STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525386	A. Building B. Wing	06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ashland Health Services	1319 Beaser Ave Ashland, WI 54806

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0680 Level of Harm - Potential for minimal harm Residents Affected - Many	Ensure the activities program is directed by a qualified professional. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17661 Based on interview and record review, the facility failed to ensure a qualified activity professional was hired to direct the activities program and to meet the activity needs of residents. This had the potential to affect all 40 residents in the facility. The facility's Life Enrichment Specialist (LES) I or Activity Director, is not a qualified therapeutic recreation specialist and does not meet the qualifications required to direct the activities program. This is evidenced by: According to Federal Guidelines, the Activity Director must be a qualified therapeutic recreation therapist or must contain one of the following: Is licensed or registered, if applicable, by the State in which practicing; and (A) Eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or (B) Has 2 years of experience in a social or recreational program within the last 5 years, one of which was full-time in a therapeutic activities program; or (C) Is a qualified occupational therapist or occupational therapy assistant; or (D) Has completed a training course approved by the State. The facility policy titled Activities dated 6/1/2017 and last reviewed 7/11/22 stated, in part, It is the policy of this facility to provide an ongoing program to support residents in their choice of activities based on their comprehensive assessment, care plan and preferences. Facility-sponsored group, individual, and independent activities will be designed to meet the interests of each resident, as well as support their physical mental and psychosocial well being .1. Each resident's interest and needs will be assessed on a routine basis. The assessment shall include, but is not limited to: a. RAI (Resident Assessment Instrument) Process: MDS/CAA (Care Area Assessment/Care Plan b. Activity assessment to include resident's interest, preferences and needed adaptations. (continued on next page)

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

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F 0680 Level of Harm - Potential for minimal harm Residents Affected - Many	c. Social history. d. Discharge information, when applicable. 2. Activities will be designed with the intent to: a. Enhance the resident's sense of well-being, belonging and usefulness. b. Promote or enhance physical activity. c. Promote or enhance cognition. d. Promote of enhance emotional health. e. Promote self-esteem, dignity, pleasure, comfort, education, creativity, success and independence. f. Reflect residents's interests and age. g. Reflect cultural and religious interests of the residents. h. Reflect choices of the residents . Surveyor noted activity programs were being conducted throughout the recertification survey in which multiple residents participated and were engaged. On 6/5/24 at 9:58 AM, Surveyor approached Life Enrichment Specialist (LES) I, who is currently the director of activity programming, to interview on her education and experience to direct activity programming. LES I stated she has [AGE] years background as a Certified Nursing Assistant and assumed the role of Activity Director in October 2023. LES I stated she has no education to date but has been reviewing programs for her to enroll in with the Nursing Home Administrator (NHA) A, but to date, has not signed up for any courses. LES I stated she works in activities 30-40 hours each week and completes all the activity programming schedules for the residents. LES I stated that at the present time, there is no one on staff that is overseeing her and the responsibilities she has as the director of activities. On 6/5/24 at 10:02 AM, Surveyor met with NHA A and asked what courses the facility was reviewing for LES I to enroll in to meet the Federal guidelines for activity directors in the State. NHA A stated, I sent LES I course information but LES I hasn't signed up for anything yet. We're looking at several different courses for her to enroll. On 6/5/24 at 10:45 AM, Surveyor again met with LES I and asked what her responsibilities are as they relate to activity programming. (continued on next page)

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F 0680 Level of Harm - Potential for minimal harm Residents Affected - Many	LES I stated that she completes all the User Designed Assessments (UDAs), the activity assessments and the life enrichment assessments on admission, which involves personal information, voting, past history, occupation, etc. LES I stated she has two activity aides that she oversees, both work part-time, and meets with them throughout the week to discuss how the programs are working for the residents (likes, dislikes). LES I also stated that she completes cognitive/mental programs and a physical program each day. In addition, LES I also holds the Resident Council Meetings each month, and just started working with Registered Nurse (RN) J, who is the Resident Care Management Director/Minimum Data Set Assessment Coordinator, on how to complete activity sections of the Minimum Data Set (MDS) Assessment. LES I stated that she develops all the activity programming for the residents and coordinates the calendar of activities. Surveyor then reviewed the job description for Life Enrichment Specialist. Under Summary/Objective: Responsible for supervising, creating and providing an exciting life enrichment program appropriate for the physical, social, cultural, spiritual, emotional and recreational needs for each resident. Provides the opportunity for residents to engage in normal pursuits while promoting a successful and well-balanced leisure lifestyle. Work with various disciplines to assist the resident in reaching their highest level of independence. Plans and monitors leisure activities for recreation and therapeutic purposes designed to enhance the quality of life for each resident while maintaining an open working relationship with the resident's center or guardian . Under Essential Functions, the Life Enrichment Specialist responsibilities include but is not limited to: - Plans, develops, organizes, implements, evaluates and directs the activity program. - Assesses individual/group resident/patient needs and develops related meaningful morning, afternoon, evening and special programs. The job description continues to describe the education and experience required for this position and includes, - Must be a qualified therapeutic recreation specialist of an activities professional who is currently licensed or registered, as required, by the State and is eligible for certification as a therapeutic recreation specialist or as an activity's professional by a recognized accrediting body - Two years of experience in a social or Life Enrichment program within the last five (5) years, one (1) of which was a full time in a patient activities program in a health care setting - Completed a training course as approved by the State LES I has no former education to meet the federal guidelines and completes all resident assessments as they relate to activity programming and coordinates, develops and assesses the activity programming throughout the facility. LES I has been in this role for 8 months with no enrollment in a course to meet the guidelines, as of this writing. All resident activity assessments and programming were being completed at the time of survey.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44863 Based on interview and record review, the facility did not ensure residents received treatment and care in accordance with professional standards of practice for 1 of 12 sampled residents (R23). The facility did not follow physician orders for R23 to obtain a video fluoroscopy swallow study (VFSS) to determine appropriate and safe diet recommendations. Findings: R23 was admitted to the facility on [DATE], after hospitalization for dehydration, confusion, and weakness. R23's hospital discharge instructions were speech therapy (ST) related to dysphagia (difficulty swallowing), occupational therapy (OT), and physical therapy (PT) for strengthening. Admitting diagnoses to facility included dementia, stroke with left sided paralysis, diabetes mellitus type 2, chronic kidney disease stage 3, dysphagia, and depression. R23's admission Minimum Data Set (MDS) assessment confirmed R23 scored 05/15 during Brief Interview for Mental Status (BIMS), indicating severe cognitive impairment. MDS determined R23 required partial or moderate assistance with eating. R23's care plan, dated 10/24/23, included a focus area of: At risk for nutritional status changes related to need for mechanically altered texture and feeding assistance, variable oral intakes, weight loss, low body mass index, and altered skin integrity. Intervention: Encourage and assist as needed to consume foods and/or supplements as ordered. R23's nutrition assessment, dated 10/24/23, confirmed R23 had swallowing difficulty related to coughing during meals. R23's intakes were 50-100%. On 11/20/23, a change in condition evaluation was entered in R23's progress notes related to diarrhea, food/fluid intake, tired, weak, confused, or drowsy. On 12/07/23, a progress note was entered to monitor R23 related to increased fatigue, nausea, intermittent emesis, and loose stools. From 12/09/23-12/13/23, R23 was hospitalized for difficulty breathing, difficulty swallowing, decreased fluid intake, and vomiting. Hospital discharge summary included diagnoses of hypernatremia (elevated sodium), pneumonia, and urinary tract infection (UTI). Discharge instructions included follow up labs for hypernatremia, fluids changed to nectar thickened, and ST evaluation and treatment. On 12/15/23, a nutrition assessment was completed confirming R23's diet was downgraded to pureed with nectar thickened liquids related to dysphagia. R23's intakes were 0-75%. On 12/16/23, a physician order was entered, Would recommend video swallow study to determine objective findings related to integrity of the swallow. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/27/23, R23 was sent to the ER related to vomiting, respiratory congestion, and cough. R23 returned to the facility this same date, with diagnosis of UTI. On 01/28/24, ST notes read, Discussed recommendation of video fluoroscopy swallow study (VFSS) in order to identify if advancement in diet is safe/appropriate. On 03/07/24, R23's MDS assessment was completed and indicated a health condition of dehydration. On 03/07/24, a nutrition assessment was completed for R23. Assessment indicated R23 had experienced a gradual weight loss since admission, swallowing difficulty related to need for nectar thickened liquids, gastrointestinal concerns, and inadequate oral intakes. R23's body mass index (BMI) was 19.9. Nutrition assessment indicated R23's intakes were 25-100%. On 03/09/24, ST notes read, ST continues to recommend VSFF to determine safety with swallow and to identify if upgrade is safe. On 04/18/24, ST notes read, ST requested swallow study multiple times. On 05/08/24, R23 completed a bedside swallow study; this was not a VFSS. On 06/04/24, a nutrition assessment was completed for R23. Assessment confirmed R23 had a gradual weight change, swallowing difficulty, received pureed and nectar thickened liquids, nutritional problem related to inadequate oral intakes, and gastrointestinal concerns. R23's intakes were 51-100%. On 06/04/24 at 1:11 PM, Surveyor interviewed Speech Therapist (ST) U. ST U reported previous ST recommended the video swallow study on 12/16/23. ST U was not sure why R23's VFSS was not scheduled shortly after the recommendation on 12/16/24. ST U reported the swallow study that was completed on 05/08/24 was a bedside swallow study, not a VFSS. ST U reported ST completes bedside swallow studies in the facility. ST U stated a VFSS would help them to know if the reason for difficulty with swallowing is physical, and provide images of pharyngeal, esophagus, and ST U stated, It would help us to determine strategies such as a chin tuck, or type of fluids or foods he can/can't eat. Maybe he doesn't need nectar thickened, maybe it's food that is the problem and he could have thin liquids or that Coke he is asking for, but we can't determine that with a bedside swallow study only a VFSS. On 06/05/24 at 8:25 AM, Surveyor interviewed Social Worker (SW) D. SW D confirmed she was responsible for scheduling appointments prior to 02/19/24, as the facility hired new staff on 02/19/24 to assist with scheduling appointments. SW D reported she did not schedule R23's VFSS as R23's family would schedule his appointments. Surveyor requested evidence the facility spoke with R23's family regarding the VFSS recommendation on 12/16/23, and evidence the family agreed or disagreed to schedule the appointment. The facility did not provide evidence requested. R23's appointment had not been scheduled.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 17661 Based on observations, interviews and record reviews, the facility failed to ensure staff practiced appropriate hand hygiene during a dressing change for a stage III Pressure Injury (PI) for 1 of 1 resident (R21) reviewed and currently in-house with a PI. The CDC had outlined the following indications for hand washing and the wearing of gloves: A. When hands are visibly dirty or contaminated with proteinaceous material or are visibly soiled with blood or other body fluids, wash hands with either a nonantimicrobial soap and water or an antimicrobial soap and water . F. Decontaminate hands after contact with a patient's intact skin. G. Decontaminate hands after contact with body fluids or excretions, mucous membranes, nonintact skin, and wound dressings if hands are not visibly soiled . J. Decontaminate hands after removing gloves . The CDC continues to direct healthcare workers with the technique of hand hygiene: .2. E. Change gloves during patient care if moving from a contaminated body site to a clean body site . Surveyor reviewed the facility policy titled Clean Dressing Change dated 7/2022. The following was noted: It is the policy of this facility to provide wound care in a manner to decrease potential for infection and/or cross contamination . 7. Wash hands and put on clean gloves .remove the existing dressing .remove gloves . Wash hands and put on clean gloves. Cleanse the wound as ordered .Wash hands and put on clean gloves . dress the wound as ordered .and wash hands . This is evidenced by: R21 has medical diagnoses that include, but are not limited to, cerebral palsy, peripheral vascular disease and a long-standing stage III PI on the outer left ankle (malleolus). R21 was on Enhanced Barrier Precautions related to the wound and a current indwelling Foley urinary catheter. According to the most recent Minimum Data Set Assessment (MDSA), which was a quarterly assessment with an Assessment Reference Date (ARD) of 4/27/24, R21 has a stage III PI. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In reviewing the history of this stage III PI, Surveyor identified that R21 has a long standing history of pressure injuries going back to admission of 2/18/21, at which time there was a PI located on the coccyx, and has since resolved. The PI that was currently being treated had an onset date of 8/19/23, of which was documented as an unstageable that measured 1.3 cm (centimeters) L (length) x 1.1 cm w (width). The wound was documented as containing 50% granulation tissue and 50% slough with light amount serous drainage; no odor or tunneling evident with distinct wound edges with a pink periwound tissue. Note: Granulation tissue is new connective tissue and microscopic blood vessels that form on the surfaces of a wound during the healing process. Slough is the yellow/white material in the wound bed. Slough is an accumulation of dead cells and is nonviable tissue that needs to be removed in order for healing to occur. Over time, this wound improved and worsened and on 11/22/23 and 2/7/24, positive cultures for MRSA (Methicillin-Resistant Staphylococcus Aureus) were obtained for the left outer ankle wound. This is an infection caused by a type of staph bacteria that's become resistant to many of the antibiotics used to treat ordinary staph infections. Without eradication of the infection, a wound would be difficult to heal. MRSA most often causes skin infections but it can also cause serious infections in the lungs, heart and bloodstream. The most recent assessment of the wound was documented on 5/28/24 and was measured as being slightly greater than 0.1 L x slightly greater than 0.1 W x slightly greater than 0.1 deep. In reviewing the care plan devised for R21, Surveyor noted the facility initiated a plan for the following: Actual infection: MRSA to wound on outer left ankle. The start date for this plan was 11/30/23 and last revised on 1/8/24. Included in the interventions were: - Encourage resident to use good clean hygiene techniques to avoid cross contamination. - Maintain Contact precautions as indicated. On 6/3/24 at 1:41 PM, Surveyor observed Licensed Practical Nurse (LPN) E complete the treatment and dressing change to the ankle wound. The following techniques were observed: - LPN E sanitized his hands upon entering the room and donned a pair of gloves. - LPN E then removed the old dressing from the left outer ankle. LPN E then removed the gloves but did not wash or sanitize his hands before proceeding to cleanse the wound with antibacterial soap and water contained in a basin. - LPN E then turned on the water faucet and rinsed the basin and filled with clean water. LPN E changed gloves but did not wash or sanitize his hands before donning a clean pair of gloves. LPN E then rinsed the wound of soap and dried the wound. LPN E then applied a Mepilex foam dressing to the wound. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- With the same gloves, LPN E opened four dresser drawers to search for clean compression socks. Unable to locate, LPN E then sanitized his hands and left the room in search for clean socks. On 6/4/24, the wound was measured again, and there was no change in the assessment from 5/28/24. On 6/5/24 at 7:45 AM, Surveyor interviewed Interim Director of Nursing (DON) B regarding the expected practice of hand hygiene during treatment changes. IDON B stated, Wash hands before you start anything, then after removing the dirty and before placing the clean, you should wash. Should sanitize or something in between, with each glove change, and then wash again when finished . On 6/5/24 at 7:50 AM, Surveyor approached LPN E and interviewed him regarding his knowledge of hand hygiene with treatments and dressing changes. LPN E correctly identified that the hands should be washed with soap and water for at least 30 seconds and should wash between each glove removal. Surveyor pointed out the treatment observation made and explained that even though LPN E removed gloves at the appropriate times, he did not wash or sanitize hands after removing the soiled gloves. LPN E stated, Oh yeah, I thought I did that, but ok, that's right. I should have.