STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535054	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Green House Living for Sheridan	2311 Shirley Cove Sheridan, WY 82801

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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 - Some	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** 51658 Based on observation, staff interview, and policy and procedure review, the facility failed to ensure residents were treated with respect and dignity in 1 of 4 resident cottages ([NAME]). The cottage census was 7. The findings were: 1. Observation on 3/11/25 at 4:47 PM showed seven residents and two resident family members were seated at the dining table. At that time, two CNAs, CNA #1 and CNA #2, were discussing resident health information at a volume that could easily be heard across the room. CNA #1 asked resident #3 how many bowel movements s/he had that day and the resident held up two fingers. Then the CNA asked CNA #2, How many times did you change [resident #18]? CNA #2 replied, Four times. 2. Observation on 3/12/25 at 4:25 PM showed three residents seated at the dining table. Two CNAs, CNA #2 and CNA #3, were discussing resident health information and CNA #2 stated loudly from the other side of the room, the nurse said she'll mark all of [resident #4]'s smearing as a small BM. 3. Interview with the administrator and DON on 3/13/25 at 9:35 AM revealed they expected staff to ask about private matters privately, not in front of other residents or visitors, because it was personal information. They confirmed discussing private health information at the dining table was not an appropriate type of interaction with residents and could be undignified. 4. Review of facility policy titled Elder Dignity and Respect Policy last updated 11/21/23 shows Elders shall always be treated with dignity and respect . and Staff shall maintain an environment in which confidential clinical information is protected, for example 'Verbal staff-to-staff communication (e.g. change of shift reports) shall be conducted outside the hearing range of elders and the public .'

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

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

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35081 Based on observation, resident and staff interview, medical record review, activity calendar review, and policy and procedure review, the facility failed to ensure resident choice of activities were provided for 3 of 4 resident cottages ([NAME], [NAME], Founders) with activity concerns. The findings were: 1. Review of the activity calendar for March 2025 showed on 3/12/25 the scheduled activities were 10 AM activities binder exercise CNA pick and assist and 2 PM Dominos in [NAME] game room. Further review showed the PM activity every day was This day in History reading by staff (read at lunch or dinner). 2. Review of the quarterly MDS assessment dated [DATE] showed resident #6 had a brief interview for mental status (BIMS) score of 15 out 15, which indicated the resident was cognitively intact, and had diagnoses which included depression. Review of the annual MDS assessment dated [DATE] showed it was very important to have books, newspapers, and magazines to read, listen to music, be around animals, keep up with the news, do his/her favorite activities, and participate in religious services or activities. Review of an Activities-Quarterly/Annual Participation Review dated 3/18/24 showed the resident enjoyed both group and individual activities, facility events and celebrations, crafts appropriate for his/her age, and music when piano players visited the facility. Review of the resident's care plan last revised on 1/20/25 showed the resident enjoyed art activities and helping with household duties such as cooking and prepping food and wanted to participate in streaming exercise. Further review showed I enjoy music. I enjoy crafts projects that have a purpose. For example, card making, jewelry making, etc. I enjoy socializing with others but also enjoy my alone time because I grew up as an only child and I find it relaxing. The following concerns were identified: a. Interview with the resident on 3/11/25 at 10:04 AM revealed the facility no longer performed activities in the cottage and s/he did most of his/her activities alone in the room. b. Observation on 3/12/25 from 9:03 AM to 9:18 AM showed a staff member was playing cards at the dining room table with 2 residents in the Founders cottage when resident #6 arrived at the table for breakfast. Further observation showed resident #6 was not invited to play cards at that time. Upon completion of breakfast at 9:18 AM, the resident returned to his/her room. Observation from 9:33 AM to 12:09 PM showed no activities were performed in the Founders cottage. Observation at 9:08 AM showed resident #6 arrived at the dining table positioned him/herself up to the dining table. Further observation showed the resident was not offered to participate in the card game being played between a staff member and another resident. c. Review of the activity participation record from 2/11/25 to 3/12/25 showed the resident participated in Coffee and Visit 6 times, Conversation 21 times, and Current Events 8 times. Further review showed no other activities were attended. