STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535031	A. Building B. Wing	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wind River Rehabilitation and Wellness	1002 Forest Drive Riverton, WY 82501

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37603 Based on medical record review, staff interview, resident representative interview, and resident rights review, the facility failed to ensure 1 of 25 sample residents (#54) was treated with dignity and care in a manner that promoted quality of life. The finding were: 1. Review of the quarterly MDS assessment dated [DATE] showed resident #54 had severely impaired cognition. The diagnoses included medically complex conditions, wound infection, other fracture, non-Alzheimer's dementia, and depression. The resident required extensive assistance with dressing, toileting, and personal hygiene. The following concerns were identified: a. Review of the 11/21/23 at 9:59 PM progress note showed Communication with Family/NOK/POA, resident's daughter, expressed her dissatisfaction with resident's haircut. I told them to let me know when [s/he] needs a haircut. I have someone hired to come in and cut [his/her] hair. I don't want [his/her] head buzzed like this. b. Review of the 11/22/23 at 3:16 PM progress note showed Communication with Family/NOK/POA, spoke with daughter regarding the hair cut. Explained to her that the staff, who are relatively new in the unit, were not aware that [daughter name] had a hairdresser who comes in to do resident's hair and for her to be notified if resident needs a haircut. DNS explained to daughter that staff was just trying to make [him/her] presentable for his/her family for Thanksgiving. She expressed that her brother is very upset over the situation. A grievance has been filed on the family's behalf. c. Interview with the social services director on 3/14/24 at 8:40 AM revealed the family did not ask the facility to cut the resident hair, and the facility did not notify the family s/he needed a hair cut. He stated the family had arrangements with somebody to cut the resident's hair when needed. The grievance was communicated with the daughter in person of the outcome on 11/22/23. Staff was educated afterwards. He revealed the facility does try and spruce the residents up, to help keep them clean. d. Review of the Establish the Baseline Plan of Care last revised on 12/13/23 showed Contact [daughter name] for any change in care/treatment or other atypical intervention. Grooming:Personal Hygiene assistance needed: Dependent. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Interview with the resident's daughter on 3/14/24 at 10:10 AM revealed the facility had cut the resident's hair before and was told not to. She stated that she hires a person to come in and cut his/her hair when needed. Further, she stated I did not authorize his/her head to be shaved. Then they go and cut it before Thanksgiving. [S/he] did not look good. 3. Review of the Notice of Resident Rights Under Federal Law given by the facility on 3/14/24 at 1:22 PM showed .4. The resident has the right to be informed, in advance, of the care furnished and the type of caregiver or professional that furnishes care.

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F 0585 Level of Harm - Minimal harm or potential for actual harm 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. 35081 Based on resident representative and staff interview, medical record review, facility grievance log review, and policy and procedure review, the facility failed to ensure the grievance procedure was followed for 1 of 6 sample residents (#104) reviewed for reported grievances. The findings were: 1. Review of the Discharge Transition Plan dated 2/9/24 and timed 8:10 AM showed resident #104 had a planned discharge scheduled for 2/10/24. Further review showed the resident's representative and social services director signed the plan on 2/10/24. Review of the Recapitulation of Resident Stay dated 2/12/24 showed the resident discharged from the facility on 2/10/24. The following concerns were identified: a. Interview with the resident's representative on 3/14/24 at 8:33 AM confirmed the resident discharged from the facility on 2/10/24 and revealed she reported concerns of missing items to the social services director at the time of discharge. The resident's representative revealed the missing items reported included a pair of swim shoes, 2 white shirts, a pair of pajamas, and a glasses case. The representative revealed 1 shirt was found and returned; however, the other items were still missing and the facility had not contacted her for resolution. b. Review of the grievance log for February 2024 and March 2024 showed no evidence of a grievance for the resident related to the missing items. c. Interview with the social services director on 3/14/24 at 9:17 AM revealed after the resident discharged from the facility, he was notified by the resident's representative there were some items missing. The missing items included swim shoes, a glasses case, and some white shirts. He confirmed 1 white shirt was found and returned to the resident's representative on 3/13/24. He revealed a grievance form was not completed because the facility continued to look for missing items and the resident's representative was aware. 2. Review of the policy titled Grievance Procedure Last revised November 2016 showed .7. When an immediate resolution is not possible, the grievance is routed to the Grievance Official and/or Social Services/designee within 24 hours. The individual receiving the grievance fills out a Grievance Form .9. Social Services or designee routes the Grievance Form to the appropriate department manager, who reviews the grievance, responds within two business days, and returns the Grievance for to Social Services or designee. 10. The Person with the grievance has a right to a written decision regarding his/her grievance. 11. Social Services/designee logs Grievance Forms on the Grievance Log .