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44863 Based on interview and record review, the facility did not ensure 1 of 2 residents (R23) reviewed was offered sufficient fluid intake to maintain proper hydration. The facility did not have a system in place for tracking daily intakes to ensure R23's fluid intake was adequate. Findings include: Findings: The facility's policy, Hydration, reads in part, The facility offers each resident sufficient fluid, including water and other liquids, consistent with resident needs and preferences to maintain proper hydration and health. 1. The facility will utilize a systemic approach to optimize the resident's hydration status: a. Identifying and assessing each resident's hydration status and risk factors. b. Evaluating/analyzing the assessment information. c. Developing and consistently implementing pertinent approaches. d. Monitoring the effectiveness of interventions and revising them as necessary. 3. Evaluation/analysis: a. The assessment shall clarify the resident's current hydration status and individual risk factors for dehydration or fluid imbalance. 4. Care plan implementation: a. The resident's goals and preferences regarding hydration will be reflected in the resident's plan of care. 5. Monitoring/revision: b. The resident will be monitored for signs and symptoms of dehydration including, but not limited to: viii. Confusion or change in mental status ix. Decreased urinary output x. Abnormal lab values (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	e. The resident will be monitored for conditions that may increase fluid needs: ii. Vomiting or diarrhea iii. Fever/infection iv. Uncontrolled diabetes R23 was admitted to the facility on [DATE], after hospitalization for dehydration, confusion, and weakness. R23's hospital discharge instructions were speech therapy (ST) related to dysphagia (difficulty swallowing), occupational therapy (OT), and physical therapy (PT) for strengthening. Admitting diagnoses to facility included dementia, stroke with left sided paralysis, diabetes mellitus type 2, chronic kidney disease stage 3, dysphagia, and depression. R23's admission Minimum Data Set (MDS) assessment confirmed R23 scored 05/15 during Brief Interview for Mental Status (BIMS), indicating severe cognitive impairment. MDS determined R23 required partial or moderate assistance with eating. On 10/20/23, a dehydration risk screen was completed. The screening tool directed further assessment to be completed for any scores of 10 or higher. R23 scored a 6, as follows: 1. Skin turgor 3 seconds, 1. Ambulates with 2 assist, wheelchair with assistance, 1. Fluid intake/Eating-limited physical assistance, 0. No weight loss, 1. Incontinent of urine, 0. Risk factors: history of dehydration, diarrhea/vomiting in last 7 days, 1. Pre-disposing factors, 1. Medications. Dehydration assessment was not an accurate assessment related to R23's history of dehydration, need for moderate assistance with eating, and documented swallowing difficulty. R23's care plan, dated 10/24/23, included a focus area of: At risk for nutritional status changes related to need for mechanically altered texture and feeding assistance, variable oral intakes, weight loss, low body mass index, and altered skin integrity. Intervention: Encourage and assist as needed to consume foods and/or supplements as ordered. R23's nutrition assessment, dated 10/24/23, calculated R23's fluid needs to be 2040 ml daily. Nutrition assessment confirmed R23 had swallowing difficulty related to coughing during meals. R23's fluid intakes from 10/20/23-12/09/23 ranged from 0-1510 ml of daily fluid. Confirming R23 did not meet his daily fluid intake needs on any days. Documentation confirmed R23's fluid intake was less than 50% of recommended values to maintain proper hydration for 32 of 54 days. There was no evidence R23's fluid intakes were being monitored. There is no care plan for hydration. On 11/20/23, a change in condition evaluation was entered in R23's progress notes related to diarrhea, food/fluid intake, tired, weak, confused, or drowsy. R23's care plan was not updated. On 12/07/23, a progress note was entered to monitor R23 related to increased fatigue, nausea, intermittent emesis, and loose stools. R23's care plan was not updated. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	From 12/09/23-12/13/23, R23 was hospitalized for difficulty breathing, difficulty swallowing, decreased fluid intake, and vomiting. Hospital discharge summary included diagnoses of hypernatremia (elevated sodium), pneumonia, and urinary tract infection (UTI). Discharge instructions included follow up labs for hypernatremia, fluids changed to nectar thickened, and ST evaluation and treatment. On 12/13/23, a dehydration risk assessment was completed for R23. R23 scored 8, as follows: 0. Skin turgor 3 seconds, 2. Bedbound, 3. Swallowing difficulty, 0. Weight loss, 1. Incontinent of urine, 0. Risk factors: history of dehydration and vomiting/diarrhea, 1. Pre-disposing factors, 1. Medication. Dehydration assessment was not an accurate assessment related to R23's history of dehydration, need for moderate assistance with eating, vomiting/diarrhea, and documented swallowing difficulty. On 12/14/23, R23's primary care physician completed a skilled nursing facility (SNF) visit. PCP's assessment and plan stated, Chronic Kidney Disease Stage 3 with hypernatremia related to free water deficit since hospitalization . Continue to monitor fluid intake and encourage free water intake. R23's care plan was implemented for dehydration. On 12/15/23, a nutrition assessment was completed for R23. Nutrition assessment indicated R23's daily fluid intake needs were 2040 ml. Assessment confirmed R23 had a nutritional problem related to inadequate oral intake. R23's daily fluid intakes from 12/13/23-12/27/23 ranged from [PHONE NUMBER] ml. Confirming R23 did not meet his daily fluid intake needs on any days. Documentation confirmed R23's fluid intake was less than 50% of recommended values to maintain proper hydration for 13 of 15 days. There was no evidence R23's fluid intakes were being monitored. On 12/16/23, a physician order was entered, Would recommend video swallow study to determine objective findings related to integrity of the swallow. On 12/27/23, R23 was sent to the ER related to vomiting, respiratory congestion, and cough. R23 returned to the facility this same date, with diagnosis of UTI. On 01/07/24, R23's record included a progress note that read, Staff reported that he is having reduced urine output with few wet pads. Bladder scan done only 29 ml urine in bladder. There was no documentation related to follow-up of R23's reduced urine output. R23's daily fluid intakes from 12/28/23-01/07/24 ranged from [PHONE NUMBER] ml. Confirming R23 did not meet his daily fluid intake needs on any days. Documentation confirmed R23's fluid intake was less than 50% of recommended values to maintain proper hydration for 11 of 12 days. There was no evidence R23's fluid intakes were being monitored. On 01/28/24, ST notes read, Discussed recommendation of video fluoroscopy swallow study (VFSS) in order to identify if advancement in diet is safe/appropriate. On 02/26/24 and 02/27/24, R23's record confirmed R23 experienced emesis both days. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ashland Health Services	1319 Beaser Ave Ashland, WI 54806

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/02/24, R23's record confirmed diagnosis of UTI per urinalysis. R23's care plan was updated with 'UTI,' interventions included: offer and encourage adequate intake of fluids. On 03/07/24, R23's MDS assessment was completed and indicated a health condition of dehydration. R23 did not have a hydration care plan implemented. On 03/07/24, a nutrition assessment was completed for R23. Assessment indicated R23 had experienced a gradual weight loss since admission, swallowing difficulty related to need for nectar thickened liquids, gastrointestinal concerns, and inadequate oral intakes. R23's body mass index (BMI) was 19.9. Nutrition assessment indicated R23's daily fluid intake needs were 1850 ml. R23's care plan was updated with 'Nutrition,' interventions included: provide diet as ordered, pureed and nectar thickened liquids. R23's daily fluid intakes from 01/08/24-03/07/24 ranged from 0-1705 ml. Confirming R23 did not meet his daily fluid intake needs on any days. Documentation confirmed R23's fluid intake was less than 50% of recommended values to maintain proper hydration for 28 of 61 days. There was no evidence R23's fluid intakes were being monitored. On 03/09/24, ST notes read, ST continues to recommend VSFF to determine safety with swallow and to identify if upgrade is safe. On 03/13/24, R23's record confirmed emesis on this date. On 03/16/24, a dehydration risk assessment was completed for R23. R23 scored 13, as follows: 2. Skin turgor 3 seconds, 2. Bedbound, 3. Swallowing difficulty, 0. No weight loss, 1. Incontinent of urine, 3. Risk factors: history of dehydration, history of refusing liquids, diarrhea/vomiting, 1. Pre-disposing factors, 1. Medications. Dehydration assessment was not an accurate assessment related to R23's BMI less than 21 and weight loss. On 04/18/24, ST notes read, ST requested swallow study multiple times. On 05/08/24, R23 completed a bedside swallow study; this was not a VFSS. On 05/24/24, a urinalysis was ordered for R23. Progress notes indicated no urine return from R23. Progress notes indicated R23 had complaints of nausea and vomiting on this date. On 05/29/24, R23 was treated with antibiotics for a UTI. R23's care plan was reviewed, with no new interventions added. On 06/04/24, a dehydration risk assessment was completed for R23. R23 scored 7, as follows: 0. Skin turgor, 1. Ambulate with 2 assist, wheelchair with assistance, 1. Eating, limited physical assistance, 0. No weight loss, 1. Incontinent of urine, 2. Risk factors: history of dehydration and vomiting/diarrhea, 1. Pre-disposing risk factors, 1. Medications. Dehydration assessment was not an accurate assessment related to R23's BMI less than 21, weight loss, and need for moderate assistance with eating. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/04/24, a nutrition assessment was completed for R23. Assessment confirmed R23 had a gradual weight change, swallowing difficulty, received pureed and nectar thickened liquids, nutritional problem related to inadequate oral intakes, and gastrointestinal concerns. R23's BMI was 19.3. Nutrition assessment confirmed R23's daily fluid intake needs were 1850 ml. R23's daily fluid intakes from 03/08/24-06/02/24 ranged from 0-1410 ml. Confirming R23 did not meet his daily fluid intake needs on any days. Documentation confirmed R23's fluid intake was less than 50% of recommended values to maintain proper hydration for 52 of 70 days. On 06/04/24 at 1:11 PM, Surveyor interviewed Speech Therapist (ST) U. ST U reported previous ST recommended the video swallow study on 12/16/23. ST U reported the swallow study that was completed on 05/08/24 was a bedside swallow study, not a VFSS. ST U reported beside ST completes bedside swallow studies in the facility. ST U stated a VFSS would help them to know if the reason for difficulty with swallowing is physical, and provide images of pharyngeal, esophagus, and ST U stated, It would help us to determine strategies such as a chin tuck, or type of fluids or foods he can/can't eat. Maybe he doesn't need nectar thickened, maybe its food that is the problem and he could have thin liquids or that coke he is asking for, but we can't determine that with a bedside swallow study only a VFSS. On 06/04/24 at 12:32 PM, Surveyor interviewed Registered Nurse (RN) M. RN M stated, We encourage him to drink fluids because he does not drink enough, we document it in the MAR. (RN checked MAR). Oh sorry, he does not have it in there. So what the CNAs document is what he is receiving at meals, the nurses are not documenting additional intakes. On 06/05/24 at 9:13 AM, Surveyor interviewed Director of Nursing (DON) B. DON B stated, We just reviewed his dehydration assessments. I agree they are not accurate. When we were reviewing the assessments we were scoring him at a 13, and the assessments are like a 7. There is no care plan which is another issue. If this had been done accurately, we would have discussed intakes in weekly or daily stand-up meetings, and reviewed his status, MD would have been updated. We are not doing anything with the data at this time, and the data may not be accurate, as it should be intakes per shift. I think the NP was updated; however it may not have been documented.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17661 Based on observations, interviews and record reviews, the facility failed to ensure 2 of 2 residents (R31 and R1) reviewed for post-traumatic stress disorder (PTSD) received culturally competent trauma-informed care in accordance with professional standards of practice and accounting for each resident's experience and preferences in order to eliminate or mitigate retraumatization. This is evidenced by: According to Substance Abuse and Mental Health Services Administration (SAMHSA, 2014) (https://www.ncbi.nlm.nih.gov/books/NBK207191/), The impact of trauma can be subtle, insidious, or outright destructive. How an event affects an individual depends on many factors, including characteristics of the individual, the type and characteristics of the event(s), developmental processes, the meaning of the trauma, and sociocultural factors. SAMHSA explains trauma causes immediate and delayed emotional, behavioral, physical, cognitive, and existential reactions. The facility's Trauma Informed Care policy, dated 10/18/22, stated, in part, It is the policy of this facility to provide care and services which, in addition to meeting professional standards, are delivered using approaches which are culturally competent, account for experiences and preferences, and address the needs of trauma survivors by minimizing triggers and/or re-traumatization . Under Policy Explanation and Compliance Guidelines, the policy continued, stating . 4. The facility will collaborate with resident trauma survivors, and as appropriate, the resident's family, friends, the primary care physician, and any other health care professionals (such as psychologists and mental health professionals) to develop and implement individualized care plan interventions. 5. The facility will identify triggers which may re-traumatize residents with a history of trauma. Trigger-specific interventions will identify ways to decrease the resident's exposure to triggers which re-traumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident and will be added to the resident's care plan . Example 1 R31 was admitted to the facility 4/2/24 with medical diagnoses that include, but are not limited to, unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, bipolar disorder, depression, history of alcohol use and post-traumatic stress disorder-chronic. R31 currently goes to psychiatric counseling, with the last visit being 5/10/24. In reviewing the dictations from these visits, the consultant mentions past trauma but did not indicate what caused the PTSD in R31's life history. Surveyor then reviewed the Admission Psychosocial assessment dated [DATE] that the facility completed. According to this, R31 has diagnoses of bipolar disease, depression, PTSD and insomnia. The following was noted by Surveyor: (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The facility checked the box: Prior trauma or history /diagnosis of PTSD: History/ Diagnosis of PTSD and entered, Has history of PTSD- unknown origin; family and [R31] unable to state PTSD diagnosis. - Under Care Planning: Trauma Informed Care is checked Section 2a. Trauma Informed Care: The facility checked the box Focus: At risk for re-traumatization of past event or experience where reminders/triggers of event or experience may cause behavioral changes and/or emotional distress; Goal: Reminder/triggering events will be avoided with minimal impact during stay within the facility. Included in the interventions: Determine, as able the triggers of traumatic event or experience, such as sights, smells, sounds and touch, which may lead to a set of emotional, physiological and behavioral responses that arise in service of survival and safety . Screen for past traumatic events that ay impact physical, emotional and mental well-being . The most recent Minimum Data Set Assessment (MDSA) was a Significant Change in Status assessment dated [DATE]. The documentation completed to justify the significant change was . Resident is determined to be a significant change due to weight loss, behaviors, falls . Behaviors include rejection of care 6 out of 7 days in the past week, poor appetite, 2 recent falls, nurse notes in past 2 days: restlessness, delusions, auditory hallucinations. SS (Social Services) has observed paranoia and suspicion by resident. Family/friend input reveals her dementia and cognition have progressively declined in the past several months. Biweekly appts with psychotherapist . According to the MDSA, R31 has a Brief Interview of Mental Status (BIMS) score of 9, indicating moderately impaired cognitive status. Behaviors identified on this MDSA include verbal behaviors and rejection of care. The mood or depression score for R31 on this assessment was listed as 10/27, indicating moderate depression. R31 has had 2 or more falls without injuries on this assessment and was also listed as having weight loss greater than 5%. In reviewing the weight loss, Surveyor identified that R31 sustained an unprescribed 13.65% weight loss since admission. On 4/2/24, R31 weighed 196.4 pounds and on 5/31/24, weighed 169.6 pounds. Note: According to the National Institute Of Mental Health clinical signs of depression can include poor concentration, feelings of excessive guilt or low self-worth, thoughts about dying or suicide, disrupted sleep, feeling very tired or low in energy or changes in appetite or weight. Surveyor reviewed the care plan developed for R31 and noted the following: 1. At risk for re-traumatization of past event or experience where reminders/triggers of event or experience may cause behavioral changes and/or emotional distress. Diagnosis of PTSD (start date 4/3/24, last revised 5/2/24). Interventions for this plan included: (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Determine as able, the triggers of traumatic event or experience, such as sights, smells, sounds and touch, which may lead to a set of emotional, physiological and behavioral responses that arise in