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of the quarterly MDS assessment dated [DATE] showed resident #11 had BIMS score of 4 out 15, which indicated severe cognitive impairment and diagnoses which included Alzheimer's disease and major depressive disorder. Review of the annual MDS assessment dated [DATE] showed it was very important to listen to music s/he liked, keep up with the news, do things with groups, do his/her favorite activities, and go outside to get fresh air when the weather was good. Review of an Activities-Quarterly/Annual Participation Review dated 3/14/24 showed the resident enjoyed painting, watching television, and enjoys the company of other residents when s/he can hear them. Review of the resident's care plan last revised on 1/29/24 showed Ensure that the activities I am attending are: Compatible with my physical and mental capabilities; Compatible with my known interests and preferences; Adapted as needed (such as large print, holders if resident lacks hand strength, task segmentation), Compatible with my individual needs and abilities; and age appropriate .I like spending time with staff 1:1. I would like to be assisted to my painting area, and paint. I like doing art related projects also .I need assistance/escort to activity functions and assistance during activities . Invite me to scheduled activities. Provide a program of activities that is of interest and empowers me by encouraging/allowing choice, self-expression and responsibility. Notify me of any changes to the calendar of activities . The following concerns were identified: a. Observation on 3/12/25 from 9:02 AM to 9:33 AM showed resident #11 was seated at the dining table in the Founders cottage, playing cards with another resident and a staff member. Observation at 9:36 AM showed CNA #4 assisted the resident to his/her room. Observation at 9:44 AM showed CNA #4 assisted the resident to the common area and into a recliner. Observation from 9:44 AM to 11:07 AM showed the resident remained in the recliner. Observation at 11:46 AM showed CNA #4 assisted the resident to stand and ambulate to the dining table. No activities were performed from 9:33 AM to 12:09 PM. b. Review of the activity participation record from 2/11/25 to 3/12/25 showed the resident participated in Coffee and Visit 3 times, Conversation 33 times, and Current Events 2 times. Further review showed no other activities were attended. 4. Review of the annual MDS assessment dated [DATE] showed resident #20 had a BIMS score of 0 out of 15, which indicated severe cognitive impairment, and diagnoses which included dementia. Further review showed it was very important to be around animals and go outside for fresh air when the weather was good, and somewhat important to have books newspaper, and magazines to read, keep up with the news, and do his/her favorite activities. Review of the resident's care plan last revised on 12/18/24 showed I enjoy 1:1 time with staff. I like to talk about elk hunting, cars, and motors. I like going for strolls outside . The following concerns were identified: a. Observation in the [NAME] cottage on 3/12/25 from 1:34 PM to 4:53 PM showed the resident independently ambulated throughout the cottage. The resident occupied the common area and his/her room with intermittent staff redirection. Observation at 4:57 PM showed the resident was attempted to exit the facility into the courtyard. RN #1 attempted to redirect the resident and held the door closed until the resident ambulated away. Interview with the RN at that time revealed the cottage needed a 1 to 1 staff member to redirect the resident. Observation at 4:59 PM showed the resident ambulated over to the table near resident #7. Resident #7 became visually upset and asked staff to get the resident away from him/her. Resident #20 was redirected by CNA #5 to sit in arm chair near the resident's room. Further observation showed Domino's was performed in the cottage from 1:34 PM to 1:58 PM which 3 residents from the cottage, which did not include resident #20, and 1 resident from another cottage attended. Further observation showed no additional activities were performed in the cottage. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. Review of the activity participation record from 2/11/25 to 3/12/25 showed the resident participated in Coffee and Visit 1 time, Conversation 34 times, and Current Events 11 times. Further review showed no other activities were attended. c. Interview with patient care tech #1 and RN #1 on 3/12/25 at 1:38 PM revealed the [NAME] Cottage should have a 1 to 1 for resident #20 and staff were unable to perform showers and other household duties, including activities which they were responsible for. Further interview revealed at that time there was 1 CNA, the RN, and the patient care tech on shift due to another CNA not showing up for the shift as scheduled and resident #20 was difficult to manage due to his/her behaviors. 5. Review of the quarterly MDS assessment dated [DATE] showed resident #26 had a BIMS score of 10 out 15, which indicated moderate cognitive impairment, and diagnoses which included depression. Review of the admission MDS assessment dated [DATE] showed it was very important for the resident to keep up with the news and somewhat important to have books, newspapers, and magazines to read and do his/her favorite activities. The following concerns were identified: a. Review of the resident's care plan last revised on 1/5/25 showed no evidence the resident's activity preferences were identified. b. Observation in the [NAME] cottage on 3/12/25 from 1:34 PM to 1:58 PM showed a Dominos game was performed in the cottage; however, the resident did not attend. Observation from 1:58 PM to 5 PM showed no other activities were performed in the cottage. 51658 6. Review of annual MDS assessment dated [DATE] showed resident #3 had a BIMS score of 15 out of 15, which indicated the resident was cognitively intact. Further review showed it was very important to do things with groups of people and to do his/her favorite activities. Review of the resident's care plan, last updated 12/26/24, showed [resident] likes to stay busy and attend lots of activities. Interventions included Invite me to scheduled activities and Provide a program of activities that is of interest to me and empowers me by encouraging/allowing choice, self-expression and responsibility. My preferred activities are: group activities, crafts, music, outdoor activities, pet visits, community outings. The following concerns were identified: a. Interview with the resident on 3/10/25 at 4:03 PM revealed s/he liked to go to bingo and dominoes but mostly spent time in his/her room doing solo activities. S/he stated s/he would like to learn how to crochet and that a staff member had begun to teach him/her but hadn't continued. S/he further stated, Every time I ask for puzzles, they don't know where they're at. b. Observation on 3/12/25 from 8:48 AM to 10:30 AM showed the activities board in [NAME] cottage said 10:00 AM activities binder; however, no activities were observed taking place with any residents during that time period. Further observation on 3/12/25 at 2:04 PM showed resident #3 returned from playing dominoes at [NAME] cottage. S/he had been gone for approximately 30 minutes and was the only resident from [NAME] cottage who participated in the group activity. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. Interview with LPN #1 and CNA #2 on 3/12/25 at 2:44 PM revealed the activities director almost never came to the houses to do activities with the residents. The interview further revealed they don't do bingo anymore, and they used to do that a lot. The previous activities director used to frequently come around and do 1:1 activities like playing a game or doing crafts. Activities and 1:1 time were very helpful for the residents in [NAME] and Founders cottages who wander. They really benefited from the 1:1 time and were a lot more calm and less likely to wander as a result. 8. Interview with the activities director on 3/13/25 at 8:54 AM revealed the staff in each cottage were expected to perform activities for the cottage and she expected them to follow the activity guidance provided in the activity binder. She revealed she expected to staff to do more activities than observed during the survey. Further interview revealed she did not feel staff could perform the activities tasks with the staffing levels of the facility. 9. Review of the policy titled Elder Preference of Activities last updated 2/16/22 showed .1. Elders are encouraged to choose the types of recreational, cultural, and religious activities and social events in which they prefer to participate .

