the physician that the insulin was being held. On 9/30/24 at 3:59 p.m. R70 was visited in her room. It was noted that R70 appeared to be alert, oriented and was non-verbal. R70 could communicate by nodding her head yes and no. R70 reported she is a diabetic, receives insulin and her blood sugars are not stable. R70 also reported the staff check her blood sugar three times daily. On 9/30/24 and 10/1/24, a clinical record review was conducted. According to R70's diagnosis she had type 1 diabetes. This review revealed an active physician order implemented on 8/30/24 that read, Insulin Glargine Solution 100 UNIT/ML Inject 24 unit subcutaneously two times a day for diabetes. There were no parameters associated with this order that indicated if the resident's blood sugar was under a certain amount to hold the insulin administration. According to the medication administration record (MAR) for September, the Glargine insulin was not administered on the 9 a.m., dose on 9/1/24, 9/7/24, 9/23/24, and 9/27/24. On 9/1/24, 9/23/24, and 9/27/24, a code to indicate parameters out of range was documented. According to the nurse progress notes, on 9/1/24, the entry read, B/S blood sugar] = 166. On 9/7/24, the nurse documented, on order as the reason it was not administered. On 9/23/24, the note indicated, BS 71 and on 9/27/24, the entry read, BS 110. On 10/2/24 at 11 a.m., an interview was conducted with the nurse practitioner (NP). The NP was asked about R70 and the order for Glargine insulin. It was discussed that the order had no parameters of when nursing was to hold the administration, but there were instances of nursing not administering the insulin. The NP stated, typically they will call me, but I was not aware in this case, it requires communication. That is long-acting so I would say give it unless the blood sugar was less than 100, then I would hold it. On 10/2/24, during an end of day meeting, the facility administrator, director of nursing and corporate staff was made aware of the above findings. No additional information was provided. 5. For Resident #27- R27, the facility staff failed to administer a blood thinner for a DVT (deep vein thromobis)/blood clot, as ordered by the physician. On 9/30/24 at 1:05 p.m., R27 was visited in his room. R27 reported he was on a blood thinner and denied any complications. When asked if he gets his medications on time, he said he gets no many he doesn't know what he gets. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/30/24, a clinical record review was conducted of R27's clinical chart. This review revealed a physician order dated 8/31/24 to give Xarelto 20 mg tablet daily for DVT (deep vein thrombosis) related to acute embolism and thrombosis. According to the medication administration record (MAR) the medication was not given 9/5/24, 9/21/24, nor 9/22/24. According to the progress notes on 9/21/24 and 9/22/24, it was noted as not given because not available. No explanation was given as to why it was not adminsitered on 9/5/24. On 10/2/24, a copy of the contents of the Omnicell (an emergency/back-up supply of medication) was reviewed. It was noted that Xarelto was available in 10 mg tablets. There was no indication within R27's chart that the provider was made aware that the medication was not available, nor given the opportunity to give an order to give two of the 10 mg tablets that was available in the Omnicell, to equal the scheduled dose. 49456 6. The facility staff failed to follow a physician's order for Resident #20's (R20) daily fluid restriction. On 9/30/24 at 11:00 a.m. an observation was conducted when touring the unit one nursing unit. R20 was observed sitting in her room and holding a cup in her hand drinking a soft drink. There was a full water pitcher on her overbed table observed. On 10/2/24 at 10:05 a.m. an observation made of R20's water pitcher was full and on her over bed table. The water pitcher had 800 milliliters of fluid in the pitcher. On 10/2/24 at 10:10 a.m. an interview was conducted with LPN#2. LPN#2 confirmed that R20 had an order for 1200 cc fluid restriction daily. LPN#2 stated that a full water pitcher should not be on her over bed table. LPN#2 stated that R20's fluids was given with her meals and with her medication pass. LPN#2 was asked if R20's fluids were monitored and LPN#2 stated, we are supposed to monitor. On 10/2/24 at 10:15 a.m. an interview was conducted with the unit one manager (LPN#1). LPN#1 stated, the nurse is supposed to monitor R20's [name redacted] fluid intake and she would not be able to monitor with a water pitcher on the overbed table. LPN#1 said she never thought about a full water pitcher should not be in R20's room because staff would not be able to monitor the fluid intake. On 10/2/24 at 11:00 a.m. a clinical record review was conducted. R20 had a physician's order that read, fluid restriction (1200 cc) BLD [breakfast, lunch and dinner] and med pass per shift that was written on 8/16/24. R20's care plan that was revised on 9/25/24 read in part, .encourage fluids of choice during meals and rounds within fluid restriction orders. R20's progress note written by the registered dietician read in part, . Resident has a 1200 ml fluid restriction in place. R20's treatment administration record (TAR) had the documentation for the monitoring of the fluid restriction daily. There were multiple days on the TAR that the amount of fluid intake was not documented: 9/1/24, 9/2/24, 9/3/24, 9/24/24 and 9/28/24. On 9/11/24 it was documented that R20 received 1680 ml's of fluid intake for the day and on 9/13/24 it was documented R20 had 3200 ml's of fluid for the day. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/2/24 at 2:00 p.m. a review of the facility documentation was conducted. The facility policy titled, Resident hydration and Prevention of Dehydration, read in part, .Physician orders to limit fluids will take priority over calculated fluid needs. The dietitian may refer calculated needs to the physician if restrictions potentially increase a risk for dehydration. Nursing will monitor and document fluid intake as ordered by the physician/practitioner or per facility protocol. 7. The facility staff failed to obtain daily weights for Resident #56 (R56) per physician orders. On 10/2/24 at 10:15 a.m. an interview was conducted with the unit one nurse manager. LPN#1 stated that she was not aware the daily weights on R56 was not being done daily. LPN#1 stated that it was not on their 24-hour reports and not one had told her. LPN#1 did confirm the order for the daily weights and that the weights were not being obtained daily. On 10/2/24 at 3:00 p.m. an interview was conducted with R56. R56 stated that he does not refuse daily weights. R56 stated, that the bed scale was broke and the facility had no Hoyer lift sling for him to be weighed with the Hoyer lift so the only way was to transfer him to the wheelchair and go the weigh station down the hall and they don't do that, and no one asks me about weighing me so I cannot refuse. On 10/2/24 at 3:30 p.m. a clinical record review was conducted. R56 care plan had weight per order. On 3/18/24 a physician's order was written to obtain daily weight in the morning and notify cardiology if any weight gain or loss of 3 pounds over night or 5 pounds in a week or increase in heart failure symptoms. R56 had a progress note from 9/10/24, 9/12/24 and 9/29/24 that the bed scale was broken or reading zero and no sling to safely weigh on the lift. R56's weight documentation had several missing days which were, x, x, x, (list the days). There were weights documented for 9/1/24, 9/3/24, 9/4/24, 9/6/24, 9/7/24 and 9/27/24. On 10/2/24 a facility policy titled, Medication and treatment orders, was reviewed and it did not address non-pharmacological physician orders. On 10/2/24, during an end of day meeting the facility Administrator, Director of Nursing and Corporate staff were made aware of the above concerns. No further information was provided.

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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. 49456 Based on observation, resident interview, staff interview, clinical record review and facility document review the facility staff failed to ensure that residents receive proper treatment and assistive devices to maintain vision abilities for one resident (Resident#43, R43) in a survey sample of 29 residents. The findings included: The facility staff failed to replace eyeglasses broken by staff timely. On 10/1/24 at 8:00 a.m. R43 was laying in his bed and was trying to read his newspaper. R43 stated, I can see far away but not up close and I have not received my glasses yet. On 10/1/24 at 2:30 p.m. During resident council meeting R43 stated, I have glasses missing that staff broke, they said they were going to replace them but that was 2 months ago. On 10/2/24 at 9:45 a.m. an interview was conducted with the social worker director. The social worker director stated, I sent out an email of high priority to the director of nursing, unit manager, activity director and unit one's social worker. The email read in part, .he[R43] mentioned that about a week ago a staff member (he did not know name) broke his [R43] new glasses and is having to use old ones. He [R43] stated they were reading glasses. The social worker director was asking for the glasses to be replaced for R43 and the email was sent out on 9/6/24. On 10/2/24 at 9:48 a.m. an interview with the director of nursing (DON) was conducted. The DON stated that she did not recall being told about R43's glasses missing or broken by staff. When the DON was asked about the email the social service director sent out on 9/6/24 high priority about the broken glasses the DON checked her emails and stated, I did get that email but I did not open it so I guess that's why I don't know about the glasses being broken. On 10/2/24 at 10:33 a.m. facility documentation was reviewed. Grievance forms were reviewed and there was no grievance provided for R43 glasses. The social worker stated that R43 did not want a grievance to be filed and he felt talking with the team was sufficient. On 10/2/24 at 2:30 p.m. an interview was conducted with the activity's director. The activities director that she replaced R43's reading glasses today. On 10/2/24 a facility document was reviewed. The facility documentation titled, Grievances, Complaints, Recording and Investigating, was reviewed. On 10/2/24, during an end of day meeting the facility Administrator, Director of Nursing and Corporate staff were made aware of the above concern. No further information was provided.