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 16146 Based on observation, medical record review, and staff and resident interview, the facility failed to promptly identify and intervene for an acute change in condition for 2 of 4 sample residents (#29, #31) who experienced a change in condition. This failure resulted in actual harm to residents #29 and #31 who experienced changes in condition including limited movement and pain following a fall and did not receive a thorough assessment in a timely manner to assess for injuries based on their signs and symptoms. The findings were: 1. Review of the 2/13/24 significant change MDS assessment showed resident #29 had diagnoses including polyosteoarthritis, non-Alzheimer's dementia, and other chronic pain. The resident received scheduled pain medication and had no pain in the last 5 days. Review of a progress note dated 3/10/24 showed the resident was found on the floor beside the bed. A new 2 cm curved lacerated noted on left forearm. Denies hitting head, admits to shoulder pain. Range of motion limited and at baseline. Chronic shoulder deformity related to previous surgery noted and at baseline. No swelling or discoloration noted .Shoulder pain treated with PRN ordered pain medications .on call provider notified. New orders received to schedule resident appointment with primary clinic for further evaluation related to recent frequent falls and further evaluation to rule out additional injuries. A progress note dated 3/11/24 and timed 5:28 AM showed .Will remind day shift nurse that [his/her] MD is requesting to see [him/her] at the clinic. The following concerns were identified: a. Observation on 3/11/24 at 3:43 PM showed RN #2 asked the resident about pain and the resident said his/her pain was an 8. b. Observation on 3/11/24 at 5:08 PM showed the resident complained of shoulder pain to CNA #1. The resident was cradling his/her left arm with the other arm and stated s/he couldn't raise their arm up. When the CNA asked the resident how s/he would rate the pain, the resident replied 10. The resident stated the nurse put some cream on his/her shoulder earlier, but it didn't help. When the surveyor asked what happened, the resident replied s/he fell the day before and had not seen a doctor. c. Observation on 3/11/24 at 5:33 PM showed the resident wasn't eating much of his/her dinner and kept looking at his/her left arm and telling the surveyor s/he couldn't raise their arm. d. On 3/11/24 at 5:40 PM RN #2 came to the SCU and CNA #1 told her the resident was complaining of pain at a 10 and couldn't raise his/her arm. The nurse evaluated the resident's arm and the resident winced when the nurse moved his/her left arm. There was bruising visible to the resident's outer bicep area. At 5:46 PM the RN cleaned a bleeding scab on the resident's arm and told the resident she would call the doctor to see if he wanted treatment for the scab. e. On 3/11/24 at 5:48 PM RN #2 took the resident to his/her room. The resident told her the pain level was a 9. The resident told the nurse s/he fell the day before. At 5:54 PM the RN applied a cream to the resident's left shoulder and arm. She stated she applied cream to the resident earlier. She also told the resident s/he last had Tylenol at noon and she would check on any other orders. The RN told the surveyor she was not notified in report that the resident fell the day before. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	f. On 3/11/24 at 6:03 PM the RN clarified to the surveyor that the report sheet did say the resident fell the day before, but it stated there were no injuries. g. Review of the nursing note dated 3/11/24 and timed 7:52 PM showed .Resident has been complaining of left shoulder to the hand pain. [S/he] has been favoring left extremity throughout the day. Topical Diclofenac Sodium Gel was applied to the shoulder and po Tylenol was given. A noted abrasion to left forearm was cleaned and left open to air. PCP appt needs to be made for resident . h. Review of progress notes from 3/11/24 and the morning of 3/12/24 showed no evidence nursing had made an appointment for the resident with his/her doctor, despite the nursing notes dated 3/10/24 and 3/11/24 which indicated an appointment was supposed to be made. i. Review of the MAR for 3/11/24 showed the resident was administered the routine medications of Diclofenac Sodium gel 1%, apply 2 grams to upper extremities, at 7 AM, 3 PM and 11 PM and Tylenol ES 500 mg, give 2 tablets, at 8 AM, noon and 4 PM. Further review of the MAR showed the resident was ordered Oxycodone HCL 5 mg every 8 hours as needed for severe pain. However, the resident was not administered any Oxycodone on 3/11/24. j. On 3/12/24 at 11:23 AM physician #1 entered the SCU and the surveyor asked if he was there to see resident #29. He stated no, he was not the resident's physician, but asked what was going on. The surveyor told the physician about the resident's complaints of shoulder pain following a fall and the physician stated he would examine the resident. The physician went in the resident's room and exited a few moments later and told the surveyor they would be getting xrays for the resident. k. During an interview on 3/12/24 at 4:34 PM the DON stated physician #1 told them to get in touch with the resident's physician, so she stated she called the resident's physician at 12:30 PM. She stated the physician had