STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056361	A. Building B. Wing	07/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fortuna Rehabilitation and Wellness Center, LP	2321 Newburg Road Fortuna, CA 95540

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 37797 Based on interview and record review, the facility failed to notify the physician of the positive test results for four days for one of 37 residents (Resident 1) who tested positive for COVID-19 during the first 10 days of a facility outbreak. This resulted in a delay of four days in starting the antiviral for a vulnerable resident with comorbities. Findings: During a record review and concurrent interview on 5/26/22 at 1:15 p.m., Director of Nursing (DON) described the symptoms experienced by each of the residents on the line list for the facility's COVID-19 outbreak. The line list, dated 5/25/22, indicated Resident 1 tested positive for COVID-19 on 5/20/22, along with six other residents on that day. DON stated Resident 1 had respiratory symptoms at his baseline and that he was experiencing an increased cough and runny nose. During an interview on 5/27/22 at 11:30 a.m., Licensed Nurse J stated residents' positive COVID tests were reported to upper management including the DON. When asked who reported the positive COVID test results to the resident's physician, Licensed Nurse J stated it depended on the scenerio. Licensed Nurse J stated, It could be the nurse or the DON, it just depends who's involved. Licensed Nurse J stated the DON ultimately makes sure it is reported, and they try to report it within 24 hours or the same day. Licensed Nurse J stated it had been so chaotic lately with so many residents positive for COVID at once that they could not report to the physician immediately. During an interview on 5/27/22 at 1:15 p.m., when asked where they were documenting physician notification of residents' positive COVID tests, DON stated the physcians had been notified by text or phone, but documentation of physician notification had been delayed due to prioritizing patient care. DON stated now that staffing was better, she could get caught up on documentation of the notifications. DON stated, I know if it's not documented, I didn't do it. DON stated the physician's order for an antiviral for COVID-19 was the only documentation of notification at this point. DON stated that the medical director wanted any residents positive for COVID to be on an antiviral even if they did not have severe symptoms due to the congregate living situation and the residents' comorbidities. Review of Resident 1's medical record revealed a physician order for an antiviral medication for COVID-19 dated 5/24/22 by Physician A. Review of Resident 1's progress notes revealed no documentation Physician A was notified of his COVID-positive status. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/23/22 at 1 p.m., DON verified there was a delay of four days in notifying Physician A of Resident 1's COVID-positive status. DON stated Physician A wanted to be notified of her patients' positive test results and get antivirals for COVID ordered for them timely. DON stated the nurse in the Yellow Zone (unit for residents who have been exposed to COVID-19 but have not yet tested positive) or herself were responsible for notifying the physician of a positive test result, but there was no designated person. DON stated in future outbreaks she would make sure they had someone designated as responsible for this task. Review of facility policy and procedure Change of Condition Notification, last revised 4/1/15, revealed, A Licensed Nurse will notify the Attending Physician of routine laboratory, diagnostic test results as soon as possible after received. a. Document notification on the reports and progress notes.

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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** 39792 Based on observation, interview and record review, the facility failed to provide a clean, sanitary, and homelike environment to four of five residents when the facility (1) failed to ensure the bathrooms of two of three sampled residents (Residents 25 and 26) were sufficiently cleaned and (2) failed to ensure three of three resident rooms (Rooms 21, 24 and 25 - occupied by Residents 24 and 201) had window screens that fully covered the window frames without gaps that could serve as an entry point for insects. These failures resulted in Residents 25 and 26 using filthy bathrooms, and flies and spiders coming into rooms of Residents 24 and 201, and had the potential for flies, spiders and other insects to come into the facility. Findings: 1. During a review of Resident 25's, Admission Record, dated 7/1/21, indicated Resident 26 was admitted to the facility on [DATE] with a history of high blood pressure, blindness in both eyes, traumatic brain injury (brain dysfunction caused by an outside force, usually impact involving the head) and pain in the right leg. A review of Resident 25's Quarterly MDS (Minimum Data Set, a clinical assessment process which provides a comprehensive assessment of the resident's functional capabilities and helps staff identify health problems), dated 4/8/22, indicated: Resident 25 had a BIMS (Brief interview of Mental Status) score of 15, indication no mental or cognition impairment. During an interview on 7/18/22 at 8:80 am with Resident 25, she stated there was a leak in her bathroom toilet and when she used the toilet, her shoes would get wet. Resident 25 stated the area around the toilet was filthy and they (the facility) were not cleaning the area decently. During a concurrent observation and interview on 7/18/22 at 3:20 p.m., with Resident 25, she ambulated from her chair next to her bed into the private bathroom in her bedroom. Resident 25 observed the toilet in the bathroom, there was a leak and water type liquid were observed on the floor. The area on the floor was wet with a brown slimy material built up to create a thick band around the bottom of the toilet to the floor. There was a larger band of brown slimy dirt at the front of the bowl between the bottom of the toilet and the floor, but the grime was observed all the way around the toilet. During an interview with the Director of Nursing (DON) on 7/19/22 at 11:46 a.m., she stated when equipment breaks or there was any problem with toilets or sinks and things like that, staff would document the issue in a maintenance book, located at the nursing station. During a review of Resident 26's, Admission Record:, dated 6/23/19, indicated Resident 25 had been admitted to the facility on [DATE] with a history of chronic kidney disease, immunodeficiency (a state in which the immune system's ability to fight infectious disease and cancer is compromised or absent) and obstructive sleep apnea (intermittent air flow blockage during sleep). (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 review of Resident 26's Quarterly MDS (Minimum Data Set, a clinical assessment process which provides a comprehensive assessment of resident's functional capabilities and helps staff identify health problems), dated 3/23/22, indicated Resident 26 had a BIM (Brief Interview of Mental Status) score of 12, indicating mild mental or cognition impairment. During a concurrent observation and interview on 7/19/22 at 11:01 a.m. with Resident 26 and his Family Member (FM) who was sitting in a chair at the bedside while Resident 25 was asleep in his bed. FM stated she was visiting from out of town and had observed the trash can next to Resident 26's bed was full and had not been picked up in a few days. FM stated the floor was dirty and inside the bathroom the sink and toilet were both filthy. The floor was observed with debris of papers, brown dirt, lint and other items scattered around the floor and under Resident 26's bed. The toilet was observed to be dirty with white type bubbles which looked like a large collection spit from a person's mouth inside the bowl. The toilet was flushed, and the toilet bowl had a lighter brown film rising approximately four inches from inside the bowl up the sides of the toilet in a circular configuration. The sink was observed to have an approximate six-inch film of tan type dirt from the drain up to the sides of the sink. The sink had remnants of the paper towel, hair and general slimy tan gunk at the drain. During a concurrent interview and record review on 7/19/22 at 12:01 p.m., with House Keeping Supervisor (HKS), House Keeping (Resident Room daily) Cleaning Logs dated 6/25/22 to 7/18/22 were reviewed for Residents 25 and 26. HKS sated the housekeeping staff were supposed to clean around the outside of the toilet, inside of the toilet, the sink (inside and outside), and floor (resident room and bathroom) one time each day. The cleaning log for Resident 25 was reviewed and indicated to be cleaned on 7/10/22, 7/11/22, 7/12/22, 7/16/22 and 7/17/22, the following dates were missing on the page, 7/13/22, 7/14/22 and 7/15/22 and HKS indicated Resident 25's room had not been cleaned on those dates. HKS stated he will usually spot check (randomly picks a room) and walk into rooms after it has been cleaned to check to see the quality of the work. HKS stated he had not been monitoring the rooms and conducting spot checks and there was no formal process for the supervisor to document the rooms were cleaned appropriately. HKS stated Residents do have a right to refuse to have their rooms cleaned but after two or three days maximum, he would then be notified about the room not being cleaned and would ensure the room was cleaned. HKS observed the toilet and floor area of Resident 25's bathroom and stated the water leaking and the dirt around the toilet area was not acceptable and did not have a reason for why the floor looked that way. Resident 26's cleaning log from 7/10/22 to 7/17/22 was reviewed and the following dates were not filled in as cleaned on the log, 7/13/22, 7/14/22 and 7/15/22. HKS observed the toilet (inside and out) and sink and stated it looked like the bathroom had not been cleaned in four or five days. HKS stated the condition of the bathroom was not acceptable and did not have a good answer as to why the bathroom had not been cleaned. During a review of the facility's policy and procedure titled, Housekeeping Policies and Procedures, dated 1/9/08, the P&P indicated, C. All rooms of the center shall be kept clean and as free as possible of germs and other contaminating agents at all times, while maintaining a pleasant and homelike atmosphere for our residents. All rooms in this center shall be cleaned daily by housekeeping staff .F. Housekeeping inspections shall be held as part of the regular weekly center safety inspections .This center shall maintain a pest control program, including a yearly inspection by a pest control company and semiannual spraying of the grounds to protect against insects . (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 review of the facility's policy and procedure titled, Housekeeping Policy and Procedures, dated 1/9/2008, the P&P indicated, 8. Follow instructions as described for each job .17. Report leaky taps, running toilets, torn drapes, etc. to your supervisor . During a review of facility's policy and procedure titled, Housekeeping Policies and Procedures, dated 1/9/08, the P&P indicated, 2. Empty and clean wastebaskets and ashtrays .7. Proceed to clean resident's restroom (refer to Cleaning, Sanitizing, Disinfecting, and Sterilizing) .8. Sweep or vacuum floor, Damp mop floor with disinfectant solution .16. Proceed to clean restroom . 37797 2. During an interview on 7/20/22, 2:30 p.m., Resident 45 stated she sometimes saw big old flies in her room, Resident 26 reported he had also seen flies in his room, and Resident 6 reported she saw a spider in her room recently. During an observation of resident rooms 21, 24 and 25 with the Director of Maintenance (DM) on 7/21/22, at 10:05 a.m., the windows in room [ROOM NUMBER] (occupied by Resident 24), room [ROOM NUMBER] (occupied by Resident 201) and room [ROOM NUMBER] (unoccupied) were open and there were gaps of approximately one inch between the window frame and the window screens. There were spider webs outside the window screens. During a concurrent interview, the DM confirmed that improperly fitted, bent or damaged window screens, such as found in Rooms 21, 24 and 25 was an ongoing problem at the facility and served as an entry point for insects. A review of facility policy titled, Maintenance Service, dated 1/1/12, indicated, The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. A review of the facility policy titled, Pest Control, dated 1/1/12, indicated, To ensure the Facility is free of insects, rodents, and other pests that could compromise the health, safety, and comfort of residents, Facility Staff, and visitors .The Facility maintains an ongoing pest control program to ensure the building and grounds are kept free of insects, rodents and other pests . I. General Practices A. Windows are screened at all times.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39792 Based on interview and record review, the facility failed to report to the Department one allegation of physical abuse for one of two sampled residents (Resident 32). This failure prevented the Department from timely investigating the abuse allegation involving Resident 32. Findings: During a review of Resident 32's, Admission Record, dated 7/29/16 indicated Resident 32 was admitted to the facility on [DATE] with a history of Parkinson's' disease (a disorder of the central nervous system that affects movement, often including tremors), paranoid disorder (an unrealistic distrust of others or a feeling of being persecuted), schizophrenia (a disorder that affects a person's ability to think, feel and behave clearly) and high blood pressure. During a review of Resident 32's Quarterly MDS (Minimum Data Set, a clinical assessment process which provides comprehensive assessment of resident's functional capabilities and helps staff identify health problems) dated 2/21/22, indicated Resident 32 had a BIMS (Brief Interview of Mental Status) score of 99, meaning she was unable to answer any of the questions due to having severe cognitive impairment. During an observation on 7/20/22 at 8:33 a.m., with Resident 32, she was in the dining room without other residents and was observed yelling to herself. Resident 32 was observed to be having a conversation with herself, answering questions while walking around the room independently. Resident 32 was observed to calm down quickly without staff intervention and remained having an internal conversation. During a review of Resident 32's, Activity Progress Note, dated 2/1/22 indicated Resident 32 had punched another resident as she was passing, and it was unclear why since the other resident was not speaking with Resident 32. The progress note indicated a nurse was informed of the incident. During an interview on 7/20/22 at 4:30 p.m., Director of Nursing (DON) stated she thought the incident had not been reported because the resident who was punched denied the event occurred. DON stated if the incident had occurred as indicated in the medical record, then the event should have been reported to the Department and she could not find a record of the report. During an interview on 7/20/22 at 4:55 p.m., Administrator stated he had only been hired at the facility a few weeks before and could not find a record of the report. Administrator stated he was told the resident who was punched had denied the event occurred and could not provide further details. During an interview on 7/21/22 at 11:39 a.m., Certified Nursing Assistant B (CNAB) stated Resident 32 would often speak to herself, but the staff would intervene to prevent violence among the residents. CNAB stated she had never seen Resident 32 become aggressive with other residents. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/21/22 at 12:48 p.m., Licensed Staff A stated she had never witnessed Resident 32 hitting or punching another resident. Licensed Staff A stated she would report any type of event to management. During a review of the facility's policy and procedure (P&P) titled, Abuse Prevention and Prohibition Program, dated 1/30/20, the P&P indicated, To ensure the Facility establishes, operationalizes, and maintains an Abuse Prevention and Prohibition Program designed to screen and train employees protect residents, and to ensure a standardized methodology for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment .Staff must not permit anyone to engage in verbal, mental or physical abuse .III Training A. All employees, contractors and volunteers will be trained through orientation and ongoing training sessions, no less than annually, on the following topics: Who is a covered individual responsible for reporting .III. Identification and recognition of signs and symptoms of abuse/neglect .VI. Reporting and documentation of abuse and neglect .X Penalties associated with failure to report .D The Facility posts information regarding procedures for reporting concerns or suspicion of abuse throughout the facility for Facility Staff .A. Staff, residents and families will be able to report concerns, incidents .E. The Facility maintains adequate staffing on all shifts to ensure that the needs of each resident are met .C. The Facility maintains a Compliance Hotline to allow anonymous reporting of abuse .A. The Facility promptly and thoroughly investigates reports of resident abuse .A. Facility Staff are Mandatory Reporters .B. Administrator, or his/her designee, as Abuse Coordinator i. In order to facilitate reporting, ensure confidentiality, and promote order at the Facility, the Administrator, or his/her designee of the Facility shall be the individual who reports known or suspected instances of abuse of residents at the Facility to proper authorities .ii. Facility Staff will report known or suspected

