STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555229	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Healthcare Center	1205 8th Street Bakersfield, CA 93304

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35649 Based on observation, interview, and record review, the facility failed to provide a language-assistance service for one of one sampled resident (Resident 64). This failure had the potential for unmet care needs. Findings: During a concurrent observation and interview on 3/25/24 at 7:05 a.m. in Resident 64's room, Resident 64 was seated at the edge of the bed trying to say something in [NAME] (language native to the Punjab region of Pakistan and [NAME]). Certified nursing assistants (CNA) 2 and CNA 3 entered Resident 64's room. CNA 3 spoke in one syllable words and made gestures to communicate with Resident 64. Resident 64 and CNA 3 could not clearly communicate and understand each other. Resident 64 put both her elbows on the overbed table, held her hair and put her head down. During an interview on 3/25/24 at 7:10 a.m. with CNA 3, CNA 3 stated she (CNA 3) communicated with Resident 64 using body language and action. CNA 3 stated Resident 64 understood bathroom. CNA 3 stated there are two staff members who speak the [NAME] language, but she (CNA 3) had to use Google Translate to communicate with Resident 64, whenever we have to ask Resident 64 questions. CNA 3 stated the facility does not have a translation service. CNA 3 stated it was very difficult to care for Resident 64 because it was hard to understand her. CNA 3 stated, I feel frustrated sometimes because I do not know what she (Resident 64) wants. During an interview on 3/25/24 at 12:06 p.m. with Administrator-in-Training (AIT), AIT stated there were two non-English speaking residents (Resident 64 and Resident 6). AIT stated the facility ensured the staff assigned to provide care for Resident 64 and Resident 6 spoke the residents' language. [Resident 64] speaks [NAME] and Resident 6 speaks Farsi (the official language of [NAME]). AIT stated, We have to call the staff-on-call at home if needing translation. For Farsi, we contact the Ombudsman for social services. AIT stated the use of Google Translate is not acceptable, make sure it is a native speaker. AIT stated, We do not have a translation service. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Translation or Interpreter Services, dated 6/1/21, the P&P indicated, 1. During Admission, facility staff will conduct an initial language assessment and notify the Social Services Department of the resident's need for translation or interpreter services. The Director of Social Services or his/her designee is the coordinator of the Facility's translation and interpretation services. Qualified interpreters are defined as those who have demonstrated proficiency in speaking and understanding at least spoken English and the spoken language in need of interpretation; and are able to interpret effectively, accurately, and impartially, both receptively and expressly, to and from such language(s) and English. using any necessary specialized vocabulary, terminology, and phraseology.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 42744 Based on observation, interview, and record review, the facility failed to ensure two of two sampled residents (Resident 15 and Resident 26) had access to a call light. This failure had the potential for unmet care needs. Findings: During a concurrent observation and interview on 3/25/24 at 10:37 a.m. with Resident 26, in Resident 26's room, Resident 26 was sitting on her bed with no call light visible. Resident 26 stated she knew how to call for help and pointed to the bed's remote control attached to the side rail. During a concurrent observation and interview on 3/25/24 at 10:40 a.m. with Certified Nursing Assistant (CNA) 4, CNA 4 retrieved Resident 26's call light from the floor at the end of her roommate's bed and attached it to Resident 26's side rail. CNA 4 stated the call light should have been where Resident 26 could reach it. 35649 During a concurrent observation and interview on 3/25/24 at 8:51 a.m. with Resident 15, in Resident 15's room, the call light was hanging on the wall located in the back of Resident 15's headboard. Resident 15 was unable to find his call light in his bed. Resident 15 stated he could push the call light, but the call light is not here. During a concurrent observation and interview on 3/25/24 at 8:55 a.m. with Licensed Vocational Nurse (LVN) 1, the call light was hanging on the wall in the back of the headboard. LVN 1 stated Resident 15's call light was on the wall. LVN 1 stated definitely, the call light should be within resident's reach. During a review of the facility's policy and procedure (P&P) titled, Call Lights, dated 7/02, the P&P indicated, All residents are provided with a call system that they are able to operate. 4. The call light will be put within reach of the resident.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 46958 Based on interview and record review, the facility failed to follow their policy and procedure (P&P) titled Notification of Responsible Party, when the responsible party was not notified of a change of condition for one of four sampled residents (Resident 17). This failure had the potential to result in family not being involved in Resident 17's care. Findings: During a concurrent interview and record review on 3/26/24 at 2:33 p.m. with Treatment Nurse (TN), Resident 17's eInteract Change in Condition Evaluation-V 5.1 (COC), dated 2/25/2024, was reviewed. The COC indicated, Resident 17 had a skin tear on toe and under Resident Representative notification had self. TN stated, Resident 17 doesn't have capacity to make her own decisions. TN stated Resident 17 had the COC on 2/25/24. TN stated Resident 17's representative was never notified about Resident 17's COC. During a record review of Resident 17's History and Physical Examination (H&P), dated February 2024, the H&P indicated, [Resident 17] does not have the capacity to understand and make health care decisions. During an interview on 3/26/24 at 2:07 p.m. with Resident 17's Responsible Party (RP) 1, RP 1 stated she last heard from facility on 12/15/23. During a review of the facility's P&P titled, Notification of Responsible Party, [undated], the P&P indicated, The appropriate resident's responsible party is to be notified upon admission, discharge, and or for any significant change of condition. Policy: It is the facility's policy that the appropriate resident's responsible party is notified of any changes involving the resident's health. 5. The charge nurse is responsible for notifying the responsible party of the significant change in condition.

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prepare residents for a safe transfer or discharge from the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35649 Based on interview and record review, the facility failed to provide accurate transfer/discharge documents signed by the Responsible Party for one of one sampled resident (Resident 55) with dementia (group of symptoms affecting memory, thinking and social abilities). This failure had the potential to result in an unsafe and unorderly transfer for Resident 55 without the family being aware. Findings: During a review of Resident 55's Admission Record (AR), the AR indicated, Resident 55 is an [AGE] year-old-female admitted on [DATE] with diagnosis including, Unspecified Dementia, Anxiety Disorder (intense, excessive, and persistent worry and fear about everyday situations), and Adult Failure to Thrive (group of symptoms including weight loss, decreased appetite and poor nutrition, and inactivity accompanied by dehydration and depression). During a review of Resident 55's Minimum Data Set (MDS-resident assessment tool), the MDS Section C-Cognitive [thinking, reasoning, remembering ability] Patterns, dated 11/17/23, indicated, BIMS [Brief Interview for Mental Status-a point system ranging from 0 to 15: 0 to 7 points: severe cognitive impairment, 8 to 12 points: moderate cognitive impairment, 13 to 15 points: cognition intact] Score: Three. During a concurrent interview on 3/26/24 at 11:54 a.m. with Social Services Director (SSD), SSD stated Resident 55's Family Member (FM 1) requested that (Resident 55) be placed in an assisted living (for people who need help with daily care, but not as much help as a nursing home provides) residence in Fresno where (Resident 55) could be close to FM 1. SSD stated arrangements were being made for (Resident 55)'s transfer, although not in Fresno. SSD stated the facility was just waiting for FM 1 to sign the transfer documents. During a concurrent interview and record review on 3/26/24 at 12 PM with SSD, Resident 55's transfer packet was reviewed. The transfer packet included, but not limited to the following documents: Consent for Telehealth, Patient Consent to Receive Services and Certification, Authorization to Release Personal and Health Information, Assisted Living Waiver Amenity Form, Assisted Living Waiver Patient's Rights, and Assisted Living Freedom of Choice Form. Resident 55 signed the above documents on 11/28/23. SSD stated she was aware [Resident 55]'s BIMS Score was three (severe cognitive impairment), and her mental status was not stable. SSD stated, I am aware and have a copy of the physician certification that stipulated [Resident 55] did not have the capacity to understand and make healthcare decisions. [Resident 55] cannot sign and make decisions for herself. During a review of Resident 55's History and Physical (H&P), dated 9/18/23, the H&P indicated, [Resident 55] does not have the capacity to understand and make healthcare decisions. During an interview on 3/26/24 at 12:15 p.m. with Resident 55's FM 1, FM 1 stated [Resident 55] had never signed any documents regarding her healthcare. FM 1 stated [Resident 55] does not have the capacity to understand and sign documents. (continued on next page)