not gotten back to her yet. She stated the resident was complaining of pain, which was normal, but was worse since the fall. l. Observation on 3/12/24 at 4:56 PM showed the staff development coordinator (SDC) took the resident to his/her room to assess the resident. When the surveyor asked the resident if s/he still had pain in that arm the resident indicated yes, and stated the upper and lower arm hurt. When the SDC was asked if the resident normally complained of pain, she stated not usually in the upper extremities. m. Review of a nursing note dated 3/12/24 and timed 5:46 PM showed .Resident had complaint of increased pain to left shoulder .Resident was unable to lift up left arm at this time. Faded bruise to left upper inner arm observed .bruise appears old .Due to increased pain and decreased function of arm, resident is being sent to receive imaging per MD order. n. Review of a progress noted dated 3/12/24 and timed 5:46 PM showed Received order from MD to send resident out to ER for X-ray to left shoulder. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	o. Review of a nursing note dated 3/12/24 and timed 9:30 PM showed .Resident recently returned to the facility from [hospital] ER tonight. Resident received x-rays to r/o [rule out] injury of left upper extremity r/t [related to] recent fall per complaints of pain. Per verbal report, resident has old, resolved injuries to left upper extremity that have been aggravated by recent fall. No acute injury. Resident was sent home with sling in place to left upper extremity. Rest of left upper extremity and follow up with Orthopedics if condition does not improve. Resident was medicated for pain at [hospital] ER before returning to the facility . p. A progress note dated 3/13/24 read IDT aware of resident's c/o left shoulder/arm pain. MD was contacted. Resident sent to ER for X-Ray to left shoulder. Resident returned from ER with diagnoses for contusion of left shoulder and post-traumatic osteoarthritis of left shoulder .Resident sent back to facility with sling in place. Therapy referral initiated. q. On 3/13/24 at 4:25 PM RN #2 stated on 3/11/24 the resident was exhibiting signs of pain and holding his/her arm. She stated she did not give the resident the ordered PRN Oxycodone because she was told to only give it to him/her at night because the resident got up and walked by himself/herself. She stated she was told that day the resident needed to see his/her PCP (primary care physician), but she was told to pass it along to the regular nurse since she was just filling in. She stated she told the night nurse, who was supposed to pass it along to the regular day nurse who would be working the following day and would know how to contact the physician. r. During an interview on 3/14/24 at 8:45 AM the resident stated his/her pain was a 9, but stated the sling on his/her arm made his/her arm more comfortable. s. Review of a nursing note dated 3/13/24 at 9:59 PM showed .Sling to left upper extremity remains in place . Slight swelling noted to left hand . 2. Review of the 1/22/24 quarterly MDS assessment showed resident #31 had a BIMS score of 0, indicating severe cognitive impairment, had a diagnosis of non-Alzheimer's dementia, had no indicators of pain, and had one fall with no injury since the previous assessment. Observation on 3/11/24 at 4:51 PM and on 3/12/24 at 9:16 AM revealed the resident was in bed. Review of an IDT note dated 3/4/24 showed on 3/3/24 the resident fell while standing in front of the recliners. The note showed the resident was exhibiting increased back pain. The following concerns were identified: a. Review of a nursing note dated 3/5/24 and timed 2:15 PM showed .Recent fall approximately 2 days ago. Declined offers to have breakfast this AM and remained in bed until lunch .Guarding of lower back also noted with repositioning .Resident agreed to get up for lunch. Resident noted to be leaning back while sitting in chair, grimacing and lower back guarding noted when resident leans forward . b. Review of a nursing note dated 3/9/24 and timed 1:37 PM showed .Resident remained in bed today . Guarding of lower back noted when resident is repositioned, otherwise no indications of pain while at rest c. Review of a nursing note dated 3/10/24 and timed 6:58 PM showed Remained in bed for shift. Facial grimacing and guarding of lower back noted with repositioning, however no other indications of pain noted while at rest. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	d. Review of the MAR for March 2024 showed the resident received PRN Tylenol 650 mg on 3/3 for back pain at a 6; on 3/6 for pain at a 4; on 3/7 for pain at a 4; on 3/10 for back pain at a 2; and on 3/12 for pain at a 3. e. Review of a progress note dated 3/12/24 and timed 8:21 AM showed Resident sent out for X-Rays to [his/her] lower back following [his/her] fall the other day. Since the fall, resident has been displaying non-verbal indicators of pain. X-ray was done. Age-indeterminate compression fractures found at L2 and L3 with degenerative arthroplasty to L5-S1 .Resident has been remaining in bed for the majority of [his/her] days . f. During an interview on 3/14/24 at 10:55 AM the DON was asked why the resident was not sent for x-rays sooner. The DON stated that she was not notified by nursing what was going on with the resident. She stated once she found out, she sent the resident for x-rays.

