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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. 49465 Based on record review and staff interview, the facility failed to treat each resident with dignity by placing undignified pictures in their medical record. This was a random opportunity for discovery during the Long-Term Care Survey Process. Resident identifiers #40 and #43. Facility Census 54. Findings Included: a) Resident #40 A record review on 11/20/24 at 4:56 PM, revealed that Resident # 40 had a Stage II pressure ulcer on her sacrum upon admission. Further record review found (2) two pictures of Resident #40's Stage II pressure ulcer to her sacrum. The picture dated 10/07/24, revealed a brown lumpy substance in Resident #40's brief. The picture dated 10/28/24, revealed a brown substance smeared up Resident # 40's intergluteal cleft. During an interview on 11/20/24 at 5:00 PM, Registered Nurse (RN) #41 (who is the wound nurse for the facility) stated, We clean the wounds, then take a picture of the area. The area is cleaned before we take the picture. State Agency (SA) showed RN #41 and the Director of Nursing (DON) the pictures in Resident #40's medical record. RN #41 had no reply. The DON stated, I see what your talking about The DON confirmed that the pictures were undignified. b) Resident #43 A record review on 11/20/24 at 4:56 PM, revealed that Resident #43 had a Stage II pressure ulcer on her sacrum upon admission. Further record review found (2) two pictures of Resident #43's Stage II pressure ulcer to left gluteus. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The picture dated 06/18/24, revealed a brown substance in Resident #43's brief. The picture dated 07/02/24, revealed a brown substance in Resident #43's brief. During an interview on 11/20/24 at 5:00 PM, Registered Nurse (RN) #41 (who is the wound nurse for the facility) stated, We clean the wounds, then take a picture of the area. The area is cleaned before we take the picture. State Agency (AS) showed RN #41 and the Director of Nursing (DON) the pictures in Resident #43's medical record. RN #41 had no reply. The DON stated, I see what you're talking about The DON confirmed that the pictures were undignified. 49751

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 49465 Based on observation, record review, staff interview and resident interview, the facility failed to ensure one (1) resident's call lights were within reach. This was a random opportunity for discovery. Resident identifiers #15. Facility Census was 54. Findings included: a) Resident # 15 During a resident interview on 11/18/24 at 11:45 AM, Resident #15 was observed reaching for her call light. She attempted to move her chair but could not. She also mentioned that her reaching tool was on the other side of the room. Resident stated that the Nurse Aide (NA) must have moved the call light when she made her bed. At 12:16 PM the surveyor rang Resident #15's call light and at 12:18 PM the Director of Marketing and Admissions #8 answered the light and acknowledged that resident's call light and reacher were not within her reach. He gave both to the resident and stated that he was sure the NA would come back. Review of resident's care plan revealed the following: -Focus Resident requires assistance and is dependent for Activities of Daily Living (ADL) care in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, toileting related to recent illness, hospitalization resulting in fatigue, activity intolerance. -Invention included: Resident with staff assist of two (2), total lift, split leg sling. Arrange resident environment as much as possible to facilitate ADL performance. 50551

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 31826 Based on record review and staff interview, the facility failed to ensure the attending physician for Resident #4 was notified when the resident developed a blister to his lower leg. This was true for one (1) of three (3) residents reviewed for the care area of pressure ulcers during the long-term care process. Resident Identifier: #4. Facility Census: 54. Findings Included: a) Resident #4 A review of Resident #4's medical record on 11/20/24 found an order for Cleanse burst blister to the left lower leg with wound cleanser, pat dry and cover with bordered dressing. Change weekly and PRN for loose or soiled dressing. This order was dated 10/31/24. Further review of the medical record found no indication the physician was notified of the residents change in condition. An interview with the Director of Nursing (DON) on 11/21/24 at 12:39 PM confirmed there was no evidence in the medical record to indicate the physician was notified of the blister to Resident #4's left lower leg.

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. 31826 Based on record review and staff interview, the facility failed to ensure the receiving facility received adequate information to ensure a safe and effective transition of care for Resident #8 when he was transferred to the hospital. This was true for one (1) of three (3) residents reviewed for the care area of hospitalization s during the long-term care survey process. Resident Identifier: #8. Facility Census: 54. Findings included: a) Resident #8 A review of Resident #8's medical record found he was transferred to the hospital on 10/08/24. The resident record contained a SNF/NF to the hospital transfer form. The facility staff indicated this is the form which is sent with the resident to the hospital at the time of transfer. This form was reviewed and found no skin issues were identified. However, further review of the record found the resident had a pressure ulcer to his sacrum, to his left and right calf and to his right thigh. None of the wounds were identified on the transfer form. This was confirmed with the Director of Nursing (DON) on 11/20/24 at 10:10 AM.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 45173 Based on record review and staff interview, the facility failed to provide a bed hold policy to Resident #23 for two (2) transfers to an acute care facility. This was true for one (1) of four (4) residents reviewed under the care area of hospitalization s. Resident identifier: #23. Facility Census: 54. Findings Included: a1) Resident #23 On 11/18/24 at 1:02 PM, a record review was completed for Resident #23. The review found the resident had been sent to an acute care facility on 03/02/24 for altered mental status. An interview was held with Business Office Manager (BOM) #36. BOM 36 stated, we don't have a bed hold policy for the transfer on 03/02/24. On 11/21/24 at 9:45 AM, the Director of Nursing (DON) was notified and confirmed the bed hold policy should have been completed. b1) Resident #23 On 11/18/24 at 1:02 PM, a record review was completed for Resident #23. The review found the resident had been sent to an acute care facility on 08/15/24 for altered mental status and increased urinary incontinence. An interview was held with Business Office Manager (BOM) #36. BOM #36 stated, We don't have a bed hold policy for the transfer on 08/15/24. On 11/21/24 at 9:45 AM, the DON was notified and confirmed the bed hold policy should have been completed.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 31826 Based on record review and staff interview, the facility failed to ensure the Minimum Data Set (MDS)for Resident #8 accurately reflected whether his pressure ulcer was in house acquired or present on admission. This was true for one (1) of three (3) residents reviewed for the care area of pressure ulcers during the long-term care survey process. Resident Identifier: #8. Facility Census: #54. Findings included: a) Resident #8 A review of Resident #8's medical record found the following MDS's: An MDS with an Assessment Reference Date (ARD) of 10/29/24 identified Resident #8 as having three (3) unstageable pressure ulcers, all of which were present on admission. However, a review of the skin evaluations found Resident #8's two (2) pressure ulcers to his calves were in house acquired. An MDS with an ARD of 11/11/24 identified Resident #8 as having three (3) unstageable pressure ulcers, all of which were present on admission. However, a review of the skin evaluations found Resident #8's two (2) pressure ulcers to his calves were in house acquired. An interview with Clinical Reimbursement Coordinator #38 at 12:04 PM on 11/20/24 confirmed the above mentions MDS's were inaccurate.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 31826 Based on record review and staff interview, the facility failed to identify diagnosis of Traumatic Brain Injury (TBI), mood disorder, personality disorder, and Post Traumatic Stress Syndrome (PTSD) on the Pre-Admission Screening and Resident Review (PASARR). This failed practice was found true for (2) two of (4) four residents reviewed for PASARR during the Long-Term Care Survey Process. Resident identifiers: #33 and #8. Facility Census: 54. Findings included: a) Resident #33 A record review on 11/18/24 at 4:09 PM, of Resident #33's diagnosis, revealed a diagnosis of TBI as an admitting diagnosis. Further record review of Resident #33's PASARR dated 04/28/22 revealed a PASARR that did not include the diagnosis of TBI. During an interview on 11/19/24 at 3:05 PM, the Licensed Social Worker (LSW) stated, I did not do hers, so I am not sure. The lady who did hers is off this week. The LSW confirmed that the diagnosis of Traumatic Brain injury was not on the PASARR. b) Resident #8 A review of Resident #8's medical record on 11/18/24 found Resident #8's diagnosis list contained the following diagnosis: Personality disorder as of 04/02/13, bipolar disorder as of 04/02/13, post-traumatic stress disorder (PTSD) as of 10/01/15, insomnia as of 09/15/19, and mood disorder due to known physiological condition with depressive features as of 04/02/13. A review of Resident #8's most recent Pre-Admission Screening (PAS) found it was dated 12/02/23 and was completed by the facility. The only mental illness diagnosis contained on the PAS was Bipolar which was noted to be controlled well with medication. Resident #8's diagnosis of personality disorder, PTSD, Mood disorder, and insomnia was not included on the PAS. The PAS did not trigger for a level II evaluation. An interview with the Social Service Director in the morning of 11/21/24 confirmed the PAS needed to be updated to include all the current diagnosis. 49465