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39792 Based on observation, interview and record review, the facility failed to provide showers as scheduled for two (Resident 26 and 43) out of 4 sampled residents. The failure had the potential to resulted in residents being dirty and unkempt. Findings: 1. During a review of Resident 26's, Admission Record:, dated 6/23/19, indicated Resident 26 had been admitted to the facility on [DATE] with a history of chronic kidney disease, immunodeficiency (a state in which the immune system's ability to fight infectious disease and cancer is compromised or absent) and obstructive sleep apnea (intermittent air flow blockage during sleep). During a review of Resident 26's Quarterly MDS (Minimum Data Set, a clinical assessment process which provided a comprehensive assessment of resident's functional capabilities and helped staff identify health problems), dated 3/23/22, indicated Resident 26 had a BIM (Brief Interview of Mental Status) score of 12, indicating mild mental or cognition impairment. During an interview on 7/19/22 at 11:01 a.m., with Resident 26 and his Family Member (FM), Resident 26 was observed to be laying down asleep with FM sitting in chair quietly beside the bed. Resident 26 woke up and started a conversation. Resident 26 stated he was being provided shower assistance twice a week without any problems. FM stated she had been there sitting in his room all day for the past five days and Resident 26 had not had a shower within those five days. FM stated she had observed Resident 26 was offered a shower twice, Resident 26 was asleep and requested to shower later but staff did not return to offer shower assistance. FM stated Resident 26 would need a shower and she could tell he had not had a shower during her absence between those daily visits. During an interview on 7/21/22 at 10:01 a.m., with Certified Nursing Assistant C (CNA), CNA C stated Resident 26 would require minimal assistance with showers but was unable to complete them himself. CNA C stated Resident 26 refused showers and there was a book where shower refusals were documented and then there was another book where the staff were supposed to document when a shower had been provided. CNA C stated Resident 26 did not like to get up in the morning and his showers were scheduled for the evening shift or later in the afternoon. During an interview on 7/21/22 at 11:39 a.m., with CNA B, CNA B stated Resident 26 would sometimes refuse to take a shower but the staff were expected to ask a resident three times before they were allowed to document there was a refusal. CNA B stated some other staff members only ask residents once if they want a shower and then document the resident refused, we were required to have the resident sign a refusal form if they did not want a shower. During an interview on 7/21/22 at 12: 48 p.m., with Licensed Nurse (LN) A, LN A stated Resident 26 did not refuse showers very often as much as she could remember. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a review of Resident 43's, Admission Record, dated 9/13/18, indicated Resident 43 was admitted to the facility on [DATE] with a history of epilepsy (a disorder in which nerve cell activity in the brain is disturbed causing seizures (a sudden uncontrolled electrical disturbance in the brain which can cause changes in behavior, movements or feelings and in level of consciousness) and muscle weakness. During a review of Resident 43's Quarterly MDS (Minimum Data Set, a clinical assessment process which provided a comprehensive assessment of resident's functional capabilities and helped staff identify health problems), dated 6/15/22, indicated Resident 43 had a BIMS (Brief Interview of Mental Status) score of 14 out of 15 possible, indicating no mental or cognition impairment. During an interview on 7/21/22 at 3:26 p.m., Resident 43 stated she was not being provided her twice weekly scheduled showers. Resident 43 stated she was not sure when she was supposed to be provided showers (which days of the week) and stated she was being provided showers this week but this had been the first time. During an interview on 7/26/22 at 2:56 p.m., Certified Nursing Assistant (CNA) D, stated Resident 43 sometimes would want a shower on the scheduled shower day and sometimes Resident 43 would not want a shower on her scheduled shower day. CNA D stated in caring for Resident 43, she would need a pre-arranged scheduled time to prepare for a shower, like would it be okay to have a shower in two hours. CNA D stated Resident 43 would refuse to have shower if the staff just presented themselves and told her it was time to take a shower. During an interview on 7/26/22 at 2:25 p.m., Licensed Staff (LS) A stated if a resident refused to have a shower, she would then encourage them to take a shower. LS A stated if a resident refused to have a shower, then she would request that the Resident sign a shower refusal form and if they (resident) were unable to sign the form, then she would sign the form. LS A stated she had not worked with Resident 43 and did not remember asking Resident 43 to sign a shower refusal form. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent document and record review on 7/27/22 at 10:02 a.m., with Director of Nursing (DON), DON stated there were multiple documents which the staff used to indicate if a Resident was provided a shower, was not provided a shower or refused. DON stated these are the documents the facility would use, 1) ADL (Activity of Daily Living) Flow Sheet where the staff document daily and specifically which shift a task like showers was completed, 2) Shower Assessment Worksheet where staff, specifically the CNA, would document the date a shower was given and if a resident refused how many times the resident had been offered to have a shower, the nurse would sign the form as acknowledgment and the DON would sign the form as way of tracking which residents were refusing showers each day (one form per day), 3) Shower Schedule where the date, day of the week and the room number were documented and the staff member who assisted the resident in having a shower would initial next to the room number (documented by the week per page) and 4) Shower Refusal Sheet where the date and signatures from Resident, CNA, Nurse and DON would be documented on the form (single page document for each date of occurrence). DON stated at one point, there was also a shower log which she would document which residents were being provided showers and which residents were not to ensure all residents were getting their scheduled showers (the log was not observed nor provided during the survey). DON stated the residents in the facility were being provided scheduled showers two times a week (scheduled days of the week, like Wednesday and Saturday) to be spaced about 72 hours apart. A review of Resident 26's, ADL Flowsheet, dated, May 2022, was reviewed and indicated Resident 26 was assisted with two showers (5/4/22 and 5/13/22) for the month. A review of Resident 26's, Shower Assessment Worksheet, dated 5/13/22 ad 5/25/22 indicated Resident 26 had two showers that month. DON stated there was a discrepancy regarding how the staff would documents Resident 26 having showers (5/25/22 was not documented on both forms). DON stated there were no refusals documented on the form or on the ADL Flowsheet (staff would mark an R to indicate refusal). DON stated Resident 26 would have had an opportunity to have seven to nine showers (for the month); but per the shower schedule Resident 26 had two showers documented on the ADL Flowsheet and the third date (5/25/22) was documented on the Shower Assessment Worksheet. DON stated if Resident 26 was in the isolation unit during the month of May, 2022, then he should have been provided an opportunity for showers two times a week and being in an isolation unit would not have made a difference. A review of Resident 26's, ADL Flowsheet dated June 2022 was reviewed and indicated Resident 26 had four showers (6/17/22, 6/19/22, 6/20/22 and 6/24/22) out of eight scheduled shower opportunities. DON stated Resident 26 should not have had two showers, two days in a row (6/19/22 and 6/20/22) since showers were scheduled 72 hours apart. DON stated there were no documented refusals on the ADL Flowsheet for the month of June (2022). DON stated she could not explain why Resident 26 was not provided his scheduled showers. A review of Resident 26's, Shower Assessment Worksheet, dated 6/24/22 indicated Resident 26 had one shower for the month of June since there was no shower assessment worksheets to correspond with the showers documented on the ADL Flowsheet. DON stated the shower schedule was adjusted to ensure all the residents were given their scheduled showers. DON could not explain why Resident 26 was not provided his scheduled showers and could not explain the discrepancy in documentation. A review of Resident 26's, ADL Flowsheet, dated July 2022, was reviewed and indicated Resident 26 had four showers (7/1/22, 7/5/22, 7/14/22 and 7/22) out of seven scheduled showers. A review of Resident 26's, Shower Assessment Worksheet dated 7/1/22 indicated he refused, 7/5/22 indicated he had a shower and 7/15/22 indicated he had shower for a total of three documented showers out of seven scheduled showers. DON stated she could not explain the discrepancy in documentation regarding 7/1/22 where one document indicated Resident 26 was provided a shower and another document indicated Resident 26 had refused a shower; but DON did state Resident 26 was not provided all of his scheduled showers. DON could not explain why Resident 26 had not received all of his scheduled showers. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fortuna Rehabilitation and Wellness Center, LP	2321 Newburg Road Fortuna, CA 95540

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 7/27/22 at 11:14 a.m., with DON, Resident 43's, ADL Flowsheet, dated May 2022, was reviewed and indicated Resident 43 was provided two showers (5/11/22 and 5/29/22) for the month of May. DON stated the ADL Flowsheet documentation was not as accurate as the shower schedule document. A review of Resident 43's, Shower Schedule dated from 5/2/22 to 5/31/22 was reviewed and Resident 43 was given one shower on 5/11/22. A review of Resident 43's, Shower Assessment Worksheet, dated 5/11/22 and 5/29/22 indicated she had two showers out of eight scheduled showers. DON stated during the month of May (2022), the facility had a widespread COVID-19 (an illness caused by a novel coronavirus which causes severe acute respiratory syndrome) outbreak so there was a lot going on in the building. DON stated the documentation across the multiple forms to address if a resident was getting their scheduled showers was not consistent, but she stated the Shower Schedule weekly document where the staff would initial the room number to denote date when a resident had a shower was the most accurate document. DON was observed looking through multiple pages to see if there was documentation to indicate Resident 43 had more showers provided on other days than the scheduled days and could not find documentation. A review of Resident 43's, Shower Schedule dated from 6/1/22 to 6/29/22 indicated Resident 43 had three showers (6/4/22, 6/15 and 6/18/22 out of nine scheduled showers. A review of Resident 43's, Shower Schedule, dated 7/1/22 to 7/23/22, indicated she was provided five showers (7/2/22, 7/6/2, 7/9/22, 7/20 and 7/23/22) but was not provided showers the week of 7/11/22 to 7/16/22. DON stated she could not explain why Resident 43 was not provided showers the week of 7/11/22 to 7/16/22. DON stated the shower assessment worksheet should correspond with the shower schedule documentation and could not explain the discrepancy in documentation regarding the two forms. During a review of the facility's policy and procedure titled, ADL (Activities of Daily Living), dated 7/1/14, indicated, To provide consistency in documentation of resident status and care given by nursing staff .III. The CNA (Certified Nursing Assistant) will document the care provided on the facility's method of documentation, manually or electronic. During a review of the facility's policy and procedure titled, Showering and Bathing, dated 1/1/12, indicated, A tub or shower bath is given to the residents to provide cleanliness, comfort and to prevent body odors.