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/26/24 at 12:30 p.m. with SSD, SSD stated, I do not know who signed for [Resident 55]. During an interview on 3/26/24 at 12:13 p.m. with FM 1, FM 1 stated, [Resident 55] is not capable of signing any paperwork. I sign all the paperwork/document for [Resident 55]. I am not aware [Resident 55] signed transfer documents; nobody notified me. FM 1 asked, Am I being forced to move [Resident 55] out. During a review of the facility's policy and procedure (P&P) titled, Notification of Responsible Party, [undated], the P&P indicated, The appropriate resident's responsible party is to be notified upon admission, discharge, and or for any significant changes of condition. Policy: It is the facility's policy that the appropriate residents responsible party is notified of any changes involving the resident's health.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46958 Based on interview and record review, the facility failed to ensure activity assessments were completed for 16 of 16 sampled residents (Resident 6, Resident 9, Resident 12, Resident 27, Resident 60, Resident 82, Resident 135, Resident 185, Resident 200, Resident 201, Resident 202, Resident 203, Resident 204, Resident 205, Resident 206, Resident 207). This failure had the potential for residents to not meet their physical, mental, and psychosocial well-being. Findings: During a concurrent interview and record review on 3/26/24 at 2:41 p.m. with Activity Director (AD), Resident 60's Admission Record (AR), dated 3/18/24, was reviewed. The AR indicated, Resident 60 was admitted on [DATE]. AD stated, Resident 60 did not have activity assessment completed. During a concurrent interview and record review on 3/26/24 at 2:46 p.m. with AD, Resident 200's AR, dated 3/13/24 was reviewed. The AR indicated, Resident 200 was admitted on [DATE]. AD stated, Resident 200 did not have activity assessment completed. During a concurrent interview and record review on 3/26/24 at 2:47 p.m. with AD, Resident 135's AR, dated 3/16/24 was reviewed. The AR indicated, Resident 135 was admitted on [DATE]. AD stated, Resident 135 did not have activity assessment completed. During a concurrent interview and record review on 3/26/24 at 2:48 p.m. with AD, Resident 12's AR, dated 2/16/24 was reviewed. The AR indicated, Resident 12 was admitted on [DATE]. AD stated, Resident 12 did not have activity assessment completed in 7 days. During a concurrent interview and record review on 3/26/24 at 2:50 p.m. with AD, Resident 9's AR, dated 3/18/24 was reviewed. The AR indicated, Resident 9 was admitted on [DATE]. AD stated, AD stated, Resident 9 did not have activity assessment completed. During a concurrent interview and record review on 3/26/24 at 2:52 p.m. with AD, Resident 201's AR, dated 2/27/24 was reviewed. The AR indicated, Resident 201 was admitted on [DATE]. AD stated, Resident 201 did not have activity assessment completed in 7 days. During a concurrent interview and record review on 3/26/24 at 2:53 p.m. with AD, Resident 27's AR, dated 2/27/24 was reviewed. The AR indicated, Resident 27 was admitted on [DATE]. AD stated, Resident 27 did not have activity assessment completed. During a concurrent interview and record review on 3/26/24 at 2:54 p.m. with AD, Resident 202's AR, dated 2/22/24 was reviewed. The AR indicated, Resident 202 was admitted on [DATE]. AD stated, Resident 202 did not have activity assessment completed. During a concurrent interview and record review on 3/26/24 at 2:55 p.m. with AD, Resident 6's AR, dated 2/22/24 was reviewed. The AR indicated, Resident 6 was admitted on [DATE]. AD stated, Resident 6 did not have activity assessment completed. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent interview and record review on 3/26/24 at 2:56 p.m. with AD, Resident 203's AR, dated 3/7/24 was reviewed. The AR indicated, Resident 203 was admitted on [DATE]. AD stated, Resident 203 did not have activity assessment completed. During a concurrent interview and record review on 3/26/24 at 2:57 p.m. with AD, Resident 204's AR, dated 3/13/24 was reviewed. The AR indicated, Resident 204 was admitted on [DATE]. AD stated, Resident 60 did not have activity assessment completed. During a concurrent interview and record review on 3/26/24 at 2:58 p.m. with AD, Resident 82's AR, dated 2/26/24 was reviewed. The AR indicated, Resident 82 was admitted on [DATE]. AD stated, Resident 82 did not have activity assessment completed in 7 days. During a concurrent interview and record review on 3/26/24 at 3 p.m. with AD, Resident 205's AR, dated 3/6/24 was reviewed. The AR indicated, Resident 205 was admitted on [DATE]. AD stated, Resident 205 did not have activity assessment completed in 7 days. During a concurrent interview and record review on 3/26/24 at 3:01 p.m. with AD, Resident 206's AR, dated 3/12/24 was reviewed. The AR indicated, Resident 206 was admitted on [DATE]. AD stated, Resident 206 did not have activity assessment completed in 7 days. During a concurrent interview and record review on 3/26/24 at 3:02 p.m. with AD, Resident 185's AR, dated 3/17/24 was reviewed. The AR indicated, Resident 185 was admitted on [DATE]. AD stated, Resident 185 did not have activity assessment completed done in 7 days. During a concurrent interview and record review on 3/26/24 at 3:04 p.m. with AD, Resident 207's AR, dated 3/14/24 was reviewed. The AR indicated, Resident 207 was admitted on [DATE]. AD stated, Resident 207 did not have activity assessment completed in 7 days. During an interview on 3/26/24 at 3:06 p.m. with AD, AD stated Activity assessment should be done within 7 days of admission. AD stated the purpose of activity assessment is to find out what is the best activity for each resident. AD stated activities will improve the residents' mental health. During a review of the facility's policy and procedure (P&P) titled, Activity Assessment/Care Plan, dated 2021, the P&P indicated, To assess each resident's preferences for customary routine and activity interests, and to develop an individualized Care Plan for each resident. Within seven (7) days of a resident's admission to the Facility, an activity assessment is completed by the Activity Director or designee to assist in developing an Activities Care Plan that reflects the choices and preferences of the resident. As appropriate, the Interdisciplinary Team (IDT) may use information from the Activity Assessment to develop care plans to address resident needs.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure that each resident's assessment is updated at least once every 3 months. 42744 Based on interview and record review, the facility failed to ensure three of five sampled residents (Resident 43, Resident 52, and Resident 3) had Minimum Data Set (MDS- resident assessment tool) assessments completed timely. This failure had the potential to result in unidentified health problems. Findings: During a concurrent interview and record review on 3/28/24 at 10:21 a.m. with MDS Coordinator (MDSC) 1, Resident 43's Quarterly MDS assessment, dated 12/31/23, was reviewed. Resident 43's Quarterly MDS Assessment indicated a status titled, Export Ready. MDSC 1stated the Quarterly MDS assessment was completed on 3/20/24 but had not been transmitted. MDSC 1 stated, Yes, it is late. During a concurrent interview and record review on 3/28/24 at 10:28 a.m. with MDSC 1, Resident 52's Quarterly MDS assessment, dated 12/29/23, was reviewed. Resident 52's Quarterly MDS Assessment indicated a status titled, Export ready. MDSC 1 stated Resident 52's Quarterly MDS assessment had not been sent and was late. During a concurrent interview and record review on 3/28/24 at 10:29 a.m. with MDSC 1, Resident 3's Annual MDS assessment, dated 1/24/24, was reviewed. Resident 3's Annual MDS Assessment indicated a status titled, In Progress. MDSC 1 stated Resident 3's Annual MDS assessment was in progress and had not been submitted. MDSC 1 stated comprehensive assessments of residents must be submitted quarterly and annually in a timely manner. During a review of the facility's policy and procedures (P&P) titled, Policy Statement Resident Assessments, dated 11/19, the P&P indicated, A comprehensive assessment of every resident's needs is made at intervals designated by OBRA [Omnibus Budget Reconciliation Act- also known as the Nursing Home Reform Act] and PPS [Prospective Payment System- a method of reimbursement for Medicare payments] requirements. 1. The resident assessment coordinator is responsible for ensuring that the interdisciplinary team conducts timely and appropriate resident assessments and reviews according to the following requirements: a. OBRA required assessments- conducted for all residents in the facility: . (2) Quarterly Assessment- Conducted not less frequently than three (3) months following the most recent OBRA assessment of any type; . (4) Annual Assessment (Comprehensive)- Conducted not less than once every twelve (12) months.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35649 Based on interview and record review, the facility failed to ensure four of four sampled residents (Resident 15, Resident 19, Resident 56, and Resident 209) received a summary of the Baseline Care Plan (BCP-the minimum healthcare information necessary to properly care for each resident immediately upon their admission) within 48 hours of admission. This failure had the potential for unmet care needs for Resident 15, Resident 19, Resident 56, and Resident 209. Findings: During a review of Resident 15's Admission Record (AR), the AR indicated, Resident 15 was readmitted on [DATE] after a recent hospitalization . Resident 15 had a diagnosis including Type 2 Diabetes Mellitus (DM-high levels of blood sugar) with Polyneuropathy (a complication of diabetes mellitus characterized by progressive death of nerve fibers, which leads to loss of nerves, increased sensitivity, and development of foot ulcers), and Hemiplegia (one-sided paralysis)/hemiparesis (loss of strength in the arm, leg, and face on one side of the body) affecting the left dominant side. During a concurrent interview and record review on 3/26/24 at 3:59 p.m. with Minimum Data Set (MDS-resident assessment tool) Coordinator (MDSC) 1, Resident 15's BCP, dated 2/29/24, was reviewed. The BCP indicated, the sections for social services and rehabilitation services were incomplete. MDSC 1 stated Resident 15 was not provided a copy of the baseline care plan summary as there was no signature of the resident or Resident 15's representative indicating receipt of the BCP. During a review of Resident 19's AR, the AR indicated, Resident 19 was admitted on [DATE] with diagnosis including Metabolic Encephalopathy (a problem in the brain caused by a chemical imbalance in the blood due to illness or organs that are not working as well as they should), Sepsis (a serious condition in which the body responds improperly to an infection), and Altered Mental Status (a change in mental function that stems from illnesses, disorders, and injuries affecting one's brain). During a concurrent interview and record review on 3/26/24 at 4:05 p.m. with MDSC 1, Resident 19's BCP, dated 1/22/24, was reviewed. BCP indicated Nursing, Social Services, Physical Therapy, and Dietary Services entered a brief assessment and plan of care. MDSC 1 stated there was no signature of Resident 19's representative on the BCP indicating receipt of the BCP. During a review of Resident 56's AR, the AR indicated Resident 56 was admitted on [DATE] with diagnosis including Unspecified Dementia (a disease affecting memory, thinking and social abilities) without behavioral disturbance, Type 2 Diabetes Mellitus (a disease characterized by high blood sugar), and Mood Disorder (psychiatric conditions that affect a person's emotional state, leading to periods of joy, mania [state of elevated energy, mood, and behavior], sadness, and/or depression). During a concurrent interview and record review on 3/26/24 at 4:10 p.m. with MDSC 1, Resident 56's BCP, dated 11/6/23, was reviewed. The BCP indicated Nursing, Social Services, Dietary, Physical Therapy, and Activities entered a brief assessment and plan of care three days after Resident 56 was admitted . MDSC 1 stated Resident 56 was not provided his baseline care plan summary within 48 hours of admission. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	39763 During a concurrent interview and record review, on 3/19/24 at 3:41 p.m. with Director of Nursing (DON), Resident 209's BCP, dated 2/18/24, was reviewed. DON stated Resident 209's BCP was not completed . During a review of the facility's policy and procedure (P&P) titled Care Plans- Baseline, undated, the P&P indicated, 1. To assure that the resident's immediate care needs are met and maintained, a baseline care plan will be developed with in forty-eight (48) hours of the resident's admission. 3. The baseline care plan will be until the staff can conduct the comprehensive assessment and develop an interdisciplinary person -centered care plan. During a review of the facility's policy and procedure (P&P) titled, Admission Assessment and Follow UP: Role of the Nurse. dated 9/2012, the P&P indicated, Gather information about the resident's physical, emotional, cognitive, and psychosocial condition upon admission for the purposes of managing the resident, initiating the care plan .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37697 Based on interview and record review, the facility failed to develop and implement a care plan for two of two sampled residents (Resident 208 and Resident 55). This failure had the potential for negative outcomes. Findings: 1. During a review of Resident 208's Progress Notes (PN), dated 1/24/24, at 7:46 p.m., the PN indicated Resident 208 refused to go to the hospital for an unidentified change of condition. During a review of Resident 208's PN dated 1/29/24 at 7:10 a.m. the PN indicated Resident 208 refused to have his blood sugar checked. During a review of Resident 208's PN dated 2/16/24 at 8:10 p.m. the PN indicated Resident 208 had a blood pressure (the pressure of blood pushing against the walls of your arteries [blood vessel]) of greater than 240/110 (extremely high, normal range is 120/80) despite being given two medications to control it. Resident 208 refused to be sent out for higher level of care. During a review of Resident 208's PN dated 3/2/24 at 11:01 a.m. the PN indicated Resident 208 refused to take his medications, refused his blood sugar checked and refused to go to dialysis (mechanical process of filtering the blood when the kidneys are not working). During a review of Resident 208's IDT Note (IDTN), dated 3/1/24, the IDTN indicated, Resident 208, has been refusing medications here and there ever since he first came into the facility and or he tells licensed nursing staff to come back at another time that is more convenient to him after being encouraged plenty of times of the importance of staying on schedule. The resident [Resident 208] is nice as far as is behavior, however, stubborn and wants things done his way which can most definitely complicate his health issues. Blood sugar can also fluctuate do [sic] to his refusal and or him wanting to change the times of blood sugar checks. During a review of Resident 208's IDTN, dated 3/13/24, the IDTN indicated, Resident 208, DON [Director of Nursing] explained to family that on multiple occasions patient [Resident 208] refused treatment and to be sent to hospital. During a concurrent interview and record review on 3/19/24 at 12:20 p.m. with DON, Resident 208's Electronic Health Record (EHR) dated January 2024 to March 2024 was reviewed. DON reviewed the EHR, and stated Resident 208 did not have a care plan in place for noncompliance with care, refusing medications, refusing dialysis and for refusing care. DON stated there should be specific care plans in place for Resident 208 regarding any issues that complicate his care, and the care plans should not be vague. 35649 (continued on next page)

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	555229	A. Building B. Wing	03/28/2024

