STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035093	A. Building B. Wing	08/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haven of Cottonwood	197 South Willard Street Cottonwood, AZ 86326

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 43863 Based on observations, staff interviews, and policy review, the facility failed to maintain an environment for residents that was free of odors. The deficient practice could result in residents not having a homelike environment. Findings include: During a facility observation conducted on 8/23/2021 of zone 4, a urine odor was detected in the hallway outside of rooms 217 - 222. During the survey from 8/23/2021 to 8/26/2021, urine odors were smelled in the zone 4 hallway by rooms 217 - 222. An interview was conducted on 08/25/2021 at 07:29 AM with a Licensed Nursing Assistant (LNA/staff #40), who stated that there was a urine odor at the end of side 2, zone 4. He further stated that the urine smell on that part of the unit happens more often than it should. The LNA stated that when he notices the urine smell, the reason is usually caused by a soiled brief or from a urine-soaked mattress. He also stated that the odor on 8/24/2021 could have been from soiled briefs. An interview was conducted on 08/25/2021 at 09:44 AM with a Licensed Practical Nurse (LPN/staff #51), who stated that he has noticed a urine odor at the end of side 2, zone 4, by one of the rooms. Staff #51 stated the odor is usually caused by a needed brief change or soiled linen. He stated that he noticed the odor throughout the day yesterday on 8/24/2021, and that he does not think that is appropriate. The LPN stated the odor should be taken care of as soon as possible, but that the odor has occurred more often than normal this week. He stated the residents should be checked every 2 hours for soiled briefs by the CNA. The LPN further stated that he knows that something was not being done, which was why there was an odor in the hallway. An interview was conducted on 08/26/2021 at 09:31 AM with the Director of Nursing (DON/staff #30), who stated that she was aware of the odor on side 2, zone 4, at the end of the hallway by one of the rooms. She also stated that she has noticed a urine odor at the end of this hall previously. The DON stated that the odor is not providing a homelike environment. The DON stated that this is not meeting facility expectations, and the risk is infection control. (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy titled, Quality of Life - Homelike Environment, revised April 2014 revealed the facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include pleasant, neutral scents. The facility staff and management shall minimize, to the extent possible, the characteristics of the facility that reflect an institutional setting, including institutional odors.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40581 Based on clinical record reviews, facility documentation, staff interviews, and policy and procedures, the facility failed to ensure the results of four of four investigations regarding allegations of abuse/neglect for four residents (#s 139, 142, 16, and 141) were submitted to the State agency. The deficient practice resulted in investigations results not being submitted to the State agency within 5 days. Findings include: -Resident #139 was admitted to the facility on [DATE] with diagnoses that included hemiplegia and hemiparesis following a cerebral infarction and dysphagia. Review of the State agency reporting system revealed the facility submitted an initial online report to the State agency on October 20, 2020 to report an allegation of abuse involving resident #139. However, further review of the State system revealed no evidence that the facility had submitted the results of the investigation to the State agency. -Resident #142 was admitted to the facility on [DATE] with diagnoses that included Bipolar Disorder, Anxiety Disorder, and Manic Depression. Review of the State agency reporting system revealed the facility submitted an initial online report to the State agency on May 3, 2021 to report an allegation of abuse involving resident #142. Continued review of the State system revealed no evidence that the facility had submitted the results of the investigation to the State agency. -Resident #16 was admitted to the facility on [DATE] with diagnoses that included hemiplegia and hemiparesis following Cerebral Infarction affecting left non-dominant side, and dysphagia. Review of the State agency reporting system revealed the facility submitted an initial online report to the State agency on May 5, 2021 to report an allegation of neglect involving resident #16. Additional review of the State system revealed no evidence that the facility had submitted the results of the investigation to the State agency. -Resident #141 was admitted to the facility on [DATE] with diagnoses that included dementia, cancer, and major depression. Review of the State agency reporting system revealed the facility submitted an initial online report to the State agency on June 16, 2021 to report an allegation of abuse involving resident #141. Further review of the State system revealed no evidence that the facility had submitted the results of the investigation to the State agency. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with the Executive Director (ED/staff #15), Director of Nursing (DON/staff #30), and Corporate Resource (staff #63) on August 24, 2021 at 10:12 a.m. The ED stated the investigations were conducted but that the results of the investigations were not submitted to the State agency. The ED stated the results of the investigations were not submitted to the State agency within 5 days because he was waiting for the State agency to come to the facility and investigate the allegations. The facility's, Abuse policy, dated 2017 stated the Executive Director (ED) will begin the investigation immediately and will complete within 5 calendar days using the Abuse Investigation Packet. The policy also stated that when the investigation is complete, the ED will submit a summary to the State Survey Agency.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43863 Based on clinical record review, staff interviews, and policy review, the facility failed to ensure a Pre-admission Screening and Resident Review (PASARR) Level 1 was completed before or upon admission for one sampled resident (#23). The census was 41. The deficient practice could result in residents not receiving the level of service they require. Findings include: Resident #23 was admitted to the facility on [DATE] with diagnoses that included malignant neoplasm of colon, urinary incontinence, delusional disorders, hallucinations, major depressive disorder, anxiety disorder, and insomnia. Review of admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident was cognitively intact. The MDS assessment also included the resident had received antipsychotic, antianxiety and antidepressant medications. However, review of the clinical record from admission on 7/23/2021 to 8/24/2021 did not reveal a Level 1 PASRR screening for serious mental disorder and/or intellectual disability had been completed before or upon admission to ensure the resident was offered the most appropriate setting to meet his needs. An interview was conducted on 08/25/2021 at 09:44 AM with a Licensed Practical Nurse (LPN/staff #51), who stated that he does admissions, but the Assistant Director of Nursing (ADON) or Director of Nursing (DON) completes the PASARR portion. A telephone interview was conducted on 08/25/2021 at 01:50 PM with the Social Services Director (staff #24), who stated that the PASARR Level 1 is completed at the hospital when a new resident is admitted from the hospital. Staff #24 stated that if the resident is not admitted from the hospital or another facility, he or the Human Resources Coordinator would complete the Level 1 PASARR. He also stated that the Level 1 PASARR should be completed before the resident has resided at the facility for 30 days. Staff #24 also stated that when a resident is admitted to the facility with a psychiatric diagnosis, a Level 1 PASARR should be completed to assess for more severe psychological issues. The Social Services Director reviewed the clinical record and stated that he did not see a Level 1 PASARR in the record and that the resident was past the first 30 days residing at the facility. He also stated that the risk of the Level 1 PASARR not being completed could relate to psychological issues. An interview was conducted on 08/26/2021 at 09:31 AM with the Director of Nursing (DON/staff #30), who stated that the PASARR Level 1 usually is completed at the hospital. She further stated that when a resident is admitted from home, the facility would complete the Level 1 PASARR. The DON then reviewed the clinical record and stated that the Level 1 PASARR was not scanned into the system until 8/26/2021, and the completion date was 8/25/2021. She also stated that this did not meet the facility expectations or policy. The DON stated the risk is that the facility would not catch a need for completion of a Level 11 PASARR and further psychiatric evaluation. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Pre-Admission Screening and Resident Review (PASRR), revealed that the facility will strive to verify that a Level 1 PASRR Screening has been conducted, in order to identify Serious Mental Illness (MI) and/or an Intellectual Disability (ID) prior to initial admission of individuals to the facility. PASRR Level 1 Screenings are used to determine whether the individual has a diagnosis or other presenting evidence that suggests the potential for MI or ID. If the resident is positive for a potential MI or ID, a Level 11 Screening referral must be submitted.

