STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055189	A. Building B. Wing	09/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenfield Care Center of Fairfield	1260 Travis Blvd Fairfield, CA 94533

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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 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to receive visitors of his or her choosing, at the time of his or her choosing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37797 Based on observation, interview and record review, the facility failed to provide immediate access to residents by family and visitors and unduly restricted resident visitation, when the facility imposed visitation limitations without a clinical or a safety justification, such as requiring visitors to make prior appointments, limiting visits to 30 minutes, only allowing visitation during two hours in the morning and three hours in the afternoon, limiting visitors to one person per resident, requiring visitors to remain six feet from the residents they were visiting, not touching them unless wearing gloves, and not allowing indoor visitation for unvaccinated or incompletely vaccinated visitors. This failure prevented all 52 facility residents from having immediate and unrestricted access to visitors. Findings: During an observation on 9/14/22, at 12:36 p.m., the facility's visitation policy was posted on a bulletin board at the entrance of the facility. A review of the visitation policy consisted of a letter dated 1/28/22, indicating the following: Effectively immediately! Public Health provided strict rules we have to follow, please see below the rules in order to visit our facility: Schedule visitation with Receptionist at [PHONE NUMBER]. Time slots are available in 30 min increments, 1 visitor per time slot. Only 1 time slot is available per day. Visiting hours are between 9 AM to 11 AM, and 2 PM to 5 PM, 7 days a week. Wearing a mask is Mandatory; Surgical or N95. Residents must also wear a mask. Social distancing, 6 feet apart. Handwashing must occur as much as possible. (continued on next page)

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

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

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F 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Screening must take place at the front desk No hand touching unless wearing disposable gloves. Resident is to have 1 visitor at a time. Visitors are limited to bring 1-2 family members at a time to visit for 30 minutes (the 30 minutes would need to be split amongst visitors). Visitors must be fully vaccinated with Booster if eligible are allowed for indoor visitation. Unvaccinated or those without all qualifying doses of the Covid vaccine are only allowed outdoor visitation. Proof of Covid Negative PCR test result within 48 hours or Antigen test within 24 hours. We are allowing 3 rapid test kit per resident for visitation of the resident only. This is subject to change based on availability. If you would like to get rapid tested at the facility please arrive 20 minutes prior to your appointment time. It takes 15 minutes to get tested . Please see the attached Visitation Grid Tool. During an interview on 9/14/22, at 12:37 p.m., the Receptionist stated resident visits must be scheduled 24 hours in advance. During an interview on 9/14/22, at 12:43 p.m., the Administrator confirmed the 1/28/22, letter was the facility's visitation policy. The Administrator confirmed family and visitors must schedule visits 24 hours in advance. The Administrator was asked to explain the clinical or safety reason behind this requirement, as well as all the other visitation restrictions listed in the letter. The Administrator stated these restrictions were required by, Public Health. The Administrator was asked to provide the, Public Health, documents containing such guidance. The Administrator stated the Infection Preventionist (IP) would provide them. During an interview on 9/14/22, at 12:49 p.m., the IP was asked for the clinical or safety justification of the visitation restrictions listed in the letter, dated 1/28/22. The IP did not provide any safety or clinical justification. The IP stated the restrictions were required by the California Department of Public Health (the Department). The IP stated she would bring the written guidance from the Department requiring the visitation restrictions. (continued on next page)

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F 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 9/14/22, at 1:05 p.m., the IP provided a copy of the, Order of the State Public Health Officer - Requirements for Visitors in Acute Health Care and Long-Term Care Setting, dated 2/7/22. The IP stated the facility's visitation restrictions were based on this order. A review of the State Public Health Officer Order indicated no restrictions or requirement for prior appointments, specific time of the day to visit, length of visitation, number of visitors, visitation slots per day, or that unvaccinated, or not fully vaccinated, individuals could only have outdoor visitation. The State Public Health Officer Order only indicated the facility must verify visitors were fully vaccinated, and for unvaccinated or incompletely vaccinated visitors, the facility must verify documentation of a negative Covid test. The State Public Health Officer Order further indicated unvaccinated or incompletely vaccinated visitors could visit indoors if they provided a negative covid test, and social distance must only be observed by visitors from facility personnel and other residents/resident/visitors not part of their group. A review of Centers for Medicare and Medicaid (CMS) QSO 20-39-NH Memorandum, revised 9/23/22, indicated, Facilities must allow indoor visitation at all times and for all residents as permitted under the regulations. While previously acceptable during the PHE [Public Health Emergency], facilities can no longer limit the frequency and length of visits for residents, the number of visitors, or require advance scheduling of visits.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44968 Based on interview and records review, the facility failed to provide the Notice of Medicare (Federal Health Insurance) Non-Coverage (NOMNC - Completed by the facility to notify the resident of his or her right to an expedited review of skilled services provided [Nursing and Rehab services either Physical Therapy, Occupational and Speech therapy]) and the Skilled Nursing Advanced Beneficiary Notice of Noncoverage (SNF-ABN - An item or service that is usually paid for by Medicare, but may not be paid for in this particular instance because it is not medically reasonable and necessary) to the Responsible Parties for three of three sampled residents (Resident 47, Resident 9, and Resident 301) who received Medicare Part A benefits. This failure resulted in the residents' Responsible Parties not given the choice to appeal the facility's decision to discontinue treatment. Findings: RESIDENT 9 During a clinical record review for Resident 9, the Face Sheet (A one-page summary of important information about a resident) indicated Resident 9 was admitted on [DATE], with diagnoses including Dementia (memory disorder). The Face Sheet indicated Resident 9's next-of-kin was listed as her Responsible Party. During a clinical record review for Resident 9, the Minimum Data Set (MDS -health status screening and assessment tool used for all residents), dated 7/6/22, indicated Resident 9 had a BIMS score of 00/15 (Brief Interview for Mental Status - a 15-point cognitive screening measure which evaluates memory and orientation. A score of 13 - 15 is cognitively intact, 08 - 12 is moderately impaired, and 00 - 07 is severe impairment). Review of the form, SNF (Skilled Nursing Facility) Beneficiary Notification Review, provided to the facility, indicated the facility initiated Resident 9's discharge from Medicare Part A Services when her benefit days were not exhausted (had skilled benefit days remaining). The form indicated Resident 9's Medicare Part A Skilled Services started on 6/29/22. During a review of the document titled, Notice of Medicare Non-Coverage, indicated Resident 9's skilled services ended on 9/8/22. The document indicated Resident 9 signed the document on 9/7/22. During a review of the document titled, Skilled Nursing Advanced Beneficiary Notice of Noncoverage, indicated Resident 9 signed the document on 9/7/22. RESIDENT 301 During a clinical record review for Resident 301, the Face Sheet indicated Resident 301 was admitted on [DATE]. The Face Sheet indicated Resident 301's grandson was listed as her Responsible Party. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a clinical record review for Resident 301, the MDS, dated [DATE], indicated Resident 301 had a BIMS score of 3/15. The MDS indicated Resident 301 had a diagnosis including altered mental status (change in mental function) and Metabolic Encephalopathy (alteration in consciousness). Review of the form, SNF Beneficiary Notification Review, provided to the facility, indicated the facility initiated Resident 301's discharge from Medicare Part A Services when her benefit days were not exhausted. The form indicated Resident 301's Medicare Part A Skilled Services started on 4/11/22. During a review of the document titled, Notice of Medicare Non-Coverage, indicated Resident 301's skilled services ended on 4/22/22. The document indicated Resident 301 signed the document on 4/19/22. During a review of the document titled, Skilled Nursing Advanced Beneficiary Notice of Noncoverage, indicated Resident 301 signed the document on 4/19/22. RESIDENT 47 During a clinical record review for Resident 47, the Face Sheet indicated Resident 47 was admitted on [DATE], with diagnoses including Alzheimer's Disease (memory disorder). The Face Sheet indicated Resident 47's sister was listed as his Responsible Party. Review of the form, SNF Beneficiary Notification Review, provided to the facility, indicated the facility initiated Resident 47's discharge from Medicare Part A Services when his benefit days were not exhausted (had skilled benefit days remaining). The form indicated Resident 47's Medicare Part A Skilled Services started on 8/2/22. During a review of the document titled, Notice of Medicare Non-Coverage, indicated Resident 47's skilled services ended on 8/18/22. The document indicated Resident 47 signed the document on 8/15/22. During a review of the document titled, Skilled Nursing Advanced Beneficiary Notice of Noncoverage, indicated Resident 47 signed the document on 8/15/22. During an interview with the Business Office Manager (BOM) on 9/14/22 at 3:16 p.m., when asked who was responsible with the issuance of the Notice of Medicare Non-Coverage and the Skilled Nursing Advanced Beneficiary Notice of Noncoverage, the BOM stated she was responsible for the issuance of the above notices. The BOM stated the notice would be issued to either the resident if he/she had the mental capacity or the resident's Responsible Party two days prior to the last day of skilled services. Review of the Facility policy and procedure titled, Notice of Medicare Non-Coverage, with no effective date, indicated, the NOMNC must be delivered at least two calendar days before Medicare covered services and or the second to the last day of service if care is not being provided daily .Notice delivery to representatives CMS requires that notification of changes in coverage for an institutionalized beneficiary/enrollee who is not competent be made to a representative. Review of the Facility policy and procedure titled, Medicare Advanced Beneficiary Notice, with no effective date, indicated: (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	I. If the director of admissions or benefits coordinator believes (upon admission or during the resident's stay) that Medicare (Part A of the Fee for Service Medicare Program) will not pay for an otherwise covered skilled service(s), the resident (or representative) is notified in writing why the service(s) may not be covered and of the resident's potential liability for payment of the non-covered service(s). a. The facility issues the Skilled Nursing Facility Advanced Beneficiary Notice (CMS form 10055) to the resident prior to providing care that Medicare usually covers but may not pay for because the care is considered, not medically reasonable and necessary, or custodial. b. The resident (or representative) may choose to continue receiving the skilled services that may not be covered and assume financial responsibility.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37797 Based on observation, interview and record review, the facility failed to ensure a safe and comfortable environment to facility residents when 21 of 25 resident rooms were in poor state of maintenance, as evidenced by missing window screens and/or window screens which were bent, broken or improperly fitted to the window frames, window blinds bent and/or broken, inoperable locks on access doors facing the outside, and bathrooms with stained fixtures. These failures left residents vulnerable to insects in their rooms, unable to control outside light in their rooms, unable to have complete privacy in their rooms, unable to properly operate fixtures in their rooms and and unable to enjoy a clean environment, potentially affecting up to 31 of 52 residents occupying these rooms. The facility also failed to exercise reasonable care for the protection of residents' property from theft or loss for 5 of 16 sampled residents (Residents 8, 39, 11, 44 and 151) when: the personal property inventory lists of residents were not properly completed or updated; the facility did not investigate resident reports of missing property; and the facility did not reimburse residents for lost or stolen property. These failures placed Residents 8, 39, 11, 44 and 151 at risk of being deprived of their personal property. Findings: During an observation on 9/11/22, at 12:50 p.m., flies were in the D wing between rooms [ROOM NUMBERS]. During a concurrent observation of resident rooms and interview with the Director of Maintenance on 9/16/22, at 11:01 a.m., the following was noticeable: room [ROOM NUMBER] (2 beds): The window screen had holes, were bent, and prevented the window from closing completely. room [ROOM NUMBER] (3 beds): The window blinds were broken and/or bent. room [ROOM NUMBER] (2 beds): The window blinds were broken and/or bent. room [ROOM NUMBER] (2 beds): The window blinds were broken and/or bent. room [ROOM NUMBER] (2 beds): The sliding door lock was broken, preventing the sliding door, which provided access to the outside, from being locked. room [ROOM NUMBER] (2 beds): The window blinds were broken and/or bent, and the window screens did not completely cover the windows. room [ROOM NUMBER] (2 beds): The window blinds were broken and/or bent. room [ROOM NUMBER] (3 beds): the window blinds were broken and/or bent. room [ROOM NUMBER] (4 beds): The window blinds were broken and/or bent. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	room [ROOM NUMBER] (2 beds): The window blinds were broken and/or bent. room [ROOM NUMBER] (2 beds): the window blinds were broken and/or bent. room [ROOM NUMBER] (2 beds): The window blinds were broken and/or bent. room [ROOM NUMBER] (3 beds): The window blinds were broken and/or bent, and the window screens did not completely cover the windows. room [ROOM NUMBER] (2 beds): The window blinds were broken and/or bent. room [ROOM NUMBER] (3 beds): The window blinds were broken and/or bent. room [ROOM NUMBER] (2 beds): The window blinds were broken and/or bent. room [ROOM NUMBER] (2 beds): The window blinds were broken and/or bent. There was no window screen. room [ROOM NUMBER] (3 beds): The window blinds were broken and/or bent, and the window screens did not completely cover the windows. room [ROOM NUMBER] (3 beds): The window blinds were broken and/or bent, and the window screens did not completely cover the windows. room [ROOM NUMBER] (3 beds): The toilet support railing was stained. room [ROOM NUMBER] (4 beds): The window screen was bent and not properly attached to the window frame, and the toilet seat was stained. A review of facility policy titled, Maintenance Service, undated, indicated: The maintenance department is responsible for maintaining the buildings, grounds, and equipment in safe and operable manner at all times. RESIDENT 151 A review of Resident 151's Facesheet indicated she was originally admitted on [DATE], later readmitted on [DATE], and had diagnoses including dementia. During an interview on 9/13/22, at 4:35 p.m., the Responsible Party of Resident 151 stated Resident 151's personal clothes are regularly lost. During an interview on 9/15/22, at 11:30 a.m., the Social Services Director (SSD) stated she oversaw theft and loss and resident property at the facility. The SSD stated the facility created a personal property inventory list for each resident upon admission. The SSD stated the list was then updated as needed whenever residents brought new property. The SSD was asked for Resident 151's current personal property inventory list. The SSD provided a copy a blank personal property list, dated 9/4/22, indicating Resident 151 had not clothes. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent and interview and observation of Resident 151's room on 9/15/22, at 11:55 a.m., CNA B was asked if Resident 151 had any clothes. CNA B opened Resident 151's closet and stated Resident 151 had two pair of pants, two sweaters, one pajama bottom and one t-shirt. 44968 RESIDENT 44 During an interview with Resident 44 on 9/13/22 at 9:54 a.m., Resident 44 stated he lost seven shirts from last year. Resident 44 stated the facility used markers to label his shirts which eventually faded away after several washings. During an interview and concurrent record review with the Social Service Director (SSD) on 9/14/22 at 3:34 p. m., when asked about Resident 44's missing shirts, the SSD stated she did not get a report regarding Resident 44's missing shirts. She stated Resident 44 tended to fabricate stories. The SSD was asked about her process for residents' reporting missing personal items. The SSD stated she would go to the laundry every week to check for missing clothes and go through the resident's closet to double check. She stated the facility would replace or reimburse for missing items listed in the resident's inventory sheet if not found. Review of the document titled, Resident's Clothing and Possessions, for Resident 44, with the SSD, it indicated Resident 44 had six tee-shirts. RESIDENT 11 During an interview with Resident 11 on 9/12/22 at 11:59 AM, Resident 11 stated he lost two sweat pants and socks last year. Resident 11 stated he had reported this issue to the Social Service Director but there was no resolution to this date. During an interview and concurrent record review with the Social Service Director (SSD) on 9/14/22 at 3:42 p. m., the SSD stated she received a report of Resident 11's missing sweat pants two months ago. The SSD concurred this issue was not resolved, and she was in the process of looking for the missing sweat pants. Review of the document titled, Resident's Clothing and Possessions, for Resident 11, with the SSD, it indicated Resident 11 had three sweat pants. Review of the document titled, Theft and Loss Record, indicated Resident 11 had two gray and one blue sweat pants, missing since July 2021. During an interview with Certified Nursing Assistant (CNA) N on 9/14/22 at 4:15 p.m., CNA N was asked about the process when she received a report from a resident of missing personal items. CNA N stated she would look around and check the laundry then report to the nurse if item was not found. During an interview with CNA P on 9/14/22 at 4:18 p.m. CNA P was asked about the process when he received a report from a resident of missing personal items. CNA P stated he would check in the resident's room and the laundry room and would do a verbal report to either the nurse or the Social Service [Director] if the missing item was not found. CNA P stated they did not have a form to fill out to report a missing item. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with Resident 44 on 9/14/22 at 4:35 p.m., regarding his missing shirts, Resident 44 was made aware he had six tee-shirts recorded on his inventory sheet. He stated he had reported his missing clothes to the previous Administrator but there was no resolution. Resident 44 was asked if he or the facility recorded in his inventory sheet every time he brought new personal belongings. Resident 44 stated a long time ago the facility provided him with a blank inventory sheet, but he was not able to complete it. During an interview with the SSD on 9/14/22 at 4:42 p.m., regarding the process when new clothes were brought in for residents. The SSD stated either the CNA or the nurse should update the inventory sheet once made aware new items were brought in, or the resident's family member could also update the inventory sheet. The SSD stated it was not the resident's sole responsibility to update the inventory sheet. She stated staff could assist the resident with this process. 46132 RESIDENT 39 Review of Resident 39'S Face Sheet (demographics) indicated he was [AGE] years-old and was admitted to the facility on [DATE]. His diagnosis included Diabetes Mellitus (DM, disease that affect how the body uses blood sugar), Hypertension (high blood pressure) and Major Depressive Disorder. During a concurrent interview, inventory list and theft and loss policy review, on 9/16/22 at 9:55 a.m., the Social Services Designee (SSD) stated the facility's policy was to report any missing item valued for $200.00 or more, to local law enforcement. She verified Resident 39's theft and loss form, dated 8/17/22, had a missing wedding ring, hearing aids and electric razor. When asked how much she thought the hearing aids cost, the SSD stated it must be expensive. When asked if she thought it could be equal or more than $200. 00, the SSD stated it would be more than $200.00 for sure. She verified she should have reported this to local law enforcement, but she did not. The SSD stated a theft and loss complaint should be resolved within 30 days, per the facility policy. The SSD stated Resident 39 losing his hearing aids and wedding ring, could put him at risk for feeling his items were not respected and were not important. During a concurrent interview, theft and loss form for Resident 39, and theft and loss policy record review on 9/16/22 at 10:58 a.m., the Administrator and Director of Nursing (DON) stated hearing aids were expensive and could sometimes cost up to $5000.00, and the wedding ring had sentimental value. The Administrator stated, per facility theft and loss policy, they should have reported this loss to the local law enforcement. The Administrator stated the policy was not followed when the theft and loss was not reported to local law enforcement. She stated this placed Resident 39 at risk for feeling frustrated since he could not hear adequately due to missing hearing aids. RESIDENT 8 Review of Resident 8's Minimum Data Set assessment (MDS, a federally-mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes. This process provides a comprehensive assessment of each resident's functional capabilities and helps nursing home staff identify health problems), dated 7/6/22, indicated her diagnosis included Hypertension and Diabetes. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/13/22 at 3:30 p.m., the SSD stated she spoke with Resident 8's son about the reported missing blanket. She stated the son was aware the facility was still looking for it and, if not be found, the facility would replace it. The SSD verified the facility policy was to fill out the theft and loss form for missing items. She verified she did not make one for Resident 8. When asked why, she was silent. When asked how she kept track of missing items, she stated she had a binder, but verified Resident 8 had no theft and loss form filled out in her binder. SSD stated it was important to ensure the log was updated and accurate. She stated if it was not the case, things could fall through the cracks, and there would be no follow-up. The SSD stated she was not aware of the facility's policy on how soon Resident 8 would get replacement for her missing blanket. During an interview on 9/15/22 at 8:45 a.m., the SSD stated the facility policy was for the Certified Nursing Assistant to complete the inventory list upon admission. The SSD verified Resident 8 did not have an inventory list completed upon admission. She stated the policy was for the SSD to fill out the theft and loss form when there was a theft and loss reported. She stated Resident 8's son verified she was missing a blanket but it was not reported to her immediately. When reminded she was made aware of the missing blanket on 8/30/22, the SSD was silent. When asked where the theft and loss form was for Resident 8's missing blanket, she stated she did not do it, and when asked why, the SSD was silent. The SSD stated theft and loss complaints should be resolved within 30 days. She stated, if residents lost an item, this would put them at risk for feeling their items were not respected nor important. Review of the Facility policy and procedure titled, Theft and Loss, revised in 7/2012, indicated: 1. The facility will make every effort to find property which has been reported as lost or stolen. 2. A theft and loss record report will be made out by the supervisor to whom the theft or loss of property of a patient, visitor, employee, or facility is reported and whose estimated value is $25.00 or more and if requested. The Administrator/SSD will investigate the situation to determine whether the reported item can be found. 3. The Theft and Loss Record report includes: a. A description of the article; b. Its estimated value; c. The date and time the theft or loss was discovered; d. If determinable, the date and time the loss of theft occurred; e. The action taken. 4. The Theft and Loss Record report is to be forwarded to the SSD/Administrator immediately for follow-up investigation and actions. 5. The Administrator/SSD will retain the Theft and Loss Record reports for a 12 month period.

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	055189	A. Building B. Wing	09/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenfield Care Center of Fairfield	1260 Travis Blvd Fairfield, CA 94533

