STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125041	A. Building B. Wing	02/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Liliha Healthcare Center	1814 Liliha Street Honolulu, HI 96817

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 42871 Based on observations, record review, and interview with staff members the facility failed to ensure three of 21 residents sampled exercised their right to a dignified existence. Resident (R) 60 and R45 were not provided privacy when receiving care requiring them to lift their shirt and a staff member was standing over R21 and R53 while providing assistance during breakfast. Findings include: Review of the facility's policy and procedure Promoting/Maintaining Resident Dignity reviewed/revised 05/20/22 documents It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as are for each resident in a manner and in an enviroment, that maintains or enhances resident's quality of life by recognizing each resident's individuality. The policy's compliance guidelines include 1. All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights .5. When interacting with a resident, pay attention to the resident as an individual .12. Maintain resident privacy . 1) On 02/07/23 at 09:20 AM, observed R60 sitting up in a wheelchair at a table in the common area. R60's shirt was lifted, exposing his abdomen, and Nurse (N)12 administered an injectable medication into his abdomen. The common room is a large open area that housed the nursing station and is used as a dining room and activity area. R60 sat at a table approximately 15 feet from the main entrance, another resident sat at a table adjacent to the table where R60 was sitting approximately 8 feet away, and several residents were doing activities with staff approximately 40 feet away. On 02/13/23 at 10:10 AM, interviewed Nurse(N)11. N11 stated that medications, especially injectable medications, are not to be given out in the common area. R60 was supposed to be brought into his room and curtain closed for dignity before his injectable medication was given. 43414 (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) On 02/07/23 at 08:19 AM observed with a second surveyor (S2) outside of R45's room in the hallway, Nurse (N) 12 provide assistance putting a patch on R45's back. R45 was observed to be standing slightly bent over, using her walker for support, with her shirt lifted. R45's curtain was not drawn closed for privacy and R45's midriff could be seen from outside R45's room in the hallway. S2 reported she could see R45's chest, including her nipple, from S2's view in the hallway, and observed Assistant Administrator walk by as R45's shirt was lifted. On 02/10/23 at 11:14 AM interview with N6 was done. N6 stated when providing care in a resident's room, such as putting a patch on that requires a resident's shirt to be lifted, the privacy curtain should be drawn closed for privacy and dignity to not expose the resident. 47783 3) On 02/08/23 at 08:26 AM, observed Certified Nurse Aide (CNA) 36 set up R21's breakfast on bedside table. After performing hand hygiene, CNA36 then assisted R21 with breakfast while standing at his bedside. 4) On 02/09/23 at 08:26 AM, observed CNA6 set up R53's breakfast on bedside table. After performing hand hygiene, CNA6 then assisted R53 with breakfast while standing at her bedside. Interview with Administrator on 2/13/23 at 02:33 PM, confirmed that staff should be sitting on the same level as the resident when they are assisting them with their meal so they do not feel intimidated and that the residents would feel like the CNA's are their companion.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43414 Based on record review and interview with staff members, the facility failed to inform three of five residents (Resident (R) 58, R7, and R74) reviewed for unnecessary medications, the risks and benefits of the use of psychotropic drugs and obtain consent. As a result of this deficiency, residents are at risk for more than minimal harm. Findings include: 1) R58 was admitted to the facility on [DATE] with diagnoses of depression and anxiety disorder. Review of R58's physician orders document R58 was receiving the following psychotropic medications; diazepam 5 milligrams (mg) twice a day as needed for anxiety and mirtazapine 15 mg once a day for depression. Review of R58's Electronic Health Record (EHR), consent for use of psychotropic medications including the risk and benefits were not found. On 02/09/23 at 12:29 PM, interview with Regional Nurse and Infection Preventionist (IP) was done. Regional Nurse confirmed the facility did not obtain consent for the psychotropic medications and was not able to find any further documentation in the EHR. 47783 2) R7 is an [AGE] year-old resident admitted on [DATE] with a diagnosis of dementia, major depressive disorder and anxiety disorder. Review of R7's EHR revealed that she is on escitalopram oxalate (antidepressant medication) 2.5 mg (milligrams) once a day and quetiapine (antipsychotic medication) 50 mg three times a day for depression. Consent for the use of psychotropic medications (medications that alter mood, perceptions and behavior) including education on risks and benefits were not found. 3) R74 is a [AGE] year-old resident admitted on [DATE] with a diagnosis on left hemiplegia (paralysis of one side of the body), anxiety disorder and depression. Psychiatry consult was done on 12/17/22 and was ordered to take escitalopram oxalate 5 mg daily in the morning for depression and trazadone (antidepressant medication) 50 mg daily at night for anxiety. Review of R74's EHR was done, consent for the use of psychotropic medications including education on risks and benefits were not found. On 2/10/23 at 12:01 PM, asked Administrator where the consents for the psychotropic medications for R7 and R74 are filed in the EHR, she said she will ask the nurses. After 30 minutes, she brought printed progress notes where the Registered Nurse is communicating to the attending physician drug to drug interactions. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/13/23 at 01:30 PM, Administrator confirmed that there is no documentation of consent for the use psychotropic medications for both R7 and R74.

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 42160 Based on observations and interviews, the facility failed ensure to post the most recent survey conducted by State surveyors in a place readily assessable to residents, family members and legal representatives of residents. Findings include: 1) On 02/08/23 at 03:17 PM, this surveyor inspected the second-floor nursing unit and was unable to locate the most recent survey results conducted by the State surveyors. Inquired with Unit Manager (UM)1 where the results were located. UM1 stated that if the survey results were available, it would be located in the designated box on the outside of the nursing station. UM2 walked to a medication cart, moved the medication cart and pointed out the survey result box. UM1 confirmed that there were no survey results located in the box and if the results were in the box, residents and resident representatives would not be able to see the results because the medication cart blocked the entire result's box. At 03:20 PM, this surveyor inspected the first-floor unit and was unable to locate the most recent State surveyor's results. Inquired with Nurse (N)8 where the results were located. N8 confirmed the results was not posted and was not readily available to residents or resident representatives. On 02/09/23 at 09:30 AM, this surveyor observed the most recent recertification survey results were posted now posted on both floors. The first-floor results were posted in a clear file holder on top of the nursing station along with the grievance forms and was posted on the second-floor results box that was still blocked by the medication cart. Eventually, the results on the second floor were placed on top of the nursing station. 43414 2) During a group interview with resident council members on 02/09/23 at 10:09 AM, four of four residents sampled (Resident (R) 47, R26, R58, R50) stated they did not know where the most recent survey results were.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 47783 Based on observations and interview with staff member, the facility failed to provide a homelike environment for residents receiving meal service in the first and second floor dining room. The facility failed to remove trays when passing meals to residents. As a result of this deficiency, resident is at risk of a negative psychosocial outcome. Findings include: 1) On 02/07/20 at 12:18 PM, observed 12 residents in the first-floor dining room. 11 of the 12 residents had their meals and beverages remain on the meal trays until they were done eating lunch. On 02/13/23 at 02:33 PM, interviewed Administrator. She confirmed that for a more homelike environment, the staff should be removing the meals and beverages off the trays and serving them on a placemat. 43414 2) During lunch dining observation on 02/08/23 at 12:43 PM, observed 11 of 15 residents on the second-floor dining room with meal trays underneath residents plates, bowls, and cups while eating and not removed. During the meal pass, observed one Certified Nursing Aide (CNA) remove the trays as he was passing meals to four residents. During dining observation on the second floor on 02/08/23 at 12:44 PM observed nine residents eat lunch with their meal trays not removed.

