| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure that every resident was treated with respect and dignity for 2 of 2 sampled Residents (R71 & R146) and 2 of 2 supplemental Residents (R13 & R67) reviewed for Resident rights.<br><br>R13, R67, R71, and R146 expressed concerns about R82 wandering into their private rooms uninvited.<br><br>This is evidenced by:<br><br>The facility policy titled Promoting/Maintaining Resident Self-Determination dated 4/22/25 states: It is the practice of this facility to protect and promote resident rights by facilitating resident self-determination through support of resident choice. The facility will ensure that each resident has the opportunity to exercise his/her autonomy regarding those things that are important in his/her life such as food, interests, and preferences.<br><br>Example 1<br><br>R13 was admitted to the facility on [DATE] with diagnoses that include: vascular dementia, hypertension (high blood pressure), chronic kidney disease, congestive heart failure, and intervertebral disc degeneration (breakdown of discs that separate the bones of the spine).<br><br>R13's Quarterly Minimum Data Set (MDS) dated [DATE] indicates R13 scored 15 out of 15 on her Brief Interview for Mental Status (BIMS), indicating she is cognitively intact.<br><br>On 4/30/25 at 9:52 AM, Surveyors observed R82 enter R13's room without knocking on the door. R82 proceeded into the room and sat in R13's wheelchair while R82 was resting in her recliner. One surveyor stayed with R13 and R82 while another Surveyor alerted LPN X (Licensed Practical Nurse), who was the nearest staff member. LPN X escorted R82 out of R13's room.<br><br>On 4/30/25 at 9:56 AM, Surveyors interviewed R13. R13 stated R82 comes into her room uninvited all the time. Surveyor asked R13, when R82 comes into your room what does she do. R13 stated, When she comes in, she sits down. Sometimes she touches me. I don't like it. They should take care of her so she doesn't come in here. I don't like it. Surveyor asked R13 if she feels safe. R13 stated she feels safe. R13 added, I don't want her around here; she's crazy. R13 was unable to specify where R82 touches her.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 4/30/25 at 10:30 AM, Surveyors spoke with LPN X. Surveyor asked LPN X, are there residents that wander into other residents' rooms uninvited. LPN X stated, R82. LPN X stated, R82 will wander the whole unit as well as the other units (within the Memory Care Units). Surveyor asked LPN X, are there any residents that get upset by R82 wandering into their room uninvited. LPN X stated, no, they know the routine and say oh there she (R82) is again. Surveyor asked LPN X, what is the facility doing to prevent R82 from wandering into other resident rooms uninvited. LPN X stated, staff will redirect R82. Surveyor asked LPN X, does R82 become aggressive, LPN X stated, no, not usually. Surveyor asked LPN X, what does R82 do when she wanders into other residents' room. LPN X stated, R82 is looking for something familiar, is bored or lost. LPN X stated, R82 has no intent she's just wandering and confused. Surveyor asked LPN X, is it acceptable for a resident to go into another resident's room uninvited. LPN X stated, no. LPN X added, if she was a resident she would not want a resident coming in her room either.<br><br>Example 2<br><br>R67 was admitted to the facility on [DATE] with diagnoses that include: post-concussion syndrome (symptoms that persist after a concussion has occurred), dysphagia (difficulty swallowing), anxiety disorder, history of ischemic attack (TIA - mini stroke) and cerebral infarction (stroke).<br><br>R67's admission Minimum Data Set (MDS) dated [DATE] indicates R67 scored 3 out of 15 on her Brief Interview of Mental Status (BIMS), indicating she is severely cognitively impaired.<br><br>On 4/30/25 at 4:22 PM, Surveyor interviewed R67. Surveyor observed R67's room is directly across from R82's room. R67 stated R82 often comes into her room uninvited, and said it bothers her because she shouldn't do that, but said that R82 seems to like when R67 talks to her. R67 said staff grabs R82's arm and pull her away and tell her to sit down when they find her in R67's room. R67 stated she feels safe in the facility.<br><br>Example 3<br><br>R71 was admitted to the facility on [DATE] with diagnoses that include spinal stenosis (spinal narrowing), major depressive disorder, type 2 diabetes, dementia, generalized anxiety disorder, insomnia (difficulty falling or staying asleep), hypertensive chronic kidney disease (kidney disease caused by high blood pressure), and repeated falls.<br><br>R71's Significant Change Minimum Data Set (MDS) dated [DATE] indicates R71 scored 6 out of 15 on his Brief Interview of Mental Status (BIMS), indicating he is severely cognitively impaired.<br><br>On 4/30/25 at 8:10 AM, Surveyor interviewed R71 while R82 was sitting nearby in the common area. R71 indicated R82 comes into his room when he is in the bathroom on the toilet and at the sink. R71 stated R82 will sit on his bed while he is in bed. R71 stated, See? She's checking me out. Wherever I go she's there. She's like a bad dream. R71 stated, R82 usually comes in his room uninvited two (2) times a day. R71 stated, he has expressed concerns to multiple staff members regarding his concern with R82 wandering into his room uninvited.<br><br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 5/5/25 at 8:57 AM, Surveyors spoke with SW CC (Social Worker). Surveyor asked SW CC, can you tell us about R82 wandering into other residents' rooms uninvited and what is being done to prevent it. SW CC indicated, she can't recall off the top of her head. Surveyor asked SW CC, are any residents upset by R82 wandering into their rooms uninvited. SW CC stated, R71. SW CC added, we have a grievance open about this. SW CC stated, she does not know when it happened. SW CC stated, R71 expressed to her that he is frustrated that R82 comes in his room. SW CC stated, she has had conversations with R71 that R82 doesn't mean any harm but validated that it is frustrating to him.<br><br>On 5/5/25 at approximately 9:15 AM, SW CC shared the grievance R71 filed on 4/30/25 with Surveyors. The grievance indicates R71 is frustrated with R82 wandering into his room. SW CC has talked with R71 regarding this concern. As of 5/5/25, the grievance was still open.<br><br>Example 4<br><br>R146 was admitted to the facility on [DATE] with diagnoses that include aftercare following joint replacement surgery, presence of left artificial knee joint, infection and inflammatory reaction due to internal left knee prosthesis (artificial joint), arthritis due to other bacteria - left knee, hypertension (high blood pressure), dementia, and chronic kidney disease.<br><br>R71's admission Minimum Data Set (MDS) dated [DATE] indicates R146 scored 8 out of 15 on her Brief Interview of Mental Status (BIMS), indicating she is moderately cognitively impaired.<br><br>On 4/29/25 at 8:12 AM, Surveyors interviewed R146. R146 stated, on 4/28/25, her first night at the facility, R82 walked into her room uninvited behind a nurse and sat on her legs. R146 added, she just had surgery on her left knee. R146 stated, That shock and that pain I will never forget. R146 stated, of course it shocked the person she followed in and it shocked me more. R146 stated, staff apologized profusely, but it still happened.<br><br>On 4/28/25 at 11:45 PM, R146's Progress Notes document the following: The resident is adjusting well. At bedtime, the resident was about to sleep when another resident entered her room and sat on her new surgery Knee. The medical doctor was notified and instructed me to monitor the resident. If the pain became unbearable we were to send the resident to the hospital .<br><br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 4/30/25 at 3:00 PM, Surveyor spoke with RN H (Registered Nurse). RN H stated, on the evening of 4/28/25, she was at the nurses' station when the CNA (Certified Nursing Assistant) notified her that R82 sat on R146's surgical knee. RN H stated, the CNA got R146 an ice pack, and she called the physician to report it. RN H stated, the physician stated to monitor R146's pain level and if it is still painful in the morning to call to call the orthopedic physician. RN H stated, she checked on R146 in the morning. RN H stated, R146 was shaken up but okay. RN H stated, she reported this off to other nurses. RN H stated, R82 has Alzheimer's disease and cognitive challenges. RN H stated, the only solution is 1:1 which challenging with staff. RN H stated, the facility implemented 1:1 quite a while ago. RN H stated, R82 likes to enter other residents' room. RN H stated, R71 gets upset when R82 wanders into his room uninvited. RN H stated, staff will take R82's hand and guide her out of the room which can be challenging. RN H stated, she will need to point to help R82 to understand what is being communicated. RN H stated, R82's family member would be a good resource. Surveyor asked RN H, is it acceptable for a resident to wander into other residents' rooms uninvited. RN H stated, no, it's not. RN H added, it's challenging with R82. RN H added, staff have tried games, coloring and other activities. RN H added, however, R82's attention span is short. RN H reiterated, 1:1 may be the only solution.<br><br>On 4/30/25 at 10:12 AM, Surveyors spoke with CNA Y. Surveyor asked CNA Y, are there any residents that wander into other resident rooms uninvited. CNA Y stated, yes, R82. CNA Y added, on 4/28/25 R82 wandered into other resident rooms uninvited all day and night but it depends on the day. CNA Y stated, R82 will lay on other residents' beds, get into the beds, sit on couches and chairs in other residents' rooms. CNA Y stated, taking R82 back to her room does not work and she will get combative with staff. Surveyor asked CNA Y, is R82 able to open closed doors. CNA Y stated, yes. CNA Y added, R82 wanders onto other units as well (within the Memory Care Units). CNA Y stated, R82 will speak multiple words in her native language. Surveyor asked CNA Y, does the facility use any alarm or stop signs for R82. CNA Y stated no, she is unsure if the facility has tried these interventions.<br><br>On 5/2/25, R82's Progress Notes document the following: Resident continues to wander into other resident's room and bed while residents are asleep. Writer was able to take resident for walk around the building and this was not effective. Resident showed physical aggression to staff during cares. Staff reports that resident hitting, kicked and scratched them during Pm cares. Resident was able to be redirected but continued with wandering shortly after. Staff have to take turns sitting with resident to prevent her from entering another resident room while they're asleep. resident is currently resting in recliner near burses [sic] station with eyes closed.<br><br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 5/5/25 at 8:20 AM, Surveyors spoke with DON B (Director of Nursing). Surveyor asked DON B, is it acceptable for a resident to wander into other residents' rooms uninvited. DON B stated, it's memory care so we definitely work hard to redirect wandering residents. DON B added, the residents have care plans due to their behaviors. Surveyor asked DON B, are you aware that R82 wanders into other residents' rooms uninvited. DON B stated, R82 used to have these behaviors (wandering) which slowed down a bit and now they are resurfacing. DON B added, it has been a challenge over the last week or two. Surveyor asked DON B, do other residents gets upset with R82 wandering into their rooms uninvited. DON B stated, R146. DON B added, she thinks that was the only wandering into a resident's room. DON B stated, R82 does go to activities and sometimes she just paces in a circle. Surveyor shared observations on 4/30/25 of R82 being checked on twice in 1 hour and then wandering into R13's room uninvited. Surveyor shared that R82 sat in R13's wheelchair while R13 remained silent in her recliner. Surveyor shared additional resident concerns from R67, R71 and R146 regarding R82 wandering into their rooms uninvited, sitting on their bed, sitting on their legs, entering their bathroom while they are on the toilet. Surveyor asked DON B, what has been done to address R82's wandering. DON B stated, we offered R146 a different room and staff redirect R82. R146 stated she does not want a different room. DON B stated, we offer to walk with R82, offer snacks/fluids, redirect her to the chair in her room. DON B stated, staff walk with R82 around the building. DON B stated, On 5/2/25 staff were taking turns sitting with R82. DON B added, she did not look at the care plan but instead looked at recent documented events. Surveyor asked DON B, why is it important that R82 (or other residents) do not wander in other residents' rooms. DON B stated, it can be uncomfortable for the other residents and put R82 at risk as well. Surveyor asked DON B, has the facility tried STOP signs (velcro signs that go across a doorway). DON B stated, she thinks the facility tried that and it was not effective. DON B stated, she had a history of wandering at home and would wander at night. Surveyor asked DON B, how often do you expect staff to check on R82. DON B stated, every one - two (1-2) hours. DON B stated, R82 is either right there into everything or relaxed and settled.<br><br>On 5/5/25 at 2:30 PM. Surveyors spoke with NHA A (Nursing Home Administrator). Surveyors asked NHA A to tell us about R82 wandering into other residents' rooms and what is being done to address it. NHA A stated, historically the facility trialed 1:1 with R82. NHA A stated, R82 worked as a schoolteacher. NHA A stated, in the dining room we sometimes will see unmet needs or tendencies from her past when she will reach out and pat other residents' heads while in the dining room. When R82 was at high risk of falls we did 1:1. NHA A stated, we found 1:1 made her more agitated especially at night. NHA A stated, the facility did trial STOP signs with her wandering and that was more of a reason for her to enter a room when curiosity took over. NHA A added, it wasn't effective.<br><br>The facility was aware that R82 is wandering into other residents' rooms uninvited. The facility did not implement interventions to prevent this from occurring. R13, R67, R71, and R146 voiced they do not want R82 wandering into their rooms uninvited.<br><br>Cross reference F689 |

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| F 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Allow residents to self-administer drugs if determined clinically appropriate.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure that all residents are clinically appropriate to self-administer medications for 1 of 1 residents (R17) reviewed for self- administration of medications.<br><br>R17 was observed to have a cup of medications left on her bedside table for her to take independently. R17 does not have an assessment for self-administration of medications indicating that she is safe to administer medications independently.<br><br>Evidenced by:<br><br>The facility's policy titled Resident Self- Administration of Medication dated 4/17/25 states in part, .3. When determining if self- administration is clinically appropriate for a resident, the interdisciplinary team should, at a minimum consider the following: a. The medications appropriate and safe for self- administration; b. The resident's physical capacity to open medication bottles, administer injections. c. The resident's cognitive status, including their ability to correctly name their medications and know what conditions they are taken for. d. The resident's capability to follow directions and tell time to know when medications need to be taken. e. The resident's comprehension of instructions for the medications they are taking, including the dose, timing, and signs of side effects, and when to report to facility staff .<br><br>R17 was admitted to the facility on [DATE] with diagnoses that include polyosteoarthritis (arthritis in five or more joints simultaneously), type 2 diabetes mellitus, muscle weakness, and unspecified macular degeneration (a type of age- related macular degeneration where the specific stage is not clearly defined- symptoms include: blurred or fuzzy vision, difficulty recognizing faces, wavy lines, or a blind spot in the center of vision).<br><br>R17's most recent Minimum Data Set (MDS) dated [DATE] states that R17 has a Brief Interview of Mental Status (BIMS) of 15 out of 15, indicating that R17 is cognitively intact. The MDS indicates that R17 requires substantial/ maximal assistance for completing Activities of Daily Living (ADLs), including bathing, oral care, dressing, and personal hygiene. The MDS also states that R17 has limited range of motion of her bilateral upper extremities (shoulder, elbow, writs, and hand).<br><br>The facility's assessment titled Self- Administration of Medications Review Tool dated 11/27/24 states in part . B. Approval 1. Physician order to self- administer medication(s): 2. No, 2. Approval to self- administer medication(s) granted: 2. No, 3. Reason for approval not granted, if applicable: Resident is unable to elaborate enough information regarding medications or administration to safely administer medications.<br><br>(continued on next page) |