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F 0686 Level of Harm - Actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **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 six residents sampled for pressure ulcer (a localized injury to the skin and underlying tissue that occurs because of intense and prolonged pressure) review (Resident 199) received care, treatment, and services consistent with physician orders and professional standards of practice to prevent and treat pressure ulcers. For Resident 199, admitted on [DATE], bed-bound and immobile, with paralysis, admitted with a pre-existing Stage 3/Unstageable pressure ulcer (a wound where the whole skin is gone and the fat layer of tissue that underlines the skin is visible) on his coccyx (tail bone): (1) The facility failed to complete a risk assessment for developing pressure injuries (Braden Scale) upon admission for Resident 199. The first Braden Scale was completed on 7/12/22 (14 days after admission and after the resident had developed five pressure ulcers); (2) The facility failed to accurately assess Resident 199's skin when licensed nurses did not document all of Resident 199's pressure ulcers during skin assessments, with one skin assessment, completed one week after Resident 199's admission, indicating he had no pressure injuries or skin wounds; (3) The facility failed to timely develop an individualized care plan (a document instructing staff on how to care for the resident) for the prevention of pressure ulcers. The first pressure ulcer care plan was developed on 7/19/22 (22 days after admission) (after the resident had acquired 10 pressure ulcers); (4) The facility failed to develop an individualized care plan for prevention of pressure and treatment of pressure ulcers according to the resident's risk factors. The pressure ulcer care plan (7/19/22) did not include key interventions pertinent to the resident's situation, such as turning and repositioning the resident every two hours, use of heel protectors, use of wedge pillows for positioning and pressure relief, and off-loading heels; interventions that had been recommended by the wound specialist physician starting on 6/29/22; (5) The facility failed to timely implement standard interventions to prevent and treat Resident 199's pressure ulcers, such as turning and repositioning the resident every two hours, use of heel protectors, use of wedge pillows for positioning and pressure relief, and off-loading heels These interventions that had been recommended by the wound specialist physician starting on 6/29/22, with the key intervention of turning and repositioning Resident 199 only consistenly documented as implemented starting on 7/19/22 (22 days after admission); (6) The facility failed to timely implement a physician's order for deployment of a pressure redistributing mattress (low air loss mattress - LAL). The LAL was ordered on 6/29/22 but the facility provided it to the resident on 7/8/22 (10 days later), even though the facility had a LAL in stock at the time it was ordered; during this delay the resident developed five pressure ulcers; (7) The facility failed to timely and consistently implement physician orders for prevention and treatment of Resident 199 pressure ulcers. Treatments ordered to treat Resident 199's pressure ulcers and prevent new ones were not provided for up to 7 days after they had been ordered, and afterwards were not provided daily as ordered; (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	(8) The facility failed to take steps to timely remove the resident's cervical collar (neck brace). The resident's transfer orders dated 6/28/22 indicated the cervical collar was to be removed on 7/4/22 (one week after admission), and the wound specialist physician recommended it removed on 7/7/22, but by 7/27/22 (30 days after admission) no steps were taken to remove the cervical collar. (9) The facility failed to develop and implement a system for monitoring and documenting the turning and repositioning of residents at risk for pressure ulcers, with documentation of the date and time and position the resident was turned. These failures resulted in Resident 199 developing a total of 10 pressure ulcers within two weeks of admission to the facility. Five pressure ulcers (one Stage I on the nose, one Stage II on the clavicle, one Unstageable on the left buttock, and one bilateral Deep Tissue Injury on each heel) were developed between within nine days of admission, from 6/29/22 to 7/7/22, and another five pressure ulcers (one Deep Tissue Injury on right leg, one Deep Tissue Injury on left leg, one Stage II and two Deep Tissue Injuries on the right buttock) were developed in the next five days, from 7/8/22 to 7/13/22. Findings: Review of the National Pressure Injury Advisory Panel revealed a pressure injury (also called a bedsore, pressure ulcer, pressure sore, or decubitus ulcer) is a localized injury to the skin and underlying tissue that occurs because of intense and prolonged pressure. Pressure injuries are classified into four stages, depending on the severity of the wound. A Stage 1 pressure injury is characterized by skin that is intact but with redness that is non-blanchable (does not turn white when pressed). A Stage 2 pressure injury shows a shallow ulceration (a break in the skin) with a red/pink wound bed, with only the superficial layers of the skin destroyed. A Stage 3 pressure injury indicates a wound where the whole skin is gone and the fat layer of tissue that underlines the skin is visible. A Stage 4 pressure injury is a wound where the both the skin and the fat tissue are destroyed, and it is possible to visualize the bones, muscles, ligaments and/or cartilage. (National Pressure Injury Advisory Panel, NPIAP Pressure Injury Stages, 2022, https://npiap.com/page/PressureInjuryStages) Review of theNational Pressure Injury Advisory Panel revealed there are also two additional types of pressure injuries: Unstageable Pressure Injures and Deep Tissue Injuries. An Unstageable Pressure Ulcer occurs when, as a result of unrelieved pressure on the skin, the whole skin is destroyed but the area is covered with slough or eschar (dead tissue), making it impossible to determine the exact stage without debridment (removal of the dead tissue). Once debrided, a Stage 3 or Stage 4 pressure injury will be revealed. A Deep Tissue Injury is also a skin wound resulting from unrelieved pressure. In a Deep Tissue Injury, there is no open wound or ulceration, but there is a non-blanchable are with a deep red and purple discoloration that indicates extensive damage to the underlying tissues, often evolving into a Stage 3 or Stage 4 pressure ulcer. (National Pressure Injury Advisory Panel, NPIAP Pressure Injury Stages, 2022, https://npiap.com/page/PressureInjuryStages). (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	Review of the American Association of Family Physicians,revealed [Pressure] ulcers are difficult to resolve. Although more than 70 percent of stage II ulcers heal after six months of appropriate treatment, only 50 percent of stage III ulcers and 30 percent of stage IV ulcers heal within this period . and because skin wounds are colonized with bacteria, pressure ulcer place patients at risk of serious, life-threatening infectious complications such as bacteremia and sepsis (systemic infection), cellulitis (skin infection), endocarditis (heart infection), meningitis (spinal cord infection), osteomyelitis (bone infection), septic arthritis, and sinus tracts or abscesses. (American Association of Family Physicians, Pressure Ulcers: Prevention, Evaluation, and Management, Am Fam Physician. 2008;78(10):1186-1194). A review of Resident 199's Facesheet indicated he was admitted to the facility on [DATE] with a primary diagnosis of spinal cord injury and additional diagnoses including history of falling, generalized muscle weakness, bed confinement status and a Stage 3 pressure ulcer in the sacrum area (a large triangular bone in base of the spine). A review of Resident 199's SKILLED NURSING FACILITY TRANSFER ORDERS (Transfer Orders), dated 6/28/22, at 3:05 p.m., indicated Resident 199 was Bed bound due to paralysis from cancer lesions and needed frequent turnings to prevent ulcerations. The Transfer Orders also indicated Resident 199 had a cervical collar (a neck brace) which was to be worn through 7/4/22. A review of Resident 199's clinical record indicated a consultant report from WOUND MD (a wound care specialist physician on contract with the facility) dated 6/29/22, titled WOUND ASSESSMENT AND PLAN. This report consisted of an assessment of Resident 199's pre-existing coccyx pressure ulcer and contained treatment recommendations. The report indicated Resident 199 had an Unstageable Pressure Ulcer on his coccyx measuring 7 cm [centimeters] in length and 8.5 cm in width. The report contained the following TREATMENT ORDER: Daily cleanse the wound with normal saline or sterile water, then apply Santyl (an ointment that removes dead tissue), then cover wound with a moist dressing. The Report also indicated: Preventative Wound Recommendations: Air mattress . Type: low air flow . and Need low air loss mattress and off load and reposition [turn and reposition resident] per facility's protocol. No other pressure injuries were documented. A review of the facility's WEEKLY PRESSURE INJURY REPORT [a tally of all residents with pressure ulcers at the facility], dated for week of 6/29/22, indicated Resident 199 had one unstageable pressure ulcer in the coccyx, as documented in the WOUND MD assessment. The Report indicated orders given. No other pressure injuries were documented. Review of the American Association of Family Physicians (AAFP) revealed pressure reduction to preserve microcirculation is a mainstay of [pressure unjury] preventive therapy and the two most important interventions are frequent turning and repositioning and the application of pressure relieving devices to redistribute localized pressure: Patients who are bedridden should be repositioned every two hours and Pressure-reducing surfaces [such as low air loss mattress] lower ulcer incidence by 60 percent compared with standard hospital mattresses. (American Association of Family Physicians, Pressure Ulcers: Prevention, Evaluation, and Management, Am Fam Physician. 2008;78(10):1186-1194). (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	A review of Wound Care Solutions revealed low air loss mattress is a mattress designed to prevent and treat pressure wounds. The mattress is composed of multiple inflatable air tubes that alternately inflate and deflate, mimicking the movement of a patient shifting in bed or being rotated by a caregiver, never leaving the patient in one position for any extended length of time. This action relieves pressure under the body - particularly in parts with less padding, like hips, shoulders, elbows, and heels - and helps ensure proper air circulation, helping to prevent, manage, and treat the occurrence of pressure wounds. (Wound Care Solutions, How a Low Air Loss Mattress Can Keep Patients Wound Free, 2022, https://www.woundcareinc.com/resources/low-air-loss). A review of Resident 199's PROGRESS NOTES indicated note dated 7/1/22, at 3:51 p.m., titled SKIN ONLY EVALUATION, indicating: Resident has current skin issues and documented three Stage 2 pressure ulcers: one Stage 2 pressure injury on the left anterior neck measuring 3 cm (length) x 2 cm (width), one Stage 2 pressure ulcer on the left medial neck measuring 2 cm (length) x 1 cm (width) and one Stage II pressure ulcer on the left posterior (outer) neck measuring 1 cm (length) x 1 cm (width). There was no documentation of Resident 199's coccyx pressure ulcer or other pressure ulcers. A review of Resident 199's PROGRESS NOTES indicated note dated 7/4/22, at 3:50 a.m., titled SKIN ONLY EVALUATION, indicating no skin wounds, as follows: Skin warm and dry, skin color WNL [within normal limits], mucous membranes moist, turgor normal. No current skin issues noted at this time. A review of Resident 199's PROGRESS NOTES indicated note dated 7/5/22, at 1:41 a.m., titled SKIN ONLY EVALUATION, indicating Resident has current skin issues and documented four pressure ulcers: one Deep Tissue Injury on his left heel, two Deep Tissue Injuries, one on each buttock, and one Stage 2 pressure injury on his left clavicle (collar bone). There was no documentation of Resident 199's coccyx pressure ulcer or other pressure ulcers. A review of Resident 199's clinical record indicated a SECOND report from WOUND MD, dated 7/7/22, 8 days after the first report, titled WOUND ASSESSMENT AND PLAN. This report indicated Resident 199 had acquired five additional pressure ulcers, in addition to the pre-existing coccyx pressure ulcer, as follows: 1) COCYX Pressure Ulcer, Unstageable, Wound Measurements: 8 cm length x 6.6 cm width. Date of onset: 6/29/22. [Treatment order unchanged]. 2) LEFT CLAVICLE Pressure Ulcer related to medical device, Stage 2, wound measurement: 0.7 cm length x 0.5 cm width x 0.1 Depth. Date of onset: 7/7/22. TREATMENT ORDER: Daily cleanse wound with normal saline or sterile water, apply medihoney (a healing ointment) then cover wound with foam dressing for pad/protection. Need to discuss with neurosurgery clinic ASAP (as soon as possible) about collar causing wound and see if safe to be removed now. If it cannot be removed, need to ask neurosurgery about their recommendation on how to prevent further skin injury. 3) LEFT BUTTOCK Pressure Ulcer, Unstageable, Wound Measurements: 3.5 cm length x 1 cm width. Date of onset: 7/7/22. TREATMENT ORDER: Daily cleanse the wound with normal saline or sterile water, then apply Santyl, then cover would with a moist dressing. The Report also indicated: Preventative Wound Recommendations: Air mattress . Type: low air flow . (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	4) LEFT HEEL Deep Tissue Pressure Ulcer, Wound Measurements: 4.5 cm length x 4.5 cm width. Date on onset: 7/7/22. TREATMENT ORDERS: Leave open to air and off load heel (place pillow, foam, soft boots or any other material that redistributes the pressure around the heels). 5) RIGHT HEEL Deep Tissue Pressure Ulcer, Wound Measurements: 2.5 cm length x 1.5 cm width. Date on onset: 7/7/22. TREATMENT ORDERS: Leave open to air and off load heel. 6) NOSE Pressure Ulcer Stage 1, Wound Measurements: not listed. Date on onset: 7/7/22. TREATMENT ORDERS: Off load area and do not use glasses if able for 7 days. Recommend eye clinic evaluation with new glasses that would not cause more pressure to the area . A review of the facility's WEEKLY PRESSURE INJURY REPORT, dated for week of 7/7/22, indicated Resident 199 had six pressure ulcers, as documented in the second WOUND MD report dated 7/7/22. A review of Resident 199's PROGRESS NOTES indicated note dated 7/11/22, at 00:28 a.m., titled SKIN ONLY EVALUATION, indicating Resident has current skin issues and noted two pressure ulcers: an Unstageable Pressure Ulcer on Left Heel and a Deep Tissue Pressure Injury on buttock. A review of Resident 199's PROGRESS NOTES indicated note dated 7/12/22, at 3:21 p.m., titled SKIN ONLY EVALUATION, indicating Resident has current skin issues and noted two pressure ulcers: Stage 3 Pressure Ulcer on Coccyx and Stage 2 Pressure Ulcer on Left Clavicle. A review of Resident 199's clinical record indicated the first assessment of Resident 199's risk for pressure ulcers, the BRADEN SCALE for Predicting Pressure Ulcer Risk, was completed on 7/12/22, 14 days after his admission, and indicated Resident 199 had a score of 9, meaning he was at a VERY HIGH RISK of developing pressure ulcers. The 7/12/22 Braden Scale indicated Resident 199's sensory perception (the ability to respond meaningfully to pressure-related discomfort) was very limited; skin moisture (the degree to which skin is exposed to moisture) was very moist; activity (degree of physical activity) was confined to bed, mobility was completely immobile (does not make even slight changes in body or extremity position without assistance); nutrition was probably inadequate; and friction was problem (requires moderate to maximum assistance in moving .requires frequent repositioning with maximum assistance .). A review of Resident 199's clinical record indicated a THIRD report from WOUND MD, dated 7/13/22, and titled WOUND ASSESSMENT AND PLAN. This report indicated the presence of 11 pressure ulcers, five more than present during the SECOND report dated 7/7/22, as follows: 1) COCYX Pressure Ulcer, Unstageable, Wound Measurements: 7.5 cm Length x 7.5 cm. [Present upon admission - Noted on First and Second Report - Treatment orders unchanged]. 2) LEFT CLAVICLE Pressure Injury related to Medical Device, Stage 2, Wound Measurement: 0.5 cm Length x 0.1 cm Width. [Noted on Second Report - Treatment orders unchanged]. 3) LEFT BUTTOCK Pressure Ulcer, Unstageable, Wound Measurements: 1.5 cm Length x 1 cm Width. [Noted on Second Report - Treatment orders unchanged]. 4) LEFT HEEL Deep Tissue Pressure Ulcer, Wound Measurements: N/A. [Noted on Second Report - Treatment orders unchanged]. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	5) RIGHT HEEL Deep Tissue Pressure Ulcer, Wound Measurements: 2.5 cm Length x 1.5 cm Width. [Noted on Second Report - Treatment orders unchanged]. 6) NOSE Pressure Ulcer Stage 1, Wound Measurements: N/A. [Noted on Second Report - Treatment orders unchanged]. 7) RIGHT LATERAL LEG Deep Tissue Pressure Ulcer, Wound Measurements: 6 cm length x 3 cm width. Date of onset: 7/13/22. TREATMENT ORDERS: Daily cleanse wound with normal saline or sterile water, apply Santyl and cover with moist gauze and apply foam dressing to the area for pad/protection. Off load and reposition per facility's protocol. Preventative Wound Recommendations: Air mattress . Type: low air flow . 8) LEFT LATERAL LEG Deep Tissue Pressure Ulcer, Wound Measurements: 4 cm length x 3 cm width. Date of onset: 7/13/22. TREATMENT ORDER: Daily cleanse wound with normal saline or sterile water, apply Santyl and cover with moist gauze and apply foam dressing to the area for pad/protection. Off load and reposition per facility's protocol. Preventative Wound Recommendations: Air mattress . Type: low air flow . 9) RIGHT BUTTOCK (DISTAL) Pressure Ulcer Stage 2, Wound Measurement: 2 cm length x 1.5 cm width x 0.1 cm depth. TREATMENT ORDER: Daily apply foam dressing to the area for pad/protection. Must off load and reposition per facility's protocol. and Preventative Wound Recommendations: Air mattress . Type: low air flow . 10) RIGHT BUTTOCK (PROXIMAL INNER) Deep Tissue Pressure Injury, Wound Measurement: 2 cm length x 2 cm width. TREATMENT ORDER: Daily apply foam dressing to the area for pad/protection. Must off load and reposition per facility's protocol. and Preventative Wound Recommendations: Air mattress . Type: low air flow . 11) RIGHT BUTTOCK (PROXIMAL LATERAL) Deep Tissue Pressure Injury, Wound Measurements: 5.5 cm Length x 2.5 cm Width. TREATMENT ORDER: Daily apply foam dressing to the area for pad/protection. Must off load and reposition per facility's protocol. and Preventative Wound Recommendations: Air mattress . Type: low air flow . A review of the facility's WEEKLY PRESSURE INJURY REPORT, dated for week of 7/13/22, indicated Resident 199 had 11 pressure ulcers, as documented in the WOUND MD'S report dated 7/13/22. A review of Resident 199's PRIMARY CARE PHYSICIAN progress note, dated 7/16/22, indicated [Resident] has decubital ulcer on left clavicular region from hard c spine collar . Several decubital ulcers on coccyx region and left heal (sic) . Must rotate him every 2 hours to prevent these ulcers. During an observation and interview on 7/18/22, at 10:50 a.m., Resident 199 had a cervical collar was lying on his back in his room. Resident 199 stated he could not move his legs or reposition himself in bed without assistance. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	During an interview on 7/27/22, at 8:24 a.m., the Director of Nursing (DON) stated Resident 199 was admitted to the facility on [DATE] from the hospital and had one Stage III pressure ulcer on his coccyx area (tailbone). The DON stated all the other pressure ulcers documented in his clinical record had been acquired at the facility. The DON stated Resident 199 was immobile, completely dependent on staff assistance for movement, and was at high risk for developing pressure ulcers. The DON was asked for the dates and scores of Resident 199's Braden Scale for Assessing the Risk of Pressure Ulcers evaluations. The DON reviewed Resident 199's record and stated the first Braden Scale for Resident 199 was completed on 7/12/22 and indicated a score of 9, meaning the resident was at a VERY HIGHT RISK of developing pressure ulcers. During the same interview on 7/27/22, at 8:24 a.m., the DON was asked, given Resident 199's risk for developing pressure ulcers, what pressure ulcer prevention care plans had been developed for him. The DON reviewed Resident 199's record and stated two pressure ulcer care plans were created for Resident 199, both on 7/19/22. The first care plan indicated, Resident has potential/actual impairment to skin integrity . and Resident will have no complications related to pressure ulcers on coccyx, clavicle, buttocks and heels. This care plan listed the following interventions: encourage good nutrition, monitor pressure ulcers, use draw sheets to lift/move resident, use caution during transfers, treatment documentation, and resident needs pressure relieving mattress. The second care, also created 7/19/22, indicated Documented Pressure Ulcer and Management of Pressure Ulcer. This care plan listed the following interventions: educate resident about skin care to prevent skin breakdown, encourage resident to frequently shift weight, evaluate skin, evaluate ulcer characteristics, monitor bony prominences for redness, and monitor nutritional status. No other interventions were listed. During the same interview on 7/27/22, at 8:24 a.m., the DON was asked what could have been done to prevent Resident 199's pressure ulcers. The DON stated two key preventative measures for Resident 199 were the use of a low air loss mattress and turning and repositioning Resident 199 at least every two hours. The DON was asked if Resident 199 had been given on a low air loss mattress. The DON stated yes. The DON was asked when. The DON reviewed Resident 199's physician orders and stated the low air loss mattress order was entered on 7/8/22 (10 days after WOUND MD recommended it), but stated she was unsure of the actual day the low air loss mattress was deployed. The DON stated the Director of Staff Development (DSD) knew. During a concurrent interview, the DSD stated she entered the order for Resident 199's low air loss mattress on 7/8/22 and stated the low air loss mattress was given to him at the same time of the order, because we have them [low air loss mattresses] in stock here [at the facility]. During the same interview on 7/27/22, at 8:24 a.m., the DON was asked if Resident 199 had been turned and repositioned every two hours. The DON stated yes. The DON was asked to provide documentary evidence this intervention had been implemented. The DON stated staff did not usually document turning and repositioning of residents at risk for pressure ulcers. The DON stated the facility did not have a system for tracking when and how residents at risk for pressure ulcers are turned and repositioned. The DON stated Resident's 199's Medication Administration Record (MAR) and Treatment Administration Record (TAR) contained documentation of turning and repositioning. The DON asked the Medical Records Director to print Resident 199's MAR and TAR for June and July 2022. A review of the MAR June and July 2022 indicated documentation of turning and repositioning Resident 199 every two hours starting on 7/20/22 (23 days after his admission). This documentation consisted of a check mark three times a day in which the staff attested the resident was turned and repositioned every two hours. It did not contain documentation of the specific times Resident 199 was turned and repositioned or the specific side the resident was placed on (left, right, back). (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	According to the AAFP, The basic components of pressure ulcer management are reducing or relieving pressure on the skin, debriding necrotic tissue, cleansing the wound, managing bacterial load and colonization, and selecting a wound dressing. (American Association of Family Physicians, Pressure Ulcers: Prevention, Evaluation, and Management, Am Fam Physician. 2008;78(10):1186-1194). During the same interview on 7/27/22, at 8:24 a.m, the DON was asked for documentary evidence that the WOUND MD's treatments and interventions had been provided to Resident 199. The DON stated the treatments were documented in Resident 199's MAR and TAR. During a concurrent interview, the Medical Records Director was asked for a copy of Resident 199's MAR and TAR for June and July 2022. A review of these records indicated the WOUND MD orders for the treatment of Resident 199's pressure ulcers were untimely implemented, with delays of up to eight days, and were implemented inconsistently (daily orders not implemented on all days), as follows: WOUND MD's order for daily treatment of Resident 199's coccyx pressure ulcer, dated 6/29/22, was implemented starting on 7/1/22, but with no documentation in the TAR the treatment was provided on 7/3, 7/4, 7/10, 7/11, 7/14, 7/17, 7/18, 7/21, 7/24 and 7/25/22 (treatment delayed by up to two days and not provided on 30% of the days). WOUND MD's order for daily treatment of Resident 199's clavicle pressure ulcer, dated 7/7/22, was implemented starting on 7/15/22, but with no documentation it the TAR the treatment was provided 7/17, 7/18, 7/21 and 7/26 (treatment delayed by up to eight days and not provided on 40% of the days). WOUND MD's order for daily treatment of Resident 199's heel pressure ulcers (left and right), dated 7/7/22, was implemented starting on 7/15/22, but with no documentation the treatment was provided on 7/17, 7/18, 7/21 and 7/24 (treatment delayed by up to eight days and not provided on 30% of the days). WOUND MD's order for daily treatment of Resident 199's bilateral legs pressure ulcers (two wounds), dated 7/7/22, was implemented starting on 7/15/22, but with no documentation the treatment was provided on 7/17, 7/18, 7/21 and 7/25 (treatment delayed by up to eight days and not provided on 30% of the days). WOUND MD's order for daily treatment of Resident 199's buttock pressure ulcers (four wounds), dated 7/7/22, was implemented starting on 7/15/22, with no documentation the treatment was provided on 7/17, 7/18, 7/21, and 7/25 (treatment delayed by up to eight days and not provided on 30% of the days). WOUND MD's order for daily treatment of Resident 199's nose pressure ulcer, dated 7/7/22, was implemented starting on 7/14/22 (treatment delayed by up to seven days). During the same interview on 7/27/22, at 8:24 a.m., the DON stated Resident 199's clavicle pressure ulcer had been caused by his cervical collar. The DON was asked why the cervical collar had not been removed. The DON stated it was not removed because the facility had been unable to obtain a neurology consult and have an x-ray done to ensure it was safe to remove it. The DON stated there were no neurology specialists available in the area and no mobile x-ray services able to come to the facility. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	A review of facility policy and procedure titled PRESSURE INJURY PREVENTION, revised September 1, 2020, indicated: A risk assessment for developing pressure injuries will be completed upon admission . Regardless of the risk score, the Licensed Nurse will develop an individualized care plan for the Resident's risk factors . The Licensed Nurse will develop a care plan that contains interventions for Residents who have risk factors for developing pressure injuries or for those Residents who have pressure injuries and [are] at risk of developing additional pressure injuries. The care plan will be initiated on admission and updated as necessary. The nursing staff will implement interventions identified in the care plan which may include, but are not limited to, the following . pressure redistributing devices for bed and chair . repositioning and turning .heel and elbow protectors . off-loading pressure from heels .use of (wedge) pillows for positioning and pressure relief . A review of facility policy and procedure titled SKIN AND WOUND MANAGEMENT, revised January 1, 2022, indicated: Facility staff will take appropriate measures to prevent and reduce the likelihood that residents will develop pressure ulcers and other skin conditions. The Licensed Nurse will complete the Braden Scale for predicting pressure score risk upon admission . A Licensed Nurse will complete the Weekly Skin Evaluation. The Licensed Nurse will develop a Care Plan to identify interventions to prevent the development of pressure ulcers. Treatments for skin problems, wounds, and non-pressure ulcers will be assessed and documented by a Licensed Nurse. A review of facility policy and procedure titled PRESSURE INJURY AND SKIN INTEGRITY TREATMENT, revised August 12, 2016, indicated: Treatments to pressure injuries or other skin integrity problems will be ordered by the physician. Treatments administered will be documented on the Treatment Administration Record.