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During a concurrent interview and record review on 3/19/24 at 3:41 p.m. with DON, DON reviewed Resident 55's medical record. DON stated Resident 55 fell on [DATE]. DON was unable to provide documented evidence the facility developed and implemented a care plan for Resident 55 fall on 3/12/24, DON stated a care plan should have been developed and implemented. During a review of the facility's policy and procedure (P&P) titled Assessment and Management of Residents Falls, undated, the P&P indicated, It is the policy . to prevent falls among resident as humanly possible and to provide interventions that may address resident's specific risks and causes of residents falls . Cause Identification 1. For an individual who has fallen, staff will attempt to define possible causes within 24 hours of the fall . Treatment/Management 1. Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and address risks of serious consequences of falling. During a review of the facility's policy and procedure (P&P) titled, Goals and Objectives, Care Plans, dated 4/2009, the P&P indicated, Care plans shall incorporate goals and objectives that lead to the resident's highest obtainable level of independence. Care plan goals and objectives are defined as the desired outcome for a specific resident problem. When goals and objectives are not achieved, the resident's clinical record will be documented as to why the results were not achieved and what new goals and objectives have been established. Care plans will be modified accordingly. Goals and objectives are entered on the resident's care plan so that all disciplines have access to such information and are able to report whether or not the desired outcomes are being achieved.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 39763 Based on interview and record review the facility failed to administer medication according to the physician's order for one of three sampled residents (Resident 209). This failure had the potential for adverse outcomes for Resident 209. Findings: During a concurrent interview and record review on 3/26/24 at 10:12 a.m. with Director of Nursing (DON). DON reviewed Resident SC's Medication Administration Record, (MAR) dated 2/2024. DON confirmed the following: Percocet [combination of medication used to relieve severe pain] Oral Tablet 10-325 MG [milligram- unit of measure] .Give 1 tablet by mouth every 4 hours as needed for severe pain (7-10) . -Order Date- 2/19/2024 1543 [3:43 p.m.] 2/18/24 at 12:30 a.m., Percocet was administered for a pain level of 5. 2/18/24 at 4:47 a.m., Percocet was administered for a pain level of 6. 2/19/24 at 4:53 a.m., Percocet was administered for a pain level of 5. 2/20/24 at 6:30 a.m., Percocet was administered for a pain level of 6. 2/22/24 at 6:17 a.m., Percocet was administered for a pain level of 5. DON stated Percocet was given outside of physician ordered pain scale five times. DON stated nurses should follow the order, go off the pain scale and contact the physician if adjustments need to be made. During a review of the facility's policy and procedure (P&P) titled, Administering Medications, revised April 2019, the P&P indicated, Medications are administered in a safe and timely manner, and as prescribed . 4. Medications are administered in accordance with prescriber orders, including any required time frames.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 37697 Based on interview and record review, the facility failed to: 1. Notify a Medical Doctor (MD) of a change in one of three sampled residents (Resident 208) condition. 2. Conduct an Interdisciplinary team (IDT - a group of various professionals that coordinate assessment and treatment for residents, so that problems can be dealt with consistently and comprehensively) for one of three sampled residents' (Resident 208) change in condition. These failures had the potential for Resident 208 to not obtain the proper treatment, not have consistent care given, not identify the best course of action for Resident 208's concerns, and potentially lead to harm up to and including death. 1. During a review of Resident 208's Progress Notes (PN), dated 2/16/24 at 8:10 p.m, the PN indicated Resident 208 had a blood pressure (the pressure of blood pushing against the walls of your arteries [blood vessel]) of 240/110 (extremely high, normal range is 120/80) despite being given two medications to control it. Resident 208 refused to be sent out for higher level of care. During a concurrent interview and record review on 3/19/24 at 12:20 p.m. with Director of Nursing (DON), Resident 208's Electronic Health Record (EHR) dated January 2024 to March 2024 was reviewed. DON stated there was no documentation that Resident 208's MD was notified on 2/16/24. DON stated MD should have been informed, Due to the possibilities with complications that the resident [Resident 208] may have. 2. During a concurrent interview and record review on 3/19/24 at 11:54 a.m. with Treatment Nurse (TN), Resident 208's Care Plans (CP) were reviewed. The CP indicated the following: A. On 11/29/23 Resident 208 was noted to have acquired at the facility a pressure wound (an injury that breaks down the skin and underlying tissue) stage 4 (involves the muscle and/or bone) to his right thigh. B. On 1/26/24 Resident 208 was noted to have skin abrasions (minor wounds) to his left and right middle finger. C. On 3/1/24 Resident 208 was noted to have necrotic (dead) tissue to his right hand, multiple fingers (not specific) and left second toe. TN stated an IDT was not done for the wound issues on 11/29/23, 1/26/24 and 3/1/24. TN stated an IDT should have been done, To notify [facility] staff and everyone [facility staff] can be aware of what to do. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/19/24 at 12:20 p.m. with DON, DON stated the facility process for any resident with new wounds is, [New wounds are] a change of condition, MD is notified, document [the wounds in resident chart], [obtain an] MD order to treat wound, [an] IDT meeting [to be done] to make sure facility [staff] is all on the same page and inform the family what is going on. During a review of the facility's policy and procedure (P&P) titled, Change in a Resident's Condition Status, dated 5/2017, the P&P indicated, Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status . The nurse will notify the resident's Attending Physician or physician on call when there has been a(an) . significant change in the resident's physical/emotional/mental condition . need to alter the resident's medical treatment significantly . need to transfer the resident to a hospital/treatment center. a 'significant change' of condition is a major decline or improvement in the resident status that . will not normally resolve itself without intervention by staff .

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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. 42744 Based on observation, interview, and record review the facility failed to: 1. Provide preventive measures for pressure injuries (break down of the skin and underlying tissue) for one of two sampled residents (Resident 5). 2. Ensure weekly wound assessments for two of two sampled residents (Resident 5 and Resident 21). These failures had the potential to result in the development of additional pressure injuries and the inability to determine the healing progress of current wounds. Findings: 1. During a review of Resident 5's Admission Record (AR), dated 3/27/24, the AR indicated Resident 5 diagnoses included quadriplegia (paralysis of all four limbs), cellulitis (skin infection) of buttocks, muscle wasting and atrophy (decrease in size) of both shoulders, generalized muscle weakness, reduced mobility, and a history of Stage 2 pressure injury (partial thickness loss of skin cause by pressure or shearing forces presenting as a shallow ulcer or fluid filled blister) to right buttocks. During a review of Resident 5's Minimum Data Set (MDS-resident assessment tool)- Section M- Skin Conditions, dated 12/18/23, the MDS indicated, Risk of Pressure Ulcers 1. Yes was checked. The MDS indicated Resident 5 had two Stage 2 pressure ulcers present. The MDS indicated, Skin and Ulcer Treatments. B. Pressure reducing device for bed was checked. During a concurrent observation and interview on 3/26/24 at 10:26 a.m. with Treatment Nurse (TN) 1 in Resident 5's room, TN 1 changed Resident 5's dressings. Resident 5 had dressings to a left knee abrasion, right second toe pressure injury, right outer ankle pressure injury, right forearm skin tear, and a sacrococcygeal area (tailbone and surrounding skin pressure injury. TN 1 placed non-padded dressings over bony prominence's (areas where the bone is close to the surface of the skin) during the dressing changes. TN 1 stated she was aware that padded dressings were available but were not used for Resident 5. Resident 5's entire tailbone area was discolored. Resident 5 was on a regular mattress. A pillow was on the nightstand, at the end of the bed. TN 1 stated Resident 5 had a regular mattress. TN 1 stated the pillow was sometimes used to lift Resident 5's right ankle off the bed. During an interview on 3/26/24 at 10:46 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 5 had a regular mattress. LVN 1 stated, I think he [Resident 5] should have a pressure relieving mattress. I'm not sure why he [Resident 5] doesn't have one. LVN 1 stated staff makes sure Resident 5 had a pillow under his right calf. LVN 1 stated Resident 5 did not have any other heel or ankle protective devices. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/27/24 at 8:10 a.m. with Director of Nursing (DON), DON stated for prevention of pressure ulcers, repositioning and good skin care was important, especially over bony prominences. DON stated the facility does not use Mepilex (a popular brand of foam dressings) dressings. DON stated Resident 5 moves a lot and creates friction on his ankle. DON stated more pressure reducing preventive measures could be implemented for Resident 5. During an interview on 3/27/24 at 10:41 a.m. with Resident 5, Resident 5 stated, They have never offered me anything. Absolutely in a heartbeat, I would accept an air mattress. Resident 5 stated he was up in his wheelchair for extended lengths of time, sometimes waiting two to three hours to be put back to bed. Resident 5 stated he believed this was the cause of his skin breakdown. Resident 5 stated staff told him he was too hard to deal with and if they put him back to bed, then they would not be able to get him up again. Resident 5 stated a treatment plan was initiated a few months ago to roll him side to side to prevent skin issues but it was not followed through. During a review of the facility's Policy and Procedure (P&P) titled, Pressure Ulcers/Skin Breakdown- Clinical Protocol, (undated) the P&P indicated, Treatment/Management 1. The physician will authorize pertinent orders related to wound treatments, including pressure reduction surfaces, wound cleansing and debridement approaches, dressing (occlusive [a type of wound dressing that provides a healing environment], absorptive, etc.), and application of topical agents. During a review of the facility's P&P titled, Pressure Ulcer Risk Assessment, (undated) the P&P indicated, Additional factors That Indicate Residents at Risk. The following are additional clinical conditions, treatments, and abnormal lab values that indicate that a resident is at risk: . 3. Paraplegia (loss of movement in two limbs)/ quadriplegia (loss of movement in four limbs). 2. During a concurrent interview and record review on 3/27/24 at 3:54 p.m. with TN 1, Resident 5's Skin Observation Tool (SOT), dated 2/22/24 was reviewed. The SOT indicated Resident 5 had the following pressure injuries: a. Right top of the second toe- measuring 1 centimeter (cm) in length and 1 cm in width; b. Right outer ankle - suspected Deep Tissue Injury (serious pressure injury, progresses rapidly from purplish discoloration to full-thickness skin and soft tissue loss) - measuring 2.5 cm in length, 2.5 cm in width, and 0.2 cm in depth; c. Tailbone - Unstageable Pressure Injury (full thickness skin loss covered by yellowish or blackish dead skin)- measuring 26 cm in length, 28 cm in width, and 0.2 cm in depth. The SOT indicated, Seen by Wound specialist [WS] on 2/21/24 with new wound treatment orders verified and carried out. TN 1 stated Resident 5's pressure injuries were first discovered on 2/21/24, documented by the WS in a visit report, and documented on the SOT on 2/22/24 by the treatment nurse. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 3/27/24 at 4:10 p.m. with TN 1, Resident 5's Wound-Weekly Observation Tool (WWOT), dated 2/29/24 was reviewed. The WWOT indicated Resident 5 was seen by WS on 2/28/24. The WWOT indicated Resident 5's pressure injury to the right outer ankle, acquired on 2/21/24, was now a Stage 3 pressure injury (full thickness tissue loss). TN 1 stated wounds should be assessed weekly, and their progress should be documented on the WWOT by the treatment nurse. TN 1 stated this was the last assessment and documentation on the WWOT for Resident 5's pressure injury to the right lateral malleolus. TN 1 stated Resident 5 was up in a wheelchair on 3/13/24 so was not assessed by the WS. TN 1 stated the WS did not see residents on 3/20/24 or 3/27/24, so no wound assessments were done. TN 1 stated she changed Resident 5's dressing on those dates but did not complete a wound assessment or document on the WWOT. During an interview on 3/27/24 at 4:15 p.m. with TN 1, TN 1 stated wounds should be assessed weekly, and their progress should be documented on the WWOT by the treatment nurse. TN 1 stated Resident 5's pressure wounds were not assessed, and weekly documentation was not done on 3/13/24, 3/20/24, and 3/27/24. During an interview on 3/28/24 at 8:42 a.m. with Director of Nursing (DON), DON stated, weekly assessments should have been done for all of Resident 5's wounds. During a concurrent interview and record review on 3/28/24 at 9 a.m. with TN 2, Resident 5's WWOTs, dated 2/29/24, and 3/7/24, were reviewed. TN 2 stated no other WWOTs were found for Resident 5. TN 2 stated wounds should be assessed and documented on weekly. TN 2 stated if the WS was not here, then the treatment nurses were responsible for the weekly documentation. 46958 During an interview on 3/27/24 at 1:51 p.m. with TN 1, TN 1 stated a wound assessment should be done once a week until wound is healed. During a concurrent interview and record review on 3/27/24 at 1:52 p.m. with TN 1, Resident 21's WWOT, [undated] was reviewed. TN 1 stated Resident 21's wound on sacrum started on 11/4/23 and reopened on 1/29/24. TN 1 stated there were no assessments from 11/4/23 through 1/29/24 to monitor Resident 21's wound. During an interview on 3/27/24 at 2:23 p.m. with DON, DON stated there should be a wound assessment done once a week. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's Policy and Procedure (P&P) titled, Wound Management, dated 11/1/17, the P&P indicated, Purpose. To provide a system for the treatment and management of residents with wounds including pressure and non-pressure ulcers. Policy. A resident who has a wound will receive necessary treatment and services to promote healing, prevent infection and prevent new pressure ulcers from developing. Procedure. I. Assessment. A. A licensed Nurse will perform a skin assessment upon admission, readmission, weekly and as needed for each resident. III. Documentation . B. Wound documentation will occur at a minimum of weekly until the wound is healed. Documentation will include: i. Location of wound. ii. Length, width, and depth measurements recorded in centimeters. Iii. Direction and length of tunneling and undermining (if applicable). Iv. Appearance of wound base. V. Drainage amount and characteristics including color, consistency, and odor. vi. Appearance of wound edges. vii. Description of the peri-wound condition or evaluation of the skin adjacent to the wound. viii. Presence or absence of new epithelium and wound rim. ix. Presence of pain. During a review of the Treatment Nurse Job Description (TNJD), [undated] the TNJD indicated, GENERAL DUTIES AND RESPONSIBILIES: CLINICAL . Document skin assessment findings during the weekly assessment on weekly Nurse's Skin Wound Progress Report form .