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39853 Based on observations, interviews and record review, the facility failed to protect one resident (R)33 from physical harm. R33 was totally dependent on staff for all activities of daily living (ADL's), including repositioning every two hours. R33 suffered an unwitnessed and unexplainable injury due to the manner in which her care was provided. As a result, R33 suffered a dislocated left (L) shoulder and pain, which affected her ability to achieve and maintain her highest level of physical well being. All residents dependent on staff are at risk of this type of unintentional abuse if they are not handled in a safe, secure manner to prevent injury. Findings include: 1) The Office of Healthcare Assurance received an initial facility incident report (FRI) regarding the injury on 12/13/2022 and the completed report on 12/20/2022 (date recorded as 2020 in error). The type of incident was marked injuries of unknown source. The FRI included It was noted during breakfast that her L shoulder was swollen and warm to touch. X-ray results in PM revealed subluxation (partial dislocation) of her humerous [sic]. Resident sent to ER for further treatment.Resident return from hospital but could not relocate injury due to swelling.Could not identify incident that would have been the source of the injury. As the resident is completely dependent upon staff we can only assess that it may have occurred during transfer or repositioning of the resident, or if while laying on her left side.'' 2) Review of the Hospital medical records revealed the following: 12/14/2022 Hospitalist Discharge Summary: Principal Diagnosis: Anterior dislocation of left shoulder, initial encounter. Brief history of presentation included: . Hx of CVA dysarthria/hemiplegia/bedbound and other medical problems presenting to the ER post fall resulting in a shoulder displacement. Apparently, the patient was found with a contracted left upper extremity during rounds . X-ray -Humerus: .Reason for Exam: Trauma . Findings: Anterior shoulder dislocation. CT-Shoulder: Reason for Exam: Shoulder Trauma, instability or dislocation suspected, xray done; Shoulder dislocation comparison Impression: 1. Anterior Glenohumeral Subluxation (Partial dislocation) 2. Small Cortical irregularity of the posterior humeral head, likely related to impaction. 3) R33 is a [AGE] year old female admitted to the facility on [DATE]. She has hemiplegia (paralysis one side of the body), hemiparesis (weakness or the inability to move on one side of the body), dysphasia (swallowing disorder) and dsyarthria (speech disorder caused by muscle weakness) following a cerebral infarction (stroke) affecting her left non-dominant side. In addition her diagnosis included, but not limited to dementia, stage 3 pressure ulcer sacral area, hypertension, diabetes type 2 and age related osteoporosis without pathological fractures. R33 was incontinent of bowel and bladder and wore diapers. She had difficulty making herself understood due to her dysarthria, had impaired vision and cognitive loss. 4) Review of R33' records included: (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Minimum Data Set (MDS) dated [DATE] Section G, Functional Status coded R33 to be totally dependent (Full staff performance every time during entire 7-day period) for bed mobility, transfers (occurred once or twice) and required the support of one staff for assist for all ADL's including dressing, bathing and eating. Nursing Progress notes: 12/13/2022 09:05 AM: Resident (R33) noted by CNA (certified nurse assistant) when feeding her this AM at about 07:50 AM that her contracted hand (L)=elbow was swollen and warm to touch and with facial grimacing when touched. RN aware and will call MD as appropriate. 12/13/2022 05:00 PM: R33 sent to Emergency Department (ER) by private ambulance. Resident crying during transfer . 12/13/2022 0836 PM: ER called and spoke with emergency room Physician (MD)1.questions with resident's ADLs and assessment when it (injury) was noted. 12/14/2022 08:35 PM: readmitted resident at 15:32 with principal diagnosis of Anterior dislocation of the left shoulder.Resident looking calm and comfortable however with pressure or movement to L arm, observed with moaning and crying and attempts to guard L arm using R arm. L arm with swelling lower arm. 12/15/2022 11:16 PM: .Left elbow/arm remains swollen and left arm still with bruise and discoloration. Continue nursing care with comfort. Noted with facial grimace during nursing care only. 12/18/2022 10:24 PM: Left elbow/arm remains swollen and left arm still bruise/dislocation. Treatment to coccyx wound done this evening as ordered with 2 person assist. Continue nursing care with comfort and gently handling.Noted with facial grimace during nursing care only. 12/21/2022 03:39 PM: . Advised caregiver assigned to maintain 2 staff assistance during nursing care, especially during turning and repositioning to ensure proper positioning while keeping L arm free of any pressure . Care Plan: 03/24/2022, the problem self care/ADL deficit included the interventions of bilateral mobility bars and 1 staff assistance for bed mobility, and use of Hoyer lift for transfers. 5) Reviewed the policy titled Safe Resident Handling/Transfers last reviewed/revised 05/20/2022, which included: Policy statement read It is the policy of this facility to ensure that residents are handled and transferred safely to prevent or minimize risks for injury and provide and promote a safe, secure and comfortable experience for the resident while keeping the employees safe in accordance with current standards and guidelines. Compliance Guidelines: 1. The interdisciplinary team or designee will evaluate and assess each resident's individual mobility needs, taking into account other factors as well, such as weight and cognitive status. 2. The resident's mobility needs will be addressed and reviewed quarterly, after a significant change in condition or based on direct care staff observations or recommendations. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The facility provided a policy titled Resident Rights-Freedom from abuse, neglect and exploitation last revised 04/11/2018. Review of the policy included: - Policy header had a different (sister) facility (F2) name on it. - Section Procedure for preventing resident abuse . 2. Willful means the individual must have acted deliberately, not that he/she must have intended to inflict injury or harm. - Section Procedure for preventing resident abuse .Does not tolerate any of the following actions, regardless of a resident's age, ability to comprehend, or degree of disability: .10. Any hitting, slapping punching, pushing, pulling . or other means of physical control of a resident. (Physical Abuse) - An attachment of a flow chart (no date or resource reference) titled Incident Reporting for Alleged Abuse. The first step of the process was to answer Was there willful infliction of injury to a resident? Note: Instances of unintended or ignorant harm does not meet facility policy or definition. 6) On 02/10/2023 at 11:30 AM, observed R33 lying in bed on her back sleeping with both arms across her chest under the sheet. On 02/10/2023 at 01:30 PM, observed R33 lying in bed positioned on her right side sleeping with both arms across her chest under the sheet. 7) On 02/10/2023 at 01:35 PM, during an interview with Charge Nurse (CN)1, inquired the last time R33 was out of bed. She said R33 doesn't really get out of bed anymore because of the pressure ulcer on her buttock. CN1 said the last time she recalled the Hoyer lift (mechanical equipment used for transfers) being used or R33 getting out of bed was when she went to the hospital for x-rays (12/13/2022). On 02/10/2023 at 04:00 PM, interviewed the two CNA's working day shift, who both said since R33's injury, when they provide care for her, they now use two staff. 8) Cross Reference F641-Accuracy of Assessments. Although R33 was to have two person assist starting 12/18/2022, the required staff support documented on the MDS (Minimal Data Sheet) dated 12/20/2022 was one person assist. In addition two of four weekly (from 01/14/2023 to 02/02/2023) assessments after the injury did not accurately reflect R33's need for two staff support for activities of daily living (ADL's). It is unknown if one person assist was the actual support being provided, or if it inappropriately documented by the RN. 9) Cross Reference 657- Care Plan (CP) Revision R33's CP was not revised timely to reflect she needed two person staff support for all ADL's. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	10) Due to R33's immobility, she would not have been able to injury herself by striking anything and could not turn herself to roll off the bed. Staff validated she had not been out of bed or transferred using the Hoyer lift and that she had been bedbound. The shoulder can dislocate forward, backward, or downward, and completely or partially. Contact sports injuries, trauma from motor vehicle accidents and falls are the most common source of dislocation. Mechanism of injury is usually a blow to an abducted (movement of a limb away from the midline of the body), externally rotated and extended (fully stretched out) extremity. (Shoulder Dislocations Overview; StatPearls Publishing LLC. 2022)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 39853 Based on interviews and document review, the facility failed to report two reportable events of suspected resident (R) abuse events to the State Agency (SA) Adult Protective Services (APS) as mandated by law. On 12/13/23 the facility identified R33 had an unobserved/unexplained dislocation of the left shoulder. On 10/28/22, R10 was allegedly abused by R7. As a result of this deficient practice the SA did not have information to determine if an investigation by their agency was needed, and there is the potential incidents are not thoroughly investigated, putting all residents of potential abuse at risk. Findings include: 1) The facility provided a policy titled Resident Rights-Freedom from abuse, neglect and exploitation last revised 04/11/2018. Review of the policy included: - Policy header had a different (sister) facility (F2) name on it. - Section Procedure for Investigation of allegations of abuse, neglect, exploitation or mistreatment: An investigation is immediately conducted when there are allegations involving abuse, neglect, exploitation, or mistreatment, including injuries . shall be immediately reported.3. The Administrator (ADM) or designee shall be notified immediately, who will immediately initiate the reporting to the Office of Healthcare Assurance, Adult Protective Services and/or the Department of Human Services via the required reporting forms for each respective agency. - Section Procedure for preventing resident abuse . 2. Willful means the individual must have acted deliberately, not that he/she must have intended to inflict injury or harm. - Section When abuse is believed to be possible, is suspected or is observed . 7. The Director of Nursing (DON)and/or Administrator conducts an immediate investigation of the circumstances of the incident. Notification of the appropriate agencies of all substantial abuse, mistreatment or neglect or exploitation occurs immediately. A written report of the investigation is submitted within 2 hours of serious bodily injury occurs, and 24 hours if no serious bodily injury occurs, with a final report sent within five days of completion, to required agencies, including the State Survey Agency (OHCA), Adult Protective Services . - Attachment of a flow chart titled Incident Reporting for Alleged Abuse. The first step of the process was to answer Was there willful infliction of injury to a resident? Note: Instances of unintended or ignorant harm does not meet facility policy or definition. Attachment directs staff to Report to State agencies if the injury was of unknown source and resident injuries resulted from an unwitnessed event, resident could not explain how injuries were received, and resident was not found on the floor and injuries consistent with a fall. Final step titled Reportable to State Agencies identifies the Risk Manager or designee responsible for review of the Incident Report and immediately notifies ADM, DON and Social Worker, coordinates and completes investigation and sends report to OHCA and APS (except resident to resident cases). The facility does not have an identified Risk Manager. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) During an interview with the Social Services Director (SSD), he said the facility process was all information regarding a possible abuse incident, including investigation results are sent to the ADM, who makes the determination if it would be reported to APS. The ADM at the time of the incidents was no longer at the facility, but SSD said the process is the same with the change of Administration. 3) During an interview with the Regional Director of Nursing, she confirmed the facility practice was the ADM makes the decision if the incident should be reported to external agencies, and sometimes would delegated to another individual such as the Social Worker to report it. 4) OCHA received an initial facility incident report (FRI) regarding R33's injury on 12/13/2022. The FRI reported R33 had an unwitnessed, unexplained injury of her Left (L) shoulder which was swollen and warm to touch. She was sent to the Emergency Department and diagnosed with a Subluxation of her humerus (dislocation). This incident met criteria for mandated reporting to APS, but was not done. 42871 5) On 02/06/23 at 3:00 PM, reviewed the document Office of Health Care Assurance (OHCA) Event Report for Aspen Complaints/Incidents Tracking System (ACTS) 9889. On 10/26/22 at 5:30 PM, Resident (R)7 allegedly hit R10. The initial report filed on 10/28/22 by the facility indicated the Type of Incident as a Mistreatment, and not as a resident to resident abuse. The Concern Form document revealed handwritten under Concern Investigation, . 5) Report abuse to Administrator and State. The Social Services Director (SSD) signed it. No document from the Adult Protective Services (APS) was found. On 02/13/23 at 2:06 PM, interviewed SSD. SSD stated that he conducts investigations for abuse and files reports to APS. SSD further stated that he did not report R10's alleged abuse by R7 to APS. Reviewed the policy and procedure, Resident Rights - Freedom from Abuse, Neglect & Exploitation. Under Procedure for Investigation of allegation of abuse, neglect, exploitation or mistreatment read, . 1. Allegations that involve abuse or result in serious bodily injury shall be reported immediately, but not later than 2 hours after the allegation is made, and .3. immediately initiate the reporting to the Office of Health Care Assurance, Adult Protective Services and/or the Department of Human Services via the required reporting forms for each respective agency and as per above time frames .