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F 0692 Level of Harm - 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** 51658 Based on observation, medical record review, staff interview, and policy and procedure review, the facility failed to maintain acceptable parameters of nutritional status for 1 of 2 sample residents (resident #4) with nutritional status concerns. This failure resulted in harm to resident #4 who experienced severe weight loss. The findings were: 1. Review of the annual MDS assessment dated [DATE] showed resident #4 had a BIMS score of 8 out of 15, which indicated moderate cognitive impairment, and diagnoses which included dementia, depression, and chronic obstructive pulmonary disease. Review of the physician orders showed a regular fortified low sodium diet with snacks 3/8/23. Review of the resident's care plan last updated 2/15/25 showed the resident had the potential for unplanned weight loss related to eating small meals. Interventions included Offer me snacks, and I do prefer ritz crackers. Encourage me to have small, frequent feedings instead of large meals. Give me supplements if needed to maintain adequate nutrition. The following concerns were identified: a. Review of resident's weight history showed the resident weight had decreased from 88.5 lbs. on 2/1/25 to 82.0 lbs. on 3/2/25, a 7.34% weight loss, which was a severe weight loss in one month. b. Observation on 3/11/25 at 8:28 AM showed the resident was seated in his/her wheelchair at the breakfast table eating without assistance. The resident was very thin appearing with hollow cheeks and temples. c. Observation on 3/12/25 from 8:48 AM to 10:30 AM showed the resident was seated in his/her wheelchair at the breakfast table. The breakfast plates had been cleared; however, the resident remained at the table for over 90 minutes. During that time, the resident was offered coffee; however, no snacks were offered or provided. d. Observation on 3/12/25 from 2:04 PM to 4:25 PM showed the resident was seated at the table in his/her wheelchair. No snacks were provided or offered during that time. e. Review of snack documentation from 2/12/25 to 3/12/25 showed no documentation the resident was offered or accepted PRN snacks. f. Review of a progress note dated 3/5/25 at 3:32 PM showed [Resident #4] has continued to lose weight and has triggered for a 5% weight loss in 30 days. [S/he] will be weighed weekly for 4 weeks to monitor weight .RD has encouraged snacks such as cookies with butter, peanut butter on cookies and desserts after each lunch and dinner. 2. Interview with dietitian on 3/13/25 at 10:40 AM revealed her expectation for staff was to offer snacks to the resident, especially between lunch and dinner. She stated, [Resident #4] will never turn down a cookie. If you offer [him/her] string cheese, [s/he] will turn it down. [S/he] might turn down a nutritional supplement, but s/he would not turn down a milkshake. Further interview confirmed offering snacks to the resident was not currently a task in the resident's medical record. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	3. Review of facility policy titled Weight Assessment and Intervention Policy last reviewed 5/23/22 showed . 5% weight loss [in one month] is significant; greater than 5% is severe and care planning for weight loss or impaired nutrition will be a multidisciplinary effort and will include the physician, nursing staff, the dietician, the consultant pharmacist, and the elder or elder's legal surrogate. Individualized care plans shall address to the extent possible: a. the identified causes of weight loss, b. goals and benchmarks for improvement, c. time frames and parameters for monitoring and reassessment .

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35081 Based on observation, staff, resident representative, and resident interview, and facility staffing review, the facility failed to ensure adequate staff in 1 of 4 cottages ([NAME]). The cottage census was 9. The findings were: 1. Review of the annual MDS assessment dated [DATE] showed resident #20 had a BIMS score of 0 out of 15, which indicated severe cognitive impairment, and diagnoses which included dementia. Review of the resident's care plan last revised on 12/18/24 showed I enjoy 1:1 time with staff. I like to talk about elk hunting, cars, and motors. I like going for strolls outside . Further review showed I may have behaviors of being verbally mean or getting agitated [related to] dementia and I may wander or try to leave my cottage r/t History of attempts to leave facility unattended. The following concerns were identified: a. Observation in the [NAME] cottage on 3/12/25 from 1:34 PM to 4:53 PM showed the resident independently ambulated throughout the cottage. The resident occupied the common area and his/her room with intermittent staff redirection. Observation at 4:57 PM showed the resident attempted to exit the facility into the courtyard. RN #1 attempted to redirect the resident and held the door closed until the resident ambulated away. Interview with the RN at that time revealed the cottage needed a 1 to 1 staff member to redirect the resident. b. Observation on 3/12/25 at 4:59 PM showed the resident ambulated over to the table near resident #7. Resident #7 became visually upset and asked staff to get the resident away from him/her. Resident #20 was redirected by CNA #5 to sit in arm chair near the resident's room. c. Review of a progress note dated 3/10/25 and timed 3:47 AM showed Elder was very restless