STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165145	A. Building B. Wing	04/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Embassy Rehab and Care Center	206 Port Neal Road Sergeant Bluff, IA 51054

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44475 Based on observations, facility records, resident, and staff interviews, the facility failed to provide a bariatric bed for 1 out of 1 resident reviewed (Resident #20) and failed to have enough mechanical lifts to meet the needs of 11 residents. The facility reported a census of 37 residents. Findings include: 1. In an interview on [DATE] at 2:43 PM, Resident #17 reported that he used a mechanical standing lift because he couldn't stand up independently. Resident #17 reported that the facility had problems getting enough lift equipment to help all of the residents. Resident #17 explained that he was OK with waiting his turn. In an interview on [DATE] at 12:29 PM, Staff L, Certified Nurse Assistant (CNA), reported that the facility only had one mechanical standing lift and 1 full body mechanical lift until recently. The residents that needed this equipment knew of the shortage and were used to waiting their turn to use the equipment. In an interview on [DATE] at 9:46 AM, the Maintenance Director, reported that there was only one standing mechanical lift and one full body mechanical lift until [DATE]. In an interview on [DATE] at 7:32 AM, the facility Administrator denied knowing about the shortage of standing mechanical lifts and full body mechanical lifts in the facility. In an email dated [DATE] at 10:29 AM the Administrator reported that six residents used the standing mechanical lift, while five residents used a full body mechanical lift, indicating 11 residents that required the use of a mechanical lift. 44465 2. Resident 20's Minimum Data Set (MDS) assessment dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The resident required extensive assistance of two people with bed mobility, transfers, dressing, personal hygiene, and bathing. The MDS coded Resident #20 as non-ambulatory and required supervision only when he used his electric wheelchair. The MDS included diagnoses of depression, muscle wasting, and atrophy in all extremities with a history of rhabdomyolysis (a breakdown of skeletal muscle tissue with irreversible muscle damage). (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 3:48 PM, Resident 20 stated he was a large man, over 6 feet tall, and nearly 400 pounds. Resident #20 explained that he came to the facility over 2 years ago with his personally purchased, specialized extra long bed. Resident #20 reported that he had gained significant amount of weight since then and his hip area extends the full width of his current bed. Resident #20 stated his size prevents him being positioned on his side safely in his current bed. Resident #20 added that the interim Director of Nursing (DON) told him months ago that the facility ordered him a bariatric bed (a bed that is reinforced and equipped to support a higher weight capacity than a traditional bed) for him to better accommodate for his size. Resident #20 commented that he appreciates any facility purchase that would improve his comfort and safety, though feels he had been lied to, as months have expired since he was told of the facility's intent to purchase the bariatric bed, and staff could not provide updates of when he could expect the delivery. The interim DON referred him to the Administrator for any updates. On [DATE] at 11:37 AM, the Administrator provided documentation of the order for the bariatric bed. A Capital Asset Request dated [DATE], and electronically signed by the Administrator on [DATE] was produced. The Chief Operating Officer (COO)/ Chief Financial Officer (CFO) signed approval on the request [DATE]. A Purchase Order document, dated [DATE], indicated an order for two bariatric beds was submitted by the Maintenance Director to their Supply company. In an interview on [DATE] at 1:40 PM, the Administrator, reported that the six month time span from the initial request to the actual ordering of the bariatric bed(s), was due to Resident #20 stated he intented to lose weight, thus he didn't require a bariatric bed. Upon seeking additional clarifications, the Administrator stated the corporation did not wish to purchase 2 beds at that time. The Administrator explained that he didn't know why they didn't order one instead of two, but he wasn't going to put words in their mouth. On [DATE] at 1:55 PM, Resident #20 explained that he had never expressed a desire for any delay in the facility's purchase of the bariatric bed. Resident #20 reported that he would accept any decision, but he just didn't want to be lied to. As Resident #20 laid in his bed, he remarked look at me, why would I refuse a wider bed ? Resident #20 stated he was instructed by staff to ask the Administrator for an update of the bariatric bed. When he approached her on [DATE], he explained that she responded to his request for an update with stating 'what bed'. Resident #20 stated the bed was ordered that day, at the end of their discussion. Resident #20 stated he was pleased the bed had arrived and he was allowed to view it with the Maintenance Director. Resident #20 explained that the bed had additional motors to accommodate his weight and has the ability to hold a 48 inch by 84 inch bariatric mattress. Resident #20 reported that the mattress for the bed hadn't arrived yet, but understood that the mattress was coming from a different distribution center than the frame did. The Nutritional Screen V7 dated [DATE] documented by the Registered Dietician Quarterly Assessment indicated that Resident #20 was obese with a body mass index (BMI) of 21 or greater, indicating excessive obesity. Resident 20's Diet Orders revised [DATE] indicated a regular diet, with a restriction of 1800 calories. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Nutritional Screen V7 dated [DATE] documented by the Registered Dietician indicated Resident #20 as mobidly obsese at 381 pounds (#) with a BMI 48.9. Resident #20's weight's were as follows ,d+[DATE]: 380.3# ,d+[DATE]: 378# ,d+[DATE]: 388.8# ,d+[DATE]: 377.2# The Nutritional Screen V7 dated [DATE] the Dietician documented a Quarterly Assessment with a weight of 384.8# with no significant change noted in past 6 months. BMI of 49.4 indicating obesity. Resident #20's Diet Order showed the maximum calorie intake for the day should be 2000 calories.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42132 Based on observations, clinical record reviews, policy reviews, resident interviews, and staff interviews the facility failed to timely and thoroughly investigate the loss of residents belongings for 1 of 3 residents reviewed (Resident #23) that reported lost and/or missing items. The facility reported a census of 37 residents. Findings Include: Resident #23's Minimum Data Set (MDS) assessment dated [DATE], identified a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating intact cognition. The MDS identified Resident #23's hearing adequate with use of hearing aids. The MDS coded Resident #23 required extensive assistance of two people for bed mobility, dressing, toilet use, extensive assistance of one person for personal hygiene; and total dependence of two people for transfers. The MDS listed diagnoses of congestive heart failure, hypertension, and diabetes. The Care Plan Focus initiated 12/13/21, identified Resident #23 for potential alteration in psychosocial well-being and activity level. The Care Plan interventions initated 12/13/21 included: a. The resident could express self, however, confused at times and needed reminded. b. Independent individual and enjoyed helping others c. Liked an activity calendar in room, required reminding of upcoming activities & require assistance to/from activities d. Vision and hearing adequate The Inventory of Personal Effects dated 12/2/21, for Resident #23, included 2 hearing aids. The undated Items Missing Or Reported lost in the Last Year form provided by the facility indicated 1/22 Resident #23 had missing clothes. The form documented that the facility reminded Resident #23 that when she moved for COVID-19 (novel Coronavirus 2019), the facility didn't move all of her belongings. Resident #23's belongings were packed up and put into storage. The form lacked documentation related to Resident #23's hearing aides. The facility Policy titled Grievance/Concern with revised date of March 2019 included: a. Any issue which involved a human being would be reported on a Grievance/Concern report form and an incident report if potential for abuse, neglect, exploitation, or misappropriation of funds. This would allow prompt investigation and reporting to appropriate agency or entity. b. The Social Service Director (SSD) would be the Grievance Official and responsible for overseeing the grievance process: receiving & tracking through the conclusion, leading necessary investigation, and informing the administrator immediately. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. All grievances/concerns logged & completed by the SSD or assigned to the appropriate designated person for the investigation. d. Written report of the investigation & recommended action to be completed & returned to the SSD/Administrator within 72 hours. During the initial tour on 4/11/22 at 1:56 PM, an observation showed Resident #23 lying in her bed. Resident #23 wore head phones, had her television, and radio volume turned up. Resident #23 removed her head phones and reported an increase in difficulties with hearing due to not having her hearing aids. Resident #23 turned off the television and radio during the interview. Resident #23 frequently asked for the questions to be repeated. During an interview on 4/13/22 at 9:27 AM, Resident #23 explained that the facility lost her hearing aids when she moved back and forth between rooms during the COVID-19 outbreak. Resident #23 said she was previously in the room next door while in isolation, and when she moved rooms, Resident #23 reported that the hearing aids got lost at the time. Resident #23 stated the facility staff informed her they would replace the hearing aids and that had not been done. Resident #23 stated she resided at the facility since December 2021, and the hearing aids went missing since that time. Resident #23 stated difficulty with hearing when does not have hearing aids. During an interview on 4/13/22 at 11:58 AM the SSD declared they were currently working with the Administrator to get the Resident #23's hearing aids replaced. The SSD denied knowing when the resident's hearing aids went missing. During an interview on 4/18/22 at 2:58 PM the Administrator denied knowing Resident #23's hearing aids were reported missing. The Administrator stated the facility replaced the resident's personal property and would replace Resident #23's hearing aids. The Administrator added they didn't recall being notified of the resident's missing hearing aids. The Administrator explained they would get Resident #23's hearing aids replaced as soon as possible.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44475 Based on facility records, staff interviews, and facility policy reviews, the facility failed to protect a resident from physical abuse for 1 out of 4 residents reviewed (Resident #186). The facility reported a census of 37 residents. Findings include: 1. Resident #186's Minimum Data Set (MDS) dated [DATE] indicated that the resident had a short-term, long-term memory problems, and severely impaired daily decision making. The MDS included diagnoses included dementia, anxiety, and transient ischemic attack (TIA, a stroke like attack with no permanent damage). The MDS documented that Resident #186 needed extensive assistance of one person with bed mobility, transfers, toilet use; and supervision of one person with eating. In an interview on 4/18/22 at 3:51 PM, Staff F, Certified Nurse Assistant (CNA), admitted that on 2/22/21, she tapped the top of Resident #186's head with a two handled cup, while he was sitting in the dining room. Staff F reported that the resident said ouch after the incident. The Facility Investigation, for the incident that occurred 2/22/21, revealed a corrective action form which was signed by both the facility Administrator and Staff F on 02/24/21. The Abuse Prevention Plan - Iowa Policy dated 3/19 revealed that in accordance with the vulnerable adult law of the state and the Centers for Medicare and Medicaid (CMS), it was the facility's policy that all residents residing in the facility would be protected from abuse, neglect, misappropriation of funds/property, exploitation or involuntary seclusion, mistreatment/maltreatment and that interventions are implemented to provide the vulnerable adult with a safe living environment. 2. The Employee File for Staff G, Certified Nurse Assistant (CNA) revealed a corrective action form which described an incident that occurred on 04/29/20 in which the facility Administrator and Staff G signed the form on 04/20/20. The incident was related to 2 unknown residents that complained that Staff G displayed inappropriate verbal behaviors, inappropriate non-verbal behaviors, displayed actions of being rude, had a lack of respect, and a lack of dignity to the residents. The same form revealed that further complaints would be investigated and if determined to be true it would lead to further disciplinary action up to termination. The Employee Counseling Form dated 6/28/21 for actions that occured on 6/19/21 - 6/21/21 indicated the type of violation displayed as resident abuse and/or harassment, improper conduct, violation of company procedure, and work performed inaccurately. Several coworkers reported harassment by Staff G of foul language when she worked. Staff G displayed fould language in front of and to Resident #8 and two additional residents. The investigation revealed that several resident reported Staff G as rude and confirmed that Staff G called her a bitch. The form indicated that speaking to the residents that way was demeaning and considered to be resident abuse. The facility believed Staff G violated the following policies: (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A. Resident rights: Calling the residents names, telling the residents they stink, and/or they were smelly. B. Free from Abuse and Neglect: The residents have a right to be free from mistreatment, neglect, or misappropriation of resident property. Staff G mistreated these residents by the way she spoke to them and called them names. C. Respect and Dignity: Calling residents names, making rude statements about them, or their condition showed the residents no respect or dignity. D. Threatening, abusive, or vulgar language: Threatening, abusive, or vulgar language has no place in front of residents, residents' families, or visitors. It impeded the effective and efficient operation of the business and showed disrespect to the residents. As a result the facility would not tolerate such actions. E. Harassment Policy on page six and seven of the Employee Handbook. F. Guidelines for appropriate conduct on pages 43-44 of the Employee Handbook. As a result of the actions, the facility terminated Staff G immediately for harassment and resident abuse. In an interview on 4/21/22 at 7:32 AM, the Administrator reported that the corporate office wrote those documents then they were to be signed by the Administrator and the employee. In the same interview, the Administrator reported that Staff G didn't work at the facility and that Staff F has had no other corrective action since the incident on 2/22/21.