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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 five residents sampled for falls review (Resident 4) received care and services to prevent falls in accordance with Resident 4's fall risk factors and professional standards of practice. For Resident 4, who had a documented history of falls, poor gait, poor balance, and muscle weakness: (1) The facility failed to perform a fall risk evaluation after Resident 4 fell on [DATE] while Resident 4 was attending physical therapy, and after a nursing assessment on 5/22/22 indicated Resident 4 had poor balance and unsteady gate; (2) The facility failed to accurately evaluate Resident 4's risk for falls when a nursing assessment dated [DATE] indicated Resident 4 had no previous falls, when Resident 4 had fallen two days earlier on 5/20/22; (3) The facility failed to review, update, and develop a fall prevention care plan after Resident 4 fell on [DATE], leaving in place an outdated fall care plan dated 12/31/21; (4) The facility failed to accurately document Resident 4's falls when a nursing note dated 6/5/22, at 2:46 a.m. , indicated Resident 4 had a fall on 6/5/22, at 3:30 a.m., and the Director of Nursing was notified of the fall on 6/5/22 at 2:58 a.m; (5) The facility failed to review, update, and develop a fall prevention after Resident 4 fell again on 6/5/22, relying on an Occupational Therapy care plan created on 6/16/22 to address Resident 4's muscle weakness; (6) The facility failed to timely and accurately evaluate Resident 4's risk for falls when a fall risk assessment for the 6/5/22 fall was completed on 6/20/22, 15 days after the fall, and the fall risk assessment indicated Resident 4 had no gait and or balance problems and no decreased muscular coordination; (7) The facility further failed to accurately evaluate Resident 4's risk for falls when Resident 4's MDS ASSESSMENTS (a standardized, federally mandated clinical assessment tool that drives the creation of care plans and interventions for residents), dated 3/25/22 and 6/24/22, did not indicate Resident 4 had falls at the facility since admission; (8) The facility failed to implement fall prevention interventions for Resident 4 to address her fall risk factors of poor balance, poor gait, and muscle weakness after Resident 4's second fall on 6/5/22, and (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	(9) The facility failed to ensure Resident 4 was properly supervised and assisted during transfers and ambulation in her room on 7/15/22 when a Physical Therapy Student (PTS) assigned to escort Resident 4 to the gym did not assist, supervise, and apply a gait belt to Resident 4 during her transfer and ambulation from her bed to the hallway, which resulted in Resident 4 falling to the floor, breaking her leg and experiencing severe pain; this failure was compounded by the fact that Resident 4 had previously sustained another fall with injury, also while ambulating and in the care of physical therapy staff, two months earlier, on 5/20/22, which should have alerted the PTS of the need for increased supervision and assistance for Resident 4 during physical therapy. These failures resulted in Resident 4 sustaining two falls at the facility, on 6/5/22 and on 7/15/22, with the last fall resulting in Resident 4 breaking her left leg and experiencing sustained severe pain for up to seven days after the fall. Findings: A review of Resident 4's FACESHEET indicated she was admitted on [DATE] with diagnoses including diabetes mellitus, hypertension, memory deficit following cerebrovascular disease and chronic pain. A review of Resident 4's PROGRESS NOTES indicated physician note dated 12/23/21, at 12:58 p.m., titled SNF VISIT NOTE, indicating Resident 4 had sustained a fall, as follows: Called by RN [Registered Nurse] due to fall and pain and [Resident] was reaching and fell on to her right wrist and right shoulder. A review of Resident 4's care plans (documents instructing staff on how care for residents) indicated one nursing care plan related to falls, dated 12/23/21, titled The resident has had an actual fall . poor balance . The care plan listed the following interventions: determine and address causative factors, monitor for pain, bruises and change in mental status, and physical therapy consult. A review of Resident 4's FALL RISK EVALUATION dated 12/29/21, at 2:37 p.m., performed after Resident 4's fall on 12/23/22, indicated Resident 4 was not at a high risk for falls and had normal gait and balance. A review of Resident 4's MDS ASSESSMENT (a standardized, federally mandated clinical assessment tool that drives the creation of care plans and interventions for residents), dated 3/25/22, indicated Resident 4 needed the supervision and assistance of one person to transfer out of bed and for ambulation and locomotion. The MDS section titled FALL HISTORY had no falls documented for Resident 4. A review of Resident 4's FALL RISK EVALUATION dated 4/5/22, at 2:37 p.m., indicated Resident 4 was not at a high risk for falls and had normal gait and balance. A review of Resident 4's PROGRESS NOTES indicated nursing note dated 5/20/22, at 7:37 p.m., titled ALERT NOTE, indicating Resident 4 had a fall that day while under the care of physical therapy staff. The note indicated Resident 4 fell outside on the sidewalk into the grass. The note further indicated Resident 4 suffered an abrasion on the left upper forehead, complained of headache, left knee pain, and bilateral wrist pain. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 4's PROGRESS NOTES indicated nursing note dated 5/22/22, at 2:53 a.m., titled WEEKLY EVALUATION, indicating the following: gait is unsteady, balance is poor, and range of motion impairment (how far you can move or stretch a part of your body) on both legs. The note indicated Resident 4 had no falls since previous WEEKLY EVALUATION. A review of Resident 4' PROGRESS NOTES indicated nursing note dated 6/5/22, at 2:46 a.m., titled POST FALL EVALUATION, indicating Resident 4 had a fall in her room on 6/5/22, at 3:30 a.m., while ambulating from the toilet to the bed in her room. The note indicated: Resident states she was coming out of the restroom and was weak and fell . The note indicated the fall was unwitnessed. The note further indicated: Reason for the fall was evident: .weakness. The note further indicated the fall resulted in hip injury/discomfort and required emergency room /hospitalization . The note indicated Resident 4 had a history of falls. The note concluded Resident [4] was weak and unable to make it back to bed after coming out of restroom. A review of Resident 4's PROGRESS NOTES indicated physician note dated 6/9/22, but signed on 6/10/22, at 8:48 a.m., written by Resident 4's physician, titled FU [Follow Up] COVID and Fall, indicating: FU Fall . [Resident 4] is tearful and worried about her weakness . Has been feeling more weaker and with balance difficulty . A review of Resident 4's CARE PLANS indicated care plan created by the Occupational Therapist (OT) dated 6/16/22, titled, The resident has a decreased ability to perform self-care related to decreased ROM [range of motion], impaired activity tolerance, weakness . and contained the following interventions: Activities of Daily Living retraining, discharge planning, establish functional maintenance plan, OT treatment as indicated, pain modalities as needed, resident/family/caregiver education, and upper extremity therapeutic exercises . A review of Resident 4's FALL RISK EVALUATION, dated 6/20/22, at 1:44 p.m., indicated Resident 4 was at a HIGH RISK for falls. The evaluation, however, indicated Resident 4 had no balance problems standing or walking, had no decreased muscular coordination, had no change in gait when walking through doorways, and did not require the use of assistive devices (cane, walker, etc.) A review of Resident 4's MDS assessment dated [DATE] but completed on 6/11/22, indicated Resident 4 required STAFF SUPERVISION during transfers and locomotion and used a walker (a mobility device). The MDS section titled FALL HISTORY was blank, with no falls documented for Resident 4 in the past 6 months. Review of the Journal of the American Medical Association, Prevention of Falls in Older Adults, [NAME] 2018, a specialized literature, indicated that a recent history of falls is the single best predictor of future falls. A review of Resident 4's PROGRESS NOTES indicated nursing note dated 7/15/22, at 9:32 a.m., titled POST FALL EVALUATION, indicating Resident 4 had a fall in her room on 7/15/22 at 9:32 a.m. while ambulating with physical therapy. The note indicated the fall was witnessed. The note further indicated the fall resulted in a fracture of her left fibula (calf bone), pain and the hospitalization of the resident. The note further indicated Was a safety evaluation completed/documented prior to the fall: No and Safety teaching documented before the fall: No. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 4's PROGRESS NOTES indicated nursing note dated 7/15/22, at 11:54 p.m., titled SYSTEM NOTE, indicating: Resident was sent to [Hospital] for X-rays of Left Foot and ankle . [Hospital] called the facility approximately at 4:30 p.m. to report Resident was found to have a left Fibula fx [fracture] and she would be returning with a walking boot, a walker, and a prescription for pain medications. Resident returned to the facility at 1740 hours [5:40 p.m.] A review of Resident 4's PROGRESS NOTES indicated nursing note dated 7/16/22, at 4:04 a.m., titled ADMINISTRATION NOTE, indicating Resident 4's pain on her left leg was 9 [on a scale of 0-10, with 0 being no pain, and 10 the worst pain]. A review of Resident 4's PROGRESS NOTES indicated nursing note dated 7/16/22, at 9:59 p.m., titled ADMINISTRATION NOTE, indicating Resident 4's pain on her left leg was 9 [on a scale of 0-10]. A review of Resident 4's PROGRESS NOTES indicated nursing note dated 7/17/22, at 4:41 a.m., titled ADMINISTRATION NOTE, indicating Resident 4's pain on her left leg was 9 [on a scale of 0-10]. A review of Resident 4's PROGRESS NOTES indicated nursing note dated 7/17/22, at 6:55 p.m., titled ADMINISTRATION NOTE, indicating Resident 4's pain on her left leg was 8 [on a scale of 0-10]. A review of Resident 4's PROGRESS NOTES indicated nursing note dated 7/18/22, at 11:30 a.m., titled IDT NOTE, indicating Resident had assisted fall w/injury 7/15: was in room, walked to doorway to meet with therapy and stated that she became light-headed and felt legs weak and would not support her, was supported/guided to floor by therapy. C/o [complains of] LLE [lower left extremity] pain; transferred to [Hospital] ED for eval and tx [treatment]; confirmed fibula fragility fracture . A review of Resident 4's PROGRESS NOTES indicated nursing note dated 7/19/22, at 00:49 a.m., titled ADMINISTRATION NOTE, indicating Resident 4's pain on her left leg was 7 [on a scale of 0-10]. A review of Resident 4's PROGRESS NOTES indicated nursing note dated 7/20/22, at 2:37 a.m., titled ADMINISTRATION NOTE, indicating Resident 4's pain on her left leg was 8 [on a scale of 0-10]. A review of Resident 4's PROGRESS NOTES indicated nursing note dated 7/21/22, at 6:08 a.m., titled ADMINISTRATION NOTE, indicating Resident 4's pain on her left leg was 7 [on a scale of 0-10]. A review of Resident 4's PROGRESS NOTES indicated nursing note dated 7/22/22, at 9:48 p.m., titled ADMINISTRATION NOTE, indicating Resident 4's pain on her left leg was 9 [on a scale of 0-10]. A review of Resident 4's PROGRESS NOTES indicated nursing note dated 7/24/22, at 4:17 a.m., titled ADMINISTRATION NOTE, indicating Resident 4's pain on her left leg was 7 [on a scale of 0-10]. A review of Resident 4's PROGRESS NOTES indicated physician note dated 7/25/22, at 6:22 p.m., written by Resident 4's physician, titled PHONE NOTE, indicating Received a call from [DON] [Resident 4] is in a lot of pain. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 7/25/22, at 2:05 p.m., the DON stated Resident 4 fell on [DATE], at 9:30 a.m., and broke her left fibula (the calf bone) because of the fall. The DON described the incident as follows: in the morning of 7/15/22 Resident 4 was in her room waiting for physical therapy; a Physical Therapy Student (PTS) went to Resident 4's room and stood at the doorway; the PTS called Resident 4 and waited for her at the doorway; Resident 4 got out of bed and started walking towards the doorway, unassisted and unsupervised by staff, and without a gait bell (belt used by a caregiver on a patient with mobility issues to assist with transfers); when Resident 4 reached the door her legs gave way and she fell to the floor; the PTS assisted Resident 4 to the ground. During the same interview on 7/25/22, at 2:05 p.m., the DON reviewed Resident 4's clinical record. The DON stated Resident 4 had a history of falls, muscle weakness, unsteady gait, and poor balance. The DON stated for a resident with these risk factors appropriate fall interventions included increased staff supervision, frequent checks, and educating the resident to use the call light and requesting staff assistance prior to getting up and ambulating. The DON was asked if these interventions were part of Resident 4's care plans and were implemented. The DON reviewed Resident 4's clinical record and confirmed there were only two fall care plans created for Resident 4, the first created on 12/23/21 by nursing staff, and the other on 6/16/22 by the Occupational Therapist. The DON confirmed none of the care plans contained the fall prevention interventions of increased staff supervision, frequent checks, and educating the resident to use the call light and request staff assistance prior to getting up and ambulating. The DON confirmed the only three fall prevention evaluations completed for Resident 4, on 12/29/21, 4/5/21 and 6/20/21. During an observation on 7/26/22, 9:30 a.m., Resident 4 was lying in bed. During a concurrent interview, Resident 4 was alert and oriented, and described the 7/15/22 fall as follows: she was in bed waiting for physical therapy; the PTS came to her room but did not come in, she stood outside the doorway; physical therapy staff did not enter resident rooms because they did not want to go through the trouble of applying gowns, gloves, mask and faceshield (required of staff when entering resident rooms in the facility); from the door, the PTS indicated it was time for physical therapy; there was no staff in the room to help her get out of bed; she got out of bed and started walking unassisted towards the PTS who was waiting at the door; she had no gait belt; when she reached the doorway she felt weakness in her legs, lost her balance, and fell to the floor; the PTS did not assist her to do the floor; Resident 4 tried to grab the door frame for support but to no avail; after the fall she felt severe pain on her left leg, 12 on a 0-10 scale. During an observation on 7/26/22, at 9:55 a.m., the Physical Therapy Assistant (PTA) was outside Resident 21's room, standing in the doorway. During a concurrent interview, the PTA stated she was waiting for Resident 21 to come out to take him to physical therapy. While PTA was waiting outside resident's room, Resident 21 transferred himself unassisted to a wheelchair and was pushing himself towards the door. During an interview on 7/26/22, 10:08 a.m., the Occupational Therapist (OT) stated he was treating Resident 4 and was familiar with her health conditions and physical limitations. The OT stated he started treating Resident 4 on 6/16/22, after her 6/5/22 fall, to improve her range of motion. The OT stated Resident 4 always complained of weakness. The OT stated Resident 4 needed a gait belt (a speciazlied belt placed by a caregiver around a person with mobility issues during transfers to prevent and mitigate falls) during transfers and close staff supervision when ambulating because of her muscle weakness and poor strength. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of facility policy and procedure titled FALL MANAGEMENT PROGRAM, dated 3/13/21, indicated: As part of the Admission Assessment, the licensed nurse will complete a fall risk evaluation. If a fall risk factor is identified, document interventions on the Resident's care plan. Document interventions for every Resident regardless of fall risk evaluation score. A licensed nurse will conduct a new fall risk evaluation quarterly, annually, upon identification of significant change in condition, post fall and as needed. The Interdisciplinary Team (IDT) and/or the licensed nurse will develop a care plan according to the identified risk factors and root causes . The IDT will initiate, review and update the Resident's fall risk status and care plan at the following intervals: on admission, quarterly, annually, upon identification of a significant change of condition, post fall and as needed. The licensed nurse will evaluate the Resident's response to the interventions on the Weekly Summary and update the Resident's care plan as necessary. Following every resident fall, the licensed nurse will perform a post-fall evaluation and update, initiate or revise the Resident's care plan as necessary. The IDT will review the circumstances surrounding the fall then summarize their conclusions on an IDT note. In an effort to prevent more falls, the IDT will review and revise the care plan as necessary.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37797 Based on observation, interview and record review, the facility failed provide care and services for one of one resident (Resident 199) with an indwelling urinary catheter (Foley Catheter) (a flexible tube inserted into the bladder used to drain urine) when, during a period of 30 days, from Resident 199's admission to the facility with a Foley catheter on 6/28/22 until 7/27/22, the facility (1) did not create or implement a Foley catheter care plan for Resident 199; (2) did not monitor Resident 199 for signs and symptoms of urinary tract infections; and (3) did not provide Foley catheter care to Resident 199 every shift, as ordered. These failures placed Resident 199 at risk of developing a urinary tract infection. Resident 199 developed a urinary tract infection on 7/23/22. Findings: A review of Resident 199's Facesheet indicated he was admitted to the facility on [DATE] with a primary diagnosis of spinal cord injury and additional diagnoses including history of falling, generalized muscle weakness, bed confinement status and a Stage 3 pressure ulcer in the sacrum area (a large triangular bone in base of the spine). During an observation on 7/18/22, at 10:50 a.m., Resident 199 was lying on his back in bed and had a Foley catheter. A review of Resident 199's care plans (documents instructing staff on how to care for residents) indicated no care plan to provide Foley catheter care to Resident 199 or to monitor Resident 199 for signs and symptoms of urinary tract infection. A review of Resident 199's Physician Orders, Medication Administration Record (MAR), and Treatment Administration Record (TAR) for June and July 2022 indicated no orders and no documentation for monitoring Resident 199 for signs and symptoms of urinary tract infections. A review of these records indicated one order dated 7/9/22, ten days after Resident 199's admission, for Foley catheter care to be provided every shift. A review of the implementation of this order, on Resident 199's TAR for July 2022, indicated Resident 199 was only provided Foley catheter care every shift on one day, on 7/12/22, during the period of 7/9/22 until 7/26/22. A review of Resident 199's physician orders indicated order dated 7/23/22 for Macrobid Capsule 100 mg [miligrams] (an antibiotic - a medication to treat infections) indicating: URINARY TRACT INFECTION. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/27/22, at 8:24 a.m., the Director of Nursing (DON) stated Resident 199 was admitted to the facility on [DATE] with a Foley catheter. The DON stated Resident 199 had a Foley catheter continuously through his stay at the facility. The DON was asked what care was to be provided for residents with Foley catheters. The DON stated the two most important interventions were providing Foley care (cleaning Foley catheter with mild soap and water every shift) and monitoring the resident for signs and symptoms of urinary tract infection (assessing urine for cloudiness, color, sediment, blood and odor). The DON was asked if these interventions were implemented for Resident 199 and whether a Foley care plan had also been created for Resident 199. The DON reviewed Resident 199's record and stated that no Foley care plan had been created for Resident 199. The DON stated Foley care interventions were documented in Resident 199's Medication Administration Record (MAR) and Treatment Administration Record (TAR). A review of these records with the DON indicated only one order for daily Foley care, dated 7/9/22, and daily documentation of the implementation of this order on the TAR which indicated it was only provided every shift to Resident 199 once, on 7/12/22. The DON confirmed Resident 199 developed a urinary tract infection on 7/23/22. A review of facility policy and procedure titled CATHETER - CARE OF, dated 6/10/21, indicated: Purpose: To prevent catheter-associated urinary tract infections . Residents with Foley catheters will be cared for utilizing the most current CDC Guidelines to prevent Urinary Tract Infections (UTIs) Licensed Nurses must periodically reassess the resident's need for continued catheter use and/or any complications associated with catheter use. Nursing Staff will assess urinary drainage for signs and symptoms of infection, noting cloudiness, color, sediment, blood, odor, and amount of urine. A Licensed Nurse will notify the Attending Physician of any signs and symptoms of infection for clinical interventions. Daily catheter care: . the area will be cleaned with mild soap and water . the catheter will be cleaned thoroughly and dried and on a regular basis (at least daily) and as needed (e.g., after each bowel movement .