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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 - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 31826 Based on record review, resident interview and staff interview, the facility failed to develop and/or implement a comprehensive care plan regarding food dislikes for Resident #23, a skin condition for Resident #14, behaviors and emotional status for Resident #8 and prevention of pressure ulcers for Resident #4. This was true for four (4) of 21 residents reviewed during the survey process. Resident Identifiers: #23, #14, #8 and #4. Facility Census: 54. Findings Included: a) Resident #23 On 11/18/24 at 11:45 AM, an interview was held with Resident #23. The resident stated, They sent my salad with chicken on it .I detest chicken and turkey .it's on my ticket. On 11/18/24 at 12:30 PM, a record review was completed for Resident #23. The review found the care plan did not list the food dislikes under any focus area on the care plan. On 11/21/24 at 9:45 AM, the Director of Nursing (DON) was notified and confirmed the dislikes were not listed in the care plan. b) Resident #14 On 11/20/24 at 10:30 AM, a record review was completed for Resident #14. The review found the care plan had a focus area of Impaired skin (intertigo) from refusing hygiene, obesity and moisture. The goal was listed as Resident's skin will remain intact. However, there were no interventions listed under the focus area. On 11/21/24 at 9:45 AM, the DON was notified and confirmed no interventions were listed under the focus area. c) Resident #8 During the initial screening process of the long term care survey it was discovered Resident #8 had an Minimum Data Set (MDS) trigger for Post Traumatic Stress Disorder (PTSD). During an interview with Resident #8 on 11/18/24 at 4:19 PM when asked if he had any problems related to PTSD he stated, I was in the army and also loosing our son was very traumatic. He further stated, I have been here for a long time and have lost many friends here and that is hard on me. A review of Resident #8's care plan found no mention of PTSD. The care plan also did not mention Resident #8's army service, the loss of his son, nor the trauma of losing friends while being at the facility. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	When asked what services the facility had provided to him to assist with his PTSD he stated, None really. He indicated that he talks to a counselor at the Veteran Administration (VA) on a video chat. He stated, I set that up myself. A review of the care plan found this also was not included in the care plan. During an interview with the Social Service Director at 12:00 PM on 11/21/24 she confirmed the care plan did not mention the residents PTSD. She agreed his triggers had not been assessed and there was no treatment plan in place. 2) Leg Immobilizers Review of Resident #8's medical record found a hospital history and physical dated 09/20/24 which indicated the resident was to wear bilateral immobilizers during transfers and as tolerated related to bilateral tibia fractures. A further review of Resident #8's care plan found no care plan focus, goal, or intervention related to the removal of the braces for checking skin integrity. An interview with the Director Of Nursing (DON) on the afternoon of 11/19/24 confirmed this finding. d) Resident #4 An observation of Resident #4 at 3:00 PM on 11/20/24 found he had a knee immobilizer on his left leg. A review of his medical record found an order dated 10/14/24 which read, Maintain knee immobilizer at all times except when bathing. A review of the treatment administration record for the months of 10/2024 and 11/2024 found there was not an order to remove the brace and check the integrity of the skin. However, during an interview with the resident on the evening of 11/20/24, he indicated they do remove the brace at least once a day and look at his leg to make sure there are not any sores present. An interview with Resident #4 on 11/20/24 at approximately 4:00 PM confirmed he did at one point have a blister to his left lower leg. He stated, It is healed now. When asked what had caused the blister her stated, I had another brace that had rods in it and it was rubbing there and caused a blister. That is why I switched to this brace. (He tapped his knee immobilizer which was currently in place on his left leg.) At 4:34 PM on 11/20/24 an interview was completed with the Director of Nursing (DON). The DON was asked where the information regarding the blister Resident #4 spoke of could be found, she stated, There should be a SWIFT assessment. She then reviewed the electronic record with the surveyor and a SWIFT assessment for the blister was not located. She stated, Let me check with (First Name of RN #41) it should be in there. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A few minutes later the DON returned with RN #41. RN #41 stated the wound was an edema blister and not related to the splint he was wearing. She confirmed she missed putting in the SWIFT assessment. She stated, It should have been done when it was discovered. RN #41 was asked what day she had discovered the blister and was asked if the physician had been notified. She stated, I will look and let you know. At approximately 5:00 PM on 11/20/24 RN #41 stated there was no evidence in the record to indicate the physician had been notified of the blister. She indicated the blister was identified on 11/10/24 because this is the date the treatment order was implemented. RN #41 indicated she removed the bandage from the area this morning and the area was resolved. She was asked how she determined it was related to edema and not to the brace the resident was wearing on his leg? She stated, He has self reported chronic edema blisters. RN #41 was then asked if Resident #4 was capacitated and able to relay such information. RN #41 and the DON both confirmed the resident was cognitively able to do so and was capacitated. RN #41 and the DON was then advised of the interview the surveyor had conducted with Resident #4 earlier where he had stated the wound was from the rod rubbing his leg. At this time the DON accompanied the surveyor back to Resident #4's room to determine if there was a different brace in his room. At this time Resident #4 was again asked what had caused the blister to his left lower leg and he stated, That other brace had a rod in it that rubbed that blister there. The DON was able to locate the other brace in the resident's closet. The resident was then asked if he had problems with blisters related to edema (swelling) in his legs. He stated, I have in the past, but this was not caused by that it was caused by the brace. The DON was present for this interview. A review of Resident #4's care plan found there was no focus statement, goal or intervention related to how the resident's skin integrity will be maintained while he has orders to wear the knee immobilizer. The only place on the care plan the knee immobilizer is mentioned is in regards to Resident #4's Activities of Daily living care plan where it notes the knee immobilizer is to be in place at all times except when bathing. In addition, the identified blister is not addressed on the residents care plan. In addition, the residents risk for developing a pressure ulcer as a result of the knee immobilizer is not addressed on the residents care plan. This finding was confirmed with the DON on the afternoon of 11/20/24. 45173

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 49465 Based on record review and staff interview, the facility failed to revise a care plan related to code status. This failed practice was found true for (1) one of 21 residents reviewed for care plan accuracy during the Long-Term Care Survey Process. Resident identifier: #45. Facility Census: 54. Findings Included: a) Resident #45 A record review on 11/18/24 at 4:25 PM, revealed a POST form dated 10/31/24 that indicated Resident #45 is marked Do Not Attempt Resuscitation (DNR) Further record review revealed a care plan for Resident #45 that had a focus that reads as follows: (Resident #45's name) has an established advanced directive of FULL CODE on file. During an interview, on 11/19/24 at 1:01 PM, the Licensed Social Worker (LSW) confirmed that the care plan had not been updated related to Resident #45's code status.