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39853 Based on interviews and document review, the facility failed to thoroughly investigate the unobserved/unexplained injury of R33, diagnosed as a dislocated shoulder. In addition there was lack of evidence administration was involved as necessary in the investigation. If thorough investigations are not completed and appropriate action taken, it increases the risk of reoccurrence of a similar event to residents who are totally dependant on staff for Activities of Daily Living (ADL's). Findings include: 1) R33 is a [AGE] year old female admitted to the facility on [DATE]. She has hemiplegia (paralysis one side of the body), hemiparesis (weakness or the inability to move on one side of the body) and dysphasia (swallowing disorder) following a cerebral infarction (stroke) affecting her left non-dominant side. In addition her diagnosis included, but not limited to dementia, mood disturbance, sacral stage 3 pressure ulcer and age related osteoporosis without pathological fractures. R33 was totally dependent on staff for all ADL's including bed mobility, and transfers. On 12/13/2023 R33 was noted to have an unwitnessed, unexplained injury of her Left (L) shoulder which was swollen and warm to touch. She was sent to the Emergency Department and diagnosed with a Subluxation of her humerus (partial dislocation). Her Care Plan at the time of injury included she was a one person assist for bed mobility and transfers and that she used a Hoyer lift (mobility equipment). 2) The Office of Healthcare Assurance received the initial facility incident reports (FRI) regarding the injury on 12/13/2022. The initial report marked injuries of unknown source, and the section Perpetrator (Non-staff) was marked Another Resident, with a residents name. The completed report was received on 12/20/2022. The section Perpetrator (Non-staff) was still marked Another Resident, but the name of that resident had been removed. The FRI included Interviewed several staff who worked with the patient and 5+ residents who live on that floor for abuse. Could not identify incident that would have been the source of the injury. As the resident is completely dependent upon staff we can only assess that it may have occurred during transfer or repositioning of the resident, or if while laying on her left side. Facility initiated transfer/positioning training from a licensed Physical therapist for all direct care staff. Facility also initiated abuse identification and reporting requirement training to remind direct line staff to report any incident that could have occurred at any hour of the day or night that may impact the health and wellbeing of the resident. 3) Request was made for all investigation documents. The only documents provided were written statements from six Certified Nursing Assistants (CNA's) and one Registered Nurse (RN) dated 12/15/2022. All statements referenced the date 12/12/2022 (injury found on 12/13/2022). Statements included: (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RN16 03:00 PM-11:00 PM shift: Assigned LN17 (licensed nurse) requested this RN to insert peripheral IV line/saline lock for IV (intravenous) ABX (antibiotics) order . for R33. Saline lock inserted aseptically to Right hand . The resident's left hand is positioned across her chest during the entire time of IV insertion. No noticeable swelling, bruise or discoloration noted. No indication of pain nor discomfort. The assigned LN/LPN didn't report any injuries or unusual changes the rest of the shift. CNA18: On December 12, 2022 Monday i [sic] worked and assigned to room [ROOM NUMBER], 210, 211, 212. (R33 was in 208-2). CNA10: .I was on duty on that day and I was assigned to room [ROOM NUMBER], 202, 203, +204 last December 12, 2022 and I didn't enter in that room on that night. CNA21: NA (CNA) 3 to 11 shift and I worked that date 12/12/22 Monday in first floor. CNA38 I'm CNA38 working at .evening shift 3-11 PM on the 12th of December on the 2nd floor, I was not the CNA who assigned to R33 at that night/evening. CNA 7: .CNA working 3-11 shift. I was on duty on the day Monday the 12 of December. I'm not the assign CNA on that group. I don't know exactly happened. CNA11: I'm the assigned of R33 for 11-7 shift since [DATE]. On 12/12/22 I did my first round. I changed her diaper. I did not see any swelling on the left arm. But I noticed an old discoloration on Right arm. I know this was reported on the charge nurse few days [sic]. After that I reposition her every two hours using the drawsheet (used to facilitate turning side to side). When i move her she's using the same tone of voice that I hear everytime. I did my 2nd rounds on her, there was no swelling on the left arm during my shift. 4) On 02/10/2023 at 11:40 AM, during an interview with the Social Services Director (SSD), he said the investigation of alleged abuse is a team effort and depends on the situation, but the Unit Manager (UM) or Director of Nursing will usually investigate the clinical side and Social Services would interview residents, family members and assist as needed. SSD said he had not been involved with R33's investigation. On 02/10/2023 at 12:00 PM. during an interview with the Unit Manager (UM)3, she stated she received an email from Regional Nurse Director (RND) to get statements from CNA's if they had cared for R33. She said she did not have specific instructions or direction how to proceed, so requested the CNAs on the unit to complete a written statement and return it to her. UM3 said she gave the statements to RND and did not have any further discussion about the allegation. She went on to say she had not been involved with an alleged abuse investigation before, and to her knowledge no one interviewed the staff. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5) Reviewed the facility policy titled Resident Rights-Freedom from abuse, neglect and exploitation last revised 04/11/2018. The policy header had a different facility's (F2/sister facility) name on it. The policy section Procedure for Investigation of allegations of abuse, neglect,exploitation or mistreatment included: An investigation is immediately conducted when there are allegations involving abuse, neglect, exploitation or mistreatment, including injures of unknown source . The content in that section all refers to reporting the event, with the exception of 4. An initial report will be initiated with a final report submitted within 5 days. If investigation is not able to completed, an interim report shall be submitted providing agencies with a revised time frame for submittal of final investigative report. There were no guidelines or directions how the investigation is completed. 6) Although there is no specific investigation process, the facility must thoroughly collect evidence to allow Administrator to determine what actions are necessary for the protection of the residents. It would be expected that the investigation would include, but not limited to conducting observations of staff interactions with R33 (i.e. how repositioned/transferred), conducting interviews with the practitioner, appropriate emergency room personnel, as well as conduct record review for pertinent information (i.e care plan for level of mobility and staff assist). It was assumed the injury occurred on 12/12/2022, as those were the only staff asked for statements. 7) The facility provided copies of the content of the referenced inservice which was completed on 12/13/2022 and 12/14/2022. The inservice included, but not limited to information on the importance of thorough abuse investigation and reporting. At that time, Physical Therapy also gave a presentation on appropriate repositioning techniques. Individual staff quizs were provided, so requested to provide percent of staff that completed the education. On 02/13/2023, facility provided attendance sheet with staff listed indicating if they completed, or did not complete. The total percentage (%) of completion for all job categories was documented to be 78%. On further review it was noted that the staff listed on the education sheet did not match the staff list provided on survey entry. Seven CNA's (CNA1, CNA21, CNA25, CNA26, CNA28, CNA30 and CNA34) were not listed on the education staff list. If all CNA's had been listed, the CNA completion would have been 41%. Further investigation of the report for accuracy of other job categories was not done.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 42871 Based on record review and interviews, the facility failed to notify the family or resident representative of one resident's (R), R39's, transfer to the hospital. The facility failed to provide a written notification to the resident's close contacts about R39's transfer out of the facility for emergent care. This deficient practice does not protect the resident from an inappropriate discharge and has the potential to affect all residents transferred out of the facility. Finding includes: On 02/07/23 at 08:47 AM, R39 was observed to be lying in bed in his room. R39 did not respond to verbal stimulation. On 02/08/23 at 11:30 AM, R39 was observed to be assessed by an Emergency Medical Technician (EMT). Record review revealed that R39 was transferred to a local area hospital for acute care. Nurse (N)12 tried notifying R39's close contacts but was unable to reach them via phone and was unable to leave a voicemail. On 02/13/23 at 2:22 PM, queried the Area Admission Director (AAD). AAD stated that the Social Services Director (SSD) is responsible for notifying the family and Long Term Care Ombudsman (LTCO) of any resident transfers and discharges. On 02/13/23 at 3:07 PM, interviewed SSD. SSD stated that a written notification was not sent to R39's close contacts informing them of his transfer to the local area hospital because he did not know he was supposed to. Reviewed the policy and procedure, Transfer to Emergency Care. Under Procedures, it stated, .5. The licensed nurse will contact the resident's physician or alternate and resident representative to inform them of situation, and if resident is to be transferred from the facility. The policy and procedure did not have direction for a written notification to be sent to close contacts of the resident if the resident is transferred to the hospital.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39853 Based on observations, interviews and record review, the facility failed to ensure one residents (R)33 functional ability and required staff support was accurately documented on the MDS (Minimal Data Sheet) dated 12/20/2022. In addition two of four weekly (from 01/14/2023 to 02/02/2023) assessments did not accurately reflect R33's need for two staff support for activities of daily living (ADL's). As a result of this deficiency, R33 may not have received the necessary support to meet her goals. This deficient practice has the potential to affect all residents. Findings include: 1) R33 is a [AGE] year old female admitted to the facility on [DATE]. She has hemiplegia (paralysis one side of the body), hemiparesis (weakness or the inability to move on one side of the body), dysphasia (swallowing disorder) and dsyarthria (speech disorder caused by muscle weakness) following a cerebral infarction (stroke) affecting her left non-dominant side. In addition her diagnosis included, but not limited to dementia, stage 3 pressure ulcer sacral area, hypertension, diabetes type 2 and age related osteoporosis without pathological fractures. R33 is incontinent of bowel and bladder and wore diapers. She had difficulty making herself understood due to her dysarthria, had impaired vision and cognitive loss. On 12/13/2022 R33 was noted to have an unexplained, unwitnessed injury which was diagnosed as a subluxation (partial dislocation) of her humerus. Prior to her injury, she required one person assist for ADL's. Staff said they could not remember the last time she had not been out of bed because of her sacral pressure ulcer. After R33's injury, it was determined she needed the support of two staff for ADL's to prevent further injury. 