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39792 Based on observation, interview and record review, the facility failed to provide adequate respirator care to three (Resident 17, 26 and 7) out of four sampled residents when the facility could not determine how continuous positive airway pressure (CPAP) machines were maintained for residents who required them. These failures had the potential result in being uncomfortable to the residents due to missing additives and potential respiratory infections by tubing not being maintained or replaced appropriately. Findings: 1. During a review of Resident 17's, Admission Record, dated 6/27/14, indicated Resident 17 was admitted to the facility on [DATE] with a history of chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), high blood pressure and generalized muscle weakness. During a concurrent observation and interview on 7/18/22 at 2:57 p.m., Resident 17 was observed taking a nap in his bed with his clothes on and wearing his CPAP machine (face type mask to cover nose and tubing would connect the mask to the device which would sit on his nightstand). Resident 17 woke up, took off his face mask and stated he was taking a nap but was able to have a conversation. Resident 17 stated he could independently put his mask on and turn on the machine. During an interview on 7/20/22 at 5:18 p.m., with Director of Nursing (DON) and Resident 17 in his room, Resident 17 stated the respiratory therapist (RT) (a specialized healthcare practitioner trained in heart and lung diseases who works with people with heart and lung diseases) had changed the tubing. During an interview on 7/20/22 at 5:27 p.m., the DON was asked about the employment of the respiratory therapist (RT) and DON stated the RT was employed through a contracted company. A copy of the RT contract was requested and was not produced during the survey. DON stated the supplies such as the distilled water was stored in a supply closet with extra tubing and other CPAP supplies. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent and interview and record review on 7/20/22 at 5:29 p.m., in supply closet with the DON, the RT's, Log Book was reviewed. Resident 17's, CPAP Cleaning Log for Resident 17 indicated his CPAP machine had been cleaned on the following dates: 1/12/22, 1/24/22 2/1/22, 2/18/22, 2/25/22, 3/11/22, 3/25/22, 4/5/22, 4/15/22, 4/22/22 (Refused), 4/29/22, 5/6/22, no cleanings in June were documented and 7/1/22, 7/7/22 and 7/14/22 were documented as done but no signature was found on the form to determine who was cleaning the machine. The DON stated she was not aware of the missing signature and the form only included done in the signature line. A review of, CPAP/BIPAP Cleaning Instructions (date not included) indicated the black filter was to be removed and cleaned weekly, the white filters would be replaced when discolored or at least once per month. The humidified chambers were indicated to be cleaned daily with dish soap and water and the chambers should be changed every six months. The mask or nasal pillows were indicated to be cleaned daily with replacement schedule of every two - six months depending on the specific apparatus. Tubing was indicated to be cleaned weekly and replaced every three months if using a heated humidifier. Weekly disinfection instructions were indicated regarding soaking the tubing and humidifier chamber. The CPAP Cleaning Log for Residents with CPAP machines did not include any specifics about what parts of the humidifier, tubing or mask had been cleaned or if the resident had been given a new mask, tubing or filter. DON stated nurses were trained and able to complete the cleaning instructions but nowhere on the CPAP Cleaning was there an indication that anyone other than the RT had completed the cleaning or maintaining the CPAP machines. Don was requested to provide the schedule of when the RT would be in the building or to interview by telephone to answer questions about the system. DON stated she thought the RT would be in the building sometime that week (7/22/22 or 7/23/22) or she would provide a contact number to interview the RT. During an interview on 7/21/22 at 9:30 a.m., with Resident 17 in his room, he stated the CPAP machines was cleaned and the tubing had been changed but was unclear who performed those tasks or when the tasks were completed. Resident 17 was not sure if just the tubing was changed and what cleaning the machine entailed; Resident 17 was not sure of the whole process. During an interview on 7/22/22 at 10:59 a.m., with DON, she was asked about contacting the RT for an interview and she stated the RT was no longer employed at the building and unable to be interviewed. 2. During a review of Resident 26's, Admission Record, dated 6/23/19, indicated Resident 26 had been admitted to the facility on [DATE] with a history of chronic kidney disease, immunodeficiency (a state in which the immune system's ability to fight infectious disease and cancer is compromised or absent) and obstructive sleep apnea (intermittent air flow blockage during sleep). During an interview on 7/19/22 with Resident 26's Responsible Party (RP), she stated the RT, DON and previous administrator had informed her that the supplies for the CPAP machine were her responsibility to replace as needed. During an interview on 7/20/22 at 5:47 p.m., with Resident 26 in his room, he stated that sometimes he would run out of water and when that occurred, his nose would become dry and cause discomfort. Resident 26 stated he would observe the CPAP machine and when it did not have water in it, he would then ask the nurses at the nursing station to put water into the machine. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 7/20/22 at 5:29 p.m., in supply closet with the DON, the RT's, Log Book was reviewed. Resident 26's, CPAP Cleaning Log for Resident 26 indicated his CPAP machine had been cleaned on the following dates: 1/12/22, 1/24/22, 2/1/22, 2/11/22, 2/18/22 2/25/22, 3/11/22, 3/25/22, 4/5/22, 4/15/22, 4/22/22 (Refused), 5/6/22, no cleanings in June were documented and 7/1/22 were documented as done but no signature was found on the form to determine who was cleaning the machine. The DON stated she was not aware of the missing signature and the form only included done in the signature line. DON stated nurses were trained and able to complete the cleaning instructions but nowhere on the CPAP Cleaning was there an indication that anyone other than the RT had completed the cleaning or maintaining the CPAP machines. 3. During a review of Resident 7's, Admission Record, dated 4/9/22, indicated he was admitted to the facility on [DATE] with a history of obstructive sleep apnea and muscle weakness. During a concurrent interview and record review on 7/20/22 at 5:35 p.m. with the DON, The Log in the supply closet, Resident 7 did not have a record of the type of CPAP machine or a record of any cleaning. DON was asked about the missing documentation, and she stated the reason why there were no CPAP Cleaning Logs or a record of the type of machine for Resident 7 was because he had just received his device. The DON did not provide a date as to when Resident 7 received his machine but did state Resident 7 was non-compliant with using his device. Review of the facility's policy and procedure titled, BiPAP and CPAP, dated 9/10/20, indicated, IV. Placing the mask on the Resident .A. Wash the resident's face to remove facial oils from the skin .B. While the resident is sitting up and with the mask straps loose, place the mask on the resident. D. Test for leaks .VI. Humidifiers .A. Fill the water chamber with distilled water to the line indicated .B. Humidification relieves the Resident of dry sinuses and mouth .VIII. A. Keep the outside of the machine free of dust and debris .B. Replace the hose weekly and as needed. D. Replace the headgear

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37797 Based on interview and record review, the facility (1) failed to ensure 4 of 5 sampled residents (Residents 8, 12, 19, and 33) reviewed for physician visits had monthly, in person, physician visits during the first 90 admission or at least every 60 days thereafter; and (2) failed to ensure 21 of 52 residents (Residents 3, 6, 8, 9, 12, 13, 18, 19, 21, 22, 23, 27, 28, 29, 32, 33, 34, 39, 41, 43, and 45) (40% of the facility residents) had an assigned physician who saw them at the facility when the physician managing the care of these residents (Medical Doctor H) was based 600 miles away in southern California and did not visit the facility. These failures resulted in Residents 8, 12, 19, and 33's care not being supervised by a physician in the frequency and format required and placed Residents 3, 6, 8, 9, 12, 13, 18, 19, 21, 22, 23, 27, 28, 29, 32, 33, 34, 39, 41, 43, and 45 at risk of not having their care supervised in the frequency and format required. Findings: A review of the census sheet for 7/18/22 indicated 52 residents at the facility. The 7/18/22 census indicated the residents were under the care of six physicians: Medical Doctors (MD) H, I, J, K, L and M. The census sheet indicated 21 residents (40%) were under the care of MDH: Residents 3, 6, 8, 9, 12, 13, 18, 19, 21, 22, 23, 27, 28, 29, 32, 33, 34, 39, 41, 43, and 45; 13 residents (25%) were under the care of MDI: Residents 2, 4, 10, 14, 15, 16, 25, 37, 38, 42, 46, 47 and 48; 12 residents (23%) were under the care of MDJ: Residents 1, 5, 7, 11, 24, 30, 44, 199, 200, 201, 202 and 209; 4 residents (8%) were under the care of MDK; one resident (2%) was under the care of MDL: Resident 35 and one resident (2%) was under the care of MDM: Resident 26. During an interview with the Director of Nursing (DON) on 7/21/22, at 10:30 a.m., the DON confirmed the resident/physician assignments as indicated in the 7/18/22 census. During a concurrent record review, a sample of five residents was selected for verification of physician visits: Residents 8, 12, 19, 33 and 36. The DON was asked to provide documentary evidence these residents had regular physician visits. The DON reviewed the clinical record of these residents and confirmed only Resident 36 had been seen regularly and in person by a physician. The DON indicated the remaining four residents had the following physician visits: RESIDENT 8 was admitted on [DATE] and had not been seen by a physician since admission. The DON stated Resident 8 was transferred from another facility on 4/14/22, and had been seen by a physician at that other facility on 3/7/22 via telehealth. The DON stated there were no records of any other physician visits in Resident 8's clinical record. RESIDENT 12 was admitted to the facility on [DATE] and had been seen in person by a Psychiatric Nurse Practitioner on 6/9/22, in person by MDJ on 5/21/22, and via telehealth by MDH on 4/12/22, 2/7/22, 12/6/21, 11/2/21, 8/31/21 and 3/31/21. The DON stated there were no records of any other physician visits in Resident 12's clinical record. RESIDENT 19 was admitted to the facility on [DATE] and was seen in person by MDJ on 7/22/22, 6/18/22, 5/21/22, 5/7/22, 4/23/22, in person by a Nurse Practitioner on 4/19/22, 3/23/22, 1/25/22, via telehealth by MDH on 12/15/21 and 11/10/21, and in person on 2/21/21 by MDK. The DON stated there were no records of any other physician visits in Resident 19's clinical record. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	RESIDENT 33 was admitted to the facility on [DATE] and was seen in person by MDI on 7/17/22, 6/10/22, 5/27/22 and 2/12/22. The DON stated there were no records of any other physician visits in Resident 33's clinical record. During an interview with the Director of Nursing (DON) on 7/21/22, at 10:30 a.m., the DON stated all physician saw their residents in person except MDH. The DON stated MDH was based in Los Angeles and saw his residents remotely via telehealth. The DON stated MDH was providing primary care to residents at the facility since 2019. The DON stated MDH had never been at the facility. During a telephone interview on 7/26/22 at 9:10 a.m., MDH stated he was based in Los Angeles and saw/managed the care of his residents at the facility remotely via telehealth. A review of the federal regulations governing physician visits in Skilled Nursing Facilities, Code of Federal Regulations, Title 42, S483.30(c) and (c)(1), indicated that physicians must see their residents in person, and telehealth visits are not allowed, as follows: S483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter . DEFINITIONS S483.30(c) Must be seen, for purposes of the visits required by S483.30(c)(1), means that the physician or NPP must make actual face-to-face contact with the resident, and at the same physical location, not via a telehealth arrangement . A review of facility policy and procedure titled PHYSICIAN SERVICES AND VISITS, dated 1/1/12, indicated: The Facility must ensure that all residents admitted to or accepted for care by the Facility are under the care of a physician . The Attending Physician must: Evaluate the resident as needed and at least every 30 days . Physician visits, frequency of visits, emergency care of residents, etc., are provided in accordance with current OBRA regulations . 39792