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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** 41449 Based on observation, resident interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to provide interventions for the prevention and/or treatment of pressure ulcers for two residents (Resident #15- R15 and Resident #24-R24) in a survey sample of 29 residents. The facility staff also failed to identify a pressure ulcer until at an advanced stage (stage III) for one resident- R15, which was harm. The findings included: 1a. For R15, who was total care, the facility staff failed to identify a pressure wound until it was at an advanced stage of III, with full thickness tissue loss. On 9/30/24 at 10:30 a.m., R15 was interviewed in their room. R15 was not verbally responsive with the surveyor and did not respond when spoken to. On 9/30/24 and 10/1/24, a clinical record review was conducted. According to the most recent Braden scale for predicting pressure score risk, dated 7/25/24, R15 scored 11 out of 23, which indicated high risk for development of pressure ulcers. This assessment also noted R15 was very limited in the ability to respond meaningfully to pressure-related discomfort, was bedfast, completely immobile, and required moderate to maximum assistance in moving. According to R15's care plan, which was last reviewed on 10/7/23, R15 .needs assistance for adl's [activities of daily living] and mobility because of weakness from recent hospitalization , dementia . The care plan also noted I have an actual impairment to skin integrity stage 3 to left buttocks r/t [related to] immobility. On 7/5/24, there was a revision that read, left buttock stage 3 pressure ulcer resolved. There was no indication on the care plan that a stage III pressure wound was identified on 9/24/24 to the sacrum. An additional focus area within R15's care plan read in part, is at risk for skin breakdown because of impaired mobility from weakness, impaired cognition from dementia, incontinence and nutrition status. Care plan interventions included but were not limited to: complete hand checks on LAL [low air loss] mattress to monitor for proper functioning and settings. Float heels while in bed. Follow facility policies/protocols for routine skin monitoring. Report any changes to MD/NP [medical doctor/nurse practitioner], pressure reducing mattress on bed . According to a weekly skin observation conducted on 9/17/24, R15's skin was noted to be intact without any bruises, open wounds, surgical incisions, skin tears, reddened areas or other skin conditions noted. There was also a progress note from the wound care specialist that was dated 9/17/24, which noted, .wound care consulted today for sacrum/low back pressure due to bed deflating which is not found on today's assessment. No wounds noted. Sacrum and back are within normal limits. According to a weekly skin observation performed on 9/24/24, it indicated, an open area to the coccyx, with the additional information that read, buttock: apply NS [normal saline], honey fiber, foam once daily and as needed. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A wound evaluation was conducted on 9/24/24, by a facility nurse. The form noted, Type of skin issue: pressure ulcer/injury or suspected deep tissue injury . location: sacrum . facility acquired . date acquired: 9/24/24 . Pressure ulcer/injury stage: Stage III: Full thickness tissue loss. The documented measurements were 4.0 centimeters (cm) in length, 3.5 cm width, and 0.3 cm depth. This evaluation noted that the wound measurements were obtained by a wound care provider and described the wound as follows: . epithelial tissue in the wound bed, serous wound exudate, heavy exudate, heavy dressing saturation, with no odor or tunneling noted. Additional comments on this wound form noted, .cluster measurement awaiting alternate mattress . R15 was seen by the wound care specialist - nurse practitioner on 9/24/24. This progress note read in part, Patient is being seen for evaluation and treatment recommendation regarding pressure ulcer to sacral region. Patient has history of pressure ulcers, is incontinent of bowel and bladder, is mostly bed bound, and depends on staff for assistance with ADLs. Patient's nurse reports some issues with patient's mattress which may have led to development of skin breakdown. Patient was seen last week by this provider with sacrum and back WNL [within normal limits]. Therefore new ulcer present for less than 7 days. Patient does endorse discomfort with cleansing/contact. Partially alleviated with repositioning. This note also evaluated the wound to be a stage III pressure ulcer of the sacral region. According to the nursing progress note dated 9/24/24 at 12:23 p.m., which read in part, Weekly skin observation completed. Stage III pressure ulcer to sacrum. Overall impression: new wound- first observation. See Wound Evaluation Weekly for additional details. On the afternoon of 10/1/24, R15 was observed to be out of bed in a geri chair [medical style recliner]. Facility staff were observed changing R15's air mattress in her room. On 10/2/24 at 8:51 a.m., an interview was conducted with a certified nursing assistant #8 (CNA #8). CNA #8 stated, When the power went out, the newer beds wouldn't work anymore. CNA #8 was asked about R15's bed. CNA #8 stated, [R15's] air mattress was deflating, so I got her up. They said it was fine, but it must have deflated on someone else, and they changed it out. The CNA stated that R15's bed had messed up previously and she was placed on a regular mattress. When asked about R15's skin, CNA #8 explained that R15 is total care for all care needs and was incontinent. CNA#8 said, [R15] got that wound about 2 weeks ago when the mattress was changed. When asked about the length of time R15 was on the regular mattress and without an air mattress, CNA #8 answered, Three to four days. 10/2/24 at 11 a.m., an interview was conducted with the nurse practitioner (NP). When asked if she was aware that R15 had a wound, the NP said, I knew about it because I sign off on it [the wound consultant reports]. When asked if she was aware that the wound was not identified until it was a stage III, the NP stated, I wasn't aware of that. That surprises me. The CNA's [certified nursing assistants] are usually good about identifying the start of skin breakdown. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 10/2/24 at 11:45 a.m., an interview was conducted with the registered nurse #6 (RN #6), who was the 2nd floor unit manager. When asked about R15 and her bed dysfunction, RN #6 stated, When the aide got her up, the air mattress was completely flat. I had put a work order in to have it replaced. I would imagine it was flat a while. When asked if there had been a prior issue with the mattress, RN #6 said, I don't know about the quality of the air mattresses we get around here. They don't inflate like they should. I switched out [R15's] bed and got a new air mattress yesterday. [R15] was put on a regular mattress over the weekend a few weeks ago when it messed up. When asked about R15's wound, RN #6 stated, [R15] had a previous stage III that healed. I'm sure the mattress contributed to the new wound developing. [R15] is totally dependent and incontinent. When asked how the wound was not identified prior to being a stage III, RN #6 said, I don't understand how it would get to a stage III like that because [R15's] skin is checked daily. When asked what interventions were put in place to prevent skin breakdown after being aware that the air mattress was not functioning, RN #6 was unable to identify any additional interventions that had been implemented. According to the maintenance work orders, R15's air mattress had been an ongoing issue. On 2/29/24, two maintenance work orders were entered that read, air mattress not inflating, low pressure, air mattress and air mattress not inflating all the way. On 3/7/24, a work order was entered that read, air mattress low pressure light on. On 4/18/24 another maintenance work order was entered that read, air mattress will not inflate. Pt [patient] is basically laying on metal bars. According to the maintenance work order entered on 9/15/24 indicated that R15 again had an air mattress malfunction. On 9/22/24, another work order was entered regarding R15's bed that read, air mattress needs to be replaced and it noted, placing resident on regular mattress til air mattress can be repaired. Thank you. The bed was not replaced until 9/24/24. R15 was not on an air mattress from 9/15/24 until the afternoon of 9/24/24, at which time the stage III pressure ulcer was identified. There was no indication within the clinical record of any additional or alternate interventions being implemented when the air mattress was noted to be malfunctioning, other than replacing it with a non-air matress. On 10/1/24, two maintenance work orders were entered that read, bed not working, needs to be switched out and needs bed switched out and air mattress. On 10/2/24 in the late morning, a surveyor made observations of R15's sacral wound with the treatment nurse (licensed practical nurse #6- LPN #6). The wound was observed to be open with full tissue loss, but appeared clean with healing tissue present. Also observed was a lightly discolored scar on the left buttock from a previously healed wound. When questioned, LPN #6 confirmed that the new wound was in fact a new wound and not an old wound that had re-opened. On 10/2/24 at 2:33 p.m., an interview was conducted with registered nurse #4 (RN #4). RN #4 reported that R15's bed went out on a weekend, and they had put R15 on a standard mattress. RN #4 said, It would pump up at the head and foot but at the sacrum it wouldn't pump up to support her. [R15] broke down a little bit after that. When asked if this is an ongoing problem with the air mattress, RN #4 said, Occasionally there is an issue, but not every day, but every few months. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 10/2/24 at approximately 2:45 p.m., an interview was conducted with licensed practical nurse #6 (LPN #6), who was the facility's treatment nurse. The treatment nurse explained that R15's .bed deflated and we were getting her a new one. I heard her mattress was changed again yesterday. The LPN #6 went on to explain about the sacral wound and said, This is the second week. The first week we [herself and the wound care specialist nurse practitioner] looked and nothing was there. Then I got a note that it was open, so I looked, and it was definitely open and was a stage III, so we started treatment. This week there has been a big decline, it is longer and there is a little granulation tissue with a little maceration around a small part of it. When asked what type of mattress R15 was on at the time the wound was discovered, LPN #6 identified that it was a regular mattress and not an alternating pressure mattress when the new developed to the sacrum. LPN #6 provided the surveyor with her notes from the wound care rounds performed with the wound care specialist. According to the wound care round notes, R15 was noted to have no wounds noted on 9/17/24. On 9/24/24, R15 was noted to have a stage III pressure wound on the sacrum, which measured 4.0 x 3.5 x 0.3 and had heavy wound drainage. These notes also indicated, . awaiting alternate mattress. According to the wound care round notes dated 10/1/24, R15's wound was documented to measure 6.5 cm. x 2.5 cm x 0.3 cm and also indicated the wound had deteriorated. The facility policy titled, Pressure Injury Prevention and Management was reviewed. The policy read in part, Definitions: . Avoidable means that the resident developed a pressure ulcer/injury and that one or more of the following was not completed: evaluation of the resident's clinical condition and risk factors; definition or implementation of interventions that are consistent with resident needs, resident goals, and professional standards of practice; monitoring or evaluation of the impact of the interventions; or revision of the interventions as appropriate . Preventative Measures: 1. Preventive interventions will be implemented based on the pressure ulcer/injury risk assessment, other related factors, and resident preferences. Such interventions may include a. education to the resident/resident representative on risks associated with pressure ulcer/injury. b. Frequent encouragement and assistance with turning, repositioning, shift of weight, etc. c. Use of pressure reducing/relieving support surfaces or devices to assist with pressure redistribution and tissue load . Identification: 1. Staff will be encouraged to promptly report any observation of a change in the resident' skin integrity. 2. Weekly skin observations will be conducted by a licensed nurse and findings will be documented in the resident's clinical record. 3. Observations of new pressure ulcer/injury will be: a. reported to the physician/practitioner for further evaluation and treatment. b. Referred to the designated wound nurse as appropriate . On 10/2/24, during an end of day meeting, the facility administrator, director of nursing, and corporate staff were made aware of the above findings. On 10/2/24 at 7:09 p.m., the facility's corporate staff provided the surveyor with the maintenance work order's regarding R15's air mattress. The nurse consultant stated that R15's mattress was not completely deflated, it was just not functioning properly, she wasn't laying on the bed frame. They went on to explain that all of the mattresses are pressure reducing and she had a pressure reducing cushion when out of bed. When it was further explained that the only issue was not just the mattress dysfunction, but the fact that the wound was not identified until at an advanced stage was problematic and that no additional interventions were implemented when the bed was known to dysfunction, the survey team was then notified that the facility's medical director wanted to speak to the survey team regarding R15. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 10/2/24 at 7:12 p.m., a telephone call was placed to the facility's medical director/physician, as requested. The medical director stated that R15 had a previous wound in the area that had healed and re-opened. The surveyor explained that the resident had a prior wound on her left buttock that had healed, and the current wound was on the sacrum and above the prior wound area. The medical director was asked if he had seen the wound, to which he stated, No. When asked if he was made aware when the wound was identified, the medical director stated, No, I was made aware by reading the wound practitioner's note. The medical director stated that R15 would always have risk factors for development of wounds due to urine and fecal incontinence, recurrent wounds, and other comorbidities. When asked if he would expect staff to identify skin issues prior to them being noted at a stage III, the medical director stated, I would think staff observe the skin with frequent changes and with the location staff may be able to make changes. When asked about an air mattress for R15, the medical director stated, Any resources to help off load the surface areas coming into contact and to offload pressure points instead of one constant pressure point. When asked if the other mattress' that are not alternating pressure mattresses are as effective, the medical directed stated, Other mattresses would limit offloading. The air mattress was the right decision for this patient. 