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	05/04/2023

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26527 Based on record review, staff, and resident interviews, the facility failed to assure residents were treated with respect and dignity for 5 of 19 residents reviewed (Resident #22, #8, #12, #35, and #14). The facility reported a census of 38 residents. Findings include: 1. According to the Minimum Data Set (MDS) assessment dated [DATE] Resident #22 scored 10 on the Brief Interview for Mental Status (BIMS) indicating moderate cognitive impairment. The resident required extensive assistance with dressing, personal hygiene, and bathing did not occur in the previous 7 day period. The resident's diagnoses included a stroke. The Care Plan included Resident #22 showed the behavior of abusive language initiated 2/14/20. Interventions included that the resident would show respect towards staff at all times, the staff would redirect the resident as needed, and the staff would show the resident respect at all times. A typed note documented on 7/23/22 at approximately 2 p.m. the Administrator received a call from a staff member reporting that other staff went to her about an incident that took place on 7/21/22 between Resident #22 and Staff D, a staffing agency Certified Nursing Assistant (CNA). The incident took place in the shower room, as the aide gave the resident a shower. On 4/17/23 at 1:40 p.m. Resident #22 stated last summer a male CNA took water in his hand, put it up to Resident #22's face, and tried to get it up his nose. He didn't remember the whole situation, what happened, or what started it. He did know something happened and he said something derogatory to the CNA which he thought made the CNA mad. And that's when he took the water up and put it in his face. On 4/25/23 at 12:12 p.m. Staff E, CNA, stated (on 7/23/22) they noticed Resident #22's face was like 1/2 shaved and they asked him what happened. He told them what happened when he had a shower (7/21/22). He was afraid to tell anyone because he said something derogatory to Staff D. Staff E and Staff F, CNA, reported it to the nurse. On 4/26/23 at 2:38 p.m. Staff F stated (on 7/23/22) that as they got Resident #22 up, he looked 1/2 shaven. When they asked him why he only had half of his face shaved, he replied that when he got his shower (7/21) Staff D got mad at him and put water in his face. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy Resident Rights revised 4/1/19, documented that the resident had the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. The resident had a right to be treated with respect and dignity. 44474 2. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #8 included diagnoses of heart failure, anxiety, and arthritis. The MDS showed the Brief Interview for Mental Status (BIMS) score of 13, indicating moderate cognitive impairment. On 4/18/23 at 3:27 p.m. Resident #8 reported that the staff came into her room without knocking or waiting before entering her room. 3. The MDS assessment dated [DATE] for Resident #12 included diagnoses of hypertension (high blood pressure), depression, and anemia (low iron in the blood). The MDS showed the BIMS score of 14, indicating no cognitive impairment. On 4/17/23 at 1:18 p.m. Resident #12 explained that when she asks for a fresh water pitcher or a refill of her water the staff tell her they are too busy to get the water for her. 4. The MDS assessment dated [DATE] for Resident #35 included diagnoses of anemia, hypertension, and depression. The MDS showed the BIMS score of 14 indicating no cognitive impairment. On 4/24/23 at 5:11 p.m. observed Resident #35 being wheeled out of the dining room with the urinary catheter bag hanging under the wheelchair with no privacy cover over the urinary catheter bag. On 4/24/23 at 5:17 p.m. watched Resident #35 being wheeled into the dining room to the table with a urinary catheter bag hanging under the wheelchair with no privacy cover over the urinary catheter bag. The Resident Rights policy revised 11/23/20 directed the following information: The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished; and the behavior of staff and of other residents; and other concerns regarding their LTC facility stay. The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have. The resident has a right to be treated with respect and dignity. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups. On 5/4/23 at 12:27 p.m. the Director of Nursing (DON) explained that she expects staff to knock on the resident's door before entering the room, that catheter bags should be covered with a privacy cover, and if a resident requests water they should get it right away. 44475 (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Resident #14's MDS dated [DATE] identified a BIMS score of 15, indicating intact cognition. The MDS revealed the resident needed extensive assistance of 1 person with transfers and toilet use. The MDS included diagnoses of heart failure (heart does not pump blood as effectively), orthostatic hypotension (blood pressure suddenly drops when you stand up from a seated or lying position), hip fracture, vascular dementia (problems with reasoning, planning, judgment, memory and other thought processes caused by brain damage from impaired blood flow to your brain), asthma (COPD, chronic obstructive pulmonary disease, cause airflow blockage and breathing-related problems) or chronic lung disease, respiratory failure, and renal insufficiency, renal failure, ESRD (end stage renal disease). The MDS listed Resident #14 as frequently incontinent of urine. On 4/17/23 at 3:46 PM, Resident #14 reported that she does not track how long it takes for her call light to be answered but that it takes a long time for staff to assist her to the restroom and she soils herself. She does not like to sit in her wet pants. Resident #14 explained that she sits in them a long time when staff do not answer her call light. The Care Plan revealed: a. The resident requires assistance by one staff for toileting initiated 12/2/22. b. The resident requires assistance by one staff to move between surfaces initiated 12/2/22. c. The resident has a history of chronic UTI's (urinary tract infections) and is incontinent initiated 5/25/21. The Call Light Accessibility and Timely Response Policy and Procedure dated October 2022 instructed to answer the call light as soon as possible. On 5/3/23 at 1:43 PM the Director of Nursing (DON) reported this was not acceptable practice and that rounding should be done more frequently for this resident.

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 44475 Based on observation, state agency website, and staff interview, the facility failed to have survey results for the past 3 years in a place readily accessible to residents, family members, and legal representatives or to post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. The facility reported a census of 38 residents. Findings include: On 4/24/23 at 5:15 PM observed a white binder titled state survey book. The book contained only the last recertification results and the Plan of Correction from April 2023. A sign next to this book indicated Compliance Concerns and Reporting Guidelines. The sign did not reveal the availability of previous survey results upon request. The Iowa Department of Inspections and Appeals (DIA) website listed the following surveys in the past three years: 1. 6/15/20 for a Focused Infection Control (FIC) survey. 2. 10/26/20 for a complaint, incident, and FIC survey. 3. 12/23/20 for a complaint revisit, incident revisit, and FIC revisit. 4. 4/26/22 for a recertification, complaint, and incident survey. 5. 6/15/22 for recertification revisit, complaint revisit, and incident revisit survey. 6. 6/27/22 for recertification revisit, complaint revisit, and incident revisit survey. On 5/3/23 at 1:27 PM the Administrator reported that the facility does not have a policy for how they display or inform residents or the public of survey results. The Administrator explained that she knew of the regulation for this, but had not looked at the survey results binder.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44475 Based on clinical record, facility policy, resident representative interview, and staff interview, the facility failed to notify a resident's representative of a podiatry appointment and a change in resident condition for 1 of 19 residents reviewed (Resident #18). The facility reported a census of 38 residents. Findings include: Resident #18's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 3, indicating severely impaired cognition. The MDS indicated that Resident #18 required extensive assistance from two persons with bed mobility, transfers, toilet use, and could independently use his manual wheelchair. The MDS included a diagnosis of encephalopathy (disease that affects brain function). On 4/17/23 at 3:09 PM, Resident #18's Representative (RR #18) reported that she learned that Resident #18 had an issue with his skin when she reviewed the pharmacy bill and noticed a wound treatment on the list of medications. RR #18 reported that she did not know that Resident #18 had a podiatry visit until she received the billing information. The resident's clinical record revealed an order for a wound treatment dated 3/23/23. The Health Status note on 3/27/23 at 11:47 AM indicated that the Wound Nurse saw Resident #18 and requested to discontinue Nystatin Powder order and change the Plender's Ointment to the perineal (peri-) area. The Podiatry Visit Note listed that Resident #18 saw the podiatrist on 3/13/23. In an Electronic Mail (email) on 5/3/23 at 3:02 PM, the Administrator reported the facility does not have a policy on notification to the Resident's Representative regarding a change in the resident's condition. On 5/3/23 at 1:27 PM, the Director of Nursing (DON) reported that the RR #18 may have been told this information, but that it was not documented in the resident's chart.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 26527 Based on record review and staff interviews, the facility failed to provide residents or their representative the appropriate written notices in a timely manner when they no longer qualified for services covered by Medicare for 1 of 3 residents reviewed (Resident #15). The facility reported a census of 38 residents. Findings include: Resident #15's Clinical Census page listed a Medicare (skilled care) stay from 11/8/22 to 1/4/23. A review of Resident #15's record showed the resident signed A Notice of Medicare Non-Coverage (NOMNC) that documented that Resident #15's skilled nursing services would end on 10/26/22. The resident signed the notice 10/27/22. A Skilled Nursing Facility Advance Beneficiary Notice (SNFABN) documented beginning on 10/27/22, the resident may have to pay out of pocket for this care if he did not have other insurance that may cover these costs. The resident signed the notice on 10/27/22. On 4/25/23 at 8:44 a.m. the Social Services Director stated she did not give the required notices timely to some residents when they went off skilled care. On 4/27/23 at 1:43 p.m. the Administrator stated the notices should be given 48 hours before they expected skilled services would no longer be covered under Medicare.