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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. 16146 Based on observation, medical record review, and staff and resident interviews, the facility failed to provide necessary treatment to promote healing for 2 of 5 sample residents (#50, #105) with pressure ulcers. The findings were: 1. Review of the 3/3/24 admission MDS assessment showed resident #50 had diagnoses including renal insufficiency and was at risk for pressure ulcers, but did not have any. Review of a progress note dated 3/5/24 showed therapy called the nurse to assess the resident's heel when blood was observed on the resident's left sock. A 5 x 4.5 x 0.1 cm serosanguinous filled blister was observed to the left heel. Review of a progress note dated 3/12/24 showed the pressure ulcer to the left heel was 4.5 x 4.5 x 0.1 cm and new epitheliazation was observed around the wound edges. Observation on 3/12/24 at 10:40 AM showed RN #1 provided wound care to the left heel. Review of physician orders showed on 3/5/24 the physician ordered for the wound to be cleaned with wound cleanser, covered with skin prep, a non adherent foam applied and then covered with mepilex. The order was for the dressing to be changed every day and as needed if the dressing became soiled or fell off. The following concerns were identified: a. During an interview on 3/12/24 at 8:38 AM the resident stated s/he had a wound on the left heel. When asked if staff were providing care for it, the resident responded that they hadn't provided treatment the last couple of days. b. Review of the medical record, including the treatment administration record (TAR), progress notes and nursing assessments, showed no evidence the facility provided wound treatment on 3/10/24 or 3/11/24. c. On 3/14/24 at 10:55 AM the DON stated wound documentation would be in the medical record and did not provide any additional documentation. 2. Review of the 3/5/24 admission MDS assessment showed resident #105 had diagnoses including weakness and cellulitis of the lower extremity and had one stage 2 pressure ulcer. Review of the 3/6/24 weekly skin evaluation showed the resident had a stage 2 pressure ulcer to the right heel which measured 6 x 6 x 0.1 cm. Observation on 03/13/24 at 11:40 AM showed the SDC performed wound care to the right heel. Review of physician orders showed on 3/6/24 the physician ordered the right heel wound to be cleansed with wound cleanser, calcium alginate applied to wound bed, and a non adherent foam placed and wrapped with gauze wrap and an ace bandage from the toes to the knees. The dressing was ordered to be changed every day and as needed if the dressing was soiled or came off. The following concerns were identified: a. Review of the medical record, including the TAR, progress notes and nursing assessments, showed no evidence the facility provided wound treatment on 3/10/24 or 3/11/24. b. On 3/14/24 at 10:55 AM the DON stated wound documentation would be in the medical record and did not provide any additional documentation.

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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. 35081 Based on observation, medical record review, and staff interview, the facility failed to ensure therapeutic diets were provided in accordance with physician's orders during 1 of 3 meal observations. Random observations showed thickened liquids were not appropriately provided for resident #28 and resident #43. The following concerns were identified: 1. Observation on 3/11/24 at 5:03 PM showed CNA #2 obtained a small container of white powder which was not covered, labeled, or dated, she referred to as thickener, from on top of the book shelf in the dining room. The CNA dumped the contents of the container into a plastic cup, then poured hot cocoa into the cup. The CNA stirred the contents briefly and provided to the cup of fluid to resident #28. The resident took a drink of the fluid and coughed several times after drinking. Continued observation throughout the meal showed the resident did not drink any more of the hot cocoa during the meal. 2. Review of the medical record for resident #28 showed s/he had an active physician's order for .puree texture, mildly thick liquid consistency . 3. Observation on 3/11/24 at 5:11 PM showed CNA #3 opened a small container from the fluid cart, which was not labeled or dated, of white powder she called thickener. The CNA placed 1 plastic spoon full in a cup then added liquid. The CNA stirred the liquid and checked consistency by lifting the spoon and allowing the fluid to run off. The CNA obtained another plastic spoon and added an additional amount of powder to the tip of the spoon and put the powder in the glass. She stirred the fluid and tested the consistency by lifting the spoon and allowing the fluid to run off. The CNA an additional amount of powder to the tip of the 2nd spoon and put the powder in the glass. She again stirred the fluid and tested the consistency by lifting the spoon and allowing the fluid to run off. The liquid was still splashing when it was dripped back into the cup of fluid, and it was provided to resident #43. Interview with CNA at that time revealed using the powdered thickener was new to her and she usually used the liquid which had a pump and instructions to determine the needed amount for different consistencies. She revealed with the powder she normally just dumps a little out at a time. 4. Review of the physician's orders for resident #43 showed no active orders for thickened liquid consistency. 5. Interview with CNA #2 on 3/11/24 at 5:20 PM revealed the kitchen usually measured out the amount of powdered thickener to use. She stated normally the facility used liquid thickener and the container indicated how many pumps to use for different consistencies. She stated with the containers of thickener on the cart, it depends how many glasses they can thicken because they have to measure them out with the scoops. Observation at that time showed there was no scoop present in the small containers or on the fluid cart. 6. Interview with the facility dietitian on 3/14/24 at 10:37 AM revealed she would direct questions about CNAs thickening liquids to the DON and the administrator. Further interview revealed the dietary department had pre-thickened liquids and staff should follow directions for using thickener to thicken fluids to the appropriate thickness. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7. Interview with the DON on 3/14/24 at 10:54 AM revealed the floor staff should not be thickening liquids and the thickening of liquids should be performed by dietary staff only.