last evening, and at times even agitated and combative. He took [his/her] medications mixed in ice cream, but no effect noted. In earlier part of shift [s/he] was fairly steady on [his/her] feet, but became more unsteady as the shift progressed. No falls this shift. No limping or signs and symptoms of pain noted from fall yesterday. Unable to obtain 2245 [10:45 PM] vitals from elder d/t [due to] [his/her] constant activity. By 2345 [11:45 PM] elder laid [him/herself] into bed, and has been resting quietly there ever since . d. Review of a progress note dated 3/9/35 and timed 5:45 AM showed Elder generally very restless and wakeful this [night]. [S/He] slept on and off for one to two hours, but then would sit up on side of bed, or get up and pace around a bit. Generally preoccupied [him/herself] with moving chairs, at one point threw a pillow into the kitchen, or rearranging [his/her] blankets. PRN Haldol was given at about 2045 [8:45 PM], it was ineffective. [His/her] muscular coordination seemed impaired, [s/he] was more unsteady on [his/her] feet, and [his/her] speech seemed more slurred than before. No agitation or aggressiveness noted this shift. At this time sitting on bedside and trying to put on [his/her] jacket like they were pants . (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	e. Review of a progress noted dated 3/7/25 and timed 1:10 AM showed this elder has continued to pace and touch anything that catches [his/her] eye. [S/He] often stops whenever there is a change in design on the carpeted floor to touch and scratch at the seams of the squares. [S/He] also picks up non-existent items from the floor and holds the items until [s/he] sees someone to give it to . f. Review of a progress note dated 3/4/25 and timed 11:03 PM showed Elder has been very restless so far this shift, pacing up and down hallway, trying to climb up onto kitchen island counter, moving chairs around, etc. No real agitation noted, although [s/he] didn't like it when [s/he] was redirected from going outside. Occasionally [s/he] verbalizes toward staff, but speech comes out as hushed whispers, and is mostly incomprehensible. PRN Haldol given at 2115 [9:15 PM], no beneficial effects noted until about an hour later. Elder is resting in [his/her] bed with eyes closed at this time and appears to be settled in for this noc, but will continue to monitor . g. Review of a progress note dated 2/27/25 and timed 3:25 PM showed Elder wandering cottage. Grabbing and trying to move objects: (table, chairs, trim on wall, closed/locked doors), touching other elders, very unsteady. Difficult to redirect. High risk for falls. Very frequent observation by staff. Elder refused breakfast and ate 25-50% of lunch. Drank small amounts of water . h. Review of a progress note dated 2/25/25 and timed 11:30 AM showed This nurse went to founder's house to fax something and when I was leaving out the front door the elder was right there. The two-[NAME] CNAs were just then running across the street. Elder was aggressively trying to get into founders with founder's family members having to use the back door to get in. Several attempts were made to redirect the elder back to [NAME] house, but this nurse was shoved by the elder. Another nurse (male) came to help and grabbed a wheelchair in hopes to get [him/her] to sit in it. After about 30 minutes the nurse and CNA were able to direct [him/her] into the back door of [NAME]. [S/He] was still agitated so this nurse gave [him/her] a PRN Haldol shot. The elder was trying to get into other residents' rooms. Daughter and DON were notified of current behaviors. Daughter mentioned to call her back if the PRN didn't help. Earlier in the morning, elder also tried to have a bowel movement on a recliner in the living room. CNA got him sat on the toilet and then [s/he] proceeded to stand back up and have a BM on the floor and spreading it with [his/her] foot. i. Interview with the resident representative on 3/11/25 at 1:13 PM revealed she did not feel the facility had adequate staff to provide the care the resident required. 2. Interview with resident #7 on 3/11/25 at 11:15 AM revealed resident #20 had severe dementia and required a significant amount of staff's time. Further, the resident revealed staff did not have time to assist other residents in the cottage due to insufficient staff and resident #20's required needs. 3. Review of the posted staff schedule in the [NAME] cottage on 3/12/25 at 3:16 PM showed there was 1 CNA, a patient care tech, and an RN working in the cottage at that time. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Interview with patient care tech #1 and RN #1 on 3/12/25 at 1:38 PM revealed the [NAME] Cottage should have a 1 to 1 staff member for resident #20 and staff were unable to perform showers and other household duties, including activities which they were responsible for. The patient care tech revealed she was currently in a CNA program; however, she had not completed the course. She revealed she had worked at the facility for 5 days and on day 2 when they did not have enough staff for the cottage, she was told to provide resident care such as perineal care and transfers. The patient care tech revealed on 3/10/25 she was told she was not allowed to perform resident care due to the survey. Further interview confirmed at that time there was 1 CNA, the RN, and the patient care tech on shift due to another CNA not showing up for the shift as scheduled and resident #20 was difficult to manage due to his/her behaviors.