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31826 Based on resident interview, record review, staff interview and observation, the facility failed to ensure a resident did not develop avoidable pressure ulcers. Resident #8 returned from the emergency room with bilateral leg immobilizes. The facility failed to implement a plan to prevent Resident #8 from developing pressure ulcers because of the leg immobilizers. Resident #8 developed bilateral unstageable pressure ulcers to both calves. The wounds have worsened and required the resident to be hospitalized and undergo debridement procedures on each of the wounds. The resident has voiced concerns and fears that his right leg will need an amputation because of the wound. The state agency (SA) determined the failures related to Resident #8 placed him and any other residents with medical devices such as leg braces in an immediate jeopardy (IJ) situation. The SA notified the facility of the IJ at 6:30 PM on 11/19/24. The SA accepted the facility's plan of correction (POC) at 8:09 PM on 11/19/24. After the SA observed for implementation of the POC which included staff interviews, resident interviews and record reviews of the required audits and training the SA abated the IJ at 5:10 PM on 11/20/24. After the immediacy was removed a deficient practice remained for Resident #4 and Resident #40. A deficient practice remains for Resident #4 who developed a blister to his lower leg because of a leg immobilizer. The facility identified it as an edema blister instead of a pressure ulcer. The facility also failed to perform a wound evaluation on the wound when it was discovered and weekly there after until it was resolved. A deficient practice was also present for Resident #40 because the facility failed to provide wound care consistent with current standards of practice. This was true for three (3) of four (4) residents reviewed for the care area of pressure ulcers during the long-term care survey process. Resident Identifiers: #8, #4, and #40. Facility Census: 54. Findings Included: a) Resident #8 Resident #8 was admitted on [DATE] and has the following diagnoses MS, DM, paraplegia lower extremities, Bipolar, PTSD, osteoporosis, HTN, Depression, GERD, Neurogenic bladder, MDRO, and fractures of both lower extremities and arthritis. Scored 15 on the Brief Interview for Mental Status (BIMS) which indicates cognitively intact. 1) Resident Interview (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with Resident #8 at 2:26 PM on 11/18/24 the resident stated, I fell and broke my legs on 09/17/24 and came back with a brace on each leg. He continued to state, They did not know what to do with the braces when I came back, and they did not take them off for a week. He stated, after a week they took them off to give him a shower and said, Oh Sh(x)t. He stated, it was then that the wounds were identified. He indicated he had been to the hospital because of the wounds, and he was scared he was going to lose his right leg. He indicated the leg he was talking about by tapping his right leg. The surveyor asked Resident #8, They never removed the brace or looked at your skin for seven (7) days? He stated, No the first time was after a week when they gave me a shower. 2) Record Review A review of Resident #8's medical record found a hospital history and physical dated 09/20/24 which indicated the resident was to wear bilateral immobilizers during transfers and as tolerated related to bilateral tibia fractures. A review of the resident's skin only evaluation dated 09/20/24 completed at 4:42 PM found the answer to question #2. External device(s) (cast, prosthetic, brace) present was answered with No. A further review of Resident #8's care plan found no care plan focus, goal, or intervention related to the removal of the braces for checking skin integrity. The treatment administration record (TAR) for the month of September 2024 was reviewed and found the following, Bilateral Knee immobilizers as resident tolerates. CMS(Circulation, motion and sensation) and skin observations/hygiene QS while in place every day and night shift. This was initialed on the TAR as being done on the night of 09/23/24, and the day and night of the 24, 25, and 26. However, Resident #8 who is completely cognitively intact denies them doing this. He stated, No the first time was after a week when they gave me a shower. It should also be noted Resident #8 has a diagnosis of paraplegia which was entered into his medical record on 09/15/19. Paraplegia is defined as a chronic condition that results in the loss of motor or sensory function in the lower half of the body, including the legs, feet, and sometimes the abdomen. Resident #8 confirmed in an interview on the afternoon of 11/18/24 that he had no sensation or motion in his legs or feet at all. 3) Left Calf The following are the wound assessments completed by the facility for the left medial calf. The facility refers to the wound being on the left lateral calf and the left medial calf, however this is the same wound. -- Wound was evaluated on 09/26/24 at 4:25 PM by RN #41 the wound care nurse. The wound was classified as a deep tissue injury. It was indicated the wound was a pressure injury caused by a medical device. The wound is located on the left medial calf. It was classified as a new wound and was an in-house acquired pressure ulcer. There was no PUSH score included in this assessment. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Pressure Ulcer Scale for Healing (PUSH) was developed by the National Pressure Ulcer Advisory Panel (NPUAP) to categorize the ulcer with respect to surface area, exudate, and type of wound tissue. There is no depth measurement with this tool. Scores can range from 0 (healed) to 17 most serious. The Dimensions of the wound are as follows: The area was 9.93 cm^2 (Centimeter). The length was 4.2 cm. The width was 3.12 cm. There was no depth recorded with this assessment. The wound bed was not described in this assessment. There was no exudate present. The edges of the wound were attached, and the surrounding tissue was described as fragile. There was no induration or edema noted. The peri wound temperature was normal. The resident had no pain noted on the wound assessment. (It should be noted that the resident is paraplegic and has no feeling or movement in his legs.) The treatment section of this assessment was not completed. The goal for the wound is to be healable. The following note was entered, Wound assessment completed per GHC policy. See care plan for interventions. Wound care/ treatment per HCP orders. See TAR for treatment plan. No evidence or complaints of pain or discomfort related to assessment or treatment. No indications of infection. The following was noted as education provided to the resident, Educated resident on ways to maintain good skin health; keeping skin clean and dry, moisturizer as needed, frequent position changes, including off-loading heels, adequate hydration and nutrition. Resident verbalized understanding and provided accurate teach back. This assessment was not signed by RN #41 until 09/27/24 at 1:19 PM. -- The wound was assessed on 09/30/24 at 11:23 AM by RN #41 the wound care nurse. The wound was classified as a Stage III pressure ulcer related to a medical device and was in house acquired. The wound age was identified as being four (4) days old. There was no PUSH score included in this assessment. The Dimensions of the wound were as follows: The area was 5.85 cm^2 (Centimeter) a decrease of 41 % since the previous assessment. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The length was 2.42 cm a decrease of 42 % since the previous assessment. The width was 3.02 cm a decrease of 3 % since the previous assessment. There was no depth recorded with this assessment despite the fact the staging was changed from a deep tissue injury to a stage III pressure ulcer. In order for the wound to be a Stage III pressure ulcer there has to full thickness tissue loss therefore the wound would have a depth measurement. In addition, the medical record contained a picture of the wound at the time of the assessment. In the picture the full thickness tissue loss is noticeable, and the wound has a noticeable depth which was not measured by RN # 41 when completing this assessment. The wound bed was not described in this assessment, other than noting there was no signs of infection. There was a light amount of serous exudate present. There was no odor from the wound. The edges of the wound were attached, and the surrounding tissue was described as erythema and fragile. There was no induration or edema noted. The peri wound temperature was normal. The resident had no pain noted on the wound assessment. (It should be noted that the resident is paraplegic and has no feeling or movement in his legs.) The treatment section of this assessment was not completed. The wound was described as improving and the goal was healable. The following note was entered, Wound assessment completed per GHC policy. See care plan for interventions. Wound care/ treatment per HCP orders. See TAR for treatment plan. No evidence or complaints of pain or discomfort related to assessment or treatment. No indications of infection. The following was noted as education provided to the resident, Educated resident on ways to maintain good skin health; keeping skin clean and dry, moisturizer as needed, frequent position changes, including off-loading heels, adequate hydration and nutrition. Resident verbalized understanding and provided accurate teach back. This assessment was not signed by RN #41 until 10/01/24 at 12:02 PM. -- The wound was evaluated on 10/08/24 at 2:41 PM by RN #41 the wound care nurse. The wound was classified as a Stage III pressure ulcer related to medical device. The wound is located on the left medial calf. It was assessed as deteriorating with a wound age of 12 days and was noted to be in-house acquired. The residents' PUSH score was 12 at the time of this assessment. The Dimensions of the wound were as follows: The area was 8.66 cm^2 (Centimeter) an increase of 48 % from the previous assessment. The length was 3.69 cm, an increase of 52 % from the previous assessment. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The width was 3.01 cm and remained the same as the previous assessment. The deepest point was recorded at 0.3 cm, which was an increase of 100 % from the previous assessment. The wound bed was described as having no granulation, 50 % Slough, and no eschar. There was no evidence of an infection. The wound was noted to be bleeding. There was a light amount of Serosanguineous exudate and there was a faint odor noted after cleansing the wound. The edges of the wound were attached, and the surrounding tissue was described as fragile. There was no induration or edema noted. The peri wound temperature was normal. The resident had no pain noted on the wound assessment. (It should be noted that the resident is paraplegic and has no feeling or movement in his legs.) The treatment section of this assessment was not completed. The wound was described as Deteriorating and the goal was healable. The following note was entered, Wound assessment completed per GHC policy. See care plan for interventions. Wound care/ treatment per HCP orders. See TAR for treatment plan. No evidence or complaints of pain or discomfort related to assessment or treatment. No indications of infection. The following was noted as education provided to the resident, Educated resident on ways to maintain good skin health; keeping skin clean and dry, moisturizer as needed, frequent position changes, including off-loading heels, adequate hydration and nutrition. Resident lethargic and does not acknowledge understanding on education provided. This assessment was signed by RN #41 the wound nurse on 10/09/24 at 8:28 AM. -- The wound was evaluated on 10/13/24 at 8:29 PM by RN #41 the wound care nurse. The wound was classified as an unstageable pressure ulcer related to Slough and/or eschar. The wound is located on the left medial calf. It was assessed as stable with a wound age of 25 days and was noted to be present on admission (It should be noted the resident was hospitalized from 10/08/24 to 10/11/24 and upon his return the facility changed the wound from in-house acquired to present on admission despite it being the same wound). The residents' PUSH score was 16 at the time of this assessment. The Dimensions of the wound are as follows: The area was 37.35 cm^2 (Centimeter). No comparison noted since this is the first assessment since his return from the hospital. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The length was 11.51 cm No comparison noted since this is the first assessment since his return from the hospital. The width was 5.08 cm No comparison noted since this is the first assessment since his return from the hospital. There was no depth recorded with this assessment. The wound bed was described as having no granulation, 40 % Slough, and 60 % eschar. There was no evidence of an infection. There was a moderate amount of serous exudate and there was a faint odor noted after cleansing the wound. The edges of the wound were attached, and the surrounding tissue was described as fragile. There was no induration or edema noted. The peri wound temperature was normal. The resident had no pain noted on the wound assessment. (It should be noted that the resident is paraplegic and has no feeling or movement in his legs.) The treatment section of this assessment was not completed. The wound was described as stable, and the goal was healable. The following note was entered, Wound assessment completed per GHC policy. See care plan for interventions. Wound care/ treatment per HCP orders. See TAR for treatment plan. No evidence or complaints of pain or discomfort related to assessment or treatment. No indications of infection. The following was noted as education provided to the resident, Educated resident on ways to maintain good skin health; keeping skin clean and dry, moisturizer as needed, frequent position changes, including off-loading heels, adequate hydration and nutrition. Resident verbalized understanding and provided accurate teach back. This assessment was signed by RN #41 the wound nurse on 10/16/24 at 12:22 PM. -- The wound was evaluated on 10/21/24 at 11:08 AM by RN #41 the wound care nurse. The wound was classified as an unstageable pressure ulcer related to slough and/or eschar. The wound is located on the left medial calf. It was assessed as stable with a wound age of 18 days and was noted to be present on admission. The residents' PUSH score was 16 at the time of this assessment. The Dimensions of the wound are as follows: The area was 18.01 cm^2 (Centimeter) a decrease of 52 % from the previous assessment. The length was 6.11 cm, a decrease of 47 % from the previous assessment. The width was 4.03 cm, a decrease of 21 % from the previous assessment. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The deepest point was recorded at .1 cm which was an increase of 100 % from the previous assessment. The wound bed was described as having no granulation, 10 % Slough, and 90 % eschar. There was no evidence of an infection. There was a moderate amount of serous exudate and there was a faint odor noted after cleansing the wound. The edges of the wound were attached, and the surrounding tissue was described as eczematous and fragile. There was no induration or edema noted. The peri wound temperature was normal. The resident had no pain noted on the wound assessment. (It should be noted that the resident is paraplegic and has no feeling or movement in his legs.) The treatment section of this assessment was not completed. The wound was described as stable, and the goal was healable. The following note was entered, Wound assessment completed per GHC policy. See care plan for interventions. Wound care/ treatment per HCP orders. See TAR for treatment plan. No evidence or complaints of pain or discomfort related to assessment or treatment. No indications of infection. The following was noted as education provided to the resident, Educated resident on ways to maintain good skin health; keeping skin clean and dry, moisturizer as needed, frequent position changes, including off-loading heels, adequate hydration and nutrition. Resident verbalized understanding and provided accurate teach back. This assessment was signed by RN #41 the wound nurse on 10/22/24 at 1:57 PM. --The wound was evaluated on 10/28/24 at 10:57 AM. This evaluation was completed by the Director of Nursing. The wound was classified as an unstageable pressure ulcer related to Slough and/or eschar. The wound is located on the left medial calf. It was assessed as stalled with a wound age of one month and was noted to be present on admission. The residents' PUSH score was 15 at the time of this assessment. The Dimensions of the wound were as follows: The area was 12.49 cm^2 (Centimeter) a decrease of 31 % from the previous assessment. The length was 6.1 cm which was the same value as the previous assessment. The width was 2.61 cm, a decrease of 35 % from the previous assessment. There was no depth recorded, which was a decrease of 100 % from the previous assessment. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The wound bed was described as having no granulation, 10 % Slough, and 20 % eschar. There was no evidence of an infection. It was noted the wound was bleeding. There was a moderate amount of Serosanguineous/bloody exudate and there was a faint odor noted after cleansing the wound. The edges of the wound were not attached, and the surrounding tissue was described as fragile. There was no induration or edema noted. The peri wound temperature was normal. The dressing was described as intact. The goal of care was noted to be healable, and the progress of the wound was noted as stalled. No other information was contained in this wound assessment. -- The wound was evaluated on 11/08/24 at 3:03 PM. This wound evaluation was completed by LPN # 9. The wound was classified as a Stage 4 pressure ulcer. The wound was located on the left lateral calf. It was assessed as a new wound with an unknown age and was noted to be present on admission. The residents' PUSH score was 15 at the time of this assessment. The wound bed was described as having 50 % granulation and 50 % eschar. There was no evidence of an infection. Under the section titled other the nurse noted the wound was bleeding and the tendon was exposed. There was a moderate amount of Serosanguineous exudate and there was a faint odor noted after cleansing the wound. The edges of the wound were attached, and the surrounding tissue was described as fragile. There was no induration or edema noted. The peri wound temperature was normal. The resident had no pain noted on the wound assessment. (It should be noted that the resident is paraplegic and has no feeling or movement in his legs.) The treatment section of this assessment was not completed. The wound was described as slow to heal, and the progress was noted as new (indicating the wound is a new wound). The following note was entered, Wound assessment completed per GHC policy. See care plan for interventions. Wound care/ treatment per HCP orders. See TAR for treatment plan. No evidence or complaints of pain or discomfort related to assessment or treatment. No indications of infection. The following was noted as education provided to the resident, Educated resident on ways to maintain good skin health; keeping skin clean and dry, moisturizer as needed, frequent position changes, including off-loading heels, adequate hydration and nutrition. Resident verbalized understanding but is non-compliant with turning and repositioning. This assessment was not signed by RN #41 the wound nurse until 11/14/24 at 10:57 AM. -- The wound was evaluated on 11/14/24 at 2:53 PM by Licensed Practical Nurse (LPN) #9. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The wound was classified as an unstageable pressure ulcer related to slough and/or eschar. The wound is located on the left medial calf. It was assessed as improving with a wound age of two (2) months and was noted to be present on admission. The residents' PUSH score was 16 at the time of this assessment. The Dimensions of the wound are as follows: The area was 14.43 cm^2 (Centimeter) an increase of 16 % from the previous assessment. The length was 9.36 cm, an increase of 54 % from the previous assessment. The width was 3.09 cm, an increase of 19 % from the previous assessment. The wound bed was described as having 50 % granulation, 10 % Slough, and 40 % eschar. There was no evidence of an infection. There was a moderate amount of Serosanguineous exudate and there was a faint odor noted after cleansing the wound. The edges of the wound were attached, and the surrounding tissue was described as erythema. There was no induration or edema noted. The peri wound temperature was normal. The resident had no pain noted on the wound assessment. (It should be noted that the resident is paraplegic and has no feeling or movement in his legs.) The treatment section of this assessment was not completed. The wound was described as healable, and the progress was noted as improving. The following note was entered, Wound assessment completed per (Facility Corporate Initials) policy. See care plan for interventions. Wound care/ treatment per HCP orders. See TAR for treatment plan. No evidence or complaints of pain or discomfort related to assessment or treatment. No indications of infection. This assessment was signed by wound care nurse #41 on 11/15/24 at 4:58 AM. 4) Right Calf The following are the wound assessments completed by the facility for the right calf. The facility referred to the wound as being on the right medial calf and the right lateral calf, however it is the same wound. -- The wound was evaluated on 09/27/24 at 11:23 AM. This assessment was completed by RN #41 the wound care nurse. The wound was classified as a medical device related to pressure deep tissue injury. This wound was located on the right medial calf and is a new pressure area. The wound was in-house acquired. There was no PUSH score included with this assessment. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Dimensions of the wound were as follows: The area was 9.48 cm^2. The length was 3.97 cm. The width was 2.63 cm. The depth was not recorded on this assessment because there is no depth to the wound on this date. The wound bed was not described in this assessment other than stating there were no signs of infection. There was no exudate from the wound on this date. The edges of the wound were attached, and the surrounding tissue was described as fragile. There was no induration or edema noted. The peri wound temperature was normal. The resident had no pain noted on the wound assessment. (It should be noted that the resident is paraplegic and has no feeling or movement in his legs.) The treatment section of this assessment was not completed. The goal for the wound is healable. The following note was entered, Wound assessment completed per GHC policy. See care plan for interventions. Wound care/ treatment per HCP orders. See TAR for treatment plan. No evidence or complaints of pain or discomfort related to assessment or treatment. No indications of infection. The following was noted as education provided to the resident, Educated resident on ways to maintain good skin health; keeping skin clean and dry, moisturizer as needed, frequent position changes, including off-loading heels, adequate hydration and nutrition. Resident verbalized understanding and provided accurate teach back. This assessment was signed by RN #41 on 09/27/24 at 2:45 PM. -- The wound was evaluated on 09/30/24 at 11:19 AM by RN #41 the wound care nurse. The wound was classified as a deep tissue injury related to a medical device. The wound was located on the right lateral calf. It was assessed as being three (3) days old and was in-house acquired. This assessment did not contain a PUSH score. The Dimensions of the wound were as follows: The area was 9.31 cm^2 a decrease of 2 % since the previous assessment. The length was 4.13 cm, an increase of 4 % since the previous assessment. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The width was 2.27 cm, a decrease of 14 % since the previous assessment. The wound had no depth. The wound bed was not described other than noting there was no sign of infection. There was no exudate or odor noted. The edges of the wound were attached, and the surrounding tissue was described as fragile. There was no induration or edema noted. The peri wound temperature was normal. The resident had no pain noted on the wound assessment. (It should be noted that the resident is paraplegic and has no feeling or movement in his legs.) The treatment section of this assessment was not completed. The goal for the wound is healable. The following note was entered, Wound assessment completed per GHC policy. See care plan for interventions. Wound care/ treatment per HCP orders. See TAR for treatment plan. No evidence or complaints of pain or discomfort related to assessment or treatment. No indications of infection. The following was noted as education provided to the resident, Educated resident on ways to maintain good skin health; keeping skin clean and dry, moisturizer as needed, frequent position changes, including off-loading heels, adequate hydration and nutrition. Resident verbalized understanding and provided accurate teach back. This assessment was not signed by RN #41 until 10/01/24 at 12:14 PM. -- The wound was assessed on 10/08/24 at 2:37 PM by RN #41 the wound care nurse. The wound was classified as a Stage III pressure ulcer related to a medical device and was in-house acquired. The wound age was identified as being 11 days old. There was no PUSH score included in this assessment. The Dimensions of the wound were as follows: The area was 29.91 cm^2 (Centimeter) an increase of 221% since the previous assessment. The length was 6.29 cm, an increase of 52 % since the previous assessment. The width was 5.99 cm, an increase of 164 % since the previous assessment. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	There was no depth recorded with this assessment despite the fact the staging was changed from a deep tissue injury to a stage III pressure ulcer. In order for the wound to be a Stage III pressure ulcer there has to full thickness tissue loss therefore the wound would have a depth measurement. In addition, the medical record contained a picture of the wound at the time of the assessment. In the picture the full thickness tissue loss is noticeable, and the wound has a noticeable depth which was not measured by RN # 41 when completing this assessment. The wound bed was not described in this assessment except for noting there were no signs of infection, and the wound was bleeding. There was a light amount of Serosanguineous exudate, and the wound had no odor. The edges of the wound were attached, and the surrounding tissue was described as fragile. There was no induration or edema noted. The peri wound temperature was normal. The resident had no pain noted on the wound assessment. (It should be noted that the resident is paraplegic and has no feeling or movement in his legs.) The treatment section of this assessment was not completed. The wound was described as deteriorating and the treatment goal was healable. The following note was entered, Wound assessment completed per GHC policy. See care plan for interventions. Wound care/ treatment per HCP orders. See TAR for treatment plan. No evidence or complaints of pain or discomfort related to assessment or treatment. No indications of infection. The following education was noted as given to the resident, Educated resident on ways to maintain good skin health; keeping skin clean and dry, moisturizer as needed, frequent position changes, including off-loading heels, adequate hydration and nutrition. Resident lethargic and does not verbalize understanding. This assessment was not signed by RN #41 the wound nurse until 10/09/24 at 12:50 PM. -- The wound was assessed on 10/28/24 at 10:49 AM by the Director of Nursing. The wound was classified as an unstageable pressure ulcer related to slough and/or eschar. The wound is located on the right lateral calf. It was assessed as being one (1) month old and being present on admission (It should be noted the resident was hospitalized from 10/08/24 to 10/11/24 and upon his return the facility changed the wound from in house acquired to present on admission despite it being the same wound). There was no push score included in this assessment. The Dimensions of the wound were as follows: The area was 59.1 cm^2. The length was 13.6 cm. The width was 5.6 cm. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The wound bed was described as having no granulation, slough was checked as being present, but a percentage was not identified, and 90 % eschar. There was no evidence of an infection. Under the section titled, other, the nurse noted, bleeding indicating the wound was bleeding. There was a moderate amount of Serosanguineous/bloody exudate and there was a moderate odor noted after cleansing the wound. The edges of the wound were not assessed, and the surrounding tissue was described as fragile. There was no induration or edema noted. The peri wound temperature was warm. The resident had no pain noted on the wound assessment. (It should be noted that the resident is paraplegic and has no feeling or movement in his legs.) The dressing was described as intact, and Dakin's solution was used for cleaning. The wound was described as deteriorating and the goal was healable. It was noted that the wound had a suspected infection. -- The wound was evaluated on 11/08/24 at 3:02 PM. The wound evaluation was completed by RN #41 who was the wound nurse. The wound was classified as an unstageable pressure ulcer related to slough and/or eschar. The wound is located on the right lateral calf. It was assessed as being a new wound which was present on admission. The residents' PUSH score was 16 at the time of this assessment. The Dimensions of the wound are as follows: The area was 115.99 cm^2. The length was 27.53 cm. The width was 6.11 cm. The deepest point was recorded as 1 cm. The wound bed was described as having 10% granulation and 90% eschar. There was no evidence of an infection. Under the section titled, other the nurse noted, bleeding and tendon indicating the wound was bleeding and the tendon was exposed. There was a moderate amount of Serosanguineous exudate and there was a faint odor noted after cleansing the wound. The edges of the wound were attached, and the surrounding tissue was described as erythema and fragile. There was no induration or edema noted. The peri wound temperature was normal. The resident had no pain noted on the wound assessment. (It should be noted that the resident is paraplegic and has no feeling or movement in his legs.) (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The treatment section of this assessment was not completed. The wound was described as slow to heal and was identified as a new wound. The following note was entered, Wound assessment completed per GHC policy. See care plan for interventions. Wound care/ treatment per HCP orders. See TAR for treatment plan. No evidence or complaints of pain or discomfort related to assessment or treatment. No indications of infection. The

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31826 Based on record review, resident interview and staff interview, the facility failed to ensure the resident environment over which it had control was as free from accident hazards as possible. Resident #8 requested the facility transport him to the bank in the facility van. The facility had decided prior to Resident #8's request to go to the bank that power wheelchairs could not be used on the facility van any longer. As a result of this decision the resident requested his manual wheelchair and chose to use the manual wheelchair in the van to go to the bank. The resident had not been in his manual wheelchair for at least a year prior to this. Since then, he had lost use of his legs and was paralyzed in both lower extremities. The resident slid from the wheelchair while on the van. A nurse aide was with him and another nurse aide responded to the scene where the van had pulled over after the resident slid from the wheelchair. The resident denied pain (please note the resident is a paraplegic and cannot feel his legs.) He stated he did not want to go to the hospital. The two (2) Nurse Aides who were on site lifted the resident back into his wheelchair and he was transported back to the facility. The facility policy indicates a resident should not be moved after a fall until a physician/advanced practice provider (APP), nurse or emergency medical services has evaluated them for possible injuries. Once evaluated and if the individual has no physical or verbal indication of injury, the patient can be moved to a safe and comfortable place when applicable. The resident was found to have bilateral tibia and fibula fractures. Based on the failure to ensure the resident was safe to be transferred in a manual wheelchair and the facility's failure to follow their policy after the fall it was determined this was an Immediate Jeopardy (IJ) situation. The facility was notified of the IJ on 11/19/24 at 5:45 PM. The State Agency (SA) accepted the facility's plan of correction (POC) at 6:10 PM. After observation of implementation of the POC which included staff interviews and record review of the required audits and education the IJ was abated at 5:10 PM on 11/20/24. This was true for one (1) of three (3) residents reviewed for the care area of accidents during the long term care survey process. Resident Identifier: #8. Facility Census: 54. Findings Included: a) Resident #8 (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 09/17/24 Resident #8 asked the facility to transport him to the bank in the facility van. A decision was made some time back by the Nursing Home Administrator (NHA) that