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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** 44474 Based on record review and interviews, the facility failed to exercise reasonable care for the protection of the resident's property from loss or theft for 2 out of 3 residents reviewed (Resident #7 and #17). The facility reported a census of 38 residents. Findings include: 1. Resident #7's Minimum Data Set (MDS) assessment dated [DATE] included diagnoses of multiple sclerosis (an illness that affects a person's movement), heart failure, and anemia (low iron in the blood). The MDS showed a Brief Interview for Mental Status (BIMS) score of 9, indicating moderate cognitive impairment. On 4/17/23 at 4:38 p.m. Resident #7's family revealed Resident #7 received some perfume as a Christmas gift and it went missing. Resident #7's family told the facility staff and did not know if the facility replaced the item. Review of Resident #7's medical record lacked information regarding her missing perfume. Review of the facility grievance logs lacked information that Resident #7 had missing perfume or the facility replacing the item. 2. Resident #17's MDS assessment dated [DATE] included diagnoses of heart failure, hypertension (high blood pressure), and diabetes mellitus. The MDS showed a BIMS score of 14, indicating no cognitive impairment. Review of the grievance log dated 3/28/23 listed that Resident #17 had a current investigation due to a missing cell phone. The grievance log lacked a resolution, follow up, answer to be satisfied with the resolution, and additional follow up needed. On 4/25/23 at 8:48 a.m. the Administrator reported that Resident #17 went to the hospital, the clinic, and had a change in condition all within one week. The Administrator explained that Resident #17 reported her cell phone missing and the facility began to look for the phone. The facility could not locate the phone inside the facility or outside of the facility. The Administrator added that she had talked to Resident #17's daughter and her insurance covered almost all the cost of the cell phone. The facility was working with the family to cover what was not covered. The Administrator revealed Resident #17 not having her cell phone has had a large impact on her quality of life as that is how she communicated with her family. On 4/26/23 at 9:33 a.m. Resident #17 explained that she had a missing cell phone. She did not know the status of her phone being replaced at the time and to talk with her daughter as she might know more. Resident #17 further revealed she is lonely without her phone. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/27/23 at 12:45 p.m. Resident #17's family revealed Resident #17 moved from one room to another and after the move she could not find her phone since. Resident #17's family revealed the insurance replaced the phone. The facility has been unable to tell them what happened to the phone. Resident #17's family revealed Resident #17 is getting frustrated not having a phone. Review of facility policy of Grievance or Concern revised March 2019 revealed the following information: To ensure the resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which have been furnished as well as those which have not been furnished, the behavior of staff and of other residents; and other concerns regarding their stay at the facility. The procedure includes the following information: 1. Grievances/Concerns will be submitted orally or in writing, using the Grievance/Concern Report form and signed by the person filing the report. 2. Completed Grievance/Concern form will be given to the facility Social Services Director or Administrator 3. All grievances/concerns will be logged and completed by the Social Services Director or assigned to the appropriate designated person for investigation. 4. A written report of investigation and recommended action(s) will be completed and returned to the Social Service Director/Administrator within 72 hours. 5. Administrator will review investigation findings and determine corrective actions to be taken. 6. A meeting with the resident/representative will occur to review the findings and actions(s) taken and/or those that will be taken. If they are not satisfied with the results, other actions will be developed as needed. 7. If the resident/representative is still not satisfied with the results of the investigation/actions, they may file a report with the Chief Operations Officer of the facility. A written response will be returned to the resident/representative within 10 (ten) days. The resident/representative also has the right to file a written grievance/concern with agencies/entities noted in policy above or others of their choice. On 5/4/23 at 12:33 p.m. the Administrator explained that the facility has addressed the grievances since being brought to their attention.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26527 Based on record review, staff and resident interview, the facility failed to assure residents were free from abuse for 1 of 2 resident's reviewed (Resident #22). The facility reported a census of 38 residents. Findings include: Resident #22's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 10, indicating moderate cognitive impairment. The resident required extensive assistance with dressing, personal hygiene, and bathing did not occur in the previous 7 day period. The resident's diagnoses included a stroke. The Care Plan included Resident #22 showed the behavior of abusive language initiated 2/14/20. Interventions included the resident would show respect towards the staff at all times, the staff would redirect the resident as needed, and staff would show the resident respect at all times. A typed note documented on 7/23/22 at approximately 2 p.m. the Administrator received a call from a staff member reporting that other staff went to her about an incident that took place on 7/21/22 between Resident #22 and Staff D, a staffing agency Certified Nursing Assistant (CNA). The incident took place in the shower room, as the aide gave the resident a shower. The resident told the staff on duty when he got a shower on 7/21/22 a staff member got rough with him. The resident said he told the CNA the water was too hot and for the CNA to turn it down. The resident stated he turned it to ice cold. The resident stated he did make a racial comment, [NAME] of the jungle go back home. Then the CNA cupped his hand with cold water and put over the resident's mouth and nose, while pressing the resident's neck down until the water went up his nose. The resident tried to yell for help but could not. When the CNA let the resident go, the CNA stated he was not going to drown him. Staff E, CNA, wrote a statement on 7/23/22 that Resident #22 told her and Staff F, CNA, about his shower on 7/21/22. Resident #22 said Staff D was rough. Resident #22 told Staff D the water was too hot and Staff D turned it to ice cold. Resident #22 said Curious [NAME], go back to the jungle. Staff D then put cold water in his hands and began to push Resident #22's head down until he breathed in water. Resident #22 tried yelling for help and when Staff D let him go, Staff D told Resident #22 he was fine and that he was not going to drown him. Staff F documented on 7/23/22 at 1:30 p.m. that Resident #22 told her and Staff E about his last shower. Resident #22 said Staff D gave it to him and the water was hot so he complained to him to turn it down. He said Staff D turned the water ice cold. Resident #22 then made a bad comment calling Staff D [NAME] of the Jungle and that he should go home. Staff D cupped his hand with water, put it over Resident #22's mouth and nose, then pressed the back of his head down until water went up his nose. Resident #22 said he tried to yell for help but couldn't and when Staff D let him go he said he wasn't going to drown him. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/25/22 Staff G, CNA, stated she had gone with Staff G to Resident #22's room to get him up for a shower. They proceeded to tell Resident #22 they would get him up for a shower. When the resident saw Staff G he got very inappropriate with her. Staff D asked the resident to please not to speak like that to her. The resident got angry that Staff D re-directed him so Resident #22 popped off telling him to go back to the jungle you Philippine. Staff D asked Resident #22 to please stop making those racial comments, then proceeded to the shower room. Staff D wrote a statement indicating that on 7/21/22 he got scheduled as a shower aide for the 6th time in this daily position. He had showered 14 residents that day, both men and women. Resident #22 was scheduled that day. He transferred with the mechanical lift so he requested assistance from Staff G. They were getting Resident #22 ready to go for his shower and he started making sexual comments toward Staff G, and Staff D asked him to stop. Resident #22 got angry and told him to go back to the jungle you Philippine. Staff D asked Resident #22 if that was a racist remark and if he could please stop. They went to the shower room and Staff D had the water running prior to starting in order to warm it up. He placed the resident in the shower stall and asked him to feel the water. He did and said it was fine. I started the limited assist shower, completed it, and told the resident thank you. On 4/17/23 at 10:25 a.m. the Social Services Director stated she found out about the incident (7/21/22) shortly after it occurred. She said the resident just prior to the incident had a BIMS score of 14 on July 20th. She said Resident #22 told her the staff member pushed his face into a handful of water with his other hand on the back of his neck. She didn't know when the resident first reported the incident. She said the previous Administrator conducted the investigation. She said Resident #22 had not made any false allegations against any staff member before or after this incident. Staff D was suspended during the investigation, and had not worked at the facility since. On 4/17/23 at 12:29 p.m. the previous Administrator stated she learned about the incident on the day of RAGBRAI (People who ride bikes from one side of the state to the other side). She had to get special permission to be able to get to the nursing home because of the area being cordoned off. She said she could only remember Resident #22 saying that the staff member had put water in his face trying to get it up his nose. She started an investigation and called the police. She didn't think Resident #22 would talk to the police at that time. She didn't remember exactly what happened, as it happened long ago. She said they decided to break Staff D's contract. On 4/17/23 at 1:40 p.m. Resident #22 stated he recalled a male CNA took water in his hand and put it up to his face trying to get it up his nose. He didn't remember the whole situation, what happened, or what started it. He did know something happened and he said something derogatory to the CNA which he thought made the CNA mad. The CNA scooped water up and put it in his face. He didn't feel it was abusive but it should never happen to anyone else. And if anybody else had that happen he would certainly tell somebody about it. On 4/18/20 at 2:41 p.m. Staff H, CNA, stated he only remembered Staff D as lazy and that he argued with the residents. On 4/18/23 at 2:52 p.m. Staff I, CNA, said she worked at the facility the previous summer and in July. She only remembered Staff D being rude to the residents and staff. He knew that Resident #22 didn't care for him and if he came in the room he told him to get out. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/18/23 at 3:25 p.m. Staff K stated he was kind of a** to the staff and residents. Residents thought he was rude and didn't like him. On 4/19/23 at 8:05 a.m. Staff L, Licensed Practical Nurse (LPN), denied knowing anything about the incident first hand just hearsay. Some of the residents reported Staff D as rough after he left. On 4/23/23 at 10:48 a.m. Staff D stated he recalled an incident at the facility. He said the resident complained about him doing something to him in the shower. Staff D stated he did the showers and even put on his statement how many days that he had done showers. Staff D explained that he gave Resident #22 showers without any issues. He said prior to him going to the shower (7/21/22) he and his girlfriend, Staff G, went to get Resident #22 up with the sit to stand lift. During that time Resident #22 became inappropriate to Staff G. At that time, Staff D told Resident #22 that was inappropriate, and please do not talk to her that way. He said Resident #22 did get upset and said a racial comment to him but he couldn't remember what he said. Staff D took Resident #22 to the shower and he'd already had the water warming up. There were no issues with the water, no complaints. The shower went fine. Staff D reported being surprised when they called him to the office to talk about it. They did not have him finish out his contract. On 4/25/23 at 12:12 Staff E stated (on 7/23/22) they noticed Resident #22's face looked only 1/2 shaved and they asked him what happened. He told them what happened when he had a shower (7/21). He was afraid to tell anyone because he said something about a monkey and going back to the jungle. Staff E and Staff F reported it to the nurse. On 4/26/23 at 2:38 p.m. Staff F stated (on 7/23/22) that as they got Resident #22 up, he looked 1/2 shaven. When they asked him why he only had half of his face shaved, he replied that when he got his shower (7/21) Staff D got mad at him and put water in his face. The facility Abuse Prevention Policy and Procedure effective August 2018, revised March 2019 and December 2022 documented all residents had the right to be free from abuse, neglect, misappropriation of resident property, exploitation, corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 44475 Based on employee file review, staff interview and facility policy review the facility failed to provide appropriate screening prior to employment for 1 of 5 employees reviewed for background checks (Staff A, Registered Nurse). The facility failed to check SING (single contact repository) to perform the required background check. The facility reported a census of 38 residents. Findings include: Review of Staff A's, Registered Nurse (RN), employee file revealed the facility completed a background check through a third-party vendor. The employee file lacked documentation of the completed SING background. The Abuse Prevention Plan policy dated February 2023 stated for all potential employees and contracted workers, after a conditional offer but before an employee starts working, the facility must obtain criminal background checks from the Department of Public Safety and abuse checks from the Department of Human Services. On 4/25/23 at 8:12 a.m. the Director of Nursing (DON) verified that Staff A did not have a SING background completed. The facility provided a completed SING background check report dated 4/25/23 at 8:46 AM.