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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** 43863 Based on clinical record review, staff interviews, and policy and procedures, the facility failed to ensure that a care plan was developed for one resident (#23) regarding hospice and activities. The sample size was 12. The deficient practice could result in care issues not being addressed in the residents' plan of care. Findings include: Resident #23 was admitted to the facility on [DATE] with diagnoses that included malignant neoplasm of colon, urinary incontinence, delusional disorders, hallucinations, major depressive disorder, anxiety disorder, and insomnia. Regarding Hospice Care Review of the clinical record revealed a health status progress note dated 7/26/2021 that stated the resident was on hospice and the hospice nurse came in to see the resident. An admission Minimum Data Set (MDS) assessment dated [DATE], revealed the resident was coded for hospice care. A review of progress notes dated 8/2/2021, revealed the hospice nurse was in to see the resident. Review of a provider note dated 8/4/2021 revealed the resident was receiving hospice care. However, review of the care plan did not reveal a care plan had been developed regarding the resident receiving hospice services and care. An interview was conducted on 08/26/2021 at 08:53 AM with the Care Coordinator (staff #59), who stated that when a resident is admitted to the facility on hospice, she would expect that a care plan would be developed for hospice. She reviewed the resident clinical record and stated that the resident was on hospice from the date of admission on 7/23/2021. Staff #59 further stated that she did not see hospice care on the care plan, and it should have been. The Care Coordinator also stated that this does not meet facility expectations, and the risk would be that the needs of the resident would not be met. An interview was conducted on 08/26/2021 at 09:31 AM with the Director of Nursing (DON/staff #30), who stated that the care plan process starts as soon as a resident is admitted . She further stated that each department does their own assessments and documentation on the care plan. The DON stated that when a resident is admitted on hospice, it should be added to the care plan. She reviewed the clinical record and stated that the hospice portion of the care plan was added on 8/26/2021. She stated that there was no hospice care plan developed before 8/26/2021. The DON stated that this does not meet facility expectations and policies, and the risk would be that the facility staff would not expect hospice to visit. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 8/26/2021 at 10:46 AM with a Registered Nurse (RN/staff #29), who stated a care plan should be developed for hospice for a resident receiving hospice care. The RN reviewed the clinical record and stated a hospice care plan had not been developed prior to 8/26/2021. A review of the facility policy titled, Hospice Program, revealed that it is the responsibility of the facility to meet the resident personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. These included collaborating with the hospice representatives and coordinating facility staff participation in the hospice care planning process for residents receiving these services. Coordinated care plans for residents receiving hospice services will include the care and services provided by the facility in order to maintain the resident's highest practicable physical, mental and psychosocial well-being. Regarding Activities Review of the admission MDS assessment dated [DATE], revealed the resident was interviewed for activity preferences. The activity assessment revealed that it was very important for the resident to have books, newspapers, and magazines to read. It further revealed that it was not important to the resident to do things with groups of people, or to do his favorite activities. A review of the care plan revealed no evidence a care plan for activity preferences had been developed. An interview was conducted on 8/25/2021 at 2:10 PM with the Activity Director (staff #7), who stated that he completes the activity portion of the MDS assessment, and would then develop the activity care plan. He stated the facility expectation and policy is to implement the MDS activity assessment into the activity care plan. The Activity Director reviewed the clinical record and stated that an activity care plan had not been developed for this resident. He stated that according to the facility policy the resident should have an activity care plan, and isolation could be the risk of the care plan not being implemented. Staff #7 then stated that he would develop an activity care plan that day. An interview was conducted on 8/26/2021 at 9:31 AM with the DON (staff #30), who stated that each department does their own assessments and documentation on the care plan. The DON stated that she would expect the activity care plan to be developed within 72 hours of admission. She reviewed the care plan in the clinical record and stated the activity care plan was not developed until 8/25/2021. She stated that this did not meet the facility expectations or polices, and the risk would be the resident would not be offered preferred activities. A review of the facility policy titled, Care Plans, Comprehensive Person-Centered, revealed that a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The care plan will identify the professional services that are responsible for each element of care and reflect currently recognized standards of practice for problem areas and conditions. The comprehensive, person-centered care plan is developed within seven days of the completion of the required comprehensive assessment (MDS). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Activity Evaluation, revealed in order to promote the physical, mental and psychosocial well-being of residents, an activity evaluation is conducted and maintained for each resident. The activity evaluation is to be conducted by the Activity Department personnel. The resident's lifelong interests, spirituality, life role goals, strengths, needs and activity pursuit patterns and preferences will be included in the evaluation. The activity evaluation is used to develop an individual activity care plan that will allow the resident to participate in activities of his/her choice and interest. Each resident's activities care plan shall relate to his/her comprehensive assessment and should reflect his/her individual needs. The completed activity evaluation will be part of the resident's medical record and shall be updated as necessary, but at least annually.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43890 Based on clinical record reviews, observations, staff interviews, and policy and procedure, the facility failed to ensure the administration of medications met professional standards of quality for two of five sampled residents (#14 and #16). The deficient practice could result in residents not receiving physician ordered medications. Findings include: -Resident #14 was admitted to the facility on [DATE] with diagnoses that included unspecified protein-calorie malnutrition, myelodysplastic syndrome, acute osteomyelitis and chronic cholecystitis. Review of the quarterly Minimum Data Set assessment (MDS) dated [DATE] revealed the resident scored 14 on the Brief Interview for Mental Status (BIMS) which indicated the resident was cognitively intact. During a medication administration observation conducted on August 25, 2021 at 7:11 A.M. with a Licensed Practical Nurse (LPN/staff #51), the LPN was observed to prepare the following medications for resident #14: Ibuprofen (nonsteroidal anti-inflammatory) 200 milligrams (mg) tablet Vitamin C 500 mg tablet Multi vitamins with minerals one tablet Zinc (mineral) 200 mg tablet Gabapentin (anticonvulsant) 100 mg capsule. The LPN was observed to place half of the medications in the resident's hand and wait until the resident took the medications. The LPN was then observed to place the rest of the medications in the resident's hand. As the resident was in the process to place the medications to her mouth, the LPN turned back and walked out of the room without observing the resident swallow the medications. Review of the clinical record revealed no evidence the resident had been assessed to self-administer medications. An interview was conducted with the LPN (staff #51) on August 25, 2021 at 9:50 AM. He stated resident #14 is not able to take medications on her own. He stated the resident need the nurse to stay with her while taking the medication as the resident need assistance sometimes. The LPN gave as an example the medication pass earlier when he had to place medications in the resident's hand few at a time. After informing the LPN what was observed during that medication pass observation, he stated that he thought the medication were in resident's #14 mouth and did not realized he left the room too soon. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident #16 was admitted to the facility on [DATE] with diagnoses that included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, dysphagia, type 2 diabetes mellitus, bipolar disorder, major depressive disorder and anxiety disorder. Review of the quarterly MDS assessment dated [DATE] revealed the resident scored a 14 on the BIMS which indicated the resident was cognitively intact. A physician order dated May 5, 2021 included for Biotene Moisturizing Mouth Solution (Artificial Saliva), give 10 milliliter (ml) by mouth two times a day for dry mouth swish and spit. A medication administration observation was conducted on August 25, 2021 at 7:35 A.M. with an LPN (staff #51). Resident #16 was sitting in a wheelchair in the dining room. The LPN was observed to administered medications to the resident except for the Biotene. The LPN left the biotin on the tray table in front of the resident for the resident to take. Staff #51 then returned to the medication cart without ensuring the resident swish and spit the Biotene. Review of the clinical record revealed no evidence the resident had been assessed to self-administer medications. During an interview conducted with the staff #51 on August 25, 2021 at 9:50 AM, he stated that he left the Biotene medication on resident #16's table because the resident is able to take and swallow the Biotene on her own. The LPN stated he did not realize the Biotene order was to swish and spit. The LPN stated that it was his mistake for not making sure the resident swish and spit the Biotene. An interview was conducted with a Registered Nurse (RN/staff #66) on August 26, 2021 at 10:58 AM. The RN stated that when administering medications to residents, the nurse cannot leave until the resident swallow their medications. The RN stated resident #16 is not able to take medications by herself because she needs help to put the medications in her mouth. An interview was conducted with the Director of Nursing (DON/staff #30) on August 26, 2021 at 2:27 PM. She stated her expectation is for the nurses to make sure the residents take their medications before the nurse leave the resident's room. The DON stated the nurses need to make sure the residents swallow their medications before leaving the room to ensure residents receive the medications they need. The facility policy titled Administering Medications revised December 2012 revealed that medications shall be administered in a safe and timely manner, and as prescribed. The policy included that medications must be administered in accordance with the orders, including any required time frame. The policy also revealed that residents may self-administer their own medications only if the Attending Physician, in conjunction with the Interdisciplinary Care Planning Team, has determined that they have the decision-making capacity to do so safely.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40581 Based on observations, resident and staff interviews, facility documentation, and policy and procedures, the facility failed to ensure three of five sampled residents (#138, #9, and #23) received the necessary services to maintain good grooming and personal hygiene, by failing to provide the assistance needed to shower. The deficient practice could result in residents not being provided hygiene care and services. Findings include: -Resident #138 was admitted to the facility on [DATE] with diagnoses that included Chronic Respiratory Failure, Dysphasia, shortness of breath, dementia, and a need for assistance with personal care. The admission Minimum Data Set (MDS) assessment dated [DATE] included a Brief Interview for Mental Status (BIMS) score of 13 indicating the resident was cognitively intact, and that the resident did not have delusions or hallucinations. The assessment also included the resident required one-person assistance with bathing and hygiene which included combing hair, bathing did not occur for the entire lookback period, and the resident did not reject care. Review of the care plan initiated on July 31, 2021 revealed the resident had an ADL (activities of daily living) self-care performance deficit related to limited mobility, gait instability, weakness, fatigue, and poor endurance. Interventions included the resident required one staff supervision-limited assistance with bathing and personal hygiene. Review of documentation revealed that there were no shower sheets for the first and second week of August. Review of the Bathing Task Sheet revealed the resident did not refuse care and was assisted with bathing on August 17 and 25, 2021. Review of the progress notes did not reveal the resident refused assistance with bathing/shower. The facility was unable to provide documentation that the resident received showers from July 31, 2021 through August 16, 2021. During an interview conducted with the resident on August 23, 2021 at 11:45 a.m., the resident's hair was observed uncombed and he was wearing a gown. The resident stated that he had received one shower since being admitted to the facility. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview conducted on August 26, 2021 at 10:27 a.m. with the Unit Secretary (staff #55), the shower sheets were reviewed and there were only three shower sheets for the resident. The shower sheets were dated August 17, 20, and 23, 2021. Staff #55 stated those were the only shower sheets she had been given for the resident. She stated the Certified Nursing Assistant (CNA) would complete a shower sheet even if the resident refused to shower and the CNA would document the refusal on the shower sheet. She also reviewed the task section for showers and stated that the CNAs had marked not applicable and that this does not mean the resident refused to shower. Staff #55 stated she did not know why the shower task was marked not applicable, and did not know what that meant. She also stated that if the resident refused, the CNA should request help from the nurse, so the nurse can encourage the resident to shower. Staff #55 stated the resident is scheduled for showers on Wednesdays and Saturdays. An interview was conducted on August 26, 2021 at 10:59 a.m. with the Director of Nursing (DON/staff #30) and the Assistant Director of Nursing (ADON/staff #1) at the nurses' station. Staff #1 stated that there were no shower sheets kept at the nurses' station. She stated the shower sheets are sent to staff #55 at the end of each day and kept with Medical Records. They looked around and did not find any shower sheets. Staff #1 stated the resident is scheduled for showers on Tuesdays and Fridays. She reviewed the tasks section for showers and acknowledged that the CNAs had marked, not applicable, and that this does not mean the resident refused a shower. She stated that even if the resident was not here, the shower should be offered when the resident returns. 