2) On 12/18/2022, nursing progress note documented Left elbow/arm remains swollen and left arm still bruise/dislocation. Treatment to coccyx wound done this evening as ordered with 2 person assist. 3) Review of R33' Minimum Data Set (MDS) dated [DATE] Section G, Functional Status coded her to be totally dependent (Full staff performance every time during entire 7-day period) for bed mobility, transfers (occurred once or twice), dressing, eating, toilet use and personal hygiene, and required the support of one staff for assist for all ADL's including dressing, bathing and eating. Section G0300 Balance During Transitions and Walking documented R33 was Not steady, Only able to stabilize with staff assistance for Moving from seated to standing position. R33 had very limited mobility, and had been bedbound for some time. If she was transferred, staff were to be using the Hoyer lift. This entry did not reflect her current status. 3) Reviewed the Observation Detail List Reports dated 01/14/2023, 01/20/2023, 01/27/2023 and 02/07/2023. The purpose of the report is to capture the residents accurate and current status by staff who work with the resident. Review of the reports revealed R1 was assessed as totally dependent for bed mobility and transfers, but there were discrepancies on the required support provided by staff. The reports included the following: 01/14/2023 completed by RN12: (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Bed mobility-Total Dependent (Resident not involved in activity, staff provided full support) with Two + person physical assist. Transfer-How resident moves between surfaces including to or from bed, chair, wheelchair, standing position; Total Dependent with support provided by staff. Two + persons physical assist. 01/20/2023 completed by RN12: Bed mobility-Total Dependent. Bed mobility-One Person Physical assist. Transfer-Total Dependent. Transfer-One person Physical assist. 01/27/2023 completed by RN14: Bed mobility-Total Dependent. Bed mobility-One Person Physical assist. Transfer-Total Dependent. Transfer-One person Physical assist. 02/02/2023 completed by RN15: Bed mobility-Total Dependent. Bed mobility-Two + person physical assist. Transfer-Total Dependent. Transfer-Two + persons physical assist. 4) On 02/10/2023 at 01:00 PM, during an interview with the MDS Coordinator, he said uses the weekly assessments to complete the required MDS assessments. On 02/10/2023 at 01:30 PM, during an interview with RN12, inquired how she gets the information to complete the assessment on the weekly observation detail list report. RN12 said she knows the residents and works with them. When asked about what type of support R33 currently needed, she replied to my knowledge, she is a one person assist. She's on the smaller side and I can do her wound care (sacral pressure ulcer) by myself .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42160 Based on observations, interviews, and record review, the facility failed to ensure a comprehensive person-centered care plan that includes measurable objectives and timeframes to meet the resident's needs were developed and/or implemented for 2 of 21 residents (Resident (R)37 and R38) sampled. R37's comprehensive person-centered care plan (CP) was not implemented to ensure the resident's Activity of Daily Living (ADLs) needs were met and the appropriate Geri sleeves were not applied to prevent bruising. A comprehensive person-centered care plan was not developed to address R38's behavioral and verbal aggression/agitation. As a result of these deficient practices, residents are at risk for the potential of harm and/or neglect. Findings include: (Cross reference to F677 ADL Care Provided for Dependent Residents) 1) R37 is a [AGE] year-old female that was admitted to the facility on [DATE] with diagnosis that include hemiplegia, hemiparesis following a cerebral infarction affecting the left non-dominant side, dysphagia, gastrostomy, dementia, diabetes mellitius type 2. Multiple observations (02/07/23 at 10:31 AM, 12:30PM, 03:35 PM; 02/08/23 at 08:51 AM, 09:34 AM, 11:21 AM; 02/09/23 at 09:15 AM, 11:15 AM, 02:45 PM; 02/10/23 at 08:30 AM, 10:15 AM, 1:13 PM) were made of R37 during which the resident had yellow non-slip socks applied to both arms. The toes of the socks were cut in a way that allowed R37's arms to past through with a strip of fabric between her thumb and pointer finger. The edges of the fabric strip had rolled together and was tightly wedged in the web of her thumb. Throughout the observation period (07/07/23 to 02/10/23) the same yellow non-slip socks were applied to R37 and had visible brown marks and appeared dirty. During these observations, R37 appeared unkept, her lips were cracked and continued to progressively crack throughout the observation period and was notably malodorous (pungent) on 02/10/23. On 02/09/23 at 01:54 PM, conducted a review of R37's Electronic Health Record (EHR). Review of R37's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/21/22 documented in Section G. Functional Status, R37 is totally dependent (full staff performance every time during entire 7-day period) and requires the support of two or more staff for bed mobility and one or more staff for dressing, eating, toilet use, and personal hygiene. During the 7-day look back period, R37 was not transferred out of bed. Review of the CP documented, R37 is at risk for complications secondary to Anti-Coagulant use. Category Anti-Coagulant Start Date 02/26/2022 Last Reviewed/Revised 11/08/2022 10:13 with intervention to protect R37 from injury/trauma (started 02/26/22). Review of the physician's orders documented an order for Geri sleeves to bilateral arms for protection, monitor placement Q (every) shift Special Instructions: monitor placement q (every) shift. Regularly monitor for skin integrity and perfusion status at least every 2 hours (signs of poor blood supply or discoloration) Every Shift Day, Evening, NOC (night) that started on 02/06/2023. r37's CP ALSO documented the resident has self-care deficits due to dementia, hemiplegia gastritis, anarthria, and decreased mobility, the goal for R37 to remain clean and comfortable, odor free, and will be treated with dignity in daily basis with an approach to assist in completing ADL task each day. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/10/23 at 04:20 PM, conducted a concurrent observation of R37 and interview with the Regional Nurse (RN)33. R37 had the same yellow-non-slip socks applied to her arms that were first observed on 02/07/23 at 10:31 AM. RN33 confirmed the yellow non-slip socks were dirty and the use of the socks in place of Geri sleeves was not appropriate due observation of the fabric strip rolled and wedged into the webbing of R37's thumb. RN33 confirmed because of not using the appropriate Geri sleeves it was just a matter of time before the sock would cut into the resident's skin. On 02/09/23 at 01:54 PM, conducted a review of R37's EHR, a quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/21/22 documented in Section G. Functional Status, R37 is totally dependent (full staff performance every time during entire 7-day period) and requires the support of two or more staff for bed mobility and one or more staff for dressing, eating, toilet use, and personal hygiene. During the 7-day look back period, R37 was not transferred out of bed. On 02/10/23 at 04:15 PM, conducted an interview with Certified Nurse Aide (CNA)87 regarding R37's ADLs. CNA87 showed this surveyor R37's shower schedule and stated R37's receives baths on Monday, Thursdays, and as needed. CNA87 reported that R37 does not receive bed baths and is transferred from the bed to the shower room. Inquired with CNA87 for documentation supporting R37's received showers as scheduled. CNA87 logged on the EHR and could not provide documentation that R37 was showered. CNA87 confirmed R37 had not received a shower that week and knew this because she had been working with the resident that week. On 02/10/23 at 04:20 PM, conducted a concurrent observation of R37 and interview with RN33. RN33 confirmed R37's lips were cracked and appeared unkept. This surveyor pulled R37's blanket down to inspect R37's arms and RN33 confirmed that R37's malodor was noticeable through the surgical mask he/she wore and stated she/he thought this surveyor was going to reveal an untreated/unknown wound due to the odor coming from the resident. RN33 confirmed R37's ADL needs were not being met and was not dignified. 47783 3) R38 is a [AGE] year-old resident admitted on [DATE]. Diagnoses that include traumatic subdural hemorrhage (bleeding in the area between the brain and the skull) and dementia with agitation. Observation on 02/07/23 at 09:10 AM, R38 was awake lying on specialty mattress, face appeared oily and started yelling in Korean and waving his arms when we knocked on door to ask permission to enter room. According to another surveyor that understands Korean, R38 was using curse words. On 02/08/23 at 12:48 PM, this surveyor knocked on door to ask permission to enter room, no response from R38. As soon as he saw us approach his bed, he started yelling in Korean so we exited the room. Interview with Certified Nurse Aide (CNA) 6 and Nurse (N) 11 on 02/09/23 at 12:52 PM. CNA6 said R38 yells a lot when the staff care for him, he sometimes refuses care. He only speaks Korean, and the staff sometimes use Google Translate on their phones to communicate with him. The staff understand some common words like change and turn. N11 also said that she knows some simple Korean words like pain and no pain. The staff also uses gestures to communicate with him. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of records done. Progress Notes revealed that R38 had episodes of yelling at staff since he was admitted . He also refuses care and medications and can be combative. R38 was started on buspirone (anti-anxiety medication) 5 (milligrams) mg three times a day for dementia on 10/17/22. Further review of records revealed that care plan meeting notes for R38 were not kept in the electronic health records (EHR) and that there were no plans to address his behavioral issues (yelling at staff, refusing care and medications and being combative). Interview and review of EHR with Social Services Director (SSD) done on 2/13/23 at 03:20 PM. SSD confirmed that there was no plan to address R38's behavioral issues and that there should be one since it happens often.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43414 Based on record review and interviews the facility failed to revise two Resident (R)33 and R58's care plans (CP) in a timely manner. Specifically the facility failed to ensure Resident (R) 58's comprehensive CP plan was person-centered and does not include safe approaches for smoking, expressing the facility's current designated smoking area is unsafe and prefers to smoke at a non-designated smoking area. R33's CP was not revised in a timely manner after it was determined she needed more staff assist for activities of daily living (ADL's). Findings include: 1) Cross reference to F689. The facility failed to identify and assess hazards and risks for Resident (R) 58's smoking environment, designated by the facility and non-designated by the facility, and implement interventions to reduce hazards and risks. On 02/07/23 at 01:46 PM interview with R58 was done. R58 stated the facility's designated smoking area is at the back of the facility and is difficult to access. R58 stated she smokes on the side walk once or twice a day at the front of the facility. R58 further stated they don't like us going in the front but in the back there are two doors and at one door you have to go down, staff have a hard time getting me back up. R58 reported there is no trash can for her to throw away her cigarette at her preference location to smoke so she throws her used cigarette in the trash can located inside the facility. Review of R58's Electronic Health Record (EHR) included a scanned document of a note R58 handwritten. The document's content included I .