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 44968 Based on interview and record review, the facility failed to ensure five of eight sampled residents (Residents 24, 25, 26, 27, 43) were made aware of the process for filing a grievance within the facility. This failure had the potential for residents' concerns not being addressed, which could affect their well-being and sense of security in the facility. Findings: During an interview with the Activities Director on 9/12/22 at 3:24 p.m., when asked when Resident Council Meetings were held, the Activities Director stated there had been no Resident Council Meeting since March, due to COVID (Corona Virus Disease - an infectious respiratory disease). He stated he would go around to meet one-on-one with the residents to conduct a, satisfaction survey. During the Resident Council Meeting held on 9/13/22 at 2 p.m., when the residents in attendance were asked about their rights in the facility and how to file a grievance, five of eight residents, who attended, stated they did not know how to file a grievance. Resident 25 stated she did not know who to talk to if she had any concerns. During the Resident Council Meeting, Resident 43 stated they had Resident Council Meetings once a month; however, there had been no meeting recently due to the closure of the dining room because of COVID. She stated, although there were no Resident Council Meetings, the Activity director would go to residents' rooms to talk to them if they had any issues. During an interview with the Social Service Director (SSD) on 9/19/22 at 12:41 p.m., when asked who was responsible to discuss, with the resident or their Responsible Party, the process of filing a grievance, the SSD stated the Activities Director was responsible for discussing the grievance process during the Resident Council Meeting. She stated the resident, or his/her Responsible Party would fill out the grievance form, located at the nurses' station, then she got a copy. The SSD stated she was responsible to investigate any grievance received. Review of the Facility policy and procedure titled, Grievances, indicated the purpose for a grievance: To ensure that any resident or resident representative has the right to express a grievance/concern without fear of restraint, interference, coercion, discrimination, or reprisal in any form To assure prompt receipt and resolution of resident/representative grievance/concern. The grievance process indicated: Upon admission and/or upon request, the resident and/or resident representative are provided with the grievance policy which informs of their right to voice grievances/concerns and the process for doing so. Review of the Facility policy and procedure titled, Resident Rights, revised in 9/2018, indicated, Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: voice grievances to the facility, or other agency that hears grievances, without discrimination or reprisal and without fear of discrimination or reprisal; and have the facility respond to his or her grievances.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 46132 Based on observation, interviews and record reviews, the facility: 1) failed protect one out of two sampled residents (Resident 39), when his roommate (Resident 33) punched the right side of his face while he was sleeping. This failure resulted in Resident 39 going to Emergency Department to seek treatment for bruising, swelling and laceration below his right eye; and, 2) failed to observe a condition, which might be predictive of potential abuse, when the facility transferred the perpetrator (Resident 33) in a room with a non-verbal, dependent resident (Resident 42). This failure had the potential to put Resident 42 at risk for abuse. Findings: Review of facility's census on 8/30/22, indicated Resident 33 was transferred to another room after an altercation with Resident 39 occurred. Review of Resident 39's Minimum Data Set assessment (MDS, a standardized assessment tool that measures health status in nursing home residents) indicated he had a diagnosis of Major Depressive Disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), with a Brief Interview for Mental Status (BIMS, a screen used to assist with identifying a resident's current cognition) score of 4, indicating severe cognitive impairment. Review of Resident 33's MDS indicated he had a diagnosis of Epilepsy and scored 15 on his BIMS, indicating his cognition was intact. Resident 42's MDS indicated he was not interviewable and was dependent on staff for provision of care. During an interview on 8/30/22 at 9:15 a.m., Licensed Nurse G stated she was not present when Resident 39 and Resident 33 had an altercation and stated it was unexpected. She described Resident 39 as dependent on staff, quiet, preferred to be in bed and slept most of the time. She stated Resident 33 was friendly to staff and other residents. She stated both residents were dependent on staff for provision of care. She stated Resident 33 was able to wheel himself around the facility independently. During an interview on 8/30/22 at 9:30 a.m., Resident 33 was awake in bed. He stated he recalled the altercation with his roommate. When asked about the altercation, Resident 33 stated, Oh yeah, and I will punch him again. I punched his smug face, my hand hurts after. He should not be calling me names! When asked who his roommate was, Resident 33 stated he did not remember his name, but would probably recall him once he saw his face. Resident 33 stated his roommate called him, a faggot and stupid, which irritated and angered him. He stated there was another roommate present when he punched Resident 39's face, but he does not recall his name either. Resident 33 stated, Ask him and he will tell you the same story. Resident 33 stated he felt good, the only thing bothering him was his current roommate (Resident 42) because he had his privacy curtain drawn all the time and was blocking the sunlight. He stated he talked to the staff about this issue. During an observation on 8/30/22 at 9:45 a.m., LN G verified Resident 42 was non-verbal, not interviewable and dependent on staff. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/30/22 at 9:47 a.m., Licensed Nurse C (LN C) verified there were three residents occupying the same room on the day of the alleged incident. She stated Resident 47 was on A bed, Resident 39 was on B bed and Resident 33 was on D bed. LN C stated Resident 39 was typically quiet and would only talk if he wanted to. LN C stated Resident 39 would typically get upset if staff tried to change his pad or clean him when he did not want to at that time. LN C stated Resident 39 was a good person. LN C stated she had not heard Resident 39 call anyone a, faggot, and she had never heard Resident 39 calling Resident 33, faggot. LN C stated she was surprised to learn Resident 33 punched Resident 39. LN C stated it was usually Resident 33 and Resident 47 who would have arguments on no particular subject. LN C stated, although Resident 33 was talkative, he had not been known to physically hurt staff or other residents. During a concurrent observation and interview on 8/30/22 at 9:50 a.m., Resident 39 was asleep in bed and was noted with greenish/yellowish-tinged discoloration below and to the side of his right eye. LN C verified this area was where Resident 33 punched him. Resident 39 denied pain when LN C asked if he was in pain. During an interview on 8/30/22 at 10 a.m., Certified Nursing Assistant T (CNA T) stated she had worked with Resident 39 in the past and had not heard him call staff or residents, faggot or stupid. CNA T stated she was surprised to learn Resident 33 punched Resident 39. She stated Resident 33 had no history of harming anyone. During a concurrent observation and interview on 8/30/22 at 10:15 a.m., Resident 39 stated he was still sleepy. When asked what happened to his right eye he stated, I woke up when I was punched, it happened about a week ago. Resident 39 did not recall the name of the person who punched him, but stated it was his roommate. Resident 39 stated he did not know why he was punched. Resident 39 refused to answer further questions and stated, I want to sleep. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/30/22 at 10:30 a.m., Licensed Nurse E (LN E) verified she was the nurse on duty when the altercation between Resident 33 and 39 occurred. LN E stated Resident 39 was very quiet and slept most of the time. LN E stated Resident 33 was talkative and friendly to staff. LN E stated it was the other roommate, Resident 47, who was known to say weird things, was the instigator, and would get Resident 33 into arguments. She stated Resident 47 would say things with conviction, and Resident 33 would believe whatever he said. Licensed Nurse E stated, maybe Resident 47 told Resident 33 that Resident 39 was talking, shit about him, and Resident 33 believed him. LN E stated there were no yelling or screaming heard prior to the discovery of this altercation. LN E stated Resident 47 was present in the room when she came to assess Resident 39. LN E verified she did not ask Resident 47 about the altercation between his roommates. LN E stated she did not understand why Resident 33 punched resident 39. LN E stated, on 8/22/22, her attention was called by the Certified Nursing Assistant F (CNA F) who reported noticing blood streaming on Resident 39's right cheek. She stated Resident 39 was in bed at that time. LN E stated Resident 33 started saying, Yes I did that, I punched him in the face. I'll do it again. LN E stated Resident 33 said he punched Resident 39 because he called him a faggot, nigger and stupid. LN E stated Resident 39 was quiet when asked what happened to his right cheek. LN E stated the laceration on Resident 39's right cheek was slightly deep, and she called the physician to get him transferred to the hospital for further evaluation. LN E stated, on the same day, Resident 33 was transferred to a room in a different hallway. LN E stated Resident 33's current roommate, Resident 42, was nonverbal, unable to move independently and just, does not do or say anything, which could irritate Resident 33. LN E stated the facility should be protecting every resident. LN E stated it would be ideal if Resident 33 did not have a roommate at this time because of his history of punching Resident 39. LN E stated there was a risk Resident 33 might do the same thing to his current roommate (Resident 42) and worried that since Resident 42 was non-verbal, things could go undetected and unreported for a period of time. LN E stated, while Resident 33 was dependent on staff during transfers, once on his wheelchair, he was able to wheel himself independently. LN E stated there was a risk he might go to his roommate and could hurt him. LN E also recalled Resident 33 getting visibly upset and cussed at her when she told him, We don't hurt people. LN E stated the altercation was reported to the local law enforcement. During an interview on 8/30/22 at 11:15 a.m., Resident 47 was in a wheelchair in front of the nursing station. Resident 47 stated he recalled an incident where his roommate was punched by their other roommate, and stated he was there when it occurred. Resident 47 stated he could not recall the name of his roommates. He said he did not understand why his roommate was punched. When asked if he heard the word, faggot or stupid, prior to the altercation, he stated, No, no, there were no name calling, nobody said faggot or stupid. During an interview on 8/30/22 at 11:20 a.m., Certified Nursing Assistant B (CNA B) stated she was working on the D wing when the altercation between Resident 39 and 33 occurred. CNA B stated she was surprised Resident 39 was punched on his face. She described Resident 39 as quiet and gentle, liked to keep to himself and slept the majority of the time. She stated Resident 39 was dependent on staff for provisions of care. She stated Resident 33 was a talker but was nice to staff. CNA B stated Resident 39 had no history of altercation with Resident 33. She stated liked Resident 39, and Resident 33 was also dependent on staff for provisions of care. CNA B stated she did not hear any verbal altercation, screaming or yelling prior to the discovery of the altercation. She stated she did not hear Resident 39 calling Resident 33, faggot or stupid. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/30/22 at 11:25 a.m., Certified Nursing Assistant F (CNA F) stated Resident 39 was under his care at the time of the altercation. He stated Resident 33 got back from his appointment around lunch time. CNA F stated he found Resident 33 in his room sitting on his WC. CNA F stated and he assisted Resident 33 to his bed. CNA F stated, after repositioning Resident 33, he turned around and noticed Resident 39's right cheek was bleeding. CNA F stated Resident 39 was silent when he asked him what happened. CNA F stated it was during this time that Resident 33 said, I did it, I punched him and I will do it again. He called me a faggot! CNA F stated, prior to this incident, he did not hear any screaming or yelling or any arguments coming from the residents' room, which is why he was surprised there was an altercation between Resident 39 and 33. During an interview on 8/30/22 at 11:40 a.m., the Infection Preventionist (IP) stated she was surprised to hear about Resident 33 punching Resident 39. The IP stated Resident 33 joked around a lot, while Resident 39 was quiet and preferred to sleep most of the time. The IP stated, placing Resident 33 with a roommate who was nonverbal and unable to defend himself, was not a very wise idea. She stated, with Resident 33's history, he might do the same thing to his new roommate (Resident 42). The IP stated, to ensure residents' safety, it would be best if Resident 33 did not have a roommate. During an interview on 8/30/22 12 p.m., the Social Service Designee (SSD) stated the altercation between Resident 39 and 33 surprised her. The SSD stated Resident 33 loved to joke around, and Resident 39 kept to himself. She stated these residents had no history of being physically or verbally abusive to staff or other residents. She stated Resident 39 had no history of calling other residents, faggot or stupid. The SSD stated it was the Interdisciplinary Team's (IDT, an approach to healthcare that integrates multiple disciplines through collaboration. These teams can help ensure patients receive the best care) decision to place Resident 33 in a room where his roommate was nonverbal and fully dependent on staff for provision of care. The SSD stated the IDT believed, since the current roommate (Resident 42) was quiet, it would be a safe option to have Resident 33 room in with him. The SSD stated Resident 42 could not talk so he could not say anything that might upset Resident 33. The SSD verified there were no reports of staff hearing any verbal altercation, yelling or screaming between Resident 39 and 33 right before the altercation occurred. The SSD stated nobody could verify whether Resident 39 did indeed call Resident 33 a, faggot or stupid, right before the physical altercation occurred. SSD stated maybe Resident 33 would not do it again because there was no risk for his roommate to be physically abused since, he does not talk. During a concurrent interview and SOC 341 record review, on 8/30/22 at 12:50 p.m., the Director of Nursing (DON) verified this report was accurate and was sent to the law enforcement agency, the Ombudsman and the State. The DON stated he was surprised to learn Resident 33 punched Resident 39. He stated Resident 33 admitted to punching Resident 39 and did so because Resident 39 called him, stupid and faggot. The DON stated Resident 39 was not able to verbalize details of the altercation except that he woke up after someone punched him. The DON stated there were no reports from other residents and staff of Resident 39 calling Resident 33 a, faggot or stupid. The DON verified there was no verbal altercation, screaming, yelling between Resident 39 and 33 right before the incident. The DON stated it was quiet, and that was why it was such a surprise. The DON verified he did not interview the third roommate, Resident 47, although he was present during the altercation. The DON stated, although the facility was not able to verify whether Resident 39 called Resident 33, stupid or faggot, the IDT decided to move Resident 33 to a room where his roommate could not talk, for safety purposes. When asked if this move was a safety concern for Resident 33's current roommate, Resident 42, the DON said, I don't think he will do it again. The DON stated the risk of Resident 33 punching his current roommate was very little. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/30/22 at 1:10 p.m., the Administrator stated there were no reports of verbal altercation, yelling or screaming between Resident 39 and Resident 33 prior to the altercation. She stated there were no reports Resident 39 called Resident 33, stupid or faggot. She stated it was a quiet day when this altercation occurred, and that was why it was such a surprise. She stated she did not interview the third roommate about this altercation. The Administrator stated, to prevent further incidents of abuse, the IDT decided to transfer Resident 33 in a room with a roommate who was nonverbal and dependent on staff for care. She stated, since Resident 33's current roommate, Resident 42, did not talk, he was safe to be in a room with Resident 33. When asked how the facility could ensure Resident 42's safety, when he was unable to talk, unable to defend himself and unable to call for help, the Administrator stated, I understand what you're saying. IDT will meet again to discuss room change. During a concurrent observation and interview on 9/13/22 at 11:13 a.m., Resident 33 was in bed and stated he did not like his current room because there was no sunlight. He stated his roommate always wanted the blinds shut and his curtains drawn, so there was no sunlight coming in. Resident 33 stated that it was annoying at times, and stated he discussed this with the staff but nothing happened. During an interview on 9/13/22 at 11:30 a.m., the Administrator verified the facility had a lot of empty beds. She verified Resident 33's current roommate, Resident 42, was unable to defend himself. The Administrator stated, despite this and Resident 33's history of punching his roommate, she did not think Resident 33 would hurt his roommate. During a review of the facility's policy and procedure (P&P) titled, Abuse Prohibition, revised 3/17, the P&P indicated the facility would ensure staff were doing all that was within their control to prevent occurrences of abuse. It also indicated the facility would identify and correct situations in which abuse was more likely to occur.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44968 Based on interview and record review, the facility failed to ensure the Minimum Data Set (MDS - health status screening and assessment tool) was accurately completed for 1 of 3 sampled residents (Residents 43), when the MDS for Resident 43 did not address her pressure ulcer. This failure resulted in lack of complete information necessary to develop a pressure ulcer care plan to meet Resident 43's wound care needs. Findings: During a clinical record review for Resident 43, the Face Sheet (A one-page summary of important information about a resident) indicated Resident 43 was admitted [DATE], with diagnoses including Chronic Obstructive Pulmonary Disease(COPD - diseases that cause airflow blockage and breathing-related problems), Heart Failure (blood often backs up and fluid can build up in the lungs, causing shortness of breath), and Diabetes Mellitus (health condition that affects how your body turns food into energy. During record review and concurrent interview with the MDS (Minimum Data Set - health status screening and assessment tool used for all residents) Coordinator on 9/16/22 at 9:36 a.m., the document titled, Weekly Skin Integrity Assessment for Pressure Ulcer/ Post-Op, dated 7/6/22, indicated Resident 43 had a Stage II sacral pressure ulcer, measuring 0.6 cm x 0.3 cm x 0.1 cm. During a clinical record review for Resident 43, the Treatment Administration Record for September 2022, indicated an ongoing wound treatment order for Resident 43's Stage II sacral pressure ulcer. During record review and concurrent interview with the MDS Coordinator on 9/16/22 at 9:49 a.m., the MDS Coordinator verified the MDS for Resident 43, dated 8/04/22, did not indicate Resident 43 had a pressure ulcer. When the coordinator was asked why an Accurate MDS was important, he stated, MDS paints the picture of the true and accurate medical condition of the resident and guides the healthcare team in the development of the resident's care plan. Review of the Job Description and Performance Standards for the Minimum Data Set (MDS) Assessment Nurse indicated, The purpose of this position is to assess residents' physical and mental function and document data on minimum data set forms completely and accurately; document all additional assessments required completely and accurately; and determine appropriate referrals to other health care professionals; and to use the resident assessment protocols to determine whether to proceed or not proceed.

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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. 44968 Based on interview and record review, the facility failed to create a pressure ulcer care plan for one of 16 sampled residents (Resident 43). This failure placed Resident 43 at risk of developing pressure ulcers. Findings: During a clinical record review for Resident 43, the Treatment Administration Record for September 2022, indicated an ongoing wound treatment order for Resident 43's Stage II sacral pressure ulcer. During record review and concurrent interview with the MDS (Minimum Data Set - health status screening and assessment tool used for all residents) Coordinator on 9/16/22 at 9:36 a.m., the document titled, Weekly Skin Integrity Assessment for Pressure Ulcer/ Post-Op, dated 7/6/22, indicated Resident 43 had a Stage II sacral pressure ulcer measuring 0.6 cm x 0.3 cm x 0.1 cm. The MDS Coordinator verified there was no pressure ulcer care plan for Resident 43. When the MDS Coordinator was asked about the purpose of care plan for residents, he stated care plans served as a basis for healthcare workers in providing patient care and treatment. During an interview with the MDS Coordinator on 9/16/22 at 9:46 a.m. when asked who was responsible in the development of care plan for residents, the MDS Coordinator stated the treatment nurse was responsible to initiate a pressure ulcer care plan as soon as she was made aware of the problem and was responsible to update the care plan for improvement or worsening of the pressure ulcer. The MDS Coordinator concurred he was responsible in making sure all problem areas were addressed and updated in Resident 43's care plan, every quarter, upon completion of the annual and quarterly MDS assessments. During an interview with Licensed Nurse M on 9/16/22 at 1:19 p.m., when asked about initiation of care plans, Licensed Nurse M stated the admission nurse was responsible in initiating a wound care plan if the resident was admitted with wounds, and she would be responsible to initiate a wound care plan for new wounds and update as needed. Review of the Facility policy and procedure titled, Policies and Procedure on Nursing Assessment, revised in 7/2012, indicated, It is the policy of the facility to assess all residents admitted within 7 days upon admission per State regulation, and completion of admission assessment within 14 days per Federal, then quarterly, annually and as often as needed .All IDT findings in the assessment will be documented or reflected in the resident's medical record in all appropriate areas including but not limited to care plan, assessment form and the like. 37797 38335

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F 0677 Level of Harm - Actual harm Residents Affected - Few	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** 37797 Based on observation, interview and record review, the facility failed to provide scheduled showers and incontinence care for 10 of 16 sampled residents (Residents 1, 5, 20, 21, 31, 35, 42, 44, 49 and 151) who were dependent on staff for Activities of Daily Living (ADLs: Hygiene, mobility, toileting, dining and communication). These failures placed Residents 1, 5, 20, 21, 31, 35, 42, 44, 49 and 151 at risk of having poor hygiene and resulted in three residents (Residents 1, 20 and 151) developing Moisture-Associated Skin Damage (MASD) on their buttocks and one resident (Resident 1) developing scabs over his shins and feet. Findings: RESIDENT 1 A review of Resident 1's Facesheet indicated he was admitted on [DATE], with diagnoses including Parkinson's (a disease of the nervous system that causes tremors, stiffness, and affects movement) and Schizophrenia (a psychiatric disease that causes delusions and hallucinations). A review of Resident 1's Minimum Data Set (MDS - an assessment tool), dated 9/7/22, indicated a Brief Interview for Mental Status (BIMs) score of 5 (scores of 0-7 indicate severe cognitive impairment). Resident 1's MDS also indicated Resident 1 was incontinent of bowel and bladder and needed, extensive assistance, with personal hygiene. A review of Resident 1's care plans indicated no care plans for hygiene or incontinence. RESIDENT 5 A review of Resident 5's Facesheet indicated he was admitted on [DATE], with diagnoses including hemiplegia (paralysis of one side of the body) following cerebral infarction (stroke). A review of Resident 5's Minimum Data Set (MDS - an assessment tool), dated 6/17/22, indicated a Brief Interview for Mental Status (BIMs) score of 3 (scores of 0-7 indicate severe cognitive impairment). Resident 5's MDS also indicated Resident 5 was incontinent of bladder, had a colostomy bag (a pouch artificially connected to the large intestine that collects feces), and was totally dependent on staff for personal hygiene. A review of Resident 5's care plans indicated a care plan, dated 10/8/21, titled, Noted with incontinent bladder . needs total assistance with toileting, with the following intervention, Provide peri care after each incontinence episode. RESIDENT 20 A review of Resident 20's Facesheet indicated he was admitted on [DATE], with diagnoses including hemiplegia (paralysis of one side of the body) following cerebral infarction (stroke). (continued on next page)

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Greenfield Care Center of Fairfield	1260 Travis Blvd Fairfield, CA 94533