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26527 Based on record review and staff interview, the facility failed to allow a resident to allow a resident to return to the facility after hospitalization for 1 of 4 residents reviewed (Resident #39). The facility reported a census of 38 residents. Findings include: Resident #39's Minimum Data Set (MDS) assessment dated [DATE] identified that she had no short term memory problem and required modified independence with skills for daily decision making. The resident's diagnoses included paranoid schizophrenia and bipolar disorder. The Progress Notes dated 2/6/23 at 1:00 a.m. indicated that the staff heard Resident #39 yelling in her room while at the nurses station. The nurse and the Certified Nursing Assistant (CNA) entered the room and Resident #39 sat up in bed talking to herself. Resident #39 verbalized the medications (meds) were making her ill and the doctor and nurses were trying to kill her. She verbalized she would not take any more meds. Staff unsuccessfully attempted to redirect her. Resident #39 yelled at the staff to get out and leave her alone. The staff saw Resident #39 walking toward the nursing station shortly after with a purse, and bending down to lay across the floor. Resident #39 appeared alert with confusion, had dry, warm skin, denied pain, and shortness of breath (SOB). Vital Signs (VS): blood pressure 162/78 (an average range 120/80), pulse - 72 (average 60-100), respirations-16 (average 12-18), oxygen - 93% (average 90-100%) temperature - 98.1 (average 98.6). Resident #39 verbalized she was going home and had discharge papers at the nurse's station from the doctor. She also verbalized that her mom was a Registered Nurse (R.N.) and the only one who knew how to take care of her. Staff notified the on-call clinician 12:20 a.m. with a new order to send to the emergency room (ER) for evaluation due delusion and safety concerns. The Progress Notes dated 2/6/23 at 5:17 a.m. documented a call to the hospital to receive update on Resident #39 and spoke with an ER nurse who stated she would be admitted to the floor. In addition, the ER nurse stated they ran a lab test and diagnosed her with a urinary tract infection (UTI). A hospital Behavioral Medicine Progress Note dated 2/23/23 documented the resident was ready for discharge and the plan was for the next day but the staff at her facility were saying they could not take her back. They had not given her a 30 day notice, but due to previous behaviors they did not want her to come back. Unfortunately Resident #39 had nowhere else to go. Administration was working with the facility related to their reluctance to take her back. Resident #39 did not have a medical reason for her to remain in the hospital. Resident #39's clinical record lacked documentation about what needs the facility could not meet for Resident #39, and what attempts the facility had made to meet the needs. The record lacked the resident's physician documenting the basis for not allowing the resident to return to the facility. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/25/23 at 11:05 a.m. the Long Term Care (LTC) Ombudsman said she received a call from the hospital about the facility refusing to take the resident back. The LTC Ombudsman contacted the facility and found they had not given the resident or her representative a 30 day discharge notice. The LTC Ombudsman informed the facility they would need to take the resident back, and then give the 30 discharge notice. The Administrator said they would not take her back, as they could not provide the care she needed. On 4/25/23 at 12:15 p.m. the Administrator stated the resident was having behavior issues and they couldn't provide the kind of care she needed at that time. They wanted to send her back when she wasn't stable, and they could not take her back that way. It had always been their intention to take her back when she was stable. On 4/26/23 at 2:13 p.m. a hospital representative stated the doctor determined Resident #39 to be stable and could return to the facility, but the facility refused to accept her back. They have had to change the way they do things to avoid having this happen again. The facility policy Discharge Plan and Summary revised March 2019 documented the resident's reason for discharge/transfer would be documented in the medical record: the basis for the discharge/transfer and appropriate information communicated to the receiving health care institution or provider. If the discharge/transfer was for resident needs unable to be met, documentation must include what needs, what attempts the facility has made to meet the needs, and the service available at the receiving facility to meet the needs. If the reason for transfer or discharge is a. or b. below the resident's physician MUST DOCUMENT IN THE MEDICAL RECORD, THE BASIS FOR THE TRANSFER. If the reason for transfer or discharge is c. or d. below, A PHYSICIAN MUST DOCUMENT IN THE MEDICAL RECORD THE BASIS FOR THE TRANSFER. a. Transfer/discharge necessary for the Resident's welfare and the Resident's needs cannot be met by facility. b. The transfer/discharge was appropriate because the Resident's health had improved sufficiently so the Resident no longer needs the services provided by the facility. c. The safety of individuals in the facility was endangered due to the clinical or behavioral status of the resident. d. The health of individuals in the facility would otherwise be endangered.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44475 Based on clinical record, facility policy, and staff interview, the facility failed to complete a significant change assessment within 14 days of hospice discharge for 1 of 1 residents reviewed (Resident #37). The facility reported a census of 38 residents. Findings include: Resident #37's Minimum Data Set (MDS) dated [DATE] indicated that they could not obtain a Brief Interview for Mental Status. The MDS listed that they had severely impaired daily decision making ability, short and long term memory problems. The MDS identified that Resident #37 received hospice services. The MDS included a diagnosis of dementia. The Discharge-Transfer Summary Report dated 3/17/23 signed by a physician revealed Resident #37 discharged from hospice services on 3/17/23. As of 5/1/23 the MDS assessment for a significant change with an assessment reference date (ARD) of 3/24/23 listed the assessment as in progress. The MDS Accuracy, Automation and Validation Process Policy revised date of March 2019 revealed that the RN (Registered Nurse) Assessment Coordinator or designee will ensure that all required MDS Item Sets are completed accurately, submitted, and accepted to the QIES (Quality Improvement and Evaluation System) ASAP (Assessment Submission and Processing) system, and that the post-submission validation reports are reviewed. At each step in this process, the MDS Item Set will be screened for accuracy and validated by the RN Assessment Coordinator. In an interview on 5/3/23 at 1:27 PM, the MDS Nurse reported that she expected a significant change MDS to be performed in a timely manner and that going forward this should occur since she took MDS training during the course of the survey. The Hospice Program policy dated March 2019 instructed that 1. When a resident participates in the hospice program, a coordinated plan of care between the facility, hospice agency and resident/family will be developed and shall include directives for managing pain and other uncomfortable symptoms. 2. The care plan shall be revised and updated as necessary to reflect the resident's current status.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident’s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44475 Based on clinical record, facility policy, and staff interview, the facility failed to submit a Minimum Data Set (MDS) entry within 7 days of the assessment for 1 of 19 residents (Resident #37). The facility reported a census of 38 residents. Findings include: Resident #37's Minimum Data Set (MDS) dated [DATE] indicated that they could not obtain a Brief Interview for Mental Status. The MDS listed that they had severely impaired daily decision making ability, short and long term memory problems. The MDS identified that Resident #37 received hospice services. The MDS included a diagnosis of dementia. The Hospice IDG (interdisciplinary group) Comprehensive Assessment and Plan of Care Update Report dated 3/22/23 signed by a physician listed the purpose of the meeting as Resident #37's discharge from hospice care. The resident's Electronic Health Record (EHR) revealed a MDS assessment for the resident's significant change with an assessment reference date of 3/24/23. As of 4/26/23, the MDS remained in progress. The MDS Accuracy, Automation and Validation Process policy dated March 2019 revealed: 1. The RN (Registered Nurse) Assessment Coordinator or designee will ensure that all required MDS Item Sets are completed accurately, submitted and accepted to the QIES (Quality Improvement and Evaluation System) ASAP (Assessment Submission and. Processing) system, and that the post-submission validation reports are reviewed. 2. At each step in this process, the MDS Item Set will be screened for accuracy and validated by the RN Assessment Coordinator. All electronic health record system warnings should be reviewed and corrected as needed. 3. It is the facility's policy to batch and export to the QIES ASAP all completed MDS on, at a minimum, a weekly basis. In an interview on 5/3/23 at 1:18 PM, the MDS nurse reported that she expected assessments to be completed on time. The MDS nurse explained that since she received MDS training during the survey progress, the MDS would be completed correctly going forward.