43863 -Resident #9 was admitted to the facility on [DATE] with diagnoses that included hemiplegia/hemiparesis, aphasia, dysphagia and need for assistance with personal care. Review of the care plan dated 8/25/2020 revealed the resident had an ADL self-care deficit related to a diagnosis of cerebrovascular accident. The goal was for the resident to improve the current level of function in personal hygiene and ADLs. Interventions included the assistance of staff to provide a bath per scheduled preference and as necessary. Review of a quarterly MDS assessment dated [DATE], revealed the resident had severely impaired cognitive skills for daily decision making. The MDS assessment also revealed that the resident was total dependent for bathing, personal hygiene, and dressing. According to a CNA shower schedule, the resident was to receive a shower every Wednesday and Saturday. An interview was conducted on 08/25/2021 at 10:59 AM with the Medical Records Manager (staff #26) who stated the bathing documentation is documented in two locations, one in the computer system and the other on a paper shower sheet. Review of both sources with staff #26 revealed the week of 7/18/2021 - 7/24/2021 the resident received one shower on 7/24/2021, the week of 8/1/2021 - 8/7/2021 the resident received one shower on 8/4/2021, and the week of 8/15/2021 - 8/21/2021 the resident received one shower on 8/18/2021. The facility was unable to provide any additional documentation that the resident received two showers per week or that the resident had refused any showers. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 8/26/2021 at 09:31 AM with the DON (staff #30), who stated that the facility process is for the CNAs to offer residents showers twice a week. She stated that when a resident declines a shower it would be documented in the clinical record and alternatives would be offered. She further stated that the documentation would be in the CNA system and that the CNAs also complete shower sheets that are signed by nursing. She reviewed the clinical record and stated there was no documentation of showers being given or refused on 7/24/2021, 8/4/2021 and 8/21/2021. The DON stated that this did not meet facility expectations and there could be increased risk of skin breakdown and infection. An interview was conducted on 08/26/2021 at 12:34 PM with a Licensed Nursing Assistant (LNA/staff #40), who stated that residents should receive showers two times a week. He further stated that the showers would be documented in the clinical record system, and on a shower sheet that would be signed by a nurse. He also stated that if a resident were to decline a shower, the CNA would document the refusal on the shower sheet and the resident would sign the sheet, and the CNA would also document in the clinical record under the shower task form. The CNA reviewed the resident's shower documentation in the clinical record and stated that he could only view 30 days in the system. He stated that the resident missed a shower on 8/7/2021 and 8/21/2021. He stated that this does not meet the facility expectations for charting showers, or giving them. The CNA stated the risk of missing a shower could be skin breakdown. -Resident #23 was readmitted to the facility on [DATE] with diagnoses that included malignant neoplasm of colon, urinary incontinence; major depressive disorder, Anxiety Disorder and insomnia. Review of the care plan initiated on July 23, 2021 revealed the resident had an ADL self-care performance deficit related to activity intolerance, musculoskeletal impairment and pain. The goal was for the resident to maintain the current level of function in personal hygiene and dressing. Interventions included the resident required limited-extensive assistance for personal hygiene and dressing; and to provide a sponge bath when a full bath or shower cannot be tolerated. Review of the admission MDS assessment dated [DATE] revealed a BIMS score of 14, which indicated the resident was cognitively intact. The assessment included the resident required extensive assistance for personal hygiene and dressing, and that bathing did not occur during the lookback period. According to a CNA shower schedule, the resident was to receive a shower every Wednesday and Saturday. Review of the bathing documentation in the computer system and the paper shower sheet sheets revealed the week of 8/1/2021 - 8/7/2021 the resident received no showers, the week of 8/8/2021 - 8/14/21 the resident received 1 bed bath on 8/11/2021, and the week of 8/15/2021 - 8/21/2021 the resident received 1 shower on 8/18/2021. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 08/25/2021 at 07:29 AM with the LNA (staff #40), who stated that the facility process is to give showers twice a week. He further stated that the resident showers are scheduled on Wednesday and Saturday. The LNA reviewed the clinical record and stated that the resident's last shower documented was on 8/11/2021. He also stated that according to the documentation in the clinical record the resident did not receive showers last week. He further stated that refusals are documented on the bathing self-performance form in the clinical record and that the last refusal for this resident was documented on 7/30/2021. The LNA stated that this was not following the facility policy and expectations. He stated that the harm to the resident could be skin breakdown and a risk of developing sores. An interview was conducted on 08/25/2021 at 09:44 AM with an LPN (staff #51), who stated that the facility has a shower schedule of two times a week, unless more showers are needed. She reviewed the resident clinical record and stated the resident has not had a shower since 7/11/2021 according to the bathing report. She also stated that if a resident refuses a shower or bath it would be documented on a shower sheet, that nurses would sign. The LPN stated that the shower sheets are turned into the DON or ADON (Assistant Director of Nursing). An interview was conducted on 08/25/2021 at 10:52 AM with the Medical Records Manager (staff #26), who stated the facility policy is to shower residents twice a week. She stated the CNA will write the resident names on the shower sheets, for those residents due to shower that day, and complete the shower sheets appropriately. She further stated that when a resident refuses a shower or bath, it would be written on the shower sheet form, signed by the resident, and then given to the nurse for review. She reviewed the shower sheets and the documentation in the clinical record for this resident. Staff #26 stated that there were no shower sheets, and no documentation in the clinical record, that the resident had received or declined showers or baths between 8/11/2021 and 8/18/2021. She stated that according to the shower sheets and the clinical record, the resident did not receive a shower for 12 days between 7/30/2021 and 8/11/2021, and did not receive showers for 7 days between 8/12/2021 and 8/18/2021. She stated that this is not following facility procedure. The Medical Records Manager further stated that the risk of not identifying skin issues timely could occur if showers are not provided as scheduled. An interview was conducted on 08/26/2021 at 09:31 AM with the DON (staff #30), who stated that the facility process is for the CNA to offer showers to residents twice a week. She stated that if a resident declines a shower it would be documented, and alternatives would be offered. The DON stated documentation for resident showers would be in the CNA system in the clinical record, and that CNAs also complete shower sheets that are signed by the nurse. She reviewed the clinical record for this resident and stated there was no documentation of showers being given or refused for the resident. She further stated that this does not meet facility expectations, and there could be increased risk of skin breakdown and infection. Review of the facility policy titled, Bath, Shower/Tub, revised February 2018 revealed that documentation for a bath or shower should include the date and time the shower was performed, name and title of individual who assisted the resident with the shower/tub bath, and how the resident tolerated the shower. Documentation should also include if the resident refused the shower/tub bath, the reason why and the intervention taken. The policy also included to notify the supervisor if the resident refused the shower/bath. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy titled, Charting and Documentation, revised July 2017 revealed that all services provided to the resident shall be documented in the resident's medical record. Documentation in the medical record may be electronic, manual or a combination. Treatments or services performed is to be documented in the resident medical record. Documentation in the medical record will be objective, complete, and accurate.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43863 Based on clinical record review, observations, resident and staff interviews, and policy review, the facility failed to provide one of two sampled residents (#23) with an ongoing program of activities to support the resident choice of activities. The deficient practice cold result in residents not having activities that are meaningful to them. Findings include: Resident #23 was admitted to the facility on [DATE] with diagnoses that included malignant neoplasm of colon, urinary incontinence, delusional disorders, hallucinations, major depressive disorder, anxiety disorder, and insomnia. A physician order dated 7/23/2021 included the resident may participate in an overall activity plan that does not interfere with the treatment plan. Review of the admission Minimum Data Set assessment dated ,d+[DATE]/ 2021 revealed it was very important to the resident to have books, newspapers, and magazines to read; listen to music the resident liked; to be around animals such as pets; and to participate in religious services or practices. The assessment also included the resident scored a 14 on the Brief Interview for Mental Status which indicated the resident was cognitively intact. Review of the clinical record did not review a care plan had been developed for activities. Review of a Psychiatric Evaluation Progress note dated 8/13/2021 revealed the practitioner recommended and encouraged the resident to attend facility activities. A review of the facility activity participation tasks from 7/23/2021 through 8/23/2021 revealed the following: -Talking-Conversing: participation documented one time on 8/7/2021 -Family-Friend visits: documented one time as occurring on 8/7/2021 -Reminisce: active participation documented on 8/7/2021 -Room visits: documentation of participation three times on 8/7/2021, 8/16/2021 and 9/24/2021 -Mail: active participation on 8/10/2021 and 8/16/2021. An interview was conducted with the resident on 8/23/2021 at 10:56 AM, who stated that he was not aware of any activities offered at the facility. He also stated that the day shift had assisted him into the wheelchair, he went down the hall, and saw where they had a bunch of puzzles and games. The resident further stated that he would be interested in puzzles, but would not have a place in his room large enough to do a puzzle. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations were conducted of the resident on 8/24/2021 from 9:10 AM to 10:30 am. -at 09:10 AM, staff in room to assist resident. Resident in bed lying on his back. - at 10:04 AM, the Activity Director was in zone 4 inviting residents to an activity. The Activity Director was not observed to go into the resident's room to invite him or his roommate to the activity. The Activity Director was observed to walk by the resident's room without stopping. -at 10:10 AM the Activity Director walked down hall past the resident's room three times. He did not stop by the room to invite the resident to activities, or engage in conversation. During this time an interview was conducted at 10:15 AM with the resident, who stated that he does not want to venture out today. -at 10:23 AM The Activity Director spoke through the speaker system letting staff and residents know he was starting a nature documentary, asking staff to bring residents that would like to attend. Further observations were conducted on 08/25/2021 at 01:00 PM, the resident was up in the wheelchair sitting in his room facing the closet, the television was not on, the resident did not have his I-pad. Another observation of the resident was conducted on 08/26/2021 at 02:14 PM. The resident was in his room, in bed lying on his back. The i-pad was sitting on the bedside table. During this time the resident was interviewed and stated that he needed a table for the I-pad, and that he has asked for a table. He further stated that he would like have 1:1 visits. The resident stated no one has come to his room with an activity cart. An interview was conducted on 8/25/2021 at 7:29 AM with a Licensed Nursing Assistant (LNA/staff #40), who stated that the resident did not want to go to the activity offered yesterday. He also stated that the resident has not joined in any activities that he is aware of at this time. The LNA stated that he is not sure what the activity department does for residents that cannot or will not come out of their rooms for activities. He stated that he has never seen a cart with activities offered to residents in their rooms. An interview was conducted on 8/25/2021 at 9:44 AM with a Licensed Practical Nurse (LPN/staff #51), who stated that he has not seen the resident participating in any activities. He also stated that he has seen the activity staff with an activity cart. An interview was conducted on 08/25/2021 at 02:10 PM with the Activity Director (staff #7), who stated that he currently has a restricted activity calendar that is given to each resident. He stated that he completes the calendar monthly and goes room to room conducting 1:1 visits. He stated that for residents that want to do puzzles but cannot leave the room, they have smaller puzzles available. The Activity Director stated that resident participation in activities is documented in the clinical record. He reviewed the clinical record for this resident, and stated that there was no documentation that the resident had attended any activities or been included in 1:1 activities. He further stated that he remembers the resident did attend an afternoon social, but that it was not documented in the clinical record. The Activity Director stated this did not meet the facility expectations. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 8/26/2021 at 9:31 AM with the Director of Nursing (DON/staff #30), who stated that after reviewing the clinical record, it did not look like the activities department had any encounters with the resident or that the resident had been offered any activities or 1:1 visits. She further stated that there was no documentation in the resident's clinical record that activities had been offered or refused. The DON stated that there was not appropriate documentation regarding resident involvement in activities, and that this did not meet the facility expectations or policies. She stated that the risk is that they would not know if the resident had participated in any activities, 1:1 visits, or been offered and refused any activity encounters. A review of the facility policy titled, Charting and Documentation, revised July 2017 revealed that all services provided to the resident, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Documentation in the medical record may be electronic, manual or a combination. The information to be documented in the resident medical record should include objective observations, services performed, progress toward or changes in the care plan goals and objectives. Documentation in the medical record will be objective, complete, and accurate. A Review of the facility policy titled, Activity Evaluation, revealed in order to promote the physical, mental and psychosocial well-being of residents, an activity evaluation is conducted and maintained for each resident. The resident's lifelong interests, spirituality, life role goals, strengths, needs and activity pursuit patterns and preferences will be included in the evaluation. The activity evaluation is used to develop an individual activity care plan that will allow the resident to participate in activities of his/her choice and interest. Each resident's activities care plan shall relate to his/her comprehensive assessment and should reflect his/her individual needs.