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F 0677 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 20's Minimum Data Set (MDS - an assessment tool), dated 8/2/22, indicated a Brief Interview for Mental Status (BIMs) score of 5 (scores of 0-7 indicate severe cognitive impairment). Resident 20's MDS also indicated Resident 20 was incontinent of bowel and bladder and was totally dependent on staff for personal hygiene. A review of Resident 20's care plans indicated a care plan, dated 2/14/20, titled, Incontinent of B&B [Bowel and Bladder] . requires total assistance with . toileting, with the following intervention, Provide skin care after each incontinence. RESIDENT 35 A review of Resident 35's Facesheet indicated she was originally admitted on [DATE], with diagnoses including hemiplegia (paralysis of one side of the body) following cerebral infarction (stroke). A review of Resident 35's Minimum Data Set (MDS - an assessment tool), dated 8/12/22, indicated a Brief Interview for Mental Status (BIMs) score of 3 (scores of 0-7 indicate severe cognitive impairment). The MDS also indicated Resident 35 was dependent on staff for toilet use and bathing. A review of Resident 35's care plans indicated a care plan, dated 12/15/15, titled, Self-care deficit with ADL functioning . needs assist in ADL's form (sic) the staff . and needs . assistance for toileting RESIDENT 151 A review of Resident 151's Facesheet indicated she was originally admitted on [DATE], with a diagnoses including dementia. A review of Resident 151's Minimum Data Set (MDS - an assessment tool), dated 7/22/22, indicated a Brief Interview for Mental Status (BIMs) score of 6 (scores of 0-7 indicate severe cognitive impairment). Resident 151's MDS also indicated Resident 151 was incontinent of bowel and bladder and was dependent on staff for toilet use and bathing. A review of Resident 151's care plans indicated no care plans for incontinence or bathing. During an interview on 9/14/22, at 3:10 p.m., the Director of Nursing (DON) stated Certified Nursing Assistants (CNAs) provided resident showers, and all residents were given showers twice a week according to the shower schedule. The DON stated residents also received showers whenever requested. The DON provided the shower schedule indicating shower days for each resident in the facility. The DON stated CNAs documented showers on shower sheets which were kept in shower binders in the nursing station. The DON stated each shower should be documented on a shower sheet, and if residents refused showers, the refusal should be documented as well. The DON provided the shower binder for residents in Wing D of the facility and stated it contained shower sheets for September 2022. A review of the shower binder indicated it contained shower sheets for July, August and September 2022. A review of the shower sheets from July to September 2022, indicated Residents 1, 5, 20, 35 and 151 received showers on the following days: Resident 1 received showers on 7/8/22, 7/15/22, 7/19/22, 8/15/22 and 8/19/22. No shower refusals documented. (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Few	Resident 5 received showers on 7/25/22, 9/1/22, 9/5/22 and 9/8/22. No shower refusals documented. Resident 20 received showers on 7/4/22, 7/11/22, 7/15/22, 7/18/22, 7/22/22, 7/25/22, 7/29/22, 8/8/22, 8/19/22, 9/5/22 and 9/12/22. No shower refusals documented. Resident 35 received showers on 7/12/22, 7/26/22, 7/29/22, 8/23/22. No shower refusals documented. Resident 151 received showers on 7/4/22, 7/7/22, 7/11/22, 7/14/22, 7/18/22, 7/21/22, 7/25/22 and 7/28/22. No shower refusals documented. During an interview on 9/15/22, at 9:08 a.m., CNA F stated CNAs documented all resident care on the facility's electronic charting system. During an observation on 09/15/22 9:30 a.m., CNAs B and F were providing care to Resident 20, who was incontinent and dependent for care. CNAs B and F stated Resident 20 was soiled. During a concurrent interview, CNAs B and F stated they would clean and provide a bed bath to Resident 20. The bed bath consisted of wiping Resident 20 with a moistened washcloth. During an interview and record review on 9/16/22, at 10:24 a.m., the DON stated CNAs also documented showers on the facility's electronic charting system (CNA Flowsheets). The DON was asked to review the CNA Flowsheets for Residents 1, 5, 20, 35 and 151, for July, August and September 2022, and to indicate when those residents had showers. The DON reviewed printed copies of the CNA Flowsheets, but stated he could not interpret them. A review of the CNA Flowsheets for Residents 1, 5, 20, 35 and 151, for July, August and September 2022, indicated a field called, BATHING, with the option to document the date of the bath and the type, with the following options: Complete Bed Bath, Partial Bed Bath, Shower, Tub Bath or Other. A review of these flowsheets indicated Residents 1, 5, 20, 35 and 151, had showers on the following days in July, August and September 2022: Resident 1 received showers on 7/1/22, 7/5/22, 7/8/22, 7/19/22, 7/29/22, 8/16/22, 8/19/22, 8/23/22 and 8/30/22. No showers noted in September and no documented shower refusals. Resident 5 received showers on 7/25/22, no documented showers in August, 9/1/22, 9/5/22, 9/8/22 and 9/12/22. Resident 20 received showers on 7/8/22, 7/15/22, 7/18/22, 7/25/22, 7/29/22, 8/15/22, 8/19/22, 8/21/22, 8/26/22, 8/29/22, 9/5/22 and 9/12/22. Resident 35 received showers on 7/26/22, 8/19/22 and 9/19/22. Resident 151 received showers on 7/4/22, 7/7/22, 7/9/22, 7/14/22, 7/18/22 and 7/25/22. (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Few	During an interview on 9/16/22, at 12:45 p.m., Licensed Nurse M stated she was the facility's Treatment Nurse responsible for monitoring residents with pressure ulcers or other skin wounds. She stated she consulted shower sheets to monitor skin wounds, but those sheets were not consistently and accurately complete by CNAs. She stated CNAs were supposed to provide showers to residents and check their skin during showers and document any skin problems in the shower sheets, but CNAs did not have time to shower residents and complete the shower sheets. She stated CNAs also did not have time to clean dependent, incontinent residents, and keep them clean and dry. She stated, when she checked dependent, incontinent residents, every resident was soiled, or their briefs were wet, which could damage their skin. She stated Resident 1 had developed scabs on his bilateral shins and feet because of lack of showers. She also stated CNAs only did bed baths, which were insufficient to properly clean residents' skins. During an observation on 9/16/22, at 1:24 p.m., Licensed Nurse M assessed Resident 1 who was lying in bed, on his back, looking at the ceiling. Licensed Nurse M undressed and turned Resident 1 to the side. Resident 1 was soiled with urine and feces, and his buttocks appeared inflamed. During a concurrent interview, Licensed Nurse M stated Resident 1 had Moisture Associated Skin Damage (MASD) on his buttocks from not being kept clean and dry. Resident 1's bilateral shins, from the ankles to the knees, and both his feet, were covered with scabs. Licensed Nurse M stated these scabs had developed because of lack of showers. During an observation on 9/16/22, at 1:30 p.m., Licensed Nurse M checked on Resident 151, who was lying in bed, on her back, looking at the ceiling. Licensed Nurse M undressed and turned Resident 151 to the side. Resident 151 was soiled with urine and feces. Licensed Nurse M stated, She is so wet. Resident's 151's buttocks appeared inflamed. During a concurrent interview, Licensed Nurse M stated Resident 151 had Moisture Associated Skin Damage (MASD) on her buttocks from not being kept clean and dry. During an observation on 9/16/22, at 1:38 p.m., Licensed Nurse M checked on Resident 20, who was lying in bed, on his back, looking at the ceiling. Licensed Nurse M undressed and turned Resident 20 to the side. Resident 20 was soiled with urine and feces. Resident's 20's buttocks appeared inflamed. During a concurrent interview, Licensed Nurse M stated Resident 20 had Moisture Associated Skin Damage (MASD) on her buttocks from not being kept clean and dry. A review of the specialized literature indicated: Moisture-Associated Skin Damage (MASD) is caused by prolonged exposure to various sources of moisture, including urine or stool, perspiration, wound exudate, mucus, saliva, and their contents. MASD is characterized by inflammation of the skin, occurring with or without erosion or secondary cutaneous infection. Journal of Wound, Ostomy and Continence Nursing: May/June 2011 - Volume 38 - Issue 3 - p 233-241. 38335 Resident 21 A review of Resident 21's Face sheet indicated he was admitted on [DATE], with diagnoses including: Cerebral Vascular Accident, CVA (a loss of blood flow to part of the brain, which damages brain tissue), Parkinson's (a disease of the nervous system that causes tremors, stiffness, and affects movement), Dysphagia (difficulty swallowing), and Essential Hypertension. (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 21's Minimum Data Set (MDS - an assessment tool), dated 4/29/22, indicated a Brief Interview for Mental Status (BIMs) score of 3 (scores of 0-7 indicate severe cognitive impairment). Resident 21's MDS also indicated he was incontinent of bowel and bladder and needed, total dependence, with personal hygiene. Review of Resident 21's care plan indicated no care plans for incontinence or bathing. During a clinical record review for Resident 21, the document titled, POC (Point of Care) Response History, for Resident 21's shower history, indicated, from 8/17/22 to 9/20/22, Resident 21 received two showers, zero complete bed baths and twenty-two partial baths. The document did not indicate Resident 21 had refused showers or partial baths. During an interview on 9/14/22 at 3 p.m., Resident 21's family member stated the facility did not take good care of Resident 21. Resident 21's family member stated the facility staff did not take Resident 21 out of bed regularly, and he was supposed to have therapy. Resident 21 was fed through a G-tube, and he did not talk well; Resident 21 spoke mainly Spanish. Resident 21's family member stated his mother came to the facility three times a week, she complained the facility did not bathe, shave or brush Resident 21's teeth. Resident 21's family member stated, when his mother came to the facility, the staff waited for her, and she would bathe, shave, and brush Resident 21's teeth. Resident 21's family member stated Resident 21 had sensitive skin, and his mother brought skin cream and applied the cream to Resident 21's skin, because the staff would not. Resident 21's family member stated his mother would bring Resident 21 clothes, and the next time she came to the facility the resident was wearing someone else's clothes. Resident 21's family member stated his mother told the nurses, but nothing ever got done. When asking Resident 21's family member if he had attended a care meeting for Resident 21. Resident 21's family member stated the facility had never called to arrange a care meeting. When asked if he asked the facility to arrange a meeting, he stated, I will do that. Resident 21's family member stated his mother had spoken to a doctor a few times, he stated she did not know who the doctor was now. Resident 21's family member stated they used to put Resident 21 in his chair and place him in the hallway, but the facility had not done that lately. During an interview on 9/16/22 at 9:51 a.m., Licensed Nurse G was asked how often Resident 21 was out of bed. Licensed Nurse G stated sometimes Resident 21 refused to get up, but when he did not, he was up in his wheelchair. When asked if Resident 21 had a shower, she stated, Yes, but sometimes refused a shower. Licensed Nurse G stated his wife came to the facility three times a week and she would give him a bed bath. Review of the paper document titled, Shower Day Skin Inspection, showed Resident 21 had a shower on 9/9/22, and refused a shower on 9/19/22. During an interview on 9/20/22 at 9:57 p.m., the DSD verified no other shower sheets were documented for September 2022. Resident 42 A review of Resident 42's Face sheet indicated he was initially admitted on [DATE], and readmitted on [DATE], with a diagnosis including: Dysphagia, Quadriplegia (a person affected by paralysis of all four limbs) with contractures to the right and left shoulders, knees, wrists, left hip, and both knees, due to an anoxic brain injury. (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 42's Minimum Data Set (MDS - an assessment tool), dated 2/26/22, indicated a Brief Interview for Mental Status (BIMs) score of 0 (scores of 0-7 suggest severe impairment). Resident 42's MDS also indicated Resident 42 was incontinent of bowel and bladder. Review of Resident 42's care plan indicated he needed total assistance with ADLs. During a clinical record review for Resident 42, the document titled, POC (Point of Care) Response History, for Resident 42's shower history indicated, from 8/17/22 to 9/15/22, Resident 42 received five showers, zero complete bed baths and fourteen partial baths. From 8/25/22 to 8/30/22, no bathing of any type was documented on the POC response history. The document did not indicate Resident 42 had refused showers or partial baths. During an interview on 9/20/22 at 9:57 a.m., the DSD stated there were no comments on the POC in, Point Click-Care (PCC), only check boxes, the comments were documented on the shower sheets by the CNAs. Review of the paper document titled, Shower Day Skin Inspection, showed Resident 42 had a shower on 9/3/22, 9/7/22 and 9/17/22, no other shower sheets were documented for September 2022. The shower sheets for August were requested during an interview with the DSD on 9/20/22 at 9:57 a.m., but the DSD could not locate them. During an interview on 9/13/22 at 10 a.m., Resident 42's family member came to the facility for an interview. Resident 42's family member was concerned that Resident 42 was not bathed on a regular basis. Resident 42's family member stated he took Resident 42 home on the weekends or when he visited, he noticed Resident 42 was not showered. Resident 42's family member stated he must wash Resident 42's hair and brush his teeth. There was one CNA who regularly showered Resident 42, and she was not here for two weeks in August, and for two weeks Resident 42 did not have a shower. The facility was supposed to dress him, change him, and get him up out of bed. When Resident 42's family member took him home, he noticed Resident 42's neck and ears were dirty. Resident 42's family member was asked if he reported this to the DON or nurses, he stated, Yes; he told the nurses several times when he came for a visit. When asked if he had attended an IDT meeting to discuss Resident 42's care, he stated in August 2022, a meeting was scheduled. The facility did not call him on the day of the meeting and called the day after to state the meeting had been canceled and gave him an update of Resident 42's condition. Resident 42's family member tried to schedule another meeting, but nothing happened. Resident 42's family member stated, The facility should train the newer staff to take better care of Resident 42. During an observation and concurrent interview on 9/16/22 at 9:51 a.m., Resident 42 was in his Geri chair fully dressed (this was the first observation of Resident 42 out of bed). Licensed Nurse G was asked how often Resident 42 was out of bed; she stated, We try to get him out of bed every other day or so if there is enough staff to help move him; [Resident 42's] family member comes to take him home on the weekends. 44968 RESIDENT 49 (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Few	During clinical record review for Resident 49, the Face sheet indicated Resident 49 was admitted on [DATE], with diagnoses including Major Depressive Disorder, Dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities) and Anxiety Disorder (feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities). During a clinical record review for Resident 49, the MDS, dated [DATE], indicated Resident 49 had a BIMS score of 2 out of 15 points (Brief Interview for Mental Status - a 15-point cognitive screening measure that evaluates memory and orientation. A score of 13 - 15 is cognitively intact, 08 - 12 is moderately impaired, and 00 - 07 is severe impairment). The MDS indicated Resident 49 required total assistance from staff, with bathing. The MDS indicated it was very important for Resident 49 to choose between a tub bath, shower, bed bath or sponge bath. The MDS indicated Resident 49 did not refuse evaluation or care necessary to achieve her goals for health and well-being. During a clinical record review for Resident 49, the document titled, POC (Point of Care) Response History, for Resident 49's shower history, indicated from 8/22/22 to 9/20/22, Resident 49 did not receive any showers; however, she received four complete bed baths. The document also indicated Resident 49 received 18 partial baths on different days. RESIDENT 44 During clinical record review for Resident 44, the Face sheet indicated Resident 44 was admitted on [DATE], with diagnoses including Diabetes Mellitus (health condition that affects how your body turns food into energy), Chronic Obstructive Pulmonary Disease (COPD - diseases that cause airflow blockage and breathing-related problems), Major Depressive Disorder (a mental disorder characterized by a persistently depressed mood and long-term loss of pleasure or interest in life), Parkinson's Disease (disorder of the central nervous system that affects movement), and Psychosis (severe mental disorder). During an interview with Resident 44 on 9/12/22 at 11:24 a.m., when asked about shower schedules, Resident 44 stated he was supposed to a have shower twice a week; however, he only got showered once a week and wanted to have more showers if possible. During a clinical record review for Resident 44, the Minimum Data Set (MDS -health status screening and assessment tool), dated 11/19/21, indicated it was very important for Resident 44 to choose between a tub bath, shower, bed bath or sponge bath. During a clinical record review for Resident 44, the MDS, dated [DATE], indicated Resident 44 had a BIMS score of 15 out of 15 points (Brief Interview for Mental Status - a 15-point cognitive screening measure that evaluates memory and orientation. A score of 13 - 15 is cognitively intact, 08 - 12 is moderately impaired, and 00 - 07 is severe impairment). The MDS indicated Resident 44 did not refuse evaluation or care necessary to achieve his goals for health and well-being. During a clinical record review for Resident 44, the document titled, POC (Point of Care) Response History, for Resident 44's shower history, indicated from 8/22/22 to 9/20/22, Resident 44 received five showers, zero complete bed baths and seven partial baths on different days. The document did not indicate Resident 44 had refused showers or partial baths. (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Few	During a clinical record review for Resident 44, the document titled, Shower Day Skin inspection, indicated Resident 44 received showers on 8/31/22 & 9/15/22. RESIDENT 31 During clinical record review for Resident 31, the Face sheet (a one-page summary of important information about a resident) indicated Resident 31 was admitted on [DATE], with diagnoses including Hemiplegia and Hemiparesis (paralysis of one side of the body), Aphasia (a disorder that affects how you communicate), and Anxiety Disorder (persistent feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), and Heart Failure (blood often backs up, and fluid can build up in the lungs). During an observation on 9/13/22 at 11:34 a.m., Resident 31 was on her bed, watching TV. Resident 31 had difficulty expressing herself. Resident 31 smiled when spoken to. Resident 31's upper teeth had plaque build up. During a clinical record review for Resident 31, the MDS, dated [DATE], indicated Resident 31 had a a BIMS score of 3 out of 15 points (Brief Interview for Mental Status - a 15-point cognitive screening measure that evaluates memory and orientation. A score of 13 - 15 is cognitively intact, 08 - 12 is moderately impaired, and 00 - 07 is severe impairment). The MDS indicated Resident 31 required total assistance from staff, with bathing. The MDS indicated it was very important for Resident 31 to choose between a tub bath, shower, bed bath or sponge bath. During a clinical record review for Resident 31, the document titled, POC (Point of Care) Response History, for Resident 31's shower history, indicated from 8/22/22 to 9/20/22, Resident 31 received four showers, four complete bed baths and 22 partial baths. The document indicated Resident 31 was totally dependent with showers and partial baths. The document did not indicate Resident 31 had refused shower. During a clinical record review for Resident 31, the document titled, Shower Day Skin inspection, indicated Resident 31 received showers on 8/26/22 & 9/09/22. During an interview with Certified Nursing Assistant (CNA) W on 9/20/22 at 9:08 a.m., when asked about residents refusing showers, CNA W stated she would give the resident the option to choose between a bed bath or shower. She stated she would at least ask the resident twice if he or she wanted to have a shower, and if the resident continued to refuse, she would report it to the nurse. When CNA W was asked the difference between a bed bath and a partial bath, CNA W stated the only difference was that a bed bath involved washing of hair while a partial bath did not involve washing of hair. During an interview with CNA V on 9/20/22 at 9:15 a.m., when asked about residents refusing showers, CNA V stated she would encourage the resident to have a shower. She stated if the resident refused a shower, she would provide a complete bed bath. CNA V stated complete bed baths included washing of hair, and a partial bath did not include washing of hair. When CNA V was asked about the risk for residents if hair was not washed, CNA V stated residents could have dandruff, itchy scalp, and smelly hair. (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Few	During an interview and concurrent record review with the Director of Staff Development (DSD) on 9/20/22 at 9:57 a.m., when asked where residents' showers were documented, the DSD stated the facility would document on both PCC (Point Click Care - an electronic health care record for residents) and a paper document called, Shower Day Skin Inspection. After review of the document titled, POC (Point of Care) Response History and the Shower Day Skin Inspection, with the DSD, the DSD verified, from 8/22/22 to 9/20/22, Resident 44 received seven showers; Resident 31 received six showers, and Resident 49 did not receive any showers; however, Resident 49 received four complete bed baths. When the DSD was asked about the difference between complete bed baths and partial baths, the DSD stated bed baths meant washing of the whole body including washing of hair, and partial bath meant washing the upper body, incontinence care and no washing of hair. When the DSD was asked about the risk of not washing residents' hair, she stated residents could have itchy scalp, and oily, dirty hair. A review of facility policy titled, ACTIVITIES OF DAILY LIVING (ADLs), SUPPORTING, undated, indicated: Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with . hygiene (bathing, dressing, grooming, and oral care) . elimination (toileting). Review of the Facility document titled, BED BATH, revised in 7/2015, indicated, It is the policy of this facility to cleanse, refresh and soothe the resident and to stimulate circulation.

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Greenfield Care Center of Fairfield	1260 Travis Blvd Fairfield, CA 94533