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785 Based on observation, record and chart review the facility failed to accurately document a resident's specific needs for 3 of 19 residents reviewed (Residents #6, #9, and #16). The facility reported a census on 38 residents. Findings include: 1. Resident #6's Minimum Data Set (MDS) dated [DATE] identified a Brief Interview for Mental Status (MDS) score of 11, indicating moderately impaired cognition. The MDS included a diagnosis of cerebral palsy. The MDS indicated that Resident #6 required supervision and assistance with meals. The MDS assessment listed that Resident #6 did not have any swallowing concerns. According to the Speech Therapy Evaluation and Plan dated 11/10/22 due to documented physical impairment and associated functional deficits, Resident #6 had a risk for aspiration, further decline in function, and pneumonia. The resident had an order dated 4/6/22 at 3:27 PM for a dysphagia Advanced Texture diet (alerted diet due to swallowing issues). On 4/24/23 at 12:50 PM observed Resident #6 get served a hot dog cut into bite sized pieces. She ate the pieces without assistance with several staff members in the dining area. According to a facility policy dated March 2019 and titled: MDS Accuracy, Automation and validation Process, The Registered Nurse (RN) Assessment Coordinator or designee would ensure that all required MDS Item Sets got completed accurately. 44475 2. Resident #16 Minimum Data Set (MDS) dated [DATE] identified a Brief Interview of Mental Status (BIMS) score of 13 which indicated intact cognition. The MDS listed Resident #16's admitted as 11/30/22. The MDS included diagnoses of medically complex conditions of major depression, hypertension (high blood pressure), diabetes mellitus, renal insufficiency (poor kidney function), renal failure, end stage renal disease, and cellulitis (skin infection). The MDS indicated that Resident #16 had a pressure ulcer. The MDS lacked a repositioning program or nutritional supplementation. The Dietary Note on 2/14/23 signed by the facility's Registered Dietician (RD) indicated that they got notified that Resident #16 had an altered skin integrity. Resident #16 took oral intakes adequately to meet their estimated needs. No new recommendations at this time. The Fax (facsimile) Cover Sheet dated 2/27/23 signed by a physician included an order for Liquicell (oral protein supplement for wound healing) one packet mixed with 8 ounces of water to promote wound healing. The Physician Clinic Sheet dated 3/8/23 signed by a physician revealed: (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Referral to wound clinic. 2. Please reposition the patient every two hours. On 5/4/23 at 1:13 PM, the MDS Nurse agreed that the MDS should include these items for the skin assessment. 3. Resident #9's MDS dated [DATE] identified a BIMS score of 10, indicating moderately impaired cognition. The MDS indicated that Resident #9 required the extensive assistance of two staff with bed mobility, transfers, and toilet use. The MDS included diagnoses of cerebral palsy, seizure disorder or epilepsy, and unspecified abnormalities of gait and mobility. The MDS listed that Resident #9 used a bed rail daily. On 5/2/23 at 8:53 AM Staff N, Licensed Practical Nurse (LPN), and Resident #4, roommate of Resident #9 reported that she only used positioning rails and that the resident never had a partial or full bed rail applied to her bed. The Order dated 3/21/23 signed by a physician directed bed rails needed to help with positioning and to perform assessments quarterly. The Physical Device and/or Restraint assessment dated [DATE] signed by Staff L, MDS Coordinator, indicated that Resident #9 used the bed rails to improve her bed mobility/repositioning. The Care Plan Intervention initiated date on 12/15/22 revealed Resident #9 had assist rails attached to the side of her bed to assist her with the bed mobility task. Resident #9 received education on the risks and benefits but still wished to continue to use them. On 5/2/23 at 8:57 AM, the MDS Coordinator reported that she coded the MDS incorrectly for the resident because she did not know until she had MDS training last week that positioning rails are not considered restraints. When asked why Resident #9 appeared to be the only resident coded for bed rail restraint use, the MDS Coordinator did not reply. On 5/2/23 at 9:58 AM, the Regional Nurse Consultant (RNC) reported that about a month ago, the facility evaluated the bed positioning rails throughout. The RNC explained that that Resident #9's MDS must have been overlooked when the resident's in the facility had their positioning rails evaluated. The Physical Restraints Policy dated March 2019 directed that the 1. Facility will complete an assessment prior to the use of the device and quarterly thereafter. 2. Least restrictive devices will be the goal. 3. If it is an assistive device and doesn't restrict the resident's movement, the purpose of the device must be identified but does not require a physician order.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44475 Based on clinical record, facility policy, and staff interview the facility failed to complete baseline care plans within 48 hours of admission for 4 of 19 residents reviewed (Residents #37, #16, #12, and #35). The facility reported a census of 38 residents. Findings include: 1. Resident #37's Minimum Data Set (MDS) dated [DATE] listed an admitted [DATE] from another nursing home. The MDS indicated that they could not obtain a Brief Interview for Mental Status. The MDS listed that they had severely impaired daily decision making ability, short and long term memory problems. The MDS identified that Resident #37 received hospice services. The MDS included a diagnosis of dementia. Resident #37's Electronic Health Record (EHR) listed the first Care Plan as initiating on 12/5/22. Resident #37's Baseline Care Plan had a date of 2/13/23. The Baseline Care Plan lacked documentation of a resident's signature or refusal of a copy of the Baseline Care Plan. In an Electronic Mail (email) dated 4/27/23 at 6:24 PM, the Administrator reported that this resident transferred from a sister facility and her Care Plan transferred over as well. 2. Resident #16 Minimum Data Set (MDS) dated [DATE] identified a Brief Interview of Mental Status (BIMS) score of 13 which indicated intact cognition. The MDS listed Resident #16's admitted as 11/30/22. The MDS included diagnoses of medically complex conditions of major depression, hypertension (high blood pressure), diabetes mellitus, renal insufficiency (poor kidney function), renal failure, end stage renal disease, and cellulitis (skin infection). The MDS indicated that Resident #16 had a pressure ulcer. Resident #16's Care Plan had an initiated date of 12/5/22. Resident #16's Baseline Care Plan had a date of 2/11/23. In the bottom section near notes included signed initials. The Baseline Care Plan lacked documentation that Resident #16 got offered a copy. The Baseline Care Plan policy dated 4/23/19 revealed that the baseline care plan will be developed within 48 hours of a resident's admission. A form included in the policy revealed spaces for the resident's signature and that the resident gets offered a copy of the Baseline Care Plan. 44474 3. Resident #12's MDS assessment dated [DATE] listed an admitted [DATE] from an acute hospital. The MDS identified a BIMS score of 14, indicating no cognitive impairment. The MDS included diagnoses of hypertension, depression, and anemia. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Order's Administration Note dated 8/4/22 at 12:26 p.m. indicated that Resident #12 did not arrive at the facility until 10:30 a.m Resident #12's Census listed an active admission on 8/4/22. Resident #12's Baseline Care Plan listed a date of 2/12/23. 4. Resident #35's MDS assessment dated [DATE] listed an admitted [DATE]. The MDS identified a BIMS score of 14, indicating no cognitive impairment. The MDS included diagnoses of anemia, hypertension and depression. The Admission Note 2 dated 8/25/22 at 2:24 p.m. indicated that Resident #35 admitted to the facility at approximately 1:00 p.m Resident #35's Census listed the resident active on Hospice Medicaid level of care on 8/25/22. Resident 35's Baseline Care Plan listed a date of 2/12/23. The Baseline Care Plan Policy effective 4/23/19 instructed the facility to develop and implement a Baseline Care Plan for each resident that includes the instructions needed to provide effective and person-centered care of the residents that meet professional standards of quality care. The Baseline Care Plan will be developed within 48 hours of a resident's admission. The Charge Nurse shall verify within 48 hours that a Baseline Care Plan has been developed. On 5/4/23 at 12:47 p.m. the [NAME] President of Operations explained that in February the facility found that residents did not have Baseline Care Plans completed. At that time, the facility went through and completed a Baseline Care Plan for all the residents in the facility. The Baseline Care Plan should have been completed and they are now being completed on all new admissions.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44475 Based on clinical record, facility policy, and staff interview, the facility failed to develop care plans to identify correct dates for when care plan areas were initiated and implement care plan interventions for 1 of 19 resident reviewed (Resident #9). The facility reported a census of 38 residents. Findings include: 1. Resident #9's MDS dated [DATE] identified a BIMS score of 10, indicating moderately impaired cognition. The MDS indicated that Resident #9 required the extensive assistance of two staff with bed mobility, transfers, and toilet use. The MDS included diagnoses of cerebral palsy, seizure disorder or epilepsy, and unspecified abnormalities of gait and mobility. The MDS listed that Resident #9 used a bed rail daily. On 5/2/23 at 8:53 AM Staff N, Licensed Practical Nurse (LPN), and Resident #4, roommate of Resident #9 reported that she only used positioning rails and that the resident never had a partial or full bed rail applied to her bed. The Order dated 3/21/23 signed by a physician directed bed rails needed to help with positioning and to perform assessments quarterly. The Physical Device and/or Restraint assessment dated [DATE] signed by Staff L, MDS Coordinator, indicated that Resident #9 used the bed rails to improve her bed mobility/repositioning. The Care Plan Intervention initiated date on 12/15/22 revealed Resident #9 had assist rails attached to the side of her bed to assist her with the bed mobility task. Resident #9 received education on the risks and benefits but still wished to continue to use them. On 5/2/23 at 9:58 AM, the Regional Nurse Consultant (RNC) reported that bed positioner rail use was evaluated throughout the facility a month ago and that that Resident #9's MDS must have been overlooked when the resident's in the facility had their positioning rails evaluated. The Care Planning policy dated 3/19 revealed: 1. Care Plans should be updated between care conferences to reflect current care needs of the individual resident as changes occur. 2. When changes are made in the EHR (electronic health record) Care plan dates, time and name/initials are automatically entered. 3. Interdisciplinary team members must confer with each other prior to changing interventions that involve multiple departments to avoid miscommunication. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/2/23 at 9:58 AM, the Regional Nurse Consultant (RNC) reported that about a month ago, the facility evaluated the bed positioning rails throughout. The RNC explained that that Resident #9's MDS must have been overlooked when the resident's in the facility had their positioning rails evaluated. Around that time, the facility discovered issues with incorrect Care Plans.