[R58] .take full responsibility to be taken off property to smoke, if anything should happen to me while off the property the facility is not liable signed by R58. The document had another resident's handwritten note below R58's note with the same statement and was dated 12/02/21. Review of R58's most recent care plan on smoking with a start date of 12/29/22 documents the following approaches for R58 to be safe; Staff to provide quarterly safe smoking observation as needed .Praise resident for being safe and responsible .Resident will not share or borrow tobacco products or paraphernalia from other .involve support person or Ombudsman as needed .Resident will follow SNF [Skilled Nursing Facility] smoking policy .Offer cessation information as desired. R58's care plan does not include how resident will be safe when smoking outside of the non-designated smoking locations, interventions to be put in place, education on risks, and/or include R58's concern with the facility's designated smoking area. 39853 2) R33 is a [AGE] year old female admitted to the facility on [DATE]. She has hemiplegia (paralysis one side of the body), hemiparesis (weakness or the inability to move on one side of the body), dysphasia (swallowing disorder) and dsyarthria (speech disorder caused by muscle weakness) following a cerebral infarction (stroke) affecting her left non-dominant side. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/13/2022 she was found to have an unwitnessed, unexplainable injury to her Left shoulder/arm, and was sent to the emergency room where she was diagnosed to have an anterior dislocation left shoulder. R33 was readmitted to the facility on [DATE]. Review of R33's progress notes included: On 12/18/2022 at 10:24 PM: Left elbow/arm remains swollen and left arm still bruise/dislocation. Treatment to coccyx wound done this evening as ordered with 2 person assist. Continue nursing care with comfort and gently handling.Noted with facial grimace during nursing care only. On 12/21/2022 at 03:39 PM: . Advised caregiver assigned to maintain 2 staff assistance during nursing care, especially during turning and repositioning to ensure proper positioning while keeping L arm free of any pressure . Review of R33's Care Plan (CP) included but not limited to: 03/24/2022, the problem self care/ADL (activities of daily living) deficit included the interventions of bilateral mobility bars and 1 staff assistance for bed mobility, and use of Hoyer lift for transfers. 12/14/2022, the problem pain was initiated with the comment Resident has pain R/T (related to) anterior dislocation of left shoulder. The change to two staff assist for ADL's was first noted in the EMR on 12/18/2022. On 12/21/2022, the intervention/approach Provide 2 staff assistance during nursing care, turning and positioning was added to the CP.

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F 0677 Level of Harm - Actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42160 Based on observations, interviews, and record review, the facility failed to ensure a resident who is unable to carry out acitvities of daily living receives the necessary services to maintain grooming, and personal and oral hygiene for two of four residents (Resident (R)37 and R3) sampled. R37 unable to perform ADLs due to diagnosis of hemoplegia, hemiparesis, progressing Dementia and is dependent on staff for all ADLs needs. Observations on 02/07/23 through 02/10/23 documented R37's ADLs were not completed, appeared increasingly unkept, lips progressed to crack, and body odor was pungent. R3 is dependent on staff for oral hygiene did not receive lip care for dry lips. As a result of severity in the neglect of R37's ADLs, any reasonable person would experience psychosocial harm. Findings include: Cross reference to F656 Develop/Implement Comprehensive Care Plan 1) Centers for Medicare & Medicaid Services (CMS), Appendix P, Seiction IV, E, Psychosocial Outcome Severity Guide, October 2022, defines the resonable person concept as a tool to assist the survey team's assessment of the severity level of negative, or potentially negative, psychosocial outcome the deficiency may have had on a reasonable person in the resident's position. It also defines psychosocial as the combined influence of psychological facotrs and the surrounding social envirno,ent on physical, emotional, and/or mental wellness. R37 is a [AGE] year-old female that was admitted to the facility on [DATE] with diagnosis that include hemiplegia, hemiparesis following a cerebral infarction (stroke) affecting the left non-dominant side and dementia. Multiple observations (02/07/23 at 10:31 AM, 12:30PM, 03:35 PM; 02/08/23 at 08:51 AM, 09:34 AM, 11:21 AM; 02/09/23 at 09:15 AM, 11:15 AM, 02:45 PM; 02/10/23 at 08:30 AM, 10:15 AM, 1:13 PM) were made of R37. During the first observsation, this surveyor asked R37 questions and asked the her to grab her call light. R37 was unable to speak and could not move her arms to grab the call light. Observed on 02/07/23 at 10:31 AM, R37 appeared unkept, her lips were cracked and peeling, and was malodorous. R37's had yellow-nonslip socks (toe of the sock was cut to allow the resident's hand through) applied to both arms that was visibly dirty with brown markings and appeared worn. The fabric strip from the socks dug into the skin between the pointer finger and thumb. (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Few	On 02/09/23 at 01:54 PM, conducted a review of R37's EHR. Review of R64's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/21/22 Section C., Cognitive Pattern documented the Brief Interview for Mental Status (BIMS) attempt to conduct interview with resident was not conducted (0. No (resident is rarely/never understood). Section G., Functional Status, R37 is totally dependent (full staff performance every time during entire 7-day period) and requires the support of two or more staff for bed mobility and one or more staff for dressing, eating, toilet use, and personal hygiene. Review of the quarterly MDS with an ARD of 11/21/22 R64's BIMS was not completed and Section G., Functional Status, remained the same and during the 7-day look back period, R37 was not transferred out of bed. Review of R37's CP documented the resident has self-care deficits due to dementia, hemiplegia gastritis, anarthria, and decreased mobility, the goal for R37 to remain clean and comfortable, odor free, and will be treated with dignity in daily basis with an approach to assist in completing ADL task each day (started 03/24/22), encourage the use of call lights when ADL assistance is needed (started 03/24/22). On 02/10/23 at 04:15 PM, conducted an interview with Certified Nurse Aide (CNA)87 regarding R37's ADLs. CNA87 showed this surveyor R37's shower schedule and stated R37's receives baths on Monday, Thursdays, and as needed. CNA87 reported that R37 does not receive bed baths and is transferred from the bed to the shower room. Inquired with CNA87 for documentation supporting R37's received showers as scheduled. CNA87 logged on the EHR and could not provide documentation that R37 was showered. CNA87 confirmed R37 had not received a shower that week and knew this because he/she had been working with the resident that week. On 02/10/23 at 04:20 PM, conducted a concurrent observation of R37 and interview with RN33. RN33 confirmed R37's lips were cracked and appeared unkept. This surveyor pulled R37's blanket down to inspect R37's arms and RN33 confirmed that R37's malodor was noticeable through the surgical mask he/she wore and stated he/she thought this surveyor was going to reveal an untreated/unknown wound due to how bad the odor was. RN33 confirmed R37's ADL needs were not being met. RN33 also confirmed that due to R37's cognitive impairment, any resonable person with the same state of ADLs as R37 would experience negative psychosocial outcomes such as depressed mood and personal embarssment to the level that would change a person's social interactions resulting in isolation. 43414 2) CMS defines oral care in the State Operating Manual (SOM) Appendix PP revised on 10/21/22 as .the maintenance of a healthy mouth, which includes not only teeth, but the lips . R3 was admitted to the facility on [DATE] with diagnoses not limited to hemiplegia and hemiparesis, dysphagia following cerebral infarction, hyperlipidemia, contractures to left hand, left elbow, and ankles, gastro-esophageal reflux disease without esophagitis, and chronic gingivitis non-plaque induced. R3 has tube feeding and has a dietary order of nothing by mouth (NPO). R3's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/23/22 under Section G. Function Status for F0110. ADL Assistance R3 needs extensive assistance with one person physical assistance for personal hygiene. Under Section GG. Functional Abilities and Goals for GG0130. Self-Care R3 is dependent in oral hygiene. During an initial observation of R3 on 02/07/23 at 08:52 AM, observed R3 lips to be dry with thick patches of peeling skin on R3's bottom lip, as well as, cracks on her top and bottom lips. (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Few	Subsequent observations of R3's lips to be dry with thick patches of peeling skin and cracks on her lips were done on 02/07/23 at 12:32 PM and 03:25 PM, on 02/08/23 at 07:59 AM and 12:07 PM. On 12/09/23 at 08:26 AM observed R3's lips without thick patches of peeling skin but observed to be dry and cracked. Review of R3's Electronic Health Record (EHR) noted R3's family member visited her in the evening on 12/08/23. Review of R3's physician order documents a reminder for nursing staff to apply Vaseline to lip every shift to moisturize and sooth dry, cracked lips. Special instructions indicated Reprocessed due to concerns received from Daughter. Review of R3's comprehensive care plan under skin integrity R3 is to use lip balm or emollient on lips. On 02/10/23 at 08:15 AM and at 11:23 AM observed R3's lips to be dry but smooth, no peeling skin or cracks. On 02/10/23 at 11:26 AM interview with Unit Manager (UM) 1 was done. UM1 stated the Nurse puts Vaseline on R3's lips after oral care, for the day shift they put Vaseline before 10:00 AM because she has tube feeding. Concurrent review of the Administration History documents nursing staff had put Vaseline on R3's lips everyday for day, evening, and night shift. Inquired if it would be obvious if R3 did not receive Vaseline on her lips and if it makes a difference, UM1 stated the Vaseline does make a difference because her lips would become so dry that her lips would be bleeding. UM1 reported if R3 did not receive Vaseline, her lips would have white dry skin on top of her lips.