service of survival and safety (4/3/24) - Monitor for decreased social interaction and explore opportunities to avoid decline (4/3/24) - Monitor for increased withdrawal, anger or depressive behaviors and explore opportunities to avoid (4/3/24) - Screen for past traumatic events that may impact physical, emotional and mental well-being (4/3/24) 2. Alteration in behavior symptoms related to bipolar, dementia, declining assist with cares (start 4/9/24; last revised 5/2/24). Interventions for this plan included: - Psych referral as needed (5/2/24) - Use consistent approaches when giving care (5/2/24) 3. Cognitive loss as evidenced by short term memory deficit, poor recall related to cognitive impairment (Start 5/20/24) Interventions for this plan included: - Allow adequate time to respond. Do not rush or supply words (5/20/24) - Approach/speak in a calm, positive/reassuring manner (5/20/24) - Attempt to provide consistent routines/caregivers (5/20/24) - Explain each activity/care procedure prior to beginning it (5/20/24) - Identify self when speaking to resident (5/20/24) 4. At risk for changes in mood related to diagnosis of bipolar (start 4/9/24). Interventions for this plan include: - Assess for physical/environmental changes that may precipitate change in mood (4/3/24) - Observe for mental status/mood state changes when new medication is started or with dose changes (4/3/24) - Offer choices to enhance sense of control (4/3/24) - Validate feelings of loss (4/3/24) (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Note: There are no potential triggers listed in R31's care plan to alert staff to potential retraumatization, how to prevent these or how staff are to intervene. On 4/7/24, the facility documented a clinical follow-up and wrote, . The current status is [AGE] year old . with diagnoses including but not limited to . bipolar disorder . PTSD . insomnia . Res. has unspecified dementia . Denied pain. Mood is pleasant and cooperative this shift . In the above, the facility identified knowledge of R31 having PTSD. This was also noted in further documentation in R31's record. On 4/22/24 at 10:09 AM, the facility documented, . Resident very pleasant. Often refuses cares. Res does self transfer which has resulted in falls. Discharge plan is to return home. Resident voiced concern to writer about wanting to see her therapist . r/t (related to) feelings of giving up. Writer spoke with resident about this and asked if she was having any suicidal thoughts or ideations. Res stated she is not having any suicidal thoughts but would like to have an appointment with her Dr. (doctor) Writer will call and ask for appt. (appointment). The appointment was made for 4/26/24. However, there was still no care plan or PTSD assessment for R31 completed to identify the cause and potential triggers, prevention strategies or individualized approaches. On 4/29/24, the facility documented R31 as having an increase in behaviors or rejection of cares. On 5/13/2024, Social Services documented a review for the significant change in status, and included, Disorganized thought process and inattention switching from one subject to another . poor appetite, feeling tired, low energy, feeling not quite right, down a bit, feeling bad about self, lose of interest in pleasurable activities. is currently seeing . counselor bi-weekly . Behaviors which have increased since last MDS include rejection of care, restlessness, delusions, auditory hallucinations. Writer has observed paranoia and suspicion when staff or visitors walk by . continues on Seroquel, benztropine, Lexapro . Cognition is impaired, poor safety awareness, ST (short term) memory deficit and difficulty staying on subject or task. Multiple falls since last assessment. Attempting to schedule cognitive testing at the memory clinic . On 6/2/24 at 10:25 AM, Surveyor met with R31 and asked if she had an event in her past that affects her today. R31 stated, Oh we all have things as children, I am sure I had something happen. I really don't wish to talk about it. R31 did not appear to have specific knowledge regarding a traumatizing event or chose to not share it with Surveyor. On 6/3/24 at 1:27 PM, Surveyor met with Social Services Director (SSD) D regarding R31 and asked what caused R31's PTSD. SSD D stated that R31 was in the facility this past fall and had been living with a son, who had no insight into R31's PTSD. SSD D affirmed that she had not determined the cause of R31's PTSD. SSD D stated she had tried to contact the psychotherapist on 4/29/24 but had not yet received a return call. SSD D also affirmed she did not complete a follow-up call with the therapist to gain knowledge of R31's PTSD. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	SSD D continued to state, I reached out today to the psychiatrist who is treating her, had been treating her for many years. The therapist told me that [R31] had a sexual assault as a child with her father . Surveyor then informed SSD D of concerns related to the care plan for R31 with no individualized triggers, prevention strategies or individualized interventions for staff to use, should R31 show retraumatization. Surveyor then asked SSD D why the delay in completing follow-up with psychiatrist to determine the cause of the PTSD. SSD D acknowledged that she should have done follow-up prior to today, and When I didn't receive a call back, I should have kept calling to get the information, but I didn't. The therapist told me that she had been working with [R31] for [AGE] years. It took working with the resident for 6 years before [R31] disclosed the assault as a child to the therapist. The therapist told me that potential triggers for her would be reminiscing about family memories or childhood . On 6/3/24, SSD D completed a Trauma Informed Care Observation that stated, Per therapist/counselor-[R31] is a survivor of childhood sexual and emotional abuse. Sexual perpetrator was her father and her mother was cold and emotionally unavailable to her. Social worker asked [R31] about her PTSD her response was I had some rough times in my life but did not disclose trauma to social worker. When answering the questions below, [R31] answered no to physical or sexual assault. On 6/4/24 at 8:14 AM, Surveyor asked what the practice was in the facility during the admission process and the determination of PTSD. SSD D stated, First we find out what the diagnosis is, sometimes it's in the History and Physical other times in any outside service or therapist dictations. Then I interview resident or family. In this case, I went to the son first, and he didn't know. Yesterday I talked to therapist, who initially saw her for depression and alcohol abuse. I asked therapist yesterday if any triggers to watch for with the worsening dementia. As [R31's] dementia progresses, we may see some of her memories surface . Surveyor informed SSD D of the concern with R31 being admitted two months prior and there was no individualized care plan for staff to refer to, to direct them on how to respond for R31, should retraumatization occur. SSD D stated, Yeah, I know. I contacted therapist on 4/29, and I did not hear back from her. I did not do any follow up. I should have done it before yesterday. I did not ask her why she didn't get back to me. I just should have followed up before now . going forward I will be more individualized with care plans, interview residents more in-depth and follow up with therapists for the residents. On 6/4/24, Surveyor interviewed the following staff who were responsible for R31 on this date: - Licensed Practical Nurse (LPN) F (8:32 AM) - Certified Nursing Assistant (CNA) G (8:55 AM) - Life Enrichment Specialist (LES) I (9:02 AM) (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- CNA H (1:40 PM) None of the above staff had any knowledge that R31 suffered from PTSD, the cause, what potential triggers could cause retraumatization or what interventions may be effective to dispel behaviors or retraumatization. Example 2 Resident (R) 1 was admitted to the facility 11/26/23 with medical diagnoses that include but are not limited to chronic pain, anxiety disorder, post-traumatic stress disorder-chronic and alcohol abuse, in remission. The facility completed an Admission Psychosocial assessment dated [DATE]. Under Section C Psychosocial-Concerns, Needs, Preferences the assessment states in 1bb. Has flashbacks at times but he is able to work through flashbacks and anxiety when they occur. 1dd. states, Prescribed Diazepam for PTSD. Section C 2. indicates resident practices Native American traditions and spiritual beliefs and values. 5. Prior Trauma and history/diagnosis of PTSD . 