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the activities program is directed by a qualified professional. 42497 Based on personnel file review, staff interview, and the job description, the facility failed to ensure the activities program was directed by a qualified professional. Findings include: A review of the personnel file for the Activities Manager (AM/staff #7) revealed he was hired on January 2, 2014, and started his current position of Activities Manager on July 2, 2020. Continued review of the personnel file did not reveal documentation regarding the qualifications staff #7 possessed to be the Activities Manager. Review of the job description for the AM (updated 2016) revealed the AM directs the development, implementation, supervision and ongoing evaluation of the activities program. The activity manager oversees the direction of an activity program, which includes scheduling of activities, both individual and groups, and the implementation of such programs. An interview was conducted with staff #7 on August 26, 2021 at 10:05 am. Staff #4 stated he was hired originally as an activities assistant and was promoted to activities manager when the previous AM left. Staff #7 stated he did not have a certification in activities, nor had he completed any training outside of the facility for managing activities programs.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40581 Based on clinical record review, resident and staff interviews, and policy review, the facility failed to ensure a physician order for a consult was implemented for one of three sampled residents (#138), one of two sampled residents (#23) had an order for hospice care, and one sampled resident (#29) had compression wraps applied as ordered. The deficient practice could result in necessary treatment and services not being provided to residents. Findings include: -Resident #138 was admitted to the facility on [DATE] with diagnoses that included chronic respiratory failure, dysphasia, shortness of breath, and dementia. A nurse health status note dated July 31, 2021 at 4:04 p.m. revealed the resident was admitted at 1130. The note included the resident was on a dysphagia diet and reported that he could only eat food chopped very fine because of his teeth. The note also included the resident had no pain at that time. A care coordinator communication note dated August 1, 2021 at 4:15 p.m. stated the resident had upper and lower full plate dentures, ill fitting, and had been working with the dentist on getting new ones made, and reports difficulty with swallowing. The note included SLP (speech-language, pathologist) ordered and the resident's diet was downgraded to mechanical soft with chopped meat related to difficulty chewing/swallowing. The admission Minimum Data Set (MDS) assessment dated [DATE] included a Brief Interview for Mental Status (BIMS) score of 13 indicating the resident was cognitively intact. The assessment included the resident did not have delusions or hallucinations. It also included that the resident had no natural teeth or tooth fragments, abnormal mouth tissue, and mouth or facial pain, discomfort or difficulty chewing. Review of a provider note with the date of service August 6, 2021 revealed the resident was delusional and had psychiatric issues. The note included a diagnosis of delusional disorder currently symptomatic. The note also included the resident was oriented to person, place, and season. A nurse health status note dated August 11, 2021 at 6:51 a.m. revealed the resident's right cheek was swollen and that the resident stated it was because of a tumor. The note included the resident stated it was becoming harder to swallow. The note also included the nurse noted the resident was breathing through the nose and encouraged the resident to utilize the oxygen that was going into the resident's nose. A nurse progress note dated August 13, 2021 at 4:51 p.m. stated the resident complained of a right lump in the right cheek and that the pain had increased the last two days. The note included the resident's family member had called upset stating the resident had told the family member that he needed surgery. The Nurse Practitioner (NP) was notified and orders were obtained to administer Tramadol for pain and to order an Ear, Nose, and Throat (ENT) consult. The note included the resident was administered Tramadol at 1227 with good effect. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Medication Review Report revealed physician orders dated August 13, 2021 to consult ENT regarding the inside right-side cheek mass, and for Tramadol HCl Tablet 50 milligrams (mg) one tablet by mouth every 6 hours as needed for pain levels 6 to 10 on a scale of 1 to 10. A care plan for the growth on the resident's right side of the mouth was initiated on August 13, 2021. Interventions included mouth inspections as needed and report changes to the nurse; and monitor, document, and report to the physician as needed signs and symptoms of oral dental problems needing attention. The care plan did not include the ENT consult or pain medication. A nurse progress note dated August 14, 2021 at 5:00 p.m. stated the resident complained of pain to right cheek and inability to swallow. The note stated the resident was administered Tramadol twice that shift. The note included the resident was able to eat the pureed meal without too much problem. The note also included the ENT consult was ordered. The note also stated that the resident's family member was visiting, concerned, and tearful. Review of the nurse progress note dated August 15, 2021 at 12:51 a.m. stated the lump in the resident's oral cavity appeared to be growing and that the resident confirmed. The note included the resident was having difficulty speaking and swallowing and that the nurse would continue to monitor. An alert charting note dated August 15, 2021 at 6:35 p.m. included a change of condition summary that revealed the resident stated the lump in the right lower jaw oral cavity appears to be growing, complained of increased difficulty speaking and swallowing. The note included the resident requested pain medication which had limited effectiveness. The note included the area had no drainage, will monitor and report any further changes in status. A nurse health status note dated August 15, 2021 at 11:45 p.m. included a change of condition that the lump in the oral cavity was growing. The note stated the resident complained of discomfort to the right cheek area and right neck gland area, and has difficulty swallowing pills and applesauce. The note included the resident had a history of dysphasia unspecified. The note also included the resident was alert and oriented to person, place, and time and that the nurse would continue to monitor. Review of multiple provider notes including notes dated August 15, 16, 17, 18, 23, and 24, 2021 all included the same documentation that the resident had a chronic mass inside the right cheek and it seems to be getting bigger, it's been there for years he wants to wait and have it addressed when he gets home. He knows if it interferes with his breathing or swallow he will need to go to the Emergency Department (ED). Review of a Social Services progress note dated August 19, 2021 at 11:29 a.m. revealed a care conference for the resident was held and that the Care Coordinator (staff #59), Rehab Director (staff #16), resident #136, resident's family member, and Resident Relations (staff #24) all attended the conference. The note included the resident had a small weight loss and was on a pureed diet. The note also included the resident had a growth inside his mouth that seemed to be growing and that the resident was scheduled to see an ENT physician who would address the growth in the resident's mouth. However, despite documentation that the right cheek lump was getting bigger, painful, and the resident had increased difficulty swallowing and speaking, no evidence was revealed the resident had a consult with an ENT or that a consult with the ENT had been scheduled. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview conducted with the resident on August 23, 2021 at 1:50 p.m., the resident stated that he was eating pureed food because he was unable to wear his dentures due to some growth in his mouth located around the right cheek area. The resident stated that he was not sure what was going on and there was no plan to rectify the issue. The right cheek was observed to be swollen. The resident stated that it was painful to eat wearing his dentures because the dentures did not fit right due to the lump. On August 25, 2021 at 2:21 p.m., an interview was conducted with the Case Manager (staff #59), who stated that it was the responsibility of the Unit Secretary (staff #55) to schedule outgoing appointments for the residents. An interview was conducted on August 25, 21 at 2:27 p.m. with the Marketing Admissions Manager (staff #14), who stated that staff #55 schedules the outside appointments, but is not available because she works nights. Staff #14 reviewed staff #55's documentation and said that she did not see an appointment in the schedule for the ENT, but she would follow up with staff #55 when she comes on shift. A second interview was conducted with staff #14 on August 26, 2021 at 8:15 a.m. She stated that she had received an email from staff #55 stating the appointment with the ENT specialist was scheduled for Monday, August 30, 2021. She said that she did not know when staff #55 had scheduled the appointment. An interview was conducted on August 26, 2021 at 8:38 a.m. with the Executive Director (staff #15) and the Marketing Admissions Manager (staff #14). Staff #14 now stated that she scheduled the appointment with the ENT specialist yesterday. She stated that the nurse never gave the order to the staff #55, so staff #55 did not know that an appointment needed to be scheduled. Staff #14 stated that she schedules appointments when the position needs to be covered, so she is aware of the process. Staff #1 and the appointment should have been made sooner, and she did not think it was reasonable that it took so long. Both staff members acknowledged that the sooner the appointment was made, the better, because resident was having pain that now extended to the neck/lymph area. An interview was conducted on August 26, 2021 at 8:50 a.m. with the Corporate Resource (staff #63), who stated that the facility did not have a policy regarding scheduling outside appointments. 43863 -Resident #23 was admitted to the facility on [DATE] with diagnoses that included malignant neoplasm of colon, urinary incontinence, delusional disorders, hallucinations, major depressive disorder, anxiety disorder, and insomnia. A review of the care plan initiated on 7/23/2021 revealed no care plan for hospice care and treatment. Review of hospice notes dated 7/23/2021 revealed that visit notes and orders had been faxed to the facility. Review of the nursing progress notes dated 7/24/2021, 7/26/2021, and 8/2/2021, revealed the resident was receiving hospice care. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the progress note dated 7/26/2021, revealed the resident was on hospice and that the hospice nurse did come in to see the resident. Review of a nurse practitioner's admission note dated 7/26/2021, 7/28/2021, and 8/4/2021, revealed the resident was receiving hospice care. A physician's history and physical dated 7/27/2021, revealed that the resident was admitted to the facility for hospice care. The note further stated that the resident would be a long-term care resident and would be overseen by the hospice team. The admission MDS assessment dated [DATE], revealed the resident was coded for hospice care. The assessment included the resident scored a 14 on the BIMS which indicated the resident had intact cognition. Hospice notes dated 8/2/21 stated that hospice was doing visit via telemedicine. Review of the clinical record revealed additional orders from hospice on 8/3/2021. However, further review of the clinical record revealed no physician's order for the resident to receive hospice care and services before 8/9/2021. An interview was conducted on 08/23/2021 at 11:13 AM with resident #23, who stated that he does receive hospice and that the hospice nurse came to see him when he was first admitted . He further stated that he had not seen the hospice nurse recently. An interview was conducted on 08/26/2021 at 08:53 AM with a Registered Nurse (RN/staff #59), who stated that when a resident is admitted to the facility with hospice care, she would expect a physician's order to be written for hospice care. The RN reviewed the clinical record and stated that resident was on hospice from admission on 7/23/2021. She further stated that she did not see a physician's order for hospice care and treatment prior to 8/9/2021. The RN stated that this does not meet the facility policy and expectations. She also stated the risk would be that the resident's needs would not be met. In an interview conducted on 08/26/2021 at 09:31 AM with the Director of Nursing (DON/staff #30), she stated that when a resident is admitted to the facility on hospice care, she would expect an order for hospice care to be written on the date of admission. The DON reviewed the clinical record and stated that there was not an order for hospice on the date of admission. She further stated that this does not meet the facility expectations or policy. The DON also stated that the risk of a hospice order not being written, could be that staff would not know that resident was on hospice. An interview was conducted on 8/26/2021 at 10:46 AM with an RN (staff #29), who stated that there should be a physician's order written, when a resident is admitted to the facility on hospice. She reviewed the clinical record and stated that she did not see a physician's order for hospice. A facility policy titled, Hospice, revised July 2017 revealed that it is the responsibility of the facility to meet the resident personal care and nursing needs in coordination with the hospice representative, and the prescribed care. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A facility policy titled, Medication and Treatment Orders, revised July 2016 revealed that orders for medications and treatments will be consistent with principles of safe and effective order writing. 43890 -Resident #29 was admitted to the facility on [DATE] with diagnoses that included hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left non-dominant side, thrombocytopenia, unspecified dementia without behavioral disturbance, muscle weakness and type 2 diabetes mellitus with diabetic neuropathy. The quarterly MDS assessment dated [DATE] revealed the resident scored 6 on the BIMS, indicating the resident's cognition was severely impaired. The MDS assessment also revealed the resident needed extensive one-person assistance with dressing and personal hygiene. A physician order dated August 10, 2021 included for compression wraps to the bilateral lower legs, start at toes and work up to knees two times a day for edema, on AM and off PM. During an observation conducted of the resident on August 23, 2021 at 10:50 AM, the resident was observed in a wheelchair with compression wraps to the bilateral legs. However, the compression wraps were wrapped from the resident's ankles to the knees, exposing the feet which were observed to be really swollen. The resident stated that she thought the compression wraps were placed a few days ago and had not been changed. Another observation was conducted of the resident on August 24, 2021 at 8:31 AM. The resident was observed in her room in a wheelchair. The resident had no compression wraps on to the bilateral legs. The bilateral legs were observed to be swollen. Multiple observations were conducted of the resident throughout the day on August 24, 2021. The resident was observed to have no compressions wrap on. Multiple times the compression wraps were observed rolled up on top of the resident's tray table or at the end of the resident's bed. Review of the TAR (Treatment Administration Record) for August 2021 revealed the order for compression wraps had been transcribed onto the TAR and that the compression wraps were marked off as completed on the AM shift on August 23 and 24, 2021. Additional review of the nursing progress notes revealed no documentation that the resident had declined placement of the compression wraps. An interview was conducted with a Licensed Practical Nurse (LPN/staff #4) on August 24, 2021 at 3:06 PM. She stated that the night shift nurses are responsible for applying the compression wraps early morning before the resident gets out of bed. The LPN stated the evening shift nurse removes the compression wraps in the evening before the resident goes back to bed. She agreed that the resident's compression wraps were not on that day and stated the compression wraps should have been placed on by the night shift nurse that morning. The LPN stated the compression wraps are very important for the resident as the resident's legs get really swollen and the swelling is painful to the resident. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with a Registered Nurse (RN/staff #66) on August 26, 2021 at 10:35 AM. She stated the resident has edema to the legs and the resident will not keep the legs elevated. She stated that for this reason the resident has an order for compression wraps to the bilateral legs. The RN stated the night shift staff applies the compression wraps to the resident's legs before the resident gets out of bed, and the day shift staff checks to see if the wraps are on. Staff #66 stated the resident is not able to put the compression wraps on herself. The RN stated the compression wraps are to be applied starting from the toes up. The RN stated the risk for not wrapping legs with the compression wraps is that the resident will have increase pain, legs will be swollen, or the resident might get cellulitis. Staff #66 further stated it is important to place the compression wraps correctly starting from her toes. An interview was conducted with the DON (staff #30) on August 26, 2021 at 2:27 PM. She stated that her expectation from the nurses is for them to follow the physician's order. She stated if a resident has an order for compression wraps, it should be placed on the resident appropriately. The DON stated the only time compression wraps can be off during the day is when the resident refuse. The DON stated in that case there should be a nurse's note stating the resident refused to wear the compression wraps. She stated compression wrap should be applied the first thing in the morning and should be removed at bedtime. She stated compression wraps are important to reduce swelling.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** 42497 Based on observations, clinical record review, resident and staff interviews, and facility policy, the facility failed to ensure one resident (#19) was adequately supervised during dining to prevent choking and burning accidents. As a result, the Conditions of Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) were identified. The deficient practice could result in choking incidents and burns. Findings include: On August 25, 2021 at 10:50 am, the Condition of IJ was identified. The executive director (staff #15), Director of Nursing (DON/staff #30), and clinical resource nurse (staff #63) were informed of the facility's failure to adequately supervise a resident (#19) who had an order regarding strict aspiration precautions during dining. Specifically, staff were informed that observations were conducted of the resident having difficulty eating unsupervised by facility staff while lying in his bed, and that interviews and record review revealed that on June 8, 2021 resident #19 received a second degree burn from spilling coffee while eating unsupervised in his bed. At this time, the facility was notified that the concerns related to supervision also resulted in SQC. The administrator presented a removal plan on August 25, 2021 at 12:36 pm. The facility was informed at 1:02 pm that the removal plan needed to be revised to include information specific to resident #19. The facility was informed that the plan also needed to include the staff who would receive education and a completion date for the education, a process for identifying residents who require supervised dining, information related to diet orders, and additional policy information. A revised removal plan was presented by the facility on August 25, 2021 at 1:55 pm. The facility was informed at 2:25 pm that the removal plan needed to be revised to include more specific information related to the education provided, specifically education for those staff who assist with dining, as well as information related to communication of diet orders. A final revised removal plan was presented by the facility on August 25, 2021 at 2:55 pm. This removal plan was accepted. The plan included the following corrective actions: -Resident #19 was assessed and his clinical record updated. -all residents needing supervision during dining were identified and supervised during dining on August 25, 2021 during the lunch meal. Supervision will continue for all identified residents moving forward. -education regarding dining supervision, choking hazards, accidents, and diet orders was provided to all staff on August 25, 2021 and will be included for new hires. -DON or designee will complete a daily audit for one month to ensure compliance with meal supervision, orders, and staff assignments during dining (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-facility wide audit completed to ensure residents care plan is appropriate and reflects the residents identified needs -resident's diet orders and tray cards updated; CNA (Certified Nursing Assistant) will be provided with in-service regarding both to be completed by the end of the day on August 25, 2021. -deficiencies will be reported to the Executive Director and taken to the Quality Assurance and Performance Improvement (QAPI) committee monthly for review. Multiple observations were conducted on August 26, 2021 of implementation of the plan of correction. Staff in-services were completed and sign in sheets were reviewed. Staff interviewed were knowledgeable regarding resident needs for supervision during dining, diet orders, and accidents. As there were no additional concerns identified, the condition of IJ was removed on August 26, 2021 at 1:38 pm. -Specifics regarding Resident #19 Resident #19 was admitted to the facility on [DATE] with diagnoses that included pneumonitis due to inhalation of food and vomit, facial weakness following unspecified cerebrovascular disease, dysphagia, pharyngeal phase, and cognitive communication deficit. Resident #19's care plan initiated on May 27, 2020 included an Activities of Daily Living (ADL) self-care performance deficit related to impaired mobility and functional decline. Interventions included the resident was able to hold a cup and feed himself independently, and that the resident required meal tray set up and supervision to eat. A diet order dated March 23, 2021 for resident #19 was reviewed and included the resident received a mechanical soft diet with ground meat texture. The order also included strict aspiration precautions and that the resident must have his head turned to the left when swallowing liquid. An order dated May 5, 2021 stated meals with help only and if resident starts choking, stop meals. This order also stated the resident must take small bites and turn to the left to swallow. Another order dated May 5, 2021 stated the resident must be seated upright (90 degrees) in wheelchair for all meals and under no circumstances should the resident eat or drink in bed. A nurse's note dated June 8, 2021 stated the resident spilled hot coffee on himself during the evening meal, receiving a significant burn along his back with a 2 centimeter (cm) by 2 cm blister. The resident's ADL care plan was revised on June 26, 2021 to include an intervention that the resident uses a cup with a lid for hot liquids to prevent spill or injury. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The quarterly Minimum Data Set (MDS) assessment for resident #19 dated July 21, 2021 included the resident scored a 13 on the Brief Interview for Mental Status (BIMS), indicating the resident was cognitively intact. The MDS assessment also included the resident needed supervision while eating, and had upper and lower extremity functional limitation in range of motion on one side. The assessment included the resident experienced loss of liquids/solids from the mouth when eating or drinking, coughing or choking during meals or when swallowing medications, and had complaints of difficulty or pain with swallowing. On August 24, 2021 at 12:33 pm, an observation was conducted of resident #19. Resident #19 was in the bed farthest from the hallway door, and the privacy curtain between the two bed in the room was closed, separating the two areas of the room. The resident was not visible from the hallway. When the surveyor entered the room, the resident was observed reclining in his bed. He was not sitting at an upright, 90-degree angle. The resident's bedside table was positioned over the bed and had the resident's lunch meal on it. The resident was struggling to feed himself green beans, and most of the food was falling out of his mouth onto his bare chest and into the sheets on his bed. At 12:41 pm on August 24, 2021, a Certified Nursing Assistant (CNA/staff #50) entered the resident's room and began to assist him with eating his lunch. The CNA stood on the right side of the resident's bed to assist him, and the resident was observed turning his head to the right while eating and swallowing. At 1:05 pm on August 24, 2021, the CNA left the resident's room to get him a beverage. An interview was conducted at this time with the resident. Resident #19 stated he does not usually have assistance from staff while eating and he makes a mess when he eats. He stated he usually eats in his bed. The CNA returned at 1:07 pm and assisted the resident with a drink. The CNA stood on the right side of the resident's bed, and the resident was observed turning his head to the right to drink and swallow. The resident began coughing at this time. An interview was conducted with staff #50 during this observation. Staff #50 stated she has assisted this resident at times with eating. She stated any special instructions for the resident would be on the meal card. Staff #50 read resident #19's meal card for the current meal and stated it included the resident needed supervision while eating, must turn his head to the left and had aspiration precautions. Staff #50 stated the resident was good about turning his head to the left on his own. Staff #50 was asked about the observation just prior of the resident turning to the right side to eat, drink, and swallow since she was standing to the right. Staff #50 again stated the resident is good about turning his own head. At this time, a copy of resident #19's meal card for the lunch meal on August 24, 2021 was obtained. It included the resident required a scoop plate, built up silverware with z handle, and nosey cup. It also included tray instructions of supervision with meal and must turn head to the left. Food instructions included aspiration precautions and supervision. An interview was conducted with resident #19 on August 25, 2021 at 8:45 am. The resident stated that he does not always receive assistance from staff during meals. He stated there were no staff members assisting him when he spilled coffee on himself in June 2021. Resident #19 stated he was sitting in his bed at the time when he spilled the coffee. He stated the facility staff do not assist him with getting out of bed to eat meals. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview was conducted on August 25, 2021 at 9:50 am with a CNA (staff #40) who stated he was familiar with resident #19 and his care. Staff #40 stated he had not received any training related to dining assistance or training specific to resident #19's needs. Staff #40 stated he would find any dining instructions on the resident's tray card or in the Kardex. Staff #40 reviewed resident #19's Kardex at this time and stated it included the resident required supervision while eating. Staff #40 stated he was not sure why the resident would need to turn his head to the left when swallowing, and is not sure what the risks might be if the resident does not turn his head to the left. Staff #40 stated he was aware that resident #19 was not able to get food onto his utensils easily. Staff #40 stated at meal times he will set up resident #19's tray and then leave the room to deliver other trays. Staff #40 stated supervision meant checking on the resident once in a while and not leaving the resident alone for long periods of time. An interview was conducted on August 25, 2021 at 9:55 am with a speech therapist (staff #17). Staff #17 stated a resident with diagnoses like resident #19 should be assessed to determine if the resident needed to be supervised during dining and what level of assistance the resident might need. Staff #17 reviewed resident #19's orders and stated those types of orders would be in place for a resident who was at risk for choking and that the resident should always be seated upright in a chair to eat to prevent choking. She stated the resident might be at risk for aspiration pneumonia, choking, weight loss, or other complications if the resident was not appropriately assisted while eating. An interview was conducted on August 25, 2021 at 9:57 am with a Licensed Practical Nurse (LPN/staff #51) who stated he was familiar with resident #19. Staff #51 stated residents who require assistance with meals will have orders for assistance. He stated the order will appear on the resident's Treatment Administration Record (TAR), and if there was no order on the TAR, the resident was able to eat independently. Resident #19's TAR was reviewed at this time and staff #51 stated there were no orders related to assistance or supervision during meals, which meant resident #19 was able to eat independently and did not require supervision. The physician's orders for resident #19 were reviewed by staff #51 at this time and staff #51 stated there was an order that the resident required supervision while eating, and an order that the resident should be out of bed for meals. Staff #51 stated these orders were not entered in such a way that the nursing staff would see them on the TAR, and that he would not look anywhere other than the TAR for orders related to dining supervision. An interview was conducted on August 25, 2021 at 10:18 am with a temporary nursing assistant (TNA/staff #58) who was working on resident #19's hall. Staff #58 stated she does not know which residents require assistance or supervision while eating, and she will make rounds to check on the residents and see if anyone is struggling and appears to need assistance. She stated the nurse will sometimes let her know which residents need assistance during meals. Staff #58 stated when she is assisting resident's with meals, she will sit on whichever side of the resident is more comfortable for the resident. Staff #58 stated she was not aware of any residents with orders for facing a certain side when swallowing. Staff #58 stated she is not familiar with the resident's diet orders, but she can look on the tray card to see if there are any special instructions. Staff #58 stated she was familiar with resident #19 and had observed him eating in the past. She stated resident #19 was usually in his bed during meals. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A wound treatment observation was conducted on August 25, 2021 at 10:30 am with the wound nurse (LPN/staff #41). Staff #41 stated the wound was a second degree burn and the burn had been present for a couple of months. Staff #41 stated the wound was improving, and the orders had recently been updated to leave the wound open to air. The wound was observed to be 2.5 cm by 7 cm on the back side of the resident's hip, near his buttocks. The wound was 100% pink granulation with no discharge or slough. An interview was conducted with staff #41 on August 26, 2021 at 1:15 pm. Staff #41 stated he has been following resident #19's burn wound since the incident occurred. Staff #41 stated he was not present at the time of the injury. Staff #41 stated he believed there had been an accident during dinner and the resident spilled coffee on himself. Staff #41 stated the wound was a fluid filled blister initially and has improved over time. An interview was conducted with the DON (staff #30) on August 26, 2021 at 2:30 pm. The DON stated she expects the nursing staff to follow the physician's orders and provide supervisions during dining when the resident needs it. She stated residents should be assessed for their ability to eat independently. Staff #30 stated staff who are assisting residents should be trained by therapy on the specific needs of the resident. The DON stated the Kardex for each resident should be accurate and the CNA will use the Kardex to see what care the resident needs. The DON stated the Kardex should match the physician's orders. She stated she would expect staff to follow all orders whether it appeared on the TAR or not. The DON stated resident #19 was supposed to be supervised when eating, and he was supposed to be sitting in a chair during meals. The DON stated she was not sure if the resident was supervised when he was burned by the coffee, but that he was supposed to be supervised at the time. The facility policy Assistance with Meals included residents shall receive assistance with meals in a manner that meets the individual needs of each resident. It also included facility staff will help residents who require assistance with eating and that all employees who provide resident assistance with meals will be trained and shall demonstrate competency in the prevention of food borne illness, including personal hygiene practices and safe food handling.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43890 Based on clinical record review, observations, and resident and staff interviews, the facility failed to ensure one of two sampled residents (#13) with a gastrostomy tube (g-tube) received consistent care and services regarding the care of the g-tube site. The deficient practice could result in infection to the site. Findings include: Resident #13 was admitted to the facility on [DATE] with diagnoses that included unspecified protein-calorie malnutrition, candida stomatitis and adult failure to thrive. The significant change Minimum Data Set (MDS) assessment dated [DATE] included the resident scored 12 on the Brief Interview for Mental Status (BIMS), indicating the resident's cognition was moderately impaired. The MDS assessment also revealed that the resident needed extensive one-person assistance with dressing and personal hygiene. A physician order dated May 10, 2021 included to cleanse the g-tube insertion site with normal saline, cover with fenestrated gauze dressing, and secure with tape daily. Review of the MAR (Medication Administration Record) for August 2021 revealed the order for the g-tube dressing change had been transcribed onto the MAR and that the g-tube dressing change was done as ordered. The weekly skin check and assessment dated [DATE] revealed that the g-tube site was clean and the stoma was beefy red, healthy appearance. Additional review of the nursing progress notes revealed no documentation regarding the g-tube dressing change and/or the resident refusal of tape to hold the dressing. During an observation conducted on August 23, 2021 at 3:13 PM, the resident was observed with no dressing on the g-tube insertion site and the site was observed to be red. Another observation of the resident was conducted on August 24, 2021 at 1:30 PM. The resident was observed in the bed with no dressing on the g-tube insertion site. The site was observed to have dried scabs. No dressing was observed in the vicinity. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with a Registered nurse (RN/staff #21) on August 24, 2021 at 2:29 PM. He stated that the resident has a g-tube and the nurses have to change the dressing at the insertion site and flush the tube. The RN stated the g-tube insertion site is kept clean and assessed every shift. Staff #21 stated the night shift does the dressing change to the g-tube insertion site daily. The RN then stated he applied a dressing that morning and did not apply tape as the resident does not like the dressing to be taped on. He stated the dressing might have come off. The RN stated he makes sure the dressing is on whenever he is giving the resident medications and fluids via the g-tube. The RN stated dressing on the g-tube insertion site is important as the site is an open way for bacteria to get in. Staff #21 then stated he will be placing a dressing on right away. An interview was conducted with the resident on August 24, 2021 at 2:41 PM. He stated that his g-tube dressing had not been done that day. An observation was conducted of the resident g-tube site on August 25, 2021 at 2:25 PM. The resident g-tube insertion site was observed with a dressing on and tapped to the resident's skin. The dressing was observed to be dated 8/25/21. An interview was conducted with a RN (staff #66) on August 26, 2021 at 11:14 AM. She stated the g-tube insertion site needs to be cleaned with normal saline, split gauze needs to be applied, and the dressing needs to be taped and dated. Staff #66 stated the dressing should be properly taped so that the dressing does not fall off. She added if a resident does not like the dressing to be taped to the skin, then the tape should be applied at the split area of the dressing to hold it in place. She stated the nurses assess the area each time during feeding or flushes. The RN stated dressing to g-tube insertion site is important as there is risk of infection, drainage and redness without the dressing. An interview was conducted with the Director of Nursing (DON/staff #30) on August 26, 2021 at 2:27 PM. She stated her expectation is for the staff to do g-tube dressing change per the physician order. Staff #30 stated the nurses should place a new dressing if the dressing falls off. She stated the resident does not like for the dressing to be taped. The DON stated a dressing is important to reduce risk of infection and irritation.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 42497 Based on observation, staff interview, and policy review, the facility failed to ensure nursing staff information was posted daily. The deficient practice could result in staffing information not being readily available to residents and visitors. The facility census was 41 residents. Findings include: On August 23, 2021 at 10:02 am, the nurse staff posting for the facility was observed in the lobby of the facility. The date on the document was August 21, 2021. An interview was conducted with the Director of Nursing (DON/staff #30) on August 26, 2021 at 2:30 pm. The DON stated the daily nurse staff posting was prepared by the staffing coordinator (staff #55) and that staff #55 worked nights and would change the posting as she left the facility following her shift. The DON stated there was no different process for the nurse staff postings on the weekends. The DON stated she did not know why the staff posting had not been changed over the previous weekend and acknowledged that the staff posting that was displayed at the surveyor's entrance to the facility was outdated. The facility's policy Posting Direct Care Daily Staffing Numbers included the facility will post, on a daily basis for each shift, the number of nursing personnel responsible for providing direct care to residents. The policy also included within 2 hours of the beginning of each shift, the number of licensed nurses and the number of unlicensed personnel directly responsible for resident care will be posted in a prominent location and in a clear and readable format.