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43414 Based on observation, record review, and interviews the facility failed to identify and assess hazards and risks for Resident (R) 58's smoking enviroment, designated by the facility and non-designated by the facility, and implement interventions to reduce hazards and risks. This deficient practice effects R58's individual safety, as well as the safety of others in the facility. Findings include: (Cross reference to F657- Care Plan Timing and Revision) The facility failed to revise and ensure Resident (R) 58's comprehensive care plan was person-centered. R58's care plan for smoking does not include approaches when expressing the facility's current designated smoking area is unsafe and prefers to smoke at a non-designated smoking area. R58 was readmitted to the facility on [DATE] with diagnoses of embolism and thrombosis of arteries of the lower extremities, acquired absence of right leg above knee, history of falls, difficulty in walking, depression, and anxiety disorder. Review of R58's Electronic Health Record (EHR) found only one smoking assessment completed on 02/07/23. R58's assessment documents Smokes in Unauthorized Areas as a minimal problem. No smoking assessment was found upon admission or prior to readmittance. On 02/07/23 at 01:46 PM interview with R58 was done. R58 stated the facility's designated smoking area is at the back of the facility and is difficult to access. R58 stated she smokes on the sidewalk once or twice a day at the front of the facility. R58 further stated they don't like us going in the front but in the back, there are two doors and at one door you have to go down, staff have a hard time getting me back up. R58 reported there is no trash can for her to throw away her cigarette at her preference location to smoke so she throws her used cigarette in the trash can located inside the facility. During an interview with resident council members on 02/09/23 at 10:09 AM, R58 reported she heard the facility is going to redo the designated smoking area to make it more assessable. R58 reported there is another way to enter the designated smoking area where you go out in the front and go down the ramp to a garden area but it is difficult for her to go down the ramp, and it is uneven and unsteady. R58 reported she tries to go as far back as possible. R58 also reported other solutions that were brought up such as going down the parking ramp but that seemed dangerous. R58 stated she usually smokes late at night. Inquired if staff supervise her while she smokes in the front at a non-designated smoking area, R58 reported sometimes they do and sometimes they don't. R58 further reported sometimes she meets nice people walking their dogs outside. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/10/23 at 10:01 AM observation was made to the entrance of the designated smoking area from the back of Unit 1. The first door was locked and needs access from a staff member. The first door led to a staircase and the size of the door was standard and heavy. It had a small transition strip (bump) at doorway. The second door, standard size and heavy, led to outside the back of the facility, the doorway had an approximately once inch step that led to a zig-zag ramp to the designated smoking area. The step at the doorway of the second door did not have a threshold ramp. Further observed the front of the facility, a ramp is located at the front main entrance/exit door of the facility that leads to the public side walk and the main street. On one side of the front of the facility is a driveway ramp to the parking structure and on the other side is a public bus stop. The sidewalk was busy with the public utilizing the walkway and bus stop. Review of R58's EHR included a scanned document of a note R58 handwritten. The document's content included I .[R58] .take full responsibility to be taken off property to smoke, if anything should happen to me while off the property the facility is not liable signed by R58. The document had another resident's handwritten note below R58's note with the same statement and was dated 12/02/21. Review of R58's most recent care plan on smoking with a start date of 12/29/22 did not include how R58 will be safe when smoking outside of the non-designated smoking locations, interventions to be put in place, education on risks, and/or include R58's concern with the facility's designated smoking area. On 02/13/23 at 09:55 AM interview and concurrent record review with Director of Nursing (DON) was done. DON reported she started working for the facility a couple of weeks ago, 02/01/23. DON stated one of the projects she recently worked on was updating the smoking policy, created a smoking assessment, and enforce using the designated smoking area with scheduled staff to provide supervision which was implemented last week (during the survey period). DON further reported maintenance is working installing a little ramp to one of the doors .because there is a little of a bit of a limp there. DON confirmed documentation of a smoking assessment done for R58 prior to the recent one created last week on 02/07/23 was not in the EHR. Inquired if R58's current assessment and care plan included the risk and hazards associated with the smoking enviroment, designated and non-designated, DON confirmed it did not.

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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. 47783 Based on observation and record review, the facility failed to adhere to professional standards of practice and infection prevention and control measures for one resident with an indwelling urinary catheter. This deficient practice has the potential to affect all residents that have an indwelling urinary catheter putting them at risk to develop complications including urinary tract infections. Finding Includes: On 02/07/23 at 09:10 AM, observed Resident (R)53 lying in bed with indwelling urinary catheter tubing and collection bag touching the floor. Then at 12:35 PM when the resident was being brought to the dining area via wheelchair, observed the urinary catheter tubing being dragged on the floor during transport. On 02/08/23 at 11:29 AM, observed R53 lying in bed and no longer has the indwelling urinary catheter. Review of records revealed that on 02/07/23 at 13:19 PM, Progress Notes documented: received report from floor nurse that resident is not at her baseline, with noted confusion, foul smelling dark colored urine with sediment. MD (attending physician) made aware received orders for UA (urine test) and C&S (culture and sensitivity, test to identify bacteria and its sensitivity to antibiotics). Further review of records revealed that on 02/07/23 at 11:03 PM, Progress Notes documented: MD made aware of resident with positive results for ESBL (extended-spectrum beta-lactamases, which is an enzyme found on some strains of bacteria) to urine. Resident was also started on ciprofloxacin (antibiotic) 250 milligrams twice a day for 7 days for ESBL to urine on the same day.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42160 Based on interviews and record reviews, the facility failed to identify and verify a significant weight loss/gain and ensure a resident maintained acceptable parameters of body weight for 1 of 4 residents (Resident (R)64) sampled. R64 had a significant weight loss of 19.30% from 10/27/22 to 11/10/22 and a significant weight gain of 20.62% from 11/10/22 to 01/29/23 that was not verified and/or addressed. As a result of this deficiency, residents are at risk for the potential of negative outcomes due to unidentified changes. Findings include: R64 was admitted to the facility on [DATE] with diagnosis that include dementia, with behavioral disturbances, diabetes mellitus type 2 without complications, anxiety disorder, major depressive disorder, and insomnia. On 02/10/22 at 10:10 AM, conducted a review of R64's Electronic Health Record (EHR). Review of the resident's weights documented: 10/27/22- 120.2 lbs (pounds); 11/10/22- 97.0 lbs; 12/22- Refused weights; and 01/29/23- 117 lbs. Indicating R64 had a significant weight loss of 19.30% from 10/27/22 to 11/10/22 and a significant weight gain of 20.62% from 11/10/22 to 01/29/23. Reviewed R64's progress notes, physician notes, and Registered Dietician for documentation that the facility was aware of the changes and addressed the resident's significant weight loss/gain and could not find documentation. On 02/10/23 at 9:24 AM, conducted a concurrent record review and interview of R63's EHR with unit Charge Nurse (CN)2. Inquired with CN2 about R64's significant weight loss/gain. CN2 confirmed that there was no documentation that weight was rechecked to confirm the changes, notification of physician, or the notification of the dietician. CN92 stated R64's weight should have been rechecked to confirm it was an accurate weight and if the weight was accurate, the physician and the registered dietician should have been notified and the weight loss would be addressed. On 02/10/23 at 12:15 PM, conducted a telephone interview and concurrent record review of R64's EHR with Registered Dietician (RD)2. RD reviewed R64's EHR and confirmed per dietician notes that the facility did not notify the registered dietician of R64's significant weight loss on 10/27/22. RD2 stated the process is if there is a weight change then the resident should be re-weighed and if the weight change is correct then the facility should notify the physician and the RD.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47783 Based on observations, interviews, and record review, the facility failed to ensure an account (route and time) of a controlled medication for one resident (Resident (R)23) sampled. As a result of this deficiency, the resident is at risk for more than minimal harm and provides an opportunity for diversion of a controlled medication. Findings include: R23 is a [AGE] year-old resident admitted with type 2 diabetes mellitus, end stage renal disease and dependence on renal dialysis, non-pressure chronic ulcers to both heels, cellulitis (bacterial skin infection causing redness, swelling and pain) to both lower limbs, chronic osteomyelitis (bone inflammation or infection) to both left and right ankles. Resident is transported to an incenter dialysis clinic three times a week and is on oxycodone (narcotic pain medication) 10 milligrams (mg) every 3 hours routinely for pain. Review of R23's electronic health record (EHR) included scanned communications between the facility and the incenter dialysis clinic in Resident Documents. Physician's order for oxycodone 10 mg every 3 hours routinely for pain included instruction that the facility may send the medication with the resident when going out for her scheduled dialysis treatments. Review of the last 10 dialysis communication records from 01/18/23 to 02/11/23 done. Dialysis treatments start times vary from 11:09 AM to 11:48 AM and end times are from 03:45 pm to 04:14 PM. Documentation for the time oxycodone was administered was only written in four out of the ten dialysis communication records reviewed. Medication administration record (MAR) also revealed that there are scheduled administration times on 01/17/23, 01/18/23, 01/19/23, 02/07/23 and 02/08/23 for oxycodone that are left blank with no explanation noted. Interview with Nurse (N)8 on 02/13/23 at 10:15 AM revealed that the 12:00 PM and 03:00 PM doses of oxycodone are secured in a plastic pouch and given to the resident to hand carry when she goes out for her dialysis treatments. N8 also said that the dialysis nurse gives the oxycodone at the incenter dialysis clinic. When asked if the dialysis nurse communicates what time the oxycodone is administered, N8 said: sometimes they write it in the dialysis communication records or we just ask the resident since she is alert. Review of the dialysis communication records and interview with the Administrator done on 02/13/23 at 01:30 PM. Asked if she can tell what time the oxycodone was given to the resident when she goes out for her dialysis treatments. Administrator confirmed that she is not able to, and that administration times should be noted in the dialysis communication records. She also said that if the administration time is not written, the nurse should call the incenter dialysis clinic and confirm what time the dialysis nurse administered the medication. Review of facility's policy and procedure Medication Pass Protocol documented: 13. Should a drug be withheld, refused, or given other than the scheduled time, the nurse must provide this information on the Medication Administration Record including an explanatory note.

