STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065121	A. Building B. Wing	09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pavilion at Villa Pueblo, The	855 Hunter Dr Pueblo, CO 81001

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38503 Based on record review and interviews the facility failed to fully ensure residents had the right to formulate advance directives, by not keeping advance directives updated and current for three (#54, #61 and #70) of five residents out of 44 sampled residents. Specifically, the facility failed to ensure advance directive forms included updated and accurate information. The facility policy was to use the Colorado medical orders for scope and treatment (MOST) form however, did not abide by its standards of practice. Resident #70 MOST form did not match their physician order, Resident #54 did not have a physician order for code status and Resident #61's MOST form had not been signed by the physician for 29 days. Findings include: I. Facility policy and procedure The Do Not Resuscitate Order policy, revised [DATE], was provided by the nursing home administrator (NHA) on [DATE] at 3:11 p.m. It documented in pertinent part, A Do Not Resuscitate (DNR) order must be obtained and entered in the electronic medical record. In addition to the advanced directive and DNR order, state-specific forms may be used to specify whether to administer CPR (cardiopulmonary resuscitation) in case of a medical emergency. State-specific forms include: -Physician Orders for Life-Sustaining Treatment (POLST); -Physician Orders for Scope of Treatment (POST); -Medical Orders for Life-Sustaining Treatment (MOLST); -Medical Orders for Scope of Treatment (MOST); -Clinicians Orders for Life-Sustaining Treatment (COLST); and, -Transportable Physician Orders for Patient Preferences ([NAME]). (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Should the resident be transferred to the hospital, a photocopy of either the order or MOST form must be provided to the personnel transporting the resident to the hospital. The Attending Physician must be informed of the resident's request to cease the DNR order. II. Resident #70 A. Resident status Resident #70, age 91, was admitted on [DATE] and readmitted [DATE]. According to the [DATE] computerized physician orders (CPO), diagnoses included malignant neoplasm (cancer) of the left lung, atrial fibrillation, and diabetes mellitus. The [DATE] minimum date set (MDS) assessment revealed Resident #70 was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. He required extensive one-person assistance with most activities of daily living (ADLs). He was occasionally incontinent of bowel and bladder. B. Record review The resuscitation care plan, initiated [DATE] revealed Resident #70 wished to be a Full Code with the primary goal was to prolong life by all medically effective means. Review of Resident #70's MOST form revealed Resident #70's wished to be Full Code, dated [DATE]. Review of Resident #70's CPO revealed a do not resuscitate order (DNR), dated [DATE]. Review of a binder at the nurse's station with MOST forms revealed no further MOST form for Resident #70. C. Interviews Registered nurse (RN) #2 was interviewed on [DATE] at 3:39 p.m. He said staff followed the physician order for advanced directives because it could take the physician up to 14 days to sign the MOST form. He said the physician order in the electronic record should match the MOST form. He acknowledged the order in the resident's electronic record did not match the MOST form. He said the resident recently readmitted from the hospital and it was possible the admitting nurse entered the order incorrectly since there was not an updated MOST form in the binder at the nurse's station. He said he would review advance directives with the resident to ensure they were following his wishes. The director of nursing (DON) and social services director (SSD) were interviewed on [DATE] 4:19 p.m. They said staff were supposed to follow the MOST form order and wishes. They acknowledged concerns of the MOST form not matching the physician orders and how it was confusing and how an error could have occurred. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nursing home director (NHA) was interviewed on [DATE] at 5:15 p.m. She said Resident #70 had a new MOST form completed upon return from the hospital. She said she had the resident's MOST form (which was updated on [DATE] to reflect DNR status) in her office for the physician to sign that week. She acknowledged the facility's process for ensuring the MOST was available in case of an emergency and for transfer to the hospital would not have been available for staff since it was kept in her office and not in the binder at the nurse's station. 43950 III. Resident #54 A. Resident status Resident #54, age 74, was admitted on [DATE]. According to the [DATE] computerized physician orders (CPO), the diagnoses included hemiplegia and hemiparesis (muscle weakness or partial paralysis on one side of the body) following cerebrovascular disease affecting the right dominant side, and aphasia (loss of ability to express speech). The [DATE] minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of zero out of 15. She required extensive assistance with one person for bed mobility, transfers, locomotion on/off the unit, dressing, toilet use and personal hygiene. The resident was totally dependent with bathing with one person physical assistance. Eating with supervision and one person physical assistance. B. Record review The comprehensive care plan revealed the resident had a do not resuscitate (DNR) advance directive with a completed MOST form in place, revised [DATE]. The goal revealed to honor the resident/resident representative choice per advance directive listed on medical orders for scope of treatment (MOST) form through next review. The interventions included: do not resuscitate, do not perform cardiopulmonary resuscitation (CPR). Review and update MOST form upon admission, quarterly, and as needed. The MOST form was found in the residents electronic medical record (EMR) under documents. It was dated and signed by son/power of attorney (POA) on [DATE], and signed by the physician on [DATE]. It was marked as No CPR: Do not attempt resuscitation. The [DATE] computerized physician orders revealed there were no orders for code status. The resident clinical profile page in the EMR read, Code status: was blank. There was no code status listed. C. Staff interview (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The MDS coordinator (MDSC) was interviewed on [DATE] at 3:19 p.m. She said for advanced directives the facility used the MOST forms. The MDSC said if there was an emergency, the staff would look up the status in the EMR for the MOST form or look in the MOST form book at the nurse station. The MDSC said the staff went to the closest source, the MOST form book or the EMR. The MDSC said in the EMR there was a section on the top of the profile page where the code status was listed. The MDSC said the clinical profile page code status was important because it was easier access to see the resident's wishes. The MDSC said the code status came from a physicians order. The MDSC looked into Resident #54's EMR and acknowledged there was no code status listed on the profile page. The MDSC said there should be a code status listed. The MDSC said she would follow up with the director of nursing (DON) and get physician orders to add the code status in the EMR. The DON was interviewed on [DATE] at 4:18 p.m. She said since Resident #54 readmission on [DATE] there had been no physicians orders for the residents code status. The DON said the nurses complete a MOST form upon admission and they should also get a code order upon admission. The DON said it was important to know what the residents wishes were and that the MOST form and the physician orders were in agreement. The DON said the advanced directive process and carry over with the orders should be verified when a resident admits or readmits. The DON acknowledged otherwise there could be mistakes. D. Facility follow up The computerized physician orders were added after being brought to the facility's attention. The orders read, Do not resuscitate (DNR), dated [DATE]. The resident clinical profile page in the EMR now read, Code status: Do not resuscitate (DNR). 44949 IV. Resident #61 A. Resident status Resident #61, age 73, was admitted on [DATE]. According to the [DATE] computerized physician orders (CPO), diagnoses included post polio syndrome, muscle weakness, lack of coordination, and abnormalities of gait and mobility. The [DATE] minimum data set (MDS) assessment indicated the resident was cognitively intact with a brief interview of mental status score of 15 out of 15. It indicated the resident required extensive, two person assistance for activities of daily living. It indicated the resident utilized a wheelchair for mobility. B. Record review The [DATE] CPO indicated Resident #61 had a code status of do not resuscitate, ordered [DATE]. The MOST form located in Resident #61's electronic medical record. It indicated the resident's preference of do not resuscitate, selective treatment, and no artificial nutrition by tube. The form was signed by the resident on [DATE]. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The form was reviewed on [DATE] and was not signed by the physician. C. Staff interviews The director of nursing (DON) was interviewed on [DATE] at 4:35 p.m. She said nursing staff tried to get MOST forms signed by the physician as soon as possible. She said a nurse practitioner was in the facility almost daily and could sign if the primary physician was not in the building. She said Resident #61's form was sent out to her primary care physician because she was under the care of an outside provider and would have to check if it was returned. -The facility provided the complete MOST form, signed by the physician, on [DATE] (during the survey).

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43950 Based on interviews and record review, the facility failed to ensure residents had the right to be free from abuse for three (#224, #16, and #32) of seven residents out of 44 sample residents. Specifically, the facility failed to ensure: -Resident #224 was kept free from physical abuse from Resident #38; -Resident #16 was kept free from physical abuse from Resident #38; and, -Resident #32 was kept free from physical abuse from Resident #68. Findings include: I. Facility policy and procedure The Abuse, Neglect, and Exploitation Prevention Policy and Procedure, last revised [DATE], was provided by the nursing home administrator (NHA) on [DATE] at 3:16 p.m. It read in pertinent part, Our facility prohibits the abuse, mistreatment, neglect, and/or exploitation of residents. We believe that all residents have the right to be free from such actions by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving our community, family members or legal guardians, friends, or any other individuals. II. Incident of physical abuse between Resident #224 and Resident #38 A. Facility investigation of the incident that occurred [DATE] at 4:30 a.m. The director of nursing (DON) and social services director (SSD) provided the [DATE] facility abuse investigation on [DATE] at 1:59 p.m. The report was completed by the SSD. The victim was Resident #224, with admitted [DATE] and discharge date of [DATE]. Witness statement by certified nurse aide (CNA) #8, undated, documented Resident #224 was awake, and Resident #38 was frustrated. At 4:15 a.m. CNA #8 could hear Resident #224 says don't hit me. CNA #8 hurried into the room. Resident #38 was sitting in a wheelchair next to Resident #224's bed and slapped Resident #224 across the left side of face open handed. Then Resident #38 started pulling up Resident #224's covers telling her she needs to stay warm. CNA #8 stayed with Resident #224 until Resident #38 got back into bed, then went to get the nurse, registered nurse (RN) #4. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Written witness statement by CNA #8 read, at 4:15 a.m. on Monday morning, [DATE], I was coming down the back of C Hall with my oxygen tanks. As I was approaching the room of Resident #38 and Resident #224, I heard Resident #224 yell 'don't hit me!' I stepped into their doorway just as Resident #38 reached her hand back, and then proceeded to slap Resident #224 with an open hand across the left side of her face. I yelled her name 'Resident #38,' she jumped a little and then started pulling Resident #224 blankets up stating 'you have to stay warm, lets cover you up.' I said her name (Resident #38) again and she turned and started going to her bed. I told her 'you cannot hit her.' She said 'I didn't hit her.' I told her 'yes you did, I saw you hit her.' She replied, 'I did not, I would never hit an old lady.' She then waved her hand across the air saying, 'I just went like this' I again stated, 'no you didn't, I saw you hit her.' Resident #38 denied it again, then returned to her bed. On [DATE] the SSD spoke to Resident #38's daughter and related the incident to her. She stated her mother (Resident #38) told her about it but denied it. The SSD informed the daughter that it was witnessed by staff. The daughter apologized and was agreeable to a room change. On [DATE] interviews conducted with other residents revealed no issues. Notice of room change: [DATE]: Resident #38 was moved due to a resident to resident altercation with roommate. Resident #38 struck her roommate in the face. Room change medically necessary due to altercation. Attending physician notified [DATE]. All parties agreed to room change. Nursing description: Resident hit her roommate's face on [DATE] at 4:30 a.m. Resident #38 hit her roommate on the left side and no injury to her roommate's face. Resident #38 states, 'My roommate is noisy and I can't sleep. I went to her bed to make her quiet.' Resident #38 was encouraged to utilize her call light for staff assistance for her roommate yelling/noisy behavior without her physical behavior. Call light within reach. Interdisciplinary team (IDT) review: Incident occurred [DATE] at 4:30 a.m. Residents were immediately separated, no injury identified. Room change was completed. Police department notified, state reportable completed. Resident #38 was educated to use her call light for assistance and that it is inappropriate for her to put her hands on other residents in the way she did. Victim information: Nursing description: Resident #224 had a physical altercation by her roommate on [DATE] at 4:30 a.m. Resident #224 was hit by her roommate on the left side of face with no injury. Resident description: Denies pain or discomfort status post physical altercation by her roommate. Immediate Action taken: Notified medical doctor (MD) on [DATE] at 5:15 a.m. regarding a physical alteration by her roommate. Notified DON, at 5:00 a.m. Left a voicemail to nephew/power of attorney (POA) at 5:20 a. m. Police notified and executive director (ED) notified at 6:20 a.m. Victim (Resident #224) Level of consciousness-Alert. Mobility-WC (wheelchair) bound. Mental status-oriented to person, oriented to place. Other-Resident remains confused with her mental status and no change. -The facility investigation failed to interview the victim as part of the investigation. The facility substantiated the abuse investigation. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. Resident #224 1. Resident status Resident #224, age 98, was admitted on [DATE], and discharged on [DATE]. According to the [DATE] computerized physician orders (CPO), diagnoses included atrial fibrillation, chronic kidney disease, and peripheral vascular disease. The [DATE] minimum data set (MDS) assessment revealed the resident was unable to complete the brief interview for mental status (BIMS). The staff assessment for mental status revealed short term and long term memory problems with severely impaired decision making regarding tasks of daily life. No inattention or disorganized thinking behaviors. She required extensive assistance with two persons physical assistance for bed mobility, and transfers. She required extensive assistance with one person for locomotion on /off unit, dressing, toilet use, and personal hygiene. 