1b. For R15, the facility staff failed to implement preventative interventions to float the heels, and the resident was subsequently found during survey to have boggy heals indicating skin breakdown, at which time interventions were implemented. On 9/30/24 at 10:30 a.m., R15 was interviewed in their room. R15 was not verbally responsive with the surveyor and did not respond when spoken to. It was observed that R15 had a heels up device to offload pressure that was in the corner of the room, on the floor, and not in use. On 9/30/24 additional observations were conducted at 2:43 p.m., and at 4:15 p.m., and the heels up device remained in the corner of the room, on the floor and not in use. On 9/30/24 at 4:20 p.m., certified nursing assistant #6 (CNA #6) accompanied the surveyor to R15's room. CNA #6 confirmed that a pillow was under R15's legs but just under her calves and that R15's feet were resting directly on the bed. When gesturing to the heels up device sitting in the corner of the room, not in use, CNA #6 confirmed that this intervention should be in place/used to prevent pressure. On 9/30/24 and 10/1/24, a clinical record review was conducted. This review revealed that R15's care plan noted I have an actual impairment to skin integrity stage 3 to left buttocks r/t [related to] immobility. On 7/5/24, there was a revision that read, left buttock stage 3 pressure ulcer resolved. Interventions, included but were not limited to: .Float heels while in bed On 10/2/24 at 11:45 a.m., an interview was conducted with the registered nurse #6 (RN #6), who was the 2nd floor unit manager. During the interview, RN #6 was made aware of the multiple observations of R15's heels not being floated. While accompanying the surveyor to R15's room, RN#6 reported that R15 had been identified that day to have boggy heels and treatments had been ordered. When arriving at R15's room, R15's feet were observed to have bunny boots on, which RN #6 removed and confirmed that both heels were boggy, indicating skin breakdown. When asked what interventions were implemented to prevent skin breakdown, RN #6 said, Not enough. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 10/2/24 at approximately 2:45 p.m., an interview was conducted with licensed practical nurse #6 (LPN #6), who was the facility's treatment nurse. The treatment nurse was asked what the purpose of a heels up device is. LPN #6 stated, To make sure the heels are floated so they don't get red or break down. LPN #6 went on to explain that on 10/1/24, R15's . left heel was red. I put an order in today for skin prep and protective boots. When asked when the bogginess was first noted on R15's feet, LPN #6 responded, Yesterday. The facility policy titled, Pressure Injury Prevention and Management was reviewed. The policy read in part, Definitions: . Avoidable means that the resident developed a pressure ulcer/injury and that one or more of the following was not completed: evaluation of the resident's clinical condition and risk factors; definition or implementation of interventions that are consistent with resident needs, resident goals, and professional standards of practice; monitoring or evaluation of the impact of the interventions; or revision of the interventions as appropriate . Preventative Measures: 1. Preventive interventions will be implemented based on the pressure ulcer/injury risk assessment, other related factors, and resident preferences. Such interventions may include a. education to the resident/resident representative on risks associated with pressure ulcer/injury. b. Frequent encouragement and assistance with turning, repositioning, shift of weight, etc. c. Use of pressure reducing/relieving support surfaces or devices to assist with pressure redistribution and tissue load . Identification: 1. Staff will be encouraged to promptly report any observation of a change in the resident' skin integrity. 2. Weekly skin observations will be conducted by a licensed nurse and findings will be documented in the resident's clinical record. 3. Observations of new pressure ulcer/injury will be: a. reported to the physician/practitioner for further evaluation and treatment. b. Referred to the designated wound nurse as appropriate . On 10/2/24, during an end of day meeting, the facility administrator, director of nursing, and corporate staff was made aware of the above findings. No additional information was provided. 21875 2. Resident #24's heels were not offloaded when in bed as required in the treatment plan for pressure ulcer care. Resident #24 (R24) was admitted to the facility with diagnoses that included osteomyelitis, chronic pressure ulcers, quadriplegia, heart failure, atrial fibrillation, methicillin resistant staphylococcus aureus and neurogenic bladder. The minimum data set (MDS) dated [DATE] assessed R24 as cognitively intact. On 9/30/24 at 12:02 p.m., R24 was observed in bed. The resident's feet/heels were observed with no elevation or off-loading. Two cushioned booties were observed in the window seal adjacent to the resident's bed. R24 was interviewed at this time about his feet/heels. R24 stated he had chronic pressure ulcers and currently had a pressure ulcer on the left heel. R24 stated he usually had the booties on his feet when in bed to protect the wound and prevent further breakdown. R24 stated staff did not put the booties on last night and he forgot to remind them. R24 stated he had socks on his feet but there had been no elevation or protective booties on since last evening (9/29/24). (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R24's clinical record documented the resident was currently treated for an unstageable pressure ulcer on the left heel. The most recent assessment by the wound consultant documented an unstageable ulcer measuring 0.5 x 0.8 x 0.1 (length by width by depth in centimeters). The treatment plan for the pressure ulcer included heel offloading with use of booties in addition to turning/repositioning and a pressure reducing mattress. R24's plan of care (revised 9/29/24) documented the resident had chronic pressure ulcers including the heel ulcer. Interventions to prevent complications included treatments as ordered and following facility protocols for prevention/treatment of skin breakdown. On 10/1/24 at 2:05 p.m., accompanied by the wound consultant nurse practitioner (other staff #6) and with the resident's permission, a dressing change to R24's left heel ulcer was observed. R24's left heel ulcer was irregularly shaped with beefy red tissue noted at the center of the wound. There were no signs of infection. The wound consultant was interviewed at this time about R24's heel ulcer. The wound consultant described the ulcer as improved and stated the resident's heels required continued offloading to prevent further breakdown and promote healing. On 10/1/24 at 2:15 p.m., the licensed practical nurse (LPN #1) was interviewed about R24 in bed without the protective booties. LPN #1 stated the booties were part of the treatment plan for the heel ulcer to promote healing and prevent further breakdown. LPN #1 stated R24 usually had them [booties] on. LPN #1 stated the heels should be floated because the resident had a current wound. The facility's policy titled Pressure Injury Prevention and Management (revised 10/19/22) documented, .The intent of this organization is to develop and maintain systems and processes to ensure that the resident does not develop pressure ulcers/injuries (PU/PIs) unless clinically unavoidable and that the facility provides care and services consistent with professional standards of practice to: Promote the prevention of pressure ulcer/injury development; Promote the healing of existing pressure ulcers/injuries (including prevention of infection to the extent possible); and Prevent development of additional pressure ulcer/injury .Treatments will be ordered by the physician/practitioner. Treatment and interventions may include .Use of support devices . This finding was reviewed with the administrator, director of nursing, and regional nurse consultants during a meeting on 10/1/24 at 4:20 p.m., with no further information provided prior to the end of the survey.

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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. 49456 Based on observation, staff interview, resident interview, clinical record review and facility document review, the facility staff failed to offer a therapeutic diet for one resident (Resident #56, R56) out of a survey sample of 29 residents. The findings included: The facility staff failed to provide large portion entrees with meals as ordered by the physician. On 9/30/24 at 12:30 p.m. an observation was made of the lunch time meal. R56 meal ticket had large entree portions. He received the regular serving size of the entree on his meal tray. The entree was Italian chicken, and he only received 3 ounces. On 9/30/24 at 12:33 p.m. a certified nursing assistant (CNA#2) was interviewed. CNA#2 stated, sometimes he [R56] gets double portions but today he [R56] did not get double entree, and he doesn't get double the meats. On 9/30/24 at 12:33 p.m. an interview with R56 was conducted. R56 said that the serving size of the food is too small with his meals. On 10/1/24 at 8:45 a.m. an observation was made of R56's breakfast tray. R56 was in his room and the aide was setting up his meal and R56 only received the regular size entree. He had two waffles on his meal tray which was the serving observed on the other resident's trays. On 10/1/24 at 9:00 a.m. an interview with CNA#2 was conducted. CNA#2 stated, that he [R56] did not receive large portion of the waffles this morning. He had the same thing everyone else had. On 10/2/24 a clinical record review was conducted. R56's care plan, updated on 8/27/24 had to provide diet per order. On 3/19/24 the registered dietician put the intervention in place of large protein portions with all meals. On 9/5/24 the nutritional risk assessment had no changes and continue with diet and refer to the meal ticket for R56's meal. On 10/2/24 a review of facility documentation was completed. The facility document titled, Therapeutic Diets, read in part, .diet ordered by a physician or delegated registered or licensed dietitian as part of treatment for a disease or clinical condition or to eliminate or decrease specific nutrients in the diet or to increase specific nutrients in the diet. On 10/2/24, during an end of day meeting the facility Administrator, Director of Nursing and Corporate staff were made aware of the above concern. No further information was provided.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41449 3. For resident #90- R90, the facility staff failed to maintain the nebulizer mask in a manner to prevent contamination to prevent infection. On [DATE] at 11:26 a.m., R90 was observed in his room having a nebulizer treatment being administered via a mask. The mask nor tubing were dated as to when they were last changed. On [DATE] at approximately 4:02 p.m., R90 was visited in his room. The nebulizer mask was observed open to air and not in a bag. On [DATE] at 3:03 p.m., R90 was again visited in the room. It was noted that the nebulizer mask was laying in the floor at the bedside. On [DATE] at 3:16 p.m., an interview was conducted with licensed practical nurse #4 (LPN #4). LPN #4 was asked about nebulizers and the storage of them. LPN #4 stated they are to be stored in a bag and are changed nightly and dated. When asked why this is important, LPN #4 stated to know it is not expired, being kept clean and safe non-bacterial place, and when things are changed last. LPN #4 was told that R90's nebulizer mask was observed on the floor. LPN #4 said, I saw it on the floor earlier and put it on the counter earlier. LPN #4 accompanied the surveyor to the resident's room, observed the nebulizer mask on the floor and picked it up off the floor and put it on the counter and began looking for a storage bag. On [DATE] at approximately 3:30 p.m., an interview was conducted with registered nurse #6 (RN #6), who was the unit manager. RN #6 stated that oxygen tubing and nebulizer masks and tubing is change weekly, every Sunday and are stored in a bag when not in use. When asked what the purpose of changing them weekly and storing in a bag was, RN #6 stated, I think they should be kept somewhere securely, you can get any kind of germs or something on it. On [DATE] at approximately 4 p.m., LPN #4 notified the surveyor that she was changing the nebulizer tubing and mask and providing a bag for it to be stored in. On [DATE], a clinical record review was conducted of R90's chart. According to the physician order dated [DATE], which remained an active order, it read, Change & date oxygen tubing, mask if used, bag, humidification bottle if used, clean filter once a week also change &date Neb tx tubing place in a bag as needed. According to the clinical record medication administration record, treatment administration record, and progress notes, there was no documentation with regards to when the nebulizer tubing and masks were being changed. On [DATE], the facility's policy regarding respiratory equipment and storage of such was requested. The policy titled; Oxygen Administration was received. The policy did not reference the storage of such equipment when not in use, nor the steps to be taken when it is noted on the floor/or other surface that may contaminate it. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE], during an end of day meeting, the facility administrator, director of nursing and corporate staff was made aware of the above findings. No additional information was provided. 49456 Based on observations, staff interview, clinical record and facility documentation the facility staff failed to provide respiratory services for two residents (Resident #20, R20, Resident # 56, R56) and maintain respiratory equipment in a sanitary manner for one resident (Resident #90. R90), in a survey sample of 29 residents. The findings included: 1. The facility staff failed to follow the physician's order for R20's oxygen administration. On [DATE] at 12:33 p.m. an observation was made of R20's oxygen setting. R20's oxygen was set on 3 liters per minute by nasal cannula. On [DATE] at 8:30 a.m. an observation was made of R20's oxygen and it was still set on 3 liters per minute by nasal cannula. [DATE] at 8:53 a.m. an interview was conducted with licensed practical nurse, LPN#2. LPN#2 verified the oxygen order was 2 liters per minute by nasal cannula. LPN#2 verified that R20's oxygen was set on 3 liters per minute by nasal cannula and that was not the correct setting. On [DATE] a clinical record review was conducted. R20's care plan was updated on [DATE]. The care plan had that R20 has emphysema/chronic obstructive pulmonary disease and to administer oxygen per orders. R20 had a physician's order dated [DATE] for oxygen 2 liters via nasal cannula. 2. The facility staff failed to follow the physician's order for R56 oxygen administration. On [DATE] at 11:24 a.m. an observation was made of R56's oxygen setting. R56's oxygen was set on 4 liters per minute by nasal cannula. On [DATE] at 10:00 a.m. an observation was made of R56's oxygen and it was still set on 4 liters per minute by nasal cannula. [DATE] at 10:15 a.m. an interview was conducted with LPN#1. LPN#1 verified the oxygen order was 2 liters per minute by nasal cannula. LPN#1 verified that R56's oxygen was set on 4 liters per minute by nasal cannula and LPN#1 stated, that was too much oxygen for the resident. On [DATE] a clinical record review was conducted. R56's had a physician's order dated [DATE] for oxygen at 2 liters per minute via nasal cannula continuous and to check setting at eye level. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] a facility document was reviewed. The facility document titled, Oxygen Administration, read in part, .purpose of this procedure is to provide guidelines for safe oxygen administration. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. On [DATE], during an end of day meeting the facility Administrator, Director of Nursing and Corporate staff were made aware of the above concerns. No further information was provided.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41449 Based on resident interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to ensure medications were available for administration for three residents (Resident #27-R27, resident #83-R83, and resident #76-R76), in a survey sample of 29 residents. The findings included: 1. For R27 the facility staff delayed treatment of bilateral impacted cerumen as ordered, due to medication not being available. On 9/30/24 at 1:05 p.m., R27 was visited in his room. It was noted that R27 had cotton in his left ear, when asked R27 reported he had wax buildup and was getting drops in his ears. On 9/30/24, a clinical record review was conducted of R27's clinical chart. This review revealed a physician order dated 9/14/24, that read, Debrox Solution 6.5 % (Carbamide Peroxide) Instill 5 drop in both ears two times a day for cerumen impaction for 7 Days. According to the medication administration record (MAR) the medication was not given but once in the 7 days ordered. According to the progress notes daily entries indicated, on order and waiting for delivery. There was no indication that nursing called the pharmacy to inquire where the medication was. There was also no indication that the doctor was made aware that the order was not carried out. On 9/23/24, the nurse practitioner saw R27 for a follow-up at which time she was made aware that the prior order had not been carried out, so she ordered the debrox drops again. 2. For R83, who had a history of seizure disorder, the facility staff failed to administer seizure medications due to the medication not being available. On 10/1/24, during a clinical record review, it was noted that R83 was ordered to receive Lamictal Tablet 200 MG (Lamotrigine) Give 1 tablet by mouth two times a day for seizures. Starting 8/7/23, an additional order was written to add Lamotrigine Oral Tablet 25 MG (Lamotrigine) Give 1 tablet by mouth in the afternoon for seizures, in addition to the 200 mg doses. According to the MAR, R83 did not receive the 25 mg afternoon doses on 8/22/24, 8/23/24, 9/19/24, 9/21/24, and 9/23/24. According to the progress note entries, the medication was not given on each of the above occurrences and the note indicated the medication was on order. On 10/1/24 at 8:43 a.m., an interview was conducted with licensed practical nurse #4 (LPN #4). LPN #4 explained that if a medication is not available, she will check the Omnicell, if the medication isn't in the Omnicell she would make sure it has been ordered and indicate that the mediation was not available and was reordered. When asked if she had to notify anyone that the medication was not available, LPN #4 stated, I can ask my manager, but normally I just document it was not available and was reordered. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/1/24 at 3:46 p.m., an interview was conducted with the director of nursing (DON). The surveyor asked the DON to describe the process if a nurse if passing medications and noted that a medication was not available. The DON stated, they should let the provider know and call the pharmacy to see where it is. When asked about the pharmacy services, the DON stated that the pharmacy delivers to the facility twice daily and they also have a Omnicell, which is an emergency supply of medications. When asked if all nurses have access to the Omnicell, the DON stated, some do and some do not, but usually there is a nurse here that has access. When asked why it is important to call the doctor when medications are not available, the DON said, so the doctor is aware that the treatment is not going to be rendered, so they can give an order to hold or order a replacement. On 10/2/24 at 9:28 a.m., an interview was conducted with licensed practical nurse #7 (LPN #7). LPN #7 stated that if medications are not in the Omnicell they are to notify the doctor. On 10/2/24 at 11 a.m., an interview was conducted with the nurse practitioner (NP). The NP stated that frequently nursing staff do not notify her when medications are not available, she will find out days later when she goes to do a follow-up. She stated that really needs to improve and communication is a big issue. On 10/2/24 at 11:45 a.m., an interview was conducted with registered nurse #6 (RN #6). RN #6 stated that she calls the pharmacy if medications are not on hand, and she expects her staff to do the same. When asked, if anyone notifies the provider, RN #6, yeah, you need to call the provider. The facility policy titled, Medication Orders, was reviewed. It did not address when medications are not available, how facility staff are to respond. On 10/1/24 and again on 10/2/24, during end of day meetings, the facility administrator, director of nursing and corporate staff was made aware of the above findings. No additional information was provided. 21875 3. Resident #76's medication calcitonin (Salmon) nasal spray was not available for administration. Resident #76 (R76) was admitted to the facility with diagnoses that included hip fracture, coronary artery disease, Alzheimer's, psychosis, mood disturbance, anxiety, atrial fibrillation, and hypertension. The minimum data set (MDS) dated [DATE] assessed R76 with severely impaired cognitive skills. R76's clinical record documented a physician's order dated 9/10/24 for calcitonin (salmon) nasal solution 200 units/spray with instructions for one spray each day for history of compression fractures. R76's medication administration record (MAR) documented the calcitonin spray was not administered on 9/27/24 and 9/28/24. Nursing notes documented the calcitonin spray was not available and was on order from the pharmacy. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/2/24 at 8:54 a.m., the licensed practical nurse unit manager (LPN #1) was interviewed about R76's unavailable calcitonin spray. LPN #1 stated the calcitonin spray was not in the back-up supply and was most likely not reordered timely from pharmacy. LPN #1 stated nurses were expected to enter a refill order when approximately five doses of a medication remained. LPN #1 stated some nurses order medications too early and others did not order quick enough to maintain a supply in the cart. LPN #1 stated she was not aware R76's calcitonin spray was not available. LPN #1 stated nurses were able to contact the pharmacy directly about needed medications. The facility's policy titled Medication and Treatment Orders (undated) documented, .Drugs and biologicals that are required to be refilled will be reordered from the issuing pharmacy in a timely manner prior to the last dosage being administered to ensure that refills are readily available . These findings were reviewed with the administrator, director of nursing and regional nurse consultants during a meeting on 10/2/24 at 6:20 p.m. with no further information presented prior to the end of the survey.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21875 Based on observation, staff interview and facility document review, the facility staff failed to properly store insulins on four out of five medication carts inspected. The findings include: Unopened insulins were stored at room temperature on 1st and 3rd floor medication carts. Insulin vials and/or insulin pens were stored on 1st, 2nd and 3rd floor medication carts without labeling of the date opened. An insulin pen on a 3rd floor medication cart was stored and available for use beyond the recommended 28 days after opening. On 10/2/24 at 9:23 a.m., accompanied by licensed practical nurse (LPN #2), a 1st floor medication cart was inspected. Stored in the cart at room temperature were two unopened 10 ml (milliliter) vials of Lispro insulin, an unopened vial of Humalog insulin and an unopened Fiasp flextouch insulin pen. Each of these insulins were labeled for current residents and had a pharmacy label stating refrigeration was required until opened. A Lantus solstar insulin pen for a current resident was also stored on the medication cart. This pen had been opened but no date recorded indicating when opened. The pharmacy label for the Lantus pen stated the insulin could be stored at room temperature for 28 days after opening. On 10/2/24 at 9:25 a.m., LPN #2 was shown and interviewed about the above insulins. LPN #2 stated she did not know why the unopened insulins were stored in the medication cart. LPN #2 stated the insulin vials and pens were supposed to be labeled with the date opened. On 10/2/24 at 9:34 a.m., the unit manager (LPN #1) was interviewed about the insulin storage on the 1st floor medication cart. LPN #1 stated the unopened insulins were supposed to remain in the medication refrigerator until opened. LPN #1 stated the opened insulins were supposed to be labeled with the date opened. On 10/2/24 at 9:40 a.m., accompanied by registered nurse (RN) #3, two 3rd floor medication carts were inspected. A Lyumjev KwikPen for a current resident was opened on 8/20/24. The label documented that this insulin should be discarded once opened and stored at room temperature beyond 28 days. There were two Levemir flexpens for a current resident that were opened with no label indicating the date opened. The Levemir pen labels documented this insulin should be discarded when opened and stored at room temperature beyond 42 days. On another 3rd floor medication cart was stored an unopened Trulicity pen. The pharmacy label for the Trulicity pen stated to refrigerate until opened. On 10/2/24 at 9:45 a.m., RN #3 was interviewed about the 3rd floor insulins listed above. RN #3 stated the Lyumjev KwikPen was beyond the 28-day storage limit and should have been discarded. RN #3 stated she did not know why the unopened insulins were stored on the medication carts and not in the refrigerator. RN #3 stated nurses were supposed to label insulins when opened to ensure proper storage times. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/2/24 at 10:03 a.m., accompanied by LPN #4, the 2nd floor medication carts were inspected. Stored on the cart for room [ROOM NUMBER] to 220 was a vial of Lantus insulin and a vial of Lispro insulin labeled for current residents. These vials had been opened but had no date opened indicated on the label. On 10/2/24 at 10:05 a.m., LPN #4 was interviewed about the unlabeled insulins. LPN #4 stated insulin vials and pens were supposed to be labeled with the date opened. The facility's policy titled Medication Storage (undated) documented, .The facility shall store all drugs and biologicals in a safe, secure, and orderly manner .The nursing staff shall be responsible for maintaining medication storage AND preparation areas in a clean, safe, and sanitary manner .The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed .Medications requiring refrigeration must be stored in a refrigerator located in the drug room at the nurses' station or other secured location. Medications must be stored separately from food and must be labeled accordingly . These findings were reviewed with the administrator, director of nursing and regional nurse consultants during a meeting on 10/2/24 at 6:20 p.m. with no further information presented prior to the end of the survey.

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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 0778 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Help the resident make transportation arrangements to and from radiology services. 49456 Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to assist one resident, Resident #121 (R121) out of a survey of 21 residents, with transportation arrangements to an appointment with radiology services. The findings included: The facility staff failed to assist R121 with transportation to a procedure he had been prepped for at the facility. On 12/9/24 at 2:44 p.m., an interview was conducted with facility's scheduler, OS5. OS5 said, there was some confusion about the appointments, but we didn't know about them. The appointment for September 28th we didn't have a time for the pre surgery, so they had to fax us a time, I do remember that. I remember that the transport driver called off and alternate transport was not available but cannot remember all the details and no note in his record about that appointment on 10/1/24. On 12/10/24 at 9:35 a.m., an interview conducted with OS5. OS5 looked up in R121 clinical record on her schedule and verified that R121 had an appointment on 10/1/24, and orders to be NPO (nothing by mouth) the night prior. OS5 was unable to find anything in her notes about why R121 did not go to the appointment. OS5 called to the radiology department at the hospital and had them on speaker phone for the surveyor to hear, the hospital employee confirmed that R121 didn't show up for his appointment on 10/1/24, and she had no notes about that appointment. On 12/10/24 at 9:40 a.m., an interview was conducted with the transport driver, OS8. OS8 said, I remember I was unable to take [R121 name redacted] to an appointment. When I cannot take them, we try to get another transport or family, but if unable we have to reschedule the appointment. On 12/10/24 at 9:50 a.m., an interview was conducted with the director of nursing (DON). The DON confirmed that R121 had an appointment on 10/1/24 according to his clinical record and that he was prepped for his appointment by being kept NPO the night before his procedure. The DON stated that she was not able to confirm that the appointment that he missed was rescheduled due to no documentation about the appointment was in his clinical record. The DON said, missed appointment you should notify provider, and responsible party, reschedule the appointment, notify provider and responsible party and document. Pretty simple, I think. Rearrange transport if ours is unavailable, we will use other transport. On 12/10/24 a review of facility documentation was reviewed. The facility document titled, Resident Rights, read in part, .the resident has the right to be treated with respect and dignity. The facility document titled, Resident Rights, read in part, .resident has the right to fully informed of, and participate in, his or her treatment. (continued on next page)