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37797 Based on observation, interview, and record review, the facility failed to provide activities of interest for 13 of 16 sampled residents (Residents 1, 4, 5, 14, 20, 21, 31, 35, 42, 44, 49, 151, and 351) and failed to ensure the activities department had sufficient staff to provide resident-centered activities to all residents. These failures resulted in 13 of 16 sampled residents not receiving activities of interest and placed all 52 facility residents at risk for not having activities designed to meet their needs and promote psychosocial well-being, resulting in a potential decline of residents' physical, mental, and psychosocial health. Findings: A review of the facility's census sheet for 9/12/22, indicated 52 residents at the facility. A review of the facility's Facility Assessment, dated 5/25/22, provided on 9/12/22, indicated an average census of 55 residents at the facility. A review of the facility's Activity Schedule for September 2022, indicated the following activities for 9/14/22: 10 a.m.: Sit and Be Fit/Ball Toss; 10:30 a.m.: Coffee and Tea Cart/TV News; 11 a.m.: Arts in Color/Word Finder; 2 p.m.: Bedside Buddies/News TV; 3 p.m.: Blackjack/Snack Cart; and, 4 p.m.: You Tube Music/Book Club. The facility's Activity Schedule for September 2022, also indicated: In-room activities daily. During an observation on 09/14/22, at 10:04 a.m., there were four residents in the dining/activities room (out of an average census of 55 residents). These residents were doing range of motion exercises. During an observation on 09/14/22, at 11:09 a.m., there were six residents in the dining/activities room (out of an average census of 55 residents). These residents were playing with a ball. During an observation on 09/14/22, at 2:50 p.m., there were six residents in the dining/activities room (out of an average census of 55 residents). These residents were watching TV. During an observation on 09/14/22, at 4:15 p.m., there were six residents in the dining/activities room (out of an average census of 55 residents). These residents were watching TV. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	RESIDENT 1 A review of Resident 1's Facesheet indicated he was admitted on [DATE], with diagnoses including Parkinson's (a disease of the nervous system that causes tremors, stiffness, and affects movement) and Schizophrenia (a psychiatric disease that causes delusions and hallucinations). A review of Resident 1's Minimum Data Set (MDS - an assessment tool), dated 9/7/22, indicated a Brief Interview for Mental Status (BIMs) score of 5 (scores of 0-7 indicate severe cognitive impairment). A review of Resident 1's most current Activity Assessment, dated 3/3/22, indicated the following activities were, important or somewhat important: Go outside for fresh air when the weather is good, have books, newspapers and magazines to read, listen to music, and be around animals, do things with groups of people, and participate in religious services. Resident 1's Activity Assessment also indicated he liked cards and table games, gardening, using computers and using the internet. A review of Resident 1's care plans indicated no Activities Care Plan listing his favorite activities. Resident 1's care plans indicated a care plan, dated 4/3/19, for participating in daily activities. The care plan contained the intervention to assist and encourage to join group activities. During six separate observations on 9/14/22, at 8:50 a.m., 10:02 a.m., 11:07 a.m., 12:23 p.m., 2:54 p.m., and at 4:18 p.m., Resident 1 was in his room, on his bed, in the same position (back), looking at the ceiling. Resident 1's room had no activities supplies or materials. There was no music in the room. A small TV located on the side of the room was turned on. RESIDENT 5 A review of Resident 5's Facesheet indicated he was admitted on [DATE], with diagnoses including hemiplegia (paralysis of one side of the body) following cerebral infarction (stroke). A review of Resident 5's Minimum Data Set (MDS - an assessment tool), dated 6/17/22, indicated a Brief Interview for Mental Status (BIMs) score of 3 (scores of 0-7 indicate severe cognitive impairment). A review of Resident 5's most current Activity Assessment, dated 3/18, indicated the following activities were, important or somewhat important: Go outside for fresh air when the weather is good, have books, newspapers and magazines to read, listen to music, and be around animals, do things with groups of people, and participate in religious services. Resident 5's Activity Assessment also indicated he liked watching TV/movies. A review of Resident 5's care plans indicated no Activities Care Plans. During two separate observations on 9/14/22, at 8:48 a.m. and 10:02 a.m., Resident 5 was in his room, on his bed, in the same position (back), looking at the ceiling. Resident 5's room had no activities supplies or materials. There was no music in the room. During three separate observations on 9/14/22, at 11:06 a.m., 12:22 p.m., and at 2:53 p.m., Resident 5 was in a wheelchair in the hallway in Wing D, looking at the ceiling. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During another observation on 9/14/22, at 4:18 p.m., Resident 5 was in his room, on his bed, on his back, looking at the ceiling. Resident 5's room had no activities supplies or materials. There was no music in the room. RESIDENT 20 A review of Resident 20's Facesheet indicated he was admitted on [DATE], with diagnoses including hemiplegia following cerebral infarction. A review of Resident 20's Minimum Data Set (MDS - an assessment tool), dated 8/2/22, indicated a Brief Interview for Mental Status (BIMs) score of 5 (scores of 0-7 indicate severe cognitive impairment). During an interview on 9/13/22, at 3:34 p.m., Resident 20's Responsible Party (RP) stated Resident 20's favorite activity was going outside for fresh air. The RP stated staff never take him outside, that he stayed in his room all day, and when she visited and wanted to take him outside, facility staff said they did not have a wheelchair to take him out. The RP stated Resident 20 just laid in his bed all day long. A review of Resident 20's most current Activity Assessment, dated 2/11/22, indicated the following activities were, important or somewhat important: Go outside for fresh air when the weather is good, have books, newspapers and magazines to read, listen to music, and be around animals. Resident 20's Activity Assessment also indicated he liked cards and table games and outings/shopping. A review of Resident 20's care plans indicated no Activities Care Plan listing his favorite activities. Resident 20's care plans indicated a care plan, dated 7/26/22, for risk of social isolation related to visitation restrictions due to COVID-19. This care plan contained the following interventions: Activities' Staff will offer in room activities based on resident preference . During six separate observations on 9/14/22, at 8:47 a.m., 10:01 a.m., 11:05 a.m., 12:21 p.m., 2:52 p.m., and at 4:17 p.m., Resident 20 was in his room, on his bed, in the same position (back), watching TV. Resident 20's room had no activities supplies or materials. RESIDENT 35 A review of Resident 35's Facesheet indicated she was originally admitted on [DATE], with diagnoses including hemiplegia following cerebral infarction. A review of Resident 35's Minimum Data Set (MDS - an assessment tool), dated 8/12/22, indicated a Brief Interview for Mental Status (BIMs) score of 3 (scores of 0-7 indicate severe cognitive impairment). A review of Resident 35's most current Activity Assessment, undated, indicated the following activities were, important or somewhat important: Go outside for fresh air when the weather is good, have books, newspapers and magazines to read, listen to music, and be around animals, do things with groups of people, and participate in religious services. Resident 35's Activity Assessment also indicated she liked watching TV/movies. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of Resident 35's care plans indicated no Activities Care Plans. During six separate observations on 9/14/22, at 8:45 a.m., 10 a.m., 11:02 a.m., 12:20 p.m., 2:51 p.m., and at 4:16 p.m., Resident 35 was in her room unengaged in any activities. There was no music, books or any activities supplies in her room. RESIDENT 151 A review of Resident 151's Facesheet indicated she was originally admitted on [DATE], with diagnoses including dementia. A review of Resident 151's Minimum Data Set (MDS - an assessment tool), dated 7/22/22, indicated a Brief Interview for Mental Status (BIMs) score of 6 (scores of 0-7 indicate severe cognitive impairment). A review of Resident 151's most current Activity Assessment, dated 9/4/22, indicated the following activities were, important or somewhat important: Go outside for fresh air when the weather is good, have books, newspapers and magazines to read, listen to music, and be around animals, do things with groups of people, and participate in religious services. Resident 151's Activity Assessment also indicated she liked arts, crafts, cards and table games, cooking, outings/shopping, watching TV/movies, and word games/puzzles. A review of Resident 151's care plans indicated two Activities Care Plans, dated 10/16/21. The care plans contained the following interventions: Staff to provide planned activities, involve resident in facility functions, provide materials for resident's activities of interest such as reading, coloring art, word search, provide monthly calendar and encourage participation in any activities of interest, and invite resident to attend activities out of room. During six separate observations on 9/14/22, at 8:53 a.m., 10:03 a.m., 11:08 a.m., 12:24 p.m., 2:55 p.m., and at 4:19 p.m., Resident 151 was in her room, on her bed, in the same position (back), looking at the ceiling. Resident 151's room had no activities supplies or materials. There was no music in the room. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 9/15/22, at 10:06 a.m., the Activities Director (AD) stated he had been Activities Director since January 2022. The AD stated the Activities Department had two staff: Himself and an Activities Assistant (AA- Activities Assistant). The AD stated they were both full-time. The AD stated he worked Monday through Friday, and the AA worked Wednesday through Sunday. The AD stated, on Monday and Tuesday, he was the only activities person at the facility, and on weekends the AA was by herself. The AD reviewed the September 2022, activities calendar. The AD stated the activities listed in the calendar were held in the dining room, which doubled as the activities room outside mealtimes. The AD stated, residents unable to come to the dining room had in-room activities according to their preferences. The AD stated he assessed residents' activities preferences and provided the most current assessment for Residents 1, 5, 20, 35, and 151. The AD confirmed those residents enjoyed the activities listed in their Activity Assessments. The AD stated, when he was at the facility, he led the activities in the activities room. The AD was asked who provided activities for residents in their rooms. The AD stated the AA did, on the days she worked, Wednesday through Sunday, and on other days, no one [provided in-room activities]. The AD was asked if there was sufficient activities staff to provide activities to residents. The AD stated he needed one additional full-time activities assistant. The AD stated the facility needed two full-time activities assistants. During an interview on 9/15/22, at 12:20 p.m., the Business Office Manager provided a list of current staff at the facility. The BOM stated this list contained the names and positions of all staff. A review of this list indicated only one activities assistant: AA. A review of the facility's Facility Assessment (a document in which the facility indicates the human resources needed to meet resident needs), dated 5/25/22, provided on 9/12/22, indicated, for an average census of 55 residents, two full-time activities assistants were needed. A review of the facility policy titled, STAFFING, dated 12/14, indicated: Our facility provides adequate staffing to meet needed care and services for our resident population. 38335 RESIDENT 4 During an observation and concurrent interview on 9/12/22 at 12 p.m., Resident 4 was lying in bed watching TV; he was unable to move all extremities due to a muscle condition. When asked the types of activities he liked, Resident 4 stated he watched TV and liked to go out for a cigarette. When asked if staff took him outside for a cigarette, he stated, Yes, only once a week. The staff leave me alone out there, I don't think they care. I receive physical therapy for my arms and legs. A review of Resident 4's Face Sheet indicated he was admitted on [DATE], with diagnoses including: Functional Quadriplegia (complete immobility due to severe physical disability or frailty), with contractures to right and left knees and ankles, Generalized Muscle weakness, Polymyositis with Myopathy (a group of muscle diseases that involves inflammation of the muscles). A review of Resident 4's Minimum Data Set (MDS - an assessment tool), dated 6/17/22, indicated a Brief Interview for Mental Status (BIMs) score of 15 (scores of 13-15 suggest cognitively intact). (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of Resident 4's most current Activity Assessment, dated 3/16/22, indicated the following activities were, important or somewhat important: Go outside for fresh air when the weather is good, for a cigarette, watch TV, word games and puzzles. Resident 4's Activity Assessment also indicated he liked cards and table games, using computers and using the internet. There was no observation of any in-room activities, other than going outside for a cigarette one time. A review of Resident 4's care plans indicated no Activities Care Plan listing his favorite activities. Resident 4's care plan, dated 3/16/22, for activity interventions, indicated to assess resident's activity preference and discuss alternate activity. The care plan did contain specific interventions to assist and encourage Resident 4's activity preferences. During separate observations on 9/13/22, at 1:50 a.m., 9/14/22 at 10:30 a.m., 9/15/22 at 11:07 a.m., Resident 4 was outside smoking a cigarette, only once, on 9/13/22. Resident 4 was wearing a [smoking] apron and talking with another resident. Resident 4's room had no activities supplies or materials. RESIDENT 14 During an initial tour observation on 9/12/22, at 11 a.m., residents were in their rooms with some still in bed sleeping, other residents were watching television and some residents were in their wheelchairs sitting in the hallways. No activities were occurring in any of the common areas (e.g., dining room). During an interview on 9/12/22 at 11:38 a.m., Resident 14 was lying in bed, and stated she did not do activities. Resident 14 stated she did go to BINGO, but since COVID, she had not done much. I have physical therapy. When asking Resident 14 what her interests were, she stated she had a pass to out to a concert with a friend on the weekend. A review of Resident 14's Face Sheet indicated she was admitted on [DATE], with diagnoses including: Coronary Artery Heart Disease, Atrial Fibrillation, acquired absence of left foot, Type 2 Diabetes Mellitus (is an impairment in the way the body regulates and uses sugar [glucose] as a fuel), and Hyperlipidemia (a condition in which there are high levels of fat particles [lipids] in the blood). A review of Resident 14's Minimum Data Set (MDS - an assessment tool), indicated a Brief Interview for Mental Status (BIMs) score of 15 (scores of 13-15 indicate cognitively intact). A review of Resident 14's Activities Care Plan, which indicated she needed to be encouraged/reminded to attend activities, and staff would assess and list Resident 14's preferred activities. Resident 14's care plan, dated 10/21/19, indicated to remind and offer assistance to activity programs and invite Resident 14 to attend activities out of her room. During three separate observations on 9/14/22, at 8:50 a.m., 9/15/22 at 10:02 a.m., and 9/16/22 at 11:07 a.m. , Resident 14 was in her room, in bed, much of the week during the survey. Resident 14's room had no activity supplies or materials. RESIDENT 21 (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation on 9/12/22 at 12:15 p.m., Resident 21 was lying in bed. When attempting to speak with Resident 21, he would shake his head, Yes. No verbal response was received. Resident 21 spoke mainly Spanish. A review of Resident 21's Face Sheet indicated he was admitted on [DATE], with diagnoses including: Cerebral Vascular Accident, CVA (a loss of blood flow to part of the brain, which damages brain tissue), Parkinson's (a disease of the nervous system that causes tremors, stiffness and affects movement), Dysphagia, and Essential Hypertension. A review of Resident 21's Minimum Data Set (MDS - an assessment tool), dated 4/29/22, indicated a Brief Interview for Mental Status (BIMs) score of 3 (scores of 0-7 indicate severe cognitive impairment). A review of Resident 21's most current Activity Assessment, dated 1/31/22, indicated the following activities were, important or somewhat important: Watch TV, listen to music, and participate in religious services. Resident 21's Activity Assessment also indicated he liked cards and other games. A review of Resident 21's care plans indicated no Activities Care Plan listing his favorite activities. The care plan indicated the Activities Director would offer in-room activities. During observations, no activities were provided. During four separate observations on 9/12/22, at 8:50 a.m., 9/13/22 10:02 a.m., 9/14/22 at 11:07 a.m., and 9/15/22 at 12:23 p.m., Resident 21 was in his room, in his bed, no lights were on in the room, the TV was on, but Resident 21 was not watching the TV. There were no music activities, supplies or materials in Resident 21's room. During an interview on 9/14/22 at 3 p.m., Resident 21's son stated the facility did not take good care of his father. They used to get him up out of bed in his chair, and he would sit outside, but not lately. During an interview on 9/16/22 at 9:51 a.m., Licensed Nurse CC stated sometimes Resident 21 refused to get up. She stated, he sometimes he refused showers. She stated his wife came in three times a week and she was the one to bathe and shave him. RESIDENT 42 During an observation on 9/12/22 at 3:12 p.m., Resident 42 was lying in bed with the TV on. Resident 42 was quadriplegic with multiple contractions of the hands, arms, and legs. Resident 42 was non-responsive when asked questions and did not make eye contact. A review of Resident 42's Face Sheet indicated he was initially admitted on [DATE], and readmitted on [DATE], with diagnoses including: Dysphagia, Quadriplegia (a person affected by paralysis of all four limbs), with contractures to the right and left shoulders, knees, wrists, left hip, and both knees, due to an anoxic brain injury. A review of Resident 42's Minimum Data Set (MDS - an assessment tool), dated 2/26/22, indicated a Brief Interview for Mental Status (BIMs) score of 0 (scores of 0-7 suggest severe impairment). (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of Resident 42's most current Activity Assessment, dated 2/24/22, indicated the following activities were, important or somewhat important: Listen to music, watch TV, and have a family or close friend involved in discussions about care. Resident 42's Activity Assessment also indicated he liked to keep up with the news and participate in religious activities. There were no observations of any in-room activities during the facility Survey. A review of Resident 42's care plans indicated no Activities Care Plan listing his favorite activities. Resident 42's care plan, revised date 08/22/22, for activity interventions, indicated, 1:1 activity, such as watching TV and listening to music, would be conducted. The care plan did contain specific interventions to assist and encourage Resident 42's activity preferences. During separate observations on 9/13/22, at 1:50 a.m., 9/14/22 at 10:30 a.m., 9/15/22 at 11:07 a.m., Resident 42 was in bed with the head of bed elevated. He was wearing sunglasses with the TV on. On 9/16/22, Resident 42 was out of bed, fully dressed in his Geri chair. During an interview on 9/13/22 at 10 a.m., Resident 42's brother stated an IDT meeting was scheduled in August, for his brother's care, but was canceled, and the facility only updated him about his care and asked him to bring in some music CDs Resident 42 could listen to. During an interview on 9/19/22 at 2:48 p.m., Licensed Nurse CC was asked when Resident 42 was out of bed. Licensed Nurse CC stated he was sometimes out of bed every other day, depending on if there was enough staff to help move him. When asked if he had 1:1 activity, she stated, Sometimes. A review of facility policy titled, CARE PLAN, dated 9/09, indicated: A care plan is the summation of the resident concerns, goals, approaches and INTERVENTIONS [emphasis added] to meet the [resident's] goals . 44968 RESIDENT 31 During clinical record review for Resident 31, the Face sheet (a one-page summary of important information about a resident) indicated Resident 31 was admitted on [DATE], with diagnoses including Hemiplegia and Hemiparesis (paralysis of one side of the body), Aphasia (a disorder that affects how you communicate), Anxiety Disorder (persistent feeling of worry, anxiety, or fear strong enough to interfere with one's daily activities), and Heart Failure (blood often backs up and fluid can build up in the lungs). During three separate observations on 9/13/22 at 10:55 a.m., 9/13/22 at 11:34 a.m. and 9/14/22 at 11:01 a.m. , in Resident 31's room, Resident 31 was on her bed awake, watching TV. Resident 31 had difficulty speaking; however, she smiled when spoken to. During two separate observations on 9/15/22 at 9:15 a.m. and 11:53 a.m., in Resident 31's room, Resident 31 was in bed asleep. During an observation on 9/15/22 at 3:29 p.m., Resident 31 was on her bed, awake. Her television was off. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During interview and clinical record review for Resident 31, with the Activities Director, on 9/15/22 at 11:55 a.m., the Activities Director was asked what activities were provided for Resident 31. The Activities Director stated Resident 31 liked watching TV. He stated Resident 31 also received in-room visits. The Activities Director verified Resident 31's Activity Care Plan, initiated on 1/01/20, indicated Resident 31 had the potential for social isolation due to Resident 31's refusal to attend group activities. The care plan indicated interventions as follows: Assessment of the resident. Assess residents activity preference gospel relaxing music. Provide materials for our resident's activities of interests such as magazine. Provide monthly calendar and encourage participation in any activities of interest. Invite resident to activities out of room. Praise resident for participation. During a clinical record review for Resident 31, the Minimum Data Set (MDS -health status screening and assessment tool used for all residents), dated 12/16/21, indicated Resident 31 had a BIMS score of 3/15 (Brief Interview for Mental Status - a 15-point cognitive screening measure that evaluates memory and orientation. A score of 13 - 15 is cognitively intact, 08 - 12 is moderately impaired, and 00 - 07 is severe impairment). The MDS indicated the following activity preferences, which were very important for Resident 31: To have books, newspapers, and magazines to read; listen to music; be around animals such as pets; keep up with the news; do things with groups of people; do her favorite activities; go outside to get fresh air when the weather is good; and participate in religious services or practices. During a clinical record review for Resident 31, the document titled, Activity Assessment, dated 6/15/22, indicated Resident 31 enjoyed watching TV and listening to music like jazz and soul music. The Activity Assessment listed the following activities, adapted for Resident 31's current abilities: Arts & crafts, exercise/ sports, music, trips/ shopping, watching TV/ movies, gardening/ plants/ pets, talking/ conversing, and helping others. RESIDENT 44 During clinical record review for Resident 44, the Face Sheet indicated Resident 44 was admitted on [DATE], with diagnoses including Diabetes Mellitus (health condition that affects how your body turns food into energy), Chronic Obstructive Pulmonary Disease (COPD - diseases that cause airflow blockage and breathing-related problems), Major Depressive Disorder (a mental disorder characterized by a persistently depressed mood and long-term loss of pleasure or interest in life), Parkinson's Disease (disorder of the central nervous system that affects movement), and Psychosis (severe mental disorder). (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview with Resident 44 on 09/13/22 at 9:40 a.m., in his room, when asked about activities provided in the facility, Resident 44 stated there were no activities provided for the residents, especially when the facility had positive cases of COVID-19 (an infectious disease caused by corona virus). Resident 44 stated he felt confined because he had to stay in his room and only watch TV all day. During an interview with the Activities Director on 9/15/22 at 11:55 a.m., when asked who oversaw the facility's Activity Program to ensure activities were met, according to resident's individual needs and preferences, the Activities Director stated he was responsible in the development of residents' activities. He stated he would review activities provided in the past from previous activities directors. The Activities Director stated he had not consulted with any licensed therapist and was not aware he had to consult with a licensed therapist when developing the facility's Activity Programs. During an interview with Resident 44 on 9/15/22 at 4:23 p.m., Resident 44 stated he was not interested with board games. Resident 44 stated he was always out of his room and not interested with in-room visits. During a clinical record review for Resident 44, the MDS, dated [DATE], indicated Resident 44 had a BIMS score of 15/15. The MDS indicated the following activity preferences, which were very important for Resident 44: To have books, newspapers, and magazines to read; listen to music; be around animals such as pets; keep up with the news; do things with groups of people; do favorite activities; go outside to get fresh air when the weather is good; and participate in religious services or practices. During a clinical record review for Resident 44, the Care Plan, created on 4/29/22, indicated, Potential for social isolation related to: [Resident 44] needs independent, self-directed activity program. Care Plan goals indicated, Resident 44 will pursue independent activities daily and will accept in-room visits daily or at least 3-4 times a week. The Care Plan indicated interventions as follows: Assessment of the resident. Assess resident's activity preference books, magazine. Provide materials for resident's activities of interest such as magazine, word search, books. Provide monthly calendar and encourage participation in any activities of interest. Invite resident to attend activities out of room. Remind and offer assistance to activity programs of choice. Praise resident for participation. RESIDENT 49 (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During clinical record review for Resident 49, the Face Sheet indicated Resident 49 was admitted on [DATE], with diagnoses including Major Depressive Disorder, Dementia (memory problem), and Anxiety Disorder. During an observation on 9/15/22 at 10:41 a.m., Resident 49 was on her bed awake, staring at the ceiling. Her television was off. During an observation on 9/15/22 at 3:29 p.m., Resident 49 was on her bed awake. Her television was off. During a clinical record review for Resident 49, the Care Plan, initiated on 1/21/22, indicated, Potential for isolation related to resident needs to be encouraged/reminded to attend activities of interest. The Care Plan indicated interventions as follows: Assessment of the resident. Assess residents activity preference bingo religious service musical programs. Provide materials for resident's activities of interest such as word search, puzzles. Provide monthly calendar and encourage participation in any activities of interest. Invite resident to attend activities out of room. Remind and offer assistance to activity programs of choice. Praise resident for participation. During a clinical record review for Resident 49, the MDS, dated [DATE], indicated Resident 49 had a BIMS score of 2/15. The MDS indicated the following activity preferences, which were very important for Resident 49: To have books, newspapers, and magazines to read; listen to music; keep up with the news; do things with groups of people; do her favorite activities; go outside to get fresh air when the weather is good; participate in religious services or practices and somewhat important, to be around animals such as pets. During a clinical record review for Resident 49, the document titled, Activity Assessment, dated 8/30/22, indicated Resident 49 responded to one-on-one, in-room visits, for reality orientation. Resident 49 liked watching television, coloring arts, browsing magazines, and playing bingo games. 46132 RESIDENT 351 Review of Resident 351's Face Sheet (demographic) indicated she was [AGE] years-old, admitted to the facility on [DATE], with a diagnosis of surgical after care. Review of Resident 351's Activity Assessment, undated and unsigned, indicated listening to blues and gospel music and participating in religious services, were important to her. It also indicated, under additional activity preferences, she preferred watching television (TV) or movies. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation on 9/12/22 at 12:18 p.m., Resident 351 was awake in bed. No TV or radio were playing. During an observation on 9/14/22 at 9:17 a.m., Resident 351 was in bed, awake. Her room was silent, the TV was off and no radio could be heard playing in the background. During an interview on 9/14/22 at 9:49 a.m., Resident 351 stated she did not recall if activity staff came to visit her. She stated she did not know what activities were offered by the facility. She stated it would be nice to know if the facility had other activities being offered so she could decide if she would like to attend any activities at all. Resident 351 stated, attending activities might help her get distracted from her pain. During a concurrent observation and interview on 9/15/22 at 10:02 a.m., the Activity Director (AD) verified he was not able to read the activity posting if he was lying on Resident 351's bed, because it was printed too small. He stated it was important for Resident 351 to know the daily facility activities so she knew which activities to attend if she wanted to. He stated it was important for residents to have activities for their mental and social well-being. He stated, not having activities could put residents at risk for depression and frustration. During an interview on 9/19/22 at 9:58 a.m., Restorative Nursing Assistant Q (RNA, health-care professionals responsible for providing restorative and rehabilitation care for residents to maintain or regain physical, mental and emotional well-being) stated it was important for residents to attend activities of choice and to know what activities were being offered daily. She stated activities were important for residents' well being. She stated, if residents did not have activities, they could be at risk for weakness, boredom, sadness and depression. During a concurrent interview and care plan and activity participation form review, on 9/19/22 at 11:40 a.m., the AD stated, having act [TRUNCATED]