2. Record review The CPO revealed an order to admit to hospice services, dated [DATE]. Admitting diagnosis of coronary artery disease. Further review of perpetrator Resident #38 revealed the facility did not update the care plan following the incident on [DATE]. Progress notes revealed Resident #224 expired [DATE] at the facility. C. Resident #38 Resident #38, age 93, was admitted on [DATE]. According to the [DATE] computerized physician orders (CPO), the diagnoses included Alzheimer's disease, chronic obstructive pulmonary disease, and depression, unspecified. The [DATE] minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. She required limited assistance with one person for transfers, locomotion on/off the unit, dressing, and personal hygiene. The Patient Health Questionnaire (PHQ-9) score was three, indicating normal or minimal depression. Physical and verbal behavioral symptoms directed towards others occurred one to three days. No wandering or rejection of care was documented. D. Staff interviews (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DON and SSD were interviewed on [DATE] at 4:05 p.m. The DON said the interventions in place for the perpetrator Resident #38 was to talk to the resident and her family and also an outside medical provider did a medication review and they may have started a new medication for her for anxiety. The DON said she educated the staff to watch Resident #38, but she still had the right to go to activities. The DON said she thought the nurses did attempt to interview the victim but after checking the medical record she could not find any documentation. The DON said maybe staff did not attempt to interview the victim Resident #224 due to the resident's terminal diagnosis and dementia. The DON said they did not know how many times the victim was hit. The DON said the last care plan update for the perpetrator Resident #38 for mood/behavior after the incident on [DATE] was on [DATE], there had been no protective intervention updates. The DON and SSD acknowledged that Resident #38 then acted out again [DATE] by striking a different resident. E. Facility follow-up The DON provided the following training documents on [DATE] at 11:16 a.m. Please be assured that Resident #38 was being supervised during activities and social events, especially during any activities that may result in loud noises or loud verb outbursts. By signing below, I acknowledge that the information listed above has been presented and reviewed with me and I fully understand this information. I have been provided with the opportunity to ask questions. I am fully aware that failure to follow the listed information will result in disciplinary action. Signed [DATE] by 42 staff members. 43135 III. Incident of physical abuse between Resident #38 and Resident #16 A. Facility investigation The facility investigation of abuse on [DATE] at 4:20 p.m. was provided by the nursing home administrator on [DATE] at 1:00 p.m. The report indicated the following: Activity assistant (AA) #1 reported that resident (#38) was yelling at another resident (#16) during (a) music program. The activity assistant asked the resident (#38) to move away from the other resident (but) she refused. Activity assistant then saw Resident #38 kick the other resident (#16) in the leg when the music was over. Resident (#38) was assisted to her room at that time. Residents were separated and assisted to appropriate rooms due to program ending. Asked (the) resident if another resident kicked her, she nodded her head and stated 'Oh ya' and moved her legs. Resident (#16) is not able to fully communicate, can answer yes and no questions. (Resident #38 said) 'I kicked at her because she was yelling and she doesn't shut up. She stares at me all the time in the dining room, I'm human and I don't like it. She kicked me too. Police and family (were) notified. The allegation was substantiated due to (a) witness report (AA #1) and interviews with residents involved. -The facility's follow-up interventions after substantiated resident to resident abuse did not include interventions for Resident #16 (the victim). Resident #16 often yelled and screamed loudly in many locations in the facility. The facility did not address interventions for the possible needs of Resident #16. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. Resident #16 1. Resident status (victim) Resident #16, age 73, was admitted on [DATE]. According to the [DATE] computerized physician orders (CPO), the diagnoses included a stroke, hemiplegia and hemiparesis (paralysis on the resident's left dominant side of the body), aphasia (disorder affecting speech), hypertension (high blood pressure), gastro-esophageal reflux disease (GERD), and major depressive disorder. The [DATE] minimum data set (MDS) revealed the resident had severe cognitive impairment and was unable to conduct a brief interview for mental status score (BIMS). The resident verbal behavioral symptoms directed towards others were screaming, threatening, and cursing others. The resident required extensive assistance with bed mobility, transfers, dressing, locomotion on and off the unit, and personal hygiene. The resident had total dependence on staff for toilet use, and bathing. The resident utilized a wheelchair. The resident did not reject care from staff. The resident had adequate hearing, no hearing aids, unclear speech, could usually understand others, and could sometimes make herself understood. 2. Resident observations On [DATE], [DATE], and [DATE] at approximately 8:45 a.m. - 9:15 a.m. Resident #16 repetitively yelled out, Juice, juice. She also yelled out nonverbally (loud moans, loud sighs, indistinguishable words) at different times during the meals. The staff in the dining room did not intervene when she yelled out or make attempts to redirect her except to give her food. 3. Resident interview On [DATE] at 11:00 a.m. the resident was unable to conduct an interview. C. Staff interviews The director of nursing (DON) and the social service director (SSD) were interviewed on [DATE] at 4:05 p.m. The DON said Resident #16 had repetitive behaviors such as yelling out juice, juice, over and over again in the dining room. She said she educated the staff to have Resident #38 and Resident #16 more supervised at activity events. She said she educated the staff to have the two residents just avoid each other. The SSD said she did not know why there were no interventions documented in the electronic medical records (EMR) for Resident #16 after the incident when she was kicked. She said she would look and see if there were interventions that were put in the comprehensive care plan for Resident #16 after the incident when she was kicked. Certified nurse aide (CNA) #9 was interviewed on [DATE] at 9:00 a.m. in the dining room while Resident #16 was yelling. She said Resident #16 screams out often. She said when staff ask her to be quieter she usually will get quieter. She said she yelled out in the dining room, activities, and in her room often. She said it was normal behavior for Resident #16 to yell and not be redirected or asked to be quieter. She said she did not monitor Resident #16's behaviors because Resident #16 was a nice person who just screamed out a lot. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	AA #1 was interviewed on [DATE] at 2:00 p.m. He said he witnessed and reported that Resident #38 kicked Resident #16. He said he brought ,d+[DATE] residents to a musical event. He said he was the only staff member who attended the event. He said Resident #38 was seated behind Resident #16 and both were in their wheelchairs. He said Resident #16 was singing very loudly. He said Resident #16 often screamed and yelled in activities, the dining room, and in her room. He said that this time Resident #16 was just loudly singing. He said Resident #38 kept telling Resident #16 to be quiet, and she told her to shut up many times. He said Resident #38 asked him to move Resident #16 to another part of the room. He said he told Resident #38 that Resident #16 had a right to sit anywhere she wanted and if Resident #38 did not like it then she could move elsewhere. He said at the end of the music show he saw Resident #38 kick Resident #16 in the leg. He said a physical therapist who did not see the incident told him to take Resident #38 to her room first. He said Resident #16's screaming and yelling often irritated other residents but this time she was just singing loudly. He said he was not trained after the incident about how to handle both residents' behaviors. He said each resident had a right to sit wherever they wanted in activities. He said he would never stop them from sitting next to each other in the future because it was their right to be seated wherever they wanted. He said he was not taught to have the residents avoid each other to avoid another incident. The NHA and DON were interviewed on [DATE] at 9:00 a.m. The NHA said an on the spot training was provided to the staff after the incident between Resident #38 and Resident #16. She said staff were told the two women were not to be seated next to each other. The DON said that AA #1 had not attended the on the spot training about the incident. She said it would be important for AA #1 to know the information especially because he was the one who reported the physical abuse. She said she was unaware AA #1 believed it was the resident's right to sit together if they still wanted to and that she would educate him right away. The DON said she would provide what comprehensive care planned interventions were put in place concerning Resident #16 and her verbal behaviors. D. Facility follow-up During survey on [DATE] (almost two months after the physical abuse incident) the cares section in the electronic medical records (EMR) was updated. It read in pertinent part, Evaluate for need and refer to psychological counseling as recommended by physician. Interact in an empathetic and supportive manner. Monitor and Document each behavioral event. Offer 1:1 interaction as needed. Offer psychosocial support as needed. -No comprehensive care plan interventions for Resident #16 were provided before the exit of the survey on [DATE]. 44949 IV. Incident of physical abuse abuse between Resident #32 and #68 A. Abuse investigation (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The abuse investigation was provided by the social services director (SSD) and director of nursing (DON) on [DATE] at 1:59 p.m. The investigation included a description of the event from nursing staff as well as a statement from a resident that witnessed the event. The altercation occurred on [DATE]. The nursing description indicated Resident #32 was heard screaming in the dining room and said He hit me and pointed to Resident #68. The nurse assessed Resident #32 and neuro checks were initiated. Resident #68 was removed from the area. The statement from the resident witness indicated Resident #68 was at his table when Resident #32 approached his table and reached for the sugar bowl. Resident #68 said No sugar! Resident #32 grabbed the bowl and Resident #68 reached for the bowl and it fell to the floor. Resident #68 hit Resident #32. Resident #32 yelled and another resident yelled for help. The facility substantiated the abuse investigation. B. Resident #68 1. Resident status Resident #68, age 72, was admitted on [DATE]. According to the [DATE] computerized physician orders, diagnoses included dementia, anxiety disorder, and muscle weakness. The [DATE] minimum data set assessment indicated the resident had a moderate cognitive impairment with a brief interview for mental status score of ten out of 15. It indicated the resident had physical and verbal behaviors and rejected care. It indicated the resident required supervised one person assistance for activities of daily living. 2. Record review The behavior care plan, revised [DATE], indicated Resident #68 had physical behaviors involving poor impulse control, anger, and depression. Interventions included document behaviors, provide physical and verbal cues to alleviate anxiety, psychiatric consult as indicated, take to safe location, and intervene before agitation escalates. -The care plan was not updated following the [DATE] altercation. Progress notes following the incident revealed the following: -On [DATE] a progress note was completed that indicated an altercation with Resident #32. It indicated Resident #32 attempted to take the sugar bowl when Resident #68 grabbed it back. The note indicated Resident #32 attempted to hit Resident #68 and he then hit her across the face with an open hand. Resident #68 was removed from the area. The assistant director of nursing, physician, police, and family were notified of the altercation. -On [DATE] a progress note was completed that indicated the resident was being monitored following the altercation. It indicated no injuries and no additional behaviors were noted. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On [DATE] a progress note was completed that indicated the resident had no behaviors and had no had contact with Resident #32. -On [DATE] a progress note was completed that indicated the resident did not have any behaviors following the altercation. C. Resident #32 1. Resident status Resident #32, age 93, was admitted on [DATE]. According to the [DATE] computerized physician orders, diagnoses included dementia, schizophrenia, and generalized muscle weakness. The [DATE] minimum data set assessment indicated the resident had a severe cognitive impairment with a brief interview of mental status score of zero out of 15. It indicated the resident did not have behaviors and did not reject care. It indicated the resident required extensive one person assistance with activities of daily living. 2. Record review The behavior care plan, revised [DATE], indicated Resident #32 had the potential for decline in mood and behavior related to dementia and schizophrenia. Interventions included administering medications as ordered, psychiatric consultation as indicated, and encouragement to attend activities. Progress notes following the altercation were reviewed and revealed the following: -On [DATE] a progress note was completed that indicated Resident #32 was heard screaming in the dining room and said Resident #68 hit her. It indicated Resident #32 went to Resident #68's table and tried to take the sugar bowl and Resident #68 took the bowl back. It indicated she threw sugar at him and he hit her across the face with an open hand. Staff separated the residents and Resident #68 was removed from the area. The assistant director of nursing, police, physician, and family were notified. -On [DATE] a progress note was completed that indicated the resident did not have behaviors, neurological check was within normal limits, and no injuries were observed. -On [DATE] a progress note was completed that indicated the resident had no injuries and the neurological check was within normal limits. -On [DATE] a progress note was completed that indicated the resident's neurological check was within normal limits. D. Staff interviews (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The SSD and DON were interviewed on [DATE] at 4:03 p.m. The SSD said following the altercation on [DATE], the residents were separated and increased supervision in the dining room was initiated. She said there were no additional interventions put in place. She said no staff training was completed because all staff acted appropriately following the altercation. She said it was a one off event for Resident #68. She said Resident #32 did not demonstrate behaviors following the event and had no recall of the event. She said Resident #32 did not avoid the dining room since the event. Certified nurse aide (CNA) #1 was interviewed on [DATE] at 1:38 p.m. She said Resident #32 would leave her room with staff encouragement but preferred to stay in her room. CNA #3 was interviewed on [DATE] at 4:00 p.m. She said Resident #32 preferred to stay in her room. She said the resident had trouble waiting to be served so staff assisted her to the dining room last and brought her back to her room first. She said there were no residents that Resident #32 needed to avoid. CNA #2 was interviewed on [DATE] at 9:18 p.m. She said Resident #32 did not like to linger in the dining room. She said the resident preferred to stay in her room. She said Resident #32 did not have behaviors. The SSD was interviewed again on [DATE] at 9:27 a.m. She said staff spoke with Resident #68 and told him to ask for help if he was having difficulty with another resident. She said this was not formal training provided to the staff and she believed his wife spoke to him about the incident as well. She said staff had verbal training about the incident but there was no formal training. She said the care plan should have been updated following the altercation. Activities assistant (AA) #2 was interviewed on [DATE] at 10:56 a.m. She said Resident #32 preferred to stay in her room. She said she would go outside and enjoyed when family visited but participation depended on her mood. She said she was not aware of any incidents with other residents that Resident #32 had been involved in.