5aa PTSD from gang involvement and violence when he lived in Chicago . Under Section D. Care Planning: - Trauma Informed Care is checked 2a. Trauma Informed Care: The facility checked the box Focus: At risk for re-traumatization of past event or experience where reminders/triggers of event or experience may cause behavioral changes and/or emotional distress; Goal: Reminder/triggering events will be avoided with minimal impact during stay within the facility. Included in the interventions: Determine, as able the triggers of traumatic event or experience, such as sights, smells, sounds and touch, which may lead to a set of emotional, physiological and behavioral responses that arise in service of survival and safety . Screen for past traumatic events that may impact physical, emotional and mental well-being . Surveyor reviewed the comprehensive care plan developed for R1 and noted the following problems were included: 1. At risk for behavior symptoms r/t (related to): depression and anxiety (12/7/23; last revised 2/11/24). Interventions for this plan included: - Psych referral as needed (5/2/24) - Use consistent approaches when giving care (12/28/23) (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Support resident's strengths and provide positive affirmations. (12/4/23) 5. At risk for re-traumatization of past event or experience where reminders/triggers of event or experience may cause behavioral changes and/or emotional distress; PTSD from gang involvement when he lived in Chicago (12/3/23; revised 5/2/24) GOAL: Reminder/triggering events will be avoided with minimal impact during stay within the facility. (12/3/23; revised 1/12/24). Interventions for this plan included: - Determine as able, the triggers of traumatic event or experience, such as sights, smells, sounds and touch, which may lead to a set of emotional, physiological and behavioral responses that arise in service of survival and safety (12/3/23) - Monitor for decreased social interaction and explore opportunities to avoid decline (12/3/23) - Monitor for increased withdrawal, anger or depressive behaviors and explore opportunities to avoid (12/3/23) - Provide a safe environment (12/3/23) - Provide choice-making activities (12/3/23) - Refer to Psychology as indicated (12/3/23) - Screen for past traumatic events that may impact physical, emotional and mental well-being (12/3/23) There were no individualized triggers listed for R1, prevention strategies or individualized interventions for staff to use should R1 display potential retraumatization. A review of the Interdisciplinary Team Progress Notes was completed. Surveyor noted the following: - On 3/5/2024, a Behavior Note was entered and stated, . review of behaviors and psychotropic medications is noted to have 2 episodes of statements of feeling jittery, needing valium, but is signed out more consistently during the past month. He was concerned for having nightmares. Resident has PTSD from his younger years involved in gang wars. Has known episodes of anxiety, nightmares, feels jittery periodically surrounding this. PRN (as needed) valium is effective, updated behavior monitoring to include c/o (complaint of) nightmares, CP (care plan) updated . - On 5/28/2024 a behavior note was entered and included the following, . quarterly review of behavioral status, medications, and diagnoses as relates to psychosocial health. Resident does have diazepam ordered for nightmares and jittery feelings, related to PTSD from his younger years in gang wars. Review of PRN medication admin indicates utilized medication 4 x this month. Resident is aware of his feelings and needs for the medication, requests it for use very intermittently, and is effective in managing his symptoms. Most recent review of medication regimen in April, renewing same orders through October 2024. No changes to cp needed. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/4/24, Surveyor noted entries in R1's medical record that were not present when reviewed on 6/3/24 from SSD D. Surveyor noted the following: 1. A Social Services note dated 6/3/2024 at 7:00 PM that included the following, . Quarterly MDS . is alert and orientated with no cognitive deficits noted . diagnosis of Anxiety disorder and PTSD long standing . discussed his mood and anxiety this quarter . mood has been stable . anxiety fluctuates . Grounding techniques have been helpful . at times of increased anxiety r/t (related to) gang trauma-such as opening the window, going outside and breathing the air, listening to the sounds of nature to focus concentration specifically the birds. Declines mental health referral, No I have seen 3 psychiatrists in the past and I don't need to see anyone right now. No documented behavior . More detailed interventions updated on PTSD care plan . 2. Surveyor also noted updates to R1's care plan were made to include: - Certain TV shows with increased violence or portray gang violence may increase his anxiety level or produce nightmares later in the evening. revised 6/3/24) - Grounding techniques have been helpful to [R1] at times of increased anxiety r/t gang trauma-such as opening the window, going outside and breathing the air, listening to the sounds of nature to focus concentration specifically the birds. (6/3/24) On 6/4/24 at 8:14 AM, Surveyor approached SSD D to discuss R1 and the PTSD with the updates made. SSD D stated the process in the facility is First we find out what the diagnosis is, sometimes it's in the History and Physical other times in any outside service or therapist dictations. Then I interview resident or family . Surveyor explained concern over R1 not having an individualized care plan to alert staff of the cause and potential triggers of R1's PTSD. Without an individualized care plan, staff would not know how to intervene. SSD D stated, Yeah, you're right. I didn't do any training with staff, and there weren't any care plan triggers until yesterday. He had a quarterly MDS review and I talked to him yesterday for the assessments and talked to him about his nightmares. I made the updates after I spoke with him. [R1] is trying to not use Valium as much and felt doing the grounding exercises helped, birds and listening to the air. Going forward will be more individualized with care plans, interview residents more in-depth and follow up with therapists for the residents . On 6/4/24, Surveyor interviewed the following staff who were responsible for R1 on this date: - LPN F (8:32 AM) - CNA G (8:55 AM) - LES I (9:02 AM) - CNA H (1:40 PM) (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	None of the above staff had any knowledge that R1 suffered from PTSD, the cause, what potential triggers could cause retraumatization or what interventions may be effective to dispel behaviors or retraumatization.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 17661 Based on observations, interviews and record reviews, the facility did not administer medications in a safe and effective manner for for 1 out of 1 resident (R1) observed having medications left at bedside. This is evidenced by: R1 has medical diagnoses that include, but are not limited to, chronic pain, chronic post-traumatic stress disorder, long term use of opiate analgesic and alcohol abuse, in remission. The most recent Minimum Data Set Assessment (MDSA) completed for R1 was a quarterly assessment with the ARD (Assessment Reference Date) 3/5/24. According to this MDSA, R1 has a Brief Interview of Mental Status (BIMS) of 15, indicating intact cognition. R1 has no mood indicators or behaviors listed. Surveyor then reviewed R1's care plan and noted the following: - History of substance use disorder as evidenced by history of addiction to alcohol, chronic opioid use. The start date of this problem was 12/4/23 and last revised 2/11/24. Interventions for this problem included: Nurse to remain in room at all times during medication administration due to history of hiding/hoarding medications. This intervention was initiated 2/11/24. On 6/3/24, while observing meal service to resident rooms on the 2nd Hall, Surveyor observed the following: - At 8:02 AM, the meal tray was delivered to R1. Resident is lying on top of the bed fully dressed. Meal remained covered in room. - At 8:06 AM, Licensed Practical Nurse (LPN) E dispensed R1's medications and delivered these in the medication cup in R1's room. - At 8:49 AM, Surveyor entered R1's room to observe meal intake. R1 remained on top of bed stretched out and asleep. Meal was not touched; entree remained covered as well as the beverage glasses and the oatmeal. Sitting in a medicine cup were 11 medications. - At 9:51 AM, R1's breakfast tray remained in room. R1 stated to Surveyor, My stomach is messed up today. I have eaten all I wish to. Until my stomach feels better, I won't be eating or taking my meds. The medications have since been removed from the room. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor then reviewed R1's record for Medication Self- Administration assessments and noted there were three completed as follows: - 2/22/19: Saline Nasal Spray, using daily each nare; Interdisciplinary Team (IDT) Review Summary: Resident able to identify his medication along with the ability to recall why he uses the Saline Nasal Spray. Easily able to demonstrate same. - 3/8/19: 1. clotrimazole cream apply topically to affected area BID 2. Betamethasone cream apply topically to affected area daily 3. Nystatin powder apply topically to affected area BID IDT review of self administration assessment and agree with resident able to self administer creams. Will keep at bedside locked drawer. Care plan to be adjusted. - 5/29/19: Metamucil in the morning and evening. IDT Review Summary: Resident is safe and competent and can self administer metamucil. There were no recent assessments completed and none located for self-administration of pills/capsules. On 6/3/24 at 11:18 AM, Surveyor approached Director of Nursing (DON) C and requested any recent Self-Administration assessments for R1. DON C was assisting Interim DON B during this survey as she is the DON at a sister facility and a former DON at this facility. DON C stated the proper procedure was to assess the resident and then call the physician for orders and put it on the care plan. At 1:54 PM on this same date, DON C approached Surveyor and stated there was no physician order or assessment completed for R1 to determine safety in self-administering medications. DON C stated that a phone call was placed to R1's physician for an order. On 6/3/24 at 1:56 PM, Surveyor approached LPN E and asked how nursing was to determine if a resident could self-administer medications. LPN E stated the resident would have a self-administration assessment completed and a physician order indicating the resident could self-administer their medications. Surveyor asked if one was completed for R1. LPN E searched the computer electronic medical record and then stated there was no assessment completed for R1 and no physician orders listed. Surveyor then asked LPN E why medications were left at R1's bedside if there was no assessment completed to determine R1 was safe to complete taking medications unsupervised. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN E stated, [R1] took a couple for me when I was standing outside his room and said he would take the rest later. Surveyor then asked LPN E to verify the medications left at bedside and in the medicine cup as being: - Docusate Sodium capsule - Furosemide - Isosorbide Mononitrate Extended Release (ER) - Loratadine - Metoprolol Succinate ER - Tamsulosin - guaifenesin - Omeprazole (2 capsules) - Spironolactone - Acetaminophen At 4:18 PM, DON C approached Surveyor and stated R1's physician will not give an order for R1 to self-administer medications based on resident's history and the medications should not have been left at the bedside by the nurse.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 41945 Based on interview and record review, the facility failed to submit accurate data to Centers for Medicare and Medicaid Services (CMS) mandatory Payroll Based Journal (PBJ) for quarter 3 2023 (April 1-June 30), quarter 4 2023 (July 1-September 30), and quarter 1 2024 (October 1-December 31). This had the potential to affect all 40 residents. This is evidenced by: On 06/05/24 at 1:00 p.m., Surveyor interviewed Nursing Home Administrator (NHA) A about the low weekend staffing data that was triggered in the PBJ report for the third quarter 2023 (April 1-June 30), fourth quarter 2023 (July 1-September 30), and quarter 1 2024 (October 1-December 31). NHA stated the issues with the data reporting were due to agency staff not punching their hours on the facility time clock, so the accurate hours were not in the facility computer system. Surveyor compared the data with time punches. Surveyor did not identify any concerns related to low weekend staffing coverage. The facility assessment states: Day shift: 2 licensed nurses, 3-5 CNAs Evening shift: 2 licensed nurses, 3-5 CNAs NOC shift: 1 licensed nurse, 2-3 CNAs The data reviewed by Surveyor meets the facility assessment for staffing. Surveyor then reviewed the staff schedules for quarter 4 2023 (July 1-September 30) and compared the data with time punches for the PBJ report, triggering that the facility failed to have licensed nursing coverage 24 hours a day. On 07/04/23 (TU), 07/22/23 (SA), 09/03/23 (SU), 09/16/23 (SA), 09/17/23 (SU), and 09/30/23 (SA), two agency Registered Nurses (RN) failed to punch the facility time clock, and the facility did not have accurate data to submit for the PBJ report. The facility had licensed nursing coverage 24 hours a day. NHA A stated the facility recognized the issue of the agency staff not punching their hours. The facility has put into place the following: 1. Any agency staff has to punch their hours in the facility time clock, 2. The Business Office Manager then compares the punches from the time clock to the schedule of staff who worked, and 3. This information is then compared to the Center for Medicare and Medicaid Services (CMS) staff posting to ensure accuracy in the submission of hours for the PBJ report. On 06/05/24, Surveyor was unable to verify processes facility put in to place were effective in correcting the PBJ errors. The quarter 2 2024 PBJ report (January 1-March 31) was unavailable from CMS for review at time of survey.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41945 Based on observations, interviews, and record reviews, the facility did not establish and maintain an infection control program designed to help prevent the development and transmission of disease. This has the potential to affect all 40 residents. No surveillance log for staff infections. Staff did not apply gloves prior to entering rooms with residents on contact precautions. Precaution signs posted for Enhanced Barrier Precautions (EBP) and Contact precautions for R34 No process for reporting residents with Methicillin-Resistant Organisms (MRDO) when transporting to other facilities. This is evidenced by: Example 1: Facility policy titled, Infection Surveillance, dated as revised 03/08/23 states: Policy: A system of infection surveillance serves as a core activity of the facility's infection prevention and control program. Its purpose is to identify infections and to monitor adherence to recommended infection prevention and control practices in order to reduce infections and prevent the spread of infections. 1. The Infection Preventionist serves as the leader in surveillance activities, maintains documentation of incidents, findings, and any corrective actions made by the facility and reports surveillance findings to the facility's Quality Assessment and Assurance Committee, and public health authorities when required. 10. Employee, volunteer, and contract employee infections will be tracked, as appropriate, such as influenza or gastrointestinal infection outbreaks. On 06/05/24, Surveyor reviewed the facility's infection control program including surveillance logs. Upon review, Surveyor discovered the only documentation on staff infections and outbreaks was an email Infection Preventionist (IP) L sent to Nursing Home Administrator (NHA) A and Director of Nursing (DON) C stating it was the only information IP L had on the staff infection control and outbreaks. The email documentation includes: Registered Nurse (RN) N tested positive for influenza A on 01/04/24. Symptoms were listed. RN N returned to work 48 hours after symptoms resolved. RN N was off of work for one week. IP L did not document date as to when RN N returned to work. Certified Nursing Assistant (CNA) O tested positive for influenza A on 02/03/24. Symptoms were listed. OP L did not document as to when CNA O's symptoms resolved or when CNA O returned to work. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	CNA P (student) tested positive for COVID-19 on 02/06/24. CNA P completed clinicals at the facility on 02/05/24. CNA O worked with a few residents on unit 3. Contact tracing with residents conducted on 02/07/24, 02/09/24, and 02/11/24. All residents tested were negative for COVID-19. The email states CNA clinicals were placed on hold. IP L did not document as to how long the CNA clinicals were placed on hold. Surveyor unable to determine if CNA P returned to the facility in accordance with CDC guidelines. Physical Therapy Assistant (PTA) Q tested positive for COVID-19 on 04/07/24. Symptoms were listed. Two negative COVID-19 tests were conducted on PTA Q with no dates listed, contact tracing with residents on 04/08/24, 04/10/24, and 04/12/24 with all negative results. IP L did not document a return-to-work date for PTA Q. On 06/05/24 at 1:30 p.m., Surveyor interviewed DON C and asked about the surveillance logs for staff infections. DON C looked for additional information and admitted there was no other documentation or surveillance logs. DON C stated the facility had an influenza A outbreak starting on 01/25/24, a COVID-19 outbreak 11/01/23 through 12/21/23 and 04/07/24 through 05/28/24. DON C stated the facility will be initiating a performance improvement plan (PIP) on the infection control processes, policies, and surveillance. 46693 Example 2: Facility policy and procedure entitled Infection Prevention and Control Program, last revised 03/14/23, stated in part, A resident with an infection or communicable disease shall be placed on transmission based precautions as recommended by current CDC guidelines. When a resident on transmission-based precautions must leave the resident care unit/area, the nurse shall communicate to all involved departments the nature of the isolation and shall prepare the resident for transport in accordance with current transmission-based precaution guidelines. R24 was admitted on [DATE] with diagnoses that include right sided paralysis, open wound to right lower leg, and methicillin resistant staphylococcus aureus (MRSA). R24's care plan identified that R24 requires assistance of 1 for bathing and toileting and needs assist sometimes with transfers and mobility. The diagnosis for MRSA was found on a lab result collected on 04/16/24 and was not in the care plan or the diagnosis sheet. R34 was admitted on [DATE] with diagnoses that include right sided paralysis, urinary retention, suprapubic urinary catheter, and MRSA. R34's care plan identified that R34 requires assistance of one for bathing, bed mobility, dressing, assist (does not state how many) for transfers requiring a mechanical lift, and assist of 2 for toileting. The diagnosis for MRSA was found on lab result collected on 04/16/24 and was not in the care plan or the diagnosis sheet. On 06/05/24 at 8:31 AM, Surveyor observed CNA G enter R24's room without gloves on. Surveyor noted a sign outside R24's room identifying R24 was on contact precautions and required gloves to be worn prior to entering the