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37797 Based on interview and record review, the facility failed to ensure it employed nursing staff with appropriate competencies and skills to care for facility residents when: (1) The facility failed to provide initial orientation, initial and annual competency/skills checks, and regular performance evaluations to six of six nursing staff sampled for verification of orientation, training and competencies: three Licensed Nurses (Licensed Nurses A, F and G) and three Certified Nursing Assistants (CNAs B, N and O); and (2) The facility failed to ensure it had an ongoing and functional staff orientation and training program when (a) the staff whose job description was to direct the facility's staff orientation, training and competencies, the Director of Staff Development (DSD), worked part-time, also worked as a nursing supervisor, and as a floor nurse, and indicated her only responsibilities were to ensure staff physical exams and tuberculosis screening were current; and (b) the residual responsibility for staff orientation, training, and competency evaluations were assigned to the Director of Nursing (DON), who in addition to being a full-time DON, was also responsible for infection prevention and control, worked as a floor nurse when staffed called in sick or did not show up, and had an outside part-time job; (c) the facility failed to have written policies establishing and outlining processes and procedures for orienting, training, evaluating, and verifying the skills and competencies of its staff. These failures placed all residents at risk of poor nursing care and not having their healthcare needs met. Findings: (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 7/26/22, 11:54 a.m., the Director of Nursing (DON) stated she and the Director of Staff Development (DSD) were responsible for the orientation, training, and skills and competency evaluation of staff. The DON stated she also had duties as infection preventionist, worked as a floor nurse when staff called off, and had an outside part-time job. The DON stated the DSD worked part time at the facility and in addition to DSD duties also worked as a nursing supervisor and floor nurse. The DON stated the nursing staff was a mixture of in-house and registry staff. The DON was asked to explain the process for orientation, training, skills and competency evaluation of staff. The DON stated they had two processes, one for registry staff and one for in-house staff. For registry staff the DON stated the facility relied on the staffing agencies to select and provide competency staff to the facility. Once the registry staff reported to work, they received an administrative orientation to the facility which included use of the time clock, breaks, and the facilities administrative policies. Following this orientation the registry staff shadowed an experienced staff, a preceptor, for one or two shifts, longer if needed, and thereafter worked independently. The DON stated the preceptor evaluated the registry staff's performance during the shadowing period and if there were deficits the DON was made aware. The DON stated the process for direct hire or in-house staff was similar but the orientation and shadow period was longer, depending on the level of experience of the staff. The DON stated there were annual competencies and skills evaluations for all staff, but these had not been done for some time. The DON was asked for the facility's policies and procedures governing the orientation, training, skills and competency evaluation. The DON provided two documents: a CNA [Certified Nursing Assistant] ORIENTATION SKILLS CHECKLIST and a LICENSED NURSE ORIENTATION SKILLS CHECK AND ANNUAL SKILLS CHECK. The DON stated there were no other policies and procedures. During an interview on 7/26/22, at 2:46 p.m., the DSD stated she was the Director of Staff Development at the facility. The DSD stated she worked about 20 hours per week at the facility but stated the DSD role was a full-time job. The DSD stated she also worked a nursing supervisor and as a floor nurse at the facility. The DSD stated her only DSD duties at the facility were ensuring staff were current with physical examinations and tuberculosis screening. The DSD stated the DON did everything else. During an interview on 7/26/22, at 3:24 p.m., the DSD and DON were asked for all the orientation, training, and skills/competencies evaluations of six sampled current nursing staff: Certified Nursing Assistants (CNAs) B, N and O and Licensed Nurses A, F and G. The following information and records were provided: For CNA B, registry staff, working at the facility since 3/3/20, there were no records of orientation to the facility and/or skills/competency or performance evaluations. For CNA N, registry staff, working at the facility since 6/19/22, there was one self-assessment skills checklist completed by CNA N where she indicated experience, no experience, or highly skilled for different skills. There were no other records of orientation and skills/competencies evaluations. For CNA O, in house staff, working at the facility since 8/29/07, there were no records of skills/competencies/performance evaluations. For Licensed Nurse A, registry staff, working at the facility since 10/14/21, there was one blank NEW EMPLOYEE ORIENTATION form. There were no other records of orientation to the facility and skills/competency or performance evaluation. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	For Licensed Nurse F, registry staff, working at the facility since 6/24/22, there was one online self-completed CLINICAL assessment dated [DATE], and one online self-completed GERIATRIC & LONG TERM CARE assessment dated [DATE]. A review of the latter indicated Licensed Nurse F stated, under the question AGE OF PATIENTS CARED FOR, for the age bracket 19 to [AGE] years: MAY NEED SOME REVIEW/OCCASIONALLY DONE (1-2 times/month). A review of the facility residents Facesheets indicated 11 of 52 (20%) residents were under this age bracket. There were no other records of orientation and skills/competencies evaluations. For Licensed Nurse G, in house staff, working at the facility since 12/2/20, there were no records of orientation to the facility and/or skills/competency or performance evaluations. A review of facility policy and procedure titled DIRECTOR OF STAFF DEVELOPMENT - JOB DESCRIPTION, undated, indicated: POSITION DESCRIPTION .the Director of Staff Development is responsible for planning, implementation, direction and evaluation of the facility's educational programs for all employees and quality assurance and improvement in the facility. GENERAL DUTIES AND RESPONSIBILITIES . ORIENTATION . coordinates theoretical and clinical orientation to all new employees . TRAINING . coordinates and conducts an effective on-going in-service plan to all employees .

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	056361	A. Building B. Wing	07/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fortuna Rehabilitation and Wellness Center, LP	2321 Newburg Road Fortuna, CA 95540

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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 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** 37797 Based on observation, interview, and record review, the facility failed to ensure its medication error rate was not greater than 5% when 12 medication errors were observed during 26 medication observations of two of six residents (Residentt 6 and 7), resulting in a medication error rate of 46%, when: (1) Resident 7 was administered 10 medications on 7/20/22 outside their prescribed scheduled times, as follows: (1) Insulin Lispro 2 units (for blood sugar control) due at 7 a.m. and given at 11:10 a.m.; (2) Metformin 1000 mg [milligrams] (for blood sugar control) due 7:30 a.m. and given at 11:10 a.m.; (3) Eliquis 5 mg (a blood thinner) due 8 a.m. and given at 11:10 a.m.; (4) Albuterol Sulfate Inhaler (for lung function) due at 8 a.m. and given at 11:10 a.m (5) Lisinopril 2.5 mg (for blood pressure) due at 9 a.m. and given at 11:10 a.m.; (6) Methadone 5 mg (for pain) due at 9 a.m. and given at 11:10 a.m.; (7) Lidocaine Patch 5% (for pain) due at 9 a.m. and given at 11:10 a.m.; (8) Diazepam 5 mg (for pain) due at 9: a.m. and given at 11:10 a.m.; (9) Carvedilol 3.125 mg (for heart failure) due at 9 a.m. and given at 11:10 a.m.;. and (10) Gabapentin 600 mg (for paraplegia) due at 9 a.m. and given at 11:10. The facility also failed to administer (11) oxygen to Resident 7 on 7/20/22, at 11:10 a.m., when Resident 7's oxygen saturation was 87% and Resident 7 had a physician for administration of suplemental oxygen if Resident 7's oxygen saturation dropped below 92%, and (2) Resident 6 was administered (12) Insulin NovoLog 70/30 (a type of insulin - a medication that lowers blood sugar), 26 units (how insulin doses are measured) subcutaneously (under the skin) on 7/20/22, at 4:30 p.m., one hour before dinner, when the insulin was supposed to be administered 15 minutes before or after dinner. Resident 6 did not eat dinner or had a snack after receiving insulin on 7/20/22 and by 9:30 p.m. felt shaky and had a blood sugar reading of 49 mg/dl [milligrams per deciliter] (normal range is between 70 and 100 mg/dl). The failure to timely administer the morning medications to Resident 7 on 7/20/22 placed Resident 7 at risk of hypertension, irregular heart rate, respiratory problems, blood clots, high blood sugar and uncontrolled pain, and the failure to administer supplemental oxygen resulted in shortness of breath. The failure to timely administer NovoLog 70/30 insulin to Resident 6 on 7/20/22 and ensure Resident 6 consumed dinner or had a snack after the insulin administration resulted in Resident 6 experiencing severe hypoglycemia. This failure placed Resident 6 at risk for fainting, coma, and death. Findings: A review of Resident 7's FACESHEET indicated he was admitted to the facility on [DATE] and had diagnoses including vertebral osteomyelitis (painful infection of the spine), Type 2 diabetes (impairment of body to control blood sugar), hypertension (high blood pressure), heart failure (impairment of heart to pump blood), obesity, muscle weakness and paraplegia (paralysis of the legs). (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 7/20/22, at 11:10 a.m., Licensed Nurse F was outside Resident 7's room and stated he was passing morning medications to his residents. Licensed Nurse F stated he had about 25 residents, which was roughly half of the facility census. Licensed Nurse F stated if he had fewer patients, he could complete his morning medication administration earlier. Licensed Nurse F stated he was going to administer morning medications to Resident 7. Licensed Nurse F administered medications to Resident 7 including: Lisinopril 2.5 mg (for blood pressure), Methadone 5 mg (for severe pain), Lidocaine patch 5% (for back pain), Diazepam 5 mg (for moderate pain), Carvedilol 3.125 mg (for heart failure), Albuterol Sulfate 90 mcg inhaler (for upper respiratory infection), Gabapentin 600 mg (for paraplegia), Metformin 1000 mg (for diabetes), Eliquis 5 mg (a type of blood thinner), and Insulin Lispro sliding scale (for diabetes) 2 units. Licensed Nurse F completed the medication administration to Resident 7 at 11:50 a.m. During the observation of Licensed Nurse F's medication administration to Resident 7, on 7/20/22, at 11:10 a.m., Licensed Nurse F stated he needed to verify Resident 7's vital signs because Resident 7 had blood pressure medications that required checking Resident 7's blood pressure and heart rate prior to administration. Licensed Nurse F applied a vital signs machine to Resident 7's arm which indicated the following values: blood pressure of 126/84, heart rate of 96, and oxygen saturation of 87%. Resident 7 was observed with labored breathing (a symptom of shortness of breath). There was an oxygen generator and nasal cannula next to Resident 7's bed. Resident 7 was not wearing the nasal cannula and was not receiving supplemental oxygen. Licensed Nurse F did not offer or apply supplemental oxygen for Resident 7 or asked if he was short of breath. A review of Resident 7's PHYSICIAN ORDERS indicated Resident 7 had an order dated 5/12/22 for supplemental oxygen via nasal cannula to maintain oxygen saturation above 92%. A review of Resident 7's PHYSICIAN ORDERS and MEDICATION ADMINISTRATION RECORD (MAR), for July 2022, indicated the morning medications administered to Resident 7 by Licensed Nurse F on 7/20/22, from 11:10 a.m. until 11:50 a.m., were scheduled for administration between 7 a.m. and 9 a.m., as follows: Insulin Lispro: to be given at 7 a.m.; Metformin: to be given at 7:30 a.m.; Eliquis: to be given at 8 a.m.; Albuterol Sulfate: to be given at 8 a.m.; Lisinopril: to be given at 9 a.m.; Methadone: to be given at 9 a.m.; Lidocaine patch: to be given at 9 a.m.; Diazepam: to be given at 9: a.m.; Carvedilol: to be given at 9 a.m.; and Gabapentin: to be given at 9 a.m. During an interview and record review on 7/22/22, at 9:15 a.m., the Director of Nursing (DON) reviewed the PHYSICIAN ORDERS and MEDICATION ADMINISTRATION RECORD (MAR) of Resident 7. The DON confirmed that Resident 7's medication orders and scheduled times indicated on the MAR were correct, and that those medications should be given at those times. The DON stated Licensed Nurse G administered the morning medications to Resident 7 on 7/22/22 at the wrong time, which was a medication error. During an interview and record review on 7/22/22, at 10 a.m., the facility's Consultant Pharmacist (CP) reviewed the PHYSICIAN ORDERS for Resident 7. The CP stated the window for medication administration was one hour before or one hour after the scheduled administration time. The CP stated the administration of medications outside this period are considered medication errors. The CP reviewed the medications administered by Licensed Nurse G to Resident 7 on 7/20/22 at 11:10 a.m. The CP stated these were medications for the control of key body functions, such blood pressure, heart rate, lung function, blood sugar, and pain and should have been administered at their scheduled time. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 6's FACESHEET indicated she was admitted to the facility on [DATE] with diagnosis including Type 2 Diabetes (impairment of the body's ability to control blood sugar levels). A review of Resident 6's PHYSICIAN ORDERS and MEDICATION ADMINISTRATION RECORD (MAR) for July 2022 indicated the following order: NovoLOG Mix 70/30 Flex Pen Suspension Pen-Injector (70-30) 100 UNIT/ML [milliliters] (Insulin Aspart Prot & Aspart) [two types of insulin combined] Inject 28 units subcutaneously [under the skin using a small needle attached to the insulin pen] in the evening for DIABETES. BEFORE DINNER DIABETES. BEFORE DINNER. IF B.G.[Blood Glucose] < 70 HOLD INSULIN, IF B.G. >450 CALL M.D. During an observation and concurrent interview on 7/20/22, at 4:15 p.m., Licensed Nurse A was outside room of Resident 6 and stated she was passing afternoon medications to her residents. Licensed Nurse A stated she had about 25 residents. Licensed Nurse A stated she would pass medications to Resident 6. Licensed Nurse A administered the medication Novolog Mix 70/30 (a type of insulin - a medication that lower blood sugars), 28 units (how insulin doses are measured), subcutaneously (under the skin using a small needle attached to the insulin pen) to Resident 6. Licensed Nurse A completed her medication administration to Resident 6 at 4:30 p.m. During an interview on 7/21/22, at 6 a.m., Licensed Nurse G stated Resident 6 reported feeling shaky the night before, on 7/20/22, at around 9:30 p.m. Licensed Nurse G stated he checked Resident 6's blood sugar and it was 49 mg/dl [milligrams per deciliter] (normal range is between 70 and 100 mg/dl). During an interview on 7/21/22, at 7:55 a.m., the Director of Nursing (DON) stated Resident 6 refused dinner the previous evening, on 7/20/22, and had a low blood sugar reading later that night, of 49 mg/dl. The DON stated the low blood sugar was because she received insulin but did not eat afterwards. A review of Resident 7's Activities of Daily Living flowsheets (where staff document resident meal consumption) for July 2022 indicated no dinner or night snack consumption on 7/20/22. During an interview on 7/21/22, at 9:04 a.m., the Dietary Services Manager stated she was at the facility all day on 7/20/22 and stated dinner was served to residents starting at 5:30 p.m. During an interview on 07/26/22, at 9:40 a.m., Resident 6 was alert and oriented and stated she recalled the day her blood sugar was low the previous week. Resident 6 stated she did not remember if she ate dinner or not that night. Resident 6 stated that at around 9 p.m. she felt dizzy and shaky. Resident 6 stated she immediately knew her blood sugar was low. Resident 6 stated she called the nurse who checked her blood sugar level, and it was low. Resident 6 stated the nurse gave her juice and snacks and she recovered. During an interview and record review on 7/22/22, at 9:15 a.m., the Director of Nursing (DON) reviewed the PHYSICIAN ORDERS and MEDICATION ADMINISTRATION RECORD (MAR) of Resident 6. The DON confirmed Resident 6's order NovoLOG Mix 70/30 Flex Pen, 28 units subcutaneously before dinner, should be given within 15 minutes of dinner and staff should ensure Resident 6 eats food afterwards. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/22/22, at 10 a.m., the facility's Consultant Pharmacist (CP) stated Novolog Mix 70/30 is a mixture of short and long-acting insulin and has an onset of 15 minutes (meaning the medication starts producing its intended effects - lowering blood sugar - within 15 minutes of administration) and a peak period (where the medication effects are strongest) of 3-4 hours. The CP stated this medication should be given within 15 minutes of the resident eating, with the meal, or immediately after. The CP stated a meal should follow the administration of this medication, and that staff should ensure that a resident consumes food following the administration; otherwise, the resident will become hypoglycemic (with a low blood sugar). The CP stated a blood sugar of 49 mg/dl is considered low and places the resident at risk of fainting and becoming unresponsive. A review of the NovoLOG Mix 70/30 manufacturer's safety information indicated its onset is between 10 and 20 minutes, the peak activity is between 1.7 and 3.6 hours, and duration of action as long as 24 hours. The safety information further indicated: Administer [the medication] within 15 minutes before meal initiation . and Hypoglycemia is the most common adverse effect of . NovoLog(R) Mix 70/30 . Severe hypoglycemia can cause seizures, may lead to unconsciousness, may be life threatening or cause death. (https://www.novomedlink.com/diabetes/products/treatments/novologmix70-30.html). A review of the Centers for Disease Control and Prevention (CDC) guidelines indicated hypoglycemia occurs when the blood sugar drops below 70 mg/dl. Severe hypoglycemia occurs when the blood sugar drops below 54 mg/dl. (CDC, Low Blood Sugar, 2022, https://www.cdc.gov/diabetes/basics/low-blood-sugar.html). During an interview on 7/22/22, at 9:15 a.m., the DON stated the facility did not have a policy and procedure on insulin administration. A review of facility policy and procedure titled MEDICATION ADMINISTRATION, dated January 1, 2012, indicated: Medications and treatments will be administered as prescribed . Medications may be administered one hour before or one hour after the scheduled medication administration time.