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F 0687 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35649 Based on observation, interview, and record review, the facility failed to ensure Licensed Vocational Nurses (LVN) 2 and LVN 4 performed skin assessment through direct observations, licensed nurses developed a care plan for the condition of the feet, licensed nurses notified the attending physician regarding the condition of the feet, Certified Nursing Assistant (CNA) 2 reported to the licensed nurses the condition of the feet, CNAs documented their observations of the condition of the feet using the facility's Comprehensive Certified Nursing Assistant Shower Review Form (CCNASRF), and the podiatrist provided appropriate medical foot care and treatment for two of two sampled residents (Resident 15 and Resident 36). This failure resulted in pain, discomfort, and neglect (state of not receiving enough care or attention) of Resident 15 and Resident 36's skin and foot care. Findings: During a review of Resident 15's Admission Record (AR), the AR indicated, Resident 15 is an [AGE] year old male, admitted on [DATE] and readmitted on [DATE] after recent hospitalization , with diagnosis including, Chronic Obstructive Pulmonary Disease (COPD- lung disease that causes airflow blockage and breathing-related problems), Type 2 Diabetes Mellitus (DM-characterized by high blood sugar) with Polyneuropathy (a complication of diabetes mellitus characterized by progressive death of nerve fibers, which leads to loss of nerves, increased sensitivity, and development of foot ulcers), and Hemiplegia (one-sided paralysis)/hemiparesis (loss of strength in the arm, leg, and face on one side of the body) affecting the left dominant side. During a concurrent observation and interview on 3/25/24 at 9:48 a.m. with Resident 15, in Resident 15's room, Resident 15 was lying in bed, awake and conversant, with the lower portion of the body covered with a blanket. Resident 15 was unable to move the left side of his body, and complained of pain on the left knee. During a concurrent observation and interview on 3/25/24 at 9:50 a.m. with CNA 1, in Resident 15's room, CNA 1 pulled Resident 15's blankets off to look at the left knee. Resident 15 had foot drop (inability to lift the forefoot due to weakness of the muscles of the foot for movement) on his left foot. CNA 1 removed the socks and exposed both feet. Resident 15 had pain and discomfort when the left foot was touched. The left foot had an appearance of a small wound on the forefoot of the left 3rd medial phalanx (bone of the toe), redness and swelling of the left foot and five toes, dry and scaly skin on the foot, toes, and blackish discoloration in-between the toes. There was yellowish/blackish discoloration on the 4th toe nail; long and yellowish discoloration of the 2nd, 3rd, and 5th toenails; thick, hard, deformed left big toenail with upward growth of the nail and fungus-like appearance: discolored, thickened, and crumbled at the edge. Resident 15's right foot and toes also had dry, scaly, flaky skin, yellowish discoloration and long toenails on the right 2nd, 3rd, and 4th toes, and the right big toenail was thick, yellowish in color, deformed with toenail growth upward, and fungus-like appearance. CNA 1 stated,It looks like the feet have not been cleaned. I will call his nurse. (continued on next page)

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F 0687 Level of Harm - Actual harm Residents Affected - Few	During an interview on 3/25/24 at 9:52 a.m. with Treatment Nurse (TN) 1and Licensed Vocational Nurse (LVN) 1, TN 1 stated, I have not seen the resident's feet. The cart nurses (referring to the nurses passing medications) do the weekly assessments of the residents. LVN 1 stated, I also have not seen the resident's foot. TN 1 stated, The feet have not been properly showered and cleaned. The right lower extremity has redness and dry skin. The right big toe is thick and has fungus-like appearance. Resident 15 needs podiatry (treatment of disorders of the foot, ankle and lower limb) care, but podiatry is not covered by insurance. Podiatrist comes to the facility every three months. During an interview on 3/25/24 at 10:11 a.m. with CNA 2, CNA 2 stated she noticed Resident 15 had flaky skin on both lower extremities. CNA 2 stated she noticed the feet were red, but she did not check in between the toes. CNA 2 stated she did not document her observations regarding Resident's feet on the person figure on the shower form, and she did not report her observation to the nurse. During an interview on 3/25/24 at 10:12 a.m. with Resident 15, Resident 15 stated it was about two to three months ago when his feet were cleansed. During a concurrent observation and interview on 3/25/24 at 10:13 a.m. with Director of Nursing (DON), in Resident 15's room, DON came to evaluate Resident 15's lower extremities. DON stated, [Resident 15] had bilateral lower extremities redness, scattered. The skin was dry and with scabs on the shin, possible rash, and with unopened wound on the left lateral area of the left lower leg. The left foot has foot drop, with some redness and swelling. The nails were large, hypertrophic (thickening, excessive growth in cells/tissues), joints were getting contracted (hardening of muscles, tissues leading to deformity/rigidity of joints). The left 3rd toe, metatarsal (five long bones in the midfoot) had dry scab. [Resident 15] needs hygiene, definitely needs attention from wound care, and needs podiatry care. DON continued to evaluate Resident 15's right foot and stated, There is redness, swelling, and dryness on the toes. The nails are large on the right big toe, 3rd, 4th, and 5th toenails. There are no wounds observed in between the toes. The left foot is worse than the right foot. DON stated the social worker is responsible for arranging podiatry visits for the residents. DON stated in the past, [Resident 15] had been seen by the podiatrist, but in looking at his feet, it's not recent. During a concurrent observation and interview on 3/25/24 at 11 a.m. with TN 1, in Resident 15's room, TN 1 measured the thickness and the length of the toenails for both feet. The following were the toenail measurements for both feet: Left Foot Toenails: Big toenail: Length 1.4-centimeter (cm) Thickness 1.8 cm. 2nd toenail: Length 0.5 cm Thickness 1 cm 3rd toenail: Length 0.5 cm Thickness 1 cm 4th toenail: Length 1.7 cm Thickness 1 cm 5th toenail: Length 1 cm Thickness 0.7 cm Right Foot Toenails: (continued on next page)

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F 0687 Level of Harm - Actual harm Residents Affected - Few	Big toenail: Length 1.3 cm Thickness 2 cm 2nd toenail: Length 0.7 cm Thickness 0.5 cm 3rd toenail: Length 1.9 cm Thickness 0.6 cm 4th toenail: Length 1.9 cm Thickness 1 cm 5th toenail: Length 1 cm Thickness 1 cm During a concurrent interview and record review on 3/25/24 at 11:21 a.m. with Social Worker (SW), Resident 15's Podiatric Evaluation and Treatment Form (PETF), dated 3/20/24, was reviewed. The PETF indicated, Chief Complaint: pain, edema (fluid retendtion in the body tissues). Skin: Check mark for Atrophy (decrease in size of tissue), Hydration, and Growth. Nails: Right and Left 1,2,3,4,5. Check mark for hypertrophic, yellow, brittle, thick subungual (under the fingernail/toenail) debris. With Pain: Check mark for pain. Edema: +2 (measurement of edema in tissue). Loss of protective sensation: Left. Check mark for: No other significant changes. Check mark for: Nails debrided (removal of infected, damaged or dead tissue) to patient's tolerance only. PETF physician' signature was blank. SW stated Podiatry comes every 45-60 days and they see all the residents. SW stated the podiatrist was last here on 3/20/24 and saw [Resident 15]. SW looked at Resident 15's feet and stated podiatrist did not provide aggressive treatment for Resident 15's feet nor made any recommendations based on the documented podiatrist notes. SW verified the podiatrist did not sign the PETF dated 3/20/24. SW was unable to find other podiatrist PETF documentation on previous visits in the chart. During a review of Resident 15's Shower Schedule, dated 3/5/24, 3/12/24, 3/19/24, and 3/22/24. the shower schedule indicated, Resident 15 is scheduled every Tuesdays and Fridays. During a concurrent interview and record review on 3/25/24 at 2:18 p.m. with TN 1, Resident 15's Skin Monitoring: Comprehensive Certified Nursing Assistant Shower Review Form (CCNASRF), dated 3/5/24, 3/19/24, and 3/22/24, were reviewed. The CCNASRF indicated, On 3/5/24, Resident 15 had completed shower and needed his toenails cut. No visual observation was documented on the person figure on the shower review form. On 3/19/22, [Resident 15] refused to shower. CNA 2 documented Resident 15 needed his toenails cut. No documentation of CNA 2's skin observation on the person figure of the shower review form. On 3/22/24, Resident 15 had full shower, but refused to have lotion applied on the legs due to pain. No documentation of CNA 2's skin observation on the person figure of the shower review form. TN 1 verified the findings and stated the CNAs must document their skin observation on the shower form. During a concurrent interview and record review on 3/25/24 at 2:30 p.m. with TN 1, Resident 15's Care Plan, dated 2/29/24 to 3/25/24, were reviewed. TN 1 was unable to find care plans for skin integrity, and problems with feet and toenails, and stated there were no care plans written. During a concurrent interview and record review on 3/25/24 at 2:40 p.m. with TN1 , Resident 15's Weekly Assessments, dated 1/10/24 to 3/22/24, were reviewed. The weekly assessments indicated the following: 1/10/24 Licensed Vocational Nurse (LVN) 2 documented toenails clean, no foot problem. No skin assessment performed. (continued on next page)