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| F 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The facility's document titled Self- Administration of Medications with a completed date of 4/28/25 states A. Assessment 1. Is the resident cognitively impaired? 2. No. 2. Does the resident have a visual deficit? 2. No. 3. Is fine motor coordination impaired? 2. No. 4. Can the resident name medication dosages, frequency, and reason for use? 2. No .B. Conclusions .B. Based on the entire assessment and answers to these listed question numbers the resident WOULD BE considered safe to self- administer medications. WOULD BE. C. Plan 1. Does the resident want to self- administer all or some of their medications? 1. Yes .2. If the nurse feels the resident would be able to successfully administer their own medication, they will discuss it with their physician and plan set up for the resident per facility policy and procedure .Resident has requested that the nurse/ MAA (Medication Administration Aide) prepared meds be left by the bedside. Provider ordered.<br><br>It is important to note that R17 has a diagnosis of macular degeneration and polyosteoarthritis.<br><br>It is also important to note that the assessment dated [DATE] was not completed, nor the order obtained until after Surveyor made the observation of the medications at bedside.<br><br>On 4/28/25 at 9:42 AM, Surveyor interviewed R17. Surveyor noticed R17's medications sitting on the bedside table. Surveyor asked R17 if staff always leave the medications for her to take by herself, R17 stated no, lately she has needed help. R17 reported that she called for someone to help with the pills, and no one had come to help.<br><br>On 4/28/25 at 12:12 PM, Surveyor interviewed MAA FF (Medication Administration Aide). Surveyor asked MAA FF if she administered R17's medications this morning, MAA FF stated yes and that R17 gets upset if her medications aren't there and then she goes back to R17's room and helps her take them. Surveyor asked MAA FF if R17 has a self- administer assessment or order, MAA FF reported that it says to observe her take mediations, but that recently they have been having to give the medications to her.<br><br>On 4/2825 at 12:27 PM. Surveyor interviewed LPN N (Licensed Practical Nurse). Surveyor asked LPN N if R17 has an assessment or order to self-administer medications, LPN N stated no. Surveyor asked LPN N if R17's medications should be left in her room unattended, LPN N stated no.<br><br>Nurse's note dated 4/28/25 at 4:18 PM states: Nrs (nurse) manager notified that resident prefers her meds to be self-administered and will not eat her breakfast unless they are nurse/MAA prepared and left at the bedside. CP (Care Plan) updated, assessment completed, and banner updated as well. Order to self-administer bedside meds obtained at an earlier date. Will continue to follow plan of care.<br><br>On 4/29/25 at 2:58 PM, Surveyor interviewed LPN GG, who is also the Unit Manager. Surveyor asked LPN GG how she was made aware that R17 wanted to self- administer her medications, LPN GG stated that the medication aide told her that R17 will only eat breakfast if the medications were present and that R17 won't eat breakfast if the medications are not on the bedside table. Surveyor asked LPN GG if R17 not eating breakfast is an appropriate reason for leaving the medications at bedside, LPN GG stated no, but they aim to please. Surveyor asked if R17 qualifies to self- administer based on the assessment that was performed, LPN GG stated that R17 does not meet all the qualifications and that R17 is not able to identify the medications. Surveyor asked LPN GG if R17 is physically able to self- administer medications, LPN GG stated yes. Surveyor asked LPN GG if she observed R17 taking her medications, LPN GG stated no, and she was going from the information reported by the med aide.<br><br>(continued on next page) |

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| F 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 4/30/25 at 10:32 AM, Surveyor interviewed R17. Surveyor asked R17 if staff are allowing her to take medications independently, R17 stated no, and that she used to be able to take them independently but now that her condition has deteriorated, she needs help. Surveyor asked R17 if she refuses to eat breakfast until the medications are in the room, R17 stated no and that she wants to have something in her stomach before taking the medications. Surveyor asked R17 if she would be agreeable to having staff bring the medications in after she has eaten breakfast R17 stated yes. Surveyor asked R17 if LPN GG has ever discussed her medications with her, R17 stated no.<br><br>On 4/30/25 at 10:52 AM, Surveyor interviewed LPN GG. Surveyor asked LPN GG if she ever spoke with R17 about her medications when completing the assessment for self- administration, LPN GG stated no. Surveyor asked LPN GG if she had ever discussed R17's preference with her, LPN GG stated no and that she was going off the information provided by the med aide. Surveyor asked LPN GG how many of the criteria on the assessment need to be met to self- administer medications, LPN GG stated that she was not sure.<br><br>On 5/1/25 at 2:05 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B what the process is for determining if a resident is safe to self- administer medications, DON B reported that staff need to complete an assessment, get an order, update the banner, and update the care plan. Surveyor asked DON B if resident has to meet all of the criteria on the assessment, DON B stated no and that the form they are using does not give a score based on the answers and that residents should know what the medications are. Surveyor asked DON B if staff that are performing the assessments should meet with the resident, DON B stated yes. |

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| F 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.<br><br>Based on observation, interview, and record review, the facility did not document a thorough investigation and did not resolve grievances as outlined in the facility policy for 1 of 4 residents (R26) reviewed for grievances.<br><br>R26 voiced concern about staff being on their cell phones. The facility failed to follow up on the grievance.<br><br>Evidenced by:<br><br>The facility policy, Resident and Family Grievances, dated 10/23, states, in part; .3. The Grievance Official is responsible for overseeing the grievance process; receiving and tracking grievances through to their conclusion; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances and notifying the person filing the grievance of the decisions and outcome .<br><br>Surveyor reviewed January 2025 Resident Council Minutes. Minutes indicate R26 voiced concern about staff on their personal cell phones while working.<br><br>On 4/30/25 at 1:53 PM, Surveyor observed LPN HH (Licensed Practical Nurse) on their personal cell phone attempting to open a bank account.<br><br>On 4/30/25 at 1:57 PM, Surveyor observed LPN GG on their cell phone on a Facetime call while this Surveyor was completing the Medication Storage task.<br><br>On 4/30/25 at 3:10 PM, Surveyor observed LPN II on their personal cell phone talking about a resident.<br><br>On 5/5/25 at 8:21 AM, Activities Director J (AD) indicated any grievances discussed during Resident Council will go to the specific department to follow up on. AD J indicated she remembers R26 voicing a concern with cell phones. AD J indicated she brought the concern to the Director of Nursing. AD J indicated this was a previous DON, and she is unsure if there was any follow up. AD J indicated staff using cell phones during their work hours is an ongoing concern and has been brought up before by management.<br><br>Surveyor reviewed grievance log and did not see R26's concern.<br><br>On 5/5/25 at 8:43 AM, R26 indicated no one followed up with her regarding concern with staff on their personal cell phones during work hours. R26 indicated it is still a concern.<br><br>On 5/5/25 at 10:28 AM, DON B (Director of Nursing) indicated there wasn't specifically a grievance regarding cell phones, but everyone reviewed the cell phone expectations in February 2025. DON B indicated she would expect a thorough investigation and follow up on grievances.<br><br>The facility did not document a thorough investigation and did not resolve grievances as outlined in facility policy. |

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| | 525276 | A. Building<br>B. Wing | 05/05/2025 |

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| Complete Care at Maple Grove LLC | 3401 Maple Grove Dr.<br>Madison, WI 53719 |

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| F 0604<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that each resident is free from physical restraints that are not required to treat the resident's medical symptoms for 1 of 3 residents reviewed for restraints (R27).<br><br>R27 was placed in a low Broda chair (a specialty wheelchair that assists with positioning) that has brakes located on the back of the wheels at the bottom of the chair. R27's brakes were engaged while R27's was at the dining table, not allowing R27 to move the chair.<br><br>Evidenced by:<br><br>The facility's policy titled Restraint Free Environment dated 2/2025 states in part .Physical Restraint refers to any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. Physical restraints may include, but are not limited to: .Using devices in conjunction with a chair, such as trays, tables, cushions, bars or belts, that the resident cannot remove and prevents the resident from rising. Placing a resident in a chair that prevents the resident from rising .<br><br>R27 was admitted to the facility on [DATE] with diagnoses that include dementia, seizure disorder, psychotic disturbance, mood disturbance and anxiety, altered mental status, and malaise.<br><br>R27's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/20/25 indicates a Brief Interview for Mental Status (BIMS) was unable to be performed. A staff assessment of R27's mental status indicates R27 has moderate cognitive impairment. Section C1310 of the assessment indicates R27 has periods of inattention and disorganized thinking. Section GG indicates R27 requires setup assistance with eating, supervision for oral hygiene and upper body dressing, partial to moderate assistance for toileting and personal hygiene, and substantial to maximum assistance for showers, lower body dressing, and footwear. R27's mobility indicates she requires partial to moderate assistance for rolling left to right, sitting to standing, lying to sitting, chair to bed transfer, toilet transfer and walking 50 feet. R27 utilizes a wheelchair and is dependent on locomotion of 150 feet while in the wheelchair. Section J1800 any falls prior assessment indicates yes. Section J1900 number of falls since admission or prior assessment indicates the following: No Injury two or more. B. Injury two or more. C. Major injury indicates one.<br><br>R27's Activities of Daily Living (ADL) care plan initiated 9/4/24 revised on 11/25/24 states: Focus: At risk and/or potential for complications with deficits with ADLs r/t (related to) current medical/ physical status. Has meds/dx (medications/diagnosis) that can/may affect ADLs dated initiated 9/4/24 revised 9/7/24. Goal: Will be clean, dry, dressed appropriately and maintain ability to participate in ADLs through next review date 9/7/24 revised 11/25/24. Will be more independent with ADLs after set-up, cues and able to return to assisted living by discharge date . Interventions: Ambulation - may ambulate in room or hallway with w/c (wheelchair) trail 9/4/24 revised 2/28/25. Bed mobility: 1 assist 9/4/24 revised 2/28/25. Locomotion: 1 assist in Broda Chair 4/1/25. Transfers: 1 assist pivot with gait belt 9/4/24 revised 2/28/25. Prefers to get up around 7:00 AM and goes to bed around 8:00 PM 9/7/24.<br><br>(continued on next page) |