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 16146 Based on observation, medical record review, staff and resident interview, and review of policies and procedures, the facility failed to adequately treat pain for 1 of 6 sample residents (#29) reviewed for pain management. This failure resulted in actual harm to resident #2 who experienced a change in condition including limited movement and pain following a fall and was not treated for severe pain. The findings were: 1. Review of the 2/13/24 significant change MDS assessment showed resident #29 had diagnoses including polyosteoarthritis, non-Alzheimer's dementia, and other chronic pain. The resident received scheduled pain medication and had no pain in the last 5 days. Review of a provider progress note dated 2/7/24 showed the resident had chronic pain of the right knee and lift hip. Review of the care plan for pain initiated 4/13/24 showed Administer analgesia as per orders . and Evaluate the effectiveness of pain interventions Q shift. Review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition. Review of physician orders and the MAR for March 2024 showed the resident was ordered the following routine medications for pain: Diclofenac Sodium 1% gel to the upper and lower extremities (4 grams to lower extremities, 2 grams to upper extremities) every 8 hours for pain (at 7 AM, 3 PM and 11 PM) and Tylenol ES 500 mg, give two tablets, three times per day (6 AM, noon, 4 PM). In addition, the resident was ordered Oxycodone HCL 5 mg every 8 hours PRN (as needed) for severe pain. Further review of physician orders and the MAR showed staff were instructed to monitor pain every shift and indicate pain level and location if applicable. The following concerns were identified: a. Review of a progress note dated 3/10/24 showed the resident was found on the floor beside the bed. A new 2 cm curved lacerated noted on left forearm. Denies hitting head, admits to shoulder pain. Range of motion limited and at baseline. Chronic shoulder deformity related to previous surgery noted and at baseline. No swelling or discoloration noted .Shoulder pain treated with PRN ordered pain medications .on call provider notified. New orders received to schedule resident appointment with primary clinic for further evaluation related to recent frequent falls and further evaluation to rule out additional injuries. b. Observation on 3/11/24 at 3:43 PM showed RN #2 asked the resident about pain and the resident said his/her pain was an 8. c. Observation on 3/11/24 at 5:08 PM showed the resident complained of shoulder pain to CNA #1. The resident was cradling his/her left arm with the other arm and stated s/he couldn't raise their arm up. When the CNA asked the resident how s/he would rate the pain, the resident replied 10. The resident stated the nurse put some cream on his/her shoulder earlier, but it didn't help. When the surveyor asked what happened, the resident replied s/he fell the day before and had not seen a doctor. d. Observation on 3/11/24 at 5:33 PM showed the resident wasn't eating much of his/her dinner and kept looking at his/her left arm and telling the surveyor s/he couldn't raise their arm. e. On 3/11/24 at 5:40 PM RN #2 came to the SCU and CNA #1 told her the resident was complaining of pain at a 10 and couldn't raise his/her arm. The nurse evaluated the resident's arm and the resident winced when the nurse moved his/her left arm. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0697 Level of Harm - Actual harm Residents Affected - Few	f. On 3/11/24 at 5:48 PM RN #2 took the resident to his/her room. The resident told her the pain level was a 9. The resident told the nurse s/he fell the day before. At 5:54 PM the RN applied a cream to the resident's left shoulder and arm. She stated she applied cream to the resident earlier. She also told the resident s/he last had Tylenol at noon and she would check on any other orders. g. Review of the nursing note dated 3/11/24 and timed 7:52 PM showed .Resident has been complaining of left shoulder to the hand pain. [S/he] has been favoring left extremity throughout the day. Topical Diclofenac Sodium Gel was applied to the shoulder and po Tylenol was given. A noted abrasion to left forearm was cleaned and left open to air. PCP appt needs to be made for resident . h. Review of the MAR for 3/11/24 showed the resident was administered the routine medications of Diclofenac Sodium gel 1%, apply 2 grams to upper extremities, at 9:30 AM, 3:40 PM and 11 PM and Tylenol ES 500 mg, give 2 tablets, at 8 AM, noon and 4 PM. However, the resident was not administered any PRN Oxycodone on 3/11/24, despite the resident indicating s/he had severe pain. i. Review of the MAR for March 2024 showed the day shift nurse did not document the resident's pain (pain level and location) on 3/11/24. Review of the vital signs in the electronic medical record showed pain level was not documented on 3/11/24. j. Observation on 3/12/24 at 4:56 PM showed the SDC took the resident to his/her room to assess the resident. When the surveyor asked the resident if s/he still had pain in that arm the resident indicated yes, and stated the upper and lower arm hurt. When the SDC was asked if the resident normally complained of pain, she stated not usually in the upper extremities. k. Review of a nursing note dated 3/12/24 and timed 5:46 PM showed .Resident had complaint of increased pain to left shoulder .Resident