power wheelchairs would no longer be used in the facility van for transport due to safety concerns. An interview with the NHA on 11/19/24 at 12:27 PM confirmed that sometime back (exact time frame is unknown) that due to the VA and (Name of Local ambulance company) a decision was made to no longer allow power chairs on the van. When asked if the two (2) residents who have power chairs were notified of this decision at the time, he indicated they had not been notified because they had not requested to go anywhere since the decision was made. The NHA stated that on this date Resident #8 had demanded to go to the bank and asked for his manual chair so he would be able to ride in the van to the bank. The NHA stated, therapy and nursing tried to convince him to wait but he was insistent and wanted to go no matter what. The NHA stated he was not in the facility on this date because he was at a meeting. An interview with The Director of Rehab # 59 at 2:00 PM on 11/19/24 found on 09/17/24 Resident #8 had come to the rehab door and was beating on the door demanding his manual wheelchair from the therapy shed because he wanted to go to the bank. She stated, she tried to convince him to wait until the NHA returned to the facility tomorrow and give them time to find a safe way for him to go but he was insistent and did not want to wait. She stated, I told him I did not think it was safe. I feel it wasn't safe because he had not been in that wheelchair for quite some time and was not sure if he had enough trunk control to hold himself in the chair. I have been working with him for [AGE] years, but just had not had him in that wheelchair for a while. I was not ready to say he was safe in it The Director of Rehab #59 further stated, He came to the door demanding that wheelchair. He was with nursing and activities and I told them all that I did not feel he was safe in that wheelchair. The surveyor also asked the Director of Rehab if she felt the power wheelchair could safely be strapped in the van? She replied, Yes. An interview with the Activity Director at 2:18 PM on 11/19/24 found that when Resident #8 slid from his chair in the van the activity assistant had called her and she left the facility to go and assist the resident. When she arrived, she indicated the resident was sitting with his legs crossed between his wheelchair and the back of the seat in front of him. She indicated she asked him if he was hurt and he stated No. When asked if the lift pad was under the resident or in the wheelchair, she stated it was still in the wheelchair. She stated, There was no room to get the lift into the van to get him out of the floor so she and the activity assistant (who are both nurse aides) two armed the resident, lifted him up while the driver slid the wheelchair under him. She stated, before we lifted him up I straightened his legs out. She stated, The resident did not want us to call 911. He wanted to go to the bank, but we took him back to the facility. An interview with the Activity Assistant on 11/19/24 at 2:30 PM found she was in the van while the resident was being transported to the bank. She stated, the resident started saying I'm sliding I'm sliding. She continued to state, When I looked back he was sitting on the floor with his back against his wheelchair and his legs were crossed. She stated while they were waiting for the Activity Director, she moved the resident's wheelchair and laid him on his back with his head on a towel so he would be comfortable. She stated his legs remained crossed when she laid him back. She stated that she and the activity director then lifted him up and the driver slid the chair under him. She stated they asked if he wanted to go to the ER and he said no he wanted to go to the bank, but they returned him to the facility instead. The NHA provided the following typed document (Typed as written), (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident (Initials of Resident #8) was evaluated by the licensed nurse upon return to the facility, orders received to obtain x-rays of bilateral lower extremities (BLE) from the physician on 09/17/24. On 09/17/24 the Director of Nursing (DON) interviewed the van driver, the nurse aide assisting with transport and the resident who is alert and orientated to identify if the van was traveling too fast, if driver hit the brakes to hard or negotiated a turn too fast causing residents to slide out of the wheelchair onto floor of the facility van. All staff interviewed indicated No to the above questions. The NHA interviewed the Director of Rehab (DOR) who was present when (Initials of Resident #8) requested his manual wheelchair for transport to the bank in the facility van. The Director of Rehab,(Initials of Resident #8) was demanding his manual wheelchair and did not want to wait. (Initials of Resident #8 was secured with the facility van seatbelt and wheelchair was locked into place in the van with securing straps per van protocol. All residents have the potential to be affected. The Director of Rehab (DOR)/designee initiated an audit on 09/23/24 for all residents in wheelchairs that utilize the facility van to determine safety for transport. Corrective action implemented immediately upon discovery. The Director of Rehab (DOR)/designee will reeducate all interdisciplinary team, medical records/resident appointment scheduling and van driver with a posttest to validate understanding regarding: appropriateness of van utilization for transportation, positioning/devices in wheelchairs . The Director of Nursing (DON)/designee will reeducate all Certified Nursing Assistants on removal of lift sling prior to transport in facility van on or before 10/04/24. Medical Records/resident appointment scheduling will bring the upcoming week's transportation schedule to IDT on Thursdays for review to ensure the appropriateness of the van for transportation. Any appointments added after the review must be discussed with the IDT team prior to transporting the Resident. An interview with Resident #8 on 11/18/24 at 2:26 PM found that on 09/17/24 he wanted to go to the bank because he had finalized the sale of his house, and he needed to go to the bank. He stated the administrator had told him he could not take his power wheelchair in the van, and he would have to use his manual chair. He stated that he had not been in his manual chair for three (3) years and in that he did not know he could take his power chair on the van, he had to get to the bank that day. He stated, It was one of the highest points I have had lately because I was finalizing the sale of my house, and the devil just knocked it out from under me. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of a Wheelchair training session therapy note dated 11/14/24 found the following, W/C (wheelchair) management: analysis of patient body alignment and functional skills in new or existing w/c and assessment of current seating system for appropriate modifications. Patient in power wheelchair for positioning and safety with on facility van. Patient positioning maintained in wheelchair on van with use of wheelchair seatbelt (lap) which patient is able to release on command 100 percent of the time. Once positioned safely in van power system turned off for safety. Patient able to follow all directions for safe use of power wheelchair on van. Patient demonstrated safe mount and dismount of wheelchair van ramp. Van safety equipment functioned properly with power wheelchair. No issues noted. DON and Administrator present for session. A review of the hospital history and physical from the hospital for the date of 09/19/24 confirmed the resident had bilateral tibia fractures. A review of the facility policy titled Accident/incidents found the following, 1. Response: . 1.1.3 DO NOT move the individual until a physician/advanced practice provider (APP), nurse or emergency medical services has evaluated them for possible injuries. Once evaluated and if the individual has no physical or verbal indication of injury, the patient can be moved to a safe and comfortable place when applicable. When the facility was notified of the immediate jeopardy the NHA asked if this would be past noncompliance. The NHA was advised it would be current noncompliance because the education he provided to the staff failed to address ensuring the policy is followed in regards to moving resident prior to them being assessed by appropriate individuals. b) Facility Plan of Correction The facility submitted the following Plan of Correction (POC) typed as written: F- 689 Resident #8 Resident was evaluated by the licensed nurse upon return to the facility, orders received to obtain x-rays of bilateral lower extremities (BLE) from the physician on 09/17/24. On 09/17/24 the Director of Nursing (DON) interviewed the van driver, the aide assisting with transport and the resident who is alert and orientated to identify if the van was traveling too fast, if driver hit the brakes to hard or negotiated a turn too fast causing residents to slide out of the wheelchair onto floor of the facility van. All staff interviewed indicated No to the above questions. The NHA interviewed the Director of Rehab (DOR) who was present when Resident #8 requested his manual wheelchair for transport to the bank in the facility van. The Director of Rehab, Resident #8 was demanding his manual wheelchair and did not want to wait. (Initials of Resident #8 was secured with the facility van seatbelt and wheelchair was locked into place in the van with securing straps per van protocol. All residents have the potential to be affected. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The director of rehab (DOR)/designee initiated an audit on 09/23/24 for all residents in wheelchairs that utilize the facility van to determine safety for transport. Corrective action implemented immediately upon discovery. The Director of Rehab (DOR)/designee will reeducate all interdisciplinary team, medical records/resident appointment scheduling and van driver with a posttest to validate understanding regarding appropriateness of van utilization for transportation, positioning/devices in wheelchairs . The Director of Nursing (DON)/designee will reeducate all Certified Nursing Assistants on removal of lift sling prior to transport in facility van on or before 10/04/24. The Director of Nursing (DON)/designee will reeducate all nursing staff on the post fall process, including any resident that has a fall must be evaluated by a nurse or medical provider prior to moving the resident on 11/19/24 and prior to nursing staff's next scheduled shift. Medical Records/resident appointment scheduling will bring the upcoming week's transportation schedule to IDT on Thursdays for review to ensure the appropriateness of the van for transportation. Any appointments added after the review must be discussed with the IDT team prior to transporting the Resident. Results of monitors will be reported by the NHA/designee monthly to the quality improvement committee for any additional follow up and/or in-servicing until the issue is resolved and randomly thereafter.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. 