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F 0687 Level of Harm - Actual harm Residents Affected - Few	1/16/24 LVN 2 documented toenails clean, no foot problem. No skin assessment performed. 1/22/24 LVN 2 documented no foot problem. No skin assessment performed. 2/4/24 LVN 3 documented no foot problem, no skin issue, toenails clean. 2/16/22 LVN 4 documented left lower leg front, no skin issues, toenails clean, no skin issues. 2/22/24 LVN 2 documented left lower leg no skin issues, fingernails/toenails clean, no foot problem. 3/10/24 LVN 2 documented left lower leg no skin issue, fingernails/toenails clean, foot problem, none. 3/16/24 LVN 4 documented fingernails/toenails clean, foot problems none, weekly assessment not completed. 3/22/24 LVN 2 documented foot problem none, fingernails/toenails clean. TN verified the above findings and stated the documentations were copied and pasted. During a concurrent observation, interview, and record review on 3/26/24 at 2:30 p.m. with Physician 2 and LVN 1, in Resident 15's room, Physician 2 examined Resident 15's feet. Physician 2 stated Resident 15 needs to be seen by another Podiatrist. Physician 2 verified Resident 15 has left foot edema and needs proper foot care. LVN 1 verified Resident 15 was on aspirin (medication with blood thinning properties). Physician 2 spoke with LVN 1 and verbally ordered to stop aspirin for two weeks due to presence of petechiae (pinpoint, round spots that form on the skin) on both lower extremities. A review of Physician's Progress Notes, dated 3/26/24, indicated Physician 2 did not document his evaluation of Resident 15's feet. During an interview on 3/27/24 at 2:59 p.m. with LVN 2, LVN 2 stated she reviews the Treatment Assessment Record (TAR) if there is any order for skin and wound issues, and if there is none, she documents no skin issues on her weekly assessment. During an interview on 3/27/24 at 4:32 p.m. with LVN 4, LVN 4 stated the weekly assessment is done whenever he passes his medications. The certified nursing assistants look at the residents' bodies when they give showers, and they notify the nurses of their observations. LVN 4 stated that's how he records his weekly assessment. LVN 4 stated, It is impossible to do head-to toe assessments for all residents. I just copy and paste. They are the same findings. During a review on 3/27/24 at 10 a.m. with Minimum Data Set (MDS-resident assessment tool) Coordinator (MDSC) 1, Resident 15's Nursing Progress Notes, dated 3/1/24-3/22/24, were reviewed. MDSC 1 was unable to find documentation the attending physician was notified of Resident 15's skin and feet condition: red rash to bilateral lower extremities, edema, dry, flaky skin, yellowish discoloration, thick, hard, upward growth of nails on the left and right big toes, and unopened wound to the 3rd phalanx of the left foot, scabs on both shins, and unopened wound on the left lateral aspect of the lower extremity. MDSC 1 stated the only physician notification documented regarding Resident 15's skin and foot condition was on 3/25/24 at 4 p.m. (continued on next page)

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F 0687 Level of Harm - Actual harm Residents Affected - Few	39356 During a review of Resident 36's Order Summary Report (OSR) [undated}, the OSR indicated, Resident 36 was admitted on [DATE]. During an interview on 3/25/24 at 10:39 a.m. with TN 1, TN 1 stated she had put in a progress note regarding Resident 36 needing podiatry care and a physician order was initiated but Resident 36 has not received any podiatry care. During a review of Nurses Notes (NN) dated 12/26/23 at 10 a.m., the NN indicated, Assessment and recommendation for podiatry consultation for resident [36], focusing on the concern of thickened toe nails. This condition is causing discomfort, unable to provide regular nail care. During a review of Order Details (OD) dated 12/28/23, the OD indicated, Podiatry Care every 60-61 days as needed. During a concurrent observation and interview on 3/25/24 at 10:50 a.m. with DON, TN 1 and Resident 36, in Resident 36's Room, Resident was lying in his bed, awake and alert, with a blanket covering his feet. TN 1 exposed Resident 36's feet, and DON and TN 1 examined the feet of Resident 36. DON stated Resident 36's has a hypertrophied nail on right big toe growing upward, third toe nail has black on it and looks like dried blood. DON stated, left foot all toes have long nails, and both feet are dry and flaky. TN 1 measured the length of the toenails and stated the large toe is approximately 2 cm in thickness and measures in length 1.7 cm from the skin. DON stated Resident 36 is in need of podiatry care and these needs have not been met. Resident 36 stated his feet and toes had been hurting him. During a concurrent interview and record review on 3/25/24 at 11:22 a.m. with DON, Resident 36's Podiatric Evaluation and Treatment (PET) dated 9/8/23 was reviewed. DON stated Resident 36 last podiatry treatment had been completed on 9/8/23. During a review of the facility's policy and procedure (P&P) titled, Grooming Care of the Fingernails and Toenails, dated 11/1/17, the P&P indicated, XVIII. Report any changes in the color of the skin around the nail or nail bed to the attending physician. XIX. Document procedure in the resident's medical record and update resident's care plan as needed. During a review of the facility's P&P titled, Showering a Resident, dated 11/1/17, the P&P indicated, XVI. Report any broken skin, bruises, rashes, cut, skin discoloration or reddened areas to the charge nurse. XVII. Update the resident's care plan.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39763 Based on interview and record review, the facility failed to complete a fall risk for assessment two of three sampled residents (Resident 209 and Resident 55). These failures had the potential for Resident 209 and Resident 55 to have unmet care needs and potential for injury. Findings: During a review of Resident 209's Admission Record, (AR), the AR indicated, Resident 209 was admitted on [DATE], with diagnoses including lack of coordination, muscle wasting, reduced mobility, and need for assistance with personal care. During a concurrent interview and record review on 3/19/24 at 3:41 p.m. with the Director of Nursing (DON), Resident 209 and Resident 55's medical records were reviewed. DON stated a fall risk assessment should be completed on admission, quarterly, and after a fall. DON reviewed Resident 209's medical record. DON confirmed Resident 209 did not have a fall risk assessment on admission. DON stated a fall risk assessment should have been completed for Resident 209. DON reviewed Resident 55's medical record. DON stated Resident 55 had a fall on 3/12/24. DON stated Resident 55 last fall risk assessment was completed on 10/5/23 (no quarterly fall risk assessment and no fall risk assessment after fall on 3/12/24). During a review of the facility's policy and procedure (P&P) titled Assessment and Management of Residents Falls, undated, the P&P indicated, It is the policy . to prevent falls among resident as humanly possible and to provide interventions that may address resident's specific risks and causes of residents falls . 1. As part of the initial assessment, the attending physician will help identify individuals with history of falls and risk factors for subsequent falling . 3. The staff will document risk factors for falling in the resident's record and discuss the resident's fall risk . Cause Identification 1. For an individual who has fallen, staff will attempt to define possible causes within 24 hours of the fall . Treatment/Management 1. Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and address risks of serious consequences of falling.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. 35649 Based on interview and record review, the facility failed to ensure five of five sampled residents (Resident 15, Resident 19, Resident 41, Resident 55, and Resident 56) were assessed to determine the level of risk for bed entrapment (an event in which an individual is caught, trapped, or entangled in the spaces in or about the bed rail, mattress, or bed frame) prior to the application of bedrails. This failure places residents at risk for harm when bed entrapment risk assessment has not been completed. Findings: During a concurrent observation and interview on 3/27/24 at 11 a.m. with Maintenance Supervisor (MS), in Resident 15, Resident 19, Resident 41, Resident 55, and Resident 56's room, all five residents's beds had quarter siderails up on each side of their beds. MS stated we just discussed bed entrapment two weeks ago with the Administrator-in training (AIT). MS stated, I do not have a log specific for the siderails and I do not have a record of bed rail measurements. I am aware of the bed entrapment requirements from previous employment, but we do not have that implemented here yet. During an interview and record review on 3/27/24 at 11:16 a.m. with Minimum Data Set (resident assessment tool) Coordinator (MDSC) 1 Resident 55's bed entrapment risk assessment was reviewed. MDSC 1 stated the facility has not started assessing residents for bed entrapment MDSC 1 stated, It was only two weeks ago when we had the discussion about the risk of bed entrapment, and nothing has been implemented yet. MDSC 1 was unable to provide documentation of Resident 55's bed entrapment risk assessment. During a concurrent interview and record review on 3/27/24 at 11:20 a.m. with MDSC 1, in Resident 56's room, MDSC 1 was unable to provide documentation of Resident 56's bed entrapment risk assessment. During a concurrent interview and record review on 3/27/24 at 11:25 a.m. with MDSC 1, MDSC 1 was unable to provide documentation of Resident 15's bed entrapment risk assessment. During a concurrent interview and record review on 3/27/24 at 11:30 p.m. with MDSC 1, MDSC 1 was unable to provide documentation of Resident 19's bed entrapment risk assessment. During a concurrent interview and record review on 3/27/24 at 11:35 p.m. with MDSC 1, MDSC 1 was unable to provide documentation of Resident 41's bed entrapment risk assessment. During a review of the facility's policy and procedure (P&P) titled, Bed Rails, dated 11/1/17, the P&P indicated, 1. If bed rails are to be used the assessment form-Bed Rail Entrapment Risk Assessment will be completed by a licensed nurse: A. Before installing a bed rail the facility will: i. Assess the resident for risk of entrapment from bed rails and ii. Ensure the bed's dimensions are appropriate for the resident's size and weight.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 42744 Based on interview and record review, the facility failed to ensure staff competencies for five of five sampled Licensed Nursing Staff (Registered Nurse [RN] 1, RN 2, RN 3, Licensed Vocational Nurse [LVN] 4, and LVN 6) were evaluated and completed. This failure had the potential to result in harm to residents. Findings: During an interview on 3/27/24 at 3:43 p.m. with TN 1, TN 1 stated she took a three-day class and then a test to become a Certified Wound Nurse. TN 1 stated she did not receive on-the-job training, even for the computerized medical record, and had to figure it out for herself. During an interview on 3/28/24 at 9:24 a.m. with Director of Nursing (DON), DON stated there used to be a competency checklist for staff, but he was updating the form and the competency checklist was not available for use. DON stated he reviewed nurses' resumes for level of experience, but no competency assessments were currently being done. During a concurrent interview and record review on 3/28/24 at 1:43 p.m. with Director of Staff Development (DSD), Employee Educational Records (EER) were reviewed for RN 1, RN 2, RN 3, LVN 4, and LVN 6. The EERs indicated there were no skills competency assessments for any of the licensed employees. DSD stated she has no competency skills assessment documentation on any of the Licensed Nurses. During an interview on 3/28/24 at 4:24 p.m. with the Administrator- in-Training (AIT), AIT stated no performance evaluations had been done on current nursing staff. During a review of the facility's Policy and Procedure (P&P) titled, On-the-Job Training, dated 2008), the P&P indicated, On-the-job training programs will be conducted when necessary to assist employees in performing their assigned tasks. 1. On-the-job training is provided to train each employee in his/her respective job assignment and our methods of performing such tasks. 3. On-the-job training begins on the first day of employment and is completed when the department director is satisfied that the employee can perform his/her assigned duties, within the time frame allotted for each particular function, without any further supervision. 7. Training records will be filed in the employee's personnel file or may be maintained by the department supervisor.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 46958 Based on interview and record review, the facility failed to ensure a Registered Nurse (RN) was scheduled and on duty eight hours a day, seven days a week. This failure had the potential for resident care to be negatively impacted. Findings: During a concurrent interview and record review on 3/28/24 at 10:26 a.m. with Director of Nursing (DON), the nursing staffing schedule dated October 2023, November 2023, December 2023 were reviewed. The nursing staffing scheduled indicated, In October 10/1/23, 10/2/23, 10/7/23, 10/8/23, 10/13/23, 10/14/23, 10/19/23, 10/20/23, 10/25/23, 10/26/23, 10/31/23, 11/1/23, 11/6/23, 11/12/23, 11/18/23, 11/19/23, 11/24/23, 11/25/23, 11/30/23, 12/1/23, 12/6/23, 12/7/23, 12/12/23, 12/13/23, 12/18/23, 12/19/23, 12/24/23, 12/25/23, 12/30/23, 12/31/23 there was no Registered Nurse (RN) on duty on above dates. DON stated there was no RN working on the floor 8 hours a day on above dates. During a review of the facility's policy and procedure (P&P) titled, Nursing Department-Staffing, Scheduling & Postings, dated 2006, the P&P indicated, To ensure an adequate number of nursing personnel are available to meet resident need.B. If the Facility is licensed for 60 to 99 beds, it will have the following: i. At least one Registered Nurse. in the Facility at all times, day and night, in addition to the Director of Nursing Services (DON).