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **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 six residents (Resident 6) was free of significant medications errors when Resident 6 was administered 28 units (how insulin doses are measured) of Novolog Insulin 70/30 (a medication that lowers blood sugar and starts working within 15 minutes of administration) subcutaneously (under the skin) on 7/20/22 one hour before Resident 6 was served dinner and without ensuring Resident 6 ate dinner or had a snack after the insulin administration. As result, Resident 6, who did not eat dinner or had a snack after receiving insulin and on 7/20/22, felt shaky and had a blood sugar reading of 49 mg/dl [milligrams per deciliter] (normal range is between 70 and 100 mg/dl) at 9:30 p.m This failure placed Resident 6 at risk of fainting or becoming unresponsive due to hypoglycemia (low blood sugar). Findings: A review of Resident 6's Facesheet indicated she was admitted to the facility on [DATE] with diagnosis including Type 2 Diabetes (impairment of the body's ability to control blood sugar levels). A review of Resident 6's Physician Orders and Medication Administration Record (MAR) for July 2022 indicated the following order: NovoLOG Mix 70/30 Flex Pen Suspension Pen-Injector (70-30) 100 UNIT/ML [milliliters] (Insulin Aspart Prot & Aspart) [two types of insulin combined] Inject 28 units subcutaneously [under the skin using a small needle attached to the insulin pen] in the evening for DIABETES. BEFORE DINNER. IF B.G.[Blood Glucose] < 70 HOLD INSULIN, IF B.G. >450 CALL M.D. During an observation on 7/20/22, at 4:30 p.m., Licensed Nurse A administered 28 units of Novolog Mix 70/30 to Resident 6 subcutaneously. During an interview on 7/21/22, at 6 a.m., Licensed Nurse G stated Resident 6 reported feeling shaky the night before, on 7/20/22, at around 9:30 p.m. Licensed Nurse G stated he checked Resident 6's blood sugar and it was 49 mg/dl [milligrams per deciliter] (normal range between 70 and 100 mg/dl). During an interview on 7/21/22, at 7:55 a.m., the Director of Nursing (DON) stated Resident 6 refused dinner the previous evening, on 7/20/22, and had a low blood sugar reading later that night, of 49 mg/dl. The DON stated the low blood sugar was because she received insulin but did not eat afterwards. A review of Resident 7's Activities of Daily Living flowsheets (where staff document resident meal consumption) for July 2022 indicated no dinner or night snack consumption on 7/20/22. During an interview on 7/21/22, at 9:04 a.m., the Dietary Services Manager stated she was at the facility all day on 7/20/22 and stated dinner was served to residents starting at 5:30 p.m. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	During an interview on 07/26/22, at 9:40 a.m., Resident 6 was alert and oriented and stated she recalled the day her blood sugar was low the previous week. Resident 6 stated she did not remember if she ate dinner or not that night. Resident 6 stated that at around 9 p.m. she felt dizzy and shaky. Resident 6 stated she immediately knew her blood sugar was low. Resident 6 stated she called the nurse who checked her blood sugar level, and it was low. Resident 6 stated the nurse gave her juice and snacks and she recovered. During an interview and record review on 7/22/22, at 9:15 a.m., the Director of Nursing (DON) reviewed the PHYSICIAN ORDERS and MEDICATION ADMINISTRATION RECORD (MAR) of Resident 6. The DON confirmed Resident 6's order NovoLOG Mix 70/30 Flex Pen, 28 units subcutaneously before dinner, should be given within 15 minutes of dinner and staff should ensure Resident 6 eats food afterwards. During an interview on 7/22/22, at 10 a.m., the facility's Consultant Pharmacist (CP) stated Novolog Mix 70/30 is a mixture of short and long-acting insulin and has an onset of 15 minutes (meaning the medication starts producing its intended effects - lowering blood sugar - within 15 minutes of administration) and a peak period (where the medication effects are strongest) of 3-4 hours. The CP stated this medication should be given within 15 minutes of the resident eating, with the meal, or immediately after. The CP stated a meal should follow the administration of this medication, and that staff should ensure that a resident consumes food following the administration; otherwise, the resident will become hypoglycemic (with a low blood sugar). The CP stated a blood sugar of 49 mg/dl is considered low and places the resident at risk of fainting and becoming unresponsive. A review of the Novolog Mix 70/30 manufacturer's safety information indicated its onset is between 10 and 20 minutes, the peak activity is between 1.7 and 3.6 hours, and duration of action as long as 24 hours. The safety information further indicated: Administer [the medication] within 15 minutes before meal initiation . and Hypoglycemia is the most common adverse effect of . NovoLog(R) Mix 70/30 . Severe hypoglycemia can cause seizures, may lead to unconsciousness, may be life threatening or cause death. (https://www.novomedlink.com/diabetes/products/treatments/novologmix70-30.html). According to the Centers for Disease Control and Prevention (CDC), hypoglycemia occurs when the blood sugar drops below 70 mg/dl. Severe hypoglycemia occurs when the blood sugar drops below 54 mg/dl. (CDC, Low Blood Sugar, 2022, https://www.cdc.gov/diabetes/basics/low-blood-sugar.html). During an interview on 7/22/22, at 9:15 a.m., the DON stated the facility did not have a policy and procedure on insulin administration.