room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	At 9:23 AM, Surveyor observed CNA G and CNA K enter R34's room that also had a sign outside the room identifying R34 is on contact precautions and staff should have gloves on prior to entering R34's room. Neither CNA donned gloves prior to entering R34's room. Surveyor observed the supply bins outside the room did not have gloves on them. Surveyor asked CNAs where they obtain gloves from and CNA G stated they are usually on top of the bins, but there were none today. We just got the gloves inside the rooms. On 06/05/24 at 9:38 AM, Surveyor interviewed DON C who stated the expectation is for any staff entering rooms with residents on contact precautions they would be wearing gloves. DON C immediately educated the CNAs and ensured all bins were stocked with gloves. Example 3: On 06/05/24, Surveyor noted R34 had two signs, one stating contact precautions and one Enhanced Barrier Precautions (EBP). On 06/05/24 at 12:10 AM, Surveyor interviewed DON C and informed her of two signs on R34's door which was confusing. DON C stated the EBP sign should have been removed. R34 was on contact precautions. Staff would be expected to follow contact precaution guidelines. Example 4: On 06/05/24, Surveyor noted R24 and R34 were both on contact precautions for MDROs. On 06/05/24 at 11:59 AM, Surveyor interviewed Licensed Practical Nurse (LPN) E and asked if they ever transferred residents to the hospital if they need it, which LPN E replied, Yes. Surveyor then asked how do you report to the hospital if a resident has an MDRO. LPN E stated, It should be on their diagnosis sheet. LPN E looked on the diagnosis sheet and care plan for R24 and R34. Neither resident had MDROs identified. LPN E said, I don't see it there. The process absolutely needs to be fixed. Surveyor inquired about the practice for reporting MDROs during transport for which DON C said she was not familiar with it in that particular facility. Surveyor informed DON C about the interview having no system to report MDROs when transferring residents. DON C stated they are hiring a new infection control and prevention staff. DON C plans to train them the correct way and set it all up for the facility.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41945 Based on interview and record review, the facility did not have a comprehensive system for ensuring 5 (R5, R8, R9, R24, R31) of 5 residents reviewed for immunizations received or were offered the pneumococcal vaccination. *R5 - No documentation of receiving or declining PCV 15 or PCV20. *R8 - No documentation of receiving or declining PCV20 or PPSV23. *R9 - No documentation of receiving or declining PCV20. *R24 - No documentation of receiving or declining PCV15 or PCV20 *R31 - No documentation of receiving or declining PCV15 or PCV20. This is evidenced by: According to the Center for Disease Control. (2024, February 6). Pneumococcal Disease in Adults and Vaccines to Prevent It. CDC Pneumococcal Disease. https://www.cdc.gov/pneumococcal/prevent-pneumococcal-factsheet/index.html#cdc_generic_section_6-vaccination, Two types of vaccines used in the United States help prevent pneumococcal disease in adults: conjugate and polysaccharide vaccines. Recommendations: Center for Disease Control (CDC) recommends pneumococcal conjugate vaccination (PCV15 or PCV20) for Adults [AGE] years or older: All Adults younger than [AGE] years: Those at increased risk for pneumococcal disease If PCV15 is used, it should be followed by a dose of pneumococcal polysaccharide vaccine (PPSV23). Previously vaccinated: Adults who received an earlier pneumococcal conjugate vaccine (PCV13 or PCV7) should talk with a vaccine provider. The provider can explain options available to complete the recommended pneumococcal vaccine series. Adults [AGE] years or older have the option to get PCV20 if they have already received both of the following: PCV13 (but not PCV15 or PCV20) at any age PPSV23 at or after the age of [AGE] years old (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy titled, Pneumococcal Vaccine (Series) dated 02/20/23, revised 01/11/24 states: Policy: It is our policy to offer residents and staff immunization against pneumococcal disease in accordance with current CDC guidelines and recommendations. Policy Explanation and Compliance Guidelines: 1. Each resident will be assessed for pneumococcal immunization upon admission. Self-report of immunizations shall be accepted. Any additional efforts to obtain information shall be documented, including efforts to determine the date of immunization or type of vaccine received. 2. Each resident will be offered a pneumococcal immunization unless it is medically contraindicated, or the resident has already been immunized. 4. The resident/representative retains the right to refuse the immunization. Refusals should be documented in the medical record, along with what education was provided and a risk vs benefit discussion. Notify MD (Medical Doctor) if immunization is refused. 5. A consent form shall be signed prior to the administration of the vaccine and filed in the individual's record. 6. The type of pneumococcal vaccine (PCV15, PCV20, or PPSV23) offered will depend upon the recipient's age and susceptibility to pneumonia in accordance with current CDC guidelines and recommendations. On 06/05/24, Surveyor reviewed five residents' pneumococcal immunizations: R5 is [AGE] years old. R5 received the PPCV23 on 10/07/03 and 03/11/16. R5's medical record has no documentation of the facility offering or R5 declining PCV15 or PCV20 vaccine. The recommendation is 1 dose PCV15 OR 1 dose PCV20. Administer either PCV15 or PCV20 at least 1 year after the last PPSV23 dose. If PCV15 is given, no additional PPSV23 doses are recommended. R8 is [AGE] years old. R8 received Prevnar 13 on 11/04/15 and PPSV23 on 09/19/12. R8's medical record has no documentation of the facility offering or R8 declining the PCV20 or PCV23 vaccine since R8 received the PPSV23 vaccine before the age of 65. R9 is [AGE] years old. R9 received Prevnar 13 on 11/17/16 and PPSV 23 dose 1 on 07/11/06. R9's medical record has no documentation of the facility offering or R9 declining the PCV20 vaccine. The recommendation is 1 dose of PCV20 at least 5 years after the last pneumococcal vaccine if the individual received both PCV13 and PPSV23 and the PPSV23 vaccine was received at age [AGE] years or older. R24 is [AGE] years old. R24 declined the PCV13 vaccine. R24 has no other documentation of offering or R24 declining any pneumococcal vaccines. The recommendation is for individuals age [AGE] years or older who have not previously received a dose of PCV13, PCV15, or PCV20: 1 dose of PCV15 or 1 dose of PCV20. If PCV15 is given, 1 year after the PCV15 dose, 1 dose of the PPSV23 should be administered. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R31 is [AGE] years old. R31's medical record has no documentation of previous pneumococcal vaccines and no documentation of the facility offering PCV15 or PCV20 if no previous vaccination or no previous vaccination history is known. If PCV15 is given, 1 dose of PPSV23 should be administered 1 year after the PCV15 dose. On 06/05/24 at 1:30 p.m., Surveyor interviewed Director of Nursing (DON) C from a sister facility and asked about the lack of documentation on the residents' pneumococcal vaccines. DON C looked for additional information on the vaccines, but there was no additional information. Surveyor asked DON C why the facility did not offer the residents pneumococcal vaccines. DON C stated there was no excuse, but the facility will put a positive improvement plan (PIP) into place to correct this.

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. 41945 Based on interview and record review, the facility did not maintain documentation of screening, education, offering, and current Coronavirus 19 (COVID) vaccination status to staff. This has the potential to affect all 40 residents. This is evidenced by: On 06/05/24, Surveyor reviewed the facility's infection control program and policies. The facility policy titled, COVID-19 Vaccination with revised date of 10/27/23 states: Policy: It is the policy of this facility to minimize the risk of acquiring, transmitting, or experiencing complications from COVID-19 (SARS-CoV-2) by educating and offering our residents and staff the COVID-19 vaccine. Policy Explanation and Compliance Guidelines: 1. It is the policy of this facility to have an immunization program against COVID-19 in accordance with national standards of practice. 13. The facility will educate and offer the COVID-19 vaccine to residents, resident representatives, and staff and maintain documentation of such. 17. If a vaccination requires additional doses, the resident, resident representative, or staff member will be provided with current information regarding the additional doses, including any changes in the benefits, risks, or potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses. Upon review, Surveyor did not find any documentation of staff screening, education, offering of the covid vaccine, or current COVID-19 vaccination status of staff members. On 06/05/24 at 1:30 p.m., Surveyor interviewed Director of Nursing (DON) C and asked about the documentation of staff screening, education, offering, and current COVID-19 vaccination status. DON C stated there was no documentation, but a performance improvement plan (PIP) will be initiated to correct this deficiency in the infection control program.