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| F 0604<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 5/5/25 at 8:30 AM, Surveyor observed R27. R27 was noted to be sitting close to the table in the Broda chair with the wheels locked, waiting for breakfast.<br><br>On 5/5/25 at 9:33 AM, Surveyor observed R27 still sitting at the dining room table in the Broda chair with the wheels locked. R27 was attempting to move the chair with her hands by grabbing onto the wheels, but the brakes remain locked.<br><br>On 5/5/25 at 10:40 AM, R27 was repositioned in the Broda chair, and the brakes were unlocked.<br><br>It is important to note that the brakes of the Broda chair are located on the back lower wheels, in a location that R27 is unable to physically reach. Additionally, this was a continuous observation of R27.<br><br>On 5/5/25 at 10:42 AM, Surveyor interviewed CNA R (Certified Nursing Assistant). Surveyor asked CNA R if R27 is able to self- propel in the Broda chair, CNA R stated that R27 used to be able to self- propel in her old wheelchair, but she hasn't seen R27 do it in the new chair.<br><br>On 5/5/25 at 1:50 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B if R27 is able to self- propel in her current chair, DON B stated yes. Surveyor asked DON B if the Broda chair brakes are located in a position that R27 cannot reach, and they are locked, and R27 is sitting up close to the table, would that be considered a restraint, DON B reported that it is hard to say. Surveyor asked DON B if R27 was attempting to move the wheels on the chair and was unable to do so because the wheels were locked, would that be considered a restraint, DON B did not reply.<br><br>On 5/5/25 at 2:40 PM, Surveyor observed R27 sitting in the Broda chair, up against the table with the wheels locked.<br><br>On 5/5/25 at 2:40 PM Surveyor interviewed RN DD (Registered Nurse). Surveyor asked RN DD if R27 can self-propel the Broda chair, RN DD stated yes, and that he has seen R27 do it. Surveyor asked RN DD if having the brakes locked is considered a restraint, RN DD stated yes.<br><br>R27's brakes were engaged while R27's was at the dining table, not allowing R27 to move the chair. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Example 3:<br><br>R28 was admitted to the facility on [DATE] and has diagnoses that include: Alzheimer's disease (Progressive brain disorder that slowly damages memory, thinking, and behavior) and polyosteoarthritis (arthritis in multiple joints).<br><br>R28's Annual Minimum Data Set Assessment (MDS), dated [DATE], shows R28's Brief Interview for Mental Status (BIMS) could not be conducted because R28 is rarely or never understood. Section C indicates R28 has short-term and long-term memory problems and has moderately impaired decision making skills regarding tasks of daily life. Section C also indicates R28 has behaviors of inattention and disorganized thinking.<br><br>R28's Comprehensive Care Plan indicates:<br><br>Focus: Mood/Behavior: Due to impaired cognition and dx (diagnosis) of other Alzheimer's disease. [Resident Name] is at risk for changes in mood and or behaviors. Exhibited behaviors consisting of calling out in native language, singing extremely loud, and striking at staff at times. Date initiated: 2/16/23.<br><br>Interventions/Tasks<br><br>BIMS/PHQ-9 (Patient Health Questionaire-9, Depression Screening) completed upon admission, quarterly, annually, and PRN (as needed) - PRN - Notify MD (Medical Doctor) as needed with concerns. Date Initiated: 2/16/23.<br><br>Calm approach. Remove stressors ie (in example): noisy/overstimulating area or other residents in personal space who are too close. Date Initiated: 2/16/23.<br><br>Check for comfort levels - pain, thirst, hunger, temperature - offering comfort as able/accepted. Date Initiated: 2/16/23.<br><br>Keep routine the same as much as able. Date Initiated: 2/16/23.<br><br>Observe/Monitor/Document behaviors/mood and notify supervisor, SW (Social Worker), and/or MD as needed. 1. Loud disruptive chanting. 2. Singing or verbalization that disrupt environment or peers. Date Initiated: 2/16/23.<br><br>Focus: Cognition: [Resident Name] has a dx of Alzheimer's dx. [Resident Name] is at risk for impaired cognition and ineffective verbal communication. Date Initiated: 2/16/23.<br><br>Meds/Labs/Treatments as Ordered/Accepted. Date Initiated: 12/20/23.<br><br>Anticipate needs. Observe for non-verbal cues indicating needs. Date Initiated: 12/20/23.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | BIMS/PHQ-9 (Patient Health Questionaire-9, Depression Screening) completed upon admission, quarterly, annually, and PRN (as needed) - PRN - Notify MD (Medical Doctor) as needed with concerns. Date Initiated: 2/16/23.<br><br>Observe for a change in cognition - level of alertness, confusion, forgetfulness. Reorient as needed, determine if able to reorient. Review changes with MD (Medical Doctor)/NP (Nurse Practitioner). Date Initiated: 2/16/23.<br><br>Remind/Redirect and/or reassure as needed. Using tactile cueing, words from her communication list. Date Initiated: 2/16/23.<br><br>SS (Social Services) to intervene as needed. Date Initiated: 2/16/23.<br><br>Resident does not use call light, anticipate needs. Date Initiated: 2/16/23.<br><br>The section of the Comprehensive Care Plan titled, Special Instructions, states, in part: .Palliative Care Interpreter contact number: Nepalese [Phone number] (ask interpreter to use simple Nepali words).<br><br>R28's Care Card, posted in R28's bathroom, indicates: Communication: Uses facial expressions to communicate, responds well to laughing and smiling/hand gestures. Psychosocial - Mood: Remind/Redirect and/or reassure as needed. Using tactile cueing, words from her communication list. The Special Instructions section of this document also lists the interpreter phone number.<br><br>Surveyor requested the facility's Language and Communication Policy. The facility provided Surveyor with instructions on how to use the facility's phone interpreter services. Surveyor notes that Nepalese is listed on the document titled, Top Language Codes.<br><br>On 4/30/25 at 10:21 AM, Surveyor interviewed LPN N (Licensed Practical Nurse). Surveyor asked LPN N how she communicates with R28. LPN N indicates the facility has a paper they ask R28 to point at but doesn't think R28 really understands. LPN N indicates she tries to show R28 two objects so she can pick between them. Surveyor asked LPN N if R28 speaks any English. LPN N indicates, no. Surveyor asked LPN N if she knew what language R28 speaks. LPN N indicates, no. LPN N also indicates she tried to download a translation app once but it did not work, so she has asked other staff to communicate with R28.<br><br>On 4/30/25 at 9:53 AM, Surveyor interviewed CNA V (Certified Nursing Assistant). Surveyor asked CNA V if she knows which language R28 speaks. CNA V indicates, no. Surveyor asked CNA V if she has ever used a translator to communicate with R28. CNA V indicates, no. Surveyor asked CNA V if R28 speaks any English. CNA V indicates, no.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 5/5/25 at 2:01 PM, Surveyor asked DON (Director of Nursing) B. Surveyor asked DON B what the expectation is for staff when communicating with residents who speak a different language. DON B indicates staff should check the care plan, use the language line (phone translator), use cueing and picture boards. Surveyor asked DON B if staff should be using a translator to communicate with residents who speak a different language. DON B indicates, yes. Surveyor asked DON B if she knows what language R28 speaks. DON B indicates she does not but it is on her care plan. Surveyor asked DON B if R28 speaks any English. DON B indicates she thinks she understands some English but does not speak English. Surveyor asked DON B what her expectation is of staff when communicating with R28. DON B indicates she expects staff to use gestures, showing the resident objects, and if having bad behaviors to use the language line.<br><br>R28's care plan was not followed for using the interpretive services to communicate with R28 in her preferred language.<br><br>Based on observation, interview, and record review, the facility failed to develop a person-centered comprehensive care plan to meet personal preferences and goals, or address the resident's medical, physical, mental, and psychosocial needs for 3 of 23 residents (R53, R70, and R28).<br><br>R53's care plan does not include a focus, goal, or interventions for religious preferences.<br><br>R70's care plan does not include a focus, goal, or interventions for religious preferences.<br><br>R28's care plan was not followed for using the interpretive services to communicate with R28 in her preferred language.<br><br>Evidenced by:<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The facility policy titled, Comprehensive Care Plans states, in part: Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident's rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality. Definitions: Culture is the conceptual system that structures the way people view the world - it is the particular set of beliefs, norms, and values that influence ideas about the nature of relationships, the way people live their lives, and the way people organize their world. Cultural Competency is a developmental process in which individuals or institutions achieve increasing levels of awareness, knowledge, and skills . Cultural competence involves valuing diversity . avoiding stereotypes, managing the dynamics of difference . and adapting to diversity and cultural contexts in communities. Person-centered care means to focus on the resident as the focus of control and support the resident in making their own choices and having control over their daily lives . Policy Explanation and Compliance Guidelines: 1. The care planning process will include an assessment of the resident's strengths and needs and will incorporate the resident's personal and cultural preferences in developing goals of care. All services provided or arranged by the facility, as outlined by the comprehensive care plan, must meet professional standards of quality, and incorporate culturally competent . care as indicated . 3. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . f. Resident specific interventions that reflect the resident's needs and preferences and align with the resident's cultural identity, as indicated. If the resident is non-English speaking, the facility will identify how communication will occur with the resident. The care plan will identify the language spoken and tools used to communicate .<br><br>Example 1:<br><br>R53 was admitted to the facility on [DATE] with diagnoses that include Adult Failure to Thrive. R53's most recent Minimum Data Set (MDS) Assessment, dated 2/4/25, indicates R53's Brief Interview for Mental Status (BIMS) score was 15 out of 15, indicating that R53 is cognitively intact.<br><br>R53's Comprehensive Care Plan indicates:<br><br>Focus: Communication: At risk and/or potential for complications with hearing/speech/communication. Hearing - Adequate. Devices - None. Speech - Clear. Understands - Usually. Date Initiated: 1/30/25. Revision on: 1/30/25.<br><br>Goal: Will be free of serious communication concerns through next review date. Date initiated: 1/30/25. Revision on: 2/17/25.<br><br>Interventions: Ask simple, short questions. Date Initiated: 1/30/25 . Encourage resident to communicate needs. Give resident time to explain needs. Date Initiated: 1/30/25 . Observe for changes in ability to understand what was said and be understood. Observe for hearing loss, cognitive loss, illness. Review with MD (Medical Director). Date Initiated: 1/30/25.<br><br>Focus: Activities/Life Enrichment: Date Initiated: 1/30/25.<br><br>Goal: Will engage in activities of interest through next review date. Date Initiated: 1/30/25. Revision on: 2/17/25.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interventions: Assist resident in becoming acclimated with their new surroundings. Date Initiated: 1/30/25 . Offer supplies for independent activities. Assist as needed. Date Initiated: 1/30/25 . Provide an overview of the life enrichment programs which they may choose to engage in. Date Initiated: 1/30/25.<br><br>Of note, nowhere in R53's comprehensive care plan does it include that R53's primary language is Yugoslavian, or that she is a practicing Muslim, which is important to her.<br><br>On 4/29/25 at 8:23 AM, Surveyor interviewed R53 who stated that she can't pray when she wants to because, as a Muslim, you have to be very clean before you pray, and you have to have a clean floor to pray on. R53 stated that she was very upset about not being able to pray, because she is used to praying seven times a day as a Muslim.<br><br>Example 2:<br><br>R70 was admitted to the facility on [DATE] with diagnoses that include Major Depressive Disorder and Depression, unspecified. R70's most recent Minimum Data Set (MDS) Assessment, dated 3/27/25, indicates R70's Brief Interview for Mental Status (BIMS) score was 13 out of 15, indicating that R70 is cognitively intact.<br><br>R70's Comprehensive Care Plan indicates:<br><br>Focus: Communication: At risk and/or potential for complications with hearing/speech/communication. Hearing - Adequate. Devices - None. Speech - Garbled. Understood/Understands - Yes. Date Initiated: 7/18/24. Revision on: 7/18/24.<br><br>Goal: Will be free of serious complications R/T (related to) communication concerns through next review date. Date initiated: 7/18/24. Revision on: 11/25/24.<br><br>Interventions: Encourage resident to communicate needs. Give resident time to explain needs. Date Initiated: 7/18/24 . Observe for changes in ability to understand what was said and be understood. Observe for hearing loss, cognitive loss, illness. Review with MD (Medical Director). Date Initiated: 7/18/24.<br><br>Focus: Activities/Life Enrichment: AT risk for social isolation due to being in a new environment. Date Initiated: 7/18/24. Revision on: 7/23/24.<br><br>Goal: Will engage in activities of interest through next review date. Date Initiated: 7/18/24. Revision on: 11/25/24.<br><br>Interventions: Assist resident in becoming acclimated with their new surroundings. Date Initiated: 7/18/24 . Invite [Resident Name] to activities. He attends church services, and many different types of activities. Date Initiated: 12/9/24. Revision on: 12/9/24 . Offer supplies for independent activities. Date Initiated: 7/18/24. Revision on: 7/23/24 . Provide an overview of the life enrichment programs which they may choose to engage in. Date Initiated: 7/18/24.<br><br>Of note, nowhere in R70's comprehensive care plan does it include that R70 is a practicing Muslim, which is important to him.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 4/29/25 at 10:16 AM, Surveyor interviewed R70 who stated that he had been a Muslim for 60 years and that he was used to praying seven times a day. R70 stated that he has asked to go to the chapel to pray by himself, but that staff will not allow him to do that because he is a Muslim. R70 stated it makes him angry that the facility tries to treat everyone the same way, without taking into consideration people's individual needs.<br><br>On 5/1/25 at 9:08 AM, Surveyor interviewed AD J (Activities Director) and asked her if she would expect that R53 and R70's religious preferences as Muslims would be included on their comprehensive care plan. AD J stated yes, if R53 and R70 were voicing these concerns, that she took it very seriously and would look into it. AD J stated that they do the religious screening on admission, and she thought that was enough.<br><br>On 5/1/25 at 1:53 PM, Surveyor interviewed DON B (Director of Nursing) about R53 and R70's religious preferences. DON B stated that if a resident has any specific requests, then she would expect that to be on their care plan.<br><br>Cross Reference: F675 |

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| F 0660<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Plan the resident's discharge to meet the resident's goals and needs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not develop a discharge plan that reflected the resident's goals for 1 of 23 residents (R76) reviewed for discharge planning.<br><br>R76's discharge care plan did not match his discharge goals.<br><br>Evidenced by:<br><br>The facility's policy titled Discharge Planning Process dated 2/28/25 states in part . Procedure: 1. The facility will support each resident in the exercise to participate in his or her care and treatment, including planning for discharge. 2. The facility will determine the resident's expected goals and outcomes regarding discharge upon admission, routinely in accordance with the MDS (Minimum Data Set) cycle, and as needed .b. Subsequent assessment information and discharge goals will be included in the resident's comprehensive plan of care .5. If discharge to the community is a goal, an active discharge care plan will be implemented and will involve the interdisciplinary team, including the resident and/ or representative. The plan shall be documented on (list facility- specific form, comprehensive care plan, etc.).<br><br>R76 was admitted to the facility on [DATE] with diagnoses that include depression, diverticulitis (inflammation or infection in one or more small pouches in the digestive tract), and obstructive and reflux uropathy (blockage in urinary tract and backward flow of urine from the bladder into the ureters and sometimes the kidneys).<br><br>R76's most recent MDS dated [DATE] states that R76 has a Brief Interview of Mental Status (BIMS) of 12 out of 15, indicating that R76 has moderate cognitive impairment.<br><br>R76's care plan dated 9/26/23, revised on 9/16/24 states in part DISCHARGE PLAN: Length of stay is viewed as long term, [R76] will always wish to return to his farm. Goal: Will continue to have needs provided by nursing home care during their life/stay through next review date. Interventions/ Tasks: Discuss feelings / goals for placement as needed. Allow them to share concerns. SS (Social Services) to intervene as needed / requested. Involve family / friends as available / able & if needed. Arrange for discharge as needed.<br><br>On 4/29/25 at 9:04 AM, Surveyor interviewed R76. R76 reported to Surveyor that he would like to go to assisted living. Surveyor asked R76 if he has spoken to the SW (Social Worker) about the discharge plan, R76 stated yes. Surveyor asked R76 if he attends the care conferences, R76 stated no.<br><br>(continued on next page) |

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| F 0660<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 4/30/25 at 2:51 PM, Surveyor interviewed SW K. Surveyor asked SW K how often care conferences are held, SW K stated every 3 months. Surveyor asked if R76 gets invited to the care conferences, SW K stated yes, Surveyor asked SW K if she was aware that R76 wished to go to assisted living, SW K stated yes, Surveyor asked SW K when she was made aware of R76's goal, SW K stated she was made aware in mid-January. SW K reported that they had received a call from an assisted living that indicated that R76 had called and requested admission. SW K stated that she had spoken with the assisted living and discussed barriers to admission, including payer source. SW K reported that after this conversation, she worked with R76 and his representative on enrolling in a MCO (Managed Care Organization) and that the MCO is currently looking for placement. Surveyor asked SW K if R76's care plan should be updated to reflect his current goals, SW K stated yes. Surveyor asked SW K if R76's care plan should have been updated, SW K stated yes.<br><br>On 5/1/25 at 2:16 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B when she would expect a care plan to be updated with new/ current goals, DON B stated as soon as staff know that the goals have changed the care plan should be updated. |

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| F 0675<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor each resident's preferences, choices, values and beliefs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not ensure that 2 of 19 Residents (R53 and R70) received the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial wellbeing in accordance with their comprehensive assessment and plan of care.<br><br>R53 is a Muslim whose custom is to pray seven times a day.<br><br>R70 is a Muslim whose custom is to pray seven times a day.<br><br>Evidenced by:<br><br>The facility policy, titled Quality of Care dated 2/28/25, states, in part: Policy: Based on comprehensive assessments, the facility will ensure that residents receive treatment and care by qualified persons in accordance with professional standards of practice, the comprehensive person-centered care plans, and the residents" choices . Policy Explanation and Compliance Guidelines: 1. Each resident will be provided care and services to attain or maintain his/her highest practicable physical, mental, and psychosocial well-being. 2. A comprehensive care plan will be developed for each resident in accordance with procedures for development of the care plan .<br><br>The facility policy, titled Promoting/Maintaining Resident Self-Determination (Activities) dated 2/28/25, states, in part: Policy: This facility's activity program is designed to promote and facilitate resident self-determination through support of resident choice and resident rights. Each resident has the opportunity to exercise his or her autonomy regarding activities participation. Policy Explanation and Compliance Guidelines: 1. A resident's right to self-determination includes, but is not limited to: . b. the right to make choices about aspects of his or her life in the facility that are significant to the resident . d. The right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility . 4. The Activity Director shall develop a plan of care for the resident based on the resident's assessment preferences. Consideration for the plan of care include but are not limited to: . c. Preferences regarding spirituality . 5. Resident preferences and interests shall be accommodated .<br><br>Example 1<br><br>R53 was admitted to the facility on [DATE] with diagnoses that include Adult Failure to Thrive. R53's most recent Minimum Data Set (MDS) Assessment, dated 2/4/25, indicates R53's Brief Interview for Mental Status (BIMS) score was 15 out of 15, indicating that R53 is cognitively intact.<br><br>Of note, nowhere in R53's comprehensive care plan does it include that R53's primary language is Yugoslavian, or that she is a practicing Muslim, which is very important to her.<br><br>R53's Progress Notes include:<br><br>2/7/25: Spiritual Care Progress Note: . [Resident Name] is a Muslim and doesn't appear to have a local mosque . I will check back in with [Resident Name] to see if she'd like me to see if there is an [NAME] in town who could visit her .<br><br>(continued on next page) |