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 35649 Based on interview and record review, the facility failed to: 1. Ensure Pharmacy Consultant conducted Medication Regimen Review (MRR- a thorough evaluation of the residents' medications and minimizing adverse consequences) for two of two sampled residents (Resident 15 and Resident 55) on psychotropic (refer to antidepressants, anti-anxiety, stimulants, antipsychotic, and mood stabilizers) medications. 2. Ensure Pharmacy Consultant conducted monthly medication review for all 71 residents in the facility . These failures had the potential for adverse consequences when there is no pharmacy oversight and monitoring of medications. Findings: 1. During a concurrent interview and record review on 3/27/24 at 8:31 a.m. with Minimum Data Set (resident assessment tool) Coordinator (MDSC) 1, Resident 15's Medication Administration Record (MAR), dated 3/1/24/ to 3/26/24, was reviewed. The MAR indicated Abilify 30 mg (milligram), give one tablet one time a day for bipolar disorder (mental illness causing extreme mood swings that include emotional highs and lows) manifested by (m/b) sexual behavior. Oxcarbazepine (medication that helps to stabilize mood, control emotions, and improve overall functioning) 600 mg one tablet by mouth one time a day for bipolar disorder m/b mood swings. Depakote Delayed Release 500 mg give one tablet by mouth two times a day for Seasonal Anxiety Disorder (type of depression related to changes in seasons) m/b inappropriate sexual behavior towards staff. During a concurrent interview and record review on 3/27/24 at 10 a.m. with MDSC 1, the Pharmacy MRR Binder Report for Resident 15's MRR, dated 1/2024, 2/2024, and 3/2024, were reviewed. The Pharmacy MRR Binder indicated, No record of the pharmacist report of MRR conducted for Resident 15 for the last three months. During a review of Resident 55's MAR, dated 3/1/24 to 3/26/24, the MAR indicated, Quetiapine Fumarate 50 mg one tablet by mouth in the afternoon for Psychosis (mental disorder characterized by a disconnection from reality) m/b having aggressive behaviors such as wanting to hit staff and/or other residents. Quetiapine Fumarate 80 mg one tablet a day in the afternoon for Unspecified Dementia (the loss of cognitive functioning: thinking, remembering, and reasoning the extent it interferes with a person's daily life and activities) m/b behavior involving agitation. Donazepil 5 mg give one tablet by mouth at bedtime for unspecified dementia. Memantine (medication to treat memory loss in dementia) 10 mg one tablet by mouth two times a day for unspecified dementia. Lorazepam 1 mg one tablet by mouth every 12 hours as needed for anxiety for 14 days m/b by restlessness, such as pacing up and down. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 3/27/24 at 1:55 p.m. with MDSC 1, The Pharmacy MRR Binder Report for Resident 55's MRR, dated 1/2024, 2/2024, and 3/2024, were reviewed. MDSC 1 was unable to find in the Pharmacy MRR Binder the pharmacy consultant reviewed the medication regimen for Residents 55 on 1/2024, 2/2024/and 3/2024. MDSC 1 stated there was an MRR dated 11/26/23 that indicated, Limit lorazepam to 14 days. MDSC 1 was unable to find pharmacy consultant review for other medications. 39356 2. During a concurrent interview and record review on 3/27/24 at 2:29 p.m. with Director of Nursing (DON), the facility's Census Report (CR) dated 9/20/23,10/18/23, 11/26/23, 12/27/23, 1/22/24, and 2/12/24, and Med [medication] Regimen Review Report [MRRR) dated 9/20/23, 10/18/23, 11/26/23, 12/27/24, and 2/12/24 were reviewed. The CR and MRRR indicated the following: 09/20/23, the census was 78, 58 residents MRRR were not reviewed by the pharmacist, 10/18/23, the census was 77, 64 residents MRRR were not reviewed by the pharmacist. 11/26/23, the census was 68, 50 residents MRRR were not reviewed by the pharmacist. 12/27/23, the census was 72, 34 residents MRRR were not reviewed by the pharmacist. 01/22/24, the census was 76, 56 residents MRRR were not reviewed by the pharmacist. 02/12/24, the census was 71, 51 residents MRRR were not reviewed by the pharmacist. DON stated he had been aware of the pharmacist not reviewing all the records, and had alerted the Administrator -in-Training (AIT), and stated the Pharmacist should review every Residents' medications and document the MRRR monthly. During a review of the facilities policy and procedure (P&P), titled Medication Monitoring [undated], the P&P indicated, The consultant pharmacist reviews the medication regimen of each resident at least monthly. During a review of the facility's policy and procedure (P&P) titled, Drug Regimen Review (Monthly Report), [undated], the P&P indicated, The consultant pharmacist reviews the medication regimen of each resident at least monthly.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 39356 Based on observation, interview, and record review, the facility failed to ensure two of four sampled residents (Resident 135 and Resident 44) were free from medication error rate of greater than five percent (%) when two medication errors occurred within 29 opportunities resulting in a 6.9 % error rate. This failure had the potential for Resident 135 and Resident 44 not receiving the full therapeutic effects of the medication and potential for adverse health outcomes. Findings: During an observation and interview on 3/27/24 at 8:20 a.m. in Resident 135's room, Registered Nurse (RN) 1 administered Resident 135's medication. At 8:27 a.m. RN 1 stated she did not administer Resident 135's Eliquis (medication used to thin the blood) 5 milligram as she did not have any in her medication cart to administer. During a concurrent observation and interview on 3/27/24 at 8:56 a.m. in Resident 44's room, Licensed Vocational Nurse (LVN) 5 administered Resident 44's medications. LVN 5 stated she did not have Resident 44's inhaler (Trelegy Ellipta Aerosol Powder Breath Activated Inhaler - medication to treat chronic obstructive pulmonary disease COPD - progressive lung disease) and will call the pharmacy. During a review of Resident 135's Medication Administration Record (MAR) dated 3/1/24 - 3/31/24, the MAR indicated, Apixaban (Eliquis) Oral tablet 5 mg Give 1 tablet by mouth two times a day for Deep Vein Thrombosis (DVT-blood clot in the vein) was not given at 9 a.m. on 3/27/24. During a review of Resident 44's MAR, dated 3/1/24 - 3/31/24, the MAR indicated, Trelegy Ellipta Aerosol Powder Breath Activated . in the morning for COPD was not given at 9 a.m. on 3/27/24. During an interview on 3/27/24 at 9:54 a.m. with RN 1, RN 1 stated she called the pharmacy and stated hopefully the medication will arrive today. During an interview on 3/27/24 at 9:57 a.m. with Director of Nursing (DON), DON stated the nurses are to call the pharmacy four or five days prior to running out of the medication to ensure the Residents do not run out of their medications. During a review on the facility's policy and procedure (P&P) titled Medication Administration dated 11/1/17, the P&P indicated, 1. Medication will be administered by a Licensed Nurse per the order of an Attending Physician or licensed independent practitioner. V. Medications may be administered one hour before or after the scheduled medication administration time.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 46958 Based on observation, interview, and record review, the facility failed to ensure safe administration of medication for one of 66 sampled residents (Resident 8) when medications were found at Resident 8's bedside table. These failures had the potential for medications to be administered incorrectly and unsafely. Findings: During a review of Resident 8's Order Summary Report (OSR), dated 3/26/24, the OSR indicated, ProAir HFA inhalation Aerosol Solution 108 (90 microgram per actuation (MCG/ACT) (Albuterol Sulfate--Medication used to prevent and treat breathing and shortness of breath) 2 puffs inhale orally every 6 hours for Chronic Obstructive Pulmonary Disease (COPD-lung disease caused by airflow blockage that can cause difficulty breathing). During an observation on 3/25/24 at 6:30 a.m. in Resident 8's room, an albuterol inhaler was on the bedside table. During a concurrent observation and interview on 3/25/24 at 6:34 a.m. with Licensed Vocational Nurse (LVN) 7 in Resident 8's room, Resident 8 had an albuterol inhaler on the bedside table. LVN 7 stated, That should not be on the table. During a concurrent observation and interview on 3/25/24 at 6:38 a.m. with LVN 8 in Resident 8's room, the albuterol inhaler was on the bedside table. LVN 8 stated, I forgot this inhaler here accidentally. During a review of the facility's policy and procedure (P&P) titled, Medication Storage in the Facility, [undated], the P&P indicated, Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medication.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35649 Based on interview and record review, the facility failed to ensure dietary staff was assigned to conduct assessment of food preferences for one of one sampled resident (Resident 56). This failure had the potential to result in unplanned weight loss. Findings: During an interview on 3/26/24 at 9:05 a.m. with Resident 56, Resident 56 stated he did not like the food served at the facility. Resident 56 stated no one has come to talk to him about his food preferences. During a concurrent interview and record review on 3/27/24 at 9:54 a.m. with Dietary Supervisor (DS) and Certified Dietary Manager (CDM), Resident 56's dietary food card was reviewed. The dietary food card indicated, Resident 56 disliked fish. DS stated he was responsible for asking residents their food likes and dislikes, but he had not seen Resident 56 since he talked to the resident during his admission to the facility on [DATE]. CDM stated, Resident 56's food preference needs to be updated. During a review of the facility's policy and procedure (P&P) titled, Food Preferences, dated 2023, the P&P indicated, Food preferences will be obtained as soon as possible through the initial resident screening . Updating of food preferences will be done as the resident's needs change and/or during the quarterly review.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39356 Based on observation, interview, and record review, the facility failed to ensure a pureed diet (a texture-modified diet useful for people who have difficulty chewing and swallowing foods and liquids) was served according to the physician's order for one of 66 sampled residents (Resident 8). This failure had the potential to adversely affect the resident's health. Findings: During a review of Resident 8's Admission Record (AR) dated 3/28/24, the AR indicated, Resident 8 is a [AGE] year-old female, admitted on [DATE], with diagnosis of cerebral infarction (lack of adequate blood flow to brain), hemiplegia (paralysis on one side of the body) and hemiparesis (partial weakness), and dysphagia (difficulty in swallowing). During a review of Resident 8's Diet Card (DC) [undated], the DC indicated, Resident 8 is on a Regular, Puree, Nectar Thick Liquids. During a review of Resident 8's Order Summary Report (OSR) dated 3/25/24, The OSR indicated, Regular Diet: Pureed texture, Nectar consistency, large portion. During a concurrent observation and interview on 3/25/24 at 7:36 a.m. with Certified Nursing Assistant (CNA) 5 and Certified Dietary Manager (CDM), in the dining room, Resident 8 was observed being fed a mechanical soft diet by CNA 5. CNA 5 stated she had thought Resident 8's diet had changed but did not look at Resident 8's diet card. CDM stated they gave the wrong diet to Resident 8. During a review of the facility's policy and procedure (P&P) titled, Diet Orders (DO) dated 2023, the DO indicated, Diet orders as prescribed by the Physician will be provided by the Food & Nutrition Services Department.