31826 Based on resident interview, record review and staff interview, the facility failed to ensure Resident #8 who was a trauma survivor received culturally competent, trauma-informed care in accordance with professional standards of practice which accounted for his experiences and preferences to eliminate or mitigate triggers that may cause re-traumatization of the resident. This was true for one (1) of two (2) residents reviewed for the care area of mood and behavior during the long-term care survey process. Resident Identifier: #8. Facility Census: 54. Findings Included: a) Resident #8 During the initial screening process of the long-term care survey, it was discovered Resident #8 had an Minimum Data Set (MDS) trigger for Post Traumatic Stress Disorder (PTSD). During an interview with Resident #8 on 11/18/24 at 4:19 PM when asked if he had any problems related to PTSD he stated, I was in the army and also losing our son was very traumatic. He further stated, I have been here for a long time and have lost many friends here and that is hard on me. A review of Resident #8's care plan found no mention of PTSD. The care plan also did not mention Resident #8's army service, the loss of his son, nor the trauma of losing friends while being at the facility. When asked what services the facility had provided to him to assist with his PTSD he stated, None really. He indicated that he talks to a counselor at the Veteran Administration (VA) on a video chat. He stated, I set that up myself. A review of Resident #8's medical record found no records from the VA regarding the residents counseling. Once the surveyor requested the records the facility contacted the VA and had them sent over. During an interview with the Director of Nursing (DON) in the afternoon of 11/21/24 she stated, (First Name of Resident #8) sets the counseling up on his own. He is very private about that. When asked how they know if the counselor makes recommendations or wants to change the resident's treatment plan she stated, If he tells us we will then call and get the records. She confirmed there were no records from the VA in the resident's record prior to the surveyor's request. During an interview with the Social Service Director at 12:00 PM on 11/21/24 she confirmed the care plan did not mention the residents PTSD. She agreed his triggers had not been assessed and there was no treatment plan in place.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 31826 49465 49751 Based on record review and interview the Pharmacist failed to accurately review and complete monthly Medication Regimen Review (MRR). This failed practices was found to be true for 3 of 5 residents reviewed for the unnecessary medication care area during the Long Term Care Survey process. Resident identifiers: #47, #8, #33. Facility census: 54. Findings included: a) Resident # 47 During record review on 11/20/24 the following orders were noticed for Resident #47 who was ordered Nothing by Mouth (NPO): (as written in medial record) NPO (nothing by mouth) diet, NPO texture, NPO consistency Diet Active 10/17/2024 09:54 Acetaminophen Tablet 325 MG (Acetaminophen) Give 2 tablet by mouth every 4 hours as needed for Mild Pain More than 3 doses in 48 hours, notify physician/advanced practice provider(APP).Do not exceed 3g/day. (standing order) Acetaminophen Tablet 325 MG Give 2 tablet by mouth every 6 hours as needed for Temp 100F or above Notify Physician/Advanced Practice provider. Do not exceed 3g/day Milk of Magnesia Suspension 400 MG/5ML (Magnesium Hydroxide) Give 30 ml by mouth as needed for Constipation give at bedtime if no BM in 3 days Midodrine HCl Tablet 5 MG Give 1 tablet by mouth three times a day for Hypotension Sennosides Tablet 8.6 MG Give 2 tablet by mouth two times a day for constipation Further record review on 11/20/24 revealed the following progress note 10/18/2024 15:17 General (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Note: All medications reviewed with (Dr. name here). In agreement with regimen. During an interview with the Director of Nursing (DON) on 11/20/24 at 3:10 PM who confirmed the MRR completed after admission did not identify the orders for resident to not receive medications by mouth. b) Resident #8 Resident #8's medical record on 11/20/24 found the pharmacist completed a drug regimen review on 05/20/24 and made recommendations according to the pharmacist note in the electronic medical record. A copy of the recommendations made by the pharmacist on 05/20/24 was requested from the Director of Nursing (DON) in the afternoon of 11/20/24. She later confirmed she could not locate the recommendation made by the pharmacist on 05/20/24. c) Resident #33 A record review on 11/20/24 at 1:18 PM, revealed a Pharmacy Review for 05/2024 that reads as follows: A medication regimen review was performed- see report for comments/recommendations noted. During an interview on 11/20/24 at 1:19 PM, the Director of Nursing (DON) stated, I cannot find what the recommendation was for May. I have a doctor's note that she started Ativan 5 days later. If that helps you any. The DON later confirmed that she can not find what the pharmacy recommended for the Month of May 2024 for Resident #33.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. 31826 Based on record review and staff interview, the facility failed to ensure all residents were free from significant medication errors. This was a random opportunity for discovery found during the investigation of a facility complaint. Resident Identifiers: Resident # #160, #11, #15, #14, #13, #161, #3, #59, #23, #164, #24, #35, #165, #166. Facility Census: 54. Findings included: a) 07/31/24 A review of a complaint received by the state agency on 08/02/24 and reviewed during a complaint survey which began on 11/18/24 found on 07/31/24 several residents missed there night time medication. A review of the incident reports found the nurse had reported to work after being involved in an accident. It was observed she was not able to perform her duties, so she was sent home, and another nurse came to take her place about an hour after she left. The nurse before leaving gave a report to the nurse who was working at the facility, but it was not clear if the medications had been administered or not. Because it was not clear if the medication had been administered the oncoming nurse who arrived at the facility an hour later did not administer any of the medications. The facility identified the errors the next morning and the physician had seen each resident who had missed medications, and no adverse reactions were identified. The facility-initiated education for nurses which included the following: Nurse hand off responsibilities/emergency situations: In the event a nurse must leave their shift unexpectedly the On- Coming nurse must ensure that they ask what tasks have been completed and what tasks haven't. - Medication that have been passed - Medications that still need to be administered - Any documentation that needs to be completed - Controlle Count If you have questions or concerns regarding mediation (administering late) contact the MD for an order to GIVE or HOLD the medications and document a short note in each residents chart. - MD verbal order obtained to administer 9a/9p/etc medication late resident/representative aware. Or MD verbal order obtained to hold all 9a/9p/etc. medications, resident/representative aware. However the facility failed to put in place a plan to ensure if the nurse was unable to give a report what they would do to ensure medications were not missed. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the Director of Nursing (DON) in the early afternoon of 11/21/24 confirmed licensed nurse #200 reported to work on the evening of 07/31/24. However, on her way to work she had been involved in an automobile accident. The nurse working with Licensed Nurse #200 phoned the DON and told her she seemed off and should not be working. They decided to send her home and have Registered Nurse (RN) #41 cover her shift. The DON indicated Licensed Nurse #200 left around 9:00 PM and RN #41 arrived at the facility between 10:00 PM and 10:30 PM. When asked why RN #41 did not give the medications considering they were not initialed off on the Medication Administration Record and were showing red on the electronic medical record system. The DON replied she was not sure if License Nurse #200 had given them because the report she received was not good. She stated, she didn't want them to have double doses. She indicated that is why they educated nursing on ensuring and accurate and comprehensive report was given if they had to leave their shift early. The following residents missed medications which are considered significant medications and omission of the medications are considered significant medication errors: Resident #160: - Eliquis Oral Tablet 2.5 MG (Apixaban) Give 1 tablet by mouth two times a day for Afib -- TEGretol Oral Tablet 200 MG (Carbamazepine) Give 0.5 tablet by mouth three times a day for Trigeminal neuralgia (Trigeminal neuralgia (TN) is a chronic pain disorder that causes sudden, severe facial pain. It's also known as tic douloureux, and it affects the trigeminal nerve, which controls sensation and movement in the face.) Resident #11: -- INSULIN GLARGINE-YFGN OUTER, SUV 100UNIT/1ML INSULN PEN Inject 14 unit subcutaneously at bedtime for a diagnosis of diabetes. Resident #15: -- Rivaroxaban Oral Tablet 10 MG (Rivaroxaban) Give 1 tablet by mouth one time a day for clot prevention (This medication thins the blood to prevent blood clots). Resident #14: - Carvedilol Tablet 25 MG Give 1 tablet by mouth two times a day for Hypertension - Furosemide Tablet 20 MG Give 3 tablet by mouth two times a day for edema Resident #13: -- Carvedilol Oral Tablet 12.5 MG (Carvedilol) Give 1 tablet by mouth two times a day for HTN (Hypertension) Resident #161: (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-- HumaLOG Injection Solution 100 UNIT/ML (Insulin Lispro) Inject as per sliding scale: if 70 - 149 = 8 BS 70 to 149 give 8 units; 150 - 199 = 11 BS 150-199 give 11 units; 200 - 249 = 14 BS 200-249 give 14 units; 250 - 400 = 17 BS 250-400 give 17 units, subcutaneously before meals for Diabetes Reisdent #3: -Keppra Solution 100 MG/ML (LevETIRAcetam) Give 5 ml by mouth two times a day for Seizures - Metoprolol Tartrate Tablet 100 MG Give 1 tablet by mouth two times a day for HTN Resident #59: -Lantus SoloStar Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Glargine) Inject 50 unit subcutaneously at bedtime for DM. -HumaLOG Injection Solution 100 UNIT/ML (Insulin Lispro) Inject as per sliding scale: if 151 - 200 = 2 units; 201 - 250 = 4 untis; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units If BS is over 400 call the physician for orders, subcutaneously before meals and at bedtime for DM if BS <70 or > 400 notify MD (Medical Doctor) for a Diagnosis of Diabetes. Resident #23: -- Lyrica Capsule 100 MG (Pregabalin) Give 1 capsule by mouth two times a day for nerve pain Resident #164: --Carvedilol Oral Tablet 12.5 MG (Carvedilol) Give 1 tablet by mouth two times a day for HTN Resident #35: -- Insulin Glargine-yfgn Subcutaneous Solution Peninjector 100 UNIT/ML (Insulin Glargine-yfgn) Inject 30 unit subcutaneously at bedtime for Diabetes. Resident #165: -- Eliquis Oral Tablet 2.5 MG (Apixaban) Give 1 tablet by mouth two times a day for blood clot prevention Resident #166: - Acyclovir Oral Tablet 400 MG (Acyclovir) Give 1 tablet by mouth two times a day for hemophilia A (Free Bleeder)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 31826 Based on observation and staff interview, the facility failed to ensure menus were followed for the noon time meal on 11/18/24. This was true for 10 residents who were eating their noontime meal in the dining room on 11/18/24. Facility Census: 54 Findings Included: a) Noon time Meal Observation An observation of the noon meal service on11/18/24 found the Certified Dietary Manager (CDM) was serving the meal from a steam table located in the dining room. Near the end of the service, it was noted the residents were no longer being served broccoli with their meal. The residents were only served pinto beans, pan fried potatoes, and corn bread. An interview with the CDM immediately following the meal service confirmed she ran out of broccoli. When asked why there was not enough broccoli for all the residents she stated, I must of over scooped (gave too much) you made me nervous. When asked how many residents did not receive broccoli, she stated 10 residents. A review of the menu for this meal found each resident should have received one half of a cup of broccoli.