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| F 0675<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 4/15/25: Spiritual Care Progress Note: Routine visit with [Resident Name] today. We watched Albanian Mosque Service on You Tube channel. She got teary eyed as we watched. She was very pleased to see the Mosque and to hear the service in her language<br><br>4/28/25: Spiritual Care Progress Note: Routine visit. [Resident Name] shared her disappointment about not being able to pray the way that she should pray as a Muslim. She said that she needs to be clean, wear clean pajamas and pray on a clean floor .<br><br>On 4/29/25 at 8:23 AM, Surveyor interviewed R53 who stated that she can't pray when she wants to because, as a Muslim, you have to be very clean before you pray, and you have to have a clean floor to pray on. R53 stated that she was very upset about not being able to pray, because she is used to praying seven times a day as a Muslim.<br><br>On 4/30/25 at 2:05 PM, Surveyor interviewed R53 and asked if she went to any of the other activities that the facility offered. R53 replied no, that they don't have any activities that she can go to. R53 stated that she just stays in her room and looks at her (R53 gestured towards her iPad tablet). R53 stated that she likes to crochet and sometimes sits outside. Surveyor asked R53 if anyone offered her one-on-one activities. R53 stated no, no one has come to her room and done individual activities with her. R53 stated that she would like to be able to take more showers, as she is used to taking a daily shower and that the showers help with her pain and would make her clean to be able to pray.<br><br>On 4/30/25 at 2:49 PM, Surveyor interviewed CNA D (Certified Nursing Assistant) about R53's activities and religious preferences. CNA D stated that R53 stays in her room most of the time and does not go to any of the facility activities. CNA D indicated that the residents receive one shower a week, but that R53 had complained about it so she was supposed to be receiving two showers a week, although her care plan had not been updated to reflect the additional shower. CNA D stated that he knew that R53 was a Muslim.<br><br>On 4/30/25 at 2:51 PM, Surveyor interviewed RN C (Registered Nurse) about R53's activities and religious preferences. RN C stated that he could not remember R53 going to any of the facility activities, and that she likes her privacy. RN C stated that R53 gets two showers a week, but that she can have additional showers whenever she requests. RN C stated he was unaware that R53 was a Muslim, but that he did notice that she keeps her head covered.<br><br>On 4/30/25 at 2:55 PM, Surveyor interviewed AD J (Activity Director) about R53's activities and religious preferences. AD J stated that R53 mainly comes to music activities, but that she had provided her in room supplies such as yarn to crochet a blanket. AD J stated that R53 was very independent, but that she checked in with her on a weekly basis. Surveyor asked AD J about R53's religious needs. AD J stated that R53 was Buddhist, so she had given her scarves to cover her head, and that R53 watches religious services on her iPad.<br><br>Of note, R53 is Muslim, not Buddhist.<br><br>(continued on next page) |

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| F 0675<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 5/1/25 at 11:36 AM, Surveyor interviewed CNA F about R53's religious activities and preferences. CNA F stated that R53 told her she was a Muslim and asked her about being able to pray seven times a day and about fasting for [NAME]. CNA F indicated that she told R53 that it really wasn't possible to observe the Muslim prayer rituals or to fast for [NAME] while residing in the facility, but that she makes sure that R53 is not served pork. CNA F stated that R53 does not go to any of activities and prefers being in her room.<br><br>Example 2<br><br>R70 was admitted to the facility on [DATE] with diagnoses that include Major Depressive Disorder and Depression, unspecified. R70's most recent Minimum Data Set (MDS) Assessment, dated 3/27/25, indicates R70's Brief Interview for Mental Status (BIMS) score was 13 out of 15, indicating that R70 is cognitively intact.<br><br>Of note, nowhere in R70's comprehensive care plan does it include that R70 is a practicing Muslim, which is important to him.<br><br>On 4/29/25 at 10:16 AM, Surveyor interviewed R70 who stated that he had been a Muslim for 60 years and that he was used to praying seven times a day, and that he has asked to go to the chapel to pray by himself, but that staff will not allow him to do that because he is a Muslim. R70 stated it makes him angry that the facility tries to treat everyone the same way, without taking into consideration people's individual needs.<br><br>On 4/30/25 at 11:14 AM, Surveyor interviewed CNA I and asked about R70's activities and religious preferences. CNA I stated that R70 did go to activities and liked to participate in the religious services. CNA I indicated that she was unaware that R70 was a Muslim, but that she knew that he didn't eat pork.<br><br>On 5/1/25 at 9:08 AM, Surveyor interviewed AD J (Activities Director) about R70 and R53. Surveyor asked her if she would expect that R53 and R70's religious preferences as Muslims would be included on their comprehensive care plan. AD J stated yes, if R53 and R70 were voicing these concerns, that she took it very seriously and would want to look into it. AD J stated that they do the religious screening on admission, and she thought that was enough. AD J indicated that she was surprised that R70 was a Muslim, because he attended the catholic and ecumenical services that the facility provided.<br><br>On 5/1/25 at 1:53 PM, Surveyor interviewed DON B (Director of Nursing) about R53 and R70's religious preferences. Surveyor asked DON B how the facility was honoring resident's religious preferences. DON B stated that they were asked about their religion on admission and if they had any specific requests, then she would expect that to be on their care plan. Surveyor asked DON B if she was aware of R53 and R70 being devout Muslim's and needing to pray seven times a day. DON B stated that she was not aware of that, but the facility should be able to accommodate that request easily. Surveyor asked DON B how often a resident could receive a shower in order to meet their religious preferences. DON B indicated that the residents could receive as many showers as they requested. DON B stated that she would expect that all residents' religious needs would be met.<br><br>Cross Reference: F656<br><br>Additonal information was received and reviewed. |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Example 2<br><br>R293 was admitted to the facility on [DATE] with diagnoses that include displaced intertrochanteric fracture of right femur (femur fracture), adult failure to thrive, malignant neoplasm of prostate (prostate cancer), anxiety disorder, and heart failure.<br><br>R293's care plan dated 4/24/25, revised on 4/28/25 states in part .The resident has an ADL (Activities of Daily Living) self- care performance deficit r/t (related to) .Goal: .Interventions/ Tasks: .Personal Hygiene/ Oral Care: The resident is totally dependent on 2 staff for personal hygiene and oral care .<br><br>R293's task documentation for showering/ bathing/ personal care is as follows:<br><br>4/24/25: no documentation<br><br>4/25/25: marked not applicable for type of bath received, was hair care provided, was nail care provided, foot care, and was resident shaved.<br><br>4/26/25: marked not applicable for type of bath received, was hair care provided, was nail care provided, foot care, and was resident shaved.<br><br>4/27/25: marked not applicable for type of bath received, was hair care provided, was nail care provided, foot care, and was resident shaved.<br><br>4/28/25: marked not applicable for type of bath received, was hair care provided, was nail care provided, foot care, and was resident shaved.<br><br>4/29/25: no documentation<br><br>4/30/25: marked not applicable for type of bath received, was hair care provided, was nail care provided, foot care, and was resident shaved.<br><br>5/1/25: no documentation<br><br>5/2/25: marked not applicable for type of bath received, was hair care provided, was nail care provided, foot care, and was resident shaved.<br><br>5/3/25: marked not applicable for type of bath received, was hair care provided, was nail care provided, foot care, and was resident shaved.<br><br>5/4/25: no documentation<br><br>5/5/24: resident refused all cares (documented at 12:52 PM).<br><br>It is important to note that, except for 5/5/25, only the night shift was documenting on R293's cares.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 5/5/25 at 9:57 AM, Surveyor observed R293 sitting in the dining room, still in his pajamas with his hair sticking up and scraggly whiskers on his face approximately ¼ inch long.<br><br>On 5/5/25 at 10:52 AM, Surveyor interviewed R293. Surveyor asked R293 if he likes the whiskers on his face, R293 stated no, and that he doesn't like them R293 stated that he needs someone to shave him. Surveyor asked R293 how it makes him feel, having the long whiskers, R293 stated that he feels crappy and reported that he used to shave every day. Surveyor asked R293 if he likes to have his hair combed, R293 stated yes.<br><br>On 5/5/25 at 10:57 AM, Surveyor interviewed CNA R (Certified Nursing Assistant). Surveyor asked CNA R how often residents get shaved. CNA R reported that residents usually get shaved on shower days, but there has been no time frame given on how often they have to shave residents.<br><br>On 5/5/25 at 2:24 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B how often residents are scheduled for a shower, DON B reported residents are scheduled for a shower twice a week and per resident preference. Surveyor asked DON B how often residents should be shaved, DON B stated as needed and per preference. Surveyor asked DON B if she would expect residents' hair to be combed in the morning before going to the dining room, DON B stated yes.<br><br>Based on observation, interview and record review, the facility did not provide toileting assistance for dependent residents for 2 of 19 residents (R37 & R293) reviewed for Activities of Daily Living (ADLs) assistance.<br><br>Staff did not assist R37 with toileting assistance after several incontinent episodes despite R37 requiring toileting assistance per his plan of care.<br><br>R293 was observed sitting in the dining room in his pajamas with his hair sticking up, and scraggly (not neat or even) whiskers on his face approximately ¼ inch long.<br><br>Evidenced by:<br><br>Facility policy, titled Activities of Daily Living (ADLs), dated 2/25, states, in part: Policy: The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate . Care and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming and oral care; 2. Transfer and ambulation; 3. Toileting . Policy Explanation and Compliance Guidelines . 3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene .<br><br>R37 was admitted to the facility on [DATE] with diagnoses that include, in part, Parkinson's Disease, Weakness, Neuromuscular Dysfunction of Bladder (lack of bladder control due to a brain, spinal cord or nerve problem), Muscle Weakness, generalized, Adult Failure to Thrive, and Unsteadiness on Feet.<br><br>R37's most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 2/4/25 documented that R37 had a Brief Interview for Mental Status (BIMS) score of 11 out of 15, indicating R37 has moderate cognitive impairment.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | R37's Care Plan, includes, in part:<br><br>Focus: Skin Integrity: Actual/At Risk/ and/or Potential for Complications with impaired skin integrity including skin tears, bruising AND/OR pressure R/T (related to) current medical/physical status. Has medications/dx (diagnoses) that can/may affect skin integrity. Chronic urethral erosion. Date Initiated: 2/17/23. Revision Date: 4/29/25<br><br>Goal: Will have clean, dry, intact skin through next review date. Date initiated: 2/17/23. Revision Date: 11/25/24.<br><br>Intervention: Incontinence care with incontinent brief changes OK to use 2nd incontinence product per resident request. Date Initiated 2/17/23. Revision Date: 2/28/25.<br><br>Focus: ADL: Actual/At Risk and/or Potential for complications with deficits with ADL's R/T current medical/physical status. Date Initiated: 2/17/23. Revision Date: 3/22/23.<br><br>Goal: Will be clean, dry, dressed appropriately and maintain ability to participate in ADLs through next review. Date Initiated: 2/17/23. Revision Date: 11/25/24.<br><br>Intervention: Toilet Use: Hoyer 2 Assist OK to use 2nd incontinent product. Date Initiated: 2/17/23. Revision Date: 4/28/25.<br><br>Intervention: Transfers: 2 Assist Hoyer Lift. Date Initiated: 4/12/23. Revision Date: 4/15/25.<br><br>Focus: Bowel/Bladder: Actual/At risk and/or Potential for complications with B&B (bowel and bladder) R/T current medical/physical status. OK to use 2nd incontinence product, per resident request. Date Initiated: 3/10/23. Revision Date: 5/9/24.<br><br>Goal: Will be clean and dry with incontinence of bowel and cares provided as needed through review date. OK to use 2nd incontinence product. Date Initiated: 3/10/23. Revision Date: 11/25/24.<br><br>Intervention: Incontinence cares with incontinent episode. OK to use 2nd incontinence product, per resident request. Date Initiated: 3/10/23. Revision Date: 2/28/25.<br><br>Intervention: Medications and creams as ordered. Date Initiated: 3/10/23.<br><br>On 4/28/25 at 9:30 AM, Surveyor observed R37 in the lounge asleep in front of the TV in his Broda chair. R37 had a Hoyer sling underneath him in the chair and was still wearing his clothing protector from breakfast.<br><br>On 4/29/25 at 8:27 AM, Surveyor observed R37 asleep at the breakfast table in his Broda chair.<br><br>On 4/29/25 at 10:48 AM, Surveyor observed R37 in the lounge asleep in front of the TV in his Broda chair. R37 had a Hoyer sling underneath him in the chair.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 4/29/25 at 3:32 PM, Surveyor interviewed CNA D (Certified Nursing Assistant) and asked about R37's needs and assistance with cares. CNA D stated that R37 had been an EZ stand transfer but that he was unsafe because he would let go of the handles instead of hanging on as instructed. CNA D stated that now R37 uses the Hoyer lift, it is a much safer transfer. CNA D stated that because R37 requires two assistance of staff with toileting and transfers, that he has to fight to get help from other staff to get R37 changed every two hours. CNA D stated that R37 will sit in his pee all day and that the other CNAs don't change him.<br><br>On 5/5/25 at 9:31, Surveyor observed R37 in the lounge asleep in front of the TV in his Broda chair. R37 had a Hoyer sling underneath him in the chair and was missing one shoe.<br><br>On 5/5/25 at 10:00 AM, Surveyor interviewed CNA G and asked if she could observe R37's transfer and incontinence care. CNA G stated that she would have to put clean sheets on R37's bed first, as his sheets had been soiled and removed by the noc (overnight) shift.<br><br>On 5/5/25 at 10:05 AM, Surveyor observed CNA G and CNA E transfer R37 from his Broda chair to the bed using the Hoyer lift. CNA G told R37 that they would have to change his pants because they were wet also. Surveyor noted there was a strong smell of urine and that R37's brief was heavily saturated with urine.<br><br>On 5/5/25 at 10:28 AM, Surveyor interviewed CNA G about R37's toileting needs and assistance. CNA G stated that R37 is to be changed and toileted every two hours. CNA G indicated that R37 wears a brief and a liner, that he is a heavy soaker and that his liner was soaked, requiring his pants to be changed. Surveyor asked CNA G if she had changed R37 earlier in the day. CNA G stated no, that was the first time she had changed R37 today.<br><br>On 5/5/25 at 10:43 AM, Surveyor interviewed RN C (Registered Nurse) and asked about R37's toileting needs and assistance. Surveyor asked RN C when the last time R37 had been toileted. RN C pulled up the CNA task charting on the electronic health record and reviewed it with Surveyor. Nothing had been charted for 5/5/25. Surveyor asked RN C if that meant R37 had not been toileted all day. RN C indicated that noc shift checks and changes R37 at 6:00 AM and brings him out by the TV before breakfast. RN C stated that the day shift CNAs had not charted yet if they had changed R37.<br><br>On 5/5/25 at 11:03 AM, Surveyor interviewed CNA E, who stated that was the first time she had changed R37 today. Surveyor asked CNA E how often R37 was supposed to be toileted and changed. CNA E stated every two hours, but that he sometimes refuses care. Surveyor asked CNA E what she does when R37 refuses care. CNA E stated that she documents the refusal in the electronic health record.<br><br>On 5/5/25 at 2:07 PM, Surveyor observed CNA D and RN H enter R37's room to toilet and change him. Surveyor interviewed CNA D and asked how often R37 is supposed to be toileted. CNA D stated every two hours but that it is not getting done. Surveyor asked CNA D when was the last time R37 was changed? R37 stated he was not sure, but that he was completely wet and that his brief, his pants, and his shirt all were soaked and had to be changed. Surveyor asked CNA D if R37 ever refuses to be changed. CNA D stated that he does refuse sometimes but that it should be documented in the electronic health record. Surveyor asked CNA D if R37 having his clothes completely soaked with urine would be considered a dignity concern? CNA D answered yes, he would call that a dignity issue. CNA D stated that some staff don't like to change R37 because he can be combative, so they just let him sit and be wet all day.<br><br>(continued on next page) |