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the activities program is directed by a qualified professional. 44968 Based on interview and records review, the facility failed to meet the requirement for an Activity Program Director, when the Activity Director did not regularly consult with a licensed therapist on the development of an Activity Program for facility residents. This failure prevented a licensed therapist to oversee the Activity Program to ensure meaningful activities, designed to meet the interests of, and support the physical, mental, and psychosocial well-being, of each resident. Findings: During an interview with the Activities Director on 9/12/22 at 3:24 p.m., the Activities Director stated he was new to the position of Activities Director. During record review and concurrent interview with the Activities Director, on 9/15/22 at 11:55 a.m., the Activities Director's certificate indicated he had satisfactorily completed 36 hours of training in a course designed for Activity Directors, from 7/7/22 to 7/10/22. The Activities Director was asked who oversaw the facility's Activity Program to ensure activities were met according to a resident's individual needs and preferences. The Activities Director stated he was responsible in the development of residents' activities. He stated he would review the activities provided in the past from previous Activities Directors. When the Activities Directors was asked if he consulted regularly with any licensed therapist in the development of Activity Programs for the residents, the Activities Director stated he had not consulted with any licensed therapist and was not aware he had to consult with a licensed therapist for the development of the facility's Activity Program. During an interview with the Director of Nursing (DON), on 9/19/22 at 12:50 p.m., when asked who oversaw the Activity Program with the Activities Director, the DON stated he was not sure if the facility had an Activity Consultant who worked with the Activities Director. The DON stated he did not know if the Activities Director was in regular consultation with a licensed therapist for the development of the facility's Activity Programs. Review of the Job Description and Performance Standards, indicated the following qualifications of Activities Director: a.At least 1 year of experience in the Activity Department as a full-time in a healthcare setting OR have satisfactorily completed at least 36 hours of training in an Activity Program leader position approved by the Department of Public Health. b. Regularly receive consultant from an occupation therapist, occupational therapy assistance or recreation therapist who has at least one year of experience in a health care setting.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46132 Based on observation, interview and record review, the facility failed to ensure: 1) Two out of two sampled residents' (Residents 351 and 44) surgical wounds were documented, assessed, and treated, to prevent complications. These failures resulted in Resident 351's re-hospitalization for wound dehiscence (partial or total separation of previously-approximated (edges of a wound fit neatly together, such as a surgical incision, and can close easily) wound edges, due to a failure of proper wound healing) and wound infection, and had the potential for Resident 44's wound to worsen or develop an infection; 2) The facility failed to properly and accurately document skin assessments for one un-sampled resident (Resident 100). This failure prevented Resident 100 from having a complete and accurate medical record; and, 3) The facility failed to ensure it used commercial-grade blood pressure monitors; instead, it used wrist blood pressure monitors intended for home use. This failure placed eight out of eight sampled residents (Residents 7, 8, 39, 3, 351,35, 151 and 46) at risk for inaccurate blood pressure readings and for potentially receiving unnecessary blood pressure medications. Findings: 1a) Review of Resident 351's Facesheet (demographics) indicated she was [AGE] years-old, and admitted to the facility on [DATE], with a diagnosis of surgical aftercare. Review of the nursing admission note indicated Resident 351 was admitted with a wound VAC (Vacuum-assisted closure, a treatment that applies gentle suction to a wound to help it heal. It's also called Negative Pressure wound therapy) on her sacrum (a triangular bone in the lower back formed from fused vertebrae and situated between the two hipbones of the pelvis). During a concurrent observation and interview on [DATE] at 9:44 a.m., Resident 351 was lying in bed. She stated she had a surgical wound on her back. She stated she used to have a wound VAC. She stated the wound VAC had been discontinued, but she could not recall receiving surgical wound care from the nurses. She stated, I don't know if the nurses knew I have a wound on my back. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and medical chart review, physician orders and Admission Assessment record review on [DATE] at 4:40 p.m., Licensed Nurse M (LN M) initially stated Resident 351 had clear skin and no wound. LN M stated she would know because, if there was a skin issue, the nurses would leave her a note to see the resident. LN M verified Resident 351 was not on the list of residents to be seen by the wound doctor this day. LN M verified the facility wound doctor had not seen Resident 351 since admission. LN M verified Resident 351 had no treatment order for the surgical wound. LN M verified there was a note on the Admission Assessment indicating Resident 351 had a wound vac on her sacrum. LN M also verified there was no Braden Scale skin assessment (a standardized tool to assess pressure ulcer (damage to an area of the skin caused by constant pressure on the area for a long time) risk for a resident. completed at the time of her admission. LN M verified there were no monitoring of Resident 351's surgical wound for signs and symptoms of infection. LN M stated the facility policy was not followed when Resident 351 did not have a Braden Scale assessment completed upon admission; there was no treatment order for the surgical wound care, and there was no monitoring of the surgical site, every shift, for signs and symptoms of infection. During an observation in Resident 351's room on [DATE] at 4:50 p.m., LN M turned Resident 351 on her right side to be able to visualize the surgical wound on her back. LN M verified the surgical wound was not covered with dry dressing, and there was a packing strip (a long, slender,continuous pieces of a fine-mesh, gauzy material intended to fill wounds that extend into the middle layer of the skin) on the lower end of her lumbar (lower back) incision. LN M measured the surgical incision then and provided this surgical wound measurement, 13.5 cm x 0.5 cm x 0 cm. During a concurrent interview and medical chart record review on [DATE] at 8:15 a.m., the Minimum Data Set (MDS, a federally mandated process for clinical assessment of all residents in Medicare or Medicaid facility) Coordinator stated he did not verify whether Resident 351 had a wound VAC upon admission. The MDS Coordinator verified Resident 351 had no weekly skin assessments completed. He stated Resident 351 should have had at least two weekly skin assessments completed since Resident 351's admission on [DATE]. He stated the facility policy was not followed if the nurses were not conducting weekly skin assessments. The MDS Coordinator verified the eMAR (electronic Medication Administration Record) did not show nurses were monitoring Resident 351's lower back incision for signs and symptoms of infection or wound dehiscence since the wound VAC was discontinued on [DATE]. He verified there was no treatment order for the surgical wound since the wound VAC was discontinued. The MDS Coordinator verified the facility policy was not followed when there was no baseline surgical skin assessment completed once the wound VAC was discontinued. He stated the facility policy was not followed when nurses failed to monitor the surgical incision site every shift. He stated these failures put Resident 351 at risk for further wound dehiscence, non-healing wounds, infection, sepsis (the body's extreme response to an infection and is a life-threatening medical emergency) and readmission to the acute hospital. During an interview on [DATE] at 8:25 a.m., Licensed Nurse G (LN G) stated the admission nurse completed the skin assessment and Braden Scale skin assessment upon admission. She stated, if these assessments were not done, the facility policy was not followed. LN G also stated the facility's policy was not followed if the nurses were not monitoring the surgical site for signs and symptoms of infection, every shift and if the nurses were not completing the weekly skin assessment. LN G stated, not monitoring the surgical site for complications every shift could put Resident 351 at risk for infection and a non-healing wound. LN G stated, not completing weekly wound assessments could result in inadequate monitoring of the wound which could result in missed opportunities to assess whether the wound was improving or getting worse or if current treatment was effective or ineffective. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on [DATE] at 4:50 p.m., Licensed Nurse O (LN O) verified she admitted Resident 351 on [DATE] at 5 p.m. LN O stated the facility policy for admission included completing the nursing assessment (time of arrival, skin assessment, nutrition assessment, fall assessment, elopement assessment, pain assessment and smoking assessment). LN O verified the facility policy was not followed when Resident 351 did not have a Braden Scale skin assessment upon admission. LN O verified she did not complete Resident 351's Braden Scale skin assessment because it was the responsibility of the treatment nurse to complete it. LN O stated it was important to ensure the Braden Scale skin assessment was completed so staff were aware of any current skin issues and potential risk of further skin issues. LN O stated the findings on the Braden Scale skin assessment could then be used for care planning with the goal of addressing both the current and potential skin issues. LN O verified there was no care plan initiated for the wound VAC, upon admission. She also verified there was no care plan or treatment order initiated for Resident 351's surgical incision once the wound VAC was discontinued. LN O stated the facility's policy was not followed when there was no treatment or monitoring of the surgical incision, every shift. She stated these placed Resident 351 at risk for not receiving appropriate care, which could result in wound infection, sepsis, non or delayed wound healing and wound dehiscence. During an interview on [DATE] at 9:28 a.m., Licensed Nurse A (LN A) verified Resident 351 was sent straight to the acute hospital after her neurosurgery (a surgical specialization that treats diseases and disorders of the brain and spinal cord) appointment on [DATE]. During an interview on [DATE] at 9:33 a.m., the Director of Nursing (DON) verified Resident 351 was at [Acute Care Hospital's Name] for further evaluation of her surgical wound. During a concurrent interview and nursing note record review on [DATE] at 10:32 a.m., the Minimum Data Set Coordinator (MDS Coordinators assess and monitor proper treatment for residents in nursing homes) verified he was not able to find nursing documentation and skin assessments when the wound VAC was discontinued on [DATE]. The MDS Coordinator verified the eMAR indicated nurses were checking the wound VAC, from [DATE] to [DATE], when it was already discontinued on [DATE]. The MDS Coordinator stated nurses were probably not reading what they were signing. He stated wound VAC monitoring should have ended once it was discontinued. During an interview on [DATE] at 12:46 p.m., LN M stated the Wound Doctor saw residents with skin issues, pressure ulcers, and surgical wounds,weekly, either in person or via telehealth (video or phone appointments between a patient and their health care practitioner). LN M verified the Wound Doctor had not assessed Resident 351 since admission on [DATE], [DATE] and [DATE]. When asked why the Wound Doctor did not assess Resident 351 when he was doing telehealth to other residents with skin issues on Wednesday, [DATE], LN M stated the Wound Doctor would like to assess Resident 351 in person. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and electronic Treatment Administration Record (ETAR) weekly wound/skin documentation record review on [DATE] at 2:33 p.m., LN H stated the facility policy was not followed when there was no new skin assessment completed for Resident 351, once the wound VAC was discontinued. She stated the skin assessment should have been initiated because now they were able to visualize the wounds. LN H verified nurses were still monitoring the wound VAC from [DATE] to [DATE], when the wound VAC was already discontinued on [DATE]. LN H stated the wound VAC monitoring should have ceased after it was discontinued on [DATE]. She stated it was important to assess, treat and document accurately to ensure wounds were healing adequately with no complications. She stated, if treatments or documentation was not accurate, it could put Resident 351 at risk for non-healing wound, infected wound and ineffective treatment. During a concurrent interview and EMAR/ETAR record review on [DATE] at 3:11 p.m., the DON verified Resident 351's wound VAC was discontinued on [DATE]. He stated the wound VAC order for monitoring was inaccurate and should not even be documented on the eMAR after it was discontinued on [DATE]. The DON stated inaccurate documentation could lead to mistakes and could result in infected and non-healing wounds. The DON stated it was possible Resident 351's wound infection, and subsequent re-hospitalization , could have been prevented if there was adequate treatment and monitoring of symptoms was reported to the Medical Doctor. The DON stated nurses should have documented and assessed wound status after the removal of wound VAC. He stated, not doing a skin assessment and implementing treatment, was safety risk which could lead to wound infections, non-healing wounds, and sepsis, if not treated immediately. During an interview on [DATE] at 3:32 p.m., Licensed Nurse C (LN C) verified she received a call from the doctor to discontinue the wound VAC and initiate treatment to cleanse the surgical wound with saline and cover with a dry dressing. LN C verified she did not carry out the treatment order. She stated she did not ask the frequency nor the duration of the treatment to the doctor. When asked why, LN C was silent. LN C verified, based on facility policy, she should have documented the surgical skin status after she discontinued the wound VAC. When asked why she did not document the skin status after discontinuing the wound VAC, LN C was silent. LN C stated it was important to document wound status to ensure Resident 351's surgical wound was healing adequately with no complications. LN C stated, if the wound was being monitored for complications or signs and symptoms of infection and treatment for the surgical wound was provided, this could have decreased the risk of Resident 351's re-hospitalization for wound dehiscence and infection. During a concurrent interview and review of Resident 351's history and physical, dated [DATE], on [DATE] at 4:30 p.m., the MDS Coordinator verified the admitting doctor did not include wound infection on Resident 351's list of admitting diagnoses. The MDS Coordinator stated Resident 351's re-hospitalization could probably been prevented if staff were monitoring the surgical wound for signs and symptoms of infection and if there was a daily treatment implemented for Resident 351's surgical wound. During an interview on [DATE] at 5:04 p.m., LN M indicated re-hospitalization could probably been prevented if staff were assessing and monitoring Resident 351's surgical wound for signs and symptoms of infection and if staff were treating her surgical wound daily. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During a review of facility's policy and procedure titled, Surgical Wound Care, revised ,d+[DATE], indicated surgical wounds should be cleansed with normal saline, pat dry and covered with dry dressing unless other special treatment /instructions were given by the surgical doctor. It further indicated documentation should be maintained in the resident's medical record, including but not limited to treatment sheets, licensed note and any appropriate area. 44968 1b) During an interview and observation with Resident 44 outside of his room on [DATE] at 11:24 a.m., Resident 44 stated he had a sore on his tailbone bottom from a surgery. Resident 44 stated wound treatment should be done once a day; however, he was not getting it. Resident 44 stated the last wound treatment he received was two days ago. Resident 44 pointed out his bed linen was soiled with brownish-yellow stains from his wound discharge. During an interview with Resident 44 on [DATE] 10:23 a.m., Resident 44 stated nurses were not doing the treatment on his tailbone properly, Resident 44 stated one of the nurses would use band aid to cover the wound. During an interview with Licensed Nurse M on [DATE] at 12:46 p.m., Licensed Nurse M stated she was the primary treatment nurse for the whole facility. Licensed Nurse M stated licensed nurses were expected to provide wound treatment to residents on her days off; however, licensed nurses were not doing it. When Licensed Nurse M was asked about the risks for residents with wounds not receiving wound treatments according to doctor's order, Licensed Nurse M stated residents' wounds could worsen. During an interview with Licensed Nurse M on [DATE] at 1:04 p.m., when asked about Resident 44's wound care, Licensed Nurse M stated Resident 44 had a cyst (an abnormal pocket in the skin which usually contained hair and skin debris) removal on his tailbone. Licensed Nurse M stated the doctor gave instruction to cover the wound with foam dressing and change every day. When Licensed Nurse M was asked if band aid could be used to cover the wound, Licensed Nurse M stated Resident 44's wound should be covered with 6 cm x 6 cm (centimeter) foam dressing. During a clinical record review for Resident 44, the progress note, dated [DATE] at 4:25 p.m., indicated Resident 44 had a sacral (relating to the sacrum - the triangular bone just below the backbone) pilonidal cyst removed. During a clinical record review for Resident 44, the Treatment Administration Record (TAR) indicated a doctor's order written on [DATE], to keep the surgical site clean, dry and cover with foam dressing every day and as needed. During a clinical record review for Resident 44, the Care Plan for surgical wound created, on [DATE], indicated to keep the surgical site clean, dry and cover the with foam dressing every day and as needed when soiled or dislodged. 27532 (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	2) During a review of record, Resident 100's Face Sheet indicated she was readmitted from an acute hospital to the facility on [DATE], with diagnoses of hemiplegia (paralysis on one side of the body) and hemiparesis (weakness or the inability to move on one side of the body) following a stroke affecting the right side of the body, dysphagia (difficulty in swallowing), Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks) and adult failure to thrive. A review of Resident 100's MDS Section M (Minimum Data Set is a federally-mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes and helps nursing home staff identify health problems. Section M provides skin assessment information including the number and stage of unhealed pressure sores present on admission), dated [DATE], indicated Resident 100 was readmitted to the facility with one Stage II pressure sore or injury (open skin or an ulcer, which is usually tender and painful. The sore expands into deeper layers of the skin. It can look like a scrape, blister, or a shallow crater in the skin. Sometimes this stage looks like a blister filled with clear fluid). Review of the weekly skin integrity assessment, dated [DATE], indicated Resident 100's Stage II pressure wound was on her sacrum (the large, triangle-shaped bone in the lower spine that forms part of the pelvis). A review of a physician order, dated [DATE], indicated to cleanse the area with Normal Saline (a sterile solution of salt and water), pat dry, apply Calmoseptine (a multipurpose ointment used to treat and prevent minor skin irritations) to sacrum, with every brief change once a day and as needed, day and evening shift. The TAR (Treatment Administration Record) indicated nurses were administering the treatment as ordered, from [DATE] to [DATE]. Continued review of Resident 100's MDS, dated [DATE], [DATE], and the MDS on discharge on [DATE], indicated Resident 100 no longer had a pressure sore during those assessment months. During an interview and concurrent review of record on [DATE], at 4:20 p.m., Licensed Nurse R stated she had been working as wound nurse in the facility for about two months. Licensed Nurse R stated she worked Tuesday and Thursday while the regular wound nurse worked the other days and weekends. Licensed Nurse R found and presented the 2022, binder of the weekly skin report. During a continued interview and concurrent review of record on [DATE] at 4:20 p.m., Licensed Nurse R showed in PCC (Point Click Care - an electronic software storing medical information of residents in the facility) where the wound nurse documented weekly skin assessments. During continued review Licensed Nurse R stated it did not look like there was weekly documentation in PCC after the initial assessment on admission. During a review, the skin report binder for 2022, contained sheets of paper indicating weekly listing of residents receiving wound care, with information on the type of wound, date the wound was first discovered and assessed, whether the wound was facility-acquired or present on admission, stage of pressure sore or injury, location, characteristics and measurements of wounds, status on assessment whether worse, improved, the same, etc. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on [DATE], at 1:12 p.m., Licensed Nurse M confirmed she did the documentation of the weekly skin assessment in the residents' charts after wound rounds with the wound doctors. When asked what the status of Resident 100's pressure sore was upon discharge to the acute hospital on [DATE], Licensed Nurse M stated she could not recall. When asked where the 2021, skin reports could be found, Licensed Nurse M responded the reports should be with Medical Records. During an interview on [DATE], at 4:04 p.m., the Medical Records Director stated she called the Wound Clinic providing the wound care to the facility. The Medical Records Director stated she asked for Resident 100's records, but the clinic informed her they did not have any records on Resident 100. When asked if the wound clinic was the same wound clinic providing wound care services in 2021, the Medical Records Director stated she would call and verify. A review of the of the binder of the Weekly Skin reports for 2021, provided by Licensed Nurse Z, indicated the binder contained the weekly wound assessments sheets for the months of January to June, but the weekly skin sheets for the months from July to December were missing. During a follow-up interview on [DATE], at 4:12 p.m., the Medical Records Director confirmed the same wound clinic was providing wound care services to the facility in 2021. The Medical Records Director stated she called the Wound Clinic again and confirmed there were no records of wound assessments for Resident 100. During an interview on [DATE], at 4:51 p.m., Licensed Nurse M confirmed she was the one who did the weekly assessments of Resident 100 on [DATE], but wondered why there were no progress notes after the initial wound assessments, until Resident 100 was discharged . Licensed Nurse M also stated she could not remember the wound doctor having seen Resident 100. When asked if she agreed the omission of documentation and monitoring were evidence of non-compliance, Licensed Nurse M nodded in agreement. A review of the Death Summary of Resident 100, dated [DATE], indicated Resident 100 was admitted to the acute hospital on [DATE], and expired on [DATE]. The death summary indicated Resident 100 was admitted for , altered mental status and profoundly abnormal laboratory, results, felt to be consistent with dehydration and failure to thrive like picture leading to acute kidney failure. Resident 100 was also found with ,a Stage III pressure injury on the right buttocks, present on admission, and an unstageable pressure injury of the left buttock, present on admission. The summary indicated the pressure injury were, probably due to her worsening debilitated state and primarily a fully bedbound status as she declined. It is unclear whether patient had been turned during her period of decline. A review of the facility Policy on Prevention of Pressure Ulcers, revised ,d+[DATE], page 1, indicated: The facility should have a system/procedure to assure assessments are timely and appropriate and changes in conditions are recognized, evaluated, reported to the practitioner, physician, and family, and addressed. The policy also indicated information on any change in the resident's condition should be recorded in the resident's medical record. 3) During an observation on [DATE] at 3:53 p.m., Licensed Nurse S used a wrist blood pressure (BP) monitor to obtain Resident 7's BP reading. During an observation on [DATE] at 8:55 a.m., Licensed Nurse C used the wrist BP monitor to obtain Resident 151's BP reading. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During a review of the physician orders for Residents 7, 8, 39, 3, 351, 35, 151 and 46, it indicated these residents' blood pressure was being monitored every shift. During an interview on [DATE] at 11:31 a.m., the Director of Nursing (DON) verified that for the longest time, the facility had been using the wrist BP monitor to measure all residents' blood pressure. During a phone call with Equate Wrist BP monitor Customer Service on [DATE] at 12:55 p.m., a Customer Service representative verified the Equate Wrist BP Monitor 4500 series, currently being used by the facility, was intended for home use only and should not be used at Skilled Nursing Facility. During an interview on [DATE] at 11:25 a.m., the Director of Staff Development (DSD) stated wrist BP monitors should not be used at the facility. She stated she discussed this with the nurses about two months ago. The DSD stated wrist BP monitors gave inaccurate BP readings, which could compromise resident safety. She stated, for quality of care and standard of care, the facility should not be using the wrist BP monitor. During a concurrent interview and user's manual instruction review on [DATE] at 12:20 p.m., the Director of Nursing (DON) stated he was not aware of what the standard of practice was, with regards to the use of a wrist BP monitor. He verified the brand/model the facility was using was Equate wrist BP monitor and should only be used in a home care setting. He stated it should not have been used in the facility. The DON stated, using a wrist BP could yield inaccurate readings and could be a safety risk for the residents. The DON verified all residents had BP monitoring. He stated this could lead to residents receiving, or not receiving, BP medication based on inaccurate BP readings. During an interview on [DATE] at 2:45 p.m., Licensed Nurse H (LN H) stated the facility had been using the wrist BP monitor for a long time and now realized the facility should not be using the wrist BP monitor because it yielded inaccurate reading. She stated, using the wrist BP monitor was a safety risk because they might be administering BP medication for a resident who may not need it. LN H stated residents could be hypotensive (low blood pressure) and could be at risk for falls or dizziness. During a review of the instruction manual titled, Equate Wrist Blood Pressure Monitor 4500 series, model # BP3KC,d+[DATE]EWM, undated, the instruction manual indicated this machine was intended for self-monitoring of BP in adults and within a home environment.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44968 Based on interview and record review, the facility failed to provided treatment, care and services to prevent pressure ulcers to two of 16 sampled residents (Residents 11 and 43). This failure resulted in Resident 11 developing a Stage III pressure ulcer and Resident 43 developing a Stage II pressure ulcer. Findings: RESIDENT 11 During a clinical record review for Resident 11, the Face sheet (A one-page summary of important information about a resident) indicated Resident 11 was admitted on [DATE], with diagnoses including Spastic hemiplegia (movement on one side of the body is affected), Stage III pressure ulcer (full thickness tissue loss, subcutaneous fat may be visible to the naked eye) of left buttock and Multiple Sclerosis (progressive disease involving damage to the sheaths of nerve cells in the brain and spinal cord). During an interview with Resident 11 on 9/12/22 at 2:54 p.m., Resident 11 stated he had a pressure ulcer on his buttocks; however, wound treatment was not done daily. During an interview with Licensed Nurse M on 9/16/22 at 12:46 p.m., Licensed Nurse M stated Resident 11 had a Stage III pressure ulcer to his sacrum (the triangular bone just below the lumbar vertebrae (series of small bones forming the backbone). Licensed Nurse M stated she was the primary treatment nurse for the whole facility. Licensed Nurse M stated licensed nurses were expected to provide wound treatment to residents on her days off; however, licensed nurses were not doing it. Licensed Nurse M stated when she came back to work on 8/12/22, after 12 days of medical leave, Resident 11's right outer leg still had the same dressing from the last time she did the treatment, which was dated 7/29/22. When Licensed Nurse M was asked about the risks for residents with wounds who did not receive wound treatment, according to doctor's order, Licensed Nurse M stated residents' wounds could worsen. During an interview with the Director of Nursing (DON) on 9/19/22 at 12:53 p.m., when asked who was responsible for providing wound care when the treatment nurse was not available, the DON stated the licensed nurses were responsible to provide wound care to the residents. During a clinical record review for Resident 11, the Care Plan for his right lower leg wound, initiated on 1/26/22, indicated interventions including: Treatment as ordered. During a clinical record review for Resident 11, the Care Plan for his left buttock Stage III pressure wound, initiated on 3/10/22, indicated interventions including: Treatment as ordered. During a clinical record review for Resident 11, the Minimum Data Set (MDS -health status screening and assessment tool used for all residents), dated 7/10/22, indicated Resident 11 had one Stage III pressure ulcer not present on admission. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During a clinical record review for Resident 11, the Treatment Administration Record (TAR) for September 2022, indicated a doctor's order, dated 5/11/2,2 for a daily wound treatment to Resident 11's right lower leg. The TAR indicated no licensed nurse signature on 9/4/22, and 9/10/22, indicating wound treatment was provided. During a clinical record review for Resident 11, the Treatment Administration Record (TAR) for September 2022, indicated and a doctor's order, dated 8/31/22, for a daily wound treatment to Resident 11's Stage II sacral pressure ulcer. The TAR indicated no licensed nurse signature on 9/4/22, indicating wound treatment was provided. During a clinical record review for Resident 11, the Treatment Administration Record (TAR) for September 202,2 indicated and a doctor's order, dated 9/7/22, for a daily wound treatment to Resident 11's Stage III sacral pressure ulcer. The TAR indicated no licensed nurse signature on 9/10/22, indicating wound treatment was provided. During a clinical record review for Resident 11, the document titled, Weekly Skin Integrity Assessment for Pressure Sore/Post-Op, dated 8/24/22, indicated Resident 11 had a Stage II pressure wound to his sacrum measuring 0.5 cm (centimeter) x 0.5 cm x 0.1 cm. During a clinical record review for Resident 11, the document titled, Weekly Skin Integrity Assessment for Pressure Sore/Post-Op, dated 9/07/22, indicated Resident 11 had a Stage III pressure wound to his sacrum measuring 3.0 cm x 1.0 cm x 0.3 cm. RESIDENT 43 During a clinical record review for Resident 43, the Face Sheet (A one-page summary of important information about a resident) indicated Resident 43 was admitted [DATE], with diagnoses including Chronic Obstructive Pulmonary Disease (COPD - diseases that cause airflow blockage and breathing-related problems), Heart Failure (blood often backs up and fluid can build up in the lungs, causing shortness of breath), and Diabetes Mellitus (health condition that affects how your body turns food into energy). During record review and concurrent interview with the MDS (Minimum Data Set - health status screening and assessment tool used for all residents) Coordinator on 9/16/22 at 9:36 a.m., the document titled, Weekly Skin Integrity Assessment for Pressure Ulcer/Post-Op, dated 7/6/22, indicated Resident 43 had a Stage II sacral pressure ulcer measuring 0.6 cm x 0.3 cm x 0.1 cm. During a clinical record review for Resident 43, the Treatment Administration Record for September 2022, indicated an ongoing wound treatment order for Resident 43's Stage II sacral pressure ulcer. During a clinical record review for Resident 43, the document titled, Nutritional Assessment - Registered Dietician, dated 4/27/22, indicated the Registered Dietitian (RD) wrote, [Resident 43] would benefit from additional protein supplementation for wound healing and weight stability. The RD recommended Prostat (ready-to-drink protein supplement) and Remeron (an antidepressant reported to also stimulate appetite and/or increase body weight) to help increase resident 43's oral intake and weight stability. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview with the Director of Nursing (DON) on 9/15/22 at 10:47 a.m., when the DON was asked about the facility process for implementation of the Registered Dietitian's (RD) recommendations, he stated the RD normally would send an email to the DON if she had recommendations for a specific resident, then the resident's doctor would be notified of the RD recommendations for approval. The DON stated, if there was no email received, there would be no follow-up. During an interview and concurrent record review with the MDS Coordinator on 9/16/22 at 9:55 a.m., when asked about their process when the facility received RD recommendations for residents, the MDS Coordinator stated nursing and the Interdisciplinary Team (IDT - group of health care professionals who work together toward the goals of the resident) would discuss about the recommendation and obtain an order from the doctor for implementation. The MDS verified there was no doctor's order written for Prostat and Remeron, per RD recommendation for Resident 43, since 4/27/22 . When asked what would be the risk for Resident 43 when RD recommendations were not implemented, the MDS Coordinator stated Resident 43's weight would continue to decline, and her wound could get worse. Review of the Facility policy and procedure titled, Prevention of Pressure Ulcers, revised in 12/2014 indicated, It is the policy of the facility to provide guidelines regarding identification of pressure ulcer risk factors and interventions for specific risk factors. The policy indicated the following under, #7. Risk Factor-Poor Nutrition: a. Dietitian will assess nutrition and hydration and make recommendations based on the individual resident's assessment. b. Monitor nutrition and hydration status. c. Administer vitamins, mineral and protein supplements in accordance with physician orders and dietitian recommendations. 37797