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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. 42744 Based on observation, interview, and record review, the facility failed to: 1. Ensure the kitchen was maintained in a sanitary manner for 71 of 71 sampled residents. 2. Ensure food was properly stored and labeled for 71 and 71 sampled residents. 3. Ensure employees followed dress code policy for two of two sampled staff (Dietary Supervisor (DS) and Cook 2 (CK) 2). 4. Ensure food was served in a sanitary manner for one of one sampled resident (Resident 61). These failures had the potential for the spread of foodborne illnesses throughout the facility. Findings: 1. During a concurrent observation and interview on 3/25/24 at 6:10 a.m. with CK 1 in the kitchen, a tall dirty ladder was leaning against a rack of clean plastic pitchers and storage bins on the right wall near the entrance, paint spatters were on the floor, and scaffolding containing paint supplies were at the end of the kitchen spanning over two freezers. CK 1 stated they were repairing and painting the ceiling in the kitchen over the past weekend. During an interview on 3/25/23 at 6:45 a.m. with Certified Dietary Manager (CDM), CDM stated after the maintenance department finished painting, they should have removed the latter and scaffolding. During an interview on 3/26/24 at 2:23 p.m. with Maintenance Supervisor (MS), MS stated he started the repair and painting of the kitchen ceiling on Friday evening after dietary staff had left for the day and finished at 4:30 a.m. on Monday morning (3/25/24). MS stated he did not have assistance to remove the scaffolding at that time and thought he could do it later. MS stated the expectation is to have everything put away after a job is completed. MS stated, I know the kitchen has to be cleaned. During a review of the facility's policy and procedure (P&P) titled, Sanitation, dated 2023, the P&P indicated, All equipment shall be maintained as necessary and kept in working order . 8. The Maintenance Department will assist Food & Nutrition Services as necessary in maintaining equipment and in doing janitorial duties which the Food & Nutrition Services employee cannot do and maintain maintenance records on all equipment. 2. During a concurrent observation and interview on 3/25/24 at 6:15 a.m. with CK 1 in the kitchen, the contents of two freezers located to the right of the stove were noted to have cardboard boxes lined with plastic bags containing pepperoni, sausage patties, thin crust pizza dough and rolls were unsealed and open, exposing food to the environment. CK 1 stated the bags should be sealed. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent observation and interview on 3/25/24 at 6:30 a.m. with CDM in the kitchen were two freezers. One freezer contained several cardboard boxes of French fries and potato patties in plastic bags. The plastic bags were open, exposing the food to the environment. Three of the boxes had no received or opened dates. The second freezer contained corn with a ripped bag. CDM verified the findings and stated the food should have been wrapped and should have received and open dates. During a concurrent observation and interview on 3/25/24 at 6:40 a.m. with CDM in the kitchen, the walk-in refrigerator there was one container of prune juice with no open date. During a concurrent observation and interview on 3/25/24 at 6:50 a.m. with CDM in the dry storage room, food thickener, lasagna noodles, and croutons were in an unsealed bag. CDM stated the foods should not be stored like that. During a review of the facility's P&P titled, Labeling and Dating of Food, dated 2023, the P&P indicated, Policy: All food items in the storeroom, refrigerator, and freezer need to be labeled and dated. Newly opened food items will need to be closed and labeled with an open date and used by date that follows the various storage guidelines within this section. 3. During a concurrent observation and interview on 3/26/24 at 12:16 p.m. with DS and CDM in the kitchen, DS and CK 2 had facial hair that was not covered. DS stated he only covers his facial hair when it gets to a certain length. CDM stated it is policy that all men with facial hair wear a mask or beard cover, no matter the length of the facial hair. During a review of the facility's P&P titled, Dress Code, dated 2023, the P&P indicated, Proper Dress . 8. If applicable, beards and mustaches (any facial hair) must wear beard restraint. 4. During a concurrent observation and interview on 3/26/24 at 12:03 p.m. with DS and CDM in the kitchen, DS was removing an already plated portion of turkey breast for Patient 61 and returning it to the tray serving line because it was not the right portion size. DS stated, I shouldn't have done that. I got nervous. CDM stated, I had told him not to do that. During an interview on 3/26/24 at 12:12 p.m. with Registered Dietitian (RD), RD stated it was not appropriate to return food to the tray serving line after it had been plated for a resident. A policy and procedure was requested but none was provided.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 39356 Based on observation, interview, and record review, the facility failed to: 1. Ensure infection control practices were implemented for 4 of 4 sampled residents (Resident 27, Resident 5, Resident 48, and Resident 15) in accordance with nationally recognized infection control and prevention guidelines. This failure had the potential to transmit infectious diseases. 2. Ensure staff implemented infection control practices for handling trash, transmission-based precautions, and laundry services for 71 of 71 residents residing in the facility. This failure had the potential to transmit infectious diseases or parasite infestations throughout the facility. 3. Conduct infection prevention surveillance activities (collection and analysis of data) on hand hygiene effectively. This failure resulted in the facility's inability to have measurable data to improve resident health outcomes, and to identify, address, and correct departures from nationally recognized infection control practices. 4. Ensure the facility has an effective Infection Control Program for 71 of 71 residents in the facility. This failure had the potential to result in unsafe and unsanitary working environment, which could lead to development and transmission of infectious diseases. Findings: 1. During an observation on 3/25/24 at 6:51 a.m., outside Resident 27's room, a sign indicating Contact Isolation was taped outside of door along with a three-drawer plastic bin with PPE (Personal Protective Equipment - gown, gloves, mask, and protective eyewear). During a review of Resident 27's Order Summary Report (OSR) dated 3/28/24, the OSR indicated, Contact Isolation due to MRSA (methicillin -resistant Staphylococcus aureus - infection difficult to treat because of resistance to some antibiotics) in wound on foot. one time only until 4/04/24. During an observation on 3/28/24 at 2:40 p.m. in Resident 27's room, Treatment Nurse (TN) 2 without wearing a gown began removing Resident 27's dressing on right foot. During an interview on 3/28/24 2:50 p.m. with TN 2, TN 2 stated, OMG (Oh My God), I am so sorry. TN 2 stated he should have been wearing a gown before entering and providing care to Resident 27. 42744 During a concurrent observation and interview on 3/26/24 at 10:31 a.m. with TN 1, TN 1 was changing a dressing to Resident 5's sacrum. Resident 5 had smears of bowel movement in the buttock area. TN 1 removed the dirty dressing and cleansed the sacrum, including some of the buttock area with wound cleanser. TN 1 did not do hand hygiene after she removed the dirty dressing and cleansed the area. TN 1 placed a clean dressing on Resident 5's right sacrum with dirty gloves. TN 1 stated she should have done hand hygiene and put on clean gloves prior to the clean dressing. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	46958 During a concurrent observation and interview on 3/25/23 at 7:45 a.m. with Resident 48 in Resident 48's room, Resident 48 was having breakfast and his ostomy's adhesive was open. There was a bowel movement leakage on Resident 48's stomach and onto his gown. Resident 48 stated it always leaks from adhesive area. During an interview on 3/25/24 at 7:50 a.m. with TN 1, TN 1 stated Resident 48 has skin irritation and it's hard for us to keep the ostomy adhesive in place. TN 1 stated, most of the time the ostomy adhesive comes off. TN 1 stated it is not sanitary for him to eat in this condition because the stool is leaking, and patient has his breakfast tray. During a review of the facility's policy and procedure (P&P) titled, Colostomy and Ileostomy Care-General, dated 2017, the P&P indicated, To maintain resident hygiene, control odor, prevent skin irritation or breakdown, and provide supportive care to the resident.vii. Center the skin barrier wafer over the stoma, adhesive side down, and press it to the skin. 35649 During a concurrent observation and interview on 3/25/23 at 2:30 p.m. with Physician 2 and Licensed Vocational Nurse (LVN) 1, in Resident 15's room, Physician 2 entered Resident 15's room with his cup of coffee and placed it on the bedside table. Physician 2 did not perform hand hygiene prior to putting on a pair of gloves. Physician 2 examined Resident 15's lower extremities and feet with gloves on. After touching Resident 15's lower extremities and feet, Physician 2 removed his gloves. Without performing hand hygiene, Physician 2 picked up his cup of coffee, exited Resident 15's room, and proceeded to the Director of Nursing (DON)'S Office. LVN 1 verified the findings and stated [Physician 2] should have washed his hands. 2. During a concurrent observation and interview on 3/27/24 at 4:30 p.m. with Certified Nursing Assistant (CNA) 4, CNA 4 carried a trash bag with her bare hands outside the building and disposed of the trash into the white trash bin located just outside the laundry dirty sorting area. CNA 4 returned inside the facility and entered Resident 3's room. CNA 4 did not perform hand hygiene after disposing the trash and before entering Resident 3's room. CNA 4 stated, I did not wash my hands. During a concurrent observation and interview on 3/28/24 at 10:45 a.m. with Laundry Aide (LA) in the dirty section of the laundry room, LA was sorting soiled linens and clothing with mask, apron, and gloves on. After sorting, LA removed the gloves she used for sorting dirty laundry and proceeded to the clean area of the laundry room without performing hand hygiene. During a concurrent observation and interview on 3/28/24 at 11:15 a.m. in the Station 2 Hallway, the Housekeeper (HSK) 1 was carrying two trash bags with bare hands and threw them into the white trash bins near the laundry. HSK 1 entered the building, and without performing hand hygiene, put on a new pair of gloves she got from the housekeeping cart, and started sweeping the floor. HSK 1 stated, I did not wash my hands. I was rushing because I have to go lunch. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of the facility's policy and procedure (P&P) titled, Handwashing /Hand Hygiene, [undated], the P&P indicated, 2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors .7. Use an alcohol-based hand rub containing at least 62% alcohol, or alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: b. Before and after direct contact with patients . i. After contact with resident's intact skin . m. After removing gloves . During a concurrent observation and interview on 3/27/24 at 4:03 p.m. with Infection Preventionist (IP), outside Resident 27's room. The following were observed: - A Contact Precaution signage was posted outside the door of Resident 27's room. - Resident 27's room was wide open and there was no trash can in the room by the exit door. - A three- tiered isolation cart outside the room contained the following: 1st drawer: gloves: medium/large 2nd drawer: plastic gowns 3rd drawer: larger gowns, plastic -The isolation cart did not have masks, goggles, face shields, and did not have hand sanitizer. - There was no hand sanitizer mounted outside the room. IP stated Resident 27 has Methicillin Resistant Staphylococcus Aureus on the lateral aspect of the right foot discovered on 3/21/24. IP stated, they do not put trash cans in the room; they only have plastic bags. The staff put the trash inside the plastic bags, and they take them out and dispose of them in the white regular trash bins. IP stated, All infectious wastes go in the white trash bins. IP also stated, she stocks the isolation cart based on the type of transmission-based precaution. IP stated, I should fully stock the Isolation cart with all the Personal Protective Equipment required. During a review of the facility's P&P titled, Resident Isolation-Initiating Transmission Based Precautions, dated 11/1/17, the P&P indicated, V. When transmission-based precautions are implemented, the Infection Control Coordinator (or designee): A. Ensures that protective equipment (i.e., gloves, gowns, masks, etc.) is maintained near the resident's room so that everyone entering the room can access what they need .C. Ensures that an appropriate linen barrel/hamper and waste container, with appropriate liner, is placed in or near the resident's room. During a concurrent observation and interview on 3/28/24 at 10:53 a.m. with LA in the clean section of the laundry room, there were comforters and residents' clothes inside plastic bags, piled on top of each other, over pillows and blankets, and some on the floor. LA stated the clothing were residents and some donated clothes that have already been washed. Also noted was a pile of washed unfolded linens on one side of the counter, with some of the linen clothing hanging down and touching the floor. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent observation and interview on 3/28/24 at 11 a.m. with LA in the laundry washing machine area, across the room is the Eye Wash Station. There were two eyewash solutions mounted on the wall. The outside of the eyewash solution bottles looked worn out, with grayish black debris. The two eyewash solutions labeled Physician Care Purified water 98.3 %, Ophthalmic (pertaining to the eye) Solution Eyewash had expiration date 11/20/20. LA stated, It's expired. No one has checked the eyewash station. In case of emergency, we are supposed to drop them into our eyes to wash our eyes. Facility policy and procedure related to expired medications or biologicals was requested, and none was provided. Facility policy and procedure on eye wash was requested, and none was provided. During a review of the facility's P&P titled Infection Prevention and Control Program, dated 12/1/21, the P&P indicated, Risk-Exposure Categories: i. The Infection Control Committee (ICC) advises the Administrator about working conditions and specific tasks that Facility Staff are expected to encounter that may pose an infection risk. ii. The administrator ensures that appropriate Facility Staff perform infection control-related tasks, including a. Evaluating the workplace .Monitoring the effectiveness of work practices and protective equipment . 3. During an interview on 3/28/24 at 11:05 a.m. with IP, IP stated the facility conducts infection control surveillance activities on the following: Hand hygiene all staff: use of hand sanitizers. Housekeeping disinfection on frequently touched points. No staff is walking in the hallways with gloves. Disinfection of beds after resident discharge. During a concurrent interview and record review on 3/28/24 at 11:10 a.m. with IP, Hand hygiene surveillance/monitoring was reviewed. IP stated she did not have a record of the hand hygiene monitoring. IP stated, It's all visual. I just watch the staff perform hand hygiene. IP had no hand hygiene indicators for surveillance, and was unable to provide data collected on hand hygiene, no tracking and trending of surveillance activities, and no overall data analysis of any of the surveillance activities mentioned above. During a review of the facility's P&P titled, Surveillance for Infections, dated 7/2016, the P&P indicated, Gathering Surveillance Data: 1. The Infection Preventionist or designated infection control personnel is responsible for gathering and interpreting surveillance data. Data Collection and Recording: Daily-record detailed information about the resident and infection on an individual infection control report. Monthly-summarize data for each nursing unit by site and by pathogen. Monthly/Quarterly-Identify predominant pathogens or sites of infection among residents in the facility or particular units by recording them month by month and observing trends. Compare incidences of current infections to previous data to identify trends and patterns. Compare subsequent rates to the average rate to identify possible increases in infection rates. (continued on next page)