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43863 Based on clinical record reviews, staff interviews, and facility policy, the facility failed to ensure two of five sampled residents (#23 and #20) were not administered unnecessary drugs, by failing to administer pain medication as ordered by the physician. The deficient practice could result in residents receiving pain medications that may not be necessary. Findings include: -Resident #23 was admitted to the facility on [DATE] with diagnoses that included malignant neoplasm of colon, urinary incontinence, delusional disorders, hallucinations, major depressive disorder, anxiety disorder, insomnia, and osteoarthritis. Review of the physician's orders dated 7/23/2021 revealed the following orders: Morphine sulfate solution (narcotic/opioid pain medication) 100 milligrams/5 milliliters, give 0.5 milliliters by mouth every 2 hours as needed for pain scale 9-10 Norco (narcotic/opioid pain medication) 5-325 milligram (mg) two tablets by mouth every 4 hours as needed for pain level 7-8 Norco 5-325 milligram one tablet by mouth every 4 hours as needed for pain level 5-6 Acetaminophen (analgesic) 650 mg by mouth every 6 hours as needed for pain scale 3-4 Acetaminophen 325 mg by mouth every 6 hours as needed for pain scale 1-2 Review of the Medication Administration Record (MAR) dated July 2021, revealed the resident was administered Norco for a pain level of 3 on 7/27/2021, and for a pain level of 0 on 7/28/2021. An interview was conducted on 8/25/2021 at 9:44 AM with a Licensed Practical Nurse (LPN/staff #51), who he administered Norco to the resident for a pain level of 3 on 7/27/2021 and a pain level of 0 on 7/28/2021. The LPN stated that this was not following the physician's order for Norco administration. He also stated that the risk of not following the physician order for pain medications could result in over medication and possible addiction. An interview was conducted on 08/26/2021 at 09:31 AM with the Director of Nursing (DON/staff #30), who stated that the facility policy is to administer medications following the physician's orders. The DON stated that the facility policy, when giving pain medication, is to ask the resident his/her pain level, and administer the pain medication according to the order parameters. She also stated that when administering as needed pain medication out of parameters, the nurse would need to get a physician's order, prior to administering. The DON reviewed the clinical record for this resident and stated that the Norco was not given following physician orders on 7/27/2021 and 7/28/2021. She further stated this does not meet facility expectations or policy. The DON stated the risk would be overmedicating the resident, it is a medication error. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	43890 -Resident #20 was admitted to the facility on [DATE] with diagnoses that included acute respiratory failure with hypoxia, acute kidney failure, shortness of breath (SOB), anxiety disorder and chronic pain syndrome. A physician's order dated July 7, 2021 included for Morphine Sulfate (Concentrate) Solution 20 mg/milliliter (ml), give 0.5 ml by mouth every 1 hour as needed for shortness of breath/pain scale 6-10 and Acetaminophen 650 mg by mouth every 6 hours as needed for pain scale 1-5. Review of the MAR for July 2021 revealed Morphine was administered for a pain level of 0 on July 22, a pain level of 5 on July 23, and a pain level of 4 on July 25. Review of the MAR for August 2021 revealed Morphine was administered for a pain level of 0 on August 17, pain level of 5 on August 19, and pain level of 4 on August 23. Review of progress notes including the eMar notes (Medication Administration notes) revealed no documentation that the resident was administered pain medication for shortness of breath. An interview was conducted with a Registered Nurse (RN/staff #66) on August 26, 2021 at 1:18 pm. She stated the process of administering pain medication is to assess the resident's pain level first, give the pain medication according to the level of pain, and reassess the pain level after an hour. Staff #66 stated the resident should not be given pain medication outside the parameter. The RN stated if residents are given pain medication outside parameters, then residents might become too sedated, confused and might have side effects such as nausea/vomiting and constipation. An interview was conducted with the DON (staff #30) on August 26, 2021 at 2:27 PM. The DON stated her expectation is for nurses to follow the parameters when administering pain medication. Staff #30 stated pain medication should not be given outside parameters. She further stated if the pain medication Morphine was given for shortness of breath then her expectation is for the nurses to write a note stating the medication was given for shortness of breath. The facility policy titled Administering Medications revised December 2012 revealed that medications shall be administered in a safe and timely manner, and as prescribed. The policy included that medications must be administered in accordance with the orders, including any required time frame.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43863 Based on clinical record review, resident and staff interviews, and policy reviews, the facility failed to ensure one of two sampled residents (#23) was assisted in obtaining routine dental care. The deficient practice could result in residents dental care needs not being met. Findings include: Resident #23 was admitted to the facility on [DATE] with diagnoses that included malignant neoplasm of colon, urinary incontinence, delusional disorders, hallucinations, major depressive disorder, anxiety disorder, and insomnia. A physician order dated 7/23/2021 included the resident may be seen by podiatrist, dentist, eye doctor, wound care consultant of choice as needed. The admission Minimum Data Set (MDS) assessment dated [DATE], included a Brief Interview for Mental Status score of 14, which indicated the resident was cognitively intact. The MDS assessment also included the resident had broken teeth, and mouth or facial pain. A review of the Activity of Daily Living care plan dated 7/23/2021, revealed that the resident had a self-care performance deficit related to activity intolerance and pain. The goal was for the resident to maintain the current level of function in personal hygiene. Interventions included oral care including oral inspection daily. A review of the Dental care plan dated 8/4/2021 revealed that the resident had poor natural dentition. The goal was for the resident to be free of infection, pain or bleeding in the oral cavity. Interventions included to monitor/document/report any signs or symptoms of dental problems, and to provide mouth care per activity of daily living (ADL) personal hygiene. An interview was conducted on 08/23/2021 at 11:09 AM with resident #23, who stated no one has looked at his mouth. He further stated that he keeps telling them he needs to see a dentist. The resident stated that he told the visiting nurse, who told him that they have to make arrangements for that. He also stated that he has rotten teeth and sore spots in his mouth when he eats something crunchy. An interview was conducted on 08/25/2021 at 07:29 AM with a Licensed Nursing Assistant (staff #40), who stated that the resident has not complained of mouth or tooth pain. An interview was conducted on 08/25/21 at 09:44 AM with a Licensed Practical Nurse (staff #51), who stated that the resident has not mentioned anything to him about sore teeth or gums, and that oral care is provided daily. (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 08/26/2021 at 09:31 AM with the Director of Nursing (DON/staff #30), who stated that facility process for dental care, depends on what the resident wants to do and also on insurance. She stated when a resident is identified to have dental issues on the MDS assessment, there should be an additional thorough evaluation completed, to ensure proper professional dental follow-up. The DON stated that when a resident brings up a dental concern during the MDS evaluation, staff should follow-up and conduct a more thorough evaluation for the need of professional dental services. She reviewed the resident's MDS assessment and stated that there should have been additional follow-up regarding oral care with this resident. She also stated that this is not following the facility expectations and policies. The DON stated that the risk could be infection, weight loss and not meeting the resident's needs. An interview was conducted on 08/26/2021 at 10:51 AM with the MDS Coordinator (staff #59), who stated that the facility process is to inform the practitioner if the resident complains of dental issues during the MDS assessment. She further stated that typically when this occurs, they will do a more in-depth assessment, asking the resident more questions. She stated that this would be documented in the resident's record. The MDS Coordinator reviewed the clinical record and stated that she performed the MDS assessment for oral care, and that she should have asked more questions as there were dental issues at that time. She also stated that she did not document that she had performed a more in-depth assessment regarding the resident's dental status. Staff #59 stated that this did not meet the facility expectations, and the risk would not be meeting the needs of the resident. Another interview was conducted with the resident on 08/26/2021 at 01:40 PM. The resident stated that he was still having problems with his teeth. The resident stated he has told the physician and nurses that he would like to see a dentist. He also stated that he just wants to do maintenance; he wants to take care of the caps on his teeth and he may have a cavity. A review of the facility policy titled, Dental Services, revealed that routine and emergency dental services are available to meet the resident's oral health services in accordance with the resident's assessment and plan of care. Routine and 24-hour emergency dental services are provided to our residents through referral to other health care organizations that provide dental services. A review of the facility policy titled, RAI and MDS Coordination, revealed that the facility is required to ensure that all residents achieve their highest level of functioning possible and maintain their sense of individuality. Completion of the RAI process is interdisciplinary and implemented for all MDS assessments within the facility. The individual sections are completed by each department as assigned.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 40581 Based on observations, staff interviews, facility documents, manufacturer manual, and facility policy and procedures, the facility failed to ensure that the dishwasher water temperature was run as per the manufacturer's instructions for the wash and rinse cycle, chemical products were locked and stored separately from food items, and produce was stored under sanitary conditions. The deficient practice could result in residents becoming ill. Findings include: Regarding the chemical sanitizing Dish Machine Temperature: Review of the Dish Machine Temperature Log dated August 2021 revealed the wash and rinse water temperatures for the chemical sanitizing machine should be 120 degrees Fahrenheit (F) or higher. Continued review of the log revealed the following temperatures during the night shift: -August 3, the temperature for the wash cycle was 100 degrees F. -August 4, the temperature for the wash cycle and the rinse cycle was 118 degrees F. -August 6, the temperature for the wash cycle and the rinse cycle was 119 degrees F. -August 7, the temperature for the wash cycle and the rinse cycle was 118 degrees F. -August 8, the temperature for the wash cycle was 100 degrees F, and the rinse cycle was not recorded. -August 9, the temperature for the wash cycle was 100 degrees F, and the rinse cycle was not recorded. -August 11, the temperature for the wash cycle and the rinse cycle was 119 degrees F. -August 12, the temperature for the wash cycle and the rinse cycle was 118 degrees F. -August 13, the temperature for the wash cycle and the rinse cycle was 118 degrees F. -August 14, the temperature for the wash cycle and the rinse cycle was 119 degrees F. -August 15, the temperature for the wash cycle and the rinse cycle was 119 degrees F. -August 16, the temperature for the wash cycle and the rinse cycle were not recorded F. -August 18, the temperature for the wash cycle and the rinse cycle was 119 degrees F. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Dish Machine Temperature Log dated August 2021 also revealed the temperatures for the wash and rinse cycle during the day shift on August 13, 2021 was 118 degrees F. An interview was conducted on August 23, 2021 at 10:10 a.m. with the Dietary Manager (staff #3), who stated that the dishwasher is a low temperature dishwasher and is supposed to run at 120 degrees. She stated she usually has to run the machine 2-3 times to get the temperature to 120 degrees before washing the dishes because the hot water heater is far away. During the interview, the dishwashing cycle was run four times: -The first time, the temperature reached 80 degrees F. -The second time, the temperature reached 98 degrees F. -The third time, the temperature reached 103 degrees F. -The fourth time, the temperature reached 110 degrees F. On August 24, 2021 at 12:00 p.m., the Corporate Dietary Manager (staff #64) ran the dishwasher through six dishwashing cycles: -The first time, the temperature reached 80 degrees F. -The second time, the temperature reached 90 degrees F. -The third time, the temperature reached 102 degrees F. -The fourth time, the temperature reached 111 degrees F. Staff #64 also used his thermometer, which he stated had just been calibrated to measure the temperature after the fourth cycle was done and his thermometer read between 110 and 111 degrees F. -The fifth time, the temperature reached 119 degrees F. -The sixth time, the temperature reached just under 120 degrees F. He stated that it was his expectation that staff run the dishwasher until the temperature reaches 120 degrees F before washing the dishes. He also stated staff may have to run it several times because the hot water heater is located far away from the kitchen. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview conducted with the Dietary Manager (staff #3) on August 25, 2021 at 10:38 a.m., staff #3 reviewed the Dish Machine Temperature Log for August 2021 that was posted on the opposite wall from the dishwasher. She acknowledged that multiple temperatures recorded were below 120 degrees F and stated that the man that installed the dishwasher told them they could wash dishes at 115 degrees F because the chemicals were strong and would sanitize the dishes. She also stated that the temperatures recorded on the Dish Machine Temperature Log were the temperatures used to wash the dishes. She stated the first column of temperatures recorded were when the dishes were washed during the day and the second column was when the night staff washed the dishes at night. She reviewed the temperatures and stated that the night staff kept running the dishwasher below 120 degrees F when washing the dishes. She stated that she has reported the problem/difficulty of reaching at least 120 degrees F to maintenance and the Executive Director multiple times and was told that there was nothing they can do because the hot water heater is far away from the kitchen and hot water is needed to bathe the residents. Staff #3 stated the purpose of checking the water temperature is to make sure it is warm enough to kill all bacteria and germs. Review of the dishwasher manufacturer's installation and operation manual dated December 5, 2007 stated the wash and rinse temperatures are to be a minimum of 120 degrees F, and recommends 140 degrees F for both cycles. The facility's policy, Dish Machine Temperature Log, dated 2018 stated dishwashing staff will monitor and record dish machine temperatures to assure proper sanitizing of dishes. The director of food and nutrition services will post a log near the dish machine for the staff to document temperatures. Staff will monitor dishwashing temperatures throughout the dishwashing process. Staff will record dish machine temperatures for the wash and rinse cycles of each meal. The director of food and nutrition services will spot check this log to assure temperatures are appropriate and staff is correctly monitoring dish machine temperatures. The director of food and nutrition services will promptly assess any dish machine problems and take action immediately to assure proper sanitation of dishes. The facility's policy, Cleaning Dishes/Dish Machine, dated 2018 stated prior to use, verify proper temperatures and machine function. Regarding chemicals: During an observation conducted on August 23, 2021 at 10:10 a.m. with the Dietary Manager (staff #3), the following cleaning products were observed on an open shelve below next to the ice machine: Silverware Presoak, Orange Surface Multi-surface Cleaner, Delta Orbital Sanitizer, and Oasis 146 Multi-Quart Sanitizer. Staff #3 stated that cleaning products/chemicals are to be stored away from the food and should not be there because there is a risk of it getting on the food. During another observation conducted on August 25, 2021 at 10:38 a.m. with the Dietary Manager (staff #3), a bottle of Orbital Sanitizer was observed in staff #3's office on the floor near the open door. She stated that it was the bottle that was previously on the shelf next to the ice maker and she had picked it up to put it away. She stored the product in a small storage closet with other chemicals and cleaners. It was observed that the door to the storage closet did not have a lock. She stated that the door had never had a lock and the chemicals were always kept in the storage closet. A bottle of Peroxide Clorox, Satin Shine, and Orange Force was observed on the shelf. She stated that the chemicals should not be near food. The dietician (staff #65) joined the interview and agreed the chemicals are to be kept away from food to prevent cross-contamination. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's policy, Food Storage and Date Marking, dated 2018 stated chemicals must be clearly labeled, kept in original containers when possible, kept in a locked area and stored away from food. Regarding produce: During an observation conducted on August 23, 2021 at 10:10 a.m. with the Dietary Manager (staff #3), a large box of tomatoes was observed in the large refrigerator to the far left on the second shelf. One of the tomatoes appeared overripe as it was soft and squished open and there was a white substance approximately 1 inch by 1 mm (millimeter), where the tomato skin was broken. She stated that she did not know what the white substance was, but thought it might be sour cream. There was a box of sour cream in the refrigerator, but it was closed and it was on the top shelf to the right of the tomatoes. There were two bags of carrots and a clear plastic container of mixed salad above the tomatoes. She stated the tomato should be removed and she took it out of the box. She was unable to say if there was a risk of cross contamination because she was not able to identify the white substance, but agreed that it should have been removed from refrigerator. Another observation was conducted with staff #3 on August 24, 2021 at 12:25 p.m. During the interview, the large refrigerator was still observed to have two bags of carrots and the clear plastic container of mixed salad sitting above the box of tomatoes. The plastic container of mixed salad dated August 23, 2021 appeared watery. It did not look fresh and the outer edges of the salad appeared slightly wilted and less green in color. She stated that the mixed salad was good for seven days, but agreed that the salad did not look fresh and should be removed from the refrigerator. She also acknowledged that the box of sour cream was closed and not near the box of tomatoes and stated that sour cream could have dripped on the tomato from a few days ago, but agreed that the white substance on the tomato could have been something else, and it was possible the substance was a contaminate. She stated that it is the responsibility of the cook and herself to check the produce daily to ensure it is fresh. Staff #3 stated the cook checks it in the morning, another staff checks it in the afternoon, and she usually checks after lunch. She stated it is her expectation that produce that is not fresh, should be removed as soon as it is observed and she did not know why the cook did not find the tomato during his check the prior morning but agreed it should have been removed. She stated that she did not think the tomato could have contaminated anything else in the refrigerator because it was in the box with the other tomatoes. The facility policy, Food Storage and Date Marking, dated 2018 stated sufficient storage facilities are provided to keep food safe, wholesome, and appetizing. Food is stored in an area that is clean, dry, and free of contaminants. Food is stored, prepared, and transported at appropriate temperatures and by methods designed to prevent contamination or cross contamination.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43890 Based on observation, resident and staff interviews, clinical record review, and review of policy, the facility failed to ensure one resident's (#13) G-tube (Gastrostomy tube) dressing change was accurately documented in the resident's clinical record. The sample size was 12. The deficient practice could result in residents' clinical records not being accurate and complete. Findings include: Resident #13 was admitted to the facility on [DATE] with diagnoses that included unspecified protein-calorie malnutrition, candida stomatitis and adult failure to thrive. A physician order dated May 11, 2021 included to cleanse the g-tube insertion site with normal saline and cover with fenestrated gauze dressing, secure with tape daily. The significant change Minimum Data Set (MDS) assessment dated [DATE] included the resident scored 12 on the Brief Interview for Mental Status, indicating the resident's cognition was moderately impaired. The MDS assessment also included the resident needed extensive one-person assistance with dressing and personal hygiene. During an observation conducted on August 23, 2021 at 3:13 PM, the resident was observed with no dressing on his g-tube insertion site. Another observation was conducted on August 24, 2021 at 1:30 PM. The resident was observed in his bed with no dressing on the g-tube insertion site. No dressing was observed in the vicinity. Review of the MAR (Medication Administration Record) for August 2021 revealed that the g-tube dressing changes were marked as done for August 23 and 24, 2021. An interview was conducted with a Registered Nurse (RN/staff #21) on August 24, 2021 at 2:29 PM. He stated the night shift does the dressing change to the g-tube insertion site daily. He then stated he applied the dressing that morning but did not apply tape as the resident does not like the dressing to be taped on. The RN stated the dressing may have come off. He stated he makes sure the dressing is on whenever he is giving the resident medications and fluids via g-tube. The RN stated the check mark on the MAR meant the dressing change was done. He then stated he would place a dressing right away. An interview was conducted with the resident on August 24, 2021 at 2:41 PM. He stated that his g-tube dressing had not been done that day. An observation was conducted of the resident g-tube site on August 25, 2021 at 2:25 PM. The resident g-tube insertion site was observed with a dressing taped to the resident's skin dated 8/25/21. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035093	A. Building B. Wing	08/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haven of Cottonwood	197 South Willard Street Cottonwood, AZ 86326

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with a RN (staff #66) on August 26, 2021 at 11:14 AM. She stated the check mark on the MAR meant the task was done. She stated the MAR should not be checked as done if the task was not done. An interview was conducted with the Director of Nursing (DON/staff #30) on August 26, 2021 at 2:27 PM. She stated her expectation is for the staff to do g-tube dressing change per the physician order. She stated if the dressing was not done then the documentation in the MAR should correctly reflect that, and a note should be written regarding the reason why the dressing change was not done. The facility policy titled Charting and Documentation revised on July 2017 revealed that documentation in the medical record will be objective (not opinionated and speculative), complete, and accurate.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 42497 Based on concerns identified during the recertification survey, staff interviews, and policy, the Quality Assessment and Assurance (QAA) committee failed to identify concerns related to a lack of resident supervision during dining and failed to implement appropriate plans of action to correct these concerns. As a result, the Conditions of Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) were identified. The deficient practice could result in other quality concerns not being identified and corrective action not being implemented. Findings include: During the recertification survey, observations were conducted of a resident having difficulty eating unsupervised by facility staff while lying in the bed, and interviews and record review revealed that the resident had previously received a second degree burn from spilling coffee while eating unsupervised in the bed. As a result of the identified concerns, the Conditions of IJ and SQC were identified during the survey. An interview was conducted on August 26, 2021 at 3:20 pm with the Executive Director (ED/staff #15) and Director of Nursing (DON/staff #30). The ED stated the QAA committee tries to meet monthly, but they make sure that there is a meeting quarterly. The ED stated the committee identifies issues through various methods and implements performance improvement projects to correct the identified issues. The ED stated the QAA committee had been focused on COVID-19 infection control issues and COVID-19 testing and vaccination rates in the facility. The ED stated supervision of residents while they were eating had not been on the committee's radar and they did not have any performance improvement projects related to supervision of residents or dining issues. Review of the facility's Quality Assessment and Performance Improvement (QAPI) policy, revised August 2021, included that the purpose of the QAPI process is to establish data driven, facility wide processes that improve the quality of care, quality of life, and clinical outcomes of our residents. Systems are in place to monitor care and services. Performance Improvement projects (PIPS) are initiated when problems are identified.