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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** 43950 Based on observation, record review and interviews, the facility failed to consistently provide activities of daily living (ADL) support for five (#54, #57, #25, #48, #70 and #48) of seven dependent residents reviewed for ADLs out of 44 sample residents. Specifically, the facility failed to provide dependent residents, Resident #54, #57, #25, #70 and #48 with consistent assistance with ADLs including bathing, meal assistance, and grooming. Findings include: I. Facility policy and procedure The Activities of Daily Living (ADLs), Supporting policy and procedure, revised March 2018, provided by the nursing home administrator (NHA) 9/1/22 at 9:35 a.m. it read in pertinent part, Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. II. Resident #54 A. Resident status Resident #54, age 74, was admitted on [DATE]. According to the August 2022 computerized physician orders (CPO), the diagnoses included hemiplegia and hemiparesis (muscle weakness or partial paralysis on one side of the body) following cerebrovascular disease affecting the right dominant side, and aphasia (loss of ability to express speech). The 6/21/22 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of zero out of 15. She required extensive assistance with one person for bed mobility, transfers, locomotion on/off the unit, dressing, toilet use and personal hygiene. The resident was totally dependent with bathing with one person physical assistance. She required supervision and one person physical assistance with eating. She said it was very important to choose between a tub bath, shower, bed bath, or sponge bath. B. Resident observation Resident #54 was observed on 8/29/22 at 12:13 p.m. Her fingernails were a fourth of inch long, jagged and dirty with yellow and brown matter under and around nails. The resident used her left hand to eat with her fingers and her right arm was in a sling. Resident #54 picked at her food with her left hand and took whipped cream off her cake. The resident touched her silverware but did not pick up. The resident ate her lunch and no meal assistance was provided by staff beyond set up. She ate less than 10% of her meal. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #54 was observed on 8/30/22 at 8:38 a.m. She was eating breakfast in the dining room. She ate all of the eggs, most of the shredded potatoes, and drank coffee and a half a cup of water. No meal assistance was observed beyond set up provided by staff. Her fingernails were a fourth of an inch long, jagged with light brown matter under the nails. Resident #54 was observed on 8/31/22 at 8:35 a.m. She ate breakfast with left hand, drinking coffee, and ate a piece of bacon held with her left hand. She ate most of the eggs and bacon and did not eat her muffin or orange juice. There was no meal assistance beyond set up provided by staff, she ate about 50% of her meal. Her fingernails continued to be long at a fourth of an inch, and jagged with brown matter under the nails. Her hair was greasy, looked wet and was pulled back into a braid. C. Record review The bathing preferences assessment dated [DATE] revealed the resident preferred to bathe one to two times per week, in the evenings, and preferred a shower with a washcloth, and lotion after bathing. The comprehensive care plan related to risk for non-pressure related skin issues, revised 5/18/22, revealed intervention to encourage the resident to keep nails trimmed as indicated, dated 12/21/17. -However, the resident did not have the functional ability to keep her nails trimmed. The comprehensive care plan related to ADLs, indicated the resident requires assistance with ADLs related to decreased mobility, revised 9/24/21. The interventions revealed bathing with one person assistance initiated 9/24/21. -However, there was nothing specific on the care plan related to the resident's bathing preferences, nail care needs or meal assistance due to her right arm being in a sling. The point of care documentation completed by the certified nurse aide (CNAs) revealed the following bathing intervention/task. August 2022: Five baths were provided, with total dependence.There was one refusals documented on 8/15/22. -No bath had been provided to the resident in the last eight days according to a record review from 8/23-8/30/22. The last bath was provided on 8/23/22. III. Resident #57 A. Resident status Resident #57, age 77, was admitted on [DATE], with re-entry 3/25/21. According to the August 2022 computerized physician orders (CPO), the diagnoses included anemia (iron deficiency), dementia without behavioral disturbance, and hemiplegia and hemiparesis (muscle weakness or partial paralysis on one side of the body) following cerebrovascular disease. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 5/8/22 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of eight out of 15. She required extensive assistance with two persons for bed mobility, transfers, dressing, and toilet use. She required extensive assistance with one person for locomotion on/off the unit, personal hygiene, and eating. Bathing activity itself did not occur over the entire seven day MDS period so no functional status was listed. Her preference was listed as very important to her to choose between a tub bath, shower, bed bath, or sponge bath. B. Resident observation and interview Resident #57 was observed on 8/29/22 at 11:26 a.m. She was in the dining room for lunch and asked for help because she said her bottom was burning. Her fingernails were a quarter of an inch long, jagged with yellowish brown matter under the nails. Her long nails pressed in the palm of the residents right contracted hand. She told an unidentified CNA her bottom had been burning for over an hour and the CNA took her back to her room to provide assistance. -At 12:57 p.m. it was the end of the meal and only one other resident remained in the dining room. Resident #57 had eaten less than 25% of the meal on her own. Resident #57 right hand appeared contracted, which was her dominant hand. Resident #57 used her left hand to eat but said it was hard to eat with that hand. An unidentified dietary aide asked the resident if she needed help eating and the resident answered yes. The resident was the last resident in the dining room and the dietary aide sat down by the resident to assist with the meal at 1:04 p.m. Cross-reference F688 failure to ensure appropriate services, equipment, and assistance to maintain or improve mobility, related to right hand contracture, with the maximum practicable independence. Resident #57 was observed on 8/30/22 at 8:50 a.m. at the breakfast meal. Her fingernails had dark brown matter under the quarter inch nail. They were jagged and the right hand contracted. Resident #57 was observed on 8/31/22 at 8:56 a.m. She was in the dining room eating with her left hand. She said showers once a week was okay. Her fingernails continued to be long (quarter of an inch) and dirty with brown matter under the nails. C. Record review The comprehensive care plan related to related to ADL, revised 6/2/2020, revealed the resident required assistance with ADLs related to decreased mobility, diuretic use, poor balance, history of falling, short term memory problems, confusion, incontinence of bowel and bladder, and discomfort/pain. Interventions revealed bathing required one person assistance. -However, there was nothing specific on the care plan related to the resident's bathing preferences, meal assistance or nail care needs. The point of care documentation completed by the certified nurse aide (CNAs) revealed the following bathing intervention/task. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	August 2022: Revealed three baths were provided, with total dependence. There were no refusals documented. IV. Resident #25 A. Resident status Resident #25, age 88, was admitted on [DATE], with re-entry 7/5/22. According to the August 2022 computerized physician orders (CPO), the diagnoses included left hip fracture, local infection of the skin and subcutaneous tissue, and candidiasis (yeast infection). The 6/30/22 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 12 out of 15. She required extensive assistance with two person for transfers, and toilet use. Extensive assistance with one person for bed mobility, and dressing. She required total dependence with one person for bathing. Her preference was listed as very important to her to choose between a tub bath, shower, bed bath, or sponge bath. B. Resident observation and interview Resident #25 was interviewed on 8/30/22 at 9:09 a.m. She wheeled herself into the bathroom to take herself to the toilet. -Although, the MDS assessment documented the resident required extensive assistance with two people for transfers and toilet use. An unidentified CNA had pushed Resident #25 wheelchair (WC) back to her room after breakfast but had not offered to take her to the bathroom. Resident #25 applied the call light after using the bathroom and an unidentified CNA went in and assisted transfer from toilet to WC and the resident washed her hands at the sink. Resident #25 said her showers were supposed to be twice a week but she would prefer them more often. Resident #25 said that Wednesdays and Sundays were her shower days, but she did not receive her shower on Sunday. Resident #25 hair was greasy and looked wet. Resident #25 said a CNA on Sunday had not offered to give her a shower. Resident #25 said she wanted a minimum of two showers per week, but sometimes she did not get even that. Resident #25 was interviewed on 8/31/22 at 8:47 a.m. Resident #25 said she had seven showers this month but she would prefer more such as three times per week. C. Record review The comprehensive care plan related to ADL, revised 10/18/21, revealed the resident required assistance with ADLs related to decreased mobility requiring assistance with ADLs or totally dependent with ADLs. Interventions revealed bathing required one person assistance, dated 10/18/21. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The comprehensive care plan related to individual preferences, revised 11/15/21, revealed the resident chooses to be highly involved in daily care decisions regarding suggested or recommended interventions and had specific preferences related to ADLs, activities, clothing, and food choices. Interventions revealed to honor individual choices and preferences as able within parameters of facility and other individuals safety and choices or preferences, dated 11/15/21. -However, there was nothing specific on the care plan related to the residents bathing preferences. The point of care documentation completed by the certified nurse aide (CNAs) revealed the following bathing intervention/task. August 2022: Seven baths were provided, with total dependence. There were no refusals documented. -No bath was provided in the last six days according to a record review from 8/24-8/29/22. The last bath was provided on 8/24/22. V. Staff interviews CNA #1 was interviewed on 9/1/22 at 9:21 a.m. She said she did not give showers to residents because they have a shower aide. CNA #1 said during a resident bath/shower, their hair was washed and lotion was applied to the skin after the shower. CNA #1 said fingernail care was a part of the bathing. CNA #1 said trimming nails was a CNA responsibility except if the resident was diabetic then the nurse would complete the nail trimming. CNA #1 said she had worked at the facility for two weeks but had noticed one time they had to skip showers because they were short handed. CNA #1 said the shower aide had to move to helping the floor CNAs when the facility was short staffed. Registered nurse (RN) #5 was interviewed on 9/1/22 at 9:30 a.m. She said resident trimming and cleaning their fingernails was a part of their bathing. RN #5 said the CNAs should look at and clean the fingernails at each shower. RN #5 viewed Resident #57's fingernails and acknowledged that the nails were long, jagged, and dirty with brown matter under the nails. RN #5 asked Resident #57 if she liked her nails long and Resident #57 answered no, she said she liked them short. Resident #57 right hand appeared contracted into a fist and her fingernails were pressing into her palm. -At 9:35 a.m. RN #5 then viewed her roommates fingernails, Resident #54. RN #5 acknowledged that Resident #54 fingernails were long, jagged, and dirty with brown matter under the nails. Resident #54's right arm was in a sling, and she used her left hand to control the television (TV) remote. RN #5 acknowledged that Resident #54's fingernails needed cleaning and trimming to be sanitary and clean. CNA #10 was interviewed on 9/1/22 at 9:51 a.m. She said she did not give showers because they have a shower aide. CNA #10 said showers consist of a full shampoo, soap, lotion and deodorant with males receiving shaving cream and shave. CNA #10 said they did trim the fingernails if the resident asked. CNA #10 said if the resident was dependent on staff, they would get fingernails cleaned and trimmed during the shower. CNA #10 said the shower aides work Monday through Friday and if a shower aide got called onto the floor to work, the RN manager would assign the residents who needed a shower that day to the CNAs. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The director of nursing (DON) was interviewed on 9/1/22 at 12:53 p.m. She said fingernail care was done during the showers. The DON said nail care was taken care of when it was noticed and nail care should be on the care plan. The DON said they typically have a bath aide scheduled for giving showers, however if they were pulled to the floor, the nurse would tell the CNAs to divide the bathing schedule between themselves. The DON said she was not aware that residents were not getting showers completed. The DON said her minimal shower expectation was typically two times per week and some residents only preferring one time a week, but other residents preferring three times per week. The DON said preferences for how often a resident wants a shower should be in the care plan. 38503 VI. Resident #70 A. Resident status Resident #70, age 91, was admitted on [DATE] and readmitted [DATE]. According to the August 2022 CPO, diagnoses included malignant neoplasm (cancer) of the left lung, atrial fibrillation, and diabetes mellitus. The 8/15/22 MDS assessment revealed Resident #70 was cognitively intact with a BIMS score of 15 out of 15. He required extensive one-person assistance with most ADLs. He was occasionally incontinent of bowel and bladder. He required physical help in part of the bathing activity and one-person physical assistance. B. Resident interview Resident #70 was interviewed on 8/30/22 at 8:21 a.m. He said he was not getting his showers. He said he would have liked a shower a couple times per week, but was not getting them and only had one shower since his admission (8/9/22 to 8/30/22). C. Record review Review of Resident #70's ADL care plan, initiated on 8/16/22 revealed Resident #70 required one-person assistance with bathing. The care plan did not document Resident #70's bathing preference. Review of Resident #70's electronic point of care shower documentation revealed the resident had a shower on 8/11/22. Resident #70 had only received one shower in the 18 days during his stay (the resident was hospitalized from 8/23/22 to 8/25/22). There was no further documentation of Resident #70 receiving his showers. D. Staff interview (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The director of nursing was interviewed on 9/1/22 at 1:05 p.m. She said the facility met with the resident on admission to ensure the resident's shower preference and it should be documented in the resident's care plan. She said the facility attempted to schedule bath aides daily and if there were staffing concerns (a call off and/or if the bath aide were pulled to the floor); her expectation was the CNAs on the floor split up the showers amongst themselves and complete them. She said some of the CNAs documented on the shower sheets instead of the electronic point of care record. She said she believed there was documentation of resident showers. -However, this was not provided during the survey 8/29/22 to 9/1/22. 44949 VII. Resident #48 A. Resident status Resident #48, age 82, was admitted on [DATE]. According to the August 2022 computerized physician orders, diagnoses included polyosteoarthritis (joint pain and swelling), abnormalities of gait and mobility, and chronic pain syndrome. The 7/21/22 minimum data set assessment indicated the resident was cognitively intact with a brief interview for mental status score of 15 out of 15. It indicated the resident required supervised, one person assistance for activities of daily living and physical, one person assistance for bathing. B. Resident interview Resident #48 was interviewed on 8/29/22 at 2:30 p.m. He said the facility was short on staff sometimes and that impacted how many showers he would get. He said the shower aide would get pulled to work the floor as a nursing assistant. He said he was supposed to get two showers a week. C. Record review The activities of daily living care plan, revised 5/21/2020, indicated Resident #48 required one person assistance for bathing. The certified nurse aide (CNA) documentation indicated that from the period of 8/1/22 to 8/31/22, Resident #48 three showers with one refusal indicated. He was only provided three showers out of an estimated nine opportunities. D. Staff interviews CNA #1 was interviewed on 8/31/22 at 1:38 p.m. She said she had worked at the facility for a few weeks and knew Resident #48 had a few showers. She said he did not refuse care. Registered nurse (RN) #1 was interviewed on 9/1/22 at 9:16 a.m. She said Resident #48 enjoyed taking showers and did not refuse care from staff. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The director of nursing (DON) was interviewed on 9/1/22 at 1:02 p.m. She said there was a bath aide for each unit but sometimes they would have to work the floor as a nurse aide. She said if a shower or bath was missed, the aides would try to make it up if possible.

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44949 Based on observation, interviews and record review, the facility failed to ensure the necessary care and treatment to prevent the development of pressure injuries for one (#61) of two residents reviewed of 44 sample residents. The facility failed to provide the necessary equipment, interventions and care timely for a resident who was identified to be at risk for developing pressure ulcers due to the presence of a right femoral fracture and use of an immobilizing device. Resident #61 was admitted to the facility on [DATE] with diagnoses of post polio syndrome, muscle weakness, lack of coordination, and abnormalities of gait and mobility. The resident was hospitalized from 7/26/22 to 8/3/22 following a fall and subsequent fracture of her right femur. A skin assessment was completed upon Resident #61's readmission to the facility on [DATE]. It indicated Resident #61 was at risk for developing pressure ulcers and indicated bruising to upper extremities. No additional skin assessments were completed until 8/21/22 in which Resident #61's skin was indicated to be intact. On 8/29/22 staff observed a dark purple area draining on the resident's right heel. The wound physician assessed the resident and it was determined that the resident had an unstageable right heel deep tissue injury (DTI). I. Professional reference According to the National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance Prevention and Treatment of Pressure Ulcers: Clinical Practice Guideline, [NAME] Haesler (Ed.), Cambridge Media: [NAME] Park, Western Australia; 2014, retrieved from https://www.ehob.com/media/2018/04/prevention-and-treatment-of-pressure-ulcers-clinical-practice-guidline.pdf on 9/12/22, Pressure ulcer classification is as follows: Category/Stage 1: Nonblanchable Erythema Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Category/Stage I may be difficult to detect in individuals with dark skin tones. May indicate at risk individuals (a heralding sign of risk). Category/Stage 2: Partial Thickness Skin Loss Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising.This Category/Stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation. Bruising indicates suspected deep tissue injury. Category/Stage 3: Full Thickness Skin Loss (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. The depth of a Category/Stage 3 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and Category/Stage 3 ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category/Stage 3 pressure ulcers. Bone/tendon is not visible or directly palpable. Category/Stage 4: Full Thickness Tissue Loss Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling. The depth of a Category/Stage 4 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Category/Stage 4 ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable. Unstageable: Depth Unknown Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore Category/Stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as ' the body's natural (biological) cover ' and should not be removed. Suspected Deep Tissue Injury: Depth Unknown Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment. II. Facility policy The Pressure Ulcer/Skin Breakdown policy and procedure, revised April 2018, was provided by the nursing home administrator (NHA) on 9/1/22 at 3:00 p.m. It read, in pertinent part, The nursing staff and practitioner will assess and document an individual's significant risk factor for developing pressure ulcers, for example immobility. The physician will order pertinent wound treatments, including pressure reduction surfaces, wound cleansing and debridement approaches, dressings, and application of topical agents. III. Resident #61 A. Resident status (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Resident #61, age 73, was admitted on [DATE] and readmitted [DATE]. According to the August 2022 computerized physician orders (CPO), diagnoses included post polio syndrome, fracture to right femur, muscle weakness, lack of coordination, and abnormalities of gait and mobility. The 8/18/22 minimum data set (MDS) assessment indicated the resident was cognitively intact with a brief interview of mental status score of 15 out of 15. It indicated the resident required extensive, two person assistance for activities of daily living. It indicated the resident utilized a wheelchair for mobility. It indicated the resident was at risk for pressure ulcers and had a stage 2 pressure ulcer that was present at admission. -The MDS assessment documented the resident had stage 2 that was present on admission, it was not indicated in her medical record (see below). B. Resident interview Resident #61 was interviewed on 8/29/22 at 11:21 a.m. She said she had a fall at the end of July 2022 and broke her leg. She said since the fall she was unable to do anything on her own and had to stay in her wheelchair. She said there was a wound on her heel that the staff noticed the previous day. The resident was sitting in her wheelchair with a foot cradle. The resident had a soft brace on her foot that was ankle length. She did not have protective (also called bunny) boots on her feet. A bandage was observed on the resident's right heel during the interview. Resident #61 was interviewed again on 8/31/22 at 9:01 a.m. She said the wound on her heel was noticed by staff on 8/28/22. She said she did not have any pain related to the wound. She said since her right leg was broken she had to wear a large brace and her right leg had been swollen. She said she was unable to move her right leg on her own. She said when she returned from the hospital she did not wear any protective items on her foot but staff would float her legs if she was in bed. She said she did not prefer to be in bed and wanted to sit in her wheelchair for most of the day. She said a nurse told her she probably got the wound from her foot rubbing up against the cushion on her wheelchair. She said when she was in her wheelchair she just had socks on. The resident was observed in her wheelchair with the foot cradle and wore a bunny boot on her right foot. C. Record review The resident was in the hospital from 7/27/22 to 8/3/22 where she had been admitted with right femur fracture. A skin assessment was completed upon Resident #61's readmission to the facility on [DATE]. It indicated Resident #61 was at risk for developing pressure ulcers. It indicated the resident had a pressure relieving device on her bed and wheelchair. Skin issues observed included shearing to coccyx, bruising to abdomen, bruising to left wrist and forearm, and bruising to right bicep and fingers. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The 8/4/22 progress note indicated the resident returned from the hospital following a right femur fracture. It indicated the resident had a right knee brace and would need to utilize a hoyer (mechanical) lift for transfers. The 8/7/22 progress note indicated the resident required one person assistance for repositioning and two person assistance for hoyer use. A Braden Scale for Predicting Pressure Sore Risk was completed again on 8/17/22. It indicated the same results as the assessment completed on 8/3/22 (see above). A skin check was completed on 8/21/22. It indicated the resident's skin was intact. No additional notes were included. -No skin assessments were completed from 8/4/22-8/21/22. The 8/29/22 a progress note indicated a certified nurse aide (CNA) noticed the residents legs were weeping. Upon further assessment it was observed that the resident had a dark purple area that was draining on her right heel. The physician was notified and orders for wound care were obtained. The 8/29/22 a progress note indicated the resident was assessed by the wound physician and had a right heel deep tissue injury (DTI). Orders were obtained for medihoney and dressing to be applied. Resident #61 was assessed by the wound physician on 8/29/22. The notes indicated the resident had an unstageable DTI to her right heel. It indicated the measurements as 3.5 centimeters by 3.5 centimeters. It indicated there was light serous exudate (fluid). It indicated slough of 5%, granulation tissue of 20%, and viable tissues at 20%. It indicated the necrotic tissue was removed by the physician. The wound was cleaned and 0.62 centimeters of devitalized tissue were removed at a depth of 0.1 centimeters with healthy bleeding tissue observed. A clean dressing was applied following the procedure. Recommendations included to off load the wound and float heels in bed. The 8/30/22 a progress note was completed that indicated the resident had a DTI to right heel with a dry intact dressing in place. It indicated the resident was wearing bunny boots on her feet and orders were placed for occupational therapy to evaluate for wheelchair positioning. The August 2022 CPO revealed the following: -Hinged knee brace to right lower extremity in extension to be work continuously, ordered 8/3/22; -Float heels every shift as tolerated, ordered on 8/4/22; -Apply mattress overlay, ordered on 8/12/22; -Cleanse right heel with wound cleaner, apply medihoney and island dressing daily and as needed, ordered on 8/29/22; -Apply bunny boot to right heel, ordered on 8/30/22; and, (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Proheal critical care (protein supplement) 30 milliliters two times a day for impaired skin, ordered on 8/30/22. The skin care plan, revised 8/29/22 indicated Resident #61 was at risk for skin breakdown related to edema, fragile skin, and immobility. Interventions included wound care specialist to evaluate and treat, air overlay on mattress, bunny boot to right foot, and float heels in bed. -The skin plan did not indicate the resident had the wound to her right heel and did not include the foot cradle to her wheelchair. D. Staff interviews Registered nurse (RN) #1 was interviewed on 8/31/22 at 8:52 a.m. She said Resident #61 had a fracture and returned from the hospital with a brace on her right leg that needed to be worn at all times. She said the resident was non-weight bearing on her right leg. She said if a resident was non-weight bearing, heel protectors should be worn and pillows should be utilized to float the heels. She said the resident did not have heel protectors when she initially returned from the hospital but her heels were being floated when she was in bed. CNA #2 was interviewed on 9/1/22 at 9:18 a.m. She said Resident #61 had a brace on her right leg. She said the resident did not wear a boot for heel protection upon return from the hospital, but her wheelchair did have a padded cushion. The director of rehabilitation (DOR) was interviewed on 9/1/22 at 10:38 a.m. He said the therapy department received orders to complete a wheelchair assessment because of the resident's leg brace. He said pressure needed to be taken off of her leg. He said the resident currently had a foot cradle on her wheelchair that was made of foam cushion and also wore bunny boots to protect her heels. -The foot cradle was not indicated on the resident's care plan or in the physician's orders. Licensed practical nurse (LPN) #1 was interviewed on 9/1/22 at 11:30 a.m. The director of nursing (DON) was present for the interview. LPN #1 said she was the facility's wound nurse. She said Resident #61's wound was reported to her on 8/29/22 and had been found by nursing staff the previous day. She said it appeared to be a ruptured blister and was purple. She said she clarified the treatment orders that day and the wound physician was in the building so he assessed it as well. She said Resident #61 had orders to float her heels since she got back from the hospital on 8/3/22. She said her wheelchair had a padded foot cradle as well. She said bunny boots were not used when she returned from the hospital as bunny boots were not automatically utilized if someone returned from the hospital with immobility of an extremity. She said the resident had an air overlay on her bed but not an air mattress because the resident did not want one. She clarified that interventions that were put into place upon discovery of the DTI included the air mattress overlay, pillows for floating heels, repositioning bars on bed, padded foot cradle on her wheelchair, bunny boots, and a therapy evaluation for wheelchair positioning. She said she believed the wound occurred due to positioning and the wheelchair. She said since the resident had a brace on her right leg, the leg was fixed into a straight position and was sitting on the foot cradle consistently. She said the resident was unable to move her right leg independently and was dependent on staff for repositioning. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Certified nurse aide (CNA) #1 was interviewed on 9/1/22 at 1:38 p.m. She said Resident #61 had a brace on her right leg. She said she also wore a boot on her right foot to protect her heel. She said she was unsure what interventions were in place when the resident returned from the hospital with her broken leg.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43950 Based on observations, resident and staff interviews and record review, the facility failed to ensure appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence for one (#57) of two residents out of 44 sample residents. Specifically, the facility failed to ensure Resident #57 received continued nursing services for right hand contractures following occupational therapy (OT) discharge (4/16/22), with no physician orders, care plan or documentation of modified hand splints (carrots or rolled towel) being offered or provided. Cross-reference F677 failure to provide appropriate activities of daily living treatment and services to maintain or improve abilities for dependent residents. Findings included: I. Facility policy and procedure The Resident Mobility and Range of Motion policy statement, revised July 2017, was provided by the nursing home administrator (NHA) on 9/1/22 at 3:16 p.m. It read in pertinent part, Residents will not experience an avoidable reduction in range of motion (ROM). Residents with limited range of motion will receive treatment and services to increase and/or prevent a further decrease in ROM. Residents with limited mobility will receive appropriate services, equipment and assistance to maintain or improve mobility unless reduction in mobility is unavoidable. The care plan will include specific interventions, exercise and therapies to maintain, prevent avoidable decline in, and/or improve mobility and range of motion. II. Resident status Resident #57, age 77, was admitted on [DATE], with re-entry 3/25/21. According to the August 2022 computerized physician orders (CPO), the diagnoses included anemia (iron deficiency), dementia without behavioral disturbance, and hemiplegia and hemiparesis (muscle weakness or partial paralysis on one side of the body) following cerebrovascular disease. The 5/8/22 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of eight out of 15. She required extensive assistance with two persons for bed mobility, transfers, dressing, and toilet use. She required extensive assistance with one person for locomotion on/off the unit, personal hygiene, and eating. Bathing activity itself did not occur over the entire seven day MDS period so no functional status was listed. The MDS incorrectly indicated that there was no upper extremity (UE) impairment or functional limitation in range of motion (see occupational therapy record review below). III. Resident observations and interviews (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #57 was observed on 8/29/22 at 11:28 a.m. Her right hand had limited ROM with the ring and pinky fingers rolled into a fist and unable to fully straighten. Her fingernails were dirty with brown matter under nails and a quarter inch long and were pressing into the palm of her hand. There was no palm protector, carrot or other brace. Resident #57 was observed on 8/30/22 at 8:51 a.m. Her right hand contracted, no brace or carrot in place. Fingernails were a quarter inch long with brown/yellow matter under nails. Her fingernails were pressing into the residents palm. Resident #57 was observed on 8/31/22 at 9:17 a.m. Her right hand contracted, fourth (ring) and fifth (pinky) fingers flexed into a ball, second (index) and third (middle) fingers extended straight out, thumb bent in and under second and third fingers. Resident #57 said her right hand was sore and painful. Resident #57 said no staff had given her a brace, carrot or palm protector. IV. Record review Review of OT evaluation and plan of treatment, dated 2/17/22, revealed, Long term goal: Patient will have an appropriate orthotic device identified and ordered for right hand to manage limited ROM in digits. Right upper extremity ROM: impaired, including right shoulder, wrist, and hand. Current orthotic device: Right hand 2nd (index finger)/3rd (middle finger) digit extension and 4th (ring finger)/5th (pinky finger) digit flexion contractures with no device known. Pain with movement 8/10 (on a scale with 10 being the worst pain), constant frequency, location right hand/UE. Clinical impressions: Patient will require an orthotic for the right hand to manage limited joint ROM in digits (fingers) with increased pain. Review of the OT discharge summary, dated 4/16/22, revealed, Long term goal met on 3/31/22 with currently using carrot orthotic device for graded increase in ROM with staff training complete. -However, following the OT evaluation, plan of treatment and discharge there were no follow up physician orders submitted, no addition to the resident's care plan, and no orders for the nursing staff to continue to apply the carrot orthotic device for right hand contracture management. -The comprehensive care plan revealed there was no resident specific plan related to right hand contracture care or ROM management. V. Staff interviews (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The director of rehab (DOR) was interviewed on 8/31/22 at 11:52 a.m. He said they last had OT services for Resident #57 from 2/17-4/16/22. The DOR said the OT did address Resident #57 right hand contracture and limited ROM and had recommended use of a carrot orthotic. The DOR said the OT evaluation revealed impairment in the right upper extremity with functional limitations in the right hand, and Resident #57 had no device at that time. The DOR said the OT evaluation reported pain in the RUE with movement and the right hand was dominant. The DOR said there were no specific measurements of the right hand ROM beyond saying ROM was impaired. The DOR said the therapy procedure for recommended equipment or carrots was to do staff training and make sure it worked well with the resident. The DOR said when a finalized piece of equipment or carrot was selected the therapy department will get physician orders for its continued use. The DOR said he was not sure how the information got added to the care plan, the therapist did not add it to the care plan. The DOR said the OT notes stated the goal for use of carrot orthotic was met on 3/31/22 and he thought the nurse staff began using the carrot then. -However when the DOR looked for the physician orders he said there were not any, there was also no care plan for use of the carrot. -At 3:17 p.m. The DOR verified there were no orders for application of the carrot device. The DOR said the OT had forgotten to write the orders, and that was where the process went wrong. The DOR said the resident had the carrot but there were no orders for applying it, so Resident #57 had not been receiving it. The DON was interviewed on 9/1/22 at 12:53 p.m. She said when a resident was discharged from OT they would provide education to the nursing staff, a physician's order, and then it would be added to the care plan by the nurse. The DON said contracture management should be in the care plan. VI. Facility follow-up New physician orders were implemented after being brought to the facility's attention, which read, Right carrot to be placed in hand during night time, at bedtime for contracture management order date 8/31/22 at 7:00 p.m.