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, facility policy, and staff interview, the facility failed to revise a care plan 4 of 19 resident reviewed (Resident #37, #16, #5, and #17). The facility reported a census of 38 residents. Findings include: 1. Resident #37's Minimum Data Set (MDS) dated [DATE] listed an admitted [DATE] from another nursing home. The MDS indicated that they could not obtain a Brief Interview for Mental Status. The MDS listed that they had severely impaired daily decision making ability, short and long term memory problems. The MDS identified that Resident #37 received hospice services. The MDS included a diagnosis of dementia. The Discharge-Transfer Summary Report dated 3/17/23 signed by a physician revealed Resident #37 discharged from hospice services on 3/17/23. The Care Plan Intervention initiated on 12/8/22 directed the staff to work cooperatively with the hospice team to ensure the resident's spiritual, emotional, intellectual, physical and social needs are met. The Hospice Program policy dated March 2019 directed that a. When a resident participates in the hospice program, a coordinated plan of care between the facility, hospice agency and resident/family will be developed and shall include directives for managing pain and other uncomfortable symptoms. b. The care plan shall be revised and updated as necessary to reflect the resident's current status. On 5/3/23 at 1:25 PM, the MDS Nurse reported that she expected Care Plans get updated when a resident is discharged from hospice care. 2. Resident #16's Minimum Data Set (MDS) dated [DATE] identified a Brief Interview of Mental Status (BIMS) score of 13, indicating intact cognition. The MDS included diagnoses of medically complex conditions of major depression, diabetes mellitus, and cellulitis. The MDS listed that Resident #16 had a pressure ulcer. The Care Plan intervention initiated 1/12/23 directed that Resident #16 have a pressure relieving cushion in their wheelchair ROHO (specialized pressure relieving cushion). The Care Plan included an additional intervention dated 2/9/23 for a ROHO cushion. The Fax (facsimile) Cover Sheet signed by a physician on 3/17/23 revealed an order for a ROHO cushion. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/3/23 at 1:18 PM, the Director of Nursing (DON) confirmed the date on the Care Plan did not reflect the order date of the cushion. 44474 3. Resident #5's MDS assessment dated [DATE] identified a BIMS score of 13, indicating moderate cognitive impairment. The MDS included diagnoses of anxiety, pain in the right hip, and hypothyroidism (underactive thyroid which helps to control metabolism). The MDS listed Resident #5's functional status related to bathing as totally dependent on staff and needing one person physical assistance. Resident #5's Care Plan revised 4/14/23 lacked information regarding bathing assistance. 4. Resident #17's MDS assessment dated [DATE] identified a BIMS score of 14, indicating no cognitive impairment. The MDS included diagnoses of heart failure, hypertension and diabetes mellitus. Resident #17's May 2023 Medication Administration Record (MAR) revealed the following orders: - Tramadol (pain medication) 50 milligrams as needed for pain with an order date of 3/21/23 - Basaglar Insulin (long-acting insulin) with an order date of 4/25/23 - Insulin Aspart Insulin (fast acting insulin) with an order date of 4/25/23 Resident #17's Care Plan lacked information regarding pain medication usage, side effects to watch for, and signs and symptoms to watch for with hyperglycemia (high blood sugar) and hypoglycemia (low blood sugar). The Care Planning Policy revised March 2019 instructed that Care Plans should be updated between care conferences to reflect current care needs of the individual resident as changes occur. When changes are made in the EHR Care Plan dates, time, and name/initials are automatically entered. The Interdisciplinary team members must confer with each other prior to changing interventions that involve multiple departments to avoid miscommunication. On 5/4/23 at 12:21 p.m. the MDS coordinator reported that bathing and medications with signs and symptoms to watch for should be on the Care Plan.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785 Based on observations, interviews, and record review the facility failed to follow physician's orders for 2 of 3 residents reviewed (Residents #139 and #16). Resident #139 had an order for a medication to regulate his high blood pressure. The order included specific parameters on when to hold the medication based on his heart rate and blood pressure. Despite Resident #139's heart rate being below the ordered guidelines, the staff administered the pills. In addition, despite the facility knowing that Resident #139 had an issue with swallowing his medication, the facility failed to intervene to ensure they did not choke while taking their medications. Resident #16 had wound care performed without a physician order. The facility reported a census of 38 residents. Findings include: 1. Resident #139's Minimum Data Set (MDS) assessment dated [DATE] identified that he had severely impaired cognitive skills for activities of daily living. The MDS indicated that he required extensive assistance of two persons for transfers, dressing, toilet use, and hygiene needs. The MDS included diagnoses of heart failure, hypertension (high blood pressure), diabetes mellitus, and renal insufficiency (underacting kidneys). Resident #139's Problem List/ Past Medical History listed dysphagia (difficulty swallowing), unspecified on 9/26/22. The Impression indicated that Resident #139 reported an intermittent sensation of his pills getting stuck. The provider added that Resident #139 did receive omeprazole (heartburn medication) due to a history of gastroesophageal reflux disease (GERD). The provider planned to refer Resident #139 to another provider as he could need an additional evaluation. The provider discussed with Resident #139 to take smaller bites when possible, avoid dry foods, and drink plenty of fluids with his medications or food. The Care Plan dated 3/24/23 identified that Resident #139 could not swallow his medications whole. The Interventions directed the staff to follow up with Resident #139 and their representative about the possibility of crushing his medications. The Interventions directed the staff to administer medications as ordered, monitor, and document for side effects, and effectiveness. Resident #139's Admission Assessment Part 3 - V5 related to Crushing/Combining Oral Medications dated 3/24/23 at 1:29 PM identified the assessment indicated to crush Resident #139's medications. On 4/19/23 at 7:21 AM observed Staff N, Licensed Practical Nurse (LPN), in the room with Resident #139 and attempting to wake him to give him his medications. He turned his head several times but did not open his eyes. She continued to wake him and eventually got him to take his medications one pill at a time. She stated that she would not give him his hypertension medications that morning due to his low blood pressure that morning. Staff N exited the room and said that Resident #139 had a difficult time taking his medications whole and that she would call the doctor to get an order to crush his pills. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Clinical Physician's Orders included an order dated 4/22/23 for metoprolol tartrate (high blood pressure medication) 25 milligrams (mg). The order instructed to give one tablet two times a day related to essential hypertension. In addition, the order directed to hold for a heart rate less than 65 Beats Per Minute (BPM) and/or a systolic blood pressure (top blood pressure number) less than 90. Resident #139's April 2023's Medication Administration Record (MAR) included documentation that indicated he received his hypertension medication several times despite his heart rate being outside the established parameters: a. April 9, 2023 the heart rate - 57 BPM b. April 16th the heart rate - 60 BPM c. April 20th the heart rate - 62 BPM d. April 23rd the heart rate - 63 BPM On 4/27/23 at 1:00 PM the Administrator acknowledged that the doctor ordered the medication with parameters for a reason. The Administrator explained that she expected the staff to follow physician orders. The Administrator added that that if a resident had difficulty swallowing his pills upon admission, she expected the staff to follow-up with the doctor. 44475 2. Resident #16's MDS assessment dated [DATE] identified a BIMS score of 13, indicating intact cognition. The MDS indicated that Resident #16 had an unstageable pressure ulcer and infection of the foot (such as, cellulitis skin infection, purulent drainage drainage that signifies an infection). Resident #16's January 2023 Treatment Administration Record (TAR) included an order dated 1/15/23 to apply Calmoseptine to affected areas on buttocks three times a day. The TAR included documentation that she received her treatment three times a day from 1/15/23 through 1/31/23 except the evenings of 1/23/23 and 1/27/23. Resident #16's February 2023 Treatment Administration Record (TAR) included an order dated 1/15/23 to apply Calmoseptine to affected areas on buttocks three times a day. The order included documentation to indicate Resident #16 received their treatment three times a day from 2/1/23 until discontinued on 2/6/23 except on the mornings of 2/1/23 or 2/2/23. The Clinical Record lacked a signed physician's order for Calmoseptine treatment for the resident's left buttock pressure ulcer. On 5/3/23 at 1:13 PM the Director of Nursing (DON) agreed that staff should wait to have a signed physician order before starting a wound treatment.