was unable to lift up left arm at this time. Faded bruise to left upper inner arm observed .bruise appears old .Due to increased pain and decreased function of arm, resident is being sent to receive imaging per MD order. l. Review of a nursing note dated 3/12/24 and timed 9:30 PM showed .Resident recently returned to the facility from [hospital] ER tonight. Resident received x-rays to r/o [rule out] injury of left upper extremity r/t [related to] recent fall per complaints of pain. Per verbal report, resident has old, resolved injuries to left upper extremity that have been aggravated by recent fall. No acute injury. Resident was sent home with sling in place to left upper extremity. Rest of left upper extremity and follow up with Orthopedics if condition does not improve. Resident was medicated for pain at [hospital] ER before returning to the facility . m. On 3/13/24 at 4:25 PM RN #2 stated on 3/11/24 the resident was exhibiting signs of pain and holding his/her arm. She stated she did not give the resident the ordered PRN Oxycodone because she was told to only give it to him/her at night because the resident got up and walked by himself/herself. n. Review of a progress note dated 3/13/24 showed .Resident was very agitated and restless at the beginning of this shift. Resident replied yes when asked if [s/he] wanted a pain pill. Resident was medicated for pain and agitation has improved. o. Review of the MAR for 3/12/24 and 3/13/24 showed the resident did receive PRN Oxycodone on those days. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	p. During an interview on 3/14/24 at 8:45 AM the resident stated his/her pain was a 9, but stated the sling on his/her arm made his/her arm more comfortable. 2. Review of the facility's policy Pain Management, updated August 2023, showed .2. Resident's pain level is evaluated every shift by the LN [licensed nurse]. Noted pain is evaulated and treated accordingly by the LN . a. Pain level is monitored and documented on the MAR using the Wong-Baker Pain Scale .3. When pain is not adequately controlled by current regimen, or if there is newly identified pain, the LN contacts the physician for consideration of new or modified treatment orders.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 16146 Based on observation, review of the menu, and staff interview, the facility failed to ensure the menu was followed for 1 of 1 meals observed for meal preparation and tray line service. The findings were: 1. Review of the menu for the 3/13/24 lunch meal showed it included cranberry glazed pork loin, baked potato, beets, and a roll for the regular diet. However, the CCHO (consistent carbohydrate diet for diabetes) menu consisted of a baked pork loin, 1/2 baked potato, beets, and no roll. The following concerns were identified during tray line service on 3/13/24 from 12:03 PM through 12:59 PM: a. Resident #40 had a CCHO diet and was served cranberry sauce over the pork, a whole potato, beets, and a roll. b. Resident #39 had a CCHO diet and was served cranberry sauce over the pork, half a potato, beets, and a roll. c. Resident #28 had a CCHO diet and puree texture and was served pureed pork with the cranberry sauce, pureed beets, mashed potatoes, and pureed bread. d. Resident #34 had a CCHO diet and soft and bite sized texture and was served ground pork with cranberry sauce, mashed potatoes, ground beets, and a roll. e. Resident #1 had a CCHO diet and was served pork with cranberry sauce, half a potato, beets, and a roll. f. Resident #24 had a CCHO diet and was served pork with cranberry sauce, half a potato, beets and a roll. g. Resident #13 had a CCHO diet and was served pork with cranberry sauce, half a potato, beets and a roll. 2. During an interview on 3/13/24 at 4:32 PM the certified dietary manager (CDM) confirmed residents with a CCHO diet order should not have received the cranberry sauce over the pork, should have received half a potato, and should not have received a roll.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16146 Based on observation, staff interview, and review of the 2022 Food Code, the facility failed to store and prepare food in accordance with professional standards related to expired food, hair restraints, and hand hygiene/gloving during 3 of 3 observations in the kitchen and 1 of 1 observation of tray line service. The findings were: 1. The following concerns were identified related to hair restraints: a. Observation on [DATE] at 3:15 PM in the kitchen revealed the certified dietary manager (CDM) was wearing a hair restraint, but was not wearing a beard restraint to cover his beard. b. Observation on [DATE] at 12:21 PM revealed the CDM was assisting staff with tray line service (putting sour cream on the trays in the carts) and was not wearing a beard restraint to cover his beard. c. During an interview on [DATE] at 4:32 PM the CDM stated he had heard about beard restraints but had never worn one. Review of the 2022 Food Code, US Food and Drug Administration, showed XXX,d+[DATE] Hair Restraints , d+[DATE].11 Effectiveness. (A) Except as provided in (B) of this section, FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES. (B) This section does not apply to FOOD EMPLOYEES such as counter staff who only serve BEVERAGES and wrapped or PACKAGED FOODS, hostesses, and wait staff if they present a minimal RISK of contaminating exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE-SERVICE and SINGLEUSE ARTICLES. 