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F 0778 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/10/24 at approximately 11:30 a.m., an end of the day meeting was conducted with the administrator and corporate staff to discuss the above concerns. The regional nurse consultant stated she had called the vascular physician office and that R121 did not have an appointment there on 10/1/24. The surveyor let the regional nurse consultant the appointment was at radiology department, and she said she would investigate it some more. On 12/10/24 at 12:25 p.m., the nurse consultant gave the surveyor some copies of R121 physician notes. Both notes given to the surveyor were dated after R121's appointment date of 10/1/24, one note was dated 10/4/24, and one was dated 10/14/24. The custom information document of R121's visits to the hospital/physicians was just a summary of visits he had made to the hospital and physicians' offices during the year, but this document had no record of missed appointments, it was only a record of visits made by R121. No additional information was provided prior to exit conference.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. 41449 Based on observation, resident interview, staff interview, and clinical record review, the facility staff failed to arrange for routine dental services for one resident (resident #5-R5) in a survey sample of 29 residents. The findings included: On 9/30/24 at 2:57 p.m., R5 was visited in his room. The surveyor noted while talking to the resident that he appeared edentulous. When asked, R5 reported he had dentures, but they broke and said, I bit into something a while back and it put a hole in one of them [referring to dentures]. R5 went on to say that he had gone to a dentist, had dentures made and was supposed to just pick them up but didn't go. He said he guesses he would have to get new ones made again since it has been so long. R5 added, I would like someone to come here to look at them versus me having to go all the way there. On 9/30/24-10/1/24, a clinical record review was conducted. This review revealed a progress note from the nurse practitioner dated 5/23/24, that read in part, . Chief Complaint/Nature of Presenting Problem: Broken dentures . seen today for complaints of improperly fitting dentures. He has not been wearing his dentures because he does not like the way they fit and states they are uncomfortable and rub on his gums . Plan: Refer to Affordable Dentures to adjust fitting of current dentures. Continue all medications as prescribed. Monitor for acute changes. The surveyor was unable to find any additional information or documentation that R5 had ever gone for a dental consult. On 10/2/24 at 11 a.m., an interview was conducted with the nurse practitioner (NP) who was also the ordering provider of the dental consult noted in the above progress note dated 5/23/24. When asked about R5's dentures, the NP said she spoke with the unit manager a couple of times. She said, it's been so long ago they will have to remake them. I'm not sure what the issue was. On 10/2/24 at 11:45 a.m., an interview was conducted with registered nurse #6 (RN #6), the unit manager. When asked about R5's dentures, RN #6 reported that he had gotten brand new dentures last year and paid $1,200-$1,300 for them himself. She said he was never satisfied with them and kept using his old ones. RN #6 said, one of those got broke and we got another referral, he needs to go back for follow-up, last time there was an issue, and he didn't get to the appointment, he needs to go back. On 10/2/24 in the afternoon, RN #6 approached the surveyor to follow up on the previous conversation regarding R5's dentures. RN #6 reported that R5 was last seen at the dentist on 6/24/24. He had an appointment that was missed in July. When asked why the appointment in July was missed, RN #6 said, they called and talked to someone on another unit and that didn't get communicated to us, so he missed the appointment. When asked what was done during the June visit, RN #6 stated she wasn't sure because there was no documentation in the record, and they called today to request the notes to be sent and made an appointment for R5 which is scheduled for 10/9/24. (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/2/24 at 2:30 p.m., R5 was visited in his room again. R5 reported that during the June visit they took impressions, and he was supposed to pick up the dentures in July. The resident said, these people here don't know what the hell they are doing half the time. It drives me crazy. On 10/2/24, during the end of day meeting held with the facility administrator, director of nursing and corporate staff, they were made aware of the above findings. No additional information was provided.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 49456 Based on observations, resident interviews, staff interviews, and facility documentation review, the facility staff failed to follow the resident food preference for two residents, Resident #103 (R103) and Resident #106 (R106), in a survey sample of 21 residents. The findings included: 1. The facility staff failed to follow the meal ticket and R103's food preference. On 12/9/24 at 12:10 p.m., an observation of the lunchtime meal was conducted. R103's lunch tray was served, according to the meal ticket on his tray, he was supposed to receive salad and soup, neither of those items were present. On 12/9/24 at 12:10 p.m., an interview was conducted with R103 about his lunch meal and meal ticket. R103 stated he was supposed to get soup and salad with two meals every day. R103 said, that generally I will get one or the other and sometimes I don't get either one. On 12/9/24 at 12:15 p.m., an interview was conducted with licensed practical nurse, LPN#5 (LPN5). LPN5 stated that R103 is supposed to have salad and soup on his lunch tray according to the meal ticket. LPN5 stated she would check with the kitchen about the meal ticket and get the items for the resident. 2. The facility staff failed to follow the meal ticket with R106's beverages of choice on the lunchtime meal tray. On 12/9/24 at 12:15 p.m., an observation of the lunchtime meal was conducted. R106's lunch tray was served, and on his ticket, he was supposed to receive hot coffee, fruit punch, and milk. None of those items were present on his lunch tray. On 12/9/24 at 12:20 p.m., an interview was conducted with R106 about his lunch meal and meal ticket. R106 said, I am supposed to get hot coffee because cold coffee isn't good, and I like to get my milk and fruit punch too. Most of the time I don't have anything to drink on my meal trays. On 12/9/24 at 12:25 p.m., an interview was conducted with the certified nursing assistant, CNA#3 (CNA3). CNA3 stated that R106's meal ticket has hot coffee, fruit punch, and milk and these items were not on the lunch tray. CNA3 stated she would go to the kitchen and try to get the items for the resident. On 12/10/24 a review of facility documentation was conducted. The policy titled, Specialized Diets, read in part, .therapeutic diets are prescribed by the attending physician to support the resident's treatment and plan of care and in accordance with his or her goals and preferences. On 12/10/24 at approximately 11:30 a.m., an end of the day meeting was conducted with the administrator and corporate staff to discuss the above concerns. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No additional information was provided prior to exit conference.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 28106 Based on observation, staff interview, and facility documentation review, the facility staff failed to store food in accordance with professional standards for food safety in the main kitchen. The findings included: Multiple open food products were not labeled with an open date and/or use by date and was accessible for distribution. On 9/30/24 at 10:45 a.m. an initial tour of the main kitchen was conducted with the dietary manager (other staff, OS #7). Prior to observation of dry goods area and refrigerators, OS #7 was asked what is the expectation of opened items (dry goods and refrigerated items) in regard to labeling. OS #7 verbalized all opened items should have an open date and used by date when the product is opened. The kitchen tour was then conducted with OS #7. The dry storage room yielded the following open products without opened or use by dates: Bag vanilla wafers, two bags of cake mix, bag of pasta noodles, and bag of corn bread mix. The walk in refrigerator had an opened container of olives with a date of 7/16/24 but no use by date, a partial ham loaf (for sandwiches) with an open date of 9/26/24 but no use by date, and a bag of opened parmesan cheese without an opened date or use by date. OS #7 again verbalized all opened food product are supposed to have an open date on them and refrigerated items should be labeled with a used by date and should be thrown out after three days. On 10/1/24 at 4:40 p.m. the administrator and director of nursing (DON) were notified of the above finding. A facility policy titled Receiving and Storage of Food was obtained and read in part, 8. All foods stored in the refrigerator or freezer will be covered, labeled and dated (use by date). No other information was provided prior to exit conference on 10/2/24.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49456 Based on observation, resident interviews, staff interviews, clinical record review and facility documentation review, the staff failed to maintain a complete and accurate clinical record for 3 residents (Resident #13, R13, Resident #78, R78, and Resident #53, R53) in a survey sample of 29 residents. The findings included: 1. The facility staff failed to accurately document R13's activity of daily living (ADL) care regarding showers. On 9/30/24 at 10:00 a.m. a tour of unit one was conducted. R13 was observed in her room and sitting in her wheelchair. Her hair was oily in appearance and lower extremities had some dry skin noted. On 9/30/24 at 10:45 a.m. an interview was conducted with R13. R13 stated, that the staff has given me one bath since I have been here and the rest of the time, I bathe myself the best I can. I have not had a shower since I have been here and staff is short especially on weekends and my bed has been like it is right now since Friday, unmade. On 10/2/24 at 10:30 a.m. a clinical record review was conducted. The ADL documentation was reviewed, and it showed that a shower had been given on 9/5/24, 9/12 and 9/19/24. On 9/26/24 there was no documentation and on 9/30/24 NA was documented. The regional nurse consultant stated, NA means it didn't happen and the blank area's we cannot say it did or didn't happen. On 10/2/24 at 11:25 a.m. an interview was conducted with CNA#4. CNA#4 stated, I have never given this resident [R13] a shower because she is a second shift shower. The surveyor showed CNA#4 the ADL sheet with the documentation of three showers, that was documented by CNA#4. CNA#4 stated, that is wrong, I did it wrong because I have never showered her because she is a second shift shower. CNA#4 was very adamant about the fact she had never given R13 a shower since she had been at the facility. For 29 days R13 has not had a showered, since her admission. On 10/2/24, during an end of day meeting the facility Administrator, Director of Nursing and Corporate staff were made aware of the above concern. No further information was provided. 41449 2. For resident #78- R78, who was being seen by a dermatologist for skin lesions, the facility staff failed to maintain a complete clinical record to include the dermatology records. On 10/1/24 at 8:34 a.m., R78 was visited in his room. R78 reported he was being seen by a dermatologist for various skin issues. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/1/24, a clinical record review was conducted which included but was not limited to the progress notes and miscellaneous tab. There was no evidence of any dermatology records. There was a progress note entry dated 8/3/24, by the nurse practitioner that read in part, . [AGE] year-old gentleman with multiple medical problems seen today for follow up on a scalp abrasion. He has been evaluated by facility wound care team and treatments are in place. See wound care notes for details. He is not responding well to current treatments, and he does have pmh [past medical history] skin cancer of his scalp however details are not available for review. He was seen by Dermatology with new orders in place . There was a note from the wound care consultant that visited the resident in the facility on 9/24/24. Their progress note read in part, .8/13/24: Patient is being worked up by dermatology - awaiting results of biopsies. He is awake and alert with mild pain. Wounds are unchanged. No new complaints .9/17/24: Wounds remain unchanged from previous. Was informed following with dermatology and was to have removal of these lesions soon however unable to find dermatology visit notes at this time. Facility to check into situation. 9/24/24: Patient has no new complaints at this time. Unit manager obtained documentation from dermatology which was reviewed after visit. Confirmed basal cell carcinoma to left arm and scalp. Will update these wound types to lesions . On 10/1/24, in the afternoon, an interview was conducted with the medical records employee. The medical records employee indicated that all records had been scanned into the clinical chart for R78 and she had no documents in her office with regards to dermatology notes. On 10/1/24, during an end of day meeting, the facility administrator, director of nursing and corporate staff was made aware of the above findings. On 10/2/24, the survey team was provided with notes from the dermatologist for R78. The facility staff confirmed they were not part of the clinical record and should have been. No further information was provided. 28106 3. The facility failed to document a fall for resident #53 (R53). The Findings Include: Diagnoses for R53 included; Dementia, Alzheimer's disease, and fracture of right clavicle. The most current MDS (minimum data set) was an significant change assessment with an ARD (assessment reference date) of 7/19/24. R53 was assessed with a cognitive score of 3 indicating severely impaired cognitively. R53 self ambulates without physical assistance or use of devices. On 10/1/24 R53's clinical record was reviewed. A progress note dated 7/6/24 read: C.n.a. [certified nursing assistant] reported that pt. [patient] had a fall on 7/4/24 and hit her head and was c/o [complaining of] pain to her rt. [right] leg this afternoon. C.n.a. stated agency nurse should have reported the fall. Nothing was documented in chart of the fall. Notified NP [nurse practitioner] will be up to assess pt. family notified. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nurse practitioners documentation assessment note dated 7/6/24 indicated that R53 was not able to elaborate on the details of the fall and was not sure if R53 had hit her head, however did appear to be having some right hip discomfort with movement, had no obvious visible injuries, vital signs and neuro checks were stable and an x-ray pf right hip was ordered. The x-ray did not indicate fracture. On 10/1/24 at 4:40 p.m. the above information was presented to the administrator and director of nursing (DON). The DON verbalized an investigation was completed regarding the fracture and would look into a possible fall on 7/4/24. On 10/02/24 at 9:52 a.m. the DON verbalized that R53 had fallen on 7/1/24 and was documented and did not evidence a fall had occurred on 7/4/24 based on incident reports and communication logs. It was explained to the DON that according to nurse progress notes and nurse practitioner progress notes R53 had a fall on or around 7/4/24. The DON verbalized not being aware of this fall and if a fall occurred it should have been documented. On 10/02/24 at 11:25 a.m. the nurse practitioner (other staff, OS #1) was interviewed. OS #1 verbalized being notified that R53 a had a fall that occurred a day or two ago and R53 was not at her baseline. On 10/02/24 at 4:33 p.m. certified nursing assistant (CNA #5, person that reported the fall to the nurse) was interviewed. CNA #5 said that R53 had fallen on 7/4/24 near to the end of the daylight shift and remembers because it was a holiday. CNA #5 said that R53's assigned CNA had called out to her (CNA #5) because R53 had fallen in her room and needed help. CNA #5 verbalized that an agency nurse was assigned to R53 that day and when R53 fell the agency nurse, R53's assigned CNA, and herself (CNA #5) went back to help R53 get into bed. CNA #5 said that she had told the agency nurse that the fall needs to be reported and assessed. Two days later R53 was acting a little differently and seemed to be favoring her right leg, so when she reported it to the nurse, the nurse reviewed the medical chart and found that the fall that occurred on 7/4/24 had not been reported. The agency nurse or the nurse notifying the nurse practitioner was unable to be contacted. A facility policy titled Assessing Falls and Their Causes was presented and read in part . Documentation- When a resident falls, the following information should be recorded in the residents medical record: Condition of which the resident was found. Assessment data,including vital signs and any obvious injuries. Interventions, first aid, or treatment administered. Completion of falls risk assessment per facility protocol. The signature and title of the person recording the data. On 10/02/24 at 6:23 p.m. the above finding was presented to the administrator, DON and nurse consultant. No other information was presented prior to exit conference on 10/2/24.