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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** 44949 Based on interviews and record review the facility failed to ensure the environment remained free from accidents and hazards and that residents received adequate supervision and assistive devices to prevent accidents for two (#61 and #7) of three residents out of 44 sample residents. Resident #61 was admitted to the facility on [DATE] with diagnoses of post polio syndrome, muscle weakness, lack of coordination, and abnormalities of gait and mobility. The resident required extensive, two person assistance for toileting and transfers. On 7/26/22, the resident fell in her bathroom during a transfer with one certified nurse aide (CNA) assisting. The resident was sent out to the hospital on 7/27/22 due to increased pain to her right lower extremity. At the hospital, it was discovered that the resident had a fracture to her right femur. Due to the facility not following the resident's transfer requirement of two staff as indicated by the 7/22/22 minimum data set assessment (four days prior to the fall), the resident had a fall that resulted in a fracture to the right femur. Resident #7 had a known history of falling. The resident fell on [DATE] and complained of pain following the fall. She reported to a physician assistant after 6/3/22 that she had fallen three other times in her room. The facility failed to investigate the other reported three falls. The facility sent the resident for an x-ray on 6/10/22 where a fracture of her left foot was confirmed. The resident was determined to have a fractured foot for seven days before it was discovered and a course of action was provided. Findings include: I. Facility policy The Falls policy and procedure, revised October 2010, was provided by nursing home administrator (NHA) on 9/1/22 at 3:00 p.m. It read, in pertinent part Falling may be related to underlying clinical conditions and functional decline, medication side effects, and/or environmental risk factors. Residents must be assessed in a timely manner for potential causes of falls. If there is evidence of a significant injury, nursing staff will help the resident to a comfortable sitting, lying, or standing position, and then document relevant details. II. Resident #61 A. Resident status Resident #61, age 73, was admitted on [DATE]. According to the August 2022 computerized physician orders (CPO), diagnoses included post polio syndrome, muscle weakness, lack of coordination, and abnormalities of gait and mobility. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The 8/18/22 minimum data set (MDS) assessment indicated the resident was cognitively intact with a brief interview of mental status score of 15 out of 15. It indicated the resident required extensive, two person assistance for activities of daily living. It indicated the resident utilized a wheelchair for mobility. B. Resident interview Resident #61 was interviewed on 8/29/22 at 11:18 a.m. She said she had a fall at the end of July 2022 and broke her leg. She said a CNA witnessed the fall. She said the fall happened in her bathroom while she was toileting. She said since the fall she was unable to do anything on her own and had to stay in her wheelchair. Resident #61 was interviewed again on 8/31/22 at 9:01 a.m. She said when she fell in her bathroom a lift device was not being used. She said her knees gave out and she went down. She said the CNA tried to help but was unable to stop her from falling. She said she had a gait belt on at the time. Resident #61 was interviewed on 9/1/22 at 9:07 a.m. She said one CNA was present when she fell in her bathroom. She said when she needed assistance with toileting she only needed one person. She said a lift device had been used with her before but it was not used consistently because she could stand with assistance. She said when she was falling her knee folded and she could not get up. She could not recall what part of her legs hit the floor but they were twisted when she was falling. She said the CNA attempted to help her sit on her wheelchair but she asked the CNA to move the wheelchair as she was falling. She said she had increased pain in her leg and was sent to the hospital shortly after. C. Fall investigation The director of nursing (DON) provided the fall investigation on 8/31/22 at 11:35 a.m The investigation indicated that on 7/26/22, a CNA was assisting Resident #61 to a standing position from the toilet. The CNA pulled the resident's pants up and the resident said she needed to sit back down. The resident sat on the edge of the toilet and the CNA attempted to assist the resident to sit further back on the toilet when the resident began to slide off the toilet. The CNA was able to push the wheelchair away and lower the resident to a seated position on the floor. The CNA then laid the resident on her back. The resident was assessed for injury and no injuries were identified though the resident reported pain to her right knee. The resident was assisted to bed by four staff members. Pain medications were administered. The root cause analysis indicated the resident's leg gave out and the interventions put into place following the event were two person transfers and recommendation of a physical therapy evaluation. The report indicated the resident was sent to the hospital on 7/27/22 due to increased pain in her right knee. A right femur fracture was identified at the hospital. D. Record review Progress notes from 7/27/22-9/1/22 revealed the following: -On 7/27/22 a progress note indicated Resident #61 had a fall on 7/26/22. It indicated the resident was at a level 4 out of 10 (on a pain scale with 10 being the worst) for pain in her right knee. It indicated no redness or swelling was observed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-On 7/27/22 a progress note indicated Resident #61 had an assist to the floor on 7/26/22. It indicated her pain was at a 4 out of 10 and she could not move her right leg but no bruising or swelling was observed. It indicated that a lift device was needed for transfers because the resident could not put weight on her right leg. It indicated the physician was notified. -On 7/27/22 a progress note revealed Resident #61 was sent out to the hospital for pain to her right leg. -On 8/4/22 a progress note was completed that indicated Resident #61 had returned from the hospital with a diagnosis of right femur fracture. The note indicated the resident would need a Hoyer lift for transfers. The MDS assessment was completed on 7/22/22, four days prior to the fall. It indicated Resident #61 required extensive, two person assistance for transfers and toileting. The fall care plan was updated on 7/26/22 to include that Resident #61 required two people for transfers. The activities of daily living care plan, revised 8/25/22, indicated Resident #61 required two person assistance with transfers and the hoyer lift to be used as needed. The hospital report revealed Resident #61 was admitted on [DATE]. The report indicated the resident stated she was getting up from her wheelchair using a lift device and fell . It indicated that after the fall the resident had severe pain in her right lower extremity. The report indicated the resident said she had been feeling weaker following a urinary tract infection and related hospital stay from 7/15/22 to 7/18/22. It indicated the resident said she was too weak to stand on her own and had been using a lift device for transfers. An orthopedic consultation was completed at the hospital on 7/28/22. The report revealed the resident had right knee pain due to a fall from a mechanical lift. The report indicated recommendations were non surgical treatment of right femur fracture, immobilizer to right leg, non-weight bearing to right leg, and skilled physical and occupational therapy treatments were ordered. The resident was discharged from the hospital on 8/3/22. The discharge summary indicated the resident had a fall from a mechanical lift device while transferring from her wheelchair in the bathroom. It indicated the resident had a right femur fracture and would need outpatient orthopedic consultation. E. Staff interviews CNA #2 was interviewed on 9/1/22 at 9:18 a.m. She said Resident #61 was one person assist for toileting and transfers prior to her fall in July 2022. She said staff did not use the Hoyer lift with her prior to the fall. She said because of her injuries from the fall, staff needed to use the Hoyer lift for all transfers. CNA #1 was interviewed on 9/1/22 at 1:39 p.m. She said she had been working at the facility for a few weeks and knew Resident #61 utilized a Hoyer lift for transfers. She was unsure what level of assistance the resident needed prior to her fall in July 2022. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Registered nurse (RN) #1 was interviewed on 9/1/22 at 10:34 a.m. She said prior to the fall, Resident #61 was one person assist for transfers. She said shortly before the fall the resident would need two person assistance on occasion because she had some weakness. She said because of the resident's fracture, the Hoyer was utilized. The director of rehabilitation (DOR) was interviewed on 9/1/22 at 10:38 a.m. He said the resident currently required a Hoyer lift for transfers. He said he was unsure if a Hoyer lift was utilized prior to the fall in July 2022. He said the therapy department had not worked on transfers with the resident since 2021. He said Resident #61 was discharged from physical therapy on 7/18/22 and no recommendations were made for transfers at discharge. The director of nursing (DON) was interviewed on 9/1/22 at 1:14 p.m. She said Resident #61 was being assisted in the bathroom by a CNA when she had her fall. She said at the time, Resident #61 was able to stand on her own. She said when the CNA pulled the resident's pants up, the resident had to sit down but slid off the toilet. She said the CNA lowered the resident to the floor into a seated position and went to get help. She said a Hoyer lift was not being used and was unsure why that was documented in the hospital report. She said staff should follow the transfer status on the MDS which would also be in the care plan. She said she did not know the MDS indicated this resident was a two person assistance for transfers and toileting. She said floor staff were reporting using one or two people for transfers around the time of the fall. 43135 III. Resident #7 A. Resident status Resident #7, age 73, was admitted on [DATE]. According to the August 2022 computerized physician orders (CPO), the diagnoses included spinal stenosis (narrowing of spaces in the spine), chronic obstructive pulmonary disease (CPOD), anxiety disorder, muscle weakness, unsteadiness on feet, pain in right leg, edema, and hypertension (high blood pressure). The 6/4/22 minimum data set (MDS) revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The resident required supervision with bed mobility, transfers, walking in her room, dressing, eating, toilet use and personal hygiene. The resident did not reject cares from staff. The resident was steady at all times when she walked, when moved from a seated to standing position, when turned around, when moving on and off the toilet. The five day look back revealed the resident had frequent pain, received pain medication, the resident's pain intensity scored a 6 (out of 10 with 10 being the worst on the scale) indicating strong pain that interferes with normal daily activities and the pain made it difficult to concentrate. B. Resident interview (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Resident #7 was interviewed on 8/30/22 at 9:01 a.m. She said a few months ago she fell out of bed and broke her left foot. She said she had to stay in bed a lot after the fall because her foot hurt. She said she did not know why the facility took so long to get her an x-ray but when she finally received one it revealed she fractured her left foot. She said she had a lot of pain in her foot after she fell . She said a few days after the x-ray she started to wear a walking boot to protect her foot. She said breaking her foot was hard on her because she was very independent, walked up and down the hallways, and enjoyed visits with her many friends in the facility. C. Record review The admission comprehensive care plan, dated 3/3/22 and revised on 3/10/22 revealed the resident was at risk for falls due to history of falls, medication use, new environment, unsteady balance/gait, weakness, pain, muscle spasms. -The resident is at risk or has right thigh pain, muscle spasms, vertebra fracture and neuropathy. -The resident will report relief of pain after receiving intervention/medications. -The resident's interventions included administering pain medications as ordered, assist in finding comfortable position in bed or wheelchair, assist with repositioning for comfort as needed, monitor for worsening of pain symptoms and report to physician as needed, and notify the physician if interventions are not consistently effective. The facility was to observe for pain every shift and as needed, and provide non-pharmacological interventions of the individual's choice which included repositioning and elevation. The nursing progress note on 6/4/22 revealed, Staff is called to resident's room by roommate. Resident #7 is found on the floor next to her bed with her legs tucked underneath her. 'I don't know how I got here' . She is assessed for injury and no injuries are noted at this time. She is assisted to a standing position and back to bed. Neuro (neurological) checks are initiated and vital signs are taken. All within normal limits. Notifications are made. -The nursing note was written on 6/4/22, the resident fell at 11:59 p.m. on 6/3/22. The nursing progress note on 6/5/22 revealed the resident revealed she had pain in the left rib/midsection area, and had a swollen left great toe. She was sore to the touch on the rib area and able to move her toe, put pressure on it, without pain. -The resident had pain levels that ranged from moderate to severe pain after the fall. An x-ray was not completed until seven days after the fall. The interdisciplinary team (IDT) report on 6/8/22 (the fall was five days previous) documented, Resident stated 'I don't know how I got here' she was not able to give any details of the fall. Resident has not had other past falls in the facility - isolated incident. Resident may have been attempting to sit up or self rise from bed. Recommendations included physical therapy evaluation and treatment. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The nursing progress note on 6/8/22 revealed the physician assistant (PA) told the resident's nurse that the resident said she had fallen three other times in her room and did not report it to the staff. She also said she had toe pain and requested to see the doctor. The nurse then documented the resident told her that she had fallen three other times and not reported the falls to the staff. The resident said she was dizzy and fell while ambulating twice in her room but was able to get herself up. She said she did not have any injuries. She said she also did not report that she rolled out of bed in the middle of the night and went back to bed on her own. She said she was now aware she needed to call for help and have the nurse assess her for injuries anytime she fell . Resident told the nurse she had great toe pain and requested to see the doctor. The nurse documented there was no injury found on the toe. (see DON interview below) -However, the facility did not investigate the report of the resident falling three times as reported to the PA and nurse. The nursing progress note on 6/8/22 revealed, as needed (PRN) narcotic was given to decrease her pain level, but the note did not record where the pain was located. The radiology report on 6/10/22 revealed, There is a fracture involving the fifth metatarsal (middle bones in the foot between toe and ankle bone) and head first proximal phalanx (large bone in the toe closest to the foot). There is associated soft tissue swelling. No foreign body is seen. Conclusion, acute left foot fracture. -There were no nursing progress notes for four days following the radiology report. The nursing progress note on 6/15/22 revealed the resident was sent to ortho (orthopedic) and received an order to wear a boot on her foot at all times except in the shower. The comprehensive care plan on 6/15/22 revealed (the) walking boot on at all times until toe heels, may be removed for showers. D. Staff interviews The nurse practitioner (NP) was interviewed on 9/1/22 at 10:20 a.m. She said she began working at the facility in July. She said the PA who did visit Resident #7 no longer worked in the facility. She said she could not comment on the fall or the resident telling the PA that she had fallen three other times, or about the pain the resident told the PA about, or about that the resident wanted to see a doctor. She said that was before her time of employment and she knew nothing about what happened in June 2022. She said since she had started in July 2022 she had done a lot of work with Resident #7. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The director of nursing (DON) was interviewed on 9/1/22 at 11:40 a.m. She said she did not know why it took about a week to x-ray Resident #7's foot. She said she could not comment on the fractured foot after the fall but she said she would look into the documentation and see why it took so long to get an x-ray and the walking boot. She said she did not know if the facility did a fall assessment after the resident told the PA she fell three times and did not inform the staff. She said if she found any documentation about the three falls, or why the facility did not order an x-ray for about a week after the fall on 6/3/22, she would provide the documentation. She said she would look into the electronic medical records to see if there were any physician notes about the three unwitnessed falls and if she found them she would provide those notes also. (see facility follow-up) E. Facility follow-up The facility did not provide any further documentation about Resident #7 during the survey (which ended 9/1/22) or after the survey via email. The facility did not send further documentation about why an x-ray was not done in a timely manner, nor was any information provided that a fall assessment had been performed after the PA told the facility that the resident had three more falls that she did not tell the facility about.