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| | 525276 | A. Building<br>B. Wing | 05/05/2025 |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 5/5/25 at 2:17 PM, Surveyor interviewed R37 and asked him about his change of clothes. R37 indicated he had his clothes changed because he was wet. R37 stated it makes him frustrated when that happens because he doesn't like being wet.<br><br>On 5/5/25 at 2:35 PM, Surveyor interviewed DON B (Director of Nursing) and asked her what her expectation was for toileting R37. DON B stated R37 should be toileted around every two hours. Surveyor shared with DON B both observations of R37 being soaked in urine and needing to have his clothes and bedding changed. Surveyor asked DON B if she would consider being soaked in urine to be a dignity issue for R37, DON B answered yes, she would consider that a dignity issue, but that sometimes R37 refuses care.<br><br>Of note, a review of R37's electronic health record revealed R37 had refused care only one time, on 4/15/25. No refusals of cares are documented thus far in May.<br><br>The facility failed to provide toileting assistance to a dependent resident, resulting in R37's loss of dignity due to being soaked with urine several times a day. |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure a resident with a pressure injury (PI) received necessary treatment and services, consistent with standards of practice to promote healing for 1 of 3 residents (R40) reviewed for PIs.<br><br>R40 has a stage 4 pressure injury, with physician orders to not be in her wheelchair for more than an hour at a time, to be repositioned every 30 minutes while in her wheelchair and to not lay on her left hip while in bed. R40's interventions were not completed as ordered.<br><br>Evidenced by:<br><br>Surveyor requested the facility's policy regarding Pressure Injury's; however, none was provided.<br><br>R40 was admitted to the facility on [DATE] with diagnoses including: hypertensive chronic kidney disease (high blood pressure within the kidneys), trochanteric bursitis (inflammation of small, fluid-filled sac on the outer edge of the left hip), hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke) affecting right dominant side, Pressure Ulcer of left hip - Stage 3, Psoas muscle abscess, and Vascular dementia.<br><br>R40's Quarterly Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 4/11/25, indicates R40 has a Brief Interview for Mental Status (BIMS) score of 12 out of 15, indicating R40 has moderate cognitive impairment. Section GG indicates R40 requires partial/moderate assistance with rolling left and right, sitting to lying, and lying to sitting. Section GG also indicates R40 is dependent on staff for moving from sitting to standing. Section M indicates R40 is at risk for developing pressure ulcers, has 1 unhealed stage 4 pressure ulcer, and treatments indicated include pressure reducing devices for R40's chair and bed, nutrition or hydration intervention, pressure ulcer care, and application of nonsurgical dressings.<br><br>R40's Physician Orders indicate:<br><br>Check placement of dressing to left hip Q (every) shift. If no dressing to site, follow treatment orders and replace dressing. Every shift. Start date: 4/17/25. Order status: Active.<br><br>Continue to offload and keep pressure away from this wound. Do not lay on your left hip while in bed. Every shift. Start date: 11/7/24. Order status: Active.<br><br>Up to chair max three times a day, max 1 hour at a time. Must reposition in chair every 30 minutes while up. -Must be seated on pressure offloading cushion when up in chair. Start date: 12/28/23. Order status: Active.<br><br>R40's Comprehensive Care Plan indicates:<br><br>Focus: Skin Integrity: At risk and/or potential for complications with impaired skin integrity including skin tears, bruising and/or pressure r/t (related to) current medical/physical status. Has meds/dx that can/may affect skin integrity. Stage 4 pressure injury left hip upon admission. Date Initiated: 11/15/23.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interventions/Tasks:<br><br>Meds/Labs/Treatments as ordered. Date Initiated: 11/15/23.<br><br>Assist/Encourage pressure relief as needed/accepted. Date Initiated: 11/15/23.<br><br>Float heels with heels up cushion. Date Initiated: 11/15/23.<br><br>Follow community skin protocol. Date Initiated: 11/15/23.<br><br>Incontinence care with incontinent brief changes. Date Initiated: 11/15/23.<br><br>Observe skin with AM/PM cares and with toileting for redness, rashes, open areas, pain, swelling and report them to team leader. Weekly skin check. Lotion to dry skin. Date Initiated: 11/15/23.<br><br>Pressure guard reduction mattress on bed. Pump settings may be titrated per resident comfort. Date Initiated: 11/15/23.<br><br>Pressure reduction cushion in W/C (wheelchair). Date Initiated: 11/15/23 .<br><br>(Of note: Physician order: Up to chair max three times a day, max 1 hour at a time. Must reposition in chair every 30 minutes while up. -Must be seated on pressure offloading cushion when up in chair. is not found on the care plan. Additionally, no interventions were added following R40's wound infection in August 2024.)<br><br>R40's Care Card, posted in R40's bathroom, indicates: Skin/Pressure Reductions: . -Float heels with heels up cushion -Pressure guard reduction mattress on bed. Pump setting may be titrated per resident comfort. -Pressure reduction cushion in W/C.<br><br>(Of note: Care Card does not contain information regarding physician orders for repositioning.)<br><br>On 2/7/25, an Office Visit Note was written by an outside facility Nurse Practitioner that states, in part: . Pertient Wound History -Location of wound: left hip -Date of wound onset: October 2023 . Was admitted to [Hospital Name] 12/29-1/9/23 for left hip wound with infected bursitis with acute encephalopathy (any disease or disorder that affects the brain's function or structure and can have various causes including infection). She underwent IR (Interventional Radiology) aspiration of the overlying abscess on 12/30/23 . Etiology of wound: pressure . Bed/Wheelchair: -Mattress: low air loss mattress and hospital bed -Wheelchair/cushion: has a thick cushion on her wheelchair, believes it is a Roho . Assessment/Plan . Offloading -Patient spends the majority of her day sitting in a chair and avoids pressure to her hip -Continue to offload and keep pressure away from wound -Do not lay on your left hip while in bed .<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 5/1/25 at 10:46 AM, Surveyor observed R40 being assisted from an off-unit activity back to her room by a staff member. R40 made a statement to the staff member that she can't sit up for too long. Staff member left R40 in her room without repositioning her. At 11:05 AM, the facility's speech therapist entered R40's room to complete a speech therapy session. R40 has yet to be repositioned. At 11:35, R40 was taken to lunch by a CNA and was not repositioned beforehand. R40 remained seated in the dining room without being repositioned. At 11:46 AM, Surveyor noted R40 had been in her wheelchair for at least one hour, had not been repositioned, and was actively eating her lunch.<br><br>On 5/1/25 at 1:45 PM, Surveyor interviewed CNA G (Certified Nursing Assistant). Surveyor asked CNA G how often R40 needs to be repositioned in her wheelchair and while she is in bed. CNA G indicates she needs to be repositioned every two hours for both. Surveyor asked where this information is located. CNA G indicates she checks the care card in the bathroom before all cares and transfers. Surveyor asked CNA G how long R40 can be in her wheelchair at a time. CNA G indicates, she can be up for 2-4 hours in the wheelchair, because that is standard, but would check the care card to make sure.<br><br>On 5/1/25 at 1:57 PM, Surveyor interviewed CNA Z. Surveyor asked CNA Z how often R40 needs to be repositioned in her wheelchair and while she is in bed. CNA Z indicates R40 can almost reposition herself, but that she should be repositioned when she is in the wheelchair twice a shift, and doesn't know how often she should be repositioned when in bed. Surveyor asked CNA Z how long R40 can stay up in her wheelchair. CNA Z indicates R40 stays up in her wheelchair for around 12 hours and likes to be up in her wheelchair. CNA Z also indicates she checks the care card in the resident rooms for all of the information regarding resident cares.<br><br>On 5/1/25 at 2:51 PM, Surveyor interviewed CNA AA. Surveyor asked CNA AA how often R40 needs to be repositioned in her wheelchair and while she is in bed. CNA AA indicates R40 needs to be repositioned every two hours in her wheelchair and in bed because staff need to keep R40 off of her wound. Surveyor asked where this information is located. CNA AA indicates she checks the care card in the resident's room or the binder at the nurses' station.<br><br>On 5/5/25 at 2:01 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B if physician orders should be followed as they are ordered. DON B indicates, yes. Surveyor asked DON B what her expectation is for staff when caring for a resident with a repositioning schedule. DON B indicates she expects the resident to be repositioned according to their schedule. Surveyor asked DON B if she knows how long R40 should be up in her chair for at a time. DON B indicates she is not sure. Surveyor asked DON B where staff can find this information. DON B indicates it should be in the physician order, wound note, and in the care plan. Surveyor asked DON B if the order for repositioning should be in the care plan. DON B indicates, not necessarily, only if outside the standard which is every 2 hours. Surveyor asked DON B if R40 lays on her left hip while in bed. DON B indicates, she does not believe R40 favors a side while sleeping. Surveyor asked DON B if not laying on her left hip should be on her care plan if it came from a physician order. DON B indicates, she would have expected staff to notify Interdisciplinary Team staff that she is consistently lying on her left hip.<br><br>R40's care plan has not been updated and R40 is not being repositioned per physician orders. |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure fall interventions were in place per the care plan and each residents received adequate supervision to prevent accidents for 3 of 23 sampled Residents (R27, R59, & R82) reviewed for falls and supervision. R27 is being cited at scope/severity level 3 (isolated/actual harm).<br><br>R27 was a fall risk and has had 23 falls since admission on [DATE]. R27's falls typically occurred in the dining room or resident room; there were similarities to the falls including location and time of day. The facility completed a root cause analysis (RCA) and collected data on the falls; however, there is no evidence the interdisciplinary team (IDT) comprehensively reviewed the data or considered increasing R27's supervision. R27 fell resulting in a head injury requiring sutures.<br><br>R59 is at risk for falls and is care planned to walk with her walker and to have a sign in her room to remind her to walk with her walker. Surveyor observed two instances on different days of R59 walking without her walker. Surveyor was unable to locate a sign in R59's room reminding her to walk with her walker.<br><br>R82 has long-standing behaviors that include wandering into other residents' rooms as well as acting out toward staff and other residents. The facility staff did not provide increased supervision to prevent R82 from wandering into other Residents' rooms, which puts R82 at risk for potential resident to resident altercations to occur.<br><br>This is evidenced by:<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | The facility's fall policy titled Fall Prevention Program, dated 2/28/25, states in part: Policy: Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. Policy and Explanation and Compliance Guidelines: 1. The facility utilizes a standardized risk assessment for determining a resident's fall risk. a. The risk assessment categorizes residents according to low, moderate or high risk. b. For program identification purposes, the facility utilizes high risk and low/moderate risk, using the scoring method designated on the risk assessment. 2. Upon admission, the nurse will complete a fall risk assessment along with the admission assessment to determine the resident's level of fall risk. 3. The nurse will indicate on the (specify location) the residents' s fall risk and initiate interventions on the resident's baseline care plan, in accordance with the resident's level of risk. 4. The nurse will refer to the facility's High Risk or Low/Moderate Risk protocols when determining primary interventions. 5. Low/Moderate Risk Protocols: a. Implement universal environmental interventions that decrease the risk of resident falling including, but not limited to: a. A clear pathway to the bathroom and bedroom doors. ii. Bed is locked and lowered to a level that allows the resident's feet to be flat on the floor when the resident is sitting on the edge of the bed. iii. Call light and frequently used items are within reach. iv. Adequate lighting. V. Wheelchairs and assistive devices are in good repair. b. Implement routine rounding schedule. c. Monitor for changes in resident's condition, gait, ability to rise/sit, and balance. D. Encourage residents to wear shoes or slippers with non-slip soles when ambulating. e. Ensure eye glasses, if applicable, are clean and the resident wears them when ambulating. f. Monitor vital signs in accordance with facility policy. g. Complete a fall risk assessment every 90 days and as indicated when the resident's condition changes. 6. High Risk Protocols: a. The resident will be placed on the facility's Fall Prevention Program. i. Indicate fall risk on care plan. ii. Place Fall Prevention Indicator (such as star, color coded sticker) on the name plate to resident's room. iii. Place Fall Prevention Indicator on resident's wheelchair. B. Implement interventions from Low/Moderate Risk Protocols. c. Provide interventions that address unique risk factors measured by the risk assessment tool: medications psychological, cognitive status, or recent change in functional status. D. Provide additional interventions as directed by the resident's assessment including but not limited to i. Assistive devices ii. Increased frequency of rounds iii. Sitter, if indicated iv. Medication regime review v. Low bed vi. Alternate call system access vii. Schedule ambulation and toileting assistance viii. Family/caregiver or resident education ix. Therapy services. 7. When a resident who does not have a history of falling experiences a fall, the resident will be placed on the facility's Fall Prevention Program. 8. Each resident's risk factors, and environmental hazards will be evaluated when developing the resident's comprehensive plan of care. a. Interventions will be monitored for effectiveness. b. The plan of care will be revised as needed. 9. When any resident experiences a fall, the facility will: a. Assess the resident b. Complete a post-fall assessment c. Complete an incident report d. Notify the physician and family e. Review the resident's care plan and update as indicated f. Document all assessments and actions g. Obtain witness statements in the case of injury.