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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** 44475 Based on clinical record, staff interview, and facility policy, the facility failed to develop or revise care plans for 3 out of 16 residents reviewed (Residents #7, 26, and 33). The facility reported a census of 37 residents. Findings include: 1. Resident #7's Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 11, indicating moderately impaired cognition. Resident #7's diagnoses included major depression and insomnia. The Mood section of the MDS indicated a Patient Health Questionnaire (PHQ)-9 score of 9, indicating moderate depression. The Clinical Physician Orders reviewed 4/12/22 included the following orders A. Bupropion HCl (hydrochloride) (an antidepressant) ER (Extended Release) SR Slow Release Tablet 12 Hour 150 milligrams (MG) initiated on 08/31/19. B. Trazodone HCl Tablet (antidepressant) 150 MG initiated 6/4/20. The Care Plan Focus revised 2/3/22 indicated Resident #7 had a diagnosis of major depressive disorder that was in remission. Resident #7's had a history of making statements of suicide, repetitive complaining about the same topic making degrading comments about other residents; voicing that everyone is out to get him. Resident #7's gets agitated when things do not go as he thinks they should. Resident #7's PHQ9 6: mild depression and had a diagnoses of major depressive disorder (MDD). Resident #7 took Bupropion. The Focus included the following interventions A. Provide medication as prescribed, monitor for effectiveness, and side effects. B. Staff to observe for therapeutic and adverse effects of psychotropic medications. Resident #7's Care Plan lacked interventions related to the list of side effects for bupropion and trazodone for staff to monitor. The Comprehensive Care Plans Policy dated 4/23/19 revealed that other factors identified by the interdisciplinary team will also be addressed in the plan of care. The comprehensive care plan directed the Care Plan to be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment. The Care Plan should also be updated between Quarterly Conferences to reflect current needs of the resident as changes occur. Alternative interventions will be documented, as needed. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #33's Minimum Data Set (MDS) assessment dated [DATE] included a BIMS score of 13, indicating intact cognition. Resident #33's diagnoses included type 2 diabetes mellitis, pain in both knees, osteoarthritis, chronic pain, and major depressive disorder. The Mood section of the MDS revealed a PHQ-9 score of 5, indicating mild depression. Resident #33 had a scheduled pain medication regimen and used opioids for seven out of seven days in the lookback period. Resident #33 received insulin injections for seven out of seven days in the lookback period. The Clinical Physician Orders reviewed on 4/12/22 included the following orders A. Escitalopram oxalate tablet 20 MG initated 1/7/21. B. Tramadol HCl 50 MG initiated 1/6/21. C. Insulin regular human solution 500 units per milliliters (ML) revised 4/11/22. The Care Plan Focus initated on 3/23/21 directed that Resident #33 had an alteration in comfort related to a diagnosis of osteoarthritis and scheduled pain medication. The Focus included the intervention dated 3/23/21 to administer scheduled pain medication as ordered, monitor for effectiveness, and side effects. The Care Plan Focus initated 3/23/21 indicated that Resident #33 had an alteration in health maintenance related to a diagnosis of diabetes and the use of required insulin therapy. The Focus included the intervention dated 3/23/21 to monitor for signs and/or symptoms of hyperglycemia, hypoglycemia, then update physician with changes. Resident #33's Care Plan initiated 1/7/21 lacked specific side effects to monitor for tramadol, insulin regular human, and listed no information about the side effects of escitalopram. 3. Resident #26's MDS assessment dated [DATE] documented a BIMS score of 9, indicating moderately impaired cognition. The MDS included diagnoses of major depressive disorder, atrial fibrillation (a heart rhythm that can cause blood clots in the heart), stage 3 chronic kidney disease (loss of kidney function indicated by moderately damaged kidneys), insomnia, mixed incontinence, and urinary tract infection (UTI). The MDS indicated Resident #33 required extensive assistance of one person with transfers and toilet use. The Progress Notes revealed that the resident was diagnosed with UTIs on 12/27/21, 1/6/22, 2/8/22, 3/23/22, and 4/11/22. The April 2022 Medication Administration Record (MAR) included the following orders A. Fosfomycin Tromethamine Packet 3 grams (GM) started 4/11/22, give 1 packet by mouth one time a day related to UTI, site not specified for one day mix with 4 ounces of water. B. Celexa Tablet 20 MG (Citalopram Hydrobromide) started 4/2/22 give 1 tablet by mouth one time a day related to depression. C. Coumadin Tablet (blood thinner) 1 MG (Warfarin Sodium) started 3/1/22, Give 1 tablet by mouth one time a day every Mon, Tue, Wed, Thu, Fri, Sat, Sun related to unspecified atrial fibrillation. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	D. Furosemide (diuretic, water pill) Tablet 20 MG started 12/2/21, give 20 MG by mouth one time a day related to chronic kidney disease, stage three unspecified. E. Melatonin (supplement) Tablet 3 MG started 12/1/21, give 3 MG by mouth at bedtime for sleep. The Care Plan last reveiwed 3/30/22 lacked interventions to monitor for the side effects of Celexa, furosemide, and melatonin. Additionally the Care Plan lacked interventions related to the resident's recurrent UTIs. The Care Plan Focus dated 12/3/21 indicated Resident #26 took an anticoagulant. The Focus included an intervention dated 12/3/21 that directed the staff to observe for signs or symptoms of bleeding. In an interview on 4/21/22 at 7:32 AM, the Interim Director of Nursing (DON) reported that she would expect Care Plans to include information about the specific side effects of high risk medications and to include interventions related to a resident who had repeated urinary tract infections (UTI).

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42132 Based on observation, clinical record review, the facility bath record review, resident interview, and staff interview the facility failed to provide bathing assistance per the resident preference to residents identified as assistance required for bathing for 4 of 4 residents reviewed (Residents #20, #21, #22, & #35). The facility reported a census of 37 residents. Findings include: 1. Resident #22's Minimum Data Set (MDS) assessment dated [DATE] documented a a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS coded Resident #22 required extensive assistance of one person with bathing. The MDS listed diagnosis of hypertension, diabetes, and schizophrenia. The Care Plan Focus revised 11/9/21 indicated Resident #22 required an assist of one person with dressing and grooming. Resident #22 needed assistance with bathing. The Focus included interventions dated 10/8/19 A. Resident #22 liked to take showers or whirlpools. B. Resident #22 wanted the staff to monitor for change in her ability to dress, groom, and bathe. Resident #22's Point of Care (POC) Response History for the last 30 days related to the task of bathing reviewed on 4/12/22 revealed she received baths on 3/15/22, 3/18/22, 3/29/22, and 4/7/22. Documentation indicated that Resident #22 refused on 4/6/22 and not applicable on 4/8/22 related to the bathing task. During an interview during the initial tour on 4/11/22 at 11:07 AM, Resident #22 reported she only received a shower once per week. Resident #22 expressed that she would get stinky and she didn't like that. Resident #22 stated she preferred a shower two times a week. Resident #22 reported that the facility had a short of help due to staff not reporting for scheduled shifts and then unable find new staff to replace them. 44465 2. Resident #21's MDS dated [DATE], documented a BIMS score of 15, indicating intact cognition. The MDS revealed Resident #21 independent with bed mobility. Resident #21 required assistance of one person with transfers, walking in room, walking in corridors, locomotion in her room, locomotion in the corridors, dressing, toilet use, and bathing. The MDS documented Resident #21 used a mobility device of a walker. The MDS listed diagnoses including a major depressive disorder, recurrent and severe, peripheral vascular disease (slow and progressive circulation disorder), hemiplegia (complete and severe loss of strength on one side of the body) and polymyalgia rheumatica (inflammatory disorder of shoulders and hips). The Care Plan dated 3/18/22, identifed a focus area of needing assistance with bathing, and assigned an intervention directing the resident required extensive assistance with her bath. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/11/22 at 3:37 PM, Resident #21 stated that she only just started to get baths twice a week. Resident #21 reported she either got no bath or one bath every week for months before the interview. Resident #21 express that she complained to the Administrator who blamed novel Coronavirus 2019 (COVID-19). Resident #21 questioned how long someone could continue to blame COVID-19? Resident #21 remarked that she felt dirty and uncomfortable without the baths. Resident #21 reported that she was embarrassed to go see her doctor. The 30-day lookback report of the ADL - Bathing Task documented Resident #21 had physical help in part of the bathing activity on 3/15/22, 3/18/22, 3/29/22, 4/6/22, 4/8/22, and total dependence on 4/10/22. The documentation indicated Resident #21 refused a bath on 4/12/22. During an interview on 4/12/22 at 2:28 PM, Resident #21 stated she has never refused a bath. Stated she no offered to give her a bath on that date and she didn't refuse. Resident #21 remarked, Are you kidding me? when asked about refusing a bath. During an interview on 4/18/22 at 12:42 PM, Staff L, CNA, confirmed that she marked that Resident #21 refused her bath on 4/12/22. Staff L reported that a coworker told her that she gave Resident #21 a shower two days before on 4/10/22, as the resident had a doctor's appointment on 4/13/22. Resident #21 wanted to be bathed prior to the appointment. Staff L added that she charted refused as she was unable to assist Resident #21 get a bath, Resident #21 arranged for the bath to occur earlier in the week. 3. Resident #20's MDS dated [DATE], documented a BIMS score of 15, indicating intact cognition. The resident was assessed as requiring extensive assistance of two people with bed mobility, transfers, dressing, personal hygiene and bathing. The resident was identified as non-ambulatory and only required supervision when in his electric wheelchair. The MDS included diagnoses of depression, muscle wasting and atrophy in all extremities with a history of rhabdomyolysis (a breakdown of skeletal muscle tissue with irreversible muscle damage). The Care Plan Focus revised 4/18/20 documented that Resident #20 required extensive assistance with his activities of daily living except with eating. The linked interventions dated 11/3/19 indicated he required extensive assist of two people with my dressing, grooming, and bathing. Resident #20 could take a bath or a shower. During an interview on 4/11/22 at 3:48 PM, Resident #20 stated he recently began getting a shower twice a week. Resident #20 addedt that for the last two to three months, he was getting a bath maybe once a week, or none. Stated he felt unclean and uncomfortable as a result. The Task: ADL-Bathing for the previous 30-days documented Resident #20 had bath that required physical assistance of one or two people on 3/21/22, 3/24/22, 3/28/22, 3/31/22, 4/03/22 and 4/7/22. The electronic health record lacked documentation of Resident #20 receiving a bath in the preceding 11 days of Resident #20's interview. The Task lacked documentation of a refusal to take a bath. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Resident #35's MDS dated [DATE] documented a BIMS score of 10, indicating moderately cognitive impairment. The MDS documented Resident #20 required extensive assistance of one person with bed mobility, transfers, walking in her room, walking in the corridor, locomotion on the unit, dressing, toilet use, personal hygiene, and bathing. The MDS included diagnoses of a history of a right pubis fracture, peripheral vascular disease (PVD) (a slow and progressive circulation disorder), diabetes mellitus and mononeuropathy (nerve damage) of her bilateral lower limbs. The MDS identified Resident #20 as occasionally incontinent of urine. The Care Plan Focus revised 6/15/21 recorded that Resident #35's had intact skin. Resident #35 had a potential for skin breakdown due to incontinence.Resident #35 had a risk of skin breakdown associated with periods of incontinence. The Focus included the intervention dated 5/9/20 directed staff to check Resident #35's skin during her weekly bath. The intervention dated 6/15/21 directed the nurse to check Resident #35's skin at least weekly during her bath. The Care Plan lacked specific hygienic interventions or focus. The General Note dated 2/5/22, documented that a nurse gave Resident #35 a shower on that date due to her hair being matted and lack of documentation that she had a shower or a bath for roughly a week. The Task: ADL-Bathing for the previous 30-days documented Resident #35 got assistance of one person for a bath on 3/23/22, 4/2/22, 4/6/22 and 4/16/22. The Task documented Resident #35 refused a bath on 3/26/22. The staff documented that the bathing task was not applicable on 3/30/22, 4/2/22, 4/6/22, and 4/16/22. During an interview on 4/12/22 at 3:05 PM, Resident #35 couldn't recall how often the staff offered her a bath. Resident #35 observed in clean clothing, with her hair loosely braided, and askew. During an interview on 4/13/22 at 10:51 AM, Staff A, Certified Nurse Aide (CNA), stated she was 'not surprised' that residents complained of not getting showers or baths. Staff A reported there were days with just one CNA assigned to a hallway on the day shift. Staff A declared there was no way someone could get showers down with only one CNA. Staff A remarked that several months ago, the management had a meeting with staff. In the meeting, the management acknowledged that showers and baths didn't get done as scheduled and or requested. Staff A explained that the management said they would help bathe and shower residents that were more independent. Staff A stated she never saw this happen and her coworkers have said the same. During an interview on 4/18/22 at 9:17 AM, the Interim DON explained that all residents were assigned a bath two times a week. The Interim DON reported that her expectation was that residents receive a bath twice a week as assigned. The Interim DON stated there is no facility policy related to resident hygiene or bathing. The Interim DON explained that the paper document was kept in the shower room, for staff to document after giving residents a bath. The Interim DON reported that the facility didn't keep that form, so she couldn't produce the previous weeks documents. On 04/18/22 at 11:10 AM, the interim DON produced a document titled Master Bath List updated 4/18. The document listed the residents bath rotation assignment as either: Monday and Thursday, Tuesday and Friday, or Wednesday and Saturday. The document directed that if a resident refused a bath, staff should document in the electronic health record and approach the resident the next day to make up. If the resident continued to refuse again let the DON know.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42132 Based on observations, clinical record reviews, policy reviews, staff, and physician interviews, the facility failed to implement physician orders for 3 of 20 residents reviewed (Residents #7, #27, and #86). The facility also failed to assure thorough completed weekly skin assessments for residents with an identified skin impairment for 1 of 1 resident reviewed (Resident #20). Resident #86 admitted to the facility on [DATE] from an acute care hospital following a fall at home that resulted in a fractured lower leg. Resident #86's primary care provider (PCP) ordered sequential compression devices to lower legs (method of a wrap around the legs that inflate with air to prevent blood clots & improve the blood flow in the legs), an incentive spirometer (a hand-held device used to improve lung function), and knee immobilizer on admission to the facility to prevent blood clots. The facility failed to implement the orders on admission on 2/24/21, and Resident #86 admitted to the local hospital on 3/18/21 with diagnosis of pulmonary embolism (blood clot in the lung). The facility reported a census of 37 residents. Findings Include: 1. Resident #86's MDS assessment dated [DATE], indicated a BIMS score of 13, indicating intact cognition. The MDS documented Resident #86 required extensive assistance of two people for bed mobility, dressing, toilet use, personal hygiene; and total dependence of two staff for transfers. The MDS listed diagnoses of congestive heart failure, hypertension, diabetes, anxiety, and displaced bicondylar fracture right tibia. The Care Plan Focus initiated 2/26/21, identified Resident #86 admitted to the facility for displaced bicondylar fracture of the right tibia and planned on short term rehabilitation stay at the facility. The Focus included the intervention that directed staff to assist Resident #86 to gain independence as much as possible. Resident #86's Care Plan Focus initiated 2/26/21, identified she required assistance with dressing, grooming and bathing. The Care Plan interventions dated 2/26/21 included the following: a. Physical Therapy (PT) and Occupation Therapy (OT) as ordered to improve dressing, grooming, and bathing abilities b. Extensive assist of 1 staff with dressing, grooming, and bathing. c. Extensive assist for a tub bath. Resident #86's Care Plan Focus initiated 2/26/21, identified she had impaired mobility related to a history of a right tibia fracture that required surgery. Resident #86 had a potential for injury related to her fall before her admission to the facility. The Care Plan interventions included: a. Non-weight bearing (3/4/21 & resolved 6/10/21) b. Staff to utilized the full-body mechanical lift to transfer. (3/4/21 & resolved 6/8/21) (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	c. Extensive assist of one staff with ambulation in the hall with walker (2/26/21) d. Extensive assist of two staff with bed mobility, transfers, and ambulation with the use of the stand-up lift (2/26/21) e. Utilized wheelchair (2/26/21) Resident #86's Care Plan initiated 2/26/21 and then resolved 4/13/21 indicated her medications and treatments listed in her orders were a part of her care plan. Some of them were identified throughout the plan of care with special interventions. The Care Plan intervention initiated on 2/26/21 and resolved on 4/13/21 stated the staff were to provide Resident #86 with the appropriate medications and treatments as ordered. Resident #86's February 2021 Treatment Administration Record (TAR) contained the following orders: a. An Incentive Spirometer five to six times per hour every shift, start date 2/26/21 and discontinue date 3/25/21. i. Documentation included: - medication unavailable, see nurse notes. - no entry (blank) from 2/26/21 - 2/28/21. - Night shift documented completed on 2/25/21 and 2/26/21. b. Right knee immobilizer every shift, start date 2/26/21 and discontinue date 3/25/21. i. Documentation included - medication unavailable, see nurse notes - no entry (blank) from 2/26 - 2/28/21. - Night shift documented completed on 2/25/21 and 2/26/21. c. Sequential compression device while in bed every shift, start date 2/26/21 and discontinue date 3/25/21. i. Documentation included: - medication unavailable, see nurse notes. - no entry (blank) from 2/26/21 - 2/28/21. - Night shift documented completed on 2/25/21 and 2/26/21. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Resident #86's March 2021 TAR contained the following orders: a. Incentive Spirometer 5-6 times per hour every shift, start date 2/26/21 and discontinue date 3/25/21. i. Documentation varied from 3/1 - 3/18/21: - medication unavailable, see nurse notes. no entry (blank), and signed off as completed. b. Right knee immobilizer every shift, start date 2/26/21 and discontinue date 3/25/21. i. Documentation varied from 3/1 - 3/18/21: - medication unavailable, see nurse notes, no entry (blank), and signed off as completed. c. Sequential compression device while in bed every shift, start date 2/26/21 and discontinue date 3/25/21. i. Documentation varied from 3/1 - 3/18/21: - medication unavailable, see nurse notes, no entry (blank), and signed off as completed. Review of the Progress Notes for Resident #86 revealed: The Admission Note 2 dated 2/24/21 at 4:17 PM recorded that Resident #86 arrived to the facility at 12:15 PM from the hospital via the facility van, accompanied by the driver. Resident #86 noted to be alert and orientated x (by) 4 (person, place, time, and situation) with an appropriate mood. The Admission Note dated 2/24/21 at 10:48 PM recorded Resident #86 on charting for new admission. Resident #86 alert and orientated x 4, able to voice needs. The resident required assist of 2 with a full-body mechanical lift to transfer. The Skilled Status Note 2 dated 2/25/21 at 1:02 PM, recorded Resident #2 required full-body mechanical lift to transfer due to non-weight bearing right lower extremity. The General Note dated 2/25/21 at 2:16 PM, identified the nurse spoke with staff at PACE (managed care program of all-inclusive care for the elderly) to request a bariatric bed for Resident #86. The Orders-Administration Note dated 2/27/21 at 8:30 AM, recorded no immobilizer available for Resident #86. Then nurse would speak with Physical Therapy on Monday. The Orders-Administration Note dated 2/27/21 at 6:36 PM, documented the nurse faxed Resident #86's PCP (primary care provider) for bed rails to assist with mobilization while in bed. The Orders-Administration Note dated 2/28/21 at 8:27 AM, recorded Resident #86 did cough and deep breathing exercises due to no incentive spirometer. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The Orders-Administration Note dated 3/1/21 at 6:04 AM, documented no available incentive spirometer, right knee immobilizer, and sequential compression device new order item, as they weren't in stock. The Orders-Administration Note dated 3/3/21 at 12:21 PM, recorded Resident #86 did deep breathing exercises due to no incentive spirometer. The Orders-Administration Note dated 3/3/21 at 12:26 PM, documented that Resident #86 had no immobilizer as she came to the facility on admission without an immobilizer. The Orders-Administration Note dated 3/4/21 at 8:17 PM, recorded no incentive spirometer, no sequential compression device, and no right knee immobilizer. The Orders-Administration Note dated 3/5/21 at 7:06 AM, recorded that the sequential compression device was unavailable as the facility didn't have the devices at that time. The Orders-Administration Note dated 3/5/21 at 8:32 PM, recorded no for the incentive spirometer. The Orders-Administration Note dated 3/5/21 at 8:32 PM, recorded Resident #86 refused to use his right knee immobilizer. The Orders-Administration Note dated 3/6/21 at 5:09 AM, 2:59 PM, & 11:47 PM, recorded the incentive spirometer, sequential compression device, and right knee immobilizer weren't available. The Orders-Administration Note dated 3/7/21 at 8:59 PM, recorded the incentive spirometer, sequential compression device, and right knee immobilizer weren't available. The Orders-Administration Note dated 3/8/21 at 1:20 AM & 12:50 PM, recorded that the incentive spirometer, sequential compression device, and right knee immobilizer weren't available. The Orders-Administration Note dated 3/10/21 at 1:37 AM, 9:05 PM, & 11:42 PM, recorded the incentive spirometer, sequential compression device, and right knee immobilizer weren't available. The Orders-Administration Note dated 3/12/21 at 8:39 AM, recorded the incentive spirometer, sequential compression device, and right knee immobilizer weren't available. The Orders-Administration Note dated 3/13/21 at 8:49 AM, recorded the incentive spirometer, sequential compression device, and right knee immobilizer PACE to bring. The Orders-Administration Note dated 3/14/21 at 9:01 AM, recorded the incentive spirometer, sequential compression device, and right knee immobilizer PACE to bring. The Orders-Administration Note dated 3/15/21 at 10:38 AM, recorded the incentive spirometer, sequential compression device, and right knee immobilizer PACE to bring. The Orders-Administration Note dated 3/16/21 at 1:21 AM recorded the incentive spirometer, sequential compression device, and right knee immobilizer PACE to bring. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The Orders-Administration Note dated 3/16/21 at 5:12 PM, recorded the incentive spirometer, sequential compression device, and right knee immobilizer PACE to bring. The Orders-Administration Note dated 3/17/21 at 2:28 AM, recorded the incentive spirometer, sequential compression device, and right knee immobilizer PACE to bring. The Health Status Note (HSN) dated 3/17/21 at 10:58 AM, recorded the nurse notified PACE regarding a bariatric bed and recliner for Resident #86 while at the facility The HSN dated 3/17/21 at 9:27 PM, identified Resident #86 complained of shortness of breath after she felt hot, followed by cold sweats. Resident #86's vital signs were within normal limits except her oxygen saturation (O2 sat) fluctuated from 88-90%. Resident #86's lung sounds sounded clear. The nurse made a phone call to the physician on call who gave an order for oxygen as needed. Resident #86 tested negative for COVID (coronavirus). The nurse updated Resident #86's family member. The HSN dated 3/17/21 at 9:54 PM, documented that Resident #86 rested in bed with her eyes open. Resident #86's O2 sat 88-90%, and encouraged to breath from nose. The General note (GN) dated 3/18/21 at 12:17 AM, documented that at approximately 10:35 PM, the nurse evaluated Resident #86 . The nurse noted earlier in the evening the previous shift's nurse notified the on-call provider due to Resident #86 complained of shortness of breath, diaphoresis (sweating), and altered mental status. The on-call provider gave an order for oxygen at 2 liters as needed, and oxygen applied at 2 liters per nasal cannula. O2 sat at 92% with oxygen on at 2 liters and Resident #86's head of bed elevated. When the nursing staff provided cares, Resident #86's O2 sat dropped to 83%, and she complained of intermittent chest pain. Blood pressure (BP) 132/64, pulse (P) 71, respirations (R) 16, temperature (T) 97.0, and O2 sat ranged from 83-92%. The nurse called the provider on call and got an order to transfer Resident #86 to the emergency room for evaluation. Resident #86's family and the facility Administrator notified. The GN dated 3/18/21 at 4:05 AM, revealed Resident #86 didn't have an incentive spirometer. Resident #86 cognitively present upon her admission to the facility. Resident #86 admitted to the facility for therapy, and she planned to return home. The nurse documented that they never received information that Resident #86 didn't have incentive spirometer. The GN dated 3/18/21 at 4:55 AM, call received from the emergency room at 3:30 AM, Resident #86 admitted to the hospital with diagnoses of pulmonary embolism and urinary tract infection. The hospital document titled Emergency Department (ED) to Hospital Admission identified Resident #27 arrival to the emergency roiagnom on [DATE] at 11:51 PM and discharge date from the hospital 3/24/21. The Computed tomography (CT) of the chest dated 3/18/21 at 3:03 AM, identified extensive right sided pulmonary emboli affecting all 3 lobar arteries and majority of the bronchopulmonary segments. The left lower lobe pulmonary embolism in the basal trunk and multiple segmental pulmonary arteries. The ED note revealed the resident arrived in the ED with cough, shortness of breath, and chest pain & palpitations. The resident noted to be ill appearing upon the arrival in the ED. The ED note on 3/18/21 at 4:35 AM, the resident received a Lovenox (blood thinner medication to treat pulmonary embolism) injection. The resident admitted to the hospital following treatment in the ED and discharged back to the facility on [DATE]. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The facility failed to implement Resident #86's admission orders to prevent blood clots written by the physician. Resident #86 subsequently admitted to the hospital on 3/18/21, with diagnosis of pulmonary embolism. During an Interview on 4/19/22 at 2:05 PM, the Interim Director of Nursing (DON) stated they weren't in the facility as the Interim DON at the time Resident #86 admitted to the facility. The Interim DON reported that she inherited the issues. The Interim DON stated she could not answer why Resident #86 didn't have an incentive spirometer, sequential compression device, or the knee immobilizer. The Interim DON explained that she expected physician orders to be followed and the facility nurse to notify the physician if unable to follow physician orders. During an interview on 4/19/22 at 2:48 PM Staff O, Registered Nurse (RN), confirmed Resident #86 admitted to the facility on [DATE]. Staff O stated they didn't recall the resident had orders for a knee immobilizer and incentive spirometer. Staff O explained that upon Resident #86's admission to the facility the incentive spirometer and knee immobilizer weren't available at the facility. Staff O reported that PACE was to provide the incentive spirometer and knee immobilizer, however, they weren't sure when the supplies arrived at the facility. Staff O remarked that they weren't sure when PACE received notification that an incentive spirometer and an immobilizer were needed. Staff O added that the facility either faxed or called to notify PACE, but they weren't sure which way occurred. Staff O stated they didn't recall what PACE did at that time. Staff O added that they notified the DON at the time, however, they didn't recall who the DON was at the time. Staff O remarked that they weren't sure what was supposed to happen, since the facility didn't have the supplies to follow the physician's orders. Staff O explained that PACE did eventually supply the incentive spirometer, but the facility never received the immobilizer, so they order was eventually discontinued. Staff O said they didn't recall an order for the sequential compression device. Staff O reported that they weren't aware to they had to notify and/or follow-up with physician if they unable to follow the physician orders. Staff O stated they were informed later that they were supposed to notify the physician any time a resident refused physicians orders. Staff O stated at the time the facility did not have the supplies for Resident #86, they didn't know they were supposed to notify the physician. Staff O stated they knew they were to attempt three times before they charted a refusal and then notify physician. Staff O reported they were unable to recall if Resident #86 had incentive spirometer at any time before her admission to the hospitalization on [DATE]. Staff O added that later the Orthopedics discontinued the knee immobilizer. During an interview on 4/20/22 at 8:03 AM, Staff P, Physical Therapy Assistant (PTA), confirmed they provided therapy services for Resident #86 in February 2021. Staff P stated Resident #86 received therapy services for quite some time due to her goal to return home. Staff P explained that Resident #86 utilized PACE. PACE dictated the services provided, including therapy. Staff P reported that initially Resident #86 was non-weight bearing to her right leg and couldn't do anything. Staff P stated Resident #86 participated with strengthening in the beginning and then eventually she could walk. Staff P explained that Resident #86 had behaviors that affected her participation in therapy and her progression. Staff P remarked that Resident #86 did have shortened therapy services in February due to her admission to the hospital. Staff P stated that they did not recall Resident #86 with an immobilizer to her right leg during therapy services. Staff P reported that Resident #86 never had an immobilizer. Staff P added that they didn't know if Resident #86 had sequential compression devices. Staff P reported that if Resident #86 had any shortness of breath or complaints during her therapy session, the therapists would document it in the daily therapy notes. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on 4/20/22 at 10:15 AM, Staff I, Licensed Practical Nurse (LPN), reported they didn't know if Resident #86 had a knee immobilizer in place at the time of her admission on 2/24/21 or before returning to the hospitalization on [DATE]. Staff I explained they did recall Resident #86 had an order for PACE to provide an incentive spirometer; but did not recall when the incentive spirometer arrived. Staff I stated that the facility didn't have the incentive spirometer at time of admission on 2/24/21. Staff I reported she couldn't recall an order for sequential compression device. Staff I said the facility's protocol would be to notify the physician if a resident refused an order, if the equipment, and/or medications weren't available. Staff I stated they didn't know the specific time frame of when to notify the physician, maybe every other day or something. During an interview on 4/21/22 at 8:42 AM, Resident #86's Primary Care Provider (PCP) reported they didn't know for a while that the facility didn't have an incentive spirometer, knee immobilizer, or sequential compression devices (SCD). The PCP stated at some point, right before Resident #86 admitted to the hospital for a pulmonary embolism (PE), the facility did notify them that the equipment was unavailable. The PCP explained that the PACE nurse informed them, that the facility had difficulty getting the ordered equipment and had stated the facility needed to figure out how to get the SCD. The PCP remarked that the facility didn't informed the PCP directly at any time that the equipment was unavailable. The PCP explained that they didn't know that PACE should provide the SCD. The PCP stated the expectation was the facility would provide the equipment needed to care for the resident. The PCP explained that theoretically that it was possible Resident #86 developed the PE due to not having the SCD. The PCP stated the reason Resident #86's had an order for the SCD because she was a high risk for an embolism. The PCP stated the SCD's weren't foolproof. The PCP stated Resident #86 had large legs, over 20 inches, and maybe there weren't SCD's to fit her. The PCP remarked that there was a lack of communication from the facility. The PCP stated the PACE nurse did good at locating durable medical equipment (DME) and if they knew the facility did not have the SCD, they could have located some for Resident #86. The PCP reported that they did not know if the needed size for Resident #86 ever existed as they never tried to obtain the SCD. The PCP stated they could have prescribed a medication like a blood thinner, however, there was high risk of side effects with that medication too. The PCP stated they chose the lesser of the two evils and ordered the SCD. The PCP explained that they didn't even want to order aspirin, but could not recall reason. The PCP stated if had been informed by the facility that they were having difficulty obtaining the SCD, maybe PACE could have got some for Resident #86. The PCP explained that in theory the SCD's were to prevent blood clots, and Resident #86 admitted to the hospital with a blood clot. 2. Resident #27's Minimum Data Set (MDS) assessment dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 8, indicating moderately cognitive impairment. The MDS documented Resident #27 required extensive assistance of one person for bed mobility, transfer, dressing, toilet use, and personal hygiene. The MDS listed diagnoses of coronary artery disease, heart failure, hypertension, and diabetes. The MDS coded Resident #27 received a diuretic seven of seven days in the lookback period. Resident #27 's Care Plan initiated 6/15/21, identified he had cardiac symptoms of sick sinus syndrome, hypertension, arterial sclerotic heart disease, congestive heart failure, and a pacemaker. The Care Plan Identified Resident #27 took cardiac and diuretic medications. The Care Plan interventions included: a. Daily weight, update the physician with weight gain of two to three pounds overnight or 4-5 pounds in 5 days (6/30/21) (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	b. A device to monitor Resident #27's implanted cardiac device in his room to transmit pacemaker information (7/7/21) c. Monitor for side effects related to diuretics (10/29/21) d. Monitor for signs and symptoms of cardiac complications and update the physician as needed (6/30/21) Resident #27's Treatment Administration Record (TAR) dated March 2022 included an order started on 3/24/22 for daily weights. On 3/30/22, the TAR lacked documentation of daily weight, blank. Resident #27's TAR dated April 2022 included an order started on 3/24/22 for daily weights. The entries for 4/7/22 - 4/10/22 lacked documentation of daily weights. Review of Resident #27's Progress Notes revealed: The General Note (GN) dated 3/23/22 at 2:34 PM revealed that the facility received new orders on the clinic sheet from Resident #27's appointment on 3/22/22. The new orders included the following: a. one-time dose of Lasix (diuretic) 40 milligrams (mg) b. daily weights, Levaquin (antibiotic) 750 mg every 48 hours for five doses c. prednisone (steroid) 40mg for five days. The GN dated 3/24/22 at 10:49 AM revealed Resident #27 refused to get out of bed, refused to eat, refused medications, and refused to drink water. The Orders-Administration Note on 3/25/22 at 3:05 PM revealed Resident #27 couldn't be weighed due to his decline in condition. The Orders-Administration Note on 3/26/22 at 2:03 PM documented that Resident #27 didn't get out of bed. The Orders-Administration Note on 3/29/22 at 10:00 AM revealed Resident #27 didn't want to get into the wheelchair to transfer to the scale. The Orders-Administration Note on 4/1/22 at 2:00 PM recorded that Resident #27 did not feel well enough to get her weight. The Orders-Administration Note on 4/5/22 at 1:57 PM documented that Resident #27 didn't feel well, so no weight obtained. Resident #27's Weight Summary lacked documentation of weights for 3/30/22, and 4/7/22 - 4/10/22. The facility failed to obtain daily weights per the physician orders and/or notify the physician of Resident #27's refusals of the daily weights. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an observation on 4/11/22 at 11:02 AM revealed Resident #27 in a recliner in his room. No edema observed to Resident #27's bilateral (both) lower extremities. During an observation on 4/13/22 at 9:42 AM revealed Resident #27 in recliner; well groomed, with gripper socks on, and no edema. During an interview on 4/19/22 at 2:05 PM, the Interim Director of Nursing (DON) stated they expected the physician orders to be followed and notify physician as needed, if the resident refused. The Interim DON confirmed Resident #27 had missing daily weights. The Interim DON reported that the physician received notification and received an order to change from daily weights to weekly weights as to Resident #27's refusals. 44465 3. Resident #20's Minimum Data Set (MDS) assessment dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The resident required extensive assistance of two people with bed mobility, transfers, dressing, personal hygiene, and bathing. The MDS coded Resident #20 as non-ambulatory and required supervision only when he used his electric wheelchair. The MDS included diagnoses of depression, muscle wasting, and atrophy in all extremities with a history of rhabdomyolysis (a breakdown of skeletal muscle tissue with irreversible muscle damage). The MDS assessed Resident #20 as always incontinent of bladder and bowel, without a toileting program in place. The MDS documented Resident #20 had MASD (moisture associated skin damage). The Care Plan Focus revised 11/8/21 recorded that Resident #20 had no skins issues but did have a potential for skin breakdown due to bowel incontinence and frequent ingrown toenails. The connected Goal indicated that Resident #20 wouldn't have skin breakdown due to incontinence through the next review. The Focus included the intervention dated 4/5/21 that Resident #20 had his own schedule, and usually sit in his recliner during the day, but doesn't allow staff to check and change him every 2 hours. When Resident #20 does allow staff to change him, he has soaked through his clothes. The staff have attempted to compromise with him but he refused to change, as he was independent in his decision-making. Resident #20 knew the risks and benefits of being checked and changed. On 04/12/22 at 11:30 AM, observed Staff M say that Resident #20's wound to his right buttocks measured 3. 5 centimeters (cm) x (by) 0.8 cm. Staff M reported that Resident #20 had macerated skin (exposed to moisture too long) due to his incontinence with a superficial abrasion type wound. Staff M reported being the wound nurse and responsible for the weekly skin assessments documented in the clinical record. A 90-day review of the clinical record for weekly skin assessments and wound care notes revealed no records for the week of 1/12/22, week of 2/9/22, week of 3/9/22 and the week of 3/16/22. The weekly wound care notes dated 3/23/22 had no wound measurements included. The wound care notes dated 3/2/22 documented a wound measurement to the resident's right buttocks of 2.0 cm x 1.4 cm. The next documented wound measurement on 4/13/22 to Resident #20's right buttocks measured 3.5 cm x 0.8 cm., revealing an overall increase in wound size. The Wound Care Notes document instructed to do weekly wound observations until the wound healed. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The Skin Program Policy revised March 2019, identified the purpose of the policy and goal as to provide cares and services to prevent the development of pressure ulcers and wounds. The document instructed that the further comprehensive skin assessments would be completed with changes in condition or surface. The Braden Scale (measure elements of risk for pressure wounds) dated 2/23/22, identified Resident #20's score as 16, indicating a risk for injury. The elements of the assessment identified Resident #20 had no sensory impairment, chairfast, very limited in mobility, often moist skin with a potential problem for friction and shearing. On 04/13/22 at 10:46 AM, the interim DON confirmed the lack of clinical records for skin assessments and wound cares as outlined. The Interim DON explained that she expected weekly skin assessments with associated wound cares to be completed and documented weekly. 44475 4. Resident #7's Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 11, indicating moderately impaired cognition. Resident #7 had diagnoses of hydrocephalus (fluid buildup in the brain that causes damage to the brain from pressure) and hypertension (high blood pressure). The MDS indicated that Resident #7 took a diuretic (used to remove excess fluid from the body) for seven out of seven days in the lookback period. The Clinical Physician Orders reviewed on 4/12/22 revealed the following orders a. (Started 1/7/21) Weigh daily and report a weight gain of more than 3 pounds per day or 5 pounds per week. b. (Started 5/13/21) Spironolactone tablet 25 MG give daily for excess fluid. c. (Started 5/13/21) Bumetanide tablet 2 MG to be administered daily for excess fluid. The Weights and Vitals: Weight Summary report reviewed on 4/12/22 documented the following: a. Lacked weights for the following days: 1/11/22, 1/14/22, 1/16/22, 1/18/22, 1/19/22, 1/23/22-1/25/22, 1/28/22, 1/30/22-2/1/22, 2/22/22, 3/1/22-3/3/22, 3/15/22-3/17/22, and 4/4/22. b. Weights that should've been reported to the Physician due to weight gain of three pounds or more occurred on the following dates: I. 1/26/22 316.3 pounds (Lbs.) to 1/27/22 320.0 Lbs. = 3.7 Lbs. weight gain ii. 2/5/22 313.6 Lbs. to 2/6/22 317.8 Lbs. = 4.2 Lbs. weight gain iii. 2/14/22 313.0 Lbs. to 2/16/22 316.2 Lbs. = 3.2 Lbs. weight gain iv. 2/24/22 314.8 Lbs. to 2/25/22 370.0 Lbs. = 55.2 Lbs. weight gain - no additional weight on 2/25/22, next weight on 2/26/22 at 313.8Lbs. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	v. 3/11/22 310.4 Lbs. to 3/12/22 315.0 Lbs. = 4.6 Lbs. weight gain The Care Plan Focus revised 4/6/21 indicated that Resident #7 had hypertension and sleep apnea that he took medications for. Resident #7 had episodes of edema and required additional medications. The Focus included the intervention initiated on 4/6/21 directed the staff to monitor Resident #7's weight daily and update his physician according to his order. The General Note dated 1/12/22 at 11:06 AM revealed the nurse notified a nurse at PACE of Resident #7's increase in weight. The nurse at PACE directed to monitor that day and call the next day with Resident #7's weight. The electronic and paper health record lacked documentation of the facility notifying the physician of Resident #7's weight increase with the exception of 1 progress note on 1/12/22 at 11:06 AM. The Orders - Administration Note dated 1/28/22 at 3:38 PM documented that Resident #7 didn't get weighed due to the facility being short staffed. In an interview on 4/21/22 at 7:32 AM, the Interim DON reported that she expected physician orders to be followed.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42132 Based on observations, clinical record review, facility policy review, staff interviews, and Wound Clinic Registered Nurse interview the facility failed to ensure the residents received care consistent with professional standards of practice, to prevent pressure ulcers, to promote healing, prevent infection, and prevent new ulcers from developing for 2 of 2 residents reviewed for facility acquired pressure ulcers (Residents #11 and #23). Resident #23 admitted to the facility on [DATE] following acute hospitalization for cellulitis to the lower extremities. On 12/8/21, the facility identified Resident #23 had a Stage III pressure ulcer to the left buttock. On 12/15/21, the Wound Clinic identified three additional pressure areas in which the facility failed to identify and assess. On 12/30/21, the Wound Clinic identified two more pressure ulcers in which the facility also failed to identify and assess. The resident requested pain medications to treat the wound pain, the wounds required debridement on multiple occasions, and the resident required oral antibiotic to treat the infected wounds. The facility reported a census of 37 residents. Findings include: 1. The admission Minimum Data Set (MDS) assessment dated [DATE], documented Resident #23 admitted to the facility on [DATE] with diagnoses of heart disease, hypertension, peripheral vascular disease, diabetes, neurogenic bladder, renal disease, and would infection other than foot. Resident #23 required extensive assistance of two staff with bed mobility and toilet use and totally dependent on two staff for transfers. Resident #23 had a Brief Interview for Mental Status Score of 15, indicating no cognitive impairments. The MDS documented Resident #23 at risk of developing pressure ulcers and had no healed or current pressure ulcers. The MDS documented treatments of pressure reducing device for bed and chair and applications of ointment/medications other than to feet. Resident #23 had Moisture Associated Skin Damage (MASD). The MDS contained the following descriptions of pressure ulcers: Stage I intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only, it may appear with persistent blue or purple hues. Stage II partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister. Stage III Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Stage IV full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling. Unstageable due to coverage of the wound bed by slough &/or eschar. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The Braden Scale Assessment for Predicting Pressure Sore Risk dated 12/2/21 documented Resident #23 had a score of 11, indicating high risk. The Care Plan date initiated 12/3/21, directed staff to use a total mechanical lift for transfers, provide extensive assistance of 2 staff with dressing and grooming, total assistance of staff with bathing, electric wheelchair, macerated/sheering area to bilateral buttocks, edema to bilateral lower extremities, and antibiotic for cellulitis, treatment as ordered, pressure redistributing pad on chair, pressure redistributing mattress on bed, and skin observed at least weekly by the nurse during bathing process. The Comprehensive Skin Inspection & Risk Factors (Admission Nursing Assessment) dated 12/2/21 documented Resident #23 had a sore (unknown type) to the second toe on the left foot measuring 0.5 centimeters (cm) in length by 0.5 cm in width by 0.1 cm depth. The Weekly Wound Form dated 12/8/21 documented Resident #23 had a Stage III pressure ulcer to the left buttock, multiple sheering areas noted to buttocks, bilateral buttocks raw and red in color. The area measured 2 cm by 1.3 cm by 0.2 cm. The wound edges macerated and no drainage or odor noted. The form documented a current treatment of calmoseptine and a plan to refer to the wound clinic. The Wound Clinic notes dated 12/15/21 documented the following wounds: a. Wound #17, a Stage III pressure ulcer to the right gluteus (buttock). Measured 12 cm by 5 cm by 0.5 cm, subcutaneous tissue exposed, medium amount of serosanguineous drainage (yellowish with blood), wound bed red, and small amount of necrotic (black, dead) tissue within the wound bed including slough. Debridement preformed, removed eschar, subcutaneous tissue, and slough. b. Wound #18, a Stage II pressure ulcer to the left gluteus. Measured 8 cm by 2.5 cm by 0.1 cm, medium amount serosanguineous drainage, red granulation wound bed, and small amount of necrotic tissue within the wound bed including slough. c. Wound # 19, a Stage II pressure ulcer to the left posterior upper thigh. Measured 17 cm by 17 cm by 0.2 cm, medium amount serosanguineous drainage, red granulation wound bed with small amount of necrotic tissue within the wound bed including slough. d. Wound #20, a Stage II pressure ulcer to the right posterior upper leg. Measured 6 cm by 2 cm by 0.1 cm, medium amount of serosanguineous drainage, red granulation wound bed with small amount of necrotic tissue within the wound bed including slough. Review of the facility wound assessments from 12/8/21 to 3/30/22 revealed the facility failed to identify and assess the three additional wounds identified on the posterior thighs by the Wound Clinic (Wound #17, Wound #19 and Wound #20). The facility assessments of the gluteal wounds failed to consistently assess both the left and right wounds. The Wound Clinic notes dated 12/30/21 documented 2 additional facility acquired wounds and all 6 wounds required debridement and chemical cauterization: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	a. Wound #17, a Stage III pressure ulcer to the right gluteus. Measured 2 cm x 1 cm x 0.3 cm, subcutaneous tissue exposed, medium amount serosanguineous drainage, red wound bed with small amount of necrotic tissue within the wound bed including slough. Debrided eschar, subcutaneous tissue, slough, and exudate. b. Wound #18, a Stage II pressure ulcer to the gluteal fold. Measured 2 cm x 1.5 cm x 0.1 cm, medium amount serosanguineous drainage, and red granulation wound bed with small amount of necrotic tissue within the wound bed including slough. Chemical cauterized the wound (reduce infection). c. Wound #19, a Stage II pressure ulcer to the left posterior upper thigh. Measured 4 cm x 2 cm x 0.1 cm, medium amount serosanguineous drainage, and red granulation wound bed with small amount of necrotic tissue within the wound bed including slough. Chemical cauterized the wound. d. Wound #20, Stage II pressure ulcer to the right posterior upper leg. Measured 4.4 cm x 1 cm x 0.1 cm, medium amount serosanguineous drainage, and red granulation wound bed with small amount necrotic tissue within the wound bed including slough. Chemical cauterized the wound. e. Wound #21, a newly acquired Stage II pressure ulcer to the right midline gluteus. Measured 0.8 cm x 0.8 cm x 0.1 cm, medium amount serosanguineous drainage, and large red/pink granulation wound bed. Chemical cauterized the wound. f. Wound #22, a newly acquired Stage II pressure ulcer to the right medial gluteus. Measured 1.6 cm x 1.1 cm x 0.1 cm, medium amount of serous (clear) drainage, large red/pink granulation wound bed. Chemical cauterized the wound. Review of the facility wound assessments from 12/30/21 to 3/30/22 revealed the facility failed to identify and assess the two additional wounds identified on 12/30/21 by the Wound Clinic (Wound #21 and Wound #22). December 2021 Treatment Administration Record (TAR) revealed the following: a. An order dated 2/2/21, to apply calmoseptine ointment to buttock/tight two times a day for wound care. The staff omitted the treatment on 12/14/21, 12/17/21, and 12/24/21 on the day shift. b. An ordered dated 12/16/21, to cleanse the right and left gluteus with soap and water, apply zinc barrier to all affected areas. Stage III to the right buttock apply 4 by 4 soaked Dakin's 0.125%, cover with ABD & secure with tape and brief two times day, The staff omitted the treatments on 12/17/21 and 12/24/21 on the day shift. January 2022 TAR revealed the following: a. Calmoseptine ointment to buttock/thigh topically two times a day, started dated 12/2/21. The staff omitted the treatment on 1/7/21 and 1/17/22 on the evening shift and on 1/18/22 on the day shift. b. Right and left gluteus, cleanse with soap and water, apply zinc barrier to all affected areas of buttock. Stage III to the right buttock ulcer apply 4x4 soaked in Dakin's 0.125%, cover with tape and brief two times a day. The staff omitted the treatment on 1/17/22 on the evening shift and 1/18/22 on the day shift. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	c. Wash right and left upper leg with soap and water, apply zinc oxide two times a day for wound care. The staff omitted the treatment on 1/17/22 in the evening shift and on 1/18/22 for the day shift. March 2022 TAR revealed the following: a. Apply calcium alginate with silver to right gluteus wound bed daily, cover with ABD, and hold in place with a brief. No tape. The staff omitted the treatment on 3/1/22, 3/5/22, 3/16/22, 3/17/22, 3/21/22, 3/28/22, and on 3/29/22. b. Calmoseptine two times a day to ischium and right posterior upper leg. The staff omitted the treatment on the day shift on 3/1/22, 3/5/22, 3/8/22, 3/16/22 and on the evening shift of 3/7/22. April 2022 TAR revealed the following: a. Calmoseptine two times a day to ischium and the right posterior upper leg two times a day start date 2/24/22. The staff omitted the treatment on 4/11/22 on the day shift. b. Apply calcium alginate with silver to the wound bed right gluteus daily, cover with ABD, and hold in place with a brief, no tape. The staff omitted the treatment on 4/5/22, 4/6/22, and 4/11/22. Review of Resident #23's Progress Notes revealed: a. On 12/5/21 at 9:01 PM, Orders-Administration note revealed the resident received Acetaminophen (analgesic for pain) 325 milligrams (mg) 2 tablets for complaint of buttock pain & discomfort b. On 12/10/21 at 6:19 PM, Nutritional Evaluation revealed the resident current diet-controlled carbohydrate renal diet. Estimated protein requirements 140 grams and estimated fluid requirements 1500-2000 milliliters. Average meal intake for the resident 50-74.9% and supplement intake not applicable. Indicated the resident's skin breakdown included cellulitis to the bilateral lower extremities, skin care in place, and on an antibiotic. c. On 12/15/21 at 10:53 AM, General Note (GN) revealed the resident hot chart due to antibiotic for cellulitis. The resident rated pain a 3 out of 10 to bottom area. d. On 12/27/21 at 12:35 AM, Orders-Administration note revealed the resident received Acetaminophen 325 mg 2 tablets for complaints of buttock pain e. On 12/30/21 at 10:33 AM GN revealed the resident returned from an appointment at the wound clinic with new orders for Cipro (antibiotic) x 2 weeks, Flagyl (antibiotic) x 2 weeks, zinc barrier ointment, and new treatment orders for the wounds to the left and right upper legs. f. On 1/21/22 at 1:52 PM, Dietary note (DN); Registered Dietician (RD) weight change and wound note. Weight trends show weight loss, however warranted. Per the wound assessment dated [DATE] the resident had Stage III pressure ulcer to the right buttock, however, improved and treatment in place. Recommend arginaid two times daily, vitamin c, vitamin e and L-arginine for wound healing. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	g. On 2/10/22 at 1:54 PM, the resident returned from the wound clinic with new orders to discontinue all treatments with the exception of the right buttock ulcer. Continue current treatment to the right buttock. h. On 2/14/22 at 5:39 PM, GN revealed new order received from the wound clinic related to culture from the right buttock. Culture revealed positive MRSA, Augmentin & Doxycycline (antibiotics) ordered for 2 weeks; family notified. i. On 3/10/22 at 10:22 AM, the resident returned from the wound clinic and to continue same treatment. Culture obtained from the wound while at the wound clinic. j. On 3/17/22 at 3:20 AM, new order received from the wound clinic for Augmentin (antibiotic) x 14 days due to wound culture results. k. On 3/30/22 at 4:12 PM, Dietary note revealed the resident continued with pressure injury to the right buttock, larger in size. Recommended increase the arginaid to aid wound healing. l. On 4/1/22 at 2:14 AM, Health status note (HSN) revealed the resident's wound larger, wound bed beefy red and sanguineous drainage noted without odor. The resident reported discomfort during treatment. m. On 4/1/22 at 12:59 PM, HSN revealed fax returned from the physician and new order to obtain culture to right buttock wound. n. On 4/4/22 at 5:18 PM, GN revealed new order received from the wound clinic related to culture results; Keflex (antibiotic) x 2 weeks; resident aware. o. On 4/7/22 at 10:41 AM, GN revealed the resident returned from wound clinic appointment and new order received for the left lower leg. Facility fax dated 3/30/22, notified the Wound Clinic Resident #23's wound to right buttock larger in size, measured 3 cm x 1 cm x 0.3 cm. Order received to obtain culture dated 4/1/22. The Pressure Ulcer Risk Assessment Policy revised March 2019 stated the purpose of procedure, to provide guidelines for the assessment and identification of residents at risk for developing pressure ulcers. General guidelines: a. If pressure ulcers are not treated when discovered, quickly get larger, become painful for the resident, and often times become infected. b. Pressure ulcers made worse by continual pressure, heat, moisture, irritating substances on the resident's skin, decline in nutrition & hydration status, acute illness, &/or decline in the resident's physical &/or mental conditions. c. Once a pressure ulcer developed can be extremely difficult to heal. d. Pressure ulcers are a serious skin condition for the resident (continued on next page)

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Embassy Rehab and Care Center	206 Port Neal Road Sergeant Bluff, IA 51054

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F 0686 Level of Harm - Actual harm Residents Affected - Few	e. Routinely assess and document the condition of the resident's skin per facility wound and skin program for any signs & symptoms of irritation or breakdown. f. Comprehensive skin assessments: on admission, readmission, annually and with change in condition or surface. g. Skin checks: skill would be checked for the presence of developing pressure ulcers on a weekly basis or more frequently if indicated h. Monitoring: staff maintain a skin alert, performing routine skin inspections daily or every other day as needed. Nurses to be notified to inspect the skin if skin changes identified. Nurses would conduct skin assessments at least weekly to identify changes. Identifying Residents at Risk: a. Extrinsic factors: pressure, friction & shear, and maceration b. Intrinsic factors: immobility, altered mental status, incontinence, and poor nutrition c. Medications d. Diagnosis Documentation a. The type of assessment conducted b. The date & tie and type of skin care provided c. Any change in the resident's condition d. The condition of the skin (size & location of any red or tender areas) e. Observations of anything unusual exhibited by the resident Reporting a. Notify the supervisor if the resident refused b. Report other information in accordance with the facility policy and professional standards of practice. Observation on 4/12/22 at 1:48 PM, with Staff M, Registered Nurse during dressing change of calcium alginate with silver & ADB, revealed no open area to the left buttock, skin dry and scaly appearance. Right buttock dry, scaly, and calloused with an open area to the inner buttock approximately 2 cm in length with 2 smaller open areas present. The wound beds red in appearance, no slough noted. Staff M applied calmoseptine to the left buttock and bilaterally under the posterior upper legs. No open areas noted to the bilaterally posterior upper legs. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Observation on 4/13/22 at 12:40 PM, Resident #23 in bed, stated requested to stay in bed due to bottom being sore, air mattress overlay on and functioning. Along with Staff M open area to the right buttock measured 2.3 cm x 0.7 cm x 0.2 cm, bright red wound base. The skin surrounding the open area red, chaffed, dry & excoriated, measured approximately 8 cm circular area. The bilateral posterior upper leg increased redness, chaffed, dry & excoriated. Interview on 4/12/22 at 3:39 PM, the Interim Director of Nursing (DON) stated would look into the resident's pressure ulcer documentation and assessments. The Interim DON stated the Wound Clinic did not typically measure wounds at appointments. Interview on 4/13/22 at 12:26 PM, Staff M, stated skin assessments completed weekly for all residents and pressure ulcers followed up on weekly. Staff M stated had seen wounds more frequently than weekly recently. Staff M confirmed the last wound assessment for Resident #23's pressure ulcers on 3/30/22. Staff M stated pressure ulcer assessment should be done weekly. Staff M stated the wound base assessment only completed during the assessment when noticed eschar or slough. Staff M stated the wound clinic assessed the pressure ulcers during visits, however, only send the full assessment when the facility requested. Interview on 4/18/22 at 11:25 AM, the Wound Clinic Registered Nurse stated Resident #23 first started at the Wound Clinic on 12/15/21, and had Stage III pressure area to right gluteal, Stage II pressure area left gluteal, and to the back of the right and left thighs Stage II pressure areas. The Wound Clinic Registered Nurse stated the resident had cellulitis to bilateral lower legs. The Wound Clinic Registered Nurse stated Resident #23 weighted over 300 pounds and with moisture, made for a perfect storm for pressure ulcer development. The Wound Clinic Registered Nurse stated the moisture and added pressure resulted in the pressure ulcers. The Wound Clinic Registered Nurse stated Resident #23 should have had a low air loss air mattress on admission to the facility. The Wound Clinic Registered Nurse seat mapping ordered and to be done in February 2022, however, not completed. The Wound Clinic Registered Nurse stated the resident placed on a special cushion to determine where the pressure is and based on the testing, new cushions recommended. The Wound Clinic Registered Nurse stated the seat mapping ordered on 2/10/22 and not done, and unsure why not. The Wound Clinic Registered Nurse stated would send a new order. The Wound Clinic Registered Nurses stated the resident required more of a pressure relieving cushion for wheelchair than light blue waffle one in place. The Wound Clinic Registered Nurse stated pressure ulcers preventable. The Wound Clinic Registered Nurse stated hard to say if the missed treatments caused the wound to deteriorate due to the infection in the wound. Interview on 4/18/22 at 11:53 AM, Staff Q, Certified Nurse Aide, stated he/she did not consistently work with Resident #23, however, aware the resident had a sore on bottom. Staff Q stated Resident #23 allowed the staff to reposition, one of the last resident's gotten up for meals and tried to make sure first one in bed after meals. Staff Q stated the resident would request to lay down when done eating. Staff W stated after breakfast and lunch the resident on back and afternoons tried to get on side. Staff Q stated the resident would wiggle and move self in bed, attempted to remind the resident to stay off bottom due to the open areas. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Interview on 4/18/22 at 12:08 PM, Staff I, Licensed Practical Nurse, stated had been present when Resident #23 admitted to the facility on [DATE]. Staff I stated Resident #23 did not have open areas to bilateral buttocks, stated macerated 90%, no open areas. Staff I stated he resident's skin and legs red and sore. Staff I stated Resident #23's legs got worse and requested different bed immediately, however, not sure when the bed came. Staff I stated Resident #23 required a bigger bed due to the bed not being big enough. Staff I stated unable to reposition Resident #23 on side due to the resident size and the size of the bed. Staff I stated not sure when the air overlay on the bed had been initiated. Staff I stated Resident #23 repositioned as much as the resident would allow. Staff I stated as soon as the facility identified skin issues, referred to the wound clinic. Staff I stated unaware of the order for pressure mapping. Interview on 4/18/22 at 12:28 PM, Staff M, Registered Nurse, stated the first-time observed Resident #23's bottom appeared shredded, bad. Staff M stated order obtained for the wound clinic to be involved at that time. Staff M stated Resident #23 could have a shearing spot one week and the next week it would not there and show up in a different spot. Staff M stated difficult to keep track of Resident #23's open areas. Staff M stated unaware of any red or open areas on admission to the posterior legs. Staff M stated did not recall interventions put into place when the resident first admitted . Staff M stated shortly after the admission air mattress overly obtained, probably within the same week. Staff M stated the base line care plan initiated in the resident's electronic health record (HER). Interview on 4/18/22 at 1:39 PM, Staff N, Certified Nurse Aide, stated Resident #23 had been at the facility for a while before received the air mattress overlay, however, did not recall when. Staff N stated when the resident admitted , refused to reposition at times and continued to refuse at times. Staff N stated the resident would refuse to allow the staff to remove the full body mechanical lift pad at times. Staff N stated did not recall if the resident always had cushion in wheelchair, stated remembered the air mattress due to asking for it multiple times before received. Interview on 4/18/22 at 2:01 PM, Staff L, Certified Nurse Aide, stated only worked with Resident #23 one day in December and then on maternity leave. Staff L stated Resident #23 on a turn/reposition program upon return from maternity leave. Staff L stated Resident #23 complained frequently about the staff not being unable to position correctly in her wheelchair. Staff L stated when Resident #23 admitted to the facility, did not feel the facility had the equipment to care for a bariatric resident. Staff L stated utilized 4 staff initially in attempt to position correctly in the wheelchair. Staff L stated the resident preferred to lay down between meals. Staff L stated if the staff know the resident wanted to go to bingo, would offer to lay the resident down first. Staff L stated the resident would reposition at times and other times would refuse. Interview on 4/19/22 at 8:42 AM, Staff F, Certified Medication Aide, stated Resident #23's bottom looked awful, like raw hamburger when admitted to the facility. Staff F stated looked the best ever right before went to hospital and then worse when returned. Staff F stated the resident had always had treatment to bottom. Staff F stated Resident #23 had MRSA in wound and did not help with the healing. Staff F stated when Resident #23 admitted to the facility, encouraged repositioning & to get up in wheelchair. Staff F stated at times the resident refused, preferred to lay on back. Staff F stated unaware how long the resident had the air overlay on bed, stated possibly 2 weeks after admission to the facility. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Interview on 4/19/22 at 9:19 AM, Staff B, Certified Nurse Aide, stated when Resident #23 admitted to the facility lower legs bad, however, did not recall if the resident had open areas on bottom. Staff B stated remembered legs were bad. Staff B stated the resident encouraged to reposition, however, did not like to because on the computer, and preferred to be flat to see the computer. Staff B stated the resident did not have the air mattress overlay for a while after admission, however, not sure how long at least couple of weeks after admission or longer. Staff B stated difficult to turn and reposition the resident due to size. Interview on 4/19/22 at 9:29 AM, Staff A, Certified Nurse Aide, stated when Resident #23 admitted to the facility, skin to bilateral lower legs, knee down, very dry/flaky. Staff A stated the resident's bottom very raw and red like a severe rash. Staff A stated the resident's bottom did not have a good layer of skin. Staff A stated did not recall when the resident's developed open areas. Staff A stated Resident #23 had regular standard bed, flat sheet, with a brief. Staff A stated the resident did not refuse to be repositioned. Staff A stated unaware of when the resident obtained the air mattress overlay on bed. Interview on 4/19/22 at 11:53 AM, Staff M, Registered Nurse, stated reviewed Resident #23's weekly documentation of the pressure areas for the left and right buttock and stated documented as the left buttock initially and when determined not left and actually the right, changed the documentation to the right buttock. Staff M stated would review the skin documentation for open areas to the posterior bilateral upper legs. Interview on 4/19/22 at 12:17 PM, Staff M, Registered Nurse, stated no skin documentation &/or assessments related to open areas to the bilateral posterior upper thighs for Resident #23. Staff M stated not aware the resident had any open areas to the posterior thighs. Interview on 4/19/22 at 2:05 PM, the Interim Director of Nurses, stated unaware Resident #23 had open areas to the bilateral posterior thighs. The Interim DON stated skin assessments completed weekly for all skin issues. The Interim DON stated expected all wound assessments to have a full description of the wounds, including the wound bed. The Interim DON stated the dietician should have been notified immediately and involved with identified pressure ulcers for Resident #23. The Interim DON stated the dietary department a contract service and for a while had been without a dietician. The Interim DON stated did not recall if it was at the particular time Resident #23 identified with the pressure ulcers. The Interim DON stated PACE directed the residents care. The Interim DON stated unaware of when the air mattress overly initiated for Resident #23. The Interim DON stated had not been in the facility when Resident #23 admitted and did not recall the interventions in place on admission to prevent the pressure ulcers. 44475 2. The Minimum Data Set (MDS) dated [DATE] for Resident #11 revealed a Brief Interview of Mental Status (BIMS) score of 5 which indicated severely impaired cognition. Resident #11 had diagnoses of disruption of wound and right sided hemiparesis and hemiplegia following cerebral vascular infarction. The same MDS revealed the resident was totally dependent on 2 for transfers and extensive assistance of 2 for toileting; 1 unstageable, unhealed pressure ulcer. The MDS dated [DATE] revealed that the resident did not have any pressure ulcers when she was admitted to the facility. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The Order dated 12/21/21 revealed an order to irrigate the right calcaneus (heel) wound with 1/4 quarter strength peroxide and 3/4 saline, rinse with saline, pat dry. Apply Santyl to wound nickel thick, cover with Dakin's soaked gauze, cover with dry gauze, wrap with kerlix. Change dressing daily. Wear prafo boot for offloading at all times. Every day shift for wound care right heel. The Order with a revision date of 03/1/22 revealed the following wound care treatment: right heel wound - irrigate with 1/4 peroxide and 3/4 saline, rinse with saline and pat dry. Apply collagen with silver Ag, cover with bordered dressing every other day. Every day shift every other day for Stage III ulcer to right heel. The Treatment Administration Record (TAR) revealed the staff omitted the treatment to the heel pressure ulcer on 2 days from 4/01/22 to 4/20/22 and omitted 6 days in March of 2022. The staff failed to complete Skin Assessments on 1/12/22 and 2/02/22. The facility failed to complete assessments after the Wound Clinic debrided the wound on 11/30/21. The Skin Program Policy dated 3/19 revealed the facility would provide care and services to promote the healing of pressure ulcers/wounds that are present and the facility would reassess the wound at least weekly to include size, stage, size, appearance of wound bed, and status of the tissue surrounding the wound.