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37797 Based on observation, interview and record review, the facility failed to ensure one of 16 sampled residents (Resident 35) received care and services to prevent falls. The facility: 1) failed to supervise and assist Resident 35 during transfers to and from bed, wheelchair and bathroom; 2) failed to provide Resident 35, who had dementia and did not know how to use the room's call light system, with an alternative communication system to relay calls directly to a staff member or to a centralized staff work area, relying instead on Resident 35 yelling for help from her room as a means of alerting staff she needed help; 3) failed to ensure fall prevention interventions were appropriate to Resident 35's severely impaired cognitive level when the facility's primary fall intervention was educating and reminding Resident 35 to use the call light system to ask staff for assistance before attempting to transfer; 4) failed to revise and update Resident 35's fall care plans and implement new or different interventions post falls, after the existing interventions, such as educating Resident 35 to use the call light system, proved ineffective in preventing falls; and 5) failed to implement the fall care plan intervention of placing Resident 35 in a supervised area when she was out of bed. These failures resulted in Resident 35 falling eight times over an 11-week period from 6/22/22 to 9/7/22. Two of these falls, on 7/8/22 and 9/7/22, resulted in Resident 35 sustaining head and knee injuries requiring hospital transfer and evaluations. These failures also placed Resident 35 at risk for further falls. Findings: A review of Resident 35's Facesheet indicated she was [AGE] years-old, was originally admitted to the facility on [DATE], and had diagnoses including dementia, depression, psychosis (a disease that causes delusions and hallucinations), hemiplegia (muscle weakness or paralysis in one side of the body), seizures, and bilateral cataract and macular degeneration (eyes diseases that impair vision). During an interview on 9/13/22, at 2:08 p.m., Resident 35's Responsible Party (RP) stated Resident 35 falls often at the facility, and the falls result in injuries. The RP stated Resident 35 falls when she tries to transfer to and from the bed or wheelchair, to use the bathroom. The RP stated Resident 35 calls for staff to help her transfer, but staff do not assist her. Resident 35 then tries to transfer herself without staff assistance and falls as a result. A review of facility document titled, LIST OF FALL INCIDENTS (PAST 90 DAY), provided by the facility on 9/12/22, indicated Resident 35 had eight falls over a period of 11 weeks, from 6/22/22 to 9/7/22, as follows: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	FIRST FALL: 6/22/22 SECOND FALL: 6/26/22 THIRD FALL: 7/5/22 FOURTH FALL: 7/8/22 FIFTH FALL: 7/27/22 SIXTH FALL: 8/9/22 SEVENTH FALL: 8/12/22 EIGHTH FALL: 9/7/22 A review of Resident 35's hospital records indicated at least two of the falls, the FOURTH and the EIGHTH falls, dated 7/8/22 and 9/7/22, resulted in Resident 35's hospitalization due to injuries, as follows: Emergency Department note, dated 7/9/22, at 2:10 a.m., indicating Resident 35 was brought to the hospital for evaluation after a fall in the facility: patient fell out of her wheelchair. The note indicated Resident 35 complained of pain in her arms, back and left knee, and she had a head contusion. The note indicated a brain scan revealed Resident 35 had a moderate-severe head trauma. The note indicated final diagnoses of head contusion and left knee contusion. Emergency Department note, dated 9/7/22, at 9/14 p.m., indicating Resident 35 was brought to the hospital for evaluation after a fall in the facility: staff found patient on floor. The note indicated Resident 35 reported pain in her neck and head. The note indicated Resident 35 had a forehead contusion/hematoma and a left knee contusion. The note indicated the cause of the injuries was accidental fall. A review of Resident 35's, FALL ASSESSMENT RISK evaluations, for the months June to September 2022, indicated the following eight assessments and scores: 6/26/22: Fall Score of 12 = HIGH RISK FOR FALLS 7/5/22: Fall Score of 13 = HIGH RISK FOR FALLS 7/8/22: Fall Score of 13 = HIGH RISK FOR FALLS 7/27/22: Fall Score of 15 = HIGH RISK FOR FALLS 8/9/22: Fall Score of 10 = HIGH RISK FOR FALLS 8/12/22: Fall Score of 15 = HIGH RISK FOR FALLS 8/12/22: Fall Score of 12 = HIGH RISK FOR FALLS (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	9/7/22: Fall Score of 12 = HIGH RISK FOR FALLS A review of Resident 35's Order Summary Report - Active Orders as of 9/14/22 indicated Resident 35 was receiving the following four scheduled medications, all of which have side effects of lethargy, sedation and drowsiness: (1) DILANTIN (an anti-seizure medication) 100 milligrams twice a day, order dated 6/25/22. (2) QUETIAPINE (an anti-psychotic medication) 25 milligrams twice a day, order dated 6/25/22. (3) TRAZODONE (an anti-depressant medication) 25 milligrams twice a day, order dated 3/30/22. (4) ZOLOFT (an anti-depressant medication) 50 milligrams at bedtime, order dated 5/23/22. A review of Resident 35's Order Summary Report - Active Orders as of 9/14/22 also indicated a PRN (as needed) order for NORCO 10-325 milligram for pain, since 6/22/22. NORCO also has side effects of lethargy, sedation and drowsiness. A review Resident 35's, Minimum Data Set assessments (MDS - a formal assessment tool) for the previous 90 days, dated 5/15/22 and 8/12/22, indicated Resident 35 had a BIMs (Brief Interview for Mental Status - a test of cognition) score of 3 (scores of 0-7 indicate severe cognitive impairment), was dependent on staff for transfers, dressing and toilet use, had unsteady balance during surface-to-surface transfers, moving from seated-to-standing position and moving on and off the toilet, had impairment on upper and lower extremities, used a wheelchair, and had two or more falls since admission. A review of Resident 35's, FALL INVESTIGATION REPORTS and IDT POST FALL FOLLOW-UP REPORTS, for the period of 6/22/22 to 9/7/22, indicated the following: FIRST FALL: 6/22/22 Fall Investigation Report, dated 6/22/22 at 5 a.m.: @ 500 [5 a.m.] [Resident] tried to go back on bed [from bathroom] with no help when slid down on the floor next to bed with head up did not seek for help . IDT Post-Fall Follow-Up Report, dated 6/23/22: Resident was observed sitting on the floor next to her bed . Resident spontaneously got out of wheelchair unassisted did not ask for help/assistance did not use call light . New Intervention Recommended: Will provide transfer pole . will re-adjust grab bars in the bathroom. SECOND FALL: 6/26/22 Fall Investigation Report, dated 6/26/22 at 10:30 p.m.: Resident had unwitnessed fall at 10:15 p.m., resident found sitting down on floor next to her bed, according to the resident, she was trying to get into wheelchair and slid down to the floor . encourage resident to use call light to call for help when in need for assistance . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	IDT Post-Fall Follow-Up Report, dated 6/26/22: Resident had unwitnessed fall at 10:15 p.m., resident found sitting down on floor next to her bed, according to the resident, she was trying to get into wheelchair and slid down to the floor . encourage resident to use call light to call for help when in need for assistance . New Intervention Recommended: Re-educate resident re; safety importance of calling/asking for help/assistance as needed. THIRD FALL: 7/5/22 Fall Investigation Report: No fall investigation report. IDT Post-Fall Follow-Up Report, dated 7/5/22: Facility licensed staff responded to resident calling out from her room. Resident was observed laying on the floor .Resident spontaneously got out of wheelchair. Did not call for assistance did not use call light . Resident continuously doing physical activities and performing ADL's unassisted beyond her physical ability. New Intervention Recommended: Non-skid strips applied to the floor and resident became verbally hostile . Non-skid floor strips was removed and resident calmed down . explained risks and benefits to resident . FOURTH FALL: 7/8/22 Fall Investigation Report, dated 7/8/22 at 11:23 p.m.: Resident was found in the bathroom, laying down on the floor, she was trying to get into the toilet and she slid down and hit her head . side of the head little swollen . has pain 8/10 . sent to hospital for further evaluation . IDT Post-Fall Follow-Up Report, dated 7/8/22, but signed 7/22/22: Resident spontaneously got out of wheelchair unassisted did not ask for help/assistance did not use call light . New Intervention Recommended: Re-educate resident re; safety importance of calling/asking for help/assistance as needed. FIFTH FALL: 7/27/22 Progress Note, dated 7/27/22 at 10:30 a.m. Heard resident's loud voice, found her on the floor, sitting position, next to her bed . Fall Investigation Report, dated 7/27/22 at 10:30 a.m.: Resident was found on the floor, next to her bed . IDT Post-Fall Follow-Up Report, dated 7/27/22: New Intervention Recommended: Keep an eye the resident and put her in front of nurse station, then if the resident wants to take a nap or wants to go back to bed and use the bathroom, CNA [Certified Nursing Assistant] will call or page to assist the resident. SIXTH FALL: 8/9/22 Fall Investigation Report, dated 8/9/22: 10:42 a.m.- I was [at] nurse station . when I heard a loud sound, I immediately went to check [Resident 35], and found her lying on floor next to her bed, wheelchair near at bedside . [Resident] non-compliant to use call light, safety instructions. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	IDT Post-Fall Follow-Up Report dated 8/9/22: Resident was observed laying on the floor at bedside . Resident apparently got out of wheelchair spontaneously without asking for help or assistance . New Intervention Recommended: no new interventions recommended. SEVENTH FALL: 8/12/22 Fall Investigation Report, dated 8/12/22 AT 10:30 a.m.: I was called by staff to see resident in her room. Went to her room found accompanied by CNA . according to CNAs report, she is helping Resident 35 transfer from chair to bed but resident slid on floor . IDT Post-Fall Follow-Up Report, dated 8/15/22, but signed on 9/7/22: CNA was assisting resident to transfer from wheelchair to the bed and resident unable to withstand standing up, CNA assisted resident to sit on the floor at bedside . New Intervention Recommended: Re educated RE; Safety including but not limited to calling for assistance as needed. EIGHTH FALL: 9/7/22 Fall Investigation Report, dated 9/7/22 at 8:56 p.m.: Resident found laying out on the floor in D wing hallway at 7:40 p.m. According to the resident she was bumped to the other wheelchair that cause her fell out from her wheelchair . complains of pain in the head and left knee 8/10 . sent out to hospital for further evaluation . IDT Post-Fall Follow-Up Report, dated 9/7/22: Resident found laying out on the floor in D wing hallway at 7:40 p.m. According to the resident she was bumped to the other wheelchair that cause her fell out from her wheelchair . complains of pain in the head and left knee 8/10 . sent out to hospital for further evaluation . A review of Resident 35's care plans indicated six fall care plans, as follows: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	FIRST CARE PLAN, titled: Resident at risk for falling related to impaired balance, unsteady gait, history of falls. Has a diagnosis of dementia, CVA [cerebrovascular accident - stroke] with right sided hemiplegia/hemiparesis, seizure . has poor safety awareness and non-compliance with needed assistance on transfers . resident spontaneously got out of bed unassisted, did not use call light, did not ask for help or assistance. DATE INITIATED: 11/28/19, 3/18/22 & 5/03/22. Interventions: (1) Assess resident, frequent check on resident, notify MD and RP of any change in condition; (2) continue frequent visual checks; (3) health education provided to the staff to initiate assistance based on resident's routine . (4) observe resident's routine and initiate staff assistance to the resident on the times she is usually going back to bed, getting up to wheelchair and going to the restroom; (5) remind resident on safety measures: to always lock wheelchair before getting up (6) Assessment of resident (7) assess resident's mobility (8) assure floor is free of glare, liquids, foreign objects (9) bed kept in low position; (10) establish as baseline, the resident's physical, mental, psychological, and functional level; (11) give resident verbal reminders not to ambulate/transfer without assistance; (12) keep call light in reach; (13) keep environment free of clutter; (14) keep personal items and frequently used items within reach; (15) observe frequently and place in supervised area when out of bed; (16) orient resident to environment; (17) orient resident when there has been new furniture placement or other changes in environment; (18) place resident in fall prevention program; (19) provide frequent staff monitoring; (20) provide proper, well-maintained footwear; (21) provide toileting assistance @ least 2x per shift; (21) teach safety measures: locking your wheelchair before getting up; (22) notify MD and resident representative for any change in condition. SECOND CARE PLAN, titled: Resident non-compliant in using bed alarm and chair pad alarm. DATE INITIATED: 6/9/22. Interventions: (1) call light within reach; (2) encourage resident to ask for assistance when in need; (3) explained the risks and benefits of using the bed pad and chair pad alarm. THIRD CARE PLAN, titled: Resident prefers to be independent as much as possible and continues to do things for herself beyond her capacity .has multiple episodes of falls . DATE INITIATED: 6/10/22. Interventions: (1) Resident assessment; (2) Encourage resident to continue to participate with care; (3) respect resident's wishes, desires and rights; (4) Explain risks and benefits; (5) inform MD of resident's wishes; (6) Encourage resident's family to continue to come and visit; (7) Refer to psych as ordered; (8) Inform MD and RP for COC. FOURTH CARE PLAN, titled: [Resident] was observed laying on the floor at bedside . did not call for assistance/or ask for help. DATE INITIATED: 8/9/22. Interventions: (1) Resident assessment; (2) Encourage resident to ask for help or assistance as needed .; (3) Explains risks and benefits; (4) Inform MD/RP ., (5) Re-educate resident re; safety measures. FIFTH CARE PLAN, titled: Resident has assisted fall during transfer. DATE INITIATED: 8/12/22. Interventions: (1) Assessment of resident; (2) Facility staff to ask for assistance as needed; (3) Monitor resident every shift for any COC [change in condition]. SIXTH CARE PLAN, titled: Unwitnessed fall. DATE INITIATED: 9/8/22. Interventions: (1) Assessment of the resident; (2) Encourage resident to ask help for assistance; (3) hallway must be free from any clutter. During an interview on 9/15/22, at 9:08 a.m., CNA F stated Resident 35 did not know to how use the room's call light system. CNA F stated Resident 35 just shouted when she needed help, and this was how staff knew she needed assistance. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an observation on 9/15/22, at 12:18 p.m., Resident 35 was in her room and transferred herself from toilet to wheelchair, unsupervised and unassisted. During an observation on 9/15/22, at 2:52 p.m., Resident 35 was in her room sitting in her bed shouting for help and pointing to the bathroom. Resident 35 was asked to press the room's call light button, which was next to her in bed. Resident 35 continued shouting for help and pointing to the bathroom. During an interview on 9/16/22, at 9:16 a.m., CNA B stated Resident 35 did not use the call light to ask for help. CNA B stated Resident 35 yelled, help when she needed something, and this was how staff knew she needed help. During an interview and record review on 9/16/22, at 10:08 a.m., the Director of Nursing (DON) reviewed Resident 35's chart. The DON stated Resident 35 was a high fall risk, falls a lot, and has hit and injured her head and hip several times because of the falls. The DON confirmed Resident 35 had eight falls in the past 90 days on 6/22/22, 6/26/22, 7/5/22, 7/8/22, 7/27/22, 8/9/22, 8/12/22 and 9/7/22. The DON stated Resident 35 had muscle weakness and the falls happened when Resident 35 attempted to transfer herself to and from her bed, wheelchair and toilet, unassisted by staff. The DON stated Resident 35, won't use the call light, before attempting to transfer. The DON stated Resident 35 must be constantly re-educated on the use of the call light. The DON stated, for communication, staff relied on Resident 35 yelling for help when she needed staff assistance for transfers. The DON stated for each fall, the facility investigated the fall, attempted to determine the cause of the fall and addressed the causative falls, and updated the resident's care plans. The DON confirmed the six fall care plans for Resident 35, initiated on 11/28/19, 6/9/22, 6/10/22, 8/9/22, 8/12/22 and 9/8/22. The DON confirmed the fall care plans were not updated after each fall. A review of facility policy titled, Fall Risk Intervention & Monitoring, revised 12/14, indicated: It is the policy of the company based on completed fall evaluation and current data to identify interventions related to the resident's specific risks and causes to try and prevent the resident from falling and to try to minimize complications from falling. The multi-disciplinary team, including the physician, will identify appropriate interventions to reduce the risk of falls . If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant. A review of facility policy titled, Falls Management, revised 12/14, indicated: The multi-disciplinary team, in collaboration with the physician, will identify pertinent interventions to try and reduce the risks associated with subsequent falls and to address risks of serious consequences of falling, following completion of the resident's fall evaluation. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	In the event, underlying causes cannot be readily identified, reduced or corrected, staff will attempt various relevant interventions, based on assessment of the nature or falling episodes, until falling reduces or stops; or until a reason is identified for its continuation (for example, if the individual continues to try to get up and walk without waiting for assistance or continues to choose to exercise his/her right to walk, despite contraindications).

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44968 Based on observation, interview and record review, the facility: 1) failed to follow the Registered Dietitians (RD) recommendation for one of six sampled residents (Resident 11), when Resident 11 had significant weight loss of 11.7% at time of RD assessment. This failure resulted to further unplanned weight loss for Resident 11; and, 2) failed to offer and provide sufficient fluids to maintain hydration and health to six of six un-sampled residents (Residents 28, 10, 53, 100, and 102). This failure placed residents 28, 10, 53 and 102 at risk of dehydration and resulted in Resident 100's experiencing dehydration (condition that occurs when the body loses too much water from severe diarrhea and vomiting or by not drinking enough water or other fluids) and admission to the acute hospital for increasing lethargy (a condition marked by drowsiness and an unusual lack of energy and mental alertness), hypernatremia (is a high concentration of sodium in the blood) and acute kidney failure (a sudden episode of kidney failure or kidney damage that happens within a few hours or a few days) contributing to the cause of her death three days after admission. Findings: 1) During a clinical record review for Resident 11, the Face Sheet (A one-page summary of important information about a resident) indicated Resident 11 was admitted on [DATE], with diagnoses including Spastic hemiplegia (movement on one side of the body is affected), Stage III pressure ulcer (full thickness tissue loss, subcutaneous fat may be visible to the naked eye) of left buttock and Multiple Sclerosis (progressive disease involving damage to the sheaths of nerve cells in the brain and spinal cord). During an interview with Resident 11 on [DATE] at 12:49 p.m., when asked about the food being served in the facility, Resident 11 stated he did not like the food being served most of the time. Resident # 11 stated dietary staff did not ask him what his food preferences were. Resident 11's lunch tray was served at time of interview. Resident 11's lunch tray had mashed potato, two slices of beef, carrots & peas, dinner roll, banana, a cup of dessert, apple juice and a plate of vegetable salad. Resident 11 stated he did not like the lunch served but he would eat the salad. During an interview with Resident 11 on [DATE] at 2:48 p.m., Resident 11 stated he had lost a lot of weight. Resident 11 stated he used to weigh 180 lbs. (pounds), and now he weighed 150 lbs. During clinical record review for Resident 11, the document title, Weights And Vitals Summary, indicated from [DATE] to [DATE], Resident 11 had a 14.8 lbs. or 8.9% weight loss in six months. During a clinical record review for Resident 11, the Registered Dietitian (RD) Nutritional Assessment, dated [DATE], indicated Resident 11 triggered for significant weight loss in 180 days, and his weight continued to trend down slowly. The RD note indicated Resident 11 needed additional calories for weight stability and recommended to increase Med Pass (nutritional shakes provides a convenient way to supplement calories and protein) to 120 ml (milliliter) three times a day. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During clinical record review for Resident 11, the document title, Weights And Vitals Summary, indicated from [DATE] to [DATE], Resident 11 had a 1 lb. or 0.63% weight gain in three weeks. During a clinical record review for Resident 11, the Medication Administration Record (MAR) for [DATE], indicated Resident 11 had an order, started on [DATE], for Med Pass 90 ml two times a day for supplemental nourishment. During a clinical record review for Resident 11, the Care Plan, initiated on [DATE], indicated Resident 11 was at risk for nutritional problem. One of the Care Plan interventions indicated to consult with RD and follow recommendations. During clinical record review and concurrent interview with the Director of Nursing (DON) on [DATE] at 10:47 a.m., the DON verified there was a recommendation for Resident 11 from the RD to increase the Med Pass to 120 ml three times a day. After reviewing the [DATE], MAR with the DON, he verified there was an active doctor's order, dated [DATE], for Med Pass 90 ml twice a day. When the DON was asked about the facility policy related to RD recommendations, he stated the RD would normally send him an email for her recommendations then he would notify the doctor to obtain an order. The DON stated he did not receive an email from the RD regarding the above recommendation, therefore the doctor was not notified. During an interview and concurrent record review with the MDS Coordinator on [DATE] at 9:55 a.m., when asked about their process when the facility received RD recommendations for residents, the MDS Coordinator stated nursing and the Interdisciplinary Team (IDT - group of health care professionals who work together toward the goals of the resident) would discuss the recommendation and obtain orders from the doctor for implementation. When asked what would be the risk for the resident when RD recommendations were not implemented. The MDS Coordinator stated resident's weight would continue to decline. Review of the Facility policy and procedure titled, Weight Assessment and Intervention, revised in , d+[DATE], indicated, It is the policy of this facility that the nursing staff and the dietitian will cooperate to prevent, monitor, and intervene for undesirable weight loss or weight gain for our residents. Procedure indicated, With the MD order including but not limited to recommendation of RD consult, laboratory work, referral to professional services like psychologist/psychiatrist, GI consult, and the like, will be complied with. 27532 2) During a review of record, Resident 100's Face Sheet indicated she was readmitted from an acute hospital to the facility on [DATE], with diagnoses of hemiplegia (paralysis on one side of the body) and hemiparesis (weakness or the inability to move on one side of the body) following a stroke affecting the right side of the body, dysphagia (difficulty in swallowing), Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks) and adult failure to thrive. During an interview on [DATE], at 2:23 PM, Resident 28 stated CNAs did not fill her water pitcher until she asked. Resident 28 stated this happened every day. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 2:27 PM, Resident 53 stated there were CNAs who really took care of changing water pitchers, but others did not. During a concurrent observation and interview on [DATE] at 10:40 AM, an unidentified resident requested water from staff. When asked why she had to come out of her room to ask for water, the unidentified resident stated she had only a little water in her room. During an observation on [DATE] at 10:43 AM, Resident 28 had drinking water in a plastic cup with a straw on her over bed table. The plastic cup had over an inch full of water, she had no water pitcher in her room. During a consequent observation on [DATE] of the residents' rooms, the following were noted: At 10:45 AM, an empty Styrofoam cup sat on a resident's over bed table in room [ROOM NUMBER]. There was no water pitcher in the room; at 11:02 AM, all three residents in room [ROOM NUMBER] did not have water pitchers on either on their over bed table or side table; at 11:03 AM, one resident in room [ROOM NUMBER] had an empty water pitcher sitting on his bedside table. The other two residents in the room did not have water pitchers; at 11:05 AM, two residents did not have water or water pitchers on their bedside or over bed tables. During a concurrent observation and interview on [DATE], at 1:50 PM, Resident 7's water pitcher was noted to be almost empty. Resident 7 stated she liked to drink water but at times ran out of water and had to ask for refill. During a concurrent observation and interview on [DATE], at 1:53 PM, Resident 102's water was noted to be almost empty. Resident 102 stated he had to ask to get drinking water. During an interview on [DATE], at 1:54 PM, Resident 10 stated water was not provided unless you asked for it. Resident 10 stated staff did not offer. During an interview on [DATE], at 1:58 PM, CNA D stated water should be provided to every resident. If the resident did not want water, they should be asked what they want. CNA D stated it really happened that residents did not get water if they did not ask. CNA D confirmed not all CNAs were distributing water to each resident. During an interview on [DATE], at 2:25 PM, when asked how staff would know if a resident was dehydrated, Licensed Nurse A stated residents were assessed on contact. Licensed Nurse A stated if a resident was dehydrated, she would report a change in condition to the physician and write a care plan to address the dehydration. A review of fluid intake records, for the period [DATE] to [DATE], indicated Resident 100 had no record of fluid intake several days prior to her transfer to the acute hospital on [DATE]. Days where no documentation of fluid intake were [DATE],[DATE], [DATE], [DATE], [DATE], and [DATE]. On other days, [DATE], [DATE], [DATE], [DATE], [DATE] and [DATE], a notation indicated: response not required, noted, instead of the amount of fluid intake. During an interview on [DATE], at 02:04 PM, when asked what, response not required, indicated, Licensed Nurse A stated the resident maybe was out of the building. Licensed Nurse A stated the whereabouts of the resident may be checked in the Nurses notes. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During consecutive interviews on [DATE], at 02:56 PM and 3:23 PM, Licensed Nurse A stated the notation, response not required, was what CNAs documented in response to a follow-up prompt in Point Click Care (PCC - an electronic recording system used in the facility) after a resident refused fluid. Licensed Nurse A stated she gave Med Pass and tried to offer fluids several times if a resident refused fluids and added, I am sure the CNAs offered several times. When asked what else she could do to prevent dehydration, Licensed Nurse A stated she would refer the resident to the physician who could give laboratory orders or an order for intravenous (IV) fluids. During an interview on [DATE], at 2:33 PM, Licensed Nurse X, who worked morning shift in ,d+[DATE], stated she could tell if the resident was dehydrated when the resident was weak and not drinking water with medication. Licensed Nurse X recalled Resident 100 was on crushed medication and thickened fluids, and there were times Resident 100 refused medication and fluids, but she almost always was able to get Resident 100 to take her medication. When the fluid intake record was reviewed on the days she worked on [DATE] and [DATE], Licensed Nurse X stated the thickened fluid she gave during medication administration was not documented. Licensed Nurse X further stated she did not receive a report from a CNA about any problem in Resident 100's fluid intake. When asked what she would have done to prevent dehydration, she stated she would have called and informed the physician to obtain an order for IV fluid or send the resident out. During an interview on [DATE], at 4:13 PM, Licensed Nurse Y, who worked afternoon shift on [DATE], stated she recalled Resident 100 refusing medication and fluids. Licensed Nurse Y stated, if the resident was refusing fluids, she would give fluids little by little as tolerated. The fluid intake record was reviewed with Licensed Nurse Y, and when asked if the record would reflect the total intake for the day, she responded, Yes. When dates were pointed to her where Resident 100 had no record of fluid intake, she stated she was not aware and added the CNA should have reported the problem. When asked how the CNAs knew how much fluids the nurses gave, Licensed Nurse Y stated the nurses recorded it in the Intake and Output (I&O) record. During a follow-up interview on [DATE], at 4:38 PM, Licensed Nurse Y stated there would be no record of the fluid taken in with medication from the medication or treatment chart, unless there was I&O monitoring. A review of the hospital record under, Death Summary, dated [DATE], it indicated Resident 100 was admitted to the acute hospital on [DATE], and expired on [DATE]. The probable cause of death was metabolic (all the physical and chemical processes in the body that convert or use energy) disorder with cardiac arrhythmia (irregular heartbeat that occurs when the electrical signals in the two upper chambers of the heart fire rapidly at the same time) due to profound hypernatremia, due to dehydration and failure to thrive, associated with progressive encephalopathy (any diffuse disease of the brain that alters brain function or structure). (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility document titled, Hydration Policy and Procedure (P/P), revised in ,d+[DATE], indicated it was the policy of the facility to encourage fluid intake to maintain the resident's hydration. The policy and procedure further indicated: Each resident would be provided with a container of fresh cooled water located at the residents' bed side table unless contraindicated, fluids would be offered to residents during socialization, the kitchen staff would prepare and stock the hydration cart prior to hydration round times between meals at 10:00 AM, 2:00 PM, and 8:00 PM, Restorative Nursing Aides (RNA) would obtain the cart from the kitchen and start distributing refreshment or fluid/water to the residents, residents noted with any sign and symptoms of dehydration would be assessed immediately by the licensed nurse, the physician would be notified for any order or interventions in addition to the hydration program. A review of the undated facility document titled, Clinical Protocol for Hydration, indicated under assessment and recognition, for the physician and staff to identify significant risk for subsequent fluid and electrolyte imbalance; for example, individuals who were not eating or drinking well.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 37797 Based on observation, interview and record review, the facility failed to provide appropriate treatment and services to prevent the enteral tube feeding (delivery of nutrition directly into the intestine via a tube placed in the abdomen) complication of aspiration pneumonia (lung infection caused by food entering the lungs) to one of five residents receiving tube feedings (Resident 20) when: 1) Resident 20's head of bed was not kept elevated at least 30 degrees for at least 30 minutes after Resident 20 received tube feedings; 2) Resident 20's care plans did not contain the intervention to keep Resident 20's head of bed elevated at least 30 degrees for at least 30 minutes after tube feedings; and 3) the facility's policy on tube feedings did not indicate the intervention to keep the head of bed of residents, receiving tube feedings, elevated at least 30 degrees for at least 30 minutes after tube feedings. These failures placed Resident 20 and other residents receiving tube feedings at risk of developing aspiration pneumonia. Findings: A review of Resident 20's Facesheet indicated he was admitted on [DATE], with diagnoses including dysphagia (difficulty swallowing) following cerebral infarction (stroke) and hemiplegia (paralysis of one side of the body) following cerebral infarction. A review of Resident 20's Order Summary Report indicated order, dated 5/5/20, titled, Enteral Feed Order Fibersource [a complete liquid nutrition formula] at 95 ml[mililiter]/hr[hour] x 20 hours, per day. A review of Resident 20's care plans (documents instructing staff on how to care for the resident) indicated a care plan, revised 3/12/22, titled: At risk for aspiration related to receiving nourishment and hydration via enteral tube . The care plan's interventions included: Enteral tube feeding per MD . x 20 hrs [hours] and Elevate HOB [Head Of Bed] > 30 degrees. There were no other care plans for tube feedings, and there was no intervention to keep Resident 20's head of bed elevated at least 30 degrees for at least 30 minutes after receiving tube feedings. A review of Resident 20's Minimum Data Set (MDS - an assessment tool), dated 5/4/22, indicated a Brief Interview for Mental Status (BIMs) score of 7 (scores of 0-7 indicate severe cognitive impairment). The MDS indicated Resident 20 was incontinent of bowel and bladder and was dependent on staff for personal hygiene. The MDS assessment indicated Resident 20 was receiving nutrition via a Percutaneous Endoscopic Gastrostomy (PEG) tube (a permanent flexible tube inserted through the skin and the stomach wall to deliver nutrition directly into the stomach and intestine bypassing the mouth and upper digestive system; used to provide nutrition for patients with swallowing difficulties or who are unable to chew or eat through the mouth). (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 20's clinical record indicated two hospital notes, History and Physical, dated 6/30/22, and Discharge Summary, dated 7/4/22, indicating Resident 20 was admitted to the hospital on 6/30/22, with diagnoses including severe sepsis (generalized infection) and suspected aspiration pneumonia (an infection resulting from food or liquids entering the airways and/or lungs instead of the digestive system). A review of Resident 20's Nurse Practitioner Progress Note, dated 7/15/22, indicated Resident 20 had been recently admitted to the hospital for aspiration pneumonia, and Resident 20 had recurrent aspiration pneumonia. The note indicated Resident 20's bed needed to be kept elevated higher than 30 degrees, all the time. A review of Resident 20's clinical record indicated Progress Note, dated 9/6/22 at 4:41 p.m., indicated Resident 20 was sent to the hospital because he had chest pain and audile gurgling sounds. A review of Resident 20's clinical record indicated an Emergency Department Physician Note, dated 9/6/22, indicating Resident 20 had aspiration pneumonia. A review of Resident 20's clinical record indicated a Progress Note, dated 9/7/22 at 3:55 a.m., indicating Resident 20 returned from the hospital with a discharge diagnosis of aspiration pneumonia. During an interview on 9/13/22, at 3:34 p.m., Resident 20's Responsible Party stated Resident 20 often acquired pneumonia while at the facility. During an observation and interview on 9/15/22, at 9:30 a.m., Resident 20 was lying in bed in his room receiving tube feeding at the rate of 95 milliliters per hour with the head of bed elevated. Certified Nursing Assistants (CNA) B and F were in Resident 20's room, and stated they would clean and change Resident 20. CNA B asked Licensed Nurse A to stop Resident 20's tube feeding so they could clean and change him. Immediately after Licensed Nurse A paused Resident 20's tube feeding pump, CNA F lowered Resident 20's head of bed all the way down leaving Resident 20 in a completely flat position. CNAs B and F proceeded to clean and change Resident 20. CNAs B and F took 15 minutes to clean and change Resident 20 and, during this time, Resident 20 was kept completely flat in his bed. CNAs B and F stated they had worked at the facility for several years and were always assigned to work in the wing which housed Resident 20. During an interview and record review on 9/16/22, at 9:39 a.m., the Director of Nursing (DON) reviewed Resident 20's clinical record. The DON confirmed Resident 20 was receiving tube feedings. The DON stated the main risk for residents receiving tube feeding was aspiration pneumonia. The DON stated the main preventative intervention to prevent aspiration pneumonia was to keep the resident's head of bed elevated at least 30 degrees during tube feedings and maintain the head of bed elevated for 30-45 minutes after stopping the tube feeding. The DON reviewed Resident 20's care plan, and indicated there was no care plan indicating for Resident 20's bed to remain elevated for at least 30-45 minutes after stopping tube feedings. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and record review on 9/19/22, at 11:29 a.m., the Director of Staff Development (DSD) stated she was responsible for staff training. The DSD was asked if CNAs had received training for the care of residents receiving tube feedings. The DSD stated they had twice, first on 6/28/22, and again on 9/16/22. The DSD provided the lesson plan for the 6/28/22, training. A review of this lesson plan did not indicate residents' tube feedings should remain with the head of bed elevated after receiving tube feedings. A review of the sign-in sheet for the 9/16/22, training indicated: After feeding, do not lie flat resident. Keep HOD [head of bed] up for at least 45 minutes. To prevent regurgitation. A review of the specialized literature indicated that patients receiving tube feedings should remain with the head of bed elevated for at least 30 minutes after ending tube feedings and before lying flat, to prevent aspiration pneumonia. ([NAME], [NAME] D. RN, CCRN, BSN; [NAME], [NAME] S. RN, CNSN, MN. Heads-up to prevent aspiration during enteral feeding. Nursing: January 2006 - Volume 36 - Issue 1 - p 76-77). A review of facility policy and procedure titled, POLICY AND PROCEDURE ON TUBE FEEDING, revised 8/12, indicated: All feeding tube residents will have bed elevated between 35 to 45 degrees when tube feeding is on. The policy did not indicate to maintain the head of bed elevated for at least 30 minutes after the end of tube feedings.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 44968 Based on observations, interviews and record review, the facility failed to answer residents' call lights in a timely manner for three of 8 sampled residents (Resident 22, Resident 25 & Resident 31). This failure kept the residents' needs not communicated to the staff, potentially placing them at risk for neglect and harm. Findings: During an interview with the Activities Director on 9/12/22 at 3:24 p.m., when asked when Resident Council Meetings were held, the Activities Director stated there had been no Resident Council Meetings since March due to COVID (Corona Virus Disease - an infectious respiratory disease). He stated he would go around to meet one-on-one with the residents to conduct a, satisfaction survey. When the Activities Director was asked about residents' concerns from his satisfaction survey, he stated residents would frequently verbalize concerns about staff taking time to answer call lights, and residents had to wait. During an interview with Resident 22 on 9/12/22 at 3:55 p.m., when asked about timeliness of staff answering her call light, Resident 22 stated staff did not answer her call light timely. During an interview with Resident 25 on 9/12/22 at 4:34 p.m., when asked about timeliness of staff answering her call light, Resident 25 stated staff took time to answer her call light to the point that her incontinence brief got too full, causing her bed to get wet with urine. Resident 22 stated this happened when the facility did not have enough staff to attend to their needs. When asked how she felt when this incident happened, Resident 22 stated she felt really bad. She stated she could use the bathroom herself when she wanted to have a bowel movement; however, she stated she would need assistance from the CNA to change her incontinence brief at night. During an observation on 9/16/22 at 10:25 a.m., the call light panel, at the nurses station, had the light on for three rooms. One license nurse and the Dietary Supervisor were at the nurses station. During an observation on 9/16/22 at 10:26 a.m., Resident 31 was on her bed yelling for help. A female CNA passed by Resident 31's room and did not stop to check what was going on with Resident 31. One license nurse and the Dietary Supervisor were at the nurses station. During an observation on 9/16/22 at 10:31 a.m., the call light in one room was answered; however, the call light in another room was still on. During an observation on 9/16/22 at 10:34 a.m., Resident 31 was desperately yelling for help. The same CNA, who was observed, earlier passed by Resident 31's room and again did not stop to check what Resident 31 might need. The same nurse, from earlier observation, and the Dietary Supervisor, were still at the nurses station. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with Restorative Nursing Assistant (RNA) U on 9/16/22 at 10:36 a.m., when she was asked about answering residents' call lights, she stated it was everybody's responsibility to answer the call lights. RNA U stated staff should answer the call lights as soon as possible, and an acceptable wait time should not take longer than five minutes. RNA U stated staff should answer the call lights even if they could not attend to the resident's needs right away. She stated staff could let the resident to wait a little longer if unable to attend right away or ask another staff to answer it. When RNA U was asked about the risks for the residents when their call lights were not answered timely, RNA U stated there could be an increased risk of fall for the residents, resident could be having some chest pain, resident could have bowel or bladder accident, and it could have an emotional impact for the resident. During an interview with CNA W on 9/20/22 at 9:08 a.m., when asked about answering residents' call light, CNA W stated staff must answer the call lights as soon as possible. CNA W stated nurses could also answer the call lights when CNAs could not attend to the call lights right away. When CNA W was asked about the risks to the residents for not answering the call lights timely, CNA W stated risks for residents would be falls, choking, bowel and bladder accidents. During an interview with CNA V on 9/20/22 at 9:15 a.m., when asked about answering residents' call light, CNA V stated call lights should be answered with in 15 to 20 minutes. When CNA V was asked about the risks to the residents for not answering the call lights timely, CNA V stated risks for residents could be falls. Review of the Facility policy and procedure titled, Call Light/ Bell, revised in 7/2012, indicated, It is the policy of this facility to provide the resident a means of communication with nursing staff. Procedures included: 1. Answer the light within a reasonable time (3 - 5 minutes). 2. Listen to the resident's request/need. 3. Respond to the request. If the item is not available or you are unable to help him/her, explain to the resident and notify the charge nurse for further instructions. 4. Upon assessment and noted that resident is unable to use call light secondary to mentation such as Alzheimer's dementia, resident needs are anticipated. 38335