<br><br>R27 was admitted to the facility on [DATE] with diagnoses that include dementia, seizure disorder, psychotic disturbance, mood disturbance and anxiety, altered mental status, and malaise (weakness).<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | R27's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/20/25 indicates Brief Interview for Mental Status (BIMS) was unable to be performed. A staff assessment of R27's mental status indicates R27 has moderate cognitive impairment. Section C1310 of the assessment indicates R27 has periods of inattention and disorganized thinking. Section GG indicates R27 requires setup assistance with eating, supervision for oral hygiene and upper body dressing, partial to moderate assistance for toileting and personal hygiene, and substantial to maximum assistance for showers, lower body dressing, and footwear. R27's mobility indicates she requires partial to moderate assistance for rolling left to right, sitting to standing, lying to sitting, chair to bed transfer, toilet transfer and walking 50 feet. R27 utilizes a wheelchair and is dependent on locomotion of 150 feet while in the wheelchair. Section J1800 any falls prior assessment indicates yes. Section J1900 number of falls since admission or prior assessment indicates the following: No Injury two or more. B. Injury two or more. C. Major injury indicates one.<br><br>R27's Activities of Daily Living (ADL) care plan initiated 9/4/24 revised on 11/25/24 states: Focus: At risk and/or potential for complications with deficits with ADLs r/t current medical/ physical status. Has meds/dx (medications/diagnosis) that can/may affect ADLs dated initiated 9/4/24 revised 9/7/24. Goal: Will be clean, dry, dressed appropriately and maintain ability to participate in ADLs through next review date 9/7/24 revised 11/25/24. Will be more independent with ADLs after set-up, cues and able to return to assisted living by discharge date . Interventions: Ambulation - may ambulate in room or hallway with w/c (wheelchair) trail 9/4/24 revised 2/28/25. Bed mobility: 1 assist 9/4/24 revised 2/28/25. Locomotion: 1 assist in Broda Chair 4/1/25. Transfers: 1 assist pivot with gait belt 9/4/24 revised 2/28/25. Prefers to get up around 7:00 AM and goes to bed around 8:00 PM 9/7/24.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | R27's Safety/Falls care plan date initiated 9/7/24 and revised on 12/16/24 states: Focus: At risk/and/or Potential for complications with or falls r/t (related to) current medical / physical and mental status. Has meds/dx (medication/diagnoses) that can/may affect fall risk. Goal: Reduce risk of fall related injuries date initiated 9/7/24. Revised on 12/18/24. Interventions/Tasks: Assist resident to sit up to table at mealtimes 9/14/24 revised on 2/28/25. Busy box on side of the bed 12/30/24 revised on 2/28/25. Do not recline resident back in wheelchair when resident is agitated 3/12/25 revised on 2/28/25. Due to increasing behaviors, support resident in her room with low lighting, low noise level, no visual stimulation 10/8/24 revised on 2/28/25. During the night when she is restless, frequent attempts to get out of bed offer shower and/or weighted blanket for comfort 1/9/25 revised on 2/28/25. Elevate HOB (head of bed) in seated position for comfort 12/30/24 revised on 2/28/25. Immediate intervention s/p (status post) fall - increased monitoring, given breakfast, NP (nurse practitioner) to see resident. Will re-educate the staff regarding current interventions 1/24/25 revised on 2/28/25. Immediate intervention s/p fall offered/received snack and placed into bed. Discussion with guardian for a perimeter mattress. Guardian in agreement. IDT (Interdisciplinary Team) to review recommendation. Add perimeter mattress to bed 1/3/25 revised on 2/28/25. Immediate intervention s/p (status post) fall send to ER (emergency room) for further evaluation 1/21/25 revised on 2/28/25. Immediate Intervention: Heated blanket placed on resident for comfort and 1:1 with staff. Suggest medication review. Medicated with Tylenol, pain gel and Melatonin 10/16/24 revised on 2/28/25. Move resident closer to the nurses station for increased supervision. Immediate intervention s/p fall 2/11/25 resident moved closer to the nurses station for increased monitoring 11/21/24 revised on 2/28/25. Nonskid socks when up in wheelchair 11/18/24 revised on 2/28/25. Offer a snack during the evening hours, around the time she is going to bed for the night and as requested 1/7/25 revised on 2/28/25. Offer assistance with ambulation in hallway if resident is restless or repeatedly attempting to stand 12/28/24 revised on 2/28/25. Offer hydration and/or snack at change of shift from PM to NOC shift if resident is awake. IDT: During routine rounding and as needed staff to ensure resident has fresh ice water or fluid of choice 12/15/24 revised on 2/28/25. Offer toileting IMMEDIATELY after meals 12/30/24 revised on 2/28/25. Perimeter mattress to better define edges of bed 1/6/25 revised on 2/28/25. Provide a quiet space to be able to rest and relax. Provide her soft lighting and white noise via the light and sound machine provided 12/27/24 revised on 2/28/25. Staff to offer assistance with walking to and from the dining room (per resident's choice) 4/1/25. Therapy to screen and treat for possible BRODA chair till current w/c (wheelchair) is fixed so resident's feet can touch the floor 4/28/25. Walk to the dining room every meal 2/14/25 revised on 2/28/25. When resident is restless, upset, crying, speaking of family offer warm heated blanket and/or busy box for comfort 10/17/24 revised on 2/28/25. Will have therapy eval for w/c positioning and safety 2/12/25 revised on 2/28/25. Call light positioned for easy access 9/7/24. Check for unmet needs: pain, toileting, hunger, thirst, temperature 9/7/24. Do not leave unattended in the Bathroom [ROOM NUMBER]/7/24. Encourage / Assist with non-skid shoes / socks 9/7/24. Ensure environment is free of clutter 9/7/24. Have commonly used articles within easy reach 9/7/24. Scoop mattress to bed 1/22/25 revised on 2/28/25. Other: (Specify) - Nonskid mat to wheelchair 11/18/24.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | R27's Care plan for Mood/Behavior dated 9/7/24 and revised on 12/17/24 states: Focus: Has a dx of MDD (mood disturbance disorder). She is at risk for changes in mood and cognition. She experiences episodes of tearfulness and heightened anxiety. Curses and makes derogatory statements to people who are not there likely r/t previous stay at ALF (assisted living facility) or past trauma. Also exhibits aggression toward staff as evidenced by grabbing, hitting, and spitting d/t cognitive impairment. Anxiety related to death of parents. She makes paranoid statements about staff at times. Goal: Mood / Behavior will not interfere with ADL status through next review 9/7/24 revised 11/25/24. Will have choices and able to make decisions through next review date 9/11/24 revised 11/25/24. Interventions/Tasks: Offer resident one of her robotic cats to assist with keeping resident calm 11/11/24 revised on 2/28/25. Offer weighted blanket 1/10/25 revised 2/28/25. Provide a quiet space for [Resident's name] to be able to rest and relax. Provide her soft lighting and white noise via the light and sound machine provided date initiated 12/27/24 revised 2/28/25. Provide a warm blanket when she is in bed and agitated 11/11/24 revised 2/28/25. Provide music therapy with resident's CDs (compact disc) 11/11/24 revised 2/28/25. Remove from noisy environment and take to a quiet area to decrease external stimuli 11/20/24 revised on 2/28/25. Resident to be on floor mate [sic] while in room [ROOM NUMBER]/17/25. Allow resident to wander within unit 9/7/24. BIMS / PHQ9 completed upon admission, quarterly, annually, and PRN (as needed) - Notify MD as needed with concerns 9/7/24 revised 2/28/25. Calm approach. Remove stressors i.e.: noisy/overstimulating area or other residents in personal space who are too close 9/7/24. Check for comfort levels - pain, thirst, hunger, temperature - offering comfort as able / accepted 9/7/24. Encourage / Assist to activities of choice 9/7/24. Encourage resident to be out of room [ROOM NUMBER]/7/24. Meds / Labs / Treatments as Ordered 9/7/24. Observe / Monitor / Document behaviors/mood and notify supervisor, SW (social worker), and / or MD as needed 9/7/24. Offer opportunities for resident to express feelings 9/7/24. PASARR Level II - Review & Follow Recommendations as able / accepted 9/7/24. Remind / Redirect and/or reassure as needed 9/7/24. Turn white noise machine on at bedtime.<br><br>Progress notes dated 9/14/2024 at 12:04 PM state in part: Resident seated in w/c at dining room table. CNA (Certified Nursing Assistant) at nurse station when resident slid out of w/c (wheelchair) and onto to left LUE (left upper extremity) and LLE (left lower extremity) making contact with the carpeted area of floor. CNA alerted wtr (writer) and nurse assessment was completed. Resident was baseline A&O (alert and oriented) and able to state her name and DOB (date of birth ), denied injury, and reported she was trying to scootch closer to the table. No apparent injuries noted on assessment, resident denied pain, nonverbal indicators of pain not present AEB (as evidenced by) a score of 0 on PAINAD scale (scale used to measure pain levels). Dr.'s nurse on call notified. Charge nurse notified. POA (power of attorney) notified.<br><br>Progress notes dated 9/14/2024 at 13:17 (1:17 PM) state in part: Resident transferred by staff into w/c (wheelchair) and engaged with other residents in activities at table nearest nurse station. Resident was monitored and observed by staff the remainder of the shift.<br><br>Progress notes dated 9/14/2024 at 16:13 (4:13 PM) state in part: IDT (Intradisciplinary Team) met to review fall. Root cause determined to be resident failed attempt at scooting self closer to the table. Intervention added for staff to assist resident to sit up to table at mealtimes. Kardex up to date.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Therapy notes dated 9/20/2024 at 08:04 AM state: patient discharging from physical, occupational, and speech therapy today, 9/20/24. Recommend continued 1 assist with transfers, ambulation, and ADLs. Diet consistency is accurate and appropriate. Patient will remain in this LTC (long-term care) facility which is most appropriate for patient. Patient scored 3.2 on the ACL ([NAME] Cognitive Level screen - a test to assess cognitive function) cognition assessment indicating patient is appropriate for 24-hour supervision.<br><br>Progress note dated 9/26/2024 at 20:44 (8:44 PM) states: resident had an unwitnessed fall in evening after supper. The resident was lying on the floor on her left side and reports that she did not hit her head. Vitals within normal limits, pain minimal to the left elbow and butt cheek. Resident reports that she was trying to move her wheelchair herself when she slipped out onto the floor. Nurse sat with the resident for an hour to monitor vitals and neuro status. Resident was baseline. Guardian contacted, nurse manager contacted, NP (nurse practitioner) contacted. Will continue to monitor.<br><br>Progress notes dated 9/27/2024 at 14:41 (2:41 PM): IDT met to review fall. Root cause of fall noted to be resident scooting to move wheelchair into place. Intervention related to root cause: non-skid pad placed in wheelchair.<br><br>Therapy notes dated 10/2/2024 at 15:51 (3:51 PM) state: PT (physical therapy) evaluated w/c positioning on 10/1/24. Patient is very short making it difficult for her to keep herself properly positioned in the wheelchair and causes her to slide forward in the wheelchair. Therapist searched through all wheelchairs in the building and in extra rooms to see if there was an appropriate w/c for patient. Patient needs a super hemi-wheelchair which most supply companies cannot provide. PT completed work order for seat to be adjusted for drop seat/seat slope: 1.5 (higher front) to see if this helps with better w/c positioning.<br><br>Progress notes dated 10/3/2024 at 13:20 (1:20 PM) state: IDT Risk. Risk Factors: Frequent Falls, Wheelchair Mobility, Height challenged, Dx Related to Risk: Unspecified Dementia, Failure to Thrive, Disc Disorder, Osteoarthritis, CKD 3 (chronic kidney disease), Unspecified Convulsions, Muscle Weakness. Nursing Issues: Pain control, Decreased mobility, Incontinence, Medications that can attribute to risk: Keppra and Sertraline. Behaviors that can attribute to risk: Noncompliance related to memory issues, Heightened startle reflex, Nutrition Risk Factors: Pureed Diet (no teeth). Weights are good - good intakes. Care Plan review and Risk intervention updates: Nonskid added to wheelchair. CP (care plan) updated. Wheelchair is being adjusted to drop the seat. Plan of care ongoing.<br><br>Progress notes dated 10/3/2024 at 20:18 (8:18 PM): Patient attempted to stand up multiple times during the shift. States that she left let [sic] hurt. Behavior improved with supper and once she laid down for the evening. Did encourage to elevate leg in WC which the resident did accept and that did help some of the behavior.<br><br>Progress notes dated 10/6/2024 at 06:00 AM: excerpt from fall report: resident was found lying in prone position on the bedside floormat in resident's bedroom. Resident was log rolled and transferred back to bed with 2 assists by mechanical lift after assessing for injury, no injury was noted, and resident did not verbalize pain. All extremities moved well per residents' baseline. Unit RN completed Neuro (neurological checks - check for potential head injury). Assessed and found to be without injury. Transferred off floor via Hoyer lift and 2 staff assist. Guardian updated. MD updated. DON updated. Care plan updated.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Progress notes dated 10/7/2024 at 15:16 (3:16 PM) state: IDT met to review fall. Root cause analysis determined root cause of fall to be resident sitting up on side of bed without assistance (lacking trunk strength/coordination to successfully lay herself back down in bed). Immediate intervention related to root cause: Care plan and Kardex updated to reflect that resident should not be left alone while sitting on the edge of her bed.<br><br>Progress notes dated 10/8/2024 at 18:21 (6:21 PM): patient was observed self-transferring writer ran to assist patient back to wheelchair patient became weak was lowered to floor, assessed patient from head to toe no injuries observed, performed rom (range of motion - check for injury to extremities) no complaints of pain, vitals measured started neuro checks, nurse on call notified order to call if any new abnormal symptoms occur, guardian notified, educated patient to ask for assistance when needed, distract patient with activities of choice offer snacks.<br><br>Progress notes dated 10/9/2024 at 12:57 PM Late Entry: IDT met to review fall. Root cause analysis performed. Root cause determined to be resident restlessness and weakness upon standing. Assessment info relayed to NP - new orders received and noted for labs (TSH lab to check thyroid function), change of sertraline timing to HS (at bedtime), and seeing psych (physician for psychiatric/behavioral health) next week.<br><br>Progress note dated 10/10/2024 at 12:43 PM: IDT clarification regarding root cause: Prior to falling, resident was sitting up at the side of her bed. CNA had offered to assist resident to lay down in bed, and resident refused.