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	555229	A. Building B. Wing	03/28/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4. During an interview on 3/28/24 at 11:20 a.m. with IP, IP stated the Infection Control Committee comprised of TN 1, Director of Staff Development (DSD), and IP. IP stated DON sometimes attends the meeting. The meetings are conducted casually on Fridays. IP was unable to provide meeting minutes for their weekly infection control committee meetings. During a review of the facility's P&P titled, Infection Prevention and Control Committee, dated 2016, the P&P indicated, Duties of the Committee: 15. Maintain a written account of meetings conducted and action taken by the committee (minutes of meeting) .19. Provide the Quality Assurance and Process Improvement (QAPI-data driven and proactive approach to quality improvement) Committee with a copy of all Infection Prevention and Control Committee meetings held .Composition of the Committee: Administrator, Director of Nursing, Medical Director, Infection Preventionist, Dietitian/Food Services Director, Environmental Services Director/Supervisor, Maintenance Director/Supervisor, Laundry Director, Others as appropriate.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop and implement policies and procedures for flu and pneumonia vaccinations. 35649 Based on interview and record review, the facility failed to ensure the Infection Control Preventionist (IP-health professional responsible for preventing and controlling the spread of infections) maintained Influenza (a contagious respiratory illness caused by influenza viruses that infect the nose, throat, and sometimes the lungs) and Pneumonia (an infection of one or both of the lungs caused by bacteria, viruses, or fungi) vaccinations for all current residents in the facility. This failure had the potential for the residents to not have the immunity for certain infectious diseases, which could be detrimental to their health and well-being. Findings: During a concurrent interview and record review on 3/28/24 at 11:38 a.m. with IP, the Immunization Report, dated 8/7/23 - 3/31/24, was reviewed. Eleven of 71 current residents were not included on the immunization report. IP was not able to provide influenza vaccination for 11 residents currently residing in the facility. IP was not able to verify receipt or refusal of pneumonia vaccination for 40 of 71 residents. IP confirmed the facility census was 71 and only 60 residents were on the Immunization Report. IP stated she does not have a record or a vaccination log for resident vaccinations. During a concurrent interview and record review on 3/28/24 at 12:10 p.m. with IP, Residents' Consents for Vaccinations (CV) were reviewed. There were only seven of 71 residents who signed the declination for either influenza vaccine, pneumonia vaccine, or both. IP verified the findings and was unable to provide proof of other residents' declination statements signed. Facility policy and procedure related to influenza/pneumonia vaccination was requested, and none was provided. During a review of the Centers for Disease Control (CDC) Guidelines, titled Vaccination Programs: General Best Practice Guidelines for Immunization, dated 7/12/17, the Guidelines indicated, All health-care providers, whether they provide immunizations or not, should incorporate immunization needs assessment into every clinical encounter, strongly recommend needed vaccine(s) and either administer vaccine(s) or refer patients to a provider who can immunize, stay up-to-date on, and educate patients about vaccine recommendations, implement systems to incorporate vaccine assessment into routine clinical care, and understand how to access immunization information systems (i.e., immunization registries).

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. 35649 Based on interview and record review, the facility failed to ensure the Infection Preventionist (IP-health professional responsible for preventing and controlling the spread of infections) maintained an accurate record of the Employee COVID-19 (a highly contagious respiratory illness caused by coronavirus) Vaccination for 110 of 159 employees. This failure resulted in incomplete employee COVID-19 vaccination record and unaccounted number of employees with or without immunity to the type of infection. Findings: During a concurrent interview and record review on 3/28/24 at 11:53 a.m. with IP, Employee COVID-19 Vaccination Records were reviewed. IP stated she did not have a log of the employee COVID-19 vaccinations, not manually or electronically. IP stated she has a binder where she keeps the employee COVID-19 vaccination cards. IP stated, Not everyone has proof of COVID-19 vaccination. I have some of the vaccination cards. There's a lot of employee movement, coming and going. During a review of the active Employee Roster on 3/28/24 at 12 PM with IP, the Active Employee Roster (AER) was reviewed. The AER indicated there were 159 active employees employed in the facility. During a review of the Employee Vaccination Cards Binder (EVCB) on 3/28/24 at 12:05 p.m., there were 49 COVID-19 employee vaccination cards on file. During an interview on 3/28/24 at 12:10 p.m. with IP, IP was aware only 49 employee vaccination cards were on file out of 159 active employees. IP stated, I requested the cards from the employees verbally, but I did not follow up. During a review of the facility's policy and procedure (P&P) titled, Infection Prevention and Control Program, dated 12/1/21, the P&P indicated, C. Duties and Responsibilities: x. Provides guidelines for, and help monitor the health status of all employees, ensuring that all personnel receive (as necessary) appropriate skin tests, chest x-rays, physical's, etc. prior to and during employment as outlined in the personnel policies, and in accordance with federal and state guidelines.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39356 Based on interview and record review, the facility failed to provide the minimum square footage as required by the regulation in 13 of the facility's resident bedrooms. This failure had the potential for insufficient space for residents' mobility, safety, and nursing care. Findings: During a concurrent interview and record review on 2/26/23 at 2:40 p.m. with Administrator in Training (AIT), the facility's Client Accommodation Analysis (CAA) dated 3/26/24, and Daily Census (DC) dated 3/24/24 was reviewed. The CAA and DC indicated the following rooms had 3 residents and less than 80 square foot per resident. AIT verified the findings. room [ROOM NUMBER]- 210 sq. ft.-3 residents room [ROOM NUMBER]- 225 sq. ft.-3 residents room [ROOM NUMBER]- 218 sq. ft.-3 residents room [ROOM NUMBER]- 220 sq. ft.-3 residents room [ROOM NUMBER]- 220 sq. ft.-3 residents room [ROOM NUMBER]- 220 sq. ft.-3 residents room [ROOM NUMBER]- 220 sq. ft.-3 residents room [ROOM NUMBER]- 220 sq. ft.-3 residents room [ROOM NUMBER]- 220 sq. ft.-3 residents room [ROOM NUMBER]- 220 sq. ft.-3 residents room [ROOM NUMBER]- 220 sq. ft- 3 residents room [ROOM NUMBER]- 220 sq. ft- 3 residents room [ROOM NUMBER]- 220 sq. ft- 3 residents The residents had a reasonable amount of privacy. Closets and storage were adequate. Bedside stands were available. There was sufficient space for nursing care and for residents to ambulate and/or use wheelchairs. Toilet facilities were accessible. The health and safety of the residents will not be adversely affected by the room waiver.

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide behavior health training consistent with the requirements and as determined by a facility assessment. 42744 Based on interview and record review, the facility failed to ensure five of five Licensed Nurses (Registered Nurse [RN] 1, RN 2, RN 3, Licensed Vocational Nurse [LVN] 4, and LVN 6) were trained to meet the behavioral health requirements of 29 of 29 sampled residents (Resident 1, Resident 11, Resident 12, Resident 13, Resident 14, Resident 15, Resident 17, Resident 21, Resident 27, Resident 28, Resident 30, Resident 31, Resident 36, Resident 37, Resident 43, Resident 44, Resident 46, Resident 48, Resident 53, Resident 55, Resident 56, Resident 60, Resident 61, Resident 71, Resident 76, Resident 135, Resident 185, Resident 202, and Resident 204). This failure had the potential to result in staff being unable to provide appropriate assessments and interventions for residents with behavioral health needs. Findings: During an interview on 3/28/24 at 9:24 a.m. with the Director of Nursing (DON), DON stated no competency assessments were currently being done for any staff on anything. During a concurrent interview and record review on 3/28/24 at 1:43 p.m. with Director of Staff Development (DSD), Employee Educational Records (EER) were reviewed for RN 1, RN 2, RN 3, LVN 4, and LVN 6. The EER's had no documentation that staff were trained to meet the needs of residents with behavioral health requirements. DSD stated no training was provided to any of the nursing staff specific to psychological or mental disorders of residents in the facility. During a concurrent interview and record review on 3/28/24 at 5:45 p.m. with the Administrator, the facility's Diagnosis Report (DR), dated 3/28/24 was reviewed. The DR indicated the facility had current residents with the following diagnoses: Anxiety Disorder- A condition in which a person has excessive worry and feelings of fear, dread, and uneasiness that can be manifested by sweating, irritability, fatigue, poor concentration, rapid heartbeat, trouble breathing, and trouble sleeping. (Resident 12, Resident 13, Resident 14, Resident 15, Resident 21, Resident 27, Resident 30, Resident 31, Resident 37, Resident 43, Resident 44, Resident 46, Resident 55, Resident 56, Resident 60, Resident 61, Resident 76, Resident 135, Resident 185, and Resident 202) Major Depressive Disorder- A mood disorder causing persistent feelings of sadness leads to physical and emotional problems and difficulty in performing day-to-day activities. (Resident 12, Resident 36, Resident 53, and Resident 60) Schizophrenia- A disorder involving delusions (false beliefs), hallucinations (seeing or hearing things that don't exist), unusual physical behavior, disorganized thinking and speech, and paranoid thoughts or hearing voices. (Resident 1, Resident 14, Resident 28, Resident 30, Resident 31, Resident 71, and Resident 204) Psychosis- A condition where person losses contact with reality and may have difficulty recognizing what is real and what is not real. (Resident 11, Resident 17, and Resident 48) (continued on next page)

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Administrator stated this list was obtained from medical records and was the current record of patients with psychiatric diagnoses in the facility. During a review of the Facility Assessment Tool (FAT), dated 3/1/24, the FAT indicated, Common diseases/conditions, physical and cognitive (mental) disabilities that the facility can manage: . Psychiatric/ Mood Disorders, Psychosis (Hallucinations, Delusions, etc.), Impaired Cognition, Mental Disorder, Depression, Bipolar Disorder (i.e., Mania/Depression), Schizophrenia, Post- Traumatic Stress Disorder (a disorder that develops when a person has experienced or witnessed a scary, shocking, terrifying, or dangerous event), Anxiety Disorder, Behavior that Needs Interventions, Behavioral and Psychological Symptoms of Dementia (BPSD). The FAT indicated, 3.4 Describe the staff training/education and competencies that are necessary to provide the level and types of support and care needed for your resident population. Caring for residents with mental and psychosocial disorders, as well as residents with a history of trauma and/OR post-traumatic stress disorder, and implementing nonpharmacological interventions.