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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** 38503 Based on observation, record review and interviews, the facility failed to provide catheter care, treatments and services to minimize the risk of urinary tract infection for one (#124) of two reviewed out of 44 sample residents. Specifically, the facility failed to ensure Resident #124 had an order for urinary catheter and catheter care in place timely. Findings include: I. Facility policy The Indwelling Catheter policy was requested from the director of nursing (DON) during survey 8/29/22 to 9/1/22, and again from the nursing home director (NHA) on 9/7/22; however, was not provided by the facility. I. Resident status Resident #124, age 89, was admitted on [DATE]. According to the August 2022 computerized physician orders (CPO), diagnoses included chronic obstructive pulmonary disease with acute exacerbation, atrial fibrillation, heart failure, pneumonia and diabetes mellitus. The 8/28/22 minimum data set (MDS) assessment, revealed Resident #124 was cognitively intact with a brief interview for mental status (BIMS) score of 15 out 15. He did not exhibit behaviors or resist care. He required total dependence with toilet use. He had an indwelling catheter. II. Observation On 8/29/22 at 12:17 p.m. Resident #124 was observed to have a catheter, which was draining, cloudy yellow urine. III. Record review Review of the Admission/Readmission Evaluation Bundle dated 8/23/22 revealed Resident #124 had a catheter in place which was inserted on 8/2/22 (in the hospital prior to admission) for urinary retention and obstructive uropathy. Review of Resident #124's CPO, medication admission record (MAR) and treatment administration record (TAR) on 8/29/22 revealed no orders for catheter care until brought to the facility's attention (see below). Review of Resident #124's baseline care plan, initiated 8/24/22 revealed no documentation of Resident #124's catheter. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The catheter care plan, initiated on 8/30/22 revealed Resident #124 had an indwelling catheter related to obstructive uropathy. Interventions included to provide catheter care each shift and as needed, the catheter size, positioning of the catheter bag below the level of the bladder, change catheter monthly, and report any signs or symptoms of urinary tract infections or bleeding to the physician. The 8/30/22 catheter care plan was initiated after being brought to the facility's attention. Physician orders dated 8/30/22 read Indwelling Foley Catheter 22 fr. (french) with a 10 cc (cubic centimeter) balloon. Change as needed for poor function. Catheter care q (every) shift and as needed. IV. Staff interviews Licensed practical nurse (LPN) #2 and registered nurse (RN) #2 were interviewed on 8/30/22 at 1:00 p.m. They said Resident #124 had a catheter. They said when a resident admitted with a catheter the admitting nurse should ensure the resident had a diagnosis for the catheter, orders for the catheter including the size, catheter care orders and the catheter needed to be care planned. They acknowledged the resident did not have orders. RN #2 said he received a message six days prior from the assistant director of nursing to add the catheter order; however, he had to work the floor and train a new nurse on night shift and did not return to work until that week so it did not get done. LPN #2 and RN #2 said any nurse caring for the resident could have entered catheter orders. The director of nursing was interviewed on 8/30/22 at 4:12 p.m. She said if a resident admitted with a catheter the admitting nurse was responsible for ensuring the resident had catheter orders to include the size, catheter orders, and ensuring the care plan was updated upon admission. V. Facility follow-up The Foley Catheter Insertion policy and procedure was provided by the nursing home administrator (NHA) on 9/14/22 at 12:20 p.m. However, the policy did not include obtaining physician orders for the catheter, orders for catheter care, monitoring the catheter ensure urine flow and/or signs of infection.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 38503 Based on observations, record review and interviews, the facility failed to ensure the medication error rate was not greater than five %. Specifically, nursing staff failed to prime an insulin pen prior to administering an insulin injection to Residents #124 and #127 which resulted in a medication error rate of 7.14% or two errors out of 28 opportunities. Cross-reference F760 failure to ensure the residents were free from a significant medication error. Findings include: I. Facility policy The Medication Administration and Management policy and procedure, revised 2/2/22 was provided by the director of nursing on 8/31/22 at 12:10 p.m. It documented in pertinent part, Authorized licensed or certified/permitted medication aide or by state regulatory guidelines staff must understand the '8 Rights' for administering medication: -The right patient/resident; -The right drug; -The right dose; -The right time; -The right route; -The right charting; -The right results; and, -The right reason. Follow manufacturer guidelines for medication pen-style delivery devices for priming and air shots. II. Observation of medication errors and staff interview (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/31/22 at 8:04 a.m., licensed practical nurse (LPN) #2 was observed preparing Resident #127's medications. She prepared Bupropion (antidepressant) 100 mg one (1) tablet (tab), Celexa (antidepressant) 40 mg 1 tab, Ferrous Sulfate (iron) 325 mg 1 tab, Fiber caplets 625 mg 1 tab Lasix (diuretic) 20 mg 1 tab, Synthroid (thyroid medication) 75 mg 1 tab, Protonix (medication for gastroesophageal reflux disease) 40 mg 1 tab, Actos (diabetes medication) 30 mg 1 tab, Robaxin (medication for spasms) 750 mg 1 tab, Lisinopril (antihypertensive) 20 mg 1 tab, Lyrica (medication for nerve pain) 150 mg 1 cap, and Tramadol (pain medication) 50 mg 1 tab. She dialed Humulin 70/30 KwikPen to 15 units and administered all the medications to the resident. She did not prime the KwikPen. -At 8:36 a.m., LPN #2 was observed preparing Resident #124's medications. She prepared Prednisone (medication for Bronchitis) 20 mg 1 tab, Acetylcysteine (mucolytic) 600 mg 1 tab, Zithromax (antibiotic) 250 mg 1 tab, Cardizem (heart medication) 240 mg 1 capsule, Eliquis (anticoagulant) 5 mg 1 tab, Proscar (medication for benign prostatic hyperplasia) 5 mg 1 tab, Levaquin (antibiotic) 500 mg 1 tab, Metoprolol (blood pressure medication) 25 mg 3 tabs, Cialis (medication for pulmonary hypertension) 5 mg 1/2 tab (2. 5mg), multivitamin 1 tab, Miralax (medication for constipation) 1 capful (17 mg), Acidophilus (probiotic) 1 capsule, Protein liquid 30 ml, and Nebulizer Budesonide 0.25mg/2ml 1 ampule. She dialed Tresiba (insulin) Flex Touch Pen to 10 units and administered all the medications to the resident. She did not prime the Flex Touch pen. LPN #2 was interviewed immediately following the medication pass. She said she worked at the facility for one year and recently switched to day shift three weeks prior. She said she did not know how to prime an insulin pen. She said she thought priming an insulin pen would consist of tilting the pen back and forth. She said she had not been observed during medication by administrative staff or by a pharmacist. III. Administrative interviews The director of nursing (DON) and assistant director of nursing (ADON) were interviewed on 8/31/22 at 10:55 a.m. The DON said she should have primed the Insulin Pens prior to administration to ensure the resident received all the medication.