<br><br>Progress note dated 10/17/2024 at 03:02 AM: resident noted sitting on floor mat; her back against the bed with feet extended outwards toward bathroom door. Bed noted in lowest position at this time. Resident stated, I got to go to my momma's house. Resident noted restless, crying and breathing rapidly. Resident denied hitting her head but stated, her legs hurt. Tylenol administered for pain and pain gel rubbed on bilateral legs. No injuries or bruises noted this shift. Neuros WNL (within normal limits). ROM WNL (Range of Motion within normal limits) for resident. PRN (As needed) Melatonin given for sleep. A heated blanket placed on resident for comfort and 1:1 with staff. Charge nurse, On-call physician, and emergency contact notified. Fall intervention suggestion: Medication review needed. All needs met at this time. Call light within reach. Will continue to monitor.<br><br>Progress note dated 10/17/2024 at 09:28 AM Late Entry: IDT met to review fall. Root cause analysis (RCA) performed. Root cause identified as agitation related to bad dreams/delusions. Intervention related to root cause: Labs, Change of Zoloft to HS and Psych follow-up scheduled.<br><br>It should be noted the IDT RCA review, dated 10/17/24, is 8 days after R27's fall on 10/9/25.<br><br>Progress note dated 10/17/2024 at 15:31 (3:31 PM) Activity Progress Note: The writer is updating about a busy box that was created for the patient. Inside this busy box will be a number of things that the patient has seem to take interest in there is some jewelry in there for her to sort due to the fact she loves jewelry. Furthermore, there is a fake pet cat in there along with some puzzles and lastly coloring pages. This is to be located in the dining room of her unit and on her table of where she sits. This is to be used for when activity staff isn't present or to occupy her.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Therapy notes dated 10/24/2024 at 13:27 (1:27 PM): Pt's (Patient's) guardian came to writer's office today asking about getting patient a different wheelchair. Guardian feels the wheelchair is not working for her. Discussed that patient has not had any falls from current wheelchair and pt (patient) had two falls from previous wheelchair. Guardian still adamant about therapy trialing different wheelchairs. Guardian requested that elevating wheelchair footrests be on patient's w/c, to have wheelchair footrests slightly elevated, and for footrest cushion to be on patient's wheelchair at all times. Guardian also requested we trial a recline back wheelchair. Writer educated guardian that we [sic] therapy can attempt to trial different chairs but will discuss with IDT before changing anything.<br><br>Progress notes dated 10/25/2024 at 18:14 (6:14 PM): nurse was advised by CNA (Certified Nursing Assistant) that patient was on the floor in the dining room. Upon assessment, patient was observed laying on the floor in dining room, in front of wheelchair. Inquired about incident and patient stated, I was looking for the door to use the restroom. Nurse assessed for injuries. No apparent injuries noted. ROM (range of motion) applied and patient complained of lower right leg pain. Received routine acetaminophen 1000 mg. Assisted patient off the floor x 2 staff members using Hoyer lift. Patient toileted. Vitals obtained bp (blood pressure): 128/114 p (pulse): 96 r (respirations): 16 O2 (oxygen): 96% room air and t (temperature): 97.1. NP notified. Received orders for neuro checks. Call placed to (guardian name). Voicemail left to call facility back. Currently sitting in wheelchair in dining room coloring. Voiced no concerns at this time.<br><br>It should be noted R27 has had several falls in the dining room however there is no evidence the IDT discussed not leaving R27 alone in the dining room or increasing supervision for R27 r/t (related to) falls in the dining room.<br><br>Progress notes dated 11/1/2024 at 16:37 (4:37 PM) state IDT note: 10/25/24, unwitnessed fall without injury. Resident observed lying on the dining room floor. Resident relayed looking for the bathroom door. She most likely needed to use the bathroom. Her dx include Dementia, weakness, failure to thrive, malaise, osteoarthritis. She has poor safety awareness, severe cognitive impairment with a BIMS of 3. Neuro checks initiated. NP, Guardian, and Family Care RN notified. Care plan and CNA Kardex updated to include toilet before and after meals. Will monitor the effectiveness of the interventions and modify as necessary.<br><br>Of note, toileting before and after meals should be a normal standard of practice for all residents.<br><br>Toilet upon rising, before and after means at HS (bedtime) and as needed was a care planned intervention dated 9/7/24 on R27's bowel and bladder care plan.<br><br>Progress notes dated 11/20/2024 at 23:17 (11:17 PM): CNA found the resident on the floor and notified nurse. Doctor was notified as well as POA (power of attorney) and director. There was no apparent injury. Resident was checked and put back in bed. Neuro checks within normal limits and low bed and mat continue to be in place. No new interventions at this time, staff is updated to round frequently throughout the night. NOC (night) charge updated.<br><br>It should be noted there is no evidence the staff asked R27 what she may have been attempting to do or if R27 had an unmet need; the facility simply returned R27 to her bed.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Progress notes dated 11/22/2024 at 08:09 AM state: IDT note unwitnessed fall 11/20/24 without injury. Resident observed on the floor beside her bed. Resident with severe cognitive impairment, BIMS (Brief Interview Mental Status) of 3, dx (diagnosis) of dementia and unable to relay how the incident occurred. She has poor safety awareness and attempted to get out of bed unassisted and slid out of bed onto the fall mat. Bed in lowest position and call light within reach at the time of the incident. No c/o (complaints of) pain. Resident was monitored frequently thru out the night and will be moved closer to the nurses station for increased monitoring. Dr. and guardian notified. Care plan and CNA Kardex updated. Will monitor the effectiveness of the interventions and modify as necessary.<br><br>Progress notes dated 12/14/2024 at 23:00 (11:00 PM): CNA coming down the hall at 2220 (10:20 PM) and heard resident talking from her room. CNA went to res room and found resident laying on the floor mat with bed in low position. Due to cognitive impairment per res baseline, res unable to articulate what she was attempting to do. VSS (vital signs stable) with neuro checks WNL (within normal limits) to res baseline. No reports of physical pain or signs of injury. PERRLA (pupils equal, round, reactive to light and accommodation - normal eye exam - check for head injury). Res incontinent pad was dry. Res was rambling with rapid speech tearful and frustrated talking about going home to be with her mother. Speech is mostly word salad per res baseline. Res thirsty and asking for something to drink. Hydration provided. Resident's primary care provider notified as residents guardian and case manager. Administrator and DON for facility also updated of fall without injury. New intervention added to POC to offer hydration and/or snack at PM to NOC (night) shift change if res awake. 1:1 provided to resident by staff with active listening and validation of resident sadness and frustration provided. Neuro checks initiated per facility policy. Will monitor.<br><br>Progress notes dated 12/16/2024 at 21:00 (9:00 PM): resident was found sitting on the floor in front of her bed on the floor mat. The resident did not appear to be in any pain or discomfort, she does not report any injuries. The resident was able to move all extremities without issue. The resident was able to stand up with 2-assist and a gait belt and into the bed. A footrest pillow was placed under her feet to elevate her legs and keep her lower extremities in bed for increased comfort. The resident then became upset and agitated with staff and began yelling and asking not to be touched. The charge nurse was notified of no injuries with the incident. A phone call was placed to the GNP (geriatric nurse practitioner) to alert her of the incident. POA (power of attorney) notified of the incident. Will continue neuro checks and vitals assessments.<br><br>Progress notes dated 12/17/2024 at 12:50 PM Addendum: IDT NOTE: unwitnessed fall 12/14/24 without injury. Resident observed on the floor parallel to bed. Resident with severe cognitive impairment, BIMS of 3, dx of dementia and unable to relay how the incident occurred. She has poor safety awareness and most likely attempted to get out of bed unassisted and slid out of bed onto the fall mat. Bed in lowest position, gripper socks, and brief clean and dry at the time of the incident. No c/o (complaints of) pain. Neuro checks initiated. Resident verbalized being thirsty and hydration provided. Will offer hydration and/or snack at pm night shift change. Staff will ensure during routine rounds and as needed she has fresh ice water or fluid or choice. Dr. and guardian notified. Care plan and CNA Kardex updated. Will monitor the effectiveness of the interventions and modify as necessary.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Progress notes dated 12/18/2024 at 13:15: IDT note met to review resident's recent fall. Fall was in her room. Root cause analysis completed. Root cause identified as confusion and attempting to get out of bed. Resident has been experiencing recent behavioral episodes. Resident was yelling out at the time of assessment. Bed was in lowest position and fall mat was in place. She had been toileted and had been offered snacks. New interventions: positioning the bed at transfer height with fall mat in place and maintaining a low stim environment in resident's room.<br><br>Progress notes dated 12/18/2024 at 13:41 (1:41 PM): IDT met to review resident's recent fall. Root cause analysis completed. Root cause identified as resident feeling thirsty. Immediate intervention was resident was assisted with a beverage. New interventions: ensure bedside pitcher will be filled with resident's drink of choice. Plan of care ongoing.<br><br>Progress notes dated 12/19/2024 at 15:15 (3:15 PM): Resident was in the dining [sic] at about 3:15pm when writer heard resident fall in the dining area. When writer looked, resident was laying on her back on the floor, wheelchair by the feet, she had non-slip socks on, she was screaming and calling out, using profanities on staff. Meanwhile, all shift today, resident was up and down in her wheelchair, standing up and dragging her wheelchair while walking around. Staff tried each time to redirect but resident kept fighting and swatting at staff. Assessment completed, VSS wnl (Vital signs stable and within normal limits), resident had a bump on the back of her head from the fall but denies pain, no other injuries noted at the time of assessment. Patient was transported to the hospital via 911.<br><br>It should be noted that resident was self-transferring in her w/c, standing up and dragging her w/c all day. Staff did attempt to redirect however this was not successful. However, this behavior should have put staff on notice of the high potential of a fall occurring. There is no evidence the facility increased supervision despite this known behavior throughout the day.<br><br>Progress notes dated 12/19/2024 at 20:45 (9:45 PM): Resident returned from the ER at 8:45pm, no new orders, follow up with primary PCP for symptom management in one week. Resident is currently eating. Floor nurse to complete skin assessment after resident is done eating and in bed.<br><br>Progress notes dated 12/20/2024 06:43 AM: Repeated fall review-Repeated falls occur due to behavioral outburst and unable to redirect of [sic] touch resident during violent outburst. Injury prevention, resident safety are intervention focus. MD team inform[TRUNCATED] |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate pain management for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that pain management was provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences for 1 of 5 residents (R31) reviewed for pain.<br><br>R31 was admitted to the facility with chronic pain that became exacerbated with the use of the EZ stand lift. The facility did not address her pain needs or seek alternative transfer options.<br><br>Evidenced by:<br><br>The facility policy titled Pain Management, dated 2/8/25, states in part, The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents goals and preferences . Recognition: . In order to help a resident attain or maintain his/her highest practicable level pf physical, mental, and psychosocial well-being and to prevent or manage pain, the facility will: a. Recognize when the resident is experiencing pain and identify circumstances when the pain can be anticipated. b. Evaluate the resident for pain and the cause(s) upon admission, during ongoing scheduled assessments, and when a significant change in condition occurs ( . new pain or an exacerbation of pain) . c. Manage or prevent pain, consistent with the comprehensive assessment and plan of care, current professional standards of practice e, and the resident's goals and preferences. 2. Facility staff will observe for nonverbal indicators which may indicate the presence of pain. These indicators include but are not limited to: . f. Behaviors such as: . depressed mood . h. Difficulty sleeping (insomnia) . i. Negative vocalizations (e.g. groaning, crying .), .Pain Assessment: . 2. Based on professional standards of practice, an assessment or evaluation of pain by the appropriate members of the interdisciplinary team (e.g. nurses, practitioner, pharmacists and anyone else with direct contact with the resident) may necessitate gathering the following information, as applicable to the resident . g. Identifying activities, resident care or treatment that precipitate or exacerbate pain and those that reduce or eliminate pain .Pain Management and Treatment: . 1.Based on the evaluation, the facility in collaboration with the attending physician/prescriber, other health care professionals and the resident and/or the resident's representative will develop, implement, monitor and revise as necessary interventions to prevent or manage each individual resident's pain . 8. Monitoring, Reassessment and Care Plan Revision. a. Facility staff will reassess resident's pain management at established intervals for effectiveness and/or adverse consequences, such as: i. Tolerance . vii. Depression .<br><br>R31 was admitted to the facility on [DATE] with diagnoses that include Type 2 Diabetes Mellitus, Hemiplegia and Hemiparesis following Cerebral Infarction (complete or partial weakness/paralysis due to stroke), Adjustment Disorder with Depressed Mood, Unilateral Primary Osteoarthritis, Other Chronic Pain, Pain in Right Shoulder, Low Back Pain, unspecified, Muscle Weakness, generalized, and Other Cervical Disk Degeneration, (a painful condition caused by weakened spinal disks that may bulge outward into the spinal canal). R31's Minimum Data Set (MDS) Assessment, dated 3/28/25 indicates that R31 has a Brief Interview for Mental Status (BIMS) of 15 out of 15, indicating that R31 is cognitively intact.<br><br>R31's Care Plan states, in part:<br><br>(continued on next page) |