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41449 Based on resident interview, staff interviews, clinical record review, and facility documentation review, the facility staff failed to follow infection control practices for one resident (Resident #106- R106). The facility also failed to develop and implement an infection control program and failed to respond to a COVID outbreak in accordance with the guidance from the Centers for Disease Prevention and Control (CDC), which involved two staff (registered nurse #6 (RN #6) and certified nursing assistant #2 (CNA #2) but had the potential to affect numerous residents on 2 of 2 nursing units. The findings included: 1. The facility staff failed to respond to and implement quarantine and testing measures in accordance with CDC (The Centers for Disease Control and Prevention) recommendations to manage COVID-19 during an outbreak. On 10/2/24 at 9:32 a.m., an interview was conducted with registered nurse #5, who is the facility's infection preventionist (IP). When asked about their most recent COVID case, the IP indicated that it was on 9/3/24, and recalls it because it was her first day of work. When asked for a line listing, the IP indicated that she didn't have one for staff because it was just the one staff member. The IP identified that it had been certified nursing assistant #2 (CNA #2), who had come into work, wasn't feeling well, and tested positive. The IP stated that they immediately sent CNA #2 home, and that she wasn't permitted to return to work until she completed a quarantine period. When asked if any contact tracing or testing was conducted, the IP deferred answering that to the director of nursing (DON). On 10/02/24 at 11:29 a.m., an interview was conducted with the DON. The DON reported that CNA #2 .had nasal congestion and didn't feel good. The unit manager tested the employee and sent her home. The DON said that CNA #2 was out of work for a week or 10 days. When asked if she had been working in the days prior to testing positive, the DON stated that CNA#2 had worked prior to testing positive. When asked if this was communicated to the local health district for guidance, the DON said, I should have included her in the emails, but I didn't think of it. She should be notified. When asked what the importance is of involving the health department, the DON stated, She can give guidance on next steps, but we also have our policy we go by. When asked if any additional COVID testing was conducted, the DON said, No, she returned within the days of our policy. When asked what constituted a COVID outbreak, the DON stated that she was unsure. When asked, when do you do COIVD testing? The DON stated, We don't do routine testing, symptom-based testing only. On 10/2/24 at 11:45 a.m., during an interview with the 2nd floor unit manager, registered nurse #6 (RN #6), RN#6 mentioned that she had recently had COVID and was out sick. When asked if the facility was aware of this, RN #6 said, Oh yeah, I sent them the test! When asked who she had sent the test results to, RN#6 stated the DON. On 10/2/24 at 11:55 a.m., the facility's payroll department was asked to provide the timecard history for CNA #2 and RN #6. Review of the timecards revealed that CNA #2 was out of work 9/11/24-9/16/24. RN #6 was out of work 9/4/24-9/8/24. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/2/24 at approximately 3:50 p.m., a follow-up interview was conducted with the DON and IP. When asked about RN #6 testing positive for COVID and being out of work, the DON stated that she had forgotten to mention her. The IP said that she was not aware and had no knowledge of RN#6 being COVID positive. During this meeting, the DON was made aware of the above concerns with regards to how they responded to a COVID outbreak, failed to conduct any contact tracing or broad-based testing, failed to notify the local health district, failed to identify they were in a COVID outbreak, and failed to implement the use of PPE (personal protective equipment). On 10/2/24 at 4 p.m., the facility administrator and corporate staff were made aware of the above findings. The regional nurse consultant confirmed that the facility does follow CDC guidance with regards to responding to COVID. The facility policy titled, COVID Infection Control and Management with an updated date of August 2024, was reviewed. Excerpts from this policy read, . Asymptomatic patients with close contact with someone with SARS-CoV-2 infection should have a series of three viral tests for SARS-CoV-2 infection. Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative again 48 hours after the second negative test . According to the CDC guidance document titled, Infection Control Guidance: SARS-CoV-2 dated 6/24/24. which read in part, .This guidance provides a framework for facilities to implement select infection prevention and control practices (e.g., universal source control) based on their individual circumstances (e.g., levels of respiratory virus transmission in the community). This guidance is applicable to all U.S. settings where healthcare is delivered (including nursing homes and home health) . Section 3. Setting-specific considerations . Nursing homes read in part, .Responding to a newly identified SARS-CoV-2-infected HCP or resident . A single new case of SARS-CoV-2 infection in any HCP or resident should be evaluated to determine if others in the facility could have been exposed. The approach to an outbreak investigation could involve either contact tracing or a broad-based approach; however, a broad-based (e.g., unit, floor, or other specific area(s) of the facility) approach is preferred if all potential contacts cannot be identified or managed with contact tracing or if contact tracing fails to halt transmission. Perform testing for all residents and HCP identified as close contacts or on the affected unit(s) if using a broad-based approach, regardless of vaccination status. Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5 Accessed online at https://www.cdc.gov/covid/hcp/infection-control/index.html No additional information was provided. 2. The facility staff failed to maintain an infection surveillance/monitoring program. On 10/2/24 at 9:32 a.m., an interview was conducted with registered nurse #5, who is the facility's infection preventionist (IP). When asked for evidence of an infection surveillance and monitoring program, the IP provided the surveyor with a 3-ring binder. The IP reported that she had only been employed at this facility in the IP role since the first week of September and would not be able to answer any questions with regards to prior months. There was no evidence of any infection surveillance or infection surveillance for residents or staff for May-August 2024. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	For the month of September there was evidence of infection surveillance and an infection line listing for residents. A review was performed of the facility policy titled, Infection Control Program, with a review date of 10/24/22. The policy read in part, . g. Development of policies and procedures for the surveillance and monitoring of infection control practices; and monitoring of infectious disease trends . On 10/2/24, at an end of day meeting, the facility administrator, director of nursing, and corporate staff were made aware of the above findings. No additional information was provided. 21875 2. Facility staff failed to don required PPE (personal protective equipment) prior to direct contact with Resident #106. According to the clinical record, Resident #106 (R106) was admitted to the facility with diagnoses that included osteomyelitis, schizophrenia, diabetes, chronic kidney disease, peripheral vascular disease, protein-calorie malnutrition, adult failure-to-thrive, above-knee amputation, prostate cancer, atrial fibrillation and anemia. The minimum data set (MDS) dated [DATE] assessed R106 with short and long-term memory problems and severely impaired cognitive skills. R106's clinical record documented a physician's order dated 9/19/24 for contact isolation due to a wound infected with Morganella morganii. On 9/30/24 at 12:59 p.m., certified nurse's aide (CNA) #1 was observed distributing meal trays on R106's unit. CNA #1 had on a surgical mask positioned on her chin. CNA #1 was observed entering R106's room with no gown or gloves and assisting the resident to move in bed, touching the resident, the bed control, and personal items on the over-bed table. It was then observed that CNA #1 assisted R106 with wiping his mouth/face and hands and then provided tray setup for the lunch. CNA#1 applied hand sanitizer as she exited the room. The door to R106's room was labeled with a contact precautions poster stating that gowns and gloves were required prior to entering the room and that a mask was required in performing tasks involving spattering. On 9/30/24 at 1:03 p.m., CNA #1 was interviewed about providing care to R106 without PPE. CNA #1 stated R106 was on contact precautions and that she was supposed to put on gown and gloves prior to moving the resident up in bed. CNA #1 stated, That's my mistake. I should have put on gown and gloves. CNA #1 states she was aware of the requirements for PPE but that she just did not put on PPE in this instance. On 10/1/24 at 2:41 p.m., the licensed practical nurse (LPN) #1 was interviewed about CNA #1 providing care to R106 without PPE. LPN #1 stated R106 was on contact precautions due to a wound infection. LPN #1 stated CNA #1 should have put on a gown and gloves prior to entering the room and discarded the PPE prior to exiting the room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's policy titled Isolation - Categories of Transmission-Based Precautions documented, . Contact precautions are implemented for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment . Contact precautions are also used in situations when a resident is experiencing wound drainage . Staff and visitors wear gloves (clean, non-sterile) when entering room . Gloves are removed and hand hygiene performed before leaving the room . Staff avoid touching potentially contaminated environmental surfaces or items in the resident's room after gloves are removed .S taff and visitors wear a disposable gown upon entering the room and remove before leaving the room and avoid touching potentially contaminated surfaces with clothing after gown is removed . This finding was reviewed with the administrator, director of nursing, and regional nurse consultants during a meeting on 10/2/24 at 6:20 p.m., with no further information presented prior to the end of the survey.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. 41449 Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to provide credible evidence of an antibiotic stewardship program, having the potential to affect residents on 3 of 3 units. The findings included: On 10/1/24 at 8:32 a.m., during an interview with resident #78 (R78), he stated that he had been on an antibiotic but didn't know why. On 10/1/24, a clinical record review was conducted of R78's medical chart. This review revealed that R78 did have an order dated 8/12/24 for Ciprofloxacin HCl Oral Tablet 500 MG that read, give 1 tablet by mouth two times a day for uti [urinary tract infection] for 7 Days. According to the medication administration record, R78 received four doses of the antibiotic before the order was discontinued on 8/14/24. According to a urinalysis that was collected on 8/13/24, the results were negative for a urinary tract infection. According to a progress note from the nurse practitioner dated 8/14/24, regarding R78's antibiotic use, it read in part, . being seen today for follow-up of abnormal penile discharge that occurred. Patient reports it has not occurred since. Patient was empirically placed on antibiotics. U/A results are all normal and will d/c [discontinue] [referring to the antibiotic]. On 10/2/24 at 9:32 a.m., an interview was conducted with registered nurse #5, who is the facility's infection preventionist (IP). The IP reported she had only been employed at this facility in the IP role since the first week of September. When asked about the antibiotic stewardship program, she stated, we review our antibiotics daily- I track what is going on. She explained, we follow McGreer criteria, we fill out McGreer form to ensure they meet the criteria for treatment with an antibiotic. The surveyor requested to see the McGreer criteria form for R78's treatment with an antibiotic from August. The IP looked in the book and it was not present. The Infection Preventionist went on to explain to the surveyor that the purpose of antibiotic stewardship is, to make sure we aren't over medicating, and we are treating with appropriate antibiotics. Getting everyone on the same page, the more antibiotics we use inappropriately the more MDRO (multidrug-resistant organisms) we will have, and we don't clear infections. I come in, in the morning and run antibiotics from the previous day, fill out form to ensure they meet McGreer criteria, if we have labs out waiting for results, I review again, and do an antibiotic timeout on day 3 or so, to make sure everything is on track. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the above interview, the IP was asked to access R78's chart and the order and indication for the cipro ordered 8/12/24. The IP did access R78's chart and noted cipro was ordered 8/12 and stopped on 8/14. She noted and said, he does have a history and has chronic kidney disease, kidney failure, and had discharge present and dysuria on 8/12. The IP accessed urinalysis and said, that looks good, and said based on the urine result she had concern. She read the progress notes and noted that the resident reported a thick discharge from his penis. She went on to state, I would have wanted a follow up, seems like it was a one-time discharge. I would have done a bigger investigation personally, ask if staff saw the discharge, or is this just a resident reporting, was he worried because had had painful urination and wanted to get ahead of it. The IP went on to comment, this is how we get into MDRO's, On 10/2/24 at 11 a.m., an interview was conducted with one of the facility's nurse practitioners. While the NP the interview was being conducted with was not the ordering provider of R78's antibiotic, that provider was not present and available. The NP was informed of the above findings for R78, where he reported discharge and dysuria, was started on an antibiotic and a urinalysis was obtained. The NP said, I personally would have waited for the culture and sensitivity [before starting an antibiotic]. On 10/2/24, a review was conducted of the facility's infection control program with the Infection Preventionist. This review included May through September 2024. For the month of May there were some forms to indicate if McGreer criteria was met. The surveyor noted multiple instances where the form indicated that criteria was not met. The IP accessed the clinical record for one sampled resident (R15) who the form indicated did not meet criteria. Upon the IP accessing the clinical record, she noted the urine culture showed E-Coli, and said, she did meet criteria and confirmed the forms were not accurate. In June and August 2024, there was a printed form from the pharmacy dated 7/18/24, that was titled, Antibiotics Dispensed. There was no evidence that the indication for antibiotic use was reviewed, a meeting held to review the data, etc. The infection preventionist had no information with regards to antibiotics prescribed in July. September's antibiotic stewardship program was intact with no concerns noted. The IP stated that prior to her coming to the facility, the director of nursing was filling in the role as IP for the facility. On 10/2/24 at 11:29 a.m., an interview was conducted with the director of nursing. When asked about the antibiotic stewardship program prior to the current IP, she stated, we discussed new antibiotics in our clinical meeting in the morning and the nurse practitioners assessed the patients and scheduled the antibiotic or not. A copy of the documentation reviewed for antibiotic stewardship was requested. On 10/2/24, after a third request, at approximately 7 p.m., copies of information for June, August and September were provided. The surveyor was also provided a listing of antibiotics prescribed for July and was told it was in the director of nursing's office. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy titled; Antibiotic Stewardship Program was reviewed. The policy read in part, .1. The facility will establish and maintain an interdisciplinary antibiotic stewardship program that will at a minimum include participation by the medical director, prescribing physicians/non-physician practitioners, consulting pharmacist, administrator, nursing leadership, and infection control preventionist. 2. The antibiotic stewardship team will meet monthly to review antimicrobial regimens for appropriate: a. drug, b. indication for use, b. opportunities for elimination of lines or devices . 3. The antibiotic stewardship program will review all routes of antibiotics . 4. A standard of criteria for defining various infections, [i.e. McGreer's Criteria] will be adopted and utilized for classifying infections and/or related symptoms .5. When symptoms of infection are identified, the clinical team will complete an evaluation of the resident and communicate findings to the resident's physician for orders related to infections that require diagnostic testing . 6. The initial tracking/surveillance tool will be initiated by the infection control preventionist or designated licensed nurse . 7. Infection and antibiotic therapy usage will be maintained for each unit/neighborhood of the facility monthly . 8. The clinical record will be reviewed to validate the presence of absence signs and symptoms of infection, implementation of orders for diagnostic testing or treatment, resident response to treatment, and related diagnostic reports . On 10/2/24, during an end of day meeting the facility administrator, director of nursing and corporate staff was made aware of the above findings. No additional information was provided.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. 41449 Based on resident interview, staff interview, clinical record review and facility documentation review, the facility staff failed to provide education and offer pneumonia immunizations, to 4 of 5 residents (resident #2-R2, Resident #24-R24, Resident #13-R13, and resident #70-R70) sampled for immunizations. The findings included: On 9/30/24, during the initial tour, R2 verbalized to the surveyor that she had been asking daily for administration of vaccines but had yet to be given any. On 10/1/24, five residents, which included R2, were reviewed for compliance with immunization protocols as part of the infection control task. During this review, the clinical record of each resident was reviewed. For R2, R24, R13 and R70, the record documented no evidence the residents had been educated nor offered the pneumonia vaccine, which all of them were eligible for. On 10/02/24 at 9:32 a.m., an interview was conducted with the facility's infection preventionist (IP). During the interview, the IP reviewed and confirmed the above findings with regards to the lack of documentation within the clinical record with regards to pneumonia immunizations for R2, R24, R13 and R70 being discussed and offered. The IP, she was asked to explain the process for immunizations. The IP stated, We are in the process of starting our flu clinic. The unit managers reach out to families to get consent. The form has what immunizations they want, the unit manager fills form out, puts a note in computer and if they refuse, they update immunization tab to indicate the refusal. If they want an immunization, they give me the form and I administer the vaccine and put in an order to monitor for 3 days post vaccination. The unit manager for the first floor was present in the office during the above review and interview with the IP. The unit manager responded with regards to R2, I have not asked her about immunizations, all she has is previous COVID vaccines. I'm going to say she is probably going to want a booster. The unit manager went on to say, normally within the first couple of days I go ask them what they want. with us having a new IP person and getting ready to do a flu clinic I was waiting to get everyone at the same time. For R24, the unit manager said, actually I was getting ready to do that yesterday [interview resident and provide education regarding immunizations] so it is on my to do list today. The unit manager added, Immunizations is what I really needed to do today. For R13, the unit manager said, I just asked her yesterday, I got her stuff signed yesterday, she didn't want anything, if I remember correctly. No, I was working on something else for her yesterday. I have a whole stack of consents, but I can't find them anywhere. On 10/2/24 at approximately 10 a.m., the IP and surveyor went to talk with R13. R13 reported, I told them I wanted to get them. I told the nurse I want the vaccines. The IP told the resident she would take care of getting the resident the immunizations. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/2/24 at 11:29 a.m., an interview was conducted with the director of nursing (DON). The DON explained that immunizations should be discussed on admission and start with admission nurse and then the unit manager and IP. It should go through 3 people. There is a consent, usually the unit manager has that. When asked about the timing of vaccines being discussed and offered, the DON said, I would think a week would be sufficient to call a primary doctor and talk to a family. On the afternoon of 10/2/24, the first floor unit manager provided the surveyor with a vaccine consent form for R24 that was dated 9/2/24, and indicated she wanted the flu and pneumonia vaccines. A review of the facility provided policy titled, Vaccination of Residents was conducted. The policy read in part, 1. Prior to receiving vaccinations, the resident or legal representative will be provided information and education regarding the benefits and potential side effects of the vaccinations . 2. Provision of such education shall be documented in the resident's medical record. 3. All new residents shall be assessed for current vaccination status upon admission . The facility's policy titled Pneumococcal Vaccine read in part, 1. Prior to or upon admission, residents will be assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, will be offered the vaccine series within thirty (30) days of admission to the facility unless medically contraindicated or the resident has already been vaccinated On 10/2/24, during an end of day meeting, the facility administrator, director of nursing and corporate staff was made aware of the above findings. No additional information was provided.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41449 Based on resident interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to provide education and offer COVID immunizations, to 3 of 5 residents (Resident #2-R2, Resident #24-R24, and Resident #13-R13) sampled for immunizations. The findings included: On 9/30/24, during the initial tour, R2 verbalized to the surveyor that she had signed the consent form and had been asking daily for administration of the COVID booster vaccine, but had yet to be given any. On 10/1/24, five residents, which included R2, were reviewed for compliance with immunization protocols as part of the infection control task. During this review, the clinical record of each resident was reviewed. For R2, R24 and R13, documentation revealed that all the residents were eligible for the COVID spike vac, and there was no evidence the residents had been educated nor offered the vaccine. On 10/02/24 at 9:32 a.m., an interview was conducted with the facility's infection preventionist (IP). During the interview, the IP reviewed and confirmed the above findings with regards to the lack of clinical documentation related to COVID immunizations for R2, R24, and R13 being discussed and offered. When asked to explain the process for immunizations, the IP stated, The unit managers reach out to families to get consent. The form has what immunizations they want, the unit manager fills the form out, puts a note in the computer, and if they refuse, they update immunization tab to indicate the refusal. If they want an immunization, they give me the form, and I administer the vaccine and put in an order to monitor for 3 days post vaccination. The unit manager for the first floor was present in the office during the above chart review and interview with the IP. The unit manager responded with regards to R2, I have not asked [R2] about immunizations, all [R2] has is previous COVID vaccines. I'm going to say [R2] is probably going to want a booster. The unit manager went on to say, Normally within the first couple of days, I go ask them what they want. With us having a new IP person and getting ready to do a flu clinic, I was waiting to get everyone at the same time. For R24, the unit manager said, Actually I was getting ready to do that yesterday [interview resident and provide education regarding immunizations]. So it is on my to do list today. The unit manager added, Immunizations is what I really needed to do today. For R13, the unit manager said, I just asked [R13] yesterday, I got [R13's] stuff signed yesterday, [R13] didn't want anything, if I remember correctly. No, I was working on something else for [R13] yesterday. I have a whole stack of consents, but I can't find them anywhere. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/2/24 at approximately 10 a.m., the IP and surveyor went to talk with R13. R13 reported, I told them I wanted to get them. I signed the paper and told the nurse I want the vaccine. The IP told R13 that she would take care of getting the resident the immunizations. On 10/2/24 at 11:29 a.m., an interview was conducted with the director of nursing (DON). The DON explained that immunizations should be discussed on admission and start with admission nurse and then the unit manager and IP. It should go through 3 people. There is a consent, usually the unit manager has that. When asked about the timing of vaccines being discussed and offered, the DON said, I would think a week would be sufficient to call a primary doctor and talk to a family. On the afternoon of 10/2/24, the first floor unit manager provided the surveyor with a vaccine consent form for R24 that was dated 9/2/24, and indicated she wanted the COVID vaccine. A review of the facility provided policy titled, Vaccination of Residents was conducted. The policy read in part, 1. Prior to receiving vaccinations, the resident or legal representative will be provided information and education regarding the benefits and potential side effects of the vaccinations . 2. Provision of such education shall be documented in the resident's medical record. 3. All new residents shall be assessed for current vaccination status upon admission . The facility's policy titled COVID-19 Vaccination for Residents read in part, 1. Prior to admission, the facility will validate COVID-19 vaccination status. 2. Resident/resident representatives will be educated on: a) risks/benefits ., b) current CDC guidelines for vaccination of residents for COVID-19 and c) symptoms 3. Residents will be encouraged to accept COVID-19 vaccinations in accordance with CDC guidance . The FDA (Food and Drug Administration) gives information about the 2023-2024 spike vaccine on their website, accessed at: https://www.fda.gov/vaccines-blood-biologics/coronavirus-covid-19-cber-regulated-biologics/novavax-covid-19-vaccine-adjuvanted. The guidance read, On October 3, 2023, the Food and Drug Administration amended the emergency use authorization (EUA) of Novavax COVID-19 Vaccine, Adjuvanted to include the 2023-2024 formula. The Novavax COVID-19 Vaccine, Adjuvanted, a monovalent vaccine, has been updated to include the spike protein from the SARS-CoV-2 Omicron variant lineage XBB.1.5 (2023-2024 formula). The Novavax COVID-19 Vaccine, Adjuvanted (Original monovalent) is no longer authorized for use in the United States. Novavax COVID-19 Vaccine, Adjuvanted (2023-2024 Formula) is authorized for use in individuals [AGE] years of age and older as follows: Individuals previously vaccinated with any COVID-19 vaccine: one dose of Novavax COVID-19 Vaccine, Adjuvanted (2023-2024 Formula) is administered at least 2 months after receipt of the last previous dose of an original monovalent (Original) or bivalent (Original and Omicron BA.4/BA.5) COVID-19 vaccine. Individuals not previously vaccinated with any COVID-19 vaccine: two doses of Novavax COVID-19 Vaccine, Adjuvanted (2023-2024 Formula) are administered three weeks apart . On 10/2/24, during an end of day meeting, the facility administrator, director of nursing, and corporate staff were made aware of the above findings.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. 41449 Based on observation, resident interview, staff interview and facility documentation review, the facility staff failed to maintain resident beds in operating condition for one resident (Resident #78-R78) in a survey sample of 29 residents. The findings included: For R78, whose bed was not operational for three days, the facility staff failed to replace the bed to provide the resident with an operational bed, which left the resident to lay in an upright position for several days. On 9/30/24 at 12:14 p.m., R78 was visited in his room and interviewed. R78 was lying in bed with the head of the bed elevated. R78 reported that his bed had been in that position since Friday, and he was uncomfortable. R78 asked if the surveyor could help with this problem. On 9/30/24 in the afternoon, certified nursing assistant #9 confirmed that R78's bed was not working throughout the entire weekend, and they had a problem with several beds. On 9/30/24 at 4:20 p.m., an interview was conducted with registered nurse #6 (RN#6), who was the unit manager. RN#6 was asked about R78's bed. RN#6 said, I just had that switched out, maintenance checked it this morning, after he looked at it, he didn't tell me what conclusion he came to, I realized later that the bed was in the same state. When asked if there was a reason for the delay in the bed being switched out and the resident being left in that position all weekend, RN #6 said, I wish I could tell you why nobody thought to switch it out. On 10/1/24, interviews were conducted with certified nursing assistant #8(CNA #8). Both confirmed that when the power went out on Friday, they had multiple beds that would not work. CNA #8 said, when the power went out the newer beds wouldn't work anymore. On 10/1/24 at 4:34 pm, during an end of day meeting held with the facility administrator, director of nursing and corporate staff, they were made aware of the above findings. On 10/2/24 at 8:35 a.m., an interview was conducted with the maintenance director. When asked about R78's bed not working and being left inoperable all weekend, the maintenance director confirmed that they are on call on the weekends. The maintenance director said he was out of town on vacation, but his assistant did come in and repair one bed on Saturday. Regarding the beds, the maintenance director said, we have old beds here, I'm not surprised. We have bought more beds in the past three months than you will believe. On 10/2/24 at 8:40 a.m., an interview was conducted with the maintenance assistant. When asked if he came in over the weekend to repair any beds, he reported he had come in on Saturday but was not told of any beds not working. No additional information was provided.