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44474 Based on clinical record review and interview, the facility lacked discharge planning for 1 of 3 residents reviewed in the closed record sample (Resident #38). The facility reported a census of 38 residents. Findings: Resident #38's Minimum Data Set (MDS) assessment dated [DATE] indicated the reason for the assessment due to his discharge from the facility without an anticipated return. The MDS identified a Brief Interview for Mental Status (BIMS) score did not get assessed. The MDS included diagnoses of diabetes mellitus, Bipolar disorder (mood disorder), and anxiety disorder. Resident #38's Census listed a discharge date of [DATE] with a status to stop billing. The Orders - Administration note dated 1/30/23 at 6:23 p.m. indicated that Resident #38 discharged from the facility at 3:55 p.m. Resident #38's Care Plan revised 2/13/23 lacked information regarding his plans for discharge. The 72 hour Care Plan Meeting and Discharge Plan lacked a list of attendees to the meeting and/or items needed to help the resident achieve his discharge goal. The Discharge Plan and Summary policy revised March 2019 instructed the following: - When a resident's goal is to return to home/previous living, and the discharge is feasible,the facility will develop and implement an effective discharge planning process that focuses on: a. Resident's discharge goals. b. Preparing residents to be active partners in post-discharge care. c. Effective transition of the resident from skilled nursing care (SNF) to post SNF care. d. Reduction of factors leading to preventable readmissions. - Discharge planning will be initiated at time of admission. a. Complete the 72-hour Care Plan Meeting and Discharge Plan. - The facility will work with the resident and their representative(s) to develop a person-centered Care Plan for Discharge. The Care Plan should include: a. Resident's goals for facility stay and their desired outcomes will be care planned. b. Resident's preference and potential for future discharge. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. Document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities for this purpose in discharge plan and care plan. d. Include discharge plans in the comprehensive care plan as appropriate. - Facility's discharge planning process will: a. Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for the resident. b. Include regular re-evaluation of the resident to identify changes that require modification of the discharge plan. The discharge plan must be updated as needed to reflect these changes. c. Consider caregiver/support person availability and the resident's or caregiver's capacity and capability to perform the required care as part of the Identification of discharge needs. d. Involve the Interdisciplinary team (IDT), resident, and resident representative(s) in development of the plan and inform resident and their representative(s) of the final plan. e. Address the resident's goals of care andTX preferences. f. Document that a resident has been asked about their interests in receiving info regarding returning to the community. - Facility will document and complete on a timely basis, based on the resident's needs, and include in the medical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation will be discussed with the resident or resident's representative. All relevant resident information will be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. On 5/4/23 at 12:24 p.m. the Director of Nursing (DON) explained that in the electronic health record each department fills out the boxes for their department and signs them. They should be filled out completely.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44474 Based on clinical record review and interview, the facility lacked a discharge summary including a recapitulation of a resident's stay for 3 of 3 residents reviewed in the closed record sample (Resident #38, #45 and #46). The facility reported a census of 38 residents. Findings Include: 1. Resident #38's Minimum Data Set (MDS) assessment dated [DATE] indicated the reason for the assessment due to his discharge from the facility without an anticipated return. The MDS identified a Brief Interview for Mental Status (BIMS) score did not get assessed. The MDS included diagnoses of diabetes mellitus, Bipolar disorder (mood disorder), and anxiety disorder. Resident #38's Census listed a discharge date of [DATE] with a status to stop billing. The Orders - Administration note dated 1/30/23 at 6:23 p.m. indicated that Resident #38 discharged from the facility at 3:55 p.m. Resident #38's clinical record lacked a completed discharge summary including a recapitulation of the resident's stay. Resident #38's clinical record included an incomplete Discharge or Transfer Summary that lacked signatures and information regarding his stay in the facility. Resident #38's Discharge instructions lacked signatures and instructions for the receiving facility. 2. Resident #45's MDS assessment dated [DATE] indicated the reason for the assessment due to his discharge from the facility without an anticipated return. The MDS identified a BIMS score of 15, indicating no cognitive impairment. The MDS included diagnoses of hypertension, major depressive disorder, and anemia. Resident #45's Census listed a discharge date of [DATE] with a status to stop billing. The Discharge Note dated 3/9/23 at 12:20 p.m. identified that Resident #45 discharged from the facility at 12:07 p.m. to another facility. Resident #45's clinical record lacked a completed discharge summary including a recapitulation of his stay. Resident #45's clinical record included an incomplete Discharge or Transfer Summary that lacked signatures and information regarding his stay in the facility. Resident #45's Discharge Instructions lacked signatures and instructions for the receiving facility. (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Resident #46's MDS assessment dated [DATE] listed the purpose of the assessment due to her discharge without an anticipated return to the facility. The MDS identified a BIMS score of 15, indicating intact cognition. The MDS included diagnoses of hypertension, major depressive disorder, and anemia. Resident #45's Census listed a discharge date of [DATE] with the status to stop billing. The Orders - Administration Note dated 11/4/22 at 11:29 a.m. indicated that Resident #46 discharged from the facility at 11:20 a.m. to another facility. Resident #46's clinical record lacked a completed discharge summary including a recapitulation of the resident's stay. The Discharge Plan and Summary policy revised March 2019 instructed the following: - IDT will complete the discharge summary on all residents who are discharged to include but not limited to: a. recapitulation of the resident's stay that includes, diagnoses, course of disorder/treatment or therapy, pertinent lab, radiology, and consult results. b. A final summary of the resident's status to include items in the comprehensive assessment at the time of discharge. c. Reconciliation of all pre-discharge medications with the resident's post discharge medications (both prescribed and over-the counter) d. A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative, which will assist the resident to adjust to his/her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow-up care, any post-discharge medical and non-medical services e Follow-up plans for resident post-discharge f. Resident's consent acquired to share information g. Resident's name and signature and date h. Name of Practitioner i. Ongoing SpecialInstructions j. Advance Directive On 5/4/23 at 12:24 p.m. the Director of Nursing (DON) explained that in the electronic health record each department fills out the boxes for their department and signs them. They should be filled out completely.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44474 Based on clinical record review, facility policy review, resident, and staff interviews the facility failed to provide bathing assistance twice weekly and/or per resident preference for 4 of 4 residents reviewed for bathing (Residents #5, #7, #12 and #26). The facility reported a census of 38 residents. Findings include: 1. Resident #5's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 13, indicating no cognitive impairment. The MDS included diagnoses of anxiety, pain in the right hip, and hypothyroidism (underactive thyroid that regulates metabolism). Resident #5's MDS assessment dated [DATE] listed her functional status for bathing as totally dependent with one person physical assistance. Resident #5's Care Plan revised 4/14/23 lacked information regarding bathing assistance. The Documentation Survey Report reviewed from 11/1/22 until 1/31/23 included documentation to indicate Resident #5 received a bath on 11/29/22 and 1/20/23. The forms lacked additional documentation to indicate Resident #5 received or got offered a bath except on 11/18/22. The documentation listed the task as not applicable. The February 2023 Documentation Survey Report lacked documentation to indicate Resident #5 received a bath from 2/1/23 - 2/10/23 and 2/12/23 - 2/18/23. The March 2023 Documentation Survey Report lacked documentation to indicate Resident #5 received a bath from 3/2/23 - 3/7/23 and 3/12/23 - 3/17/23. The documentation for 3/8/23 listed the task as not applicable. The April 2023 Documentation Survey Report reviewed on 4/24/23 lacked documentation to indicate Resident #5 received a bath from 4/1/23 - 4/3/23 and from 4/15/23 - 4/24/23. 