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F 0729 Level of Harm - Potential for minimal harm Residents Affected - Many	Verify that a nurse aide has been trained; and if they haven't worked as a nurse aide for 2 years, receive retraining. 35081 Based on employee file review and staff interview, the facility failed to ensure the CNA abuse registry was checked prior to resident contact for 4 of 4 CNA files (#6, #7, #8, #9) reviewed. The census was 28. The findings were: 1. Review of the employee filed for CNA #6 showed the CNA had an active Wyoming certification and there was no evidence the abuse registry was checked prior to resident contact. 2. Review of the employee filed for CNA #7 showed the CNA had an active Wyoming certification and there was no evidence the abuse registry was checked prior to resident contact. 3. Review of the employee filed for CNA #8 showed the CNA had an active Wyoming certification and there was no evidence the abuse registry was checked prior to resident contact. 4. Review of the employee filed for CNA #9 showed the CNA had an active Wyoming certification and there was no evidence the abuse registry was checked prior to resident contact. 5. Interview with human resources #1 and human resources #2 on 3/13/25 at 12:39 PM revealed the facility only checked for abuse through the department of family services and did not check the state CNA abuse registry. Further interview revealed they were not aware CNA abuse registry needed to be checked prior to resident contact.

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	535054	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Green House Living for Sheridan	2311 Shirley Cove Sheridan, WY 82801

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35081 Based on observation, medical record review, and resident representative and staff interview, the facility failed to ensure residents with dementia received the appropriate treatment and services to attain their highest practicable physical, mental, and psychosocial well-being for 1 of 4 residents (#20) reviewed for dementia care. The findings were: 1. Review of the annual MDS assessment dated [DATE] showed resident #20 had a BIMS score of 0 out of 15, which indicated severe cognitive impairment, and diagnoses which included dementia. Review of the resident's care plan last revised on 12/18/24 showed I enjoy 1:1 time with staff. I like to talk about elk hunting, cars, and motors. I like going for strolls outside . Further review showed I may have behaviors of being verbally mean or getting agitated r/t [related to]dementia and I may wander or try to leave my cottage r/t History of attempts to leave facility unattended. The following concerns were identified: a. Observation in the [NAME] cottage on 3/12/25 from 1:34 PM to 4:53 PM showed the resident independently ambulated throughout the cottage. The resident occupied the common area and his/her room with intermittent staff redirection. Observation at 4:57 PM showed the resident was attempted to exit the facility into the courtyard. RN #1 attempted to redirect the resident and held the door closed until the resident ambulated away. Interview with the RN at that time revealed the cottage needed a 1 to 1 staff member to redirect the resident. Observation at 4:59 PM showed the resident ambulated over to the table near resident #7. Resident #7 became visually upset and asked staff to get the resident away from him/her. Resident #20 was redirected by CNA #5 to sit in arm chair near the resident's room. Further observation showed Domino's was performed in the cottage from 1:34 PM to 1:58 PM which 3 residents from the cottage, which did not include resident #20, and 1 resident from another cottage attended. Further observation showed no additional activities were performed in the cottage. b. Review of a progress note dated 3/10/25 and timed 3:47 AM showed Elder was very restless last evening, and at times even agitated and combative. He took [his/her] medications mixed in ice cream, but no effect noted. In earlier part of shift [s/he] was fairly steady on [his/her] feet, but became more unsteady as the shift progressed. No falls this shift. No limping or signs and symptoms of pain noted from fall yesterday. Unable to obtain 2245 vitals from elder d/t [due to] [his/her] constant activity. By 2345 [11:45 PM] elder laid [him/herself] into bed, and has been resting quietly there ever since . c. Review of a progress note dated 3/9/35 and timed 5:45 AM showed Elder generally very restless and wakeful this [night]. [S/He] slept on and off for one to two hours, but then would sit up on side of bed, or get up and pace around a bit. Generally preoccupied [him/herself with moving chairs, at one point threw a pillow into the kitchen, or rearranging [his/her] blankets. PRN Haldol was given at about 2045 [8:45 PM], it was ineffective. [His/her] muscular coordination seemed impaired, [s/he] was more unsteady on [his/her] feet, and [his/her] speech seemed more slurred than before. No agitation or aggressiveness noted this shift. At this time sitting on bedside and trying to put on [his/her] jacket like they were pants . (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	d. Review of a progress noted dated 3/7/25 and timed 1:10 AM showed this elder has continued to pace and touch anything that catches his eye. [S/He] often stops whenever there is