2. The following concerns were identified related to hand hygiene/gloving: a. Observation during tray line service on [DATE] from 12 PM to 12:59 PM showed cook #1 washed her hands and put on gloves at the beginning of the service. During the service, the cook was observed to touch the microwave buttons and handle with her gloved hands, and then touched the bread of grilled cheese sandwiches, tortillas, and cooked baked potatoes with the same gloved hands. This happened on at least five occasions. b. During an interview on [DATE] at 4:32 PM the CDM stated staff had been educated on hand hygiene and glove use. He stated staff should perform hand hygiene and change gloves between tasks and confirmed the cook should have performed hand hygiene after touching the microwave surface and before handling food. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the 2022 Food Code, US Food and Drug Administration, showed XXX,d+[DATE].14 When to Wash. FOOD EMPLOYEES shall clean their hands and exposed portions of their arms as specified under S , d+[DATE].12 immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTENSILS, and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES and: (A) After touching bare human body parts other than clean hands and clean, exposed portions of arms; P (B) After using the toilet room; P (C) After caring for or handling SERVICE ANIMALS or aquatic animals as specified in ,d+[DATE].11(B); P (D) Except as specified in ,d+[DATE].11(B), after coughing, sneezing, using a handkerchief or disposable tissue, using TOBACCO PRODUCTS, eating, or drinking; P (E) After handling soiled EQUIPMENT or UTENSILS; P (F) During FOOD preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; P (G) When switching between working with raw FOOD and working with READY-TO-EAT FOOD; P (H) Before donning gloves to initiate a task that involves working with FOOD; P and (I) After engaging in other activities that contaminate the hands. 3. The following concerns were identified regarding expired food: a. Observation of the dry storage room on [DATE] at 3:15 PM showed 2 packages of flour tortillas that expired [DATE]. b. Observation on [DATE] at 10:52 AM of the dry storage showed one of the two packages of expired flour tortillas remained on the shelf. c. On [DATE] at 10:55 AM the CDM stated everything in dry storage was useable, and stated he did not know the tortillas were expired. d. On [DATE] at 11:20 AM in the kitchen the CDM showed the surveyor a box which contained flour tortillas. He stated that was the box the flour tortillas from the dry storage came from and they received the box on [DATE]. He showed the surveyor that all of the tortillas in the box expired in [DATE].

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16146 35081 Based on observation, staff interview, and professional reference review, the facility failed to ensure infection prevention techniques were followed for 1 of 5 sample residents (#50) during wound care. The findings were: 1. Observation of wound care for resident #50 on 3/12/24 at 10:40 AM showed RN #1 cleaned a surgical wound on the resident's abdomen, below the umbilical, with wound cleanser and gauze. Without removing her gloves or performing hand hygiene, the RN opened a package of xeroform impregnated gauze and placed it over the site, opened a second package of xeroform impregnated gauze and placed it over the site, and opened an abdominal (ABD) dressing and applied over the xeroform. At that time, the RN removed her gloves, used some scissors from her pocket, cut a strip of medifix tape, and applied it to the top of the ABD dressing. The RN tucked the lower bottom portion of the ABD dressing into the resident's incontinence brief. The RN applied clean gloves and got on her hands and knees in a position to perform a dressing change to the resident's left heel, touching the floor with the clean gloves in the process. Without removing her gloves, she removed the resident's left heel dressing, and cleaned the wound with wound cleanser and gauze. The RN obtained the scissors from the bed side table, opened a dermarite foam dressing, cut the dressing to size, and applied the foam to the resident's heel wound. The RN covered the dermarite foam dressing with a comfortfoam border dressing, and secured it to the resident's heel. At that time, the RN got off the floor and placed the contaminated scissors in her pants pocket with pens and other items. The RN entered the bathroom, removed her gloves, and performed hand hygiene. 2. Interview with the wound nurse/infection preventionist on 3/14/24 at 9:30 AM revealed she expected staff to clean items before leaving a resident's room because items in the room are considered contaminated. She confirmed she would consider the scissors contaminated, when they were used during a wound dressing change, if they were not cleaned after use. In addition, she expected gloves to be changed after cleaning a wound, prior to touching a clean dressing, to prevent contamination. 3. Review of [NAME]/[NAME] seventh edition Nursing Interventions & Clinical Skills copyright 2020 showed Performing a Wound Assessment .5. Perform hand hygiene. b. expose only the area of the wound . 8. Apply clean gloves and remove soiled dressings . 10. Perform hand hygiene and apply clean gloves. 11. Inspect wound . 14. Apply dressings per order. Place time, date, and initials on new dressing .