2. Resident #7's MDS assessment dated [DATE] identified a BIMS score of 9, indicating moderately impaired cognition. The MDS include diagnoses of multiple sclerosis, heart failure, and anemia. The MDS indicated Resident #7's functional status for bathing required physical help in part of the bathing activity from one person physical assistance. Resident #7's Care Plan revised 4/18/23 identified that bathing and showering required assistance of two people. The Documentation Survey Report reviewed from 11/1/22 until 12/31/22 included documentation to indicate Resident #7 received a bath on 11/2/22 and 12/14/22. The forms lacked additional documentation to indicate Resident #7 received or got offered a bath except on 11/26/22. The documentation listed the task as not applicable. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The January 2023 Documentation Survey Report lacked documentation that Resident #7 received a bath from 1/1/23 - 1/13/23 and 1/15/23 -1/20/23. The February 2023 Documentation Survey Report lacked documentation that Resident #7 received a bath from 2/6/23 - 2/13/23 and 2/16/23 - 2/21/23. The March 2023 Documentation Survey Report lacked documentation that Resident #7 received a bath from 3/2/23 - 3/7/23 and 3/16/23 -3/21/23. The April 2023 Documentation Survey Report reviewed on 4/24/23 lacked documentation that Resident #7 received a bath from 4/1/23 - 4/5/23 and 4/18/23 - 4/24/23. 3. Resident #12's MDS assessment dated [DATE] identified a BIMS score of 14, indicating intact cognition. The MDS included diagnoses of hypertension, depression and anemia. The MDS indicated Resident #12's functional status for bathing required physical help in part of the bathing activity from one person physical assistance. On 4/17/23 at 1:20 p.m. Resident #12 explained that when the facility is short staffed, residents did not get their baths done. Resident #12's Care Plan revised 4/10/23 lacked any information on bathing assistance. The Documentation Survey Report reviewed from 11/1/22 until 1/31/23 included documentation to indicate Resident #12 received a bath on 11/4/22 and 11/29/23. The forms lacked additional documentation to indicate Resident #12 received or got offered a bath except on 11/18/22 and 1/24/23. The documentation listed the task as not applicable. The February 2023 Documentation Survey Report lacked documentation that Resident #12 received a bath from 2/1/23 - 2/10/23 and 2/12/23 - 2/17/23. The March 2023 Documentation Survey Report lacked documentation that Resident #12 received a bath from 3/2/23 - 3/7/23 and 3/12/23 - 3/17/23. The documentation on 3/8/23 listed the task as not applicable. The April 2023 Documentation Survey Report reviewed on 4/24/23 lacked documentation that Resident #12 received a bath from 4/10/23 - 4/24/23. The documentation on 4/13/23 listed the task as not applicable. 4. Resident #26's MDS assessment dated [DATE] identified a BIMS score of 15, indicating no cognitive impairment. The MDS included diagnoses of hypertension, atrial fibrillation (abnormal heart rate) and cardiac murmur (abnormal heart rhythm). The Documentation Survey Report reviewed from 11/1/22 until 2/28/23 included documentation to indicate Resident #26 received a bath on 11/7/22, 11/10/22, 11/21/22, and 1/12/23. The forms lacked additional documentation to indicate Resident #26 received or got offered a bath. The March 2023 Documentation Survey Report lacked documentation to indicate Resident #26 received a bath from 3/17/23 - 3/22/23. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The April 2023 Documentation Survey Report reviewed on 4/24/23 lacked documentation to indicate Resident #26 received a bath from 4/1/23 - 4/5/23 and 4/7/23 - 4/24/23. The forms lacked additional documentation to indicate Resident #26 received or got offered a bath except documentation on 4/3/23, 4/10/23, and 4/13/23 that listed the task as not applicable. The facility verified that they do not have a policy on bathing. On 5/4/23 at 12:42 p.m. the Director of Nursing (DON) reported that bathing is to be done two times a week or as the resident prefers.

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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 0684 Level of Harm - Minimal harm or potential for 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** 26527 Based on record review, staff, and resident interview, the facility failed to assess residents after alleged reports of physical abuse for 1 of 3 residents reviewed (Resident #22). The facility reported a census of 38 residents. Findings include: According to the Minimum Data Set (MDS) assessment dated [DATE] Resident #22 scored 10 on the Brief Interview for Mental Status (BIMS) indicating moderate cognitive impairment. The resident required extensive assistance with dressing, personal hygiene, and bathing did not occur in the previous 7 day period. The resident's diagnoses included a stroke. The Care Plan included Resident #22 showed the behavior of abusive language initiated 2/14/20. Interventions included that the resident would show respect towards staff at all times, the staff would redirect the resident as needed, and the staff would show the resident respect at all times. A typed note documented on 7/23/22 at approximately 2 p.m. the Administrator received a call from a staff member reporting that other staff went to her about an incident that took place on 7/21/22 between Resident #22 and Staff D, a staffing agency Certified Nursing Assistant (CNA). The incident took place in the shower room, as the aide gave the resident a shower. The resident told the staff on duty when he got a shower on 7/21/22 a staff member got rough with him. The resident said he told the CNA the water was too hot and for the CNA to turn it down. The resident stated he turned it to ice cold. The resident stated he did make a racial comment, [NAME] of the jungle go back home. Then the CNA cupped his hand with cold water and put over the resident's mouth and nose, while pressing the resident's neck down until the water went up his nose. The resident tried to yell for help but could not. When the CNA let the resident go, the CNA stated he was not going to drown him. The resident's clinical record lacked any documentation that the facility conducted an assessment or follow-up of the resident related to the report. On 5/2/23 at 11:48 a.m. an email from the Administrator documented there should have been a Risk Management Incident Report that would have prompted staff to contact the physician and follow appropriate measures. The Administrator could not find any documentation in his chart for any follow up and interventions. The Administrator remarked that an incident such as this should have been examined by the Interdisciplinary Team to ensure proper treatment and Care Planning. The Risk Management Incident would have driven this focus to this incident.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44475 Based on observation, clinical record, facility policy, and staff interview, the facility failed to provide care consistent with professional standards of practice, to prevent pressure ulcers and provide necessary treatment and services to promote the healing of a pressure ulcer, prevent an infection for 1 of 1 resident reviewed (Resident #16). The facility reported a census of 38 residents. The MDS assessment identifies the definition of pressure ulcers: Stage I is an intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching (change to white); in dark skin tones only, it may appear with persistent blue or purple hues. Stage II is partial thickness loss of dermis (outer skin layer) presenting as a shallow open ulcer with a red or pink wound bed, without slough (dead tissue, usually cream or yellow in color). May also present as an intact or open/ruptured blister. Stage III Full thickness tissue loss. Subcutaneous fat (fat just under the skin) may be visible but the wound did not have exposed bone, tendon or muscle. Slough may be present but does not obscure (hide) the depth of tissue loss. May include undermining (wound extends unseen under the skin) and tunneling (moves through multiple layers of skin that appear like a tunnel). Stage IV is full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar (dry, black, hard necrotic tissue). may be present on some parts of the wound bed. Often includes undermining and tunneling or eschar. Unstageable Ulcer: inability to see the wound bed. Other staging considerations include: Deep Tissue Pressure Injury (DTPI): Persistent non-blanchable deep red, maroon or purple discoloration. Intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue. This area may have started as tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent (next to) tissue. These changes often precede skin color changes and discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. Findings include: Resident #16's Minimum Data Set (MDS) dated [DATE] listed an admitted [DATE]. The MDS identified a Brief Interview of Mental Status (BIMS) score of 13, indicating intact cognition. The MDS included diagnoses of medically complex conditions of major depression, diabetes mellitus, and cellulitis. The MDS indicated that Resident #16 had a risk for pressure ulcers. The MDS listed that Resident #16 had a pressure ulcer and infection in his foot (such as cellulitis skin infection or purulent drainage infection related drainage). (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 4/17/23 at 12:25 PM Staff Z, Certified Nurse Aide (CNA) exited Resident #16's room after delivering her lunch. Staff Z completed hand hygiene but did wear any personal protective equipment (PPE). Staff Z reported that Resident #16 is on contact precautions, but she did not know why. Staff Z explained that Resident #16 did have a wound on her bottom. On 4/17/23 at 3:59 PM Resident #16 reported that she had a wound on her buttock On 4/26/23 at 2:00 PM observed Staff N, Licensed Practical Nurse (LPN), with the Director of Nursing (DON) present perform a dressing change procedure to Resident #16's pressure ulcer to her left buttock. After cleansing the wound with soap, Staff N changed her gloves without performing hand hygiene. The MDS dated [DATE] indicated that Resident #16 did not have a pressure ulcer. The MDS listed Resident #16 as a risk for pressure ulcers. The Braden Scale Assessment for Predicting Pressure Sore Risk dated 11/30/22 indicated that Resident #16 had a risk for pressure ulcers. The Comprehensive Skin Assessment and Risk Factors dated 11/30/22 revealed that Resident #16 did not have pressure ulcers present at admission. The Wound - Initial (New) Documentation Form dated 1/5/23 at 11:06 AM listed that Resident #16 had an unstageable pressure ulcer to her left buttock that measured 0.7 centimeters (cm) x 0.5 cm. The assessment indicated that the nurse notified the physician of Resident #16's wounds and requested treatment orders. The Wound - Initial (New) Documentation Form dated 1/5/23 at 11:09 AM listed that Resident #16 had an unstageable pressure ulcer to her right buttock that measured 0.3 cm x 0.3 cm. The assessment indicated that the nurse notified the physician of Resident #16's wounds and requested treatment orders. The General Note dated 1/5/23 at 11:11 AM identified the nurse found two open areas on Resident #16's buttock one on the left buttock that measured 0.7 cm x 0.5 cm and one on the right buttock that measured 0. 