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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. 42160 Based on observations and interviews, the facility failed to ensure medication error rates are not 5 percent (%) or greater. The survey team observed a total of 28 medications, the total number of errors were 2, and the medication error rate was 7.14%. As a result of this deficient practice, there is potential for more than minimal harm. Findings include: On 02/09/23 at 08:24 AM, conducted observation of medication administration on the second-floor unit with Registered Nurse (RN)71 for R33. RN71 prepared the residents medication and crushed all medications (Acetaminophen 325 mg (2 tablets, total dose 650 mg); Laxatives (2 tablets); and Vitamin C 500 mg (1 tab, not factored into percent rate)) and mixed the crushed medications with applesauce in a medication cup. RN71 administered the crushed medications to R33 then proceeded to walk towards the trash in the resident's room. This surveyor inquired if RN71 completed administering the medication to R33. RN71 confirmed he/she had administered the medication and was going to throw the medication cup away. Asked RN71 if there were any administrable medication in the cup. RN71 replied, No, I gave her all the medication. Requested for RN71 to attempt to scoop the medication cup to ensure all the crushed medications were given. RN71 complied and was able to scoop more crushed medications (approximately half of a regular spoon) and confirmed all medications were not administered and would not have been administered if this surveyor did not intervene.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 42160 Based on observations, interviews, and record review, the facility failed to ensure all drugs are stored in locked compartments and intravenous (IV) fluid was discarded when IV therapy was discontinued. A treatment cart with topical medications was not kept locked or under the direct observation of authorized staffing in an area where residents could access it. No medications were taken by the resident but the potential for more than minimal harm exist. Findings include: 1) On 02/08/23 at 08:15 AM, observed the treatment cart on 1 of 2 units was unlocked in the main dining/activity room. The treatment cart was unsupervised, there were two residents in the area, unsupervised, and no staff in the immediate area. This surveyor opened the treatment cart and documented the cart had topical creams that included Clotrimazole cream, Ketoconazole cream, and Triamcinolone Acetonide ointment. On 02/08/23 at 2:35 PM, conducted a review of R48's Electronic Health Record (EHR). Review of R48's most recent annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/09/22 Section G. Functional Status, documented R48 requires limited assistance (resident highly involved in activity, staff provide guided maneuvering of limbs or other non-weight bearing assistance) for bed mobility, transfers, and walking in room and requires supervision (oversight, encouragement or cueing) for locomotion on the unit. On 02/08/23 at 2:37 PM, conducted a review of R38's EHR documented the most recent quarterly MDS with an ARD of 01/30/23, Section G. Functional Status, locomotion on the unit occurred only once or twice. The most recent annual MDS with an ARD of 11/17/22 documented R38 required limited assistance for locomotion on the unit. On 02/08/23 at 08:16 AM, conducted an interview with Registered Nurse (RN)33 regarding observation of the unlocked treatment cart with unsupervised residents in the area. RN83 confirmed the treatment cart should be locked and if it is unlocked then the cart should not be unsupervised. 43414 2) During observation of the second floor medication storage room on 02/09/23 at 03:40 PM with Licensed Practical Nurse (LPN) 4, observed on the bottom of a shelf a box of facility stock IV fluid. Observed the facility stock IV fluids sealed individually with a thick plastic bag and one IV fluid, sodium chloride injection 1000 milliliters (ml), without the thick plastic bag on top of the facility's stock. Inquired with LPN4 why one of the IV fluids was not sealed in a thick plastic bag, LPN4 looked at it and stated it was specifically for a resident, R27. Inquired if R27 was still receiving IV fluid treatment, LPN4 stated R27 was not. LPN4 reported discontinued medications are put into a large container and are discarded every Wednesday and R27's IV fluid should have been discarded. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R27's physician order documents R27's sodium chloride IV therapy for dehydration and decreased PO [Per Oral] intake was discontinued on 01/14/23. On 02/13/23 at 09:53 AM interview with Director of Nursing (DON) stated if the IV fluid was designated to a specific individual and was discontinued it should be piled with the discontinued medications to be disposed of. Review of the facility's policy and procedures Disposal of Medications documents for non-controlled prescribed medications that is discontinued .containing only dextrose, saline, sterile water, or electrolytes, or a combination thereof, may be discharged , disposed of, flushed, poured, or emptied into a public waste water collection system or s septic system.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 43414 Based on observations, record review and interviews the facility failed to provide sufficient dietary staff to safely and effectively carry out the functions of food and nutrition services. As A result of this deficiency, there is the potential for more than minimal harm. Findings include: 1) On 02/13/23 at 01:54 PM, Resident (R)28's Family Member (FM)1 reported she was frustrated because breakfast and lunch has frequently arrived to the dining area late. FM1 reported dinner sometimes comes early and sometimes comes late. FM1 also reported the lunch today just came at 01:50 PM, and R28 is a diabetic and it is important for R28 to eat timely, so her blood sugar does not drop. 47783 2) On 02/07/23 at 12:47 PM, observed broccoli and green beans served to R14 and R53 at bedside for lunch was not cut into half-inch pieces. Both meal tickets taped to meal trays stated that food consistency is chopped. On 02/08/23 at 08:29 AM, observed cranberry juice served to R53 at bedside for breakfast was not thickened. Meal ticket taped to R53's meal tray stated that liquids be nectar thick consistency. On 02/09/23, observed miso soup and cranberry juice served to R53 at the first-floor dining area for lunch was not thickened. On 02/09/23 at 10:19 AM, read memo with the subject Temporary Adjustment of Mealtime Service from Rocky Mountain Care and interim administrator dated 02/03/23 inside elevator. Memo stated that: Due to staffing shortage, mealtimes will be adjusted ., .snacks must be offered if mealtime goes over 14 hrs (hours). Concurrent interview and observation done with Dietary Manager (DM) on 02/13/21 at 11:40 AM while he was preparing meals for lunch in the kitchen. Asked DM what is the process the kitchen staff follow to make sure the food served to the residents are the same as what the diet order is. DM said that the Dietary Aide (DA) would call out diet order on the meal ticket. DM would then plate the meal as it was called out and place it in a tray. The DA would then tape the meal ticket on the tray and place it in the cart that holds all the finished trays that will be brought up to the resident's floor. DM also said that if they had enough staff, another DA would check the food on the trays against the meal ticket before placing it on the cart. This check is not being done since according to the DM, I'm already preparing the plates, I can't be in two places at the same time. Observed schedule posted in the kitchen area for January 29 to February 11, 2023. DM is scheduled to work from 04:30 AM to 01:00 PM for 12 of the 14 days and 04:30 AM to 07:00 PM for the other two days, a total of 14 days straight. DM said he does not get a day off.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 43414 Based on observations, interview, and record reviews, the facility failed to ensure Resident (R) 58's menu was followed to meet her choices and preferences. Findings include: On 02/09/23 at 08:08 AM, observed R58 receive her breakfast tray and inform nursing staff she did not get milk on her tray. At 08:20 AM, inquired with R58 how breakfast was, R58 reported her milk was not on her tray. On 02/09/23 at 10:09 AM, interview with R58 with resident council members was done. R58 reported sometimes their meal tickets (menu) are not followed. R58 stated For instance, my meal ticket said milk and on the meal tray, I did not get milk this morning. R58 stated she had to let nursing staff know so she could get her milk but is worried about those who cannot speak for themselves. On 02/10/23 at 09:28 AM, observed R58 eating breakfast. R58 stated she received papaya and hot cereal although her meal ticket says no papaya and no hot cereal. R58 reported she gave her papaya to the resident next to her. Observed papaya on a plate with the resident next to R58 and hot cereal on R58's tray. Review of R58's meal ticket documents NO HOT CEREAL .NO PAPAYA .