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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. 37797 Based on observation, interview, and record review the facility failed to implement an effective infection control program when staff were not wearing masks inside the facility, staff touched their mask after touching a mask contaminated with SARS-CoV-2 (the virus that causes COVID-19), and housekeeping staff entered rooms of residents on contact and droplet precautions without performing hand hygiene between rooms, without wearing the personal protective equipment (PPE) required, and using one rag to clean multiple rooms. This failure potentially caused spread of COVID-19 in a vulnerable population in a facility experiencing an outbreak of COVID-19. Findings: During an observation and concurrent interview on 5/26/22 at 9:50 a.m., a tour of the facility was conducted with Nurse Consultant B. The facility had a Yellow Zone for residents who had been exposed to COVID-19 and a Red Zone for residents who had tested positive for COVID-19. At the entrance to the Red Zone, Licensed Nurse C stated she had 15 residents assigned to her, and the other nurse in the Red Zone also had 15 residents. During an interview on 5/26/22 at 10:17 a.m., County Health Director stated the facility currently had 30 residents positive for COVID-19 out of a total of 54 residents. He also stated two residents had been hospitalized . During a record review and concurrent interview on 5/26/22 at 12 p.m., the line list for the COVID outbreak dated 5/25/22 revealed a total of 11 staff and 37 residents had been infected. The facility COVID mitigation plan stated the facility had a full-time Infection Preventionist (IP). When asked where she was, Nurse Consultant B stated the IP was part-time and did not comment further. During an interview on 5/26/22 at 1:48 p.m., DON stated response testing had just been completed and three more residents had tested positive for COVID. During an interview on 5/26/22 at 3:45 p.m., Administrator stated the facility's IP worked 2.25 hours per week and just does Wednesday reporting and data entry. During an interview on 5/27/22 at 9:30 a.m., when asked who was monitoring infection control practices in the resident care areas, County Health Director stated, Well, they don't have an IP. IPs are few and far between, hard to come by. (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 observation and concurrent interview on 5/27/22 at 10:29 a.m., Environmental Services Staff (EVS) D, wearing an N95 mask, rolled his cart down to the end of the hall in the Yellow Zone and stopped at a resident room. All the doors in the hall had signs indicating contact and droplet precautions with additional signage indicating what PPE to wear (gown, gloves, faceshield, and N95 mask) and how to don and doff it. Several sets of drawers containing PPE lined the hallway. EVS D entered the resident room without donning any PPE and began to wipe surfaces, including the resident's bedside table, with a white rag. EVS D went into the bathroom, then came to the cart and got a mop. EVS D mopped the floor, returned the mop to the cart, then entered the resident room across the hall without performing hand hygiene or donning PPE. EVS D performed the same procedure, then rolled his cart to the next room and prepared to enter. When asked what disinfectant he was using, EVS D stated he just used the rags, they were wet with disinfectant, and he pointed at the rags sitting on top of his cart. There were two blue rags and the white rag he just used was wadded up on top of them. EVS D stated he did not know where all the rags went, so he just had these three. When asked if he used three rags to clean all the rooms in the hallway, EVS D stated he just used one rag on all the rooms. EVS D stated, Usually I have a whole stack, but I don't know where all the rags went. When asked how he kept the rags wet, EVS D stated he got them out of a bucket in the laundry room and they stayed wet. EVS D's cart had no bucket on it or inside it. When asked about wearing PPE in the resident rooms, EVS D stated he was not told to use PPE in the rooms, No one has said anything to me about it. When asked about hand hygiene between rooms, EVS D stated, Oh, I guess I should use some and reached for the hand sanitizer dispenser next to him. During an observation and concurrent interview on 5/27/22 at 10:49 a.m., Dietary Staff E had her mask under her chin exposing her nose and mouth and was talking to a dietary staff who had his mask pulled down exposing his nose. When queried, Dietary Staff E stated the dietary staff was new and she needed to explain something to him, so she pulled her mask down so he could hear. During an observation and concurrent interview on 5/27/22 at 10:53 a.m., Laundry Staff G had no mask on and was talking to EVS H. EVS H stated they had rags on backorder. EVS H stated the laundry staff washed and stacked the rags and then put them on a shelf. EVS H pointed at the shelf for the clean rags, which was empty. During an observation and concurrent interview on 5/27/22 at 11 a.m., DON was informed that EVS D was cleaning multiple rooms with one rag, his lack of PPE and hand hygiene, and the shortage of rags. DON stated she would go talk to him. Five minutes later, DON was observed in the business office manager's (BOM) office with the door closed. EVS D was in the same hallway, donning a gown and preparing to enter another resident room. DON was informed, and she asked EVS D to hold on until she gets him some clean rags. BOM brought EVS D some wash cloths, and DON put on a glove and put the two blue rags in the dirty linen. BOM and DON left the hallway. The dirty white rag was still on the cart. When queried, EVS D stated, I guess that should go in the laundry and he picked up the rag with his bare hand, and put it in the dirty linen. EVS D came back to his cart and prepared to enter a resident room. EVS D did not perform hand hygiene. When queried, EVS D stated he already used hand sanitizer, but it can't hurt and used the hand sanitizer outside the resident room door. EVS D entered the resident room without gloves or a faceshield and cleaned the room. EVS D exited the room with the gown on, and without performing hand hygiene, he wheeled his cart around the corner toward the kitchen. EVS D stopped in the hallway outside the therapy room, pulled the gown off and stuffed it in the trash, and continued down the hall without performing hand hygiene. (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 5/27/22 at 1:49 p.m., BOM stated she was assisting the IP with COVID testing last weekend when she saw the IP reminding EVS D that he needed to wear a gown when entering resident rooms. BOM stated, She told him he has to wear a gown, please wear a gown, I've told you this before. BOM stated she then saw him a few minutes later go in and out of a resident room without wearing PPE. During an observation on 5/27/22 at 2:15 p.m., DON adjusted twice the N95 mask of a Red Zone resident without performing hand hygiene before or after, and then reached up and adjusted her own mask. During an interview on 5/27/22 at 2:50 p.m., DON verified she did touch the resident's mask and then touched her own mask. DON stated she should not touch her mask without performing hand hygiene first. During an interivew on 6/2/22 at 2:08 p.m., when asked how often he observed EVS staff clean a room from start to finish for proper procedure, EVS Director stated they used to do it quarterly, but had not done an observation for a year or two due to being overwhelmed. EVS Director stated they had an IP to help with infection control protocols until recently, now it's me. When asked about the rag shortage, EVS Director stated they had run low on disinfectant wipes, so the staff started using the rags and then throwing them away as if they were disposable. When asked if he knew EVS staff were using one rag to clean all rooms, EVS Director stated he had one staff who needed to retire. EVS Director stated that as soon as he heard about it, he had pulled him off the floor. EVS Director stated he expected staff to wear an N95 at all times when the facility was on lockdown with COVID. Review of facility procedure titled Cleaning Residents' Rooms, dated 1/9/08, indicated housekeeping staff should empty trash, damp wipe surfaces in the resident's room, straighten furniture, clean the bathroom, and then sweep and mop. The procedure does not indicate what staff should do with the cleaning rag after cleaning the bathroom and before cleaning the next room. Review of facility document titled COVID-19 Mitigation Plan, last revised 4/27/22, indicated, Staff should always wear a surgical/procedure mask (an N95 respirator is required in the yellow or red areas) for universal source control while they are in the facility. Yellow Area: Contact and Droplet Precautions . Wear goggles or a face shield for the duration of the shift when providing care to a resident or within six feet of a resident. Gowns should be worn and changed between resident encounters. Gloves are worn and changed between every resident encounter with adherence to hand hygiene. Review of facility policy and procedure titled, Hand Hygiene, last revised 9/2020, indicated, Facility staff . must perform hand hygiene to prevent the transmission of HAIs (healthcare acquired infections). Review of the Centers for Disease Control and Prevention guidance Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings -Recommendations of the HICPAC (Healthcare Infection Control Practices Advisory Committee) (not dated), subheading Hand Hygiene revealed, Use an alcohol-based hand rub or wash with soap and water for the following clinical indications: . a. Immediately before touching a patient. d. After touching a patient or the patient's immediate environment.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. 39792 Based on observation, interview and record review the facility failed to follow their policy on antibiotic stewardship by not replacing the Infection Preventionist. This failure resulted in residents not being tracked and monitored regarding their antibiotic usage and efficacy creating potential inappropriate use of antibiotics and potential resistance to antibiotics. During a telephone interview on 7/26/22 at 12:35 p.m., with Infection Preventionist (IP), she stated as of 4/28/22, she was part-time, working one hour a day to assist in reporting data for the facility. IP was asked who was in charge in antibiotic stewardship and she stated she was until 4/28/22 but did not know who had taken over the role. During an interview on 7/26/22 at 1:10 p.m. with Director of Nursing (DON), she stated there was corporate person who was assisting the facility with infection prevention and control, but that employee was on vacation and unable to be interviewed. DON stated another corporate person who was also assisting the facility in infection prevention and control would be able to answer questions. During a concurrent interview and record review on 7/27/22 at 11: 45 a.m. with DON, Antibiotic Stewardship binder dated January 2022 to December 2022 was reviewed. The binder was organized by month with all of the data for the corresponding month located within the tab labeled by the month. The months of January through April were reviewed and found to have resident names listed, the antibiotic which was prescribed and the corresponding data to correspond with the rationale for the antibiotic which was chosen. The month of May 2022 was reviewed and the pages located within the binder had not been filled out. DON was asked about Resident 44 since during a review of Resident 44's medical record dated 5/10/22 indicated he had been diagnosed with a urinary tract infection and had been prescribed an antibiotic. DON stated she could find the information in the chart and proceeded to leave the room to bring the hard copy chart to discuss. At 12:03 p.m. DON returned with the chart and started to research the corresponding laboratory data to confirm the appropriate use of the antibiotic prescribed to Resident 44. DON was unable to locate the laboratory results. DON was asked about Resident 49 and during a review of the medical record, dated 5/13/22, Resident 49 had been diagnosed with a urinary tract infection and been prescribed an antibiotic. DON stated she would have to review the chart to find out that information since it was not located in the antibiotic stewardship binder. Resident 49 was no longer a resident of the building. DON was asked about a list of residents who had been prescribed antibiotics for the months of May and June and could not answer why there was not a list of residents. DON stated she understood that since Resident 49 was no longer at the facility, there was no way to capture that infection if there was not a system to tract infections and the appropriateness of the antibiotic. DON stated she was trying to do this position but had been away from the facility and did not have the time with all of her other responsibilities to complete the antibiotic stewardship binder or capture the information elsewhere. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure titled, Antibiotic Stewardship, dated, 7/25/19, indicated, C. Identifying an Infection Preventionsist (IP) to oversee the ASP (Antibiotic Stewardship Program) ensuring the policies regarding stewardship and monitored and enforced. V. Tracking A. The IP will be responsible for surveillance and MDRO (Multi-Drug Resistant Organism) tracking B. The Ip will track whether or not the resident met McGeer's Criteria when the antibiotic was ordered. D. The IP will track if cultures were ordered. E. The IP will track changes in antibiotic orders during therapy. F. The IP will track outcome of therapy. C. The IP will maintain list of all residents with MDRO's and active infection for room placement options, monitoring of infection control practices and surveillance. D. The IP will provide results of tracking antibiotic use, outcomes and adverse effects to the clinical staff.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 37797 Based on observation, interview, and record review, the facility failed to employ an infection preventionist (IP) who worked at least part-time. This failure resulted in minimal oversight of the infection prevention and control program during an outbreak of COVID-19 in the facility. Findings: During an observation and interview on 5/26/22 at 9:35 a.m., the facility front door was propped open and no one was at the screening table (table set up to document persons entering the building, check temperature for fever, and screen for signs or symptoms of COVID or potential COVID exposure). Nurse Consultant B came to the screening table and stated she had just arrived. Nurse Consultant B stated she was texting the administrator and the director of nursing to inform them of this surveyor's arrival. Nurse Consultant B confirmed Administrator and Director of Nursing (DON) were not at the facility. Nurse Consultant B stated she did not work at the facility, she worked for a shell company. During an observation and concurrent interview on 5/26/22 at 9:50 a.m., a tour of the facility was conducted with Nurse Consultant B and County Health Director. The facility had a Yellow Zone for residents who had been exposed to COVID-19 and a Red Zone for residents who had tested positive for COVID-19. At the entrance to the Red Zone, Licensed Nurse C stated she had 15 residents assigned to her, and the other nurse in the Red Zone also had 15 residents. Nurse Consultant B stated she and County Health Director had just completed a line list yesterday (5/25/22, nine days after the first resident tested positive) and she would email it. During an observation on 5/26/22 at 10:10 a.m., Nurse Consultant B called the corporate IP on speaker phone. The corporate IP stated he had already left the county and would not be coming to the facility. During an interview on 5/26/22 at 10:17 a.m., Administrator arrived to the facility. County Health Director stated the facility currently had 30 residents positive for COVID-19 out of a total of 54 residents. He also stated two residents had been hospitalized . During a record review and concurrent interview on 5/26/22 at 12 p.m., the line list for the COVID outbreak dated 5/25/22 revealed a total of 11 staff and 37 residents had been infected. The first staff member tested positive on 5/10/22, and the first resident tested positive 5/16/22. The facility COVID mitigation plan stated the facility had a full-time Infection Preventionist (IP), IP Nurse. When asked where she was, Nurse Consultant B stated IP Nurse was part-time and did not comment further. During an interview on 5/26/22 at 1:48 p.m., DON stated response testing had just been completed and three more residents had tested positive for COVID. (continued on next page)

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/26/22 at 3:45 p.m., with Administrator, DON, and Nurse Consultant B, Administrator stated the facility's IP took another position elsewhere, now worked 2.25 hours per week and just does Wednesday reporting and data entry. Administrator stated IP Nurse was available by phone and worked all last weekend. Nurse Consultant B stated the corporate IP and another corporate nurse were here Monday, Tuesday, and Wednesday (5/23/22, 5/24/22, 5/25/22) but they just left to go back. Nurse Consultant B stated she was here indefinitely, but just as a consultant. Nurse Consultant B stated DON was the point-person tracking the outbreak and she was her back-up. Nurse Consultant B stated the medical director had come to the facility, but he was based out of town [118 miles away] and had not been feeling very well. During an observation and concurrent interview on 5/27/22 at 9:20 a.m., DON screened this surveyor at the facility front door and stated she needed to go test someone. Nurse Consutant B was just arriving to the facility. During an interview on 5/27/22 at 9:30 a.m., when asked who was monitoring infection control practices in the resident care areas to prevent further spread, County Health Director stated, Well, they don't have an IP. IPs are few and far between, hard to come by and he stated they did not have an IP in the pipeline that he knew of. During an observation on 5/27/22 at 10:02 a.m., a list titled Administrative Staff, not dated, was posted in the hallway on a bulletin board. The positions IP and DSD (director of staff development) were left blank. During an observation and concurrent interview on 5/27/22 at 11:42 a.m., DON was coordinating the resident testing with the county public health staff, Adminstrator's office was empty, and Nurse Consultant B was on the phone in an office. Nurse Consultant B stated Administrator was not here at the facility, she was on the phone with the county public health department, and then she continued the phone call on speaker phone. The county staff stated she wanted to ask Nurse Consultant B about IP Nurse. The county staff stated she had heard IP Nurse was no longer an employee of the facility, but then on the last call she was told IP Nurse was part time. Nurse Consultant B stated IP Nurse was point-two-five (0.25) and only works a couple hours in the morning, so she will not be able to participate in these calls. During an observation and concurrent interview on 5/27/22 at 1:15 p.m., a county public health staff person informed DON of the names of the residents who had just tested positive for COVID, and DON wrote down the names. When queried, DON stated IP Nurse had given her notice on 4/18/22 that she would no longer be full-time as of 4/27/22. DON stated IP Nurse came in very early in the morning to do reports. During a record review on 5/27/22 at 3 p.m., a print out was provided of the open Infection Control Coordinator position, not dated, posted on the facility website. During a record review and concurrent interview on 6/23/22 at 8:47 a.m., DON stated the Red Zone opened on 5/16/22. Facility documents titled Nursing Sign-in Sheet dated 5/12/22 to 5/27/22 revealed, and DON confirmed, she had worked the following shifts on the floor caring for residents at bedside: 5/14/22 7 a.m. to 3 p.m. (continued on next page)

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5/19/22 11 a.m. to 5 a.m. (18 hours) 5/21/22 7 p.m. to 7 a.m. 5/23/22 7 p.m. to 7 a.m. 5/24/22 7 p.m. to 7 a.m. DON stated, I have a med[ication] cart and I'm on the floor when she had a resident assignment. Review of IP Nurse's time sheets revealed she was clocked-in to work the following hours: 5/20/22 8 a.m. to 10 a.m., and then 10:51 p.m. to 4:32 p.m. (17.25 hours) 5/22/22 8 a.m. to 9:30 a.m. 5/23/22 8 a.m. to 9:30 a.m. 5/24/22 8 a.m. to 9:30 a.m. 5/25/22 5 a.m. to 8 a.m. Review of Nursing Sign-In Sheets dated 5/12/22 to 5/27/22 revealed IP Nurse worked the NOC shift (11 p.m. to 7 a.m.) on 5/20/22 as the Station 1 nurse assigned to care for residents. Review of the 5/25/22 line list for the COVID outbreak revealed Resident 2 had tested positive for COVID on 5/20/22. Resident 2's medical record revealed an antiviral for COVID was ordered on 5/20/22 to be given twice daily for seven days. Resident 2's medication administration record (MAR) revealed she received no doses on 5/20/22, no doses on 5/21/22, one dose on 5/22/22, and then two doses on 5/23/22. Resident 2 was given the antiviral medication twice daily as ordered on four out of the the seven days. During an interview on 6/23/22 at 1 p.m., DON stated the reason Resident 2 missed doses of her antiviral medication was that it was hectic, residents were turning positive in droves, there was a lot of activity, it probably had to do with that. Review of facility document COVID-19 Mitigation Plan, last revised 4/27/22, indicated, The facility has a full-time Infection Preventionist(s) which may be achieved by more than one staff member (but no more than two) sharing the role . If more than one Infection Preventionist is fullfilling the position, one will be the lead and the lead will monitor and improve infection control practices based on public health advisories (local, state, and federal). The Infection Preventionist(s) shall be focused on activities dedicated to infection control . 39792

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 37797 Based on interview and record review, the facility failed to provide training on abuse prevention and reporting to its nursing staff (licensed nurses and certified nursing assistants) when (1) only one quarter of its nursing staff (12 of 47 staff) received annual training on abuse prevention and reporting and when (2) six of six nursing staff (Licensed Nurse A and Certified Nursing Assistants H, P, W, Y and Z) could not correctly answer basic questions about abuse prevention and reporting. These failures placed the facility residents at risk of abuse. Findings: During an interview on 07/21/22, at 2:36 p.m. the Director of Payroll (DP) provided a list of all the nursing staff - licensed nurses and certified nursing assistants - employed by the facility including registry, full-time and part-time. A review of this list indicated 15 Licensed Nurses and 32 Certified Nursing Assistant (CNAs). During an interview on 7/26/22, at 2:46 p.m., the Director of Nursing (DON) and the Director of Staff Development (DSD) stated they were responsible for abuse prevention and reporting training. The DON and DSD were asked for documentation of staff training on abuse prevention and reporting in the past 12 months. The DON and the DSD stated there had been only one abuse in-service (training) in the past year, on 4/27/22. The DON and DSD stated there were no other records of staff training on abuse prevention and reporting. A review of the 4/27/22 abuse training attendance sheet, titled IN-SERVICE EDUCATION - ATTENDANCE and Title of Program: ABUSE indicated 12 nursing staff attended the training: six licensed nurses (Licensed Nurses S, T, U, V, X and the DSD) and six CNAs (CNAs C, P, Q, R, B and O.) During an interview on 7/26/22, at 4:30 p.m., CNA Y was asked if the facility had provided her training on abuse prevention and reporting and answered, a few days ago. CNA Y was asked what abuse was and stated, emotional, physical and financial. She was asked if she knew what a MANDATED REPORTER was and stated, Something you have to do. She was asked what she would do if she witnessed abuse and she stated she would report it to the charge nurse. During an interview on 7/26/22, at 4:35 p.m., CNA W was asked if the facility had provided her training on abuse prevention and reporting and answered, recently. She was asked what abuse was and she stated, physical, verbal and financial. She was asked if she knew what a MANDATED REPORTER was and stated she did not know. She was asked what she would do if she witnessed abuse and stated she would report it to the nurse and call the state. During an interview on 7/26/22, at 4:40 p.m., CNA Z was asked if the facility had provided her training on abuse prevention and reporting and answered, I don't know. She was asked what abuse was and stated, physical, mental, financial, emotional, and verbal. She was asked if she knew what a MANDATED REPORTER was and stated, What is it? She was asked what she would do if she witnessed abuse and stated she would report it to the registered nurse. (continued on next page)

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/26/22, at 4:45 p.m., Licensed Nurse A was asked if the facility had provided her training on abuse prevention and reporting and answered, Yes. She was asked when, and she answered, I don't know. She was asked what abuse was and she stated, any type of mistreatment of residents . verbal physical. She was asked if she knew what a MANDATED REPORTER was and provided the correct definition. She was asked what she would do if she witnessed abuse and stated she would stop it and report it to the Administrator. During an interview on 7/26/22, at 4:50 p.m., CNA H was asked if the facility had provided him training on abuse prevention and reporting and answered, Yes. He was asked when and answered, Last week. He was asked what abuse was and stated, I don't know . corporal .financial. He was asked if he knew what a MANDATED REPORTER and stated, I don't know. He was asked what he would do if he witnessed abuse and stated he would report it to the nurse and the Administrator. During an interview on 7/26/22, at 4:55 p.m., CNA P was asked if the facility had provided her training on abuse prevention and reporting and answered, The other day I looked through some lessons plans. She was asked what abuse was and stated, Any type .verbal, physical, neglect. She was asked if she knew what a MANDATED REPORTER was and provided the correct definition; she was asked what she would do if she witnessed abuse and stated she would report it to the charge nurse and the Director of Nursing. A review of facility policy and procedure titled ABUSE PREVENTION AND PROHIBITION PROGRAM, dated 1/30/20, indicated: TRAINING . All employees . will be trained through orientation and on-going training sessions, no less than annually, on the following topics . who is a covered individual responsible for reporting .abuse prevention . identification and recognition of signs and symptoms of abuse/neglect .protection of residents during an abuse investigation . investigation . reporting and documentation of abuse .