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35081 Based on observation and staff interview, the facility failed to ensure a safe environment for residents, staff, and public. The census was 56. The findings were: 1. Observation on 3/12/24 at 4:40 PM showed broken floor tiles outside the soiled utility room near room [ROOM NUMBER]. The area had built-up dirt and debris in the tile cracks which appeared black in color. In addition, the hand rails in the area were discolored and the sealant had been worn away, which created a porous surface, and the rails could not be effectively sanitized. 2. Observation on 3/12/24 at 4:43 PM showed an EZ Way sit to stand mechanical lift positioned in the hallway, outside room [ROOM NUMBER]. The lift had dirt and debris built-up on the standing platform which appeared black in color. 3. Observation on 3/12/24 at 4:46 PM showed a heater vent cover in room [ROOM NUMBER] which had visible rust and damaged brackets sticking out. The damaged brackets had sharp edges visibly noticeable. 4. Observation on 3/12/24 at 4:48 PM showed the carpet in the owl creek common area was worn down and appeared shiny from wear. The area was black in color. Further observation showed the tan and black couch had visible discoloration on the seating area and tears in the cushions. 5. Observation on 3/12/24 at 4:50 PM showed the hand rails in the main dining room were discolored and the sealant had been worn away, which created a porous surface, and the rails could not be effectively sanitized. 6. Observation on 3/12/24 at 4:53 PM showed a urine smell was present in the hallway near room [ROOM NUMBER]. There were no residents present in the area. In addition, the hand rails in the area were discolored and the sealant had been worn away, which created a porous surface, and the rails could not be effectively sanitized. 7. Observation on 3/12/24 at 4:53 PM showed the transition between the secure unit and the hall way had built-up dirt and debris which was black in color. 9. Observation on 3/12/24 at 4:55 PM showed a urine smell was present in the hallway near room [ROOM NUMBER]. There were no residents present in the area. In addition, the hand rails in the area were discolored and the sealant had been worn away, which created a porous surface, and the rails could not be effectively sanitized. 10. Observation on 3/12/24 at 4:55 PM showed built-up dirt and debris in the transition between the hallway and room [ROOM NUMBER] which appeared black in color. 12. Observation on 3/12/24 at 4:56 PM showed broken tiles with built-up dirt and debris in the transition between the hallway and room [ROOM NUMBER] which appeared black in color. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	13. Observation on 3/12/24 at 4:56 PM showed built-up dirt and debris in the transition between the hallway and room [ROOM NUMBER] which appeared black in color. 14. Observation on 3/12/24 at 4:57 PM showed built-up dirt and debris in the transition between the hallway and room [ROOM NUMBER] which appeared black in color. 15. Observation on 3/12/24 at 4:57 PM showed built-up dirt and debris in the transition between the hallway and room [ROOM NUMBER] which appeared black in color. 16. Interview with the administrator on 3/14/24 at 11:05 AM revealed she was aware of some cleanliness concerns and the facility was in the process of ending the contract with the current housekeeping agency. In addition, the facility had plans for some upgrades which included the carpet in the television area. She revealed the facility was aware of the condition of the handrails revealed she planned to request for new handrails because attempts to sand and stain took a long time. 17. Observations with maintenance director and housekeeping manager on 3/14/24 beginning at 11:15 AM showed a heater vent cover in the secure unit which was pulled away from the wall, which created a gap large enough for residents to place their hands, and was damaged in a way the vent cover had sharp edges. A second heater vent cover, near the emergency exit, was dented on one side which created a protruding metal angle sticking out and was sharp. In addition, there was a chipped area in the wood hand rail near room [ROOM NUMBER] and a chipped area in the wood hand rail near the purple sage dining room, which created sharp edges. Interview with the maintenance director and housekeeping supervisor, during the observations, confirmed the hand rails could not be effectively sanitized. It was confirmed the identified transitions were not cleaned appropriately. The housekeeping supervisor revealed they could not clean the transition into the secure unit due to the doors sounding an alarm if they are open for too long. They revealed there was a plumbing leak on owl creek and the discoloration outside the soiled utility room was due to the leak. Further interview confirmed the maintenance had attempted to sand and seal hand rail; however, the process was very time consuming to complete. Further interview revealed the damaged heater vent cover and hand rails created a safety risk to residents.