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 38503 Based on observations, interviews and record review the facility failed to ensure residents were kept free from significant medication errors for two (#124 and #127) of four reviewed out of 44 sample residents. Specifically, the facility failed to ensure an insulin pen was primed before administering to Residents #124 and #127. Cross-reference F759 failure to ensure the facility's medication error rate was not greater than 5%. Findings include: I. Professional reference According to Humulin 70/30 KwikPen, Instructions for Use, retrieved on 9/6/22 from https://pi.lilly.com/us/HUMULIN-7030-KWIKPEN-IFU.pdf read in pertinent part, Prime before injection. Priming your Pen means removing the air from the Needle and Cartridge that may collect during normal use and ensures that the Pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin. To prime your Pen, turn the Dose Knob to select 2 (two) units. Hold your Pen with the Needle pointing up. Tap the Cartridge Holder gently to collect air bubbles at the top. Continue holding your Pen with Needle pointing up. Push the Dose Knob in until it stops, and zero is seen in the Dose Window. Hold the Dose Knob in and count to 5 (five) slowly. You should see insulin, repeat priming steps 8 (eight) to 10, no more than 4 (four) times. If you still do not see insulin, change the Needle and repeat priming steps 8 to 10. According to Tresiba Flex Touch Pen (Insulin degludec injection) label, retrieved on 9/6/22 from https://www.accessdata.fda.gov/drugsatfda_docs/label/2015/203314lbl.pdf read in pertinent part, Turn the dose selector to select 2 units. Hold the Pen with the needle pointing up. Tap the top of the Pen gently a few times to let any air bubbles rise to the top. Hold the Pen with the needle pointing up. Press and hold in the dose button until the dose counter shows 0 (zero). The 0 (zero) must line up with the dose pointer. A drop of insulin should be seen at the needle tip. If you do not see a drop of insulin, repeat steps 7 (seven) to 9 (nine), no more than 6 (six) times. II. Observation of medication errors and staff interview On 8/31/22 at 8:04 a.m., licensed practical nurse (LPN) #2 was observed preparing Resident #127's medications. She dialed Humulin 70/30 KwikPen to 15 units and administered all the medications to the resident. She did not prime the KwikPen. -At 8:36 a.m., LPN #2 was observed preparing Resident #124's medications. She dialed Tresiba (insulin) Flex Touch Pen to 10 units and administered all the medications to the resident. She did not prime the Flex Touch pen. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN #2 was interviewed immediately following the medication pass. She said she worked at the facility for one year and recently switched to day shift three weeks prior. She said she did not know how to prime an insulin pen. She said she thought priming an insulin pen would consist of tilting the pen back and forth. She said she had not been observed during medication by administrative staff or by a pharmacist. III. Administrative interviews The director of nursing (DON) and assistant director of nursing (ADON) were interviewed on 8/31/22 at 10:55 a.m. The DON said she should have primed the Insulin Pens prior to administration to ensure the resident received all the medication. The ADON said LPN #2 had a recent competency for medication administration. The DON said they would provide immediate education to LPN #2 regarding priming of insulin pens. IV. Facility follow-up On 8/31/22 at 12:10 p.m., the DON provided a copy of the LPN #2's competency titled Med Pass Clinical Competency training dated 9/30/22 and a copy of Medication Management Skills Evaluation dated 8/31/22 which included training for insulin and non-insulin pens.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 38503 Based on observations and staff interviews, the facility failed to label, safely store and properly dispose of medications in a manner consistent with applicable federal and state standards of practice for two of two medication storage rooms and one of two medication carts. Specifically, the facility failed to ensure: -Multi-dose vials Tuberculin was dated when first opened; and, -Expired medications were removed from the medication rooms and medication carts in a timely manner. Findings include: I. Professional reference According to the Tubersol package insert, retrieved on 9/7/22 from https://www.fda.gov/media/74866/download, A vial of TUBERSOL which has been entered and in use for 30 days should be discarded. II. Facility policy and procedure The Storage of Medications policy and procedure, revised November 2020 was provided by the director of nursing (DON) on 8/31/22 at 12:10 p.m. It read in pertinent part, The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. Drug containers that have missing, incomplete, improper, or incorrect labels are returned to the pharmacy for proper labeling before storing. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed. III. Observations and interviews On 8/31/22 at 11:01 a.m., the long term care medication storage room was observed with registered nurse (RN) #1. Located in the medication refrigerator were hemorrhoid suppositories with an expiration date April 2022 and one opened undated Tuberculin vial. Located on a tall storage rack was one liquid protein bottle with an expiration date of 6/13/22. -RN #1 said she would ensure the expired and undated medications were discarded. She said the medication storage process was to put medications for destruction in a box on a counter until the DON was ready to prepare medications for destruction. However, the medications were not in the box on the counter. On 8/31/22 at 11:23 a.m., the D hall medication cart was observed with licensed practical nurse (LPN) #3. There was one bottle of Ferrous Sulfate (iron) with an expiration date of June 2022. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-LPN #3 said she was going to discard the expired medication. On 9/1/22 at 10:35 a.m., the P hall medication room was observed with LPN #2. There were two bottles of ferrous sulfate with an expiration date of June 2022, one bottle of liquid Tylenol with an expiration date of April 2022. In the medication refrigerator there was a box of Tylenol suppositories with an expiration date of July 2022 and one Tuberculin vial that was opened and undated. -LPN #2 said she would remove all the expired and undated medication and take it to the DON for destruction. IV. Administrative interview The DON was interviewed on 9/1/22 at 1:12 p.m. She said all nurses were responsible for dating Tuberculin vials and ensuring expired medications were removed and discarded from the medications rooms and medication carts.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38503 Based on observations, interviews,and record review the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and infection, including COVID-19 in two of four hallways. Specifically, the facility failed to: -Ensure nursing staff were wearing appropriate personal protective equipment (PPE) in resident care areas; -Ensure staff used proper infection control practices during medication pass; and, -Ensure dirty laundry was contained. Findings include: I. Professional references A. According to the Centers of Disease Control (CDC) guidance, Use Personal Protective Equipment (PPE) When Caring for Patients with Confirmed or Suspected COVID-19, dated 6/3/2020, retrieved on 9/6/22 from https://www.cdc.gov/coronavirus/2019-ncov/downloads/A_FS_HCP_COVID19_PPE.pdf. It read in pertinent part, PPE must be donned correctly before entering the patient area. PPE must remain in place and be worn correctly for the duration of work in potentially contaminated areas. PPE should not be adjusted. Face masks should be extended under the chin. Both your mouth and nose should be protected. B. According to the CDC guidance, Appendix D: Linen and Laundry Management, 3/27/2020, retrieved from https://www.cdc.gov/hai/prevent/resource-limited/laundry.html reviewed on 9/6/22 revealed in pertinent part, II. Facility policy and procedure The COVID-19 Infection Control policy, revised 3/11/22, was provided by the nursing home administrator (NHA) via email on 8/29/22 at 3:52 p.m. It revealed in pertinent part, Support hand hygiene and respiratory/cough etiquette by residents, visitors, and making sure tissues, soap, paper towels, and alcohol-based hand rubs are available. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate staff on proper use of personal protective equipment and application of standard, contact, droplet, and airborne precautions, including eye protection. All staff must wear facemasks while in the facility. Staff who are caring for COVID-19 positive residents and those caring for residents with unknown COVID-19 must wear an N95, isolation gown, goggles or face shield. Staff should encourage unvaccinated residents to wear masks when in common areas and when personal care is being provided by caregivers. Promote easy and correct use of personal protective equipment (PPE) by: Posting signs on the door or wall outside of the resident room that clearly describe the type of precautions needed and required. Make PPE, including facemasks, eye protection, gowns, and gloves, available immediately outside of the resident's room. Position a trash can near the exit inside any resident room to make it easy to discard PPE. Procedure when individual is COVID-19 positive: Place resident on droplet isolation in a private room (containing a private bathroom) with the door closed. If private room is not available, resident can be cohorted with another COVID-19 resident if warranted. III. Failure to ensure staff wore personal protective equipment appropriately and consistently A. Observations and interviews On 8/30/22 at 3:13 p.m. four certified nurse aides (CNAs #4, #5, #6, and #7) were observed not wearing masks at the long term care (LTC) nurses station. The CNAs said the nursing station was where they did charting for the LTC units. All four CNAs had their masks off in the front row of the nurse station and were all sitting next to each other four in a row and were eating a snack and drinking liquids. They said there was no place, close by, to go to eat and drink. They said they barely had time to hydrate and that their coffee from breakfast was still there. They said they had no secured place to remove their masks, that was close by, to get hydration or food. On 8/31/22 at 7:35 a.m., the plant operations manager (POM) was observed without a facial covering while in the lobby of the facility. He exited the front door, he had a bucket of water and poured it onto the pavement. He walked back into the building down a hallway adjacent to the front desk and then returned with an N95 mask on. The POM was immediately interviewed. He said he forgot to place his mask back on when he left his office. He said he went to fill the bucket with water to clear the pavement of spit because he did not want anyone to step in it. He acknowledged the importance of having a facial covering as the facility was in active outbreak status. There were no residents observed in the lobby, no one was at the receptionist area. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 3:50 p.m., registered nurse (RN) #2 was observed walking from the nurses station to an exit door. RN #2 was not wearing a mask. He told another staff member in the hallway he was going outside for a break. No residents were in the area at the time. At 3:55 p.m., the nursing home administrator (NHA) was notified of RN #2 in a resident care area without a mask. She said she was going to complete education with RN #2 once he returned from his break. On 9/1/22 at 10:10 a.m., occupational therapist (OT) was in room [ROOM NUMBER] assisting the resident who was in isolation for being COVID-19 positive. She had on an N95 mask with eye protection; however, did not have on a gown. The OT was interviewed when she exited the room. She said she was called into the room by the resident's wife to assist him out of bed. She said she knew the resident was in isolation and she was supposed to don appropriate PPE (a gown), but forgot to. B. Administrative interview The director of nursing (DON) was interviewed on 8/30/22 at 4:02 p.m. She said the staff break room was on the main level, and on the opposite side of the facility from the LTC units. The DON said the nurses station was not a designated break/snack area. The DON said the CNAs should have gone to a non resident care area to remove masks and take liquids or snacks. The DON acknowledged the concern that the facility was currently in COVID-19 outbreak status. The staffing coordinator (SC) was interviewed on 8/31/22 at 9:30 a.m. She said when the CNAs took a break, they could come to the staffing coordinator office which was located close to the LTC unit. There was coffee and snacks located in the staff coordinators office and the SC said that the office had been designated as a staff break area for a long time. The SC said the four CNAs should have come down yesterday to her office to hydrate and take a snack. The director of nursing (DON), assistant director of nursing and clinical nurse consultant were interviewed on 8/31/22 at 10:55 a.m. They said all staff were supposed to have on a mask when they entered the building and had provided staff education on how, when and where to wear PPE. C. Facility follow-up The nursing home administrator (NHA) provided a copy of the immediate education that was provided to the POM on 8/31/22 at 5:23 p.m. It read, all staff were to wear a mask at all times while in the building. Surgical masks may be worn in the front lobby. An N95 mask was required when staff passed through the double doors near the elevator and on the skilled nursing unit. Masks must cover your nose and mouth entirely. Break room areas are the only exception while eating and drinking. -The NHA said she had staff actively observing staff on the floor to ensure staff were utilizing PPE appropriately and would continue to provide on the spot education if needed. The DON provided documentation of on the spot training on 9/1/22 at 9:30 a.m. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-It revealed there was to be no food or drink at the nurses station or other working areas and to not remove masks in the resident areas and the nurses stations. Signed by DON 8/30/22. Signed by 16 staff members including the four CNAs found at the nurses station not wearing masks. On 9/1/22 at 12:00 p.m., the NHA provided documentation of education with RN #2 that was completed on 8/31/22. The education covered the use of an N95 mask in resident care areas. VI. Failure to ensure proper infection control practices during medication pass A. Observation and interview On 8/31/22 at 8:04 a.m., licensed practical nurse (LPN) #2 was observed preparing Resident #127's medications. She poured three of the resident's medications (Bupropion, Lisinopril and Lyrica) into her hand before placing them into a medicine cup. -At 8:36 a.m., LPN #2 was observed preparing Resident #124's medications. She poured Prednisone into her hand before placing it into the medicine cup. LPN #2 was interviewed immediately after the medication administration. She said she typically did not pour medications in her hand, but she was nervous because this was the first time she was observed during a medication pass. She said she knew she was not supposed to touch the medications. B. Administrative interview The director of nursing (DON) and the assistant director of nursing (ADON) were interviewed on 8/31/22 at 10:55 a.m. The DON acknowledged she it was not a standard of practice to pour medication into your hand during medication pass. C. Facility follow-up The DON provided a copy of the immediate education that was provided to LPN #2 on 8/31/22 at 12:10 p.m. It read in pertinent part, Medication Management Skill Evaluation, Infection Control: -Maintains clean medication workstation environment, cart, crusher, pitcher, supplies; -Performs hand hygiene as required; -Wears appropriate PPE during medication administration; and, -Maintains appropriate precautions (standard, transmission). 43135 V. Failure to ensure dirty laundry was contained A. Observations (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/31/22 at 10:26 a.m. the dirty linen room on the Short P hallway revealed the following: -The Short P dirty linen room had a red open laundry transport cart which contained three light blue laundry bags covered in approximately 25 items of soiled dirty clothing that were not bagged but thrown on top of the blue bags. The room also contained a used rolled up air mattress, a wet mop in a bucket, and several plastic three tiered containers. B. Interviews The plant operation manager (POM) and the laundry aide (LA) #1 was interviewed on 8/31/22 at 10:26 a.m. LA #1 said he would a few times a day take the red linen cart from each soiled laundry room and pushed it to the laundry area where clothes were sorted before washing. He said the laundry that was thrown unbagged on top of dirty laundry bags could be from COVID-19 rooms or not and that there was no way to know. LA #2 was interviewed on 9/1/22 at 2:10 p.m. He said the floor staff sometimes placed dirty laundry not in bags in the same dirty laundry bin that contained bags of soiled clothes from residents. He said sometimes dirty clothes were just thrown on top of bagged dirty laundry. The NHA was interviewed on 9/1/22 at 3:00 p.m. The NHA said all dirty laundry should be put in appropriate dirty laundry bags and not put unbagged in the laundry room. VI. Facility COVID-19 status The director of nurses (DON) was interviewed on 8/29/22 at 11:00 a.m. She said the facility had three COVID-19 positive residents, and expected one resident to return to the facility from the hospital during the week who also had COVID-19 (the fourth resident returned to the facility on [DATE]). She said there were zero COVID-19 positive staff. 43950 44949