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| Complete Care at Maple Grove LLC | 3401 Maple Grove Dr.<br>Madison, WI 53719 |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Focus: Impaired Coping related Mood Disorders (adjustment disorder with depressed mood). [Resident Name] had planned to be at the care center for short term stay; however, she plateaued in therapy and did not progress to the level that would allow her to discharge home. [Resident Name] can become agitated and frustrated with herself and her current health status. She will express her frustration with reacting to small situations in her plan of care with larger reactions such as anger, frustration or tearfulness. [Resident Name] is frustrated and when there are changes, she struggles. Date Initiated: 3/19/25 Revision on: 3/19/25.<br><br>Intervention: Evaluate pain management treatment plan for effectiveness. Date Initiated: 3/19/25.<br><br>Focus: Mood/Behavior. At risk and/or potential for complications with mood/behavior. Date Initiated: 6/21/23. Revision on: 6/21/23.<br><br>Intervention: Check for comfort levels - pain, thirst, hunger, temperature - offering comfort as accepted. Date Initiated: 6/21/23.<br><br>Focus: Pain. At risk and/or potential for complications with pain R/T (related to) current medical/physical status. Has dx (diagnosis) that can/may affect pain status. Date Initiated: 6/21/23. Revision on: 6/21/23.<br><br>Intervention: Meds/Labs/Tx (treatments) as ordered. Observe meds (medications) for effectiveness. If ineffective after following MD orders, need to review sx's (symptoms) with MD (Medical Director) for recommendations. Date Initiated: 6/21/23.<br><br>Focus: ADL (Activities of Daily Living): At risk and/or potential for complications with deficits with ADL's R/T current medical/physical status. Has meds/tx that can/may affect ADLs/ Date Initiated: 63/21/23. Revision on: 6/21/23.<br><br>Intervention: Transfers with EZ stand and 1 assist. Date Initiated: 6/28/23. Revision on: 2/28/25.<br><br>R31's Physician Orders include the following pain medications:<br><br>-Diclofenac Sodium External Gel 1% (Diclofenac Sodium Topical). Apply to both upper arms. Start Date: 5/1/25<br><br>-Lidocaine External Patch 4 % (Lidocaine). Apply to L knee & both shoulders topically in the morning for arthritis. On for 12 hours off for 12 hours and remove per schedule. Start Date 4/3/25<br><br>-HYDROcodone-Acetaminophen Oral Tablet 5-325 MG (Hydrocodone-Acetaminophen). Give 1 tablet by mouth two times a day for Pain. Start Date 7/31/25<br><br>-HYDROcodone-Acetaminophen Oral Tablet 5-325 MG (Hydrocodone-Acetaminophen). Give 1 tablet by mouth as needed for Pain. May take THREE TIMES daily (TID) PRN. Start Date 9/23/24<br><br>-Acetaminophen Oral Tablet 500 MG (Acetaminophen). Give 500 mg by mouth three times a day for Pain. Start Date 8/2/24<br><br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | R31's January 2025 Medication Administration Record (MAR) documents numerical pain ratings from 0 to 7 out of 10. PRN (as needed) Hydrocodone-Acetaminophen Oral Tablet 5-325 MG tablet was administered 16 times in addition to the scheduled Hydrocodone-Acetaminophen and Acetaminophen Oral Tablet.<br><br>R31's February 2025 MAR documents numerical pain ratings from 0 to 7 out of 10. PRN (as needed) Hydrocodone-Acetaminophen Oral Tablet 5-325 MG tablet was administered 15 times in addition to the scheduled Hydrocodone-Acetaminophen and Acetaminophen Oral Tablet.<br><br>R31's March 2025 MAR documents numerical pain ratings from 0 to 7 out of 10. PRN (as needed) Hydrocodone-Acetaminophen Oral Tablet 5-325 MG tablet was administered 6 times in addition to the scheduled Hydrocodone-Acetaminophen and Acetaminophen Oral Tablet.<br><br>R31's April 2025 MAR documents numerical pain ratings from 0 to 7 out of 10. PRN (as needed) Hydrocodone-Acetaminophen Oral Tablet 5-325 MG tablet was administered 13 times in addition to the scheduled Hydrocodone-Acetaminophen and Acetaminophen Oral Tablet.<br><br>R31's Physician Notes indicate the following:<br><br>Encounter Date 7/31/24: [Resident Name] seen today for pain complaints per nursing staff. RN (Registered Nurse) assessment states pain all over and unaddressed . Pain is everywhere - it is different every day - excruciating at times - when asked for specifics she reports: 1 - low back pain from sitting - comes and goes - tries to reposition self. Up in chair a good share of the day. Leg tire by the end of the day. 2 - both shoulders - can't use arms to propel w/c (wheelchair) or raise arms up - worse pain 9. Radiates across her back - variable timing - hurts with transfers to bed and staff being rushed and rough. 3- Right knee - just feels funny - its not pain - above knee cap - variable - has a pain patch that helps sometimes. She is transferred with EZ stand. Tylenol is ineffective .<br><br>Encounter Date 8/15/24: She continues to have significant bilateral shoulder pain and left knee pain. States scheduled hydrocodone bid (twice daily) has been helpful. Chronic bilateral shoulder pain due to osteoarthritis. Continue hydrocodone 5/325 one tab bid for pain.<br><br>Encounter Date 11/21/24: She states her left hip pain is less frequent and less severe. She is most bothered by left knee pain and right shoulder pain. her pain did lessen after steroid injection but remains uncomfortable. Chronic bilateral shoulder pain due to osteoarthritis/rotator cuff pathology. Received steroid injection to both shoulders on 10/8/24. Recommend continue lidocaine patch to right shoulder, acetaminophen 500 mg tid (three times a day), and hydrocodone 5/325 one tablet bid for pain.<br><br>A facility Grievance Form dated 3/11/25, completed by SW K (Social Worker), states the following in part: [Resident Name] expressed some feelings regarding her physical ability and transfer status . [Resident Name] is frustrated because she is no longer in therapy and struggling with understanding her current plan of care. [Resident Name] was provided with time to voice her feelings and frustrations .<br><br>R31's Progress Notes indicate the following:<br><br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Nursing Note dated 4/3/25: Patient expressed concern to have lidocaine patch applied to both shoulders. Call placed to (name) NP (Nurse Practitioner) and received phone order to apply three patches for pain.<br><br>Social Service Note dated 4/14/25: . At this time, [Resident Name] uses the EZ stand for her transfers, and this is a source of frustration for her. [Resident Name} has asked about other methods of transfer and has asked the staff to let her try other transfer methods .<br><br>On 4/28/25 at 2:54 PM, Surveyor interviewed R31 who stated that she has pain all the time from using the EZ stand. R31 indicated that she has torn rotator cuffs in both shoulders and that she is of the age where the doctors are unable to do surgery. Surveyor asked R31 what her current pain level was. R31 stated it was currently a 5 and that she is getting pain pills and using heating pads, which seemed to help, but that the EZ stand causes so much pain that she cries multiple times a day with each transfer. R31 indicated that she has asked therapy over and over to be re-evaluated to transfer with a stand-pivot so that her shoulders would not hurt so bad from using the EZ stand. R31 stated that she has talked to DON B (Director of Nursing), NHA A (Nursing Home Administrator) and SW K about the pain and being evaluated to transfer a different way, but she has heard nothing back since the end of February.<br><br>On 4/30/25 at 1:07 PM, Surveyor interviewed CNA I (Certified Nursing Assistant) about R31's pain and transfer status. CNA I stated that yes, R31 was having some pain with transfers and the EZ stand. CNA I stated that when R31 says she is in pain she offers to stop, but that can be difficult if she is mid-transfer. CNA I indicated that she reported R31's complaints of pain to RN C (Registered Nurse).<br><br>On 5/1/25 at 11:25 AM, Surveyor interviewed RN C about R31's pain and transfer status. RN C stated that R31 does have pain in both shoulders and left knee, and that they had been using lidocaine patches in these areas to reduce the pain. RN C indicated that he felt that R31's scheduled medication regimen of Tylenol and Hydrocodone was efficient at managing her pain. RN C stated that the EZ stand hurt R31's shoulders when it was put up all the way. Surveyor asked RN C approximately how many times a day R31 is using the EZ stand for transfers. RN C stated R31 is using the EZ stand approximately 3-4 times a shift. Surveyor asked RN C if R31 was in pain 3-4 times a shift during the transfers. RN C stated yes, because the EZ stand hurts R31's shoulders.<br><br>On 5/1/25 at 11:36 AM, Surveyor interviewed CNA F and asked her about R31's pain during transfers. CNA F stated that R31 keeps on crying every time she is transferred with the EZ stand. CNA F stated that R31 uses a pain patch to help reduce the pain, but that she cries several times a day during the transfers. Surveyor asked if she had told anyone about how much pain R31 was in every day. CNA F stated that everybody knows about R31's pain.<br><br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 5/1/25 at 11:42 AM, Surveyor interviewed SW K and asked her about R31's pain and transfer status. SW K stated that she had had a couple of conversations with R31 about the EZ stand lift and her pain. SW K indicated that R31 gets very frustrated when there is new staff and how they are using the lift because she only likes to come up a little ways because it hurts her shoulders. SW K stated that she lets R31 vent her frustrations and let her talk about the EZ stand. SW K stated that R31 had asked some staff to transfer her without the EZ stand and they educated her that is not safe and she needs to continue to use the EZ stand. Surveyor asked SW K what alternatives were being offered to R31 in light of her continued daily pain with the use of the EZ stand. SW K indicated that R31 had plateaued in therapy so there was nothing more they can do. Surveyor asked SW K how long she has known about R31's daily pain. SW K stated the last she talked to R31 about her pain was a month ago.<br><br>On 5/1/25 at 1:53 PM, Surveyor interviewed DON B about R31's pain. DON B stated that R31 doesn't like the EZ stand so they've put her on therapy several times to try to see if there were alternatives to safely transfer but she just doesn't like the lift. DON B stated most of the aides know to only go halfway up, but sometimes they may have to lift R31 up higher which causes R31 more pain. DON B stated that the EZ stand stretches her arms too much and hurts her shoulders.<br><br>Surveyor asked DON B if she was aware that R31 was experiencing a significant amount of daily pain due to continued use of the EZ stand. DON B stated that she had not had a chance to look at her pain assessments or talk to the nurse about it. Surveyor asked DON B how the aides are to be made aware not to lift R31 all the way up on the EZ stand, which causes her greater shoulder pain. DON B stated that they just know, and that she was not sure if this information was on R31's care card. Surveyor asked DON B what her expectation was regarding resident's pain management? DON B indicated that for residents that were experiencing pain they would increase the pain assessments daily for 3-4 days then the IDT (Interdisciplinary team) will meet see what the intervention was, update the care plan, and contact the MD. After that they would continue with pain reassessment and interview the resident to see if it was effective. Surveyor asked if this had been completed for R31. DON B stated that she was not aware that it had been done yet.<br><br>The facility failed to provide adequate pain management for a resident with chronic daily pain needs. The facility did not reassess the resident's pain or develop and implement new approaches to transferring. The facility did not update the resident's care plan or notify front line staff of her preferences regarding transfers, resulting in continued daily pain. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>Based on observation, interview, and record review, the facility did not ensure drugs and biological's used in the facility were stored and labeled in accordance with currently accepted professional practices and include the expiration date when applicable for 1 of 3 medication carts reviewed for compliance.<br><br>Surveyor observed the following:<br><br>R36's fluticasone propionate nasal spray did not have an open date and R36's Systane Ultra Ophthalmic Solution 0.4- 0.3% eye drops had an open date of 3/15/25.<br><br>R45's PRN (as needed) Hydralazine card expired on 2/22/25.<br><br>R32's PRN Chest Congestion Relief card expired 2/27/24 and PRN ondansetron card expired on 2/22/25.<br><br>R48's PRN stimulant laxative card expired on 2/27/24.<br><br>R194's PRN calcium antacid card expired on 2/25/24.<br><br>R16's PRN ondansetron card expired on 2/22/25.<br><br>Evidenced by:<br><br>The facility's policy titled Medication Storage dated 2/28/25 states in part .4. Unused Medications: All medication rooms are routinely inspected by the consultant pharmacist for discontinued, defective, or deteriorated medications with worn, illegible, or missing labels.<br><br>On 4/28/25 at 11:55 AM, Surveyor observed medication cart #1 with LPN N (Licensed Practical Nurse). Surveyor found R36's fluticasone propionate nasal spray did not have an open date and R36's Systane Ultra Ophthalmic Solution 0.4- 0.3% eye drops had an open date of 3/15/25. Surveyor found R45's PRN Hydralazine card expired on 2/22/25. Surveyor found R32's PRN Chest Congestion Relief card expired 2/27/24 and PRN ondansetron card expired on 2/22/25. Surveyor found R48's PRN stimulant laxative card expired on 2/27/24. Surveyor found R194's PRN calcium antacid card expired on 2/25/24. Surveyor found R16's PRN ondansetron card expired on 2/22/25.<br><br>On 4/28/25 at 12:04 PM, Surveyor interviewed LPN N. Surveyor reviewed the expired medications, nasal spray, and eye drops with LPN N. Surveyor asked how long eye drops are good for after being opened, LPN N reported 28 days. Surveyor asked LPN N if nasal sprays should have an open date, LPN N stated yes. Surveyor asked LPN N what the process is for checking the medication carts for expired medications, LPN N stated that the cards should be checked every time the medications is being administered. Surveyor asked LPN N what the process is for checking PRN medications for expired medications, LPN N stated that they should be checked before they are given. Surveyor asked LPN N if the expired medications should have been discarded, LPN N stated yes.<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 5/1/25 at 2:05 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B what the process is for ensuring that expired medications are removed from the medication carts and medication rooms, DON B stated that the pharmacist is supposed to come and audit the carts and room, and expired medications should be taken out and sent back to the pharmacy. Surveyor asked DON B how often the carts and rooms should be checked, DON B stated that she thought is was monthly, but that she has to call and schedule it ahead of time. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation, interview, and record review, the facility did not store, prepare, distribute, and serve food in accordance with professional standards for food service safety. This has the potential to affect all 94 residents who reside at the facility.<br><br>Surveyor observed staff taking temperatures of food during lunch meal. Staff did not take temperatures of all foods on steam table.<br><br>Surveyor observed staff taking temperatures of food during lunch meal. Staff did not allow time for thermometer to dry after using alcohol wipe and placed directly into food.<br><br>Evidenced by:<br><br>The facility policy, Record of Food Temperatures, dated, 2/25, states, in part; .6. Measure and record the temperatures for each food product and milk at all meals. Record temperature on temperature log. 7. When holding hot foods for service, food temperature should be measured when placing it on the steam table line . 14. Food temperatures will be verified using a thermometer which is both clean, sanitized and calibrated to ensure accuracy .<br><br>On 4/30/25 at 11:03 AM, Surveyor observed DA Q (Dietary Aide) taking the temperature of the food being placed into steam table. DA Q was observed cleaning thermometer with alcohol wipe and placing directly into food, not allowing time for thermometer to dry. DA Q was observed doing this with all foods being temped. DA Q failed to take the temperature of ground and pureed food items in steam table. Surveyor asked DA Q if DA Q was going to temp all the food. DA Q indicated DA Q only temps the foods that are important.<br><br>On 5/1/25 at 9:12 AM, DM P (Dietary Manager) indicated all food temps should be taken at every meal. DM P indicated thermometer should be dry before placing it into the next food. DM P indicated understanding of the above concerns.<br><br>The facility did not store, prepare, distribute, and serve food in accordance with professional standards for food service safety. |