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 37797 Based on interview and record review, the facility failed to ensure a sample of seven of seven nursing staff (Certified Nursing Assistants B, F and CC and Licensed Nurses A, C, Y and O) had skills/competency checks completed upon hire and annually thereafter. These failures placed all 52 facility residents at risk of receiving poor care. Findings: During an interview and record review on 9/19/22, at 11:29 a.m., the Director of Staff Development (DSD) sated she was responsible for staff training at the facility. The DSD was asked how the facility ensured nursing staff had the competencies and knowledge to care for the resident population. The DSD stated Certified Nursing Assistants (CNAs) and Licensed Nurses must complete a skills/competency checklist upon hire and annually thereafter. The DSD was asked for the skills/competency checklist of seven randomly-selected nursing staff: Three CNAs (CNAs B, F and CC) and four Licensed Nurses (Licensed Nurses A, C, Y and O). The DSD stated the following: CNA B was hired on 8/17/04, and since then had only two skills/competency checks or performance evaluations completed, on 7/6/17 and 6/15/22. CNA F was hired on 3/26/22, and since then had only one skills/competency check or performance evaluation completed, on 6/15/22. CNA CC was hired on 6/27/18, and since then had only one skills/competency check or performance evaluation completed, on 8/15/20. Licensed Nurse A was hired on 8/25/21, and had no skills/competency checks or performance evaluations completed. Licensed Nurse C was a Registry/Agency nurse and started working at the facility on 11/11/21, and had no competency checks or performance evaluations on record. Licensed Nurse Y was hired on 6/5/17, and had no skills/competency checks or performance evaluations completed. Licensed Nurse O was a Registry/Agency nurse and started working on 4/16/22, and had no competency checks or performance evaluations on record. During an interview on 9/19/22, at 2:42 p.m., the DSD stated she located the skills/competency checks for two licensed nurses, Licensed Nurses A and Y. The DSD stated the Director of Nursing (DON) completed the skills/competency checks for nurses. A review of the records provided by the DSD indicated documents titled, Licensed Nurse Competency Checklist, for Licensed Nurse A, dated 6/17/21, and Licensed Nurse Competency Checklist, for Licensed Nurse Y, dated 8/25/21. A review of these records indicated they were unsigned by any evaluator/mentor/orientator, and the methods of evaluation and the verification fields were blank. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 9/19/22, at 2:45 p.m., the DON confirmed the skills/competency checklists for Licensed Nurses A and Y, dated 6/17/21 and 8/25/21, were the only ones the facility had on record for those nurses. A review of Facility Assessment, dated 5/25/22, indicated, Staff training/education and competencies . Competency skills/evaluation are conducted and checked upon hire and annually thereafter. Performance evaluations are performed annually to ensure staff meets our facility standards of performance and conduct. A review of Competency of Nursing Staff, undated, indicated, .Licensed nurses and nursing assistants .will: demonstrate specific competencies and skill sets deemed necessary to care for the needs of residents .

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46132 Based on observations, interviews and record reviews, the facility failed to ensure: 1) Residents diagnosed with Dementia had pharmacological and non-pharmacological interventions to reduce any symptoms, maintain function and promote independence, for two out of two sampled residents (Resident 35 and Resident 151). This failure could result in worsening of their condition more quickly; and, 2) Certified Nursing Assistants (CNAs) responded to residents' distress or behavioral issues, according to the individualized care plan developed by the Interdisciplinary Team (IDT), for two out of two sampled residents (Resident 35 and 151). This failure could result in resident having unmet needs, frustration and worsening of behaviors. Findings: Review of Resident 35's Face Sheet (demographics) indicated she was [AGE] years-old with a diagnoses of Major Depressive disorder (A mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life.), Brief Psychotic Disorder, a short-term disturbance that involves sudden onset of at least one positive psychotic symptom like delusions (a fixed, false beliefs that conflict with reality), hallucinations (sensory experience of something not present), disorganized speech, grossly disorganized or catatonic behavior (a behavioral syndrome marked by an inability to move normally) and Dementia with behavioral Disturbance (mental disorder in which a person loses the ability to think, remember, learn, make decisions, and solve problems). During a review of Resident 151's Face Sheet, it indicated she was [AGE] years-old with a diagnosis of Major Depressive disorder and Dementia with no Behavioral Disturbance. During a Physician's Order record review for Resident 35 and Resident 151 on 9/15/22 at 3:28 p.m., it indicated there were no medications or non pharmacologic interventions ordered for these residents, to address Dementia. During a concurrent observation of a resident room and interview, on 9/15/22 at 3:37 p.m., Resident 35's room appeared to be devoid of personal belongings. Resident 35 stated, nothing in there, its clean. When asked if she would like some family pictures on the wall, Resident 35 nodded her head and said, Yes. During a concurrent interview and ADL (Activities of Daily Living) charting review for Resident 35 and Resident 151, on 9/16/22 9:55 a.m., CNA B and F verified that on their ADL charting, there were no behavior care plan for these residents. They verified that residents' behaviors and interventions were not documented on their ADL charting. CNA B stated it would be helpful if there was a way for the CNAs to know about residents' behaviors and how to address them appropriately. CNA F stated, if CNAs did not know about residents' behavior and how to address them appropriately, it could be frustrating for the resident, and staff may not be able to meet their needs. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and ADL charting review on 9/16/22 at 10:07 a.m., the Director of Staff Development (DSD) verified Resident 35's and Resident 151's ADL charting did not have a CNA care plan to address Resident 35's and Resident 151's behavior. The DSD stated it was important to have the behavior care plan and interventions included on the CNA ADL charting so they could better care for the residents. She stated staff not knowing how to appropriately address residents' needs or calls for distress, would put residents at risk for feeling angry, sad and frustrated. During an interview on 9/19/22 at 11:23 a.m., the DSD stated the facility Dementia program consisted of staff receiving a Dementia in-service upon hire, which included watching a movie showing staff how to care for residents with dementia, and understanding and managing difficult behavior. The DSD stated behavior care plans should be included on CNAs ADL charting. She stated it was important for CNAs to know how to care for, and address the needs of, residents. She stated not knowing how to address resident needs or behavior could be a safety risk where residents and staff could get hurt. It also created a risk for residents not receiving the care they needed and their needs not being met. During a review of the facility's policy and procedure (P&P) titled, Dementia- Clinical Management, revised 12/14, the P&P indicated the physician would order appropriate medication and other interventions to manage behavioral and psychiatric symptoms related to Dementia. During a review of the facility's P&P titled, Policy and Procedure-Care Plan, revised 9/2009, the P&P indicated care plans were the summation of resident concerns, goals, approaches and interventions in order to meet goals and help minimize/eradicate residents' problems.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46132 Based on observation, interview, and record review, the facility failed to ensure the medication error rate did not exceed 5%, for two out of four sampled residents (Resident 1 and 151). 1. Resident 151 did not receive her scheduled dose of Docusate Sodium (a medication that prevents and treats occasional constipation) tablet, when the medication dose was not available to be administered. 2. Resident 151 did not receive the correct dose of aripiprazole (Abilify - an antipsychotic medication needed to affect the mind, emotions or behavior), as prescribed by the doctor. 3. Resident 1 did not receive the correct vitamin D3 (a supplement the body needs to function and stay healthy) formulation, as prescribed by the doctor. This failure resulted in three medication errors being identified, out of 27 opportunities, during observation of medication administration, which then resulted in the facility having a medication error rate of 11.11 percent. Findings: 1-2) During a review of Resident 151's Face Sheet (demographics), it indicated Resident 151 was initially admitted on [DATE], and was readmitted on [DATE]. Resident 151's multiple diagnoses included Unspecified Psychosis (a mental disorder characterized by disconnection from reality) not due to a substance (a drug or abuse) or known physiologic condition (a general medical condition) and Visual Hallucination (a perception of having seen something not actually there). A review of Resident 151's Physician's order, indicated she was receiving Docusate Sodium for Bowel Regularity and aripiprazole (antipsychotic used to treat mental condition) for Unspecified Psychosis. During a medication pass observation on 09/14/22 at 8:55 a.m., Licensed Nurse (LN C) administered Resident 151's morning medications. Among the medication she administered was half a tablet of Aripiprazole. During an interview on 9/14/22 at 8:55 a.m., LN C stated she did not administer Resident 151 Docusate Sodium, since the right dosage form/dose was not available in the medication cart. LN C stated Resident 151's order for aripiprazole was decreased by the physician the day before. She stated Resident 151 should be receiving 5 milligram (mg, a unit of measure) of aripiprazole, per physician order. She stated Resident 151's previous order for aripiprazole was to administer 7.5 mg daily. LN C nurse verified one whole pill was equal to 5 mg, and 1/2 a tablet was equal to 2.5 mg. LN C verified it was a medication error when she administered 1/2 a tablet of Abilify to Resident 151. LN C verified it was also a medication error when she did not administer Docusate Sodium to Resident 151. During an interview with the Director of Nursing (DON), on 9/15/22 at 12:10 p.m., the DON acknowledged the Docusate Sodium and aripiprazole were not administer, according to the physician order for Resident 151. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3) During a review of Resident 1's Physician Orders, it indicated Resident 1 was admitted to the facility on [DATE], with multiple diagnoses including Vitamin D deficiency. During a medication pass observation on 09/14/22 at 9:12 a.m., LN C administered Vitamin D3, 25 microgram (mcg, a unit of measure) with Calcium Carbonate, 25 mg 2 tablets daily. During a review of Physician Orders on 9/14/22 at 2:54 p.m., LN C indicated Resident 1 had an order for Cholecalciferol (also called Vitamin D3), give 2,000 international unit (IU, a unit of activity or potency for vitamins) one time a day for Vitamin D deficiency. During an interview on 9/14/22 at 2:54 p.m., LN C verified she took two tablets of Vitamin D3, 25 1000 IU, with the calcium component, and administered to Resident 1, as this was the only Vitamin D3 medication available in the medication cart. LN C verified this was a medication error. LN C stated she probably gave the same medication to Resident 1 yesterday because there were no other Vitamin D3 bottles in the medication cart. During an interview with the Director of Nursing (DON), on 9/15/22 at 12:10 p.m., the DON acknowledged an incorrect formulation of Vitamin D was administered to Resident 1. During a review of the facility's policy and procedure (P&P) titled, Policy and Procedure in Medication Administration, revised 7/13, the P&P indicated, Drugs must be administered in accordance with the written order of the attending physician.

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Greenfield Care Center of Fairfield	1260 Travis Blvd Fairfield, CA 94533

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 46132 Based on observation, interview and record review, the facility failed to ensure medications were stored safely and correctly, when: 1. A medication cart was not locked and was left unattended during medication pass, rendering it accessible to residents and unauthorized personnel; 2. An unlabeled and unsecured pill was left on top of the medication cart unattended and accessible to residents and unauthorized personnel; 3. Loose pills were found in the medication carts; 4. There were three bottles of expired glucose testing strips in the medication room; 5. Acetaminophen bottles, were opened without proper open-date label or expiration dates; 6. There were expired oral (medication taken by mouth) and ophthalmic (medication used to treat eye infections) medications. Inhalers (medication that helps with breathing) were not open-dated in C wing's medication cart. There was no expiration date on the Glucotabs (used to treat low blood sugar levels). 7. There was an unlabeled, white-colored weekly pill box, containing multiple pills, in C wing's medication cart; and, 8. There were expired antibiotic, antifungal and steroidal cream and ointments, in the treatment cart, some with no expiration dates. These failures had the potential for medication misuse, drug diversion and medications being ineffective. Findings: During a concurrent observation and interview on 09/13/22 at 10:43 a.m., Licensed Nurse C (LN C) was inside assisting Resident 1 in her room. The med cart was parked outside the room and was left unlocked. There was one medication, a white tablet, left in a cup on the top of the medication cart, located outside this room. When asked about the white tablet, LN C stated there should be no medications left on top of med carts, and her med cart should be locked and not left unattended, at all times. LN C stated the facility had a lot of confused residents who could take medications from the medication carts and swallow them. She stated, leaving medication carts unlocked and leaving medications on top of the med carts, unattended, was a safety issue and could put residents at risk for harm. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview in the medication room on 9/13/22 at 1:41 p.m., LN C verified there were three bottles of expired blood glucose testing strips. She verified one bottle expired on 5/31/22, and the other two bottles expired on 7/13/22. LN C verified she was not able to locate the expiration date on the opened bottle of acetaminophen retrieved from the medication supply cabinet. During a concurrent observation of C wing's medication cart and interview with LN H on 9/13/22 at 2:20 p.m., LN H verified there was a round, white-colored loose pill found inside the cart, and she was unable to identify the medication. LN H also verified there were seven bubble packs of expired midodrine (a medication that provides blood pressure support) in the medication cart. LN H verified the glucose (sugar) tablet, the facility used to treat hypoglycemia (low blood sugar), had no expiration date. She verified the unlabeled white-colored weekly pill box, should not have been stored in the medication cart. She stated, since the pill box was unlabeled, she was not able to identify who the pill box belonged to and what medications were inside the pill box. The following medications were expired: 1. Anoro and Ellipta inhalers (used for breathing issues) were not dated when opened. Per manufacture's recommendation, discard the medication six weeks after opening. LN H acknowledged the medication was already expired. 2. Combivent (used for breathing issues) was not dated when opened. Per manufacture's recommendation, discard the medication six weeks after opening. LN H acknowledged the medication was already expired. 3. Fluticasone (used for breathing) was not dated when opened. Per manufacture's recommendation, discard the medication 28 days after opening. LN H acknowledged the medication was already expired. 4. Brimonidine (medication used to lower pressure inside the eye) was not dated when opened. Per manufacture's recommendation, discard the medication four weeks after opening. LN H acknowledged the medication was already expired. 5. Latanoprost (a medication that treats high pressure inside the eyes) was opened, dated 7/4/22. Per manufacture's recommendation, discard the medication 42 days after opening. LN H acknowledged the medication was already expired. During a concurrent observation of B wing's medication cart and interview with LN L on 9/13/22 at 4:31 p.m., LN L verified there was one Combivent Respimat inhaler on the cart, not open-dated, thus unable to determine expiration date. During a concurrent observation of the treatment cart and interview on 9/14/22 at 11:25 a.m., Licensed Nurse E (LN E) verified the following medications were expired: 1) Two tubes of Calmoseptine (a medication used to treat and prevent minor skin irritation --bumpy scaly or itchy patches of skin) 113 gram (gm, unit of measure) had no expiration date. 2) One tube of urea cream (medication used to treat dry/rough skin conditions) 85 gm, expired on 5/2022. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3) One tube of ketoconazole cream (a medication used to treat skin fungal infections) 2 percent (%, a fraction or ratio in which the value of a whole was 100) 60 gm, expired on 8/2022. 4) One tube of mupirocin ointment 2% (a medication used to treat infected skin lesions) 22 gm, expired on 8/22. 5) nystatin 100,000 unit (U, amount of medication administered in a single dose) cream (a medication used to treat fungal/yeast infection) 30 gm, expired on 5/22. 6) fluorouracil cream (a medication used to treat pre-cancerous and cancerous skin growth) 40 gm, expired on 5/22. 7) triamcinolone cream (a medication used to help relieve redness, itching and swelling of the skin) 0.1% 80 gm, expired on 12/21. LN E verified residents receiving these treatments were still at the facility. She stated she was not sure why the expired treatment medications were still in the treatment cart. During an interview at the Administrator's office on 9/15/22 at 12:20 p.m., the DON verified and agreed, the facility had issues with labeling, and there were multiple expired medications in both the medication cart and treatment cart. During a review of facility's policy and procedure (P&P) titled, Labeling and Storing Medications, revised 7/2012, the P&P indicated Liquid medications-vials, Injectables, Irrigations, Solutions, Opthalmic/Otic, must be dated and initialed by the Licensed Nurse who first opened it .It indicated that medications that were expired will be disposed of in accordance with Federal and State laws .It indicated the medication cart was to be locked at all times when not in direct use, and medications were not to be left on top of cart.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 38335 Based on dietetic services observations, dietary staff and consultant Registered Dietitian interview and administrative document review, the facility failed to ensure the Registered Dietitian effectively evaluated dietetic service operations, in accordance with the facility-executed contract. The facility also failed to ensure integration of the Registered Dietitian in care plan committee meetings. Failure to ensure effective oversight of day-to-day dietetic services operations may result in putting residents at nutritional risk, in turn further compromising the medical status of residents. Findings: During the annual Recertification survey from 9/12/22-9/19/22, multiple issues surrounding the delivery of dietetic services (Cross Reference 800, 801, 804, 806, and 808), in relationship to the assessment of resident nutritional needs, evaluation of staff competency, evaluation and oversight of food production activities, were identified. During an interview on 9/12/22 at 10:30 a.m., the Dietary Supervisor (DS) was asked what her responsibilities were for the kitchen. The Dietary Supervisor stated she just started at the facility on 9/1/22, and her responsibilities included: Supervise the kitchen, purchase food, and conduct in-services for the staff, and review the food preferences with the residents. When asking the DS who conducted the nutritional assessments, she stated the Registered Dietician(RD) conducted the assessments, and she helped the RD by gathering initial information (e.g., height, weights, and preferences). When the DS was asked how often the RD was in the facility, she stated the RD worked remotely, and she worked very closely and spoke with the RD throughout each day. (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 9/15/22 at 9:20 a.m., the Registered Dietician (RD) described her oversight of dietetic services operations. The RD stated she was temporary and worked remotely (the RD lived in Arizona). The RD stated the goal for the facility was to find a full time RD; the RD had been in the facility since February 2022. The RD stated she was responsible for resident nutritional assessments. When asked how she assessed the Residents' Dietary needs, she stated she had zoom calls with residents and families, when needed. The RD completed the dietary assessments and plan for new admissions, reviewed the IDT notes, reviewed the staff and physician progress notes, and called family members when needed. She relied on the assessments done by staff. The RD stated the DS spoke to the residents about food preferences. The RD assessed food preferences Quarterly and conducted Nutrition consults for issues reported (e.g., decreased albumin levels). The RD stated she did her own dietary assessments and used the notes from the Dietary Supervisor's assessment during her reviews. The RD had not come physically to the facility, but she kept in constant contact with the Administrator, DON and followed the MDS guidance. The RD stated she managed things well with the goal that the facility will hire a permanent RD. The RD stated she was available to the facility every day or any time they needed her. When asked what the RD did if the residents were not eating the food or did not like the food, she stated if the residents did not like the food, they connected with her or spoke with the DS. When asked if she was aware the residents did not like the food, she stated, No. When asked what her oversight of the kitchen staff was, she stated the DS helped manage the kitchen staff and called her with any questions. The RD also stated she had not completed any formal in-service training for the facility or departmental staff, and if the facility would like her to do in-services for the staff, she would do that, she was completely open. The RD stated she was in attendance for the IDT meetings when they needed her; she did not attend the care plan meetings for care planning assessments in PCC (Point Click Care -- an electronic medical records system); however, received information from the Dietary Services Supervisor. The RD stated, for new admissions, she completed the nutritional assessments, she printed off a blank assessment form, she looked at Physician orders, resident cultural preferences were discussed, and entered in the Kardex system in PCC. The DS maintained the Kardex. The RD stated her primary responsibility was to ensure Physician orders were carried out and updated on the Kardex. Review of the undated facility's job description titled, Consultant Dietician, noted the Consultant responsibilities included: Supervise the overall functions of the facility's dietary services in that the dietician shall: 1) Schedule visits to assure the professional dietetic service needs of the facility are met. Adequate time shall be allowed to observe the preparation and serving of food at mealtime .4) Assist the dietary supervisor with dietary guidelines 8) Develop and participate in in-service training programs for dietary service and other related services 10) Attend and participate in resident assessment meetings and the conducting of resident assessments relative to dietary services . A copy of the signed Consultant Dietician agreement was requested, but not provided.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 38335 Based on food production observations, resident and dietary staff interviews, and test tray evaluation, the facility failed to prepare and serve palatable and flavorful meals, when: 1) Preparation of meals were not flavorful or palatable; and, 2) The facility failed to prepare food conserving nutritive value and flavor, when pureed, mechanical soft, and ground foods were prepared hours before serving. Failure to ensure food palatability and nutritive value may result in decreased dietary intake and unplanned weight loss and/or unplanned weight gain, from eating food ordered from the outside, not suitable for therapeutic diets and potentially further compromising residents' medical status. Findings: During an initial tour on 9/12/22 at 10 a.m., multiple residents complained the food was awful. One resident (Resident 14) stated the food was awful, and she had complained to the dietician in the past, but nothing was done. Resident 14 stated she did not eat the food and ordered out through door dash, which was expensive; she also bought her own food and stored it in a small refrigerator near her bed. Resident 14 was diabetic. Another resident (Resident 4) stated the food was awful and had no taste. Crackers and crinkle potato chips were on Resident 4's bedside table. Resident 4 stated he had complained to the dietician several times, but nothing was done. Another resident (Resident 38) did not eat her lunch and stated she would save it for later, indicating the food was not so good, had no taste. A pile of graham crackers (individually wrapped) was on top of Resident 38's side table; she was keeping them to eat later. During an interview with Resident 44 on 9/12/22 at 11:24 a.m., when asked about the food being served in the facility, Resident 44 stated the facility did not cook the food according to, American standard. During an interview with Resident 11 on 9/12/22 at 12:49 p.m., when asked about the food being served in the facility, Resident 11 stated he did not like the food being served most of the time. Resident 11 stated dietary staff did not ask him what his food preferences were. Resident 11's lunch tray was served at time of interview. Resident 11's lunch tray consisted of mashed potatoes, two slices of beef, carrots & peas, dinner roll, banana, a cup of dessert, apple juice and a plate of vegetable salad. Resident 11 stated he did not like the lunch served, but he would eat the salad. During an interview with Resident 24 on 9/12/22 at 4:04 p.m., when asked about the food being served in the facility, Resident 24 stated, Food was terrible. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and concurrent interview on 9/13/22 at 8:30 a.m., food preparation for lunch was occurring in the kitchen. When Cook AA was asked about the menu for lunch, Cook AA stated he was baking fish and had prepared most of the lunch for today, he opened the oven to show where most of the entrees were kept warming. When asked what time lunch was served, Dietary Cook AA stated they started serving lunch at noon, and then he would start prepping for dinner because he was the only Cook for the day. During an interview on 9/13/22 at 10 a.m., the Dietary Supervisor was asked when food preparation began for lunch, she stated usually around 10 a.m. (A copy of the kitchen P&P for meal preparation was requested, a copy of the, Hazard Analysis Critical Control Points was provided. During Resident Council Meeting, conducted on 9/13/22 at 1:30 p.m., 5 of 8 residents complained about the food not tasting very good. As a result of resident complaints during initial screening and complaints from the Resident Council Meeting, a test tray was conducted. During an observation on 9/14/22 at 9 a.m., Cook DD was preparing cold slaw and pureed vegetable couscous which were on the menu for lunch. The rest of the lunch menu entrees were prepared and in the oven. During a taste tray sampling on 4/14/22 at 12:53 p.m., four Surveyors participated in sampling the lunch tray, with the Dietary Supervisor present. The lunch tray consisted of pureed and regular entrees, including: (Crispy Gourmet Fish (Salmon), Vegetable Couscous and Spice Square). In the regular and pureed consistency, the salmon was hard, dry and had no flavor, the couscous had no flavor and had a gummy texture. All surveyors agreed the salmon and the couscous had no flavor and a gummy consistency in both the regular and pureed entrees. Review of the facility Policy and Procedure titled, Hazard Analysis Control Points was provided (HACCP), revision date 12/14, indicated, keep hot foods above 140 degrees for no more than 4-hours (HACCP Guidelines) preferred time would be less than 1-hour to maintain quality. Check temperatures every 30 minutes. Hold foods prior to service for less than 1 hour, keeping cold foods at 40 degrees Fahrenheit or below and hot foods at 140 degrees Fahrenheit. Review of Nutrition.gov indicated, the nutritional value of food, which are heated multiple times compromises both the palatability and nutritional value of food. 44968