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 31826 Based on record review and staff interview, the facility failed to ensure the medical record was complete and accurate for 18 residents reviewed during the long-term care survey process. Resident identifiers: #4, #209, #47, #23, #8, #160, #11, #15, #14, #13, #161, #3, #59, #164, #24, #35, #165, and #166. Facility Census: 54. Findings Included: a) Resident #4 An interview with Resident #4 on 11/20/24 at approximately 4:45 PM, Resident #4 stated, I have to wear this brace all the time. I changed braces recently because the bar on the other rubbed a blister on my lower leg, but it is healed now. When asked if the facility staff remove the brace daily to look at his skin he stated, Yes they take it off every day and look at my skin underneath it and then put it back on. A review of Resident #4's treatment administration record for the months of October 2024 and November 2024 found no documentation to indicate the resident's brace was removed and the skin was checked for integrity. During an interview with the Director of Nursing (DON) in the morning of 11/21/24 when asked if they were monitoring the resident skin for skin integrity she provided the surveyor with an ordered dated 11/21/24 which read as follows, Left knee immobilize at all times while out of bed. Remove QS for hygiene and skin check. When asked if there was documentation prior to this order about the brace being removed she reviewed the Treatment Administration Records and handed them back to the surveyor and said, I just gave you the updated current order. b) Resident #8 1) Code Status A review of Resident #8's medical record on 11/19/24 found a Physician Orders for Scope of Treatment (POST) form which indicated the resident wanted to be a full code and receive all life sustaining treatment. This form was signed by the resident on 10/11/24 and by the physician on 10/14/24. The record also contained a POST form signed by the resident on 11/09/24 and by the physician on 11/11/24 which also indicated the resident wanted to be full code and received all life sustaining treatment. A review of the Social Service Assessment and Documentation Dated 11/11/24 indicated under section 5. Resident Rights/Healthcare Decision Making/Advance Directives under letter g. Social Worker #4 had entered DNR/Select Treatments to indicate the resident did not want to be a full code and receive full medical treatment. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the Social Service Director on the morning of 11/21/24 confirmed the social service assessment was not accurate. 2) Diagnosis of Post Traumatic Stress Disorder (PTSD) A review of Resident #8's medical record found he had a diagnosis of PTSD entered into his medical record 10/01/15. Further review of the medical record found Social Services Assessment and Documentation assessments completed on 10/11/24 and 11/11/24. Contained in the assessments was this question, Does the patient/resident report or does the medical record reflect any history of trauma and/or Post Traumatic Stress Disorder (PTSD)? Social Worker #4 answered no to this question on all of the above referenced assessments despite an active diagnosis of PTSD since 2015. An interview with the Social Service Director on the morning of 11/21/24 confirmed the social service assessment was not accurate. c) 07/08/24 While reviewing the medication administration record for multiple residents related to an incident which occurred on 07/31/24 it was noted there were blanks for the same residents and medications for 07/08/24. When asked why the medications were not given on 07/08/24 the Director of Nursing (DON) stated, I will have look and see why there are blanks on the MAR for 07/08/24. In an interview on 11/21/24 at 11:17 AM the DON reported the Internet was down at this time and the staff were not able to document the medication as given in the electronic medical record. She was asked if they had a backup paper system where the medications were documented. She indicated there should have been, but she could not locate it. The following residents medical record was inaccurate in regard to medication administration for 07/08/24 for the following medications. The following residents missed medications which are considered significant medications and omission of the medications are considered significant medication errors: Resident #160: - Eliquis Oral Tablet 2.5 MG (Apixaban) Give 1 tablet by mouth two times a day for Afib -- TEGretol Oral Tablet 200 MG (Carbamazepine) Give 0.5 tablet by mouth three times a day for Trigeminal neuralgia (Trigeminal neuralgia (TN) is a chronic pain disorder that causes sudden, severe facial pain. It's also known as tic douloureux, and it affects the trigeminal nerve, which controls sensation and movement in the face.) Resident #11: -- INSULIN GLARGINE-YFGN OUTER, SUV 100UNIT/1ML INSULN PEN Inject 14 unit subcutaneously at bedtime for a diagnosis of diabetes. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #15: -- Rivaroxaban Oral Tablet 10 MG (Rivaroxaban) Give 1 tablet by mouth one time a day for clot prevention (This medication thins the blood to prevent blood clots). Resident #14: - Carvedilol Tablet 25 MG Give 1 tablet by mouth two times a day for Hypertension - Furosemide Tablet 20 MG Give 3 tablet by mouth two times a day for edema Resident #13: -- Carvedilol Oral Tablet 12.5 MG (Carvedilol) Give 1 tablet by mouth two times a day for HTN (Hypertension) Resident #161: -- HumaLOG Injection Solution 100 UNIT/ML (Insulin Lispro) Inject as per sliding scale: if 70 - 149 = 8 BS 70 to 149 give 8 units; 150 - 199 = 11 BS 150-199 give 11 units; 200 - 249 = 14 BS 200-249 give 14 units; 250 - 400 = 17 BS 250-400 give 17 units, subcutaneously before meals for Diabetes Resident #3: -Keppra Solution 100 MG/ML (LevETIRAcetam) Give 5 ml by mouth two times a day for Seizures - Metoprolol Tartrate Tablet 100 MG Give 1 tablet by mouth two times a day for HTN Resident #59: -Lantus SoloStar Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Glargine) Inject 50 unit subcutaneously at bedtime for DM. -HumaLOG Injection Solution 100 UNIT/ML (Insulin Lispro) Inject as per sliding scale: if 151 - 200 = 2 units; 201 - 250 = 4 untis; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units If BS is over 400 call the physician for orders, subcutaneously before meals and at bedtime for DM if BS <70 or > 400 notify MD (Medical Doctor) for a Diagnosis of Diabetes. Resident #23: -- Lyrica Capsule 100 MG (Pregabalin) Give 1 capsule by mouth two times a day for nerve pain Resident #164: --Carvedilol Oral Tablet 12.5 MG (Carvedilol) Give 1 tablet by mouth two times a day for HTN Resident #35: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-- Insulin Glargine-yfgn Subcutaneous Solution Peninjector 100 UNIT/ML (Insulin Glargine-yfgn) Inject 30 unit subcutaneously at bedtime for Diabetes. Resident #165: -- Eliquis Oral Tablet 2.5 MG (Apixaban) Give 1 tablet by mouth two times a day for blood clot prevention Resident #166: - Acyclovir Oral Tablet 400 MG (Acyclovir) Give 1 tablet by mouth two times a day for hemophilia A (Free Bleeder) d) Resident #23 On 11/20/24 at 1:30 PM, a record review was completed for Resident #23. The review found the resident was transferred to an acute care facility on 08/15/24 for altered mental status. However, the transfer form listed the transfer date as 03/02/24. On 11/21/24 at 9:45 AM, the Director of Nursing was notified and confirmed the date listed on the transfer form was incorrect. e) Resident#47 During record review on 11/20/24 the following orders were noticed for Resident #47 who was ordered Nothing by Mouth (NPO); As written in the medial record: NPO (nothing by mouth) diet, NPO texture, NPO consistency Diet Active10/17/2024 09:54 Acetaminophen Tablet 325 MG (Acetaminophen) Give 2 tablets by mouth every 4 hours as needed for Mild Pain More than 3 doses in 48 hours, notify physician/advanced practice provider(APP).Do not exceed 3g/day. (standing order) Acetaminophen Tablet 325 MG Give 2 tablets by mouth every 6 hours as needed for Temp 100F or above Notify Physician/Advanced Practice provider. Do not exceed 3g/day Milk of Magnesia Suspension 400 MG/5ML (Magnesium Hydroxide) Give 30 ml by mouth as needed for Constipation give at bedtime if no BM in 3 days Midodrine HCl Tablet 5 MG Give 1 tablet by mouth three times a day for Hypotension (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Pharmacy Active 10/18/2024 21:00 Sennosides Tablet 8.6 MG Give 2 tablets by mouth two times a day for constipation During an interview with the Director of Nursing (DON) on 11/20/24 at 3:00 PM, who states, some of those orders are prepopulated standing orders and was clicked by the admitting nurse, and a nurse that did not do the admission are supposed to check the orders within 24 hours after admission, and only new orders are looked at daily. f) Resident #209 Record review on 11/19/24 at 3:05 PM revealed Resident #209 had an order for a catheter due to urinarily retention, and was care planned for a catheter for urinary retention, however, does not have a medical diagnosis for urinary retention in the diagnosis list on the medical record. An interview on 11/19/24 at 3:28 PM the Director of Nursing (DON) confirmed the Urinary Retention diagnosis was not listed on the medical Diagnosis portion of the medical record. 45173 49751

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 49751 Based on observations and staff interviews, the facility failed to have an effective infection control program by leaving an oxygen tube laying on the floor. This was a random opportunity for discovery during the long-Term Care Survey process. Resident identifier: #47. Facility Census: 54. Findings included: a) Resident #47 An observation on 11/18/24 at 11:38 AM revealed Oxygen nasal tubing on floor beside bed and under chair for Resident #47. Another observation on 11/19/24 at 11:51 AM revealed Oxygen nasal tubing remained on the floor beside bed under the chair. Further observation and staff Interview on 11/20/24 at 9:37 AM Oxygen nasal tubing still in the same spot in the floor corporate staff #77 confirmed it should not be on the floor and immediately gloved up and threw the oxygen nasal tubing that had been on the floor from 11/18/24 through 11/20/24 in the trash.