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41449 Based on observation, resident interviews, staff interviews and facility documentation review, the facility staff failed to have an alternate means for residents to communicate with staff after an extended call bell outage affecting residents on two of three nursing units. The findings included: On 9/30/24 at approximately 10:45 a.m., an initial tour was conducted on each of the three resident care units. It was noted that the call bell system was not functioning at all on the entire second floor. Multiple residents verbalized that the call bells had not been operational for the entire weekend. On the third floor it was noted that the call bell system was not operating in various areas and not affecting the entire unit. On 9/30/24, in the afternoon, various call bells were attempted to be engaged, which included but were not limited to resident #78 and resident #15 and were noted to not function, no visual notification or auditory notification of the call bell being engaged was noted. Certified nursing assistant #6 (CNA#6) accompanied the surveyor to R15's room and confirmed the call bell was not working. On 9/30/24 at 2:49 p.m., during an interview with resident #5 (R5), the resident reported their call bell had not been working for a few days. R5 engaged the call bell in the presence of the surveyor, and it didn't engage any alarm in the room, hall or at the nursing station. On 9/30/24 at 3:12 p.m., an interview was conducted with resident #27 (R27). R27 engaged his call bell, and it was noted that it wasn't working and didn't send any alert to the staff. On 9/30/24 at 10:30 a.m., R15 was observed in bed. The call bell was clipped to the cord at the box on the wall and was not in reach of the resident. On 9/30/24 at 2:43 p.m., the call bell was noted in the same position. On 9/30/24 at 4:20 pm, certified nursing assistant #6 (CNA #6) accompanied the surveyor to the room. CNA #6 attempted to engage the call bell and confirmed it was not functioning. On 9/30/24, interviews were conducted with various staff to include CNA #6, CNA #7, CNA #8, CNA #10 registered nurse #6, who was the unit manager, and the maintenance assistant. All of whom reported that the call bell system had gone down on Friday afternoon following storms and had not been operational on the entire 2nd floor throughout the entire weekend. On 9/30/24 at 4:20 p.m., an interview was conducted with RN #6, the unit manager. When asked about the call bell system and that it was noted to not be working. RN #6 confirmed the call bells on her unit were not operating and stated, apparently Friday we had some electrical stuff going on and call bells, lights, telephones, and the internet were going crazy. We are making frequent rounds through the rooms; from my understanding someone has been called. When asked if any alternatives were put into place for residents to be able to alert staff when assistance was needed, she stated, I don't know how many tap bells we have, that could be something we can do. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/1/24 at 8:56 a.m., an interview was conducted with the facility's regional maintenance director (Corporate staff #4). The corporate staff #4 was asked about what was going on since Friday. He and the facility administrator went on to report that a transformer went bad on the pole outside the facility on Friday night. We had a technician out, they changed the transformer on the pole, I put the ticket in with [power company name redacted] Friday night. [phone company name redacted] came out for the phone lines, the power just flickered. We were doing more frequent rounds, we had fire watch going. When asked why fire watch was being done the regional maintenance director explained that with the transformer out the level of power to the facility was inconsistent and the phone company was not certain that the fire system would remain on-line the entire time nor that the auto dial to dispatch emergency personnel in the event of an emergency would work, so they recommended fire watch be done. He stated, Fire watch was for the lapse in electrical service until the technician could clear us Monday. [Phone company provider name redacted] recommended fire watch in case there were surges in the area, the power was not consistent to keep the fire alarm up and running. When asked about outage in the call bell system, the regional maintenance director stated he was not aware of the call bell system not working until 9/30/24. During the above interview with the regional maintenance director, the facility administrator was present. The facility administrator confirmed that the call bell system was operational when she left on Friday and was not aware that it was down until she arrived to work on 9/30/24. The administrator was asked to provide evidence of the fire watch that was conducted throughout the weekend. On 10/1/24 at 11:14 a.m., a telephone interview was conducted with registered nurse #7 (RN #7), who was the weekend supervisor. RN #7 confirmed that she had worked the weekend of September 28-29. When asked about the call bell system, RN #7 confirmed that the call bells had not been working through the weekend on the 2nd or 3rd floors. She stated she made rounds on each unit every hour as she always does. On 10/1/24 at 2:30 p.m., during a resident council meeting held with six residents, they expressed concern about the lack of call bells throughout the weekend. They reported there was not a mechanism for them to call for assistance. Following several follow-up requests, the facility provided documents regarding the fire watch. The documents noted from Friday, 9/27 at 5 p.m., fire watch was conducted hourly. The documented noted call bell rounds. On 10/1/24 at 4:34 pm, during an end of day meeting held with the facility administrator, director of nursing and corporate staff, the above concern regarding the lack of a means for residents to communicate with staff if they needed assistance was discussed. Again, the facility administrator confirmed she was not aware the call bell system had not been working until she arrived to work on Monday, 9/30/24. The administrator was asked about the fire watch documents provided to the survey team that were from the weekend and had written call bell rounds, if she wasn't aware the call bells were not working until Monday, 9/30/24. The administrator stated, I just wrote that because that's what I thought you were looking for. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/02/24 at 8:35 a.m., an interview was conducted with the facility's maintenance director, who had been on vacation prior to this date. The maintenance director reported he had received phone calls on Friday and on Saturday, called his assistant to come to the facility to help trouble shoot some of the electrical issues. The maintenance director was asked if he was aware that the call bell system was not functioning and he said, He didn't share that the call bells weren't working. A review was conducted of the facility policy titled, Call light outage with an effective date of 4/1/24. The policy read, In the event that the call light system is not functioning hand bells will be issued to all residents. Guidelines: Hand bells will be kept in Central Supply and will be accessed and distributed by the house supervisor. Floor staff will be instructed to do a minimum of 30-minute checks of all residents during the call system outage. When the call light system returns to service all hand bells will be collected and returned to central supply. No additional information was provided.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41449 Based on observation, resident interviews, staff interviews, and facility documentation review, the facility staff failed to maintain an effective pest control program ensure the facility is free of pests affecting 2 of 3 resident care units. The findings included: The facility staff failed to maintain an effective pest control program to ensure the resident care areas were free of mice. On 9/30/24 and 10/1/24, during resident interviews, multiple residents on the 2nd and 3rd floors complained of an ongoing problem with mice. On 9/30/24 at 10:35 a.m., an interview was conducted with resident #83-R83. R83 said, they have a mouse problem. When asked what is being done R83 said, maintenance sets traps and caught one and I caught one in a Walmart bag. R83 went on to report that he told the staff on Friday he is hearing them in the wall, but maintenance was off the weekend, so he was expecting them to come that day to set some traps. On 9/30/24, in the afternoon resident #78 (R78) and his roommate reported an ongoing problem with mice that has been occurring for months. It was observed that the facility had a wooden wire snap style mouse trap in the room. The maintenance assistant was in the room checking the trap and R78's roommate was asking the maintenance assistant if he had peanut butter to put on the trap and if not, he (the resident) had some the maintenance worker could use. On 9/30/24 at 3:12 p.m., resident #27 reported he has been seeing mice in his room on a routine basis. On 10/1/24 at 10:07 a.m., during an interview with resident #68-R68, the resident reported that she has been seeing mice in her room for several months. R68 reported they come from around the bathroom and go to her side of the room. On 10/1/24 at approximately 8:15 a.m., an interview was conducted with the maintenance assistant. The maintenance assistant reported he had only been working at the facility for a short period of time and this was his third week. When asked about reports of mice, he said he has been getting a lot of reports today and had used all the glue traps he had downstairs. When asked about the wooden snap traps the surveyor had seen in resident rooms, he indicated he was not accustomed to seeing them used in a setting like this, so he was placing glue traps. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/1/24 at 8:56 a.m., an interview was conducted with the regional maintenance director (RMD) in the presence of the facility administrator. When asked about pest control, the RMD reported they had a contract with an outside vendor who provides service monthly. He went on to say that the vendor doesn't want the facility staff providing any treatment in-house, we don't put down any chemicals. When asked about reports of mice, the RMD said, I've had heard that in the past, you will see it in some of their reports, they use bait in the building. The surveyor explained that multiple residents are reporting there is an ongoing problem with mice and the surveyor had observed the wooden wire snap trap in a resident room and the concern of this being a safety hazard if a resident's foot touched it and was caught in the trap. The RMD said he was not aware that style mouse trap was being used. The pest control records for the past year were requested. On 10/1/24 at 9:30 am., an interview was conducted with the housekeeping supervisor. The housekeeping supervisor confirmed having received ongoing reports of mice. When asked what is being done, she indicated, maintenance uses mouse traps. When asked what type of trap is used, she said, wooden with metal bar is all she has ever seen used. On 10/1/24 at 2:30 p.m., a group interview was conducted with six residents, with two being from each floor/unit. The residents reported that the 2nd and 3rd floor have been having a problem with mice since the renovation was done to add the dialysis unit, which was months ago. On the afternoon of 10/1/24, the facility provided the survey team with the pest control records that were requested, and they were reviewed. Review of the report revealed that the pest control vendor was providing services monthly. On 9/18/24, the report noted, . all areas inspected and treated. One rat was in bait station but ran into borrow [sic] going into basement area. On 5/1/24, the report noted, . 1 mouse found inside tincat. The reports provided no comments or recommendations to the facility on how to control the ongoing problem with mice. On 10/1/24, the maintenance work orders for the second floor for the past three months were reviewed. room [ROOM NUMBER] was noted to report pests on a frequent basis. The work order dated 7/1/24 read, mice trap needs emptying. The one dated 7/9/24, read, reset mouse traps 217. Another work order was entered on 9/30/24 for room [ROOM NUMBER] that read, remove old trap and replace. Additional maintenance work orders that involved mice were as follows: On 7/1/24, a work order read, mice evidence in 216A wardrobe. On 8/15/24, it read, set up a mouse trap in room [ROOM NUMBER]. This work order was not completed until 8/23/24, and noted, traps set. On 8/17/24, a work order was entered that read, Mouse trap needed for alive mouse seen running between rooms 200-202. This work order was not completed until 8/23/24 and noted traps set. On 9/24/24, a work order was entered that noted, mouse heard in 208. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/1/24 at 4:34 pm, during an end of day meeting held with the facility administrator, director of nursing and corporate staff, the survey team asked the administration, what she would expect from her pest control company. The administrator said, from my experience it is them setting traps outside and providing recommendations of entry problems. She was notified that the pest control vendor's report doesn't show any evidence of them making any recommendations to resolve the problem. On 10/2/24 at 8:35 a.m., an interview was conducted with the facility's maintenance director. When asked about the complaints of mice, he said the vendor, has been on it as best they can, we have been on it as best we can, we have taken care of 95% of it. When asked what they have done, he reported that anytime a resident place a concern we place traps in the room and check them twice daily. When asked about the type of traps used, the maintenance director said, we like to use the live traps, the metal boxes and when it is obvious they are still in there, we have to use the snap traps, we stick them out of the way. The surveyor verbalized the concern with the snap trap and that it could pose as a safety hazard to residents who move around, the maintenance director said it was at the recommendation of the pest control company to use that style trap and we put them in corners and under the p-tac where there isn't normal traffic, that is a last resort. The maintenance director was asked to provide the survey team with evidence of the recommendations from the pest control vendor for the use of the wooden wire snap style mouse trap. A review of the facility policy titled; Pests Control was conducted. The policy read, 1. This facility maintains an on-going pests control program to ensure that the building is kept free of insects and rodents . No further information was provided prior to conclusion of the survey.