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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** 42132 Based on observations, clinical record reviews, policy reviews, and staff interviews the facility failed to implement interventions for 3 of 3 residents reviewed (Residents #5, #27, and #35) to prevent accidents and/or falls. The facility reported a census of 37 residents. Findings include: 1. Resident #27's Minimum Data Set (MDS) assessment dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 8, indicating moderately impaired cognition. The MDS documented Resident #27 required extensive assistance of one person for bed mobility, transfers, dressing, toilet use, and personal hygiene. The MDS included diagnoses of coronary artery disease, heart failure, hypertension, and diabetes. The MDS identified Resident #27 had a history of one fall without injury since the previous assessment. The Care Plan Focus initiated 6/15/21, identified Resident #27 required assistance with mobility; including transfers, bed mobility, and ambulation related to pain and recent fracture. Resident #27 had a history of falls at home and at the facility. The Care Plan interventions included: a. Assist of one staff to ambulate with assistive device to all destinations to/from meals/to and from bathroom when requested, and nonskid shoes when ambulating (6/16/21) b. Gripper strips by the bed (2/18/22) c. Gripper strips in front of the recliner (2/17/22) d. Grab bar on bed for positioning (7/8/21) e. Wheeled walker (6/30/21) f. Privacy curtain open except for cares being completed (3/8/22) g. Physical therapy evaluation (1/31/22) h. Reminded to use call light and not attempt to move furniture independently, voiced understanding (10/24/21) i. Transferred to the emergency room (ER) due to frequent falls 2/19/22, and admitted due to viral infection (2/21/22) Resident #27's Fall Assessments documented a score of 10 or above indicated a risk of falling. Implement fall prevention protocol and place approaches on the Care Plan. The Fall Assessment indicated the following score and fall prevention protocols that would be initiated (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. 12/29/21 at 2:52 PM, score 11. Fall prevention protocols initiated: see the Care Plan for fall interventions b. 3/9/22 at 12:32 PM, score of 17. Fall prevention protocols initiated: see Care Plan for all fall interventions. c. 4/4/22 at 12:06 PM, score of 22. Fall prevention protocols initiated: see Care Plan for all fall interventions. Review of the Progress Notes for Resident #27 revealed: The Incident (SBAR) dated 2/15/22 at 3:36 PM, identified Resident #22 found on the floor. The resident stated attempted to transfer from the wheelchair to the recliner and did not make it. The resident educated on the call light, close to the nurses station, and call light in reach. The General Note (GN) dated 2/17/22 at 10:16 AM, identified Resident #27 left the facility to go to an appointment with his primary care provider (PCP). The GN dated 2/17/22 at 1:22 PM, recorded Resident #27 returned to the facility with a clinic sheet. The Incident Note dated 2/18/22 at 5:15 PM labeled late entry indicated that staff found Resident #27 on the floor in his room, near the closet wearing a winter coat and tennis shoes Resident #27 explained that he got cold, so he went to closet to get a coat, and sat himself on the floor. The nurse educated Resident #27 about using his call light, closed his window, and gave Resident #27 two blankets. The Orders-Administration Note dated 2/19/22 at 5:22 PM documented that Resident #27 went to the local hospital due to a fall. The facility document titled Fall dated 2/17/22 at 2:52 PM identified Resident #27 had a fall in his room. The Incident Description included the Nursing description of observing Resident #27 on the floor between his recliner and his bed. The resident description indicated Resident #27 stated he attempted to lay down in bed. The Immediate action taken documented as range of motion (ROM) assessed without complaints of pain, no injuries, neurological assessments started, the physician notified by fax, and Resident #27's family notified. Resident #27 didn't go to the hospital. Resident #27's mental status indicated he was orientated to person and place. The notation on the bottom of document directed Privileged and Confidential document - Not part of the Medical Record - Do Not Copy. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility document titled Fall dated 2/18/22 at 5:15 PM identified Resident #27 fell in his room Walnut 10-B. The Incident Description included the Nursing description indicated that the nurse got called to the resident's room, where they found Resident #27 on the floor. The resident description indicated Resident #27 explained that he got cold, so he went to closet to get a coat, and sat himself on the floor. The nurse educated Resident #27 about using his call light, closed his window, and gave Resident #27 two blankets. The Incident Description recorded that the nurse found Resident #27 on the floor near his closet with his knees bent, and his feet were flat on the floor. Resident #27 wore tennis shoes and winter coat. Resident #27 denied being injured or hitting head. Resident #27 didn't go to the hospital. Resident #27 had no injuries at time of the incident. Resident #27 mental status showed him orientated to person and situation. Gait (walking) imbalance listed as the predisposing physiological factors and ambulating (walking) without staff assistance as the predisposing situation factors. The notation on the bottom of the document indicated the form was a Privileged and Confidential document - Not part of the Medical Record - Do Not Copy. The facility document titled Fall dated 2/19/22 at 5:27 PM identified Resident #27 had a fall in his room. The Incident Description included the Nursing description of observing Resident #27 on the floor. Upon assessment, Resident #27's blood pressure was elevated at 152/92, [NAME] 90, Temperature 97.7, Respirations 26, and oxygen saturation 95% on room air. Resident #27's mental status indicated he was orientated to two, confused but responsive. The nurse observed a lump and a hematoma (bruise) at the right side base of his skull, with pain in his upper cervical spine. The resident's description reported that he stood up, fell , and hit his head. The Immediate action taken documented Resident #27 had his third fall in three days. The nurse called the on-call physician and sent Resident #27 to the local hospital. The nurse called Resident 27's family to notify them of his fall. The nurse called the local hospital and gave them report given. Resident #27 did go to the hospital. Resident #27's injuries observed at time of the incident included hematoma to the back of his head. Resident 27's mental status indicated that he was orientated to person and situation. Resident #27's predisposing physiological factors of confusion, gait imbalance, and other. Resident #27's predisposing situation factors included ambulating without assistance, recent room change, and wanderer. The notation on the bottom of the document directed Privileged and Confidential document - Not part of the Medical Record - Do Not Copy. The facility document titled Fall dated 3/8/22 at 10:30 AM, identified Resident #27 fell in his room, Cedar 33-B. The Incident Description included the Nursing description of observing Resident #27 on the floor in front of his recliner, walker in front of him, and with his shoes on. Resident #27's description indicated he slipped out of his recliner. The immediate action taken included an assessment of Resident #27, who denied hitting his head, assisted with three staff to a standing position, and transferred to his wheelchair. Resident #27 didn't go to the hospital. Resident #27's mental status documented as orientated to person, place, and situation at the time of fall. Resident #27 ambulated without assistance and his catheter bag on the floor noted as the predisposing situation factors. The notation on the bottom of the document indicated it was Privileged and Confidential document - Not part of the Medical Record - Do Not Copy The facility failed to implement the interventions of the gripper strips in front of the recliner (2/17/22) and by the bed (2/18/22) as directed by the Care Plan and Resident #27 sustained additional falls on 2/19/22 and 3/8/22 in room. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 4/11/22 at 11:02 AM, Resident #27 appeared well groomed, in his recliner in his room with his call light in reach. The floor contained no gripper strips by his bed or in front of his recliner. During an observation on 4/12/22 at 9:06 AM, Staff A, Certified Nurse's Aide (CNA), & Staff N, CNA, transferred Resident #27 to the recliner in his room using a gait belt and walker. No gripper strips observed on the floor in front of Resident #27's recliner or by his bed. During an observation on 4/13/22 at 9:42 AM, Resident #27 appeared well groomed in his recliner in his room wearing gripper socks and his call light in reach. The floor contained no gripper strips on the floor in front of Resident #27's recliner or by his bed. Duirng an observation on 4/13/22 at 11:30 AM, Staff A and Staff L, CNA, transferred Resident #27 to his recliner in his room, using a gait belt and walker. The floor contatined no gripper strips on the floor in front of Resident #27's recliner or by his bed. During an observation on 4/13/22 at 12:17 PM, noted gripper strips in place by Resident #27's bed and in front of his recliner. During an interview on 4/13/22 at 11:45 AM, Staff A and Staff L confirmed Resident #27 didn't have gripper strips in front of his recliner or by his bed in his room. Staff A and Staff L said that since Resident #27 moved into room [ROOM NUMBER], he didn't have any gripper strips on the floor by his bed or in front of his recliner. Staff A stated the resident had been in room [ROOM NUMBER] for 3-6 months. During an interview on 4/13/22 at 11:55 AM, the Interim Director of Nursing (DON) remarked that they would take care of having gripper strips be put in Resident #27's room immediately. During an interview on 4/19/22 at 2:05 PM, the Interim DON stated they expected the gripper strips to be in place in Resident #27's room as directed by the Care Plan, in front of the recliner, and by the bed. 44465 2. Resident 5's MDS assessment dated [DATE], documented a BIMS score of 12, indicating moderately impaired cognition. The MDS documented Resident #5 required limited assistance of one person with bed mobility, extensive assistance of one person with transfers, walking in her room, walking in the corridor, locomotion on the unit, dressing, and bathing. The MDS documented Resident #5 as unsteady and only able to stabilize with staff assistance. Resident #5 used mobility devices of a walker and wheelchair. The MDS listed diagnoses including unspecified dementia without behavioral disturbance, chronic lung disease, cerebral vascular disease, and an overactive bladder. The MDS documented the resident was frequently incontinent of bladder. Resident #5's MDS assessment dated [DATE], documented a BIMS score of 15, indicating intact cognition. The MDS documented Resident #5 independent with bed mobility, transfers, toilet use, and personal hygiene. The MDS documented Resident #5 required supervision when walking in her room, the corridor, and required supervision with locomotion. The MDS documented Resident #5 as unsteady and only able to stabilize with staff assistance. Resident #5 used mobility devices of a walker or wheelchair. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The clinical record revealed the resident experienced a witnessed fall dated 12/17/21 at 16:55 PM. The fall documentation stated the resident went to sit on her seated walker and slipped, falling to the floor. No injury was documented. The Care Plan dated 10/15/21, identified the resident as having an alteration in mobility, with a goal to not sustain a major injury over the following 90 days. An intervention added, as a result of the 12/17 fall, documented a Dycem (material that provides for a nonslip surface) was to be added to the resident's seated walker. The clinical record , dated 4/14/22 at 10:30 AM, documented the resident had an unwitnessed fall. Documentation stated the resident slipped out of her recliner and fell to the floor. No injury was reported. A subsequent unwitnessed fall, dated 4/14/22 at 21:58 PM, noted the resident on the floor, stating the walker slipped away from her. The current Care Plan, dated 01/17/22, revealed no additional interventions added as a result of the residents fall dated 4/14/22. The current Care Plan continued to include interventions added as a result of her falls since admission of 4/28/21. These interventions included a Dycem added to her wheelchair cushion dated 6/2/21, a low bed with a fall mattress next to bed dated 4/29/21, and a Dycem on her walker seat dated 12/17/21. On 4/20/22 at 1:25 PM, in a joint observation of the resident's room with the interim DON, revealed no Dycem material on the walker seat or wheelchair cushion, a bed elevated off the floor and the absence of a fall mat. The resident stated she has never seen any Dycem material added to her wheelchair or walker, she stated the bed will not go any lower than the current elevated position and she has never seen a fall mat in her room. The resident stated she has never refused these items or interventions. A review of the facility policy titled 'Fall Prevention and response Policy' revised April 20, identifies the intent is to identify residents who are at high risk for falls and develop individual precautions to prevent further falls. Item #8 directs the Interdisciplinary Team Fall Committee will meet weekly and review each resident that has fallen during the preceding week and the Care Plan is to be updated with any new or decided interventions. This will continue for 3 weeks post-fall or until the resident has had no further falls for 30 days, which indicates the interventions are working. The policy directs that verbal and written communication via the nursing Care Plan are essential for success and residents need to be reassessed according to the Fall Prevention Policy and as needed. On 4/14/22 at 1:35 PM , in an interview with the interim DON, stated she expected Care Plan fall interventions to be in place and utilized as directed in the Care Plan. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Resident 35's MDS assessment dated [DATE], documented a BIMS score of 10, indicating moderately impaired cognition. The MDS documented Resident #35 required extensive assistance of one person with bed mobility, transfers, walking in her room, walking in the corridor, locomotion on the unit, dressing, toilet use, personal hygiene, and bathing. The MDS documented Resident #35 as unsteady moving on and off the toilet, but able to stabilize without staff assistance. The MDS documented Resident #35 an assessment indicating Resident #35 as unsteady, only able to stabilize when walking, or turning around with her assistive device. The MDS identified Resident #35 only used a wheelchair. The MDS assessed Resident #35 as occasionally incontinent of bladder. Resident #35 was on a bladder toileting program. The MDS listed diagnoses of a history of a right pubis fracture, peripheral vascular disease (PVD) (a slow and progressive circulation disorder), diabetes mellitus, and mononeuropathy (nerve damage) of her bilateral (both) lower limbs. Resident #35's Care Plan Focus revised 8/10/21, identified she needed assistance with transfers and mobility. The linked Goal revised 8/10/21 indicated Resident #35 wanted to be safe in all of her movements. The connected intervention dated 8/10/21 documented that Resident #35 needed an extensive assistance of one staff person with bed mobility, transfers, and ambulation. Resident #35's Care Plan Focus for Skin documented that Resident #35's skin as intact, but she did have a potential for breakdown due to incontinence. Resident #35 had a risk of skin breakdown associated with periods of incontinence. Resident #35 had a bruise on her left lower leg, getting in, and out of her bed. The linked goal revised 8/10/21 indicated that Resident #35 wanted to prevent any kind of skin breakdown, she expected her bruise to get better without any problems. The connected interventions dated 9/15/19 indicated Resident #35 used a two hour toileting schedule. An additional intervention dated 5/9/29 recorded Resident #35 required extensive assistance of one person with toileting, Resident would transfer on her own at times in her bathroom. Resident #35's Care Plan Focus labeled Fall Prevention documented she did or didn't have falls in the past. The circumstances of the falls were related to a fall while in an assisted living apartment and broke her right hip. Resident #35 determined as a risk for falls due to incontinence, impaired mobility, and cognitive status. Resident #35 had the following falls on 2/7/21, 6/8/21, 8/3/21, and 2/3/22. The Focus included the following interventions: A. Gripper strips placed in front of the toilet, dated 2/3/22. B. Maintenance to check Resident #35's wheelchair's anti-rollback safety attachments on a monthly basis, for proper functioning, dated 3/10/21. The Health Status Note dated 2/3/22 at 4:41 PM documented an unwitnessed fall. The staff found Resident #35 on the floor in front of her toilet. Resident #35 reported she slipped off the toilet. Resident #35 stated she had asked for assistance but took herself. During an observation on 4/14/22 at 9:53 AM, of Resident #35's bathroom with Staff M, revealed an absence of gripper strips on the floor. Staff M expressed Resident #35 likely changed rooms and the gripper strips didn't follow her. Staff M declared that it had happened before. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/13/22 at 3:30 PM, the Maintenance Director denied knowing of any work order or Care Plan directives to check Resident #35's anti-rollback mechanism monthly. The Maintenance Director added that he responds to work orders submitted by staff for any wheelchair repairs, and had recently replaced an arm pad to her chair as a result of a work order. The Maintenance Director declared that anti-rollbacks were very important for resident safety . During an interview on 4/14/22 at 1:35 PM, the interim DON stated she expected the Care Plan fall interventions to be in place and used as directed in the Care Plan.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44475 Based on clinical record reviews, resident, and staff interviews, the facility failed to follow the toileting schedule for 2 out 2 residents reviewed (Resident #7 and Resident #3) for the bowel and bladder program. The facility reported a census of 37 residents. Findings include: 1. Resident #7's Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 11, indicating moderately impaired cognition. The MDS included diagnoses of benign prostatic hyperplasia (urine flow is blocked by an enlarged prostate), cyst of kidney, hydrocephalus (fluid build up in the brain that causes damage to the brain from pressure), and major depressive disorder. Additionally the MDS included that Resident #7 needed extensive assistance of one person with transfers and toileting. In an interview on 4/18/22 at 1:53 PM, the resident reported that he didn't like to get up every two hours during the night. Due to that he would occasionally refuse offers of going to the toilet during the night. Resident #7 reported that he had issues with incontinence when he got up in the morning and moved around more getting dressed for the day. Resident #7 reported that he would ask to use the toilet during the day, but the staff didn't ask him to use the toilet every two hours. Resident #7 explained that he liked to wear a disposable brief as a precaution because he dribbled a bit during the day. The Clinical Physician Orders documented the following medications: A. Tamsulosin HCl 0.4 milligrams (MG) initated 8/17/20, for benign prostatic hyperplasia. B. Spironolactone 25 MG, initiated 5/12/21 for excess fluid that increases urination. C. Bumetanide 2 MG initiated 5/13/21, for fluid that increases urination. D. Myrbetriq 24 hour 25 MG initiated 12/11/19, for urinary incontinence. The Care Plan Focus revised 5/29/20 indicated that Resident #7 required assistance with activities of daily living (ADLs), except with eating. The Focus continued indicating that Resident #7 as a risk for skin breakdown due to episodes of incontinent and limited mobility. A. Initiated 5/29/20: Administer medications as ordered for incontinence, monitor for effectiveness and side effects. B. Revised 5/29/20: Resident #7 could use the urinal but at times he became incontinent and would need staff assistance. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Care Plan Focus revised 2/22/22 recorded Resident #7 required assistance with transfers, bed mobility, and ambulation. The Focus continued indicated Resident #7 as a risk for fall due to a past history of falls and balance difficulties. The Focus included the following interventions A. Revised 1/17/22: Resident #7 needed assistance with toilet use every two hours from 6:00 AM to 10:00 PM. B. Initated 6/22/20: A sign posted in Resident #7's room with his approval reminding him to use his walker and ask for staff assistance. The Health Status Note dated 6/23/20 at 1:14 AM recorded that the staff offered to assist Resident #7 to the toilet on rounds. Resident #7 refused to get up to use the toilet. After the staff reminded Resident #7 of being incontinent of urine in his bed, if he didn't get up to use the toilet, he reluctantly got up. The Task: Toilieting every two hours when away reviewed on 4/13/22 at 9:24 AM for a 30-day lookback period from 4/19/22 documented four times that Resident #7 refused to go to the toilet from 10:00 PM until 6:00 AM. The Task documented eight times that staff marked Resident #7 as not available for toileting. The Task lacked any days with documentation of Resident #7 went to the toilet every 2 hours between 6:00 AM and 10:00 PM. The Task: Urinary Continence reviewed on 4/13/22 for a 30-day look back period documented 94 times for Resident #7 as incontinent. In an interview on 4/21/22 at 7:32 AM, the Interim Director of Nursing (DON) reported that Resident #7 wasn't in the building all the time to be toileted every 2 hours. The Interim DON reported that she would expect for the staff to follow the residents' Care Plan interventions. 44465 2. Resident #3's MDS assessment dated [DATE] documented a BIMS score of 15, indicating intact cognition. The MDS documented Resident #3 required extensive assistance of 2 people with bed mobility, transfers, toilet use and bathing. The MDS identified that Resident #3 required extensive assistance of one person with locomotion, and used a wheelchair as a mobility device. The MDS documented Resident #7 as occasionally incontinent of bowel and bladder. Resident #3 had a urinary toileting program. The MDS included diagnoses of encephalopathy (swollen brain) unspecified, anxiety, depressive disorders, Bell's palsy (facial muscle weakness one sided), muscle wasting, and atrophy (muscle weakness) to bilateral (both) upper extremities, atrophy to Resident #3's right lower extremity, left sided foot drop (difficulty raising the front of the foot), and an overactive bladder. The Care Plan Focus dated 10/28/19 identified Resident #3 needed assistance in dressing, grooming, and bathing. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Care Plan Focus revised 5/3/21 identified Resident #3 needed assistance with my transfers, bed mobility, and ambulation.The Focus continued that Resident #3 as a risk for falls due to a history of falling, choosing to transfer self without assistance. The linked interventions directed the following A. Initiated 3/30/22: Staff to use the mechanical standing lift for toileting. B. Initiated 12/24/20: Staff to assist Resident #3 to the toilet every two hours, to deter her from taking herself to the bathroom. A review of the clinical record revealed an unwitnessed fall on 12/23/20 at 07:40 AM. Documentation describes resident found on the floor in front of her toilet with her wheelchair next to her. On 04/12/22 at 10:05 AM, in an interview with Resident 3, stated she is occasionally incontinent of urine, though does not wear incontinent briefs. Stated she is suppose to be offered the bathroom every 2 hours, and this has not occurred, 'for a long time'. The Task: B&B - Bladder Elimination documentation, revealed four occurrences of bladder incontinency in a 30 day lookback. The Task: B&B - Bowel Elimination documentation revealed two occurrences of bowel incontinency. The Task: B&B for the Bladder and Bowel Elimination lacked documentation of refusals to go to the bathroom in the 30 day lookback. During an interview and a joint review of the clinical records on 4/20/22 at 8:53 AM, the interim DON, identified the staff didn't document Resident #3 being offered to go to the toilet every two hours as care planned. The Interim DON confirmed that Resident #3 experienced occurrences of urinary and bowel incontinency, without documentation of the refusal to go to the bathroom. The Interim DON added they would review and follow-up. During a follow-up interview on 4/20/22 at 12:40 PM, the Interim DON stated they revised the Care Plan and discontinued the task to take Resident #3 to the toilet every 2 hours, as Resident #3 could alert the staff when she needed to use the toilet. Resident #3 maintained her continence of bowel and bladder with the program . The DON stated she expected Care Plans to be followed as directed and updated as appropriate.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 44420 Based on observations, the planned menu review, staff interviews and facility record review, the facility staff failed to follow the planned menu for residents on regular, mechanical soft, and pureed textured diets. The facility identified a census of 37 residents. Findings include: The facility's Week 1 menu identified a dinner roll or bread with margarine planned to be served for the resident's lunch meal on 4/11/21. During an observation on 4/13/22 at 1:02 PM Staff D, Cook, did not include the dinner roll or bread with margarine with the lunch meal. During an interview on 4/13/22 at 1:43 PM, Staff A, Certified Nursing Assistant (CNA), Staff B, Licensed Practical Nurse (LPN), and Staff C, CNA, reported that the residents did not receive a dinner roll or bread at lunch. In an interview on 4/12/22 at 11:35 PM, the Dietary Manager (DM), explained that she did not receive notification before the meal that the dinner roll or bread would not be served. The DM expressed that she planned to notify the Dietician. In an interview on 4/13/22 at 10:32 AM, the DM stated that the Cook reported that he did not have time to cook the dinner rolls for lunch. The DM stated that she educated the Cook that bread could have been used if he did not have time to cook the dinner rolls. The undated Menu Policy instructed staff to serve the menus as written, unless a substitution is provided in response to preference, unavailability of an item, or a special meal. In an interview on 4/13/22 at 9:10 AM, the Administrator reported that they very much expected the staff to follow the menu. The Administrator added, the had done audits, as it was problem before the survey.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42132 Based on observations, clinical record reviews, policy reviews, and staff interviews the facility failed to meet professional standards of care for 2 of 20 residents reviewed (Resident #19 and #27). The facility failed to consistently document follow-up fall assessments for Resident #19 in the clinical record after a fall that had occurred on 12/16/21 at 10:39 PM. The facility failed to document in Resident #27's clinical record when falls occurred on 2/17/22 at 2:52 PM and on 2/19/22 at 5:27 PM. The facility also failed to document in the clinical record when Resident #27 transferred to the local hospital on 2/19/22. The facility reported a census of 37 residents. Findings Include: 1. Resident #27's Minimum Data Set (MDS) assessment dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 8, indicating moderately cognitive impairment. The MDS documented Resident #27 required extensive assistance of one person for bed mobility, transfer, dressing, toilet use, and personal hygiene. The MDS listed diagnoses of coronary artery disease, heart failure, hypertension, and diabetes. The MDS identified Resident #27 had one fall without injury since previous assessment. Resident #27's Care Plan Focus initiated 6/15/21, identified he required assistance with mobility included transfers, bed mobility, and ambulation related to pain and recent fracture. The Care Plan identified Resident #27 had history of falls at home and at the facility. The care plan interventions included: a. Assist of one staff to ambulate with assistive device to all destinations to/from meals/to and from bathroom when requested, and nonskid shoes when ambulating (6/16/21) b. Gripper strips by the bed (2/18/21) c. Gripper strips in front of the recliner (2/17/22) d. Grab bar on bed for positioning (7/8/21) e. Wheeled walker (6/30/21) f. Privacy curtain open except for cares being completed (3/8/22) g. Reminded to use call light and not attempt to move furniture independently, voiced understanding (10/24/21) h. Transferred to the emergency room (ER) due to frequent falls and admitted due to viral infection (2/21/22) Review of the Progress Notes for Resident #27 revealed: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The General Note (GN) dated 2/17/22 at 10:16 AM, indicated Resident #27 went out of the facility for an appointment with his primary care provider (PCP). The GN dated 2/17/22 at 1:22 PM, recorded that Resident #27 returned with a clinic sheet. The Health Status Note (HSN) on 2/18/22 at 4:12 AM, documented Resident #27 continued on fall with neurological charting. Active range of motion x 4, normal for the resident. Resident #27 didn't transfer during the night. Resident #27's urinary catheter was patent and drained yellow urine. His vital signs were as followed: blood pressure (BP) 136/64, pulse (P) 75, respirations (R) 18, temperature (T) 97.7, and oxygen saturation 93% on room air. The resident denied complaints, signs, or symptoms of pain or discomfort. The Orders-Administration Note dated 2/19/22 at 5:22 PM, recorded Resident #27 went to the local hospital due to a fall. The Orders-Administration Note dated 2/19/22 at 8:55 PM, identified Resident #27 admitted to the hospital. The facility document titled Fall dated 2/17/22 at 2:52 PM identified Resident #27 had a fall in his room. The Incident Description included the Nursing description of observing Resident #27 on the floor between his recliner and his bed. The resident description indicated Resident #27 stated he attempted to lay down in bed. The Immediate action taken: was range of motion (ROM) assessed without complaints of pain, no injuries, neurological assessments started, the physician notified by fax and Resident #27's family notified. The resident didn't go to the hospital. Resident #27's mental status indicated he was orientated to person and place. The notation on the bottom of document directed Privileged and Confidential document - Not part of the Medical Record - Do Not Copy. The facility document titled Fall dated 2/19/22 at 5:27 PM identified Resident #27 had a fall in his room. The Incident Description included the Nursing description of observing Resident #27 on the floor. Upon assessment, Resident #27's blood pressure was elevated at 152/92, [NAME] 90, Temperature 97.7, Respirations 26, and oxygen saturation 95% on room air. Resident #27's mental status indicated he was orientated to two, confused but responsive. The nurse observed a lump and a hematoma (bruise) at the right side base of his skull, with pain in his upper cervical spine. The resident's description reported that he stood up, fell , and hit his head. The Immediate action taken documented Resident #27 had his third fall in three days. The nurse called the on-call physician and sent Resident #27 to the local hospital. The nurse called Resident 27's family to notify them of his fall. The nurse called the local hospital and gave them report given. Resident #27 did go to the hospital. Resident #27's injuries observed at time of the incident included hematoma to the back of his head. Resident 27's mental status indicated that he was orientated to person and situation. Resident #27's predisposing physiological factors of confusion, gait (walking) imbalance, and other. Resident #27's predisposing situation factors included ambulating (walking) without assistance, recent room change, and wanderer. The notation on the bottom of the document directed Privileged and Confidential document - Not part of the Medical Record - Do Not Copy. The clinical record for Resident #27 failed to include documentation that the resident had fallen on 2/17/22 at 2:52 PM or on 2/19/22 at 5:27 PM. The clinical record lacked documentation that Resident #27 transferred to the local hospital on 2/19/22 following the fall. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Fall Prevention and Response Policy revised April 2020 identified the Procedure when a fall occurred: a. An Incident Report and a Fall Scene Investigation form should be completed after each fall. b. Falls should be logged through completion of the Incident Report the resident's electronic health record. During an interview on 4/13/22 at 3:47 PM the Interim Director of Nursing (DON) stated the facility nurses documented a fall on an incident report in the risk management and in the resident's progress notes under Incident in the electronic health record. The Interim DON stated they expected the fall documentation and the documentation related to Resident #27's transfer to the hospital be in the resident's clinical record, the progress notes. The Interim DON stated that the documentation should be completed in two separate locations, however, the Interim DON reported they were okay with the documentation being done in the resident's progress notes and not an incident report. The Interim DON confirmed that Incident Reports were not part of the resident's clinical record. The Interim DON confirmed the missed documentation on 2/17/22 & 2/19/22 for Resident #27. 2. Resident #19's MDS assessment dated [DATE], documented a BIMS score of 8, indicating moderately impaired cognition. The MDS documented Resident #20 as independent with bed mobility, transfers, locomotion, dressing, toilet use, and dressing. The MDS identified Resident #19 as steady with mobility and utilized a walker as a mobility device. The MDS included diagnoses of a cerebral aneurysm nonruptured, anemia, seizure disorder, muscle weakness generalized, unsteadiness on feet, and a cognitive communication deficit. Resident had a history of one fall with minor injury since the prior assessment. The Care Plan Focus revised 12/21/21 indicated Resident #19 required an assist of person with transfers, ambulation, and mobility. Resident #19 had a history of falls related to unsteadiness and muscle weakness. Resident #19 had falls on the following dates 7/10, 9/16, 10/26/21, and 12/16/21. The clinical record revealed the resident experienced an unwitnessed fall on 12/16/21 at 22:39 PM. The notes indicate a neuro sheet was started and notification of family and physician occurred. The clinical record revealed no post fall nurses notes in the clinical record documented for the PM shift of 12/18/21, the night shift of 12/18/21, the AM shift of 12/19/21 and the PM shift of 12/19/21. The Fall Prevention and Response Policy revised April 2020, directed the staff to document post-fall status in the progress notes every shift for at least 72 hours (3 days) and as needed. The policy recorded post-fall documentation includes notifications to physician, family, responsible party, root-cause analysis, interventions, response to interventions, effectiveness of interventions, and injuries noted. During an interview on 4/22/22 at 10:21 AM, the interim DON, produced the neurological (neuros) assessment checks paper documentation. The neuro assessments lacked documentation for pupil size and reaction for two shifts, movement assessments missing for one shift, and vital signs assessment for one shift, for the 3 day post fall neuro checks. The DON confirmed the lack of documentation of 4 shifts related to the post-fall nursing assessments in the clinical record for the 72 hours post-fall. The Interim DON reported that she expected post fall status, including assessments, be documented per policy. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165145	A. Building B. Wing	04/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Embassy Rehab and Care Center	206 Port Neal Road Sergeant Bluff, IA 51054

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	44465 Based on observations, clinical record reviews, policy reviews, and staff interviews the facility failed to meet professional standards of care for 2 of 20 residents reviewed (Resident #19 and #27). The facility failed to consistently document follow-up fall assessments for Resident #19 in the clinical record after a fall that had occurred on 12/16/21 at 10:39 PM. The facility failed to document in Resident #27's clinical record when falls occurred on 2/17/22 at 2:52 PM and on 2/19/22 at 5:27 PM. The facility also failed to document in the clinical record when Resident #27 transferred to the local hospital on 2/19/22. The facility reported a census of 37 residents. Findings Include: 1. Resident #27's Minimum Data Set (MDS) assessment dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 8, indicating moderately cognitive impairment. The MDS documented Resident #27 required extensive assistance of one person for bed mobility, transfer, dressing, toilet use, and personal hygiene. The MDS listed diagnoses of coronary artery disease, heart failure, hypertension, and diabetes. The MDS identified Resident #27 had one fall without injury since previous assessment. Resident #27's Care Plan Focus initiated 6/15/21, identified he required assistance with mobility included transfers, bed mobility, and ambulation related to pain and recent fracture. The Care Plan identified Resident #27 had history of falls at home and at the facility. The care plan interventions included: a. Assist of one staff to ambulate with assistive device to all destinations to/from meals/to and from bathroom when requested, and nonskid shoes when ambulating (6/16/21) b. Gripper strips by the bed (2/18/21) c. Gripper strips in front of the recliner (2/17/22) d. Grab bar on bed for positioning (7/8/21) e. Wheeled walker (6/30/21) f. Privacy curtain open except for cares being completed (3/8/22) g. Reminded to use call light and not attempt to move furniture independently, voiced understanding (10/24/21) h. Transferred to the emergency room (ER) due to frequent falls and admitted due to viral infection (2/21/22) Review of the Progress Notes for Resident #27 revealed: The General Note (GN) dated 2/17/22 at 10:16 AM, indicated Resident #27 went out of the facility for an appointment with his primary care provider (PCP). (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The GN dated 2/17/22 at 1:22 PM, recorded that Resident #27 returned with a clinic sheet. The Health Status Note (HSN) on 2/18/22 at 4:12 AM, documented Resident #27 continued on fall with neurological charting. Active range of motion x 4, normal for the resident. Resident #27 didn't transfer during the night. Resident #27's urinary catheter was patent and drained yellow urine. His vital signs were as followed: blood pressure (BP) 136/64, pulse (P) 75, respirations (R) 18, temperature (T) 97.7, and oxygen saturation 93% on room air. The resident denied complaints, signs, or symptoms of pain or discomfort. The Orders-Administration Note dated 2/19/22 at 5:22 PM, recorded Resident #27 went to the local hospital due to a fall. The Orders-Administration Note dated 2/19/22 at 8:55 PM, identified Resident #27 admitted to the hospital. The facility document titled Fall dated 2/17/22 at 2:52 PM identified Resident #27 had a fall in his room. The Incident Description included the Nursing description of observing Resident #27 on the floor between his recliner and his bed. The resident description indicated Resident #27 stated he attempted to lay down in bed. The Immediate action taken: was range of motion (ROM) assessed without complaints of pain, no injuries, neurological assessments started, the physician notified by fax and Resident #27's family notified. The resident didn't go to the hospital. Resident #27's mental status indicated he was orientated to person and place. The notation on the bottom of document directed Privileged and Confidential document - Not part of the Medical Record - Do Not Copy. The facility document titled Fall dated 2/19/22 at 5:27 PM identified Resident #27 had a fall in his room. The Incident Description included the Nursing description of observing Resident #27 on the floor. Upon assessment, Resident #27's blood pressure was elevated at 152/92, [NAME] 90, Temperature 97.7, Respirations 26, and oxygen saturation 95% on room air. Resident #27's mental status indicated he was orientated to two, confused but responsive. The nurse observed a lump and a hematoma (bruise) at the right side base of his skull, with pain in his upper cervical spine. The resident's description reported that he stood up, fell , and hit his head. The Immediate action taken documented Resident #27 had his third fall in three days. The nurse called the on-call physician and sent Resident #27 to the local hospital. The nurse called Resident 27's family to notify them of his fall. The nurse called the local hospital and gave them report given. Resident #27 did go to the hospital. Resident #27's injuries observed at time of the incident included hematoma to the back of his head. Resident 27's mental status indicated that he was orientated to person and situation. Resident #27's predisposing physiological factors of confusion, gait (walking) imbalance, and other. Resident #27's predisposing situation factors included ambulating (walking) without assistance, recent room change, and wanderer. The notation on the bottom of the document directed Privileged and Confidential document - Not part of the Medical Record - Do Not Copy. The clinical record for Resident #27 failed to include documentation that the resident had fallen on 2/17/22 at 2:52 PM or on 2/19/22 at 5:27 PM. The clinical record lacked documentation that Resident #27 transferred to the local hospital on 2/19/22 following the fall. The Fall Prevention and Response Policy revised April 2020 identified the Procedure when a fall occurred: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. An Incident Report and a Fall Scene Investigation form should be completed after each fall. b. Falls should be logged through completion of the Incident Report the resident's electronic health record. During an interview on 4/13/22 at 3:47 PM the Interim Director of Nursing (DON) stated the facility nurses documented a fall on an incident report in the risk management and in the resident's progress notes under Incident in the electronic health record. The Interim DON stated they expected the fall documentation and the documentation related to Resident #27's transfer to the hospital be in the resident's clinical record, the progress notes. The Interim DON stated that the documentation should be completed in two separate locations, however, the Interim DON reported they were okay with the documentation being done in the resident's progress notes and not an incident report. The Interim DON confirmed that Incident Reports were not part of the resident's clinical record. The Interim DON confirmed the missed documentation on 2/17/22 & 2/19/22 for Resident #27. 2. Resident #19's MDS assessment dated [DATE], documented a BIMS score of 8, indicating moderately impaired cognition. The MDS documented Resident #20 as independent with bed mobility, transfers, locomotion, dressing, toilet use, and dressing. The MDS identified Resident #19 as steady with mobility and utilized a walker as a mobility device. The MDS included diagnoses of a cerebral aneurysm nonruptured, anemia, seizure disorder, muscle weakness generalized, unsteadiness on feet, and a cognitive communication deficit. Resident had a history of one fall with minor injury since the prior assessment. The Care Plan Focus revised 12/21/21 indicated Resident #19 required an assist of person with transfers, ambulation, and mobility. Resident #19 had a history of falls related to unsteadiness and muscle weakness. Resident #19 had falls on the following dates 7/10, 9/16, 10/26/21, and 12/16/21. The clinical record revealed the resident experienced an unwitnessed fall on 12/16/21 at 22:39 PM. The notes indicate a neuro sheet was started and notification of family and physician occurred. The clinical record revealed no post fall nurses notes in the clinical record documented for the PM shift of 12/18/21, the night shift of 12/18/21, the AM shift of 12/19/21 and the PM shift of 12/19/21. The Fall Prevention and Response Policy revised April 2020, directed the staff to document post-fall status in the progress notes every shift for at least 72 hours (3 days) and as needed. The policy recorded post-fall documentation includes notifications to physician, family, responsible party, root-cause analysis, interventions, response to interventions, effectiveness of interventions, and injuries noted. During an interview on 4/22/22 at 10:21 AM, the interim DON, produced the neurological (neuros) assessment checks paper documentation. The neuro assessments lacked documentation for pupil size and reaction for two shifts, movement assessments missing for one shift, and vital signs assessment for one shift, for the 3 day post fall neuro checks. The DON confirmed the lack of documentation of 4 shifts related to the post-fall nursing assessments in the clinical record for the 72 hours post-fall. The Interim DON reported that she expected post fall status, including assessments, be documented per policy.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 44465 Based on observations and staff interviews, the facility failed to use appropriate infection control practices during the transport of resident towels and clothing protectors, during transport within the facility. The facility reported a census of 37 residents. Findings include: On 4/12/22 at 4:20 PM, an observation revealed the laundry staff transporting uncovered clothing protectors, in a wheeled basket cart, from the laundry room area, though the hallways, through the communal areas, and to the residents' dining room. On 4/19/22 at 9:08 AM, an observation revealed laundry staff transporting uncovered bathing towels, in a wheeled basket cart, from the laundry room area through resident occupied hallways, to the communal shower rooms. On 4/19/22 at 10:51 AM, an interview with the Housekeeping Supervisor reported being new to her position and didn't know of the infection control practice regarding covering linens, towels, and clothing protectors in an open cart during transport in the facility. The Housekeeping Supervisor explained that it would make sense to cover and protect those items to prevent possible contamination from airborne or contact contaminants. On 4/19/22 at 10:56 AM, the interim Director of Nursing (DON), expressed that she expected laundry carts to be covered for transport and when unattended in the facility. The Interim DON explained that the facility didn't have a policy specifically addressing linen transport, but it was standard infection control practice to cover during transport within the facility. The Covid-19 Vaccination Policy and Procedure dated 1/21, directed the facility to continue practicing transmission based precautions and other infection control practices, post immunization, according to CDC (Centers for Disease Control) and CMS (Centers for Medicaid/Medicare Services)guidelines.