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43414 Based on observation, interviews, and record review, the facility failed to ensure residents receive foods in the appropriate form as prescribed by a physician for 2 of 2 residents (Resident (R)28 and R14). As a result of this deficient practice, residents are at risk for more than minimal harm. Findings include: Review of the facility's policy and procedure Dietary Services documents All diets shall be meet the nutrient, texture, and fluid needs of each resident. 1) R28 was admitted to the facility with hospice on 12/05/22 with diagnoses that include Alzheimer's disease, dementia, and Parkinson's disease. Review of R28's comprehensive person-centered care plan documented .Provide diet as ordered: Regular diet, chopped texture and thin liquids . Review of R26's dietary order documented Chopped texture was prescribed. On 02/07/23 at 12:34 PM, observed R28 in the dining room, eating lunch, with her personal caregiver (PCG). The mixed vegetables on R28's lunch plate included pieces of whole broccoli and green beans (approximately one inch long). R28's lunch meal ticket documented the texture of the resident's food is chopped. On 02/09/23 at 08:26 AM, conducted an interview with PCG. PCG reported R28 needs more assistance when eating breakfast, but for lunch and dinner the resident is encouraged to eat on her own. PCG reported she needed to cut the vegetables (whole broccoli and one inch long green beans) in half for R28 on 02/07/23 during lunch. On 02/10/23 at 12:17 PM, interview with Registered Dietician (RD)1 via telephone was done. RD1 reported vegetables with more texture should be chopped into half an inch cubes. 47783 2) R14 is a [AGE] year-old resident admitted on [DATE] with diagnoses that include chronic obstructive pulmonary disease (disease that blocks air from entering the lungs making it harder to breath), diabetes (high levels of sugar in the blood), anxiety, and depression. Review of R14's Electronic Health Records (EHR) under Orders dated 10/07/2022, documented the resident's food texture as chopped. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/07/23 at 12:47 PM, observed R14 in her room, sitting up in bed with a tray of food on her bedside table. Meal ticked that was taped to the tray indicated diet was chopped. Broccoli and green beans, greater than one inch in size, were observed on R14's plate. Asked Certified Nurse Aide (CNA)17 if the mixed vegetables looked chopped. CNA17 replied No and said she will call the kitchen to send up the correct consistency. 3) R53 is a [AGE] year-old resident admitted on [DATE] with diagnoses that include hemiplegia (loss of strength leading to paralysis on one side of the body) affecting right side, aphasia (disorder affecting how a person communicates), and dysphagia (difficulty swallowing). Review of R53's EHR under Orders dated 12/28/22 indicated diet consistency as chopped and liquids as nectar thick. On 02/07/23 at 12:57 PM, observed family member (FM) 2 assisting R53 for lunch at bedside. The meal ticket documented the resident's diet texture as chopped and liquids as nectar thick. Broccoli and green beans on R53's plate were greater than one inch in size. FM2 was cutting the vegetables into smaller pieces before giving it to R53. On 02/08/23 at 08:29 AM, CNA6 was assisting R53 with breakfast at bedside. Meal ticket taped to the tray indicated diet as chopped and liquids to be nectar thick. Observed cranberry juice not coating spoon when dipped indicating it was regular consistency. Asked CNA6 if cranberry juice was thickened, she replied: No, I'll ask the nurse to thicken it. On 02/09/23 at 12:28 PM, observed FM2 assisting R53 with lunch (4 pieces of tuna sushi roll, miso soup, and cranberry juice). R53's repeatedly coughed and Unit Manager (UM) 4 came to the resident to investigate. Conducted an interview with UM4 regarding texture and consistency of R53's lunch. R53's lunch ticket documented the diet texture should be chopped and liquids should be nectar thick. Reviewed the texture of the miso soup and cranberry juice with UM4. UM4 confirmed both items were not nectar thick. UM4 stated there has been issues with receiving the correct consistency of food and liquids from the kitchen. Inquired wit UM4 as to how the facility ensures the residents receive the correct diet and consistency of food and liquids. UM4 stated the kitchen should do a check when preparing the food and the CNAs or staff delivering the meals should also check the food and liquids before giving it to the resident. On 02/10/23 at 12:17 PM, conducted a telephone interview with Registered Dietician (RD) 1. Shared my observations of the texture of solid food and consistency of liquids received by R53 during meals. RD1 confirmed the broccoli and green beans should be cut into half inch pieces for chopped order. Also, the miso soup and cranberry juice should have been nectar thick consistency before it was served to R53.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 43414 Based on observations and interviews, the facility failed to provide nourishing snacks at bedtime, for meals more than 14 hours between a substantial evening meal and breakfast the following day. Findings include: Review of the facility's policy and procedure Dietary Services documents Three meals plus a bedtime snack shall be serves at regular intervals with no more than 14 hours between dinner and breakfast. 1) During a group interview with resident council members (Resident (R) 47, R26, R58, R50) on 02/09/23 at 10:09 AM, R58 reported and R26, R47, and R50 concurred, the residents eat dinner at 05:30 PM and breakfast comes late at 08:30 AM and they have not received a snack in between for about a month. The facility will sometimes offer soda crackers or graham crackers, but it is not enough. R58 stated they used to serve sandwiches but that has stopped and reported starting Tuesday or Wednesday they were provided sandwiches again but believe it is because surveyors are here. On 02/13/23 at 10:20 AM, conducted an interview with Certified Nursing Aide (CNA) 6. CNA6 stated she occasionally works the evening shift and residents complain about the snacks because they always get soda cracker or graham cracker and juice. 47783 2) On 02/13/23 at 12:32 PM, conducted an interview with Dietary Aide (DA) 4 regarding snacks for residents. DA4 stated kitchen staff only prepare sandwiches for snacks, every other day. On the days kitchen staff are not scheduled to prepare sandwiches, residents receive soda crackers or graham crackers for snack.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 42871 Based on observations, interviews, and record review, the facility failed to provide a clean environment for residents and staff, by not instituting the process of checking the facility's water for Legionella, not providing resident (R)38 a clean area to have his meal, 2 of 2 thickener scoopers were stored in the containers on one unit, and reusable medical equipment was not sanitized between residents. This deficient practice encourages the development and transmission of communicable diseases and infections and has the potential to affect all residents, staff, and visitors in the facility. Findings include: 1) On 02/13/23 at 2:34 PM, interviewed the Infection Preventionist (IP). The IP stated that the process for checking the facility's water for Legionella contamination has not started and that she will have to check if the facility has a policy and procedure. On 02/13/23 at 3:51 PM, interviewed the Maintenance Manager (MM) via phone. MM stated that the facility's water has not been checked for Legionella and the facility did not have a policy and procedure for Legionella surveillance. On 02/13/23 at 3:53 PM, in a query with the Administrator, the Administrator confirmed that the facility has not checked the water for Legionella and did not have a policy and procedure to surveil the facility's water for Legionella contamination. On 02/13/23 at 4:30 PM, the Administrator gave the state agency (SA) the policy and procedure for LEGIONELLA SURVEILLANCE, date implemented 06/22 and date reviewed/revised 06/22. 2) On 02/07/23 at 12:05 PM, observed R38. R38 laid in his bed with his urinal filled with urine sat on his bedside table located adjacent to his bed. On 02/08/23 at 08:00 AM, observed R38's empty urinal on his bedside table. On 02/08/23 at 12:00 PM, observed R38's urinal filled with urine on his bedside table. Certified Nursing Assistant (CNA)9 put on gloves, emptied the urinal, and placed it back on his bedside table. CNA9 removed her gloves, did hand hygiene, and left the room. CNA9 returned with R38's lunch tray and placed it next to the empty urinal. On 02/13/23 at 10:30, a concurrent observation of R38 in his room and interview of nurse (N)11 was done. N11 saw the urinal on R38's bedside table and she was queried if R38 should receive his meal trays on the same bedside table where his urinal resides. N11 stated to prevent contamination and infection, R38's meal tray should not be placed on the same bedside table where R38 keeps his urinal. N11 then directed a CNA to place another bedside table to be used for meals next to R38's bed. 42160 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3) On 02/09/23 at 08:15 AM, observed RN71 using a wrist blood pressure cuff on R33. RN71 did not disinfect the wrist blood pressure cuff before or after use. Inquired with RN71 how the wrist blood pressure cuffs should be disinfected due to the porous material that is in direct contact with the resident's skin and if it should have been disinfected before and/or after use. RN71 stated the wrist blood pressure cuff should have been cleaned before it was used on R33 but was not and purple wipes are used to clean the reusable equipment and had not thought about the band of the cuff is fabric and the purple wipes may not be an appropriate way to disinfect it. Conducted an interview with the facility's IP and shared my observation of staff not disinfecting the reusable wrist blood pressure cuff. The IP confirmed reusable medical equipment should be disinfected before and after use, at a minimum, before it is used. IP also confirmed that due to the fabric on the wrist blood pressure cuff, the purple wipes is not an appropriate disinfectant and staff should use blood pressure cuffs that can be adequately cleaned to prevent the spread of communicable disease and infections. 4) On 02/09/23 at 08:35 AM, during observation of medication administration, both medication carts had a can of liquid thickener with the scooper stored in the container. An observation was made of Registered Nurse (RN71) opening the thickener can, using the scooper with bare hands, then placing the scooper back in the container. Inquired with RN71 if the scooper should be stored in the container. RN71 confirmed the scooper should not be stored in the can. Conducted an interview with the facility IP and shared the observation of staff storing the thickener scoopers in the can. IP confirmed the scoopers should not be stored in the can with the thickening product.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47783 Based on observation, interviews, and record review, the facility failed to provide a safe, clean equipment for a resident (Resident(R14) sampled. R14 is dependent on supplemental oxygen and the filter of the oxygen concentrator machine had a layer of dust on it. As a result of this deficient practice, the resident is at risk for more than minimal harm. Finding includes: R14 is a [AGE] year-old resident admitted on [DATE] with diagnosis that include chronic obstructive pulmonary disease (disease that blocks air from entering the lungs making it harder to breath), chronic respiratory failure, and dependence on supplemental oxygen. On 02/07/23 at 09:47 AM, Observed R14 lying in bed, receiving oxygen 2 liters (L) of oxygen via nasal cannula. The external filter located on the right side of the machine, was covered with a layer of whitish/grayish dust. On 02/08/23 at 08:42 AM, conducted a concurrent observation and interview with Unit Manager (UM) 4 of R14 and the oxygen concentrator filter. It was observed to be the same filter from the observation made on 02/07/23 at 09:47 AM and the layer of dust remained. Inquired with UM4 how often they clean the filter of the oxygen concentrator. UM4 stated housekeeping cleans the oxygen concentrator filters weekly. UM4 was shown R14's filter and confirmed it had not been cleaned. UM4 stated R14 is at risk of breathing in the dust form the filter and will notify housekeeping to clean it. she replied that the residents could be breathing in the dust. On 02/09/23 at 08:26 AM, conducted a concurrent observation and interview with Nurse (N)11 regarding the dust on R14's oxygen concentrator filter. The oxygen concentrator filter had not been replaced or cleaned and still had a layer of dust on it. N11 was unaware if housekeeping was notified to clean the filter, removed the filter and took it to the nursing station. At 08:33 AM, N11 returned to R14's room and installed the cleaned filter on the oxygen concentrator. Inquired with N11 when are the filters cleaned. N11 stated housekeeping cleans the filters weekly.