a change in design on the carpeted floor to touch and scratch at the seams of the squares. [S/He] also picks up non-existent items from the floor and holds the items until [s/he] sees someone to give it to . e. Review of a progress note dated 3/4/25 and timed 11:03 PM showed Elder has been very restless so far this shift, pacing up and down hallway, trying to climb up onto kitchen island counter, moving chairs around, etc. No real agitation noted, although [s/he] didn't like it when [s/he] was redirected from going outside. Occasionally [s/he] verbalizes toward staff, but speech comes out as hushed whispers, and is mostly incomprehensible. PRN Haldol given at 2115 [9:15 PM], no beneficial effects noted until about an hour later. Elder is resting in [his/her] bed with eyes closed at this time and appears to be settled in for this [night], but will continue to monitor . f. Review of a progress note dated 2/27/25 and timed 3:25 PM showed Elder wandering cottage. Grabbing and trying to move objects: (table, chairs, trim on wall, closed/locked doors), touching other elders, very unsteady. Difficult to redirect. High risk for falls. Very frequent observation by staff. Elder refused breakfast and ate 25-50% of lunch. Drank small amounts of water . g. Review of a progress note dated 2/25/25 and timed 11:30 AM showed This nurse went to founder's house to fax something and when I was leaving out the front door the elder was right there. The two-[NAME] CNAs were just then running across the street. Elder was aggressively trying to get into founders with founder's family members having to use the back door to get in. Several attempts were made to redirect the elder back to [NAME] house, but this nurse was shoved by the elder. Another nurse (male) came to help and grabbed a wheelchair in hopes to get [him/her] to sit in it. After about 30 minutes the nurse and CNA were able to direct [him/her] into the back door of [NAME]. [S/He] was still agitated so this nurse gave [him/her] a PRN Haldol shot. The elder was trying to get into other residents' rooms. Daughter and DON were notified of current behaviors. Daughter mentioned to call her back if the PRN didn't help. Earlier in the morning, elder also tried to have a bowel movement on a recliner in the living room. CNA got him sat on the toilet and then [s/he] proceeded to stand back up and have a BM on the floor and spreading it with [his/her] foot. h. Interview with the resident representative on 3/11/25 at 1:13 PM revealed the facility did not engage the resident in activities and staff could be more patient with the resident. The representative revealed staff approach with the resident could be better and it did not seem like staff were trained on dementia care as they did not allow the resident time to process requests or reapproach when the resident refused care. i. Interview with patient care tech #1 and RN #1 on 3/12/25 at 1:38 PM revealed the [NAME] Cottage should have a 1 to 1 for resident #20 and staff were unable to perform showers and other household duties, including activities which they were responsible for. Further interview revealed at that time there was 1 CNA, the RN, and the patient care tech on shift due to another CNA not showing up for the shift as scheduled and resident #20 was difficult to manage due to his/her behaviors. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	j. Interview with LPN #1 and CNA #2 on 3/12/25 at 2:44 PM revealed the activities director almost never came to the houses to do activities with the residents. The interview further revealed they don't do bingo anymore, and they used to do that a lot. The previous activities director used to frequently come around and do 1:1 activities like playing a game or doing crafts. Activities and 1:1 time were very helpful for the residents in [NAME] and Founders cottages who wander. They really benefited from the 1:1 time and were a lot more calm and less likely to wander as a result.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 35081 Based on medical record review, staff interview, and policy and procedure review, the facility failed to ensure residents' drug regimen was free of unnecessary drugs for 1 of 6 sample residents (#26) reviewed for unnecessary medications. The findings were: 1. Review of the physician orders for resident #26 showed the resident had an order for Cephalexin 250 milligrams (mg) 1 tablet by mouth one time a day for infection management which was ordered on 9/27/24 and didn't have a stop date. Review of a hospital discharge note-physician 9/26/24 showed the discharge plan indicated the resident had recurrent infection with no current symptoms and Cephalexin 250 mg was ordered daily for prophylaxis. Further review showed no evidence a physician rationale was provided for long-term antibiotic use. 2. Interview with the DON and administrator on 3/13/25 at 10:04 AM confirmed the physician had not provided rationale for the long-term use of the antibiotic. 3. Review of the policy titled Antibiotic Stewardship last revised on 8/20/23 showed .The Antibiotic Stewardship Committee Will: 1. Support and promote antibiotic use protocols which include: b. Therapeutic decisions regarding antibiotic prescriptions based on evidence (e.g., guidelines and consensus statements from clinical and academic societies) that is appropriate for the care of long-term facility residents .