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 37797 Based on interview and record review, the facility failed to complete an accurate and comprehensive Facility Assessment, when the Facility's Assessment lacked a description of the common diseases, conditions, physical and cognitive disabilities and overall acuity of the resident population and lacked a quantification of the number of Licensed Nurses and Certified Nursing Assistants required to meet the needs of its resident population, given its average census. These failure placed all facility residents at risk of not having their needs met. Findings: During an interview on 9/12/22 at 10:25 a.m., the Administrator was asked for the most current Facility Assessment. The Administrator provided a Facility Assessment, dated 5/25/22. A review of the Facility Assessment, dated 5/25/22, indicated an average census of 55 residents. The Facility Assessment's section titled, Diseases/conditions, physical and cognitive disabilities, was blank, except for the phrase (See attached exhibit 1). There were no exhibits attached to the Facility Assessment. The Facility Assessment's section titled, Acuity, contained the following: Skilled Nursing Unit: 90 beds. Skilled Nursing Unit provides 24 hours of continuous around the clock care 7 days a week to meet the needs of our residents. See specific type of residents, Listed under categories. There were no specific types of residents listed. The Facility Assessment's section titled, Staffing Plan, did not indicate the number of Licensed Nurses and CNAs required to meet the needs of the resident population, given the average census of 55 residents. The Staffing Pan instead indicated, adequate staffing, will be provided to meet to the needs of the residents and made reference to nursing PPD (Per Patient Day) requirements (a state regulation requiring skilled nursing facilities to provide a minimum of 3.5 hours of nursing care per patient per day). During an interview on 9/19/22, at 3:35 p.m., Licensed Nurse Y, who stated she was the facility's Staffing Coordinator, stated, for an average census of 50 residents, the following minimum nursing staffing levels were required to meet resident needs: Three direct care licensed nurses and seven CNAs, for the morning shift; three direct care licensed nurses and five CNAs, for the afternoon shift; two direct care licensed nurses and four CNAs, for the night shift. During an interview on 9/20/22, at 9:40 a.m., the Interim Administrator confirmed the Facility Assessment, dated 5/25/22, was the most current assessment and confirmed it did not quantify the nursing staff required to meet resident needs.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 37797 Based on interview and record review, the facility failed to develop and implement plans of actions to correct quality deficiencies in resident care identified by its Quality Assessment and Assurance (QAA) committee, during the period of January to August 2022. These failures placed all facility residents at risk of not having their needs met. Findings During an interview and record review on 9/20/22, at 9:40 a.m., the Interim Administrator (IA) reviewed the facility's Quality Assessment and Assurance (QAA) program. The IA stated the facility's QAA committee met monthly and was composed of the facility's Medical Director, Administrator, Director of Nursing, Director of Staff Development, Infection Preventionist, Director of Rehabilitation, Social Services Director, Activities Director, Dietary Services Manager, Medical Records Director, Business Office Manager, Maintenance Director and Admission's Director. The IA stated, once per quarter the Consultant Pharmacist and a Laboratory representative joined the QAA meetings. The IA stated the QAA committee documented its activities in attendance sheets, agendas, and meeting minutes, which recorded the quality deficits identified each month and any actions taken to address them. The IA reviewed the records of the QAA meetings from January to August 2022. The IA stated the QAA met every month during this period. The IA stated the January 2022, meeting identified quality deficiencies in hand washing, pharmacy services, falls, staffing and activities; the February 2022, meeting identified quality deficiencies in food services (complaints about the food); the March 2022, meeting identified quality deficiencies in falls; the April 2022, meeting identified quality deficiencies in skin wound assessments and pressure ulcers; the August 2022, meeting identified quality deficiencies in pressure ulcers, falls and activities. The IA was asked if the facility had implemented any plans of actions to address the quality deficiencies identified in the QAA meetings. The IA reviewed the QAA binder records, and stated he did not see any performance improvement plan for those issues. A review of facility policy and procedure titled, Quality Assurance and Performance Improvement (QAPI) Program, undated, indicated: The responsibilities of the QAPI committee are to: .(g) coordinate the development, implementation, monitoring and evaluation of performance improvement projects .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 44968 Based on observations, interviews, and records review, the facility failed to implement measures to reduce the risk of disease and infection transmission, when: 1. Four of ten sampled residents (Residents 20, 5, 43 and 26) did not receive annual PPD (Purified Protein Derivative - a method used to diagnose silent (latent) tuberculosis (TB) infection). This failure had the potential risk for elderly residents to be undiagnosed with silent TB and, without treatment, could result in fatal TB infection, exposing other residents, staff, and visitors, of the infectious disease. 2. Certified Nursing Assistants (CNA) did not perform proper hand hygiene before and after providing care and passing food trays, to four of four residents (Residents 1, 18, 19 and 39). This failure had the potential to result in a spread infections and/or transmission of diseases to the residents. 3. The air conditioning unit's vent in the kitchen, was not regularly cleaned. This failure had the potential to contaminate the food being prepared in the kitchen, putting residents at risk for food-borne illness. 4. The facility failed to adequately sanitize vital signs monitors when staff used one piece of sanitizing wipe to sanitize multiple vital signs monitors. This failure had the potential to result in spread of infections and/or transmission of diseases to the residents. 5. The facility failed to clean two out of two respiratory inhalers, per manufacturer's guideline. This failure had the potential risk for accumulation of bacteria and debris, which could cause respiratory infection and inadequate medication delivery for the residents. Findings: 1. During clinical record review for Resident 20, the document titled, Clinical-Immunizations, indicated Resident 20 received an annual PPD on 6/20/21. During clinical record review for Resident 20, the Medication administration Record (MAR) did not indicate Resident 20 was not scheduled for an annual PPD for September 2020. During clinical record review for Resident 5, the document titled, Clinical-Immunizations, indicated Resident 5 received an annual PPD on 6/20/21. During clinical record review for Resident 5, the Medication administration Record (MAR) did not indicate Resident 5 was not scheduled for an annual PPD for September 2020. During clinical record review for Resident 43, the document titled, Clinical-Immunizations, indicated Resident 43 received an annual PPD on 6/20/21. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During clinical record review for Resident 43, the Medication administration Record (MAR) did not indicate Resident 43 was not scheduled for an annual PPD for September 2020. During clinical record review for Resident 26, the document titled, Clinical-Immunizations, indicated Resident 26 received an annual PPD on 7/01//21. During clinical record review for Resident 26, the Medication administration Record (MAR) did not indicate Resident 26 was not scheduled for an annual PPD for September 2020. During record review and concurrent interview with the IP on 9/19/22 at 12:19 p.m., after reviewing the document titled, Clinical-Immunizations, the IP verified Resident 20, Resident 5, Resident 43 and Resident 26, were overdue for an annual PPD testing. When the IP was asked about the purpose of PPD, the IP stated PPD was done to screen residents for tuberculosis. When the IP was asked about the risk for residents who were not tested for TB, the IP stated, residents who were positive and not showing symptoms of TB, could not get the proper care/treatment they needed and potentially spread of the disease to other residents, staff, and visitors Review of the Facility policy and procedure, revised in 7/2012, indicated, Resident will have Mantoux/Skin test (injecting a small amount of fluid (called tuberculin) into the skin on the lower part of the arm) or chest x-ray (produces a black-and-white image that shows the organs in the chest) as required, to ensure that health and safety of the resident and other residents in the facility are looked after .In this connection facility will comply with MD order regarding the Mantoux/Skin test and/or Chest x-ray upon admission if the resident cannot or does not have a copy of the recent 90 days Mantoux/Skin and/or Chest x-ray done from an accepted institution and yearly thereafter. 2. During an observation on 9/14/22 at 12:37 p.m. on D wing hall, CNA B and CNA F were passing meal trays to residents, without performing hand hygiene before entering a resident room. During an observation on 9/14/22 at 12:41 p.m., CNA F was delivering the tray to Resident 39. CNA F did not offer Resident 39 to wash his hands. Resident 39 started picking up the food with his bare hands and started eating. During an observation on 9/14/22 at 12:42 p.m., CNA F started feeding Resident 1 without washing his hands. Resident 1 was not offered to wash his hands. During an observation on 9/14/22 at 12:44 p.m., CNA B was delivering the tray to Resident 18 without performing hand hygiene before entering Resident 18's room. Resident 18 was not offered hand hygiene. During an observation on 9/14/22 at 12:50 p.m., CNA F came out of a resident room, did not perform hand hygiene after leaving the room, and before grabbing the lunch tray for Resident 19. Resident 19 was not offered hand hygiene. During an interview with CNA P on 9/14/22 at 4:20 p.m., when asked about hand hygiene, CNA P stated he would performed hand hygiene only before entering the bathroom. When CNA P was asked if hand hygiene was required when passing food trays to residents, CNA P stated they used gloves when passing food tray. CNA P stated he would offer hand hygiene to independent residents only if they wanted to wash their hands. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent observation and interview on 9/14/22 at 4:45 p.m., Certified Nursing Assistant P (CNA P) was supposed to help reposition Resident 351. He verified he did not perform hand hygiene (HH, a term used to cover both hand washing using soap and water, and cleaning hands with waterless or alcohol-based hand sanitizers) prior to donning and doffing gloves. CNA P stated he should have performed HH prior to donning and doffing gloves, for safety and infection control. He stated HH is important to keep residents safe from sickness and infections During an interview with CNA V on 9/20/22 at 9:15 a.m., when asked about facility policy on hand hygiene, CNA V stated staff should wash their hands before and after resident care, emptying catheter bags and urinals, passing food trays, and feeding residents. CNA V stated she would offer residents a washcloth to wash their hands before meals. During an interview with the Infection Preventionist (IP) Nurse on 9/20/22 at 9:25 a.m., when asked about facility policy on hand hygiene, the IP stated staff were expected to wash their hands before and after entering residents room, before and after providing resident care, before and after passing meal trays and feeding residents, before and after medication pass, and before and after gloves use. Review of the Facility policy and procedure titled, Handwashing/Hand Hygiene, with no effective dated indicated, This facility considers hand hygiene the primary means to prevent the spread of infections .Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: before and after direct contact with residents; after removing gloves; before and after assisting a resident with meals. 3. During an observation on 9/14/22 at 9:44 a.m., in the kitchen, the air conditioning (AC) unit's vent above the freezer, was covered with dust. During an interview with Dietary Cook AA on 9/14/22 9:45 a.m., when asked about maintenance of the air conditioning unit, Dietary Cook AA stated he could not remember when the last time the vent was cleaned. Dietary Cook AA concurred dust could accumulate, and it could contaminate the food during food preparation. During an interview with the Dietary Supervisor on 9/14/22 10:21 a.m., the Dietary Supervisor stated the Maintenance Director told her the last time the vent was cleaned, was last month. The Dietary Supervisor stated she had instructed maintenance to clean the vent after food preparation. The Dietary Supervisor stated, dust from the vent could spread and contaminate the food during food preparation. During an interview with the Maintenance Director on 9/14/22 at 3:11 p.m., when asked how often they cleaned the air conditioning unit above the freezer in the kitchen, the Maintenance Director stated, cleaning of AC vent was once a month. The Maintenance Director was not able to provide a copy of a tracking log confirming when the AC vent was cleaned. Review of the Facility policy and procedure titled, Infection Control Policies/ Practices/ Programs, revised in 6/2012, indicated, It is the policy of this facility that the primary principle of this facility's infection control policies, practices and programs are to establish guidelines to abide by to provide a safe, sanitary and comfortable environment and to assist in preventing the development and transmission of diseases and infections. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the Facility policy and procedure titled, Maintenance Service, with no effective date, indicated, The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times .Functions of maintenance personnel include but are not limited to: providing routinely scheduled maintenance service to all areas; Maintenance personnel shall follow established infection control precautions in the performance of their daily work assignments. 46132 4. During a concurrent interview and medication pass observation for Resident 26 on 9/13/22 at 3:53 p.m., Licensed Nurse S verified she only used one piece of sani-cloth plus (a disposable wipe that kills bacteria and viruses within two minutes of surface contact) to collectively sanitize the wrist BPs, glucose strip (small, plastic strips that help to test and measure blood glucose levels) bottle, thermometers and pulse oximeters (an electronic device that measures the saturation of oxygen carried in the red blood cells) after use. During a medication pass observation for Resident 151 on 9/14/22 at 8:55 a.m., Licensed Nurse C verified she only used one piece of sani-cloth plus to collectively sanitize the BP wrist monitors, thermometers and pulse oximeters after use. 5. During a concurrent observation and interview on 9/20/22 at 9:13 a.m., Licensed Nurse A verified she held Resident 46's Diltiazem 24 ER (medicine used to treat high blood pressure and prevent chest pain) with her bare hands. LN A verified she should not be touching medications with her bare hands, for infection control. LN A verified she forgot to perform HH prior to donning and after doffing gloves. LN A verified she administered Spiriva (medicine used to control symptoms of Chronic Obstructive Pulmonary Disease [COPD], a chronic inflammatory lung disease that causes obstructed airflow from the lungs, by relaxing the airways and keeping them open) and Albuterol (a medication used to treat or prevent bronchospasm, a tightening of the muscles that line the airways in the lungs) inhaler to Resident 46. LN A verified she did not clean the Spiriva nor Albuterol after Resident 46 used them. She stated she only cleaned the inhalers if they were dirty. She stated, in this case, the inhalers were not dirty, so she did not clean them. LN A stated she were not aware of how to clean Spiriva's handihaler device or Albuterol's plastic actuator. LN A verified she did not wipe the mouth piece with tissue after every use. LN A stated she was not aware of the last time the Spiriva inhaler was cleaned. She stated, not cleaning the inhalers after use was an infection control issue. She stated, if a handihaler device and mouthpiece were not cleaned, there could be build-up of medication, and blockage could occur causing inadequate delivery of medications. During an interview on 9/20/22 at 9:54 a.m., the Infection Preventionist (IP) stated staff should be using one disinfecting wipe for each vital signs monitor. The IP stated she was not aware of any policy and procedure regarding cleaning of inhalers. She stated the expectation was for nurses to wipe the inhalers with a tissue after use, for infection control. The IP stated, not cleaning the inhalers and not sanitizing the vital signs monitor correctly, could put residents at risk for acquiring infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 9/20/22 at 10:10 a.m., The Director of Nursing (DON) stated he expects the nurses to clean the inhalers after every use. If this was not being done by the nurses, then the standards of practice were not followed. He stated, cleaning the inhalers was necessary for hygienic purposes and infection control. The DON stated he expected the nurses to use one sanitizing wipe for each vital sign monitors. He stated, not sanitizing the vital sign monitors effectively and not cleaning the inhalers, could put residents at risk for infections. During a telephone interview on 9/20/22 at 10:18 a.m., the facility's Registered Pharmacist stated nurses should be cleaning the inhaler devices and should keep an eye for medication build-up. He stated, not cleaning the inhalers could result in medication build-up which could lead to infections. During an interview on 9/20/22 at 10:24 a.m., Licensed Nurse H (LN H) stated the facility policy was for nurses to clean the inhalers after use, with a tissue. She stated it was important to clean the inhalers after use for infection control. LN H stated residents could end up with respiratory infections if the inhalers were not cleaned after use. During a review of Spiriva's instruction sheet, undated, it indicated, after taking the daily dose, it was recommended to remove any Spiriva capsule pieces or powder, by turning the handihaler device upside down and gently but firmly, tapping it. It also indicated to rinse the complete inhaler with warm water to remove any powder, then leaving the dust cap, mouthpiece and base open to air dry. It further indicated the outside of the mouthpiece may be cleaned with moist tissue. During a review of Albuterol Sulfate Inhalation Aerosol medication guide, undated, it indicated cleaning the device was very important to keep the plastic actuator clean so the medicine would not build-up and block the spray. It also indicated to wash the actuator at least one time each week, by holding the actuator under the faucet and running warm water through it for about 30 seconds.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44968 Based on interview and records review, the facility failed to offer the pneumococcal vaccine, recommended by the Advisory Committee on Immunizations Practices (ACIP-group of medical a public health experts), for four of ten residents (Resident 31, Resident 43, Resident 26, and Resident 39). This failure had the potential risk for residents to acquire and transmit pneumococcal bacteria, potentially resulting in serious respiratory infections. Findings: During clinical record review for Resident 31, the document titled, Clinical-Immunizations, indicated Resident 31 received, Pneumovax (pneumococcal vaccine) Dose 1, on 12/17/19. Resident 31 was [AGE] years-old. During clinical record review for Resident 43, the document titled, Clinical-Immunizations, indicated Resident 43 received, Pneumovax Dose 1, on 6/06/17. Resident 43 was 77 years-old. During clinical record review for Resident 26, the document titled, Clinical-Immunizations, indicated Resident 26 received, Pneumovax Dose 1, on 4/22/16. Resident 26 was 79 years-old. During clinical record review for Resident 39, the document titled, Clinical-Immunizations, indicated Resident 39 received PPSV23 (pneumococcal polysaccharide vaccine - protect against many, but not all types of pneumococcal bacteria), on 4/12/2006. Resident 39 was [AGE] years-old. He had a diagnosis of Diabetes Mellitus. During clinical record review and concurrent interview with the Infection Preventionist (IP) Nurse on 9/19/22 at 12:01 p.m., the IP verified four of ten sampled residents did not receive the pneumococcal vaccine, recommended by the ACIP. When the IP was asked about her system of tracking residents' pneumococcal vaccines, she stated did not have a system in place to keep track of residents' pneumococcal immunizations. When the IP was asked about the risks for residents who did not receive the recommended pneumococcal vaccine, the IP stated this could result in an increased risk of respiratory infection for the residents. Review of the Facility policy and procedure titled, Pneumococcal Vaccine, revised in 10/2016, indicated, All residents to the center will be screened for the pneumococcal vaccine. Residents who have not been vaccinated and who meet the criteria established by the CDC will be offered the recommended pneumococcal vaccination to reduce morbidity and mortality from pneumococcal disease. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Centers for Disease Control and Prevention (CDC) recommended revaccination of PPSV23 at least one year after PCV13 dose and at least five years after any PPSV23 dose, for resident over [AGE] years-old, with underlying medical conditions or other risk factors, including: Alcoholism, Chronic Heart Disease, Chronic Liver Disease, Chronic Lung Disease, Cigarette Smoking, Diabetes Mellitus, and Cochlear Implant. (https://www.cdc.gov/vaccines/vpd/pneumo/downloads/pneumo-vaccine-timing.pdf)

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F 0912 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. 37797 Based on observation and interview, the facility failed to ensure 29 of 35 multiple-occupancy resident rooms measured at least 80 square feet per resident. This failure had the potential to limit the personal belongings of each resident and compromise their ability to move freely and receive adequate care in their rooms. Findings: During an observation and interview on 9/16/22, at 10:01 a.m., the Director of Maintenance Director (MD) measured the dimensions of all resident rooms. The following resident rooms did not meet the minimum space requirement for each resident: Room Occupancy Req'd/Actual Sq. ft./Res 1 2 beds 160 / 145 72.5 3 2 beds 160 / 148 74 4 2 beds 160 / 148 74 5 2 beds 160 / 148 74 6 2 beds 160 / 148 74 7 2 beds 160 / 148 74 8 4 beds 320 / 282 70.5 9 4 beds 320 / 289 72.2 10 2 beds 160 / 155 77.5 12 2 beds 160 / 148 74 14 2 beds 160 / 148 74 15 2 beds 160 / 148 74 16 2 beds 160 / 148 74 17 2 beds 160 / 148 74 18 3 beds 240 / 218.5 72.8 (continued on next page)

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F 0912 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	19 2 beds 160 / 149 74.5 20 2 beds 160 / 151.5 75.7 21 4 beds 320 / 289 72.2 22 2 beds 160 / 151.5 74.5 23 2 beds 160 / 151.5 74.5 24 2 beds 160 / 148 74 25 2 beds 160 / 148 74 26 2 beds 160 / 148 74 28 2 beds 160 / 147 73.5 29 2 beds 160 / 147.8 73.9 31 2 beds 160 / 146 73 32 2 beds 160 / 148 74 33 2 beds 160 / 148 74 37 4 beds 320 / 285 71.2 The Department recommends the continuation of granting room size waiver for the above rooms.