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 35081 Based on observation, resident and staff interview, and recipe review, the facility failed to ensure palatable food was served to 1 of 4 resident cottages (Founders). The cottage census was 9. The findings were: 1. Observation on 3/12/25 at 12:06 PM showed the lunch meal was Creamy Chicken and [NAME] Soup; however, the soup appeared to have a thick texture with no visible fluid similar to clay. Interview with resident #6 at that time revealed the flavor was ok; however, the soup was supposed to be creamy and it was too thick to eat. Interview with resident #19 at that time revealed s/he did not want to discuss the meal because there was nothing good to say. 2. Interview with the dietitian on 3/12/25 at 4:06 PM confirmed the soup prepared for lunch was thicker than it should have been. She revealed the staff member who prepped the meal the previous night did not prepare it correctly and the dietitian had added broth to the recipe following the meal for future servings. Further interview confirmed there should have been broth in the soup. 3. Review of the recipe for Creamy Chicken [NAME] Soup a picture of the prepared meal which had visible liquid broth.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 35081 Based on staff interview, the facility failed to ensure a qualified infection preventionist was designated. The census was 28. The findings were: Interview with the facility administrator on 3/10/25 at 3:28 PM revealed the infection preventionist position was open and she was keeping up with the program with assistance from the hospital. Further interview confirmed there was nobody on staff who had completed specialized training in infection prevention and control. 51658

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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. 51658 Based on medical record review, staff interview and policy and procedure review, the facility failed to document if residents were educated about the benefits and potential side effects of the influenza and pneumococcal immunizations and if residents received the immunizations for 4 of 6 sample residents (#12, #14, #24, #28) reviewed for immunization status. The findings were: 1. Review of the immunization records for resident #12 showed there was no evidence of education, offer, refusal or receipt of a current pneumococcal immunization. 2. Review of the immunization records for resident #14 showed there was no evidence of education, offer, refusal or receipt of an annual influenza, current COVID-19, or current pneumococcal immunization. 3. Review of the immunization records for resident #24 showed there was no evidence of education, offer, refusal or receipt of an annual influenza or current pneumococcal immunization. 4. Review of the immunization records for resident #28 showed there was no evidence of education, offer, refusal or receipt of an annual influenza, current COVID-19, or current pneumococcal immunization. 5. Interview with the administrator and director of nursing on 3/13/25 at 9:35 AM revealed the facility should offer and encouraged all immunizations. Further interview confirmed the facility did not have evidence the immunizations were offered or provided for resident #12, #14, #24 and #28. 6. Review of facility policy titled Vaccination of Elders Policy last updated 3/3/22 showed .Prior to receiving vaccinations, the elder or legal representative will be provided information and education regarding the benefits and potential side effects of the vaccinations. Provision of such education shall be documented in the elder's medical record . If vaccinations are refused, the refusal shall be documented in the elder's medical record. If the elder receives a vaccination, at least the following information shall be documented in the elder's medical record: a. Site of administration, b. Date of administration, c. Lot number of the vaccine, d. Expiration date, e. Name of person administering the vaccine .