3 cm x 0.3 cm. The nurse applied Calmoseptine to the opens areas and requested a treatment from the physician. The Wound - Weekly Form (One wound per form until healed) dated 1/26/23 at 11:59 AM listed that Resident #16 had an unstageable pressure ulcer to her left buttock that measured 0.6 cm x 0.9 cm. Resident #16's January 2023 Treatment Administration Record (TAR) included an order started on 1/15/23 to apply calmoseptine to affected areas on buttocks three times a day. The evenings of 1/23/23 or 1/27/23 lacked documentation to indicate the completion of the treatment. The Wound - Weekly Form (One wound per form until healed) dated 2/8/23 at 3:56 PM listed that Resident #16 had an unstageable pressure ulcer to her left buttock that measured 1 cm x 1.5 cm. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The Dietary Note dated 2/14/23 at 10:52 PM written by the facility's Registered Dietician (RD) indicated they received notification recently of Resident #16's altered skin integrity. The noted directed to see the nursing skin assessment for details. Resident #16's had adequate intakes to meet her estimated needs. The RD had no new recommendations at the time. The Wound - Weekly Form (One wound per form until healed) dated 2/15/23 at 6:41 PM listed that Resident #16 had a pressure ulcer to her left buttock that measured 1.2 cm x 0.5 cm. The wound's edges appeared pink and intact. The Wound - Weekly Form (One wound per form until healed) dated 2/25/23 at 10:49 AM listed that Resident #16 had a pressure ulcer to her left buttock that measured 1 cm x 0.2 cm. The wound appeared stable with edges that appeared pink and intact. The Fax (facsimile) Cover Sheet dated 2/27/23 signed by a physician included an order for LiquaCel 1 packet mixed with 8 ounces of water to promote wound healing. The Clinical Record lacked a signed physician order for calmoseptine treatment for the resident's left buttock pressure ulcer. Resident #16's February 2023 TAR included the following orders: 1. Start date 1/15/23: Apply calmoseptine to affected areas on buttocks three times a day. Discontinued on 2/6/23. a. No documentation on the mornings of 2/1/23 or 2/2/23 to indicate completion of the treatment. 2. Start date 2/7/23: Apply calcium alginate dressing to the open area on Resident #16's left buttocks and change daily every day shift for wound care. Discontinued on 2/23/23. a. No documentation of administration on 2/7/23, 2/10/23, 2/13/23, or 2/23/23. The Wound - Weekly Form (One wound per form until healed) dated 3/1/23 at 3:45 PM listed that Resident #16 had a pressure ulcer staged as a suspected deep tissue injury to her left buttock that measured 1 cm x 0. 5 cm. Documentation indicated the wound improved. The Wound - Weekly Form (One wound per form until healed) dated 3/8/23 at 10:54 AM listed that Resident #16 had a stage II pressure ulcer to her left buttock that measured 2 cm x 0.9 cm x 0.2 cm. The wound contained 25% epithelial tissue (basic body tissue), 50% granulation tissue (new tissue), and 25% slough tissue (dying tissue that is usually yellow/white and wet). The wound's edges appeared indurated (hard) with erythema (redness). The note listed the wound as declined due to large measurement with redness and slough. The nurse notified the physician who replied to continue the current treatment at that time. Resident #16 scheduled to see the physician that day and the nurse planned to send the skin assessments with her. The Physician Clinic Sheet dated 3/8/23 indicated that Resident #16 had a 60-day follow-up. The Advanced Registered Nurse Practitioner (ARNP) provided the following orders: a. Cephalexin 500 milligrams (mg) three times a day for ten days. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	b. Please reposition resident every two hours. c. Please make sure to follow the wound care orders. d. Order for Resident #16 to see the hospital's Wound Care to assess wound to buttocks and treatment e. Please follow orders as resident did not have adequate treatment to wound upon assessment in the office. f. Return in two weeks for follow-up on cellulitis on 3/27/23 at 11:15 AM. The Physician Visit note dated 3/8/23 at 4:09 PM identified that the hospital's wound care to assess and treat Resident #16's wound to her buttocks. The Wound - Weekly Form (One wound per form until healed) dated 3/15/23 at 11:25 AM listed that Resident #16 had a stage II pressure ulcer to her left buttock that measured 1 cm x 0.9 cm x 0.2 cm. The wound had a scant (small) amount of serosanguineous drainage (occurs as the wound tries to heal, it appears pale red or pink in color). The wound appeared indurated with erythema. The description detailed the buttocks wound to appear smaller with slough to the entire wound bed with indurated edges and bright red surrounding tissue. The note listed the progress as improved. The physician did not receive notification due to the improved status. The Wound - Weekly Form (One wound per form until healed) dated 3/22/23 at 9:52 AM listed that Resident #16 had a stage II pressure ulcer to her left buttock that measured 1.5 cm x 0.9 cm x 0.2 cm. The wound had no drainage or odor. The wound appeared indurated with erythema and edema (swelling). The description detailed the buttocks wound to appear smaller with slough to the entire wound bed with indurated edges and bright red surrounding tissue. The RN Analysis and Plan indicated Resident #16 at the Wound Clinic at time of documentation. The nurse provided staff education to move the ROHO cushion from the recliner to the wheelchair and encourage her to get up and out of her room. The note listed the progress as improved. The physician did not receive notification due to no change in status. The Physician Clinic Sheet dated 3/22/23 included the following orders a. Discontinue the previous wound care orders b. Left Buttock Ulcer Treatment a. Wash with soap and water. b. Apply Aquacel AG or silver alginate c. Cover with border gauze or a four by four (4x4) with Medipore tape and change daily. c. Follow-up in one week (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The Orders - Administration Note dated 3/22/23 at 11:32 AM indicated that Resident #16 returned from the Wound Clinic and had a new appointment for 3/29/23 at 9:45 AM. The Wound Clinic Progress Note dated 3/22/23 indicated the left buttock wound did not have tunneling or undermining, it included a medium amount of serous (fluid) drainage, a thickened wound margin, medium pink granulation tissue in the wound bed, medium necrotic (dead tissue) including adherent (sticky) slough in wound bed, stage III measured 0.9 cm length, 0.5 cm width, 0.5 cm depth. Wound culture obtained. The Microbiology Routine Culture laboratory report dated 3/25/23 identified that Resident #16's left buttock wound culture revealed an infection resistant to Vancomycin (antibiotic). Resident #16's clinical record lacked information related to her right buttock wound from 1/5/23 until 3/28/23. The Wound Clinic Progress Notes signed 3/28/23 included a new order for gentamicin (antibiotic) ointment. The order directed to apply to the left gluteal wound twice daily due to a diagnosis of VRE (Resistant infection to the vancomycin antibiotic). The Wound Clinic Progress Note dated 3/29/23 sign by an ARNP indicated that Resident #16 had a stage II pressure ulcer to her right gluteus that measured 0.4 cm length x 0.3 cm width x 0.2 cm depth. The note continued to indicate that an assessment of her wheelchair revealed a broken cushion. The wound had undermining (wound edges separate from healthy tissue create a pocket under the skin) from 7:00 to 11:00 o'clock with a maximum depth of 0.6 cm. The wound had a medium amount of serous drainage, thickened wound margin, medium pink granulation in wound bed, small necrotic including adherent slough in wound bed, stage III pressure ulcer that measured 0.8 cm length, 0.4 cm width, 0.5 cm depth. The Physician Clinic Sheet dated 3/29/23 indicated that the offloading cushion in Resident #16's chair had a broken valve that needed fixed. The order directed the resident to return in two weeks. The Wound Center's Discharge Instructions dated 3/29/23 listed a follow-up appointment of 4/12/23 at 9:45 AM. The note included handwriting that directed to see the telephone order. The Telephone Order dated 3/29/23 at 1:22 PM included an order for treatment of the Left Buttock Wound. The order directed to clean with soap and water, dry, apply Aquacel AG or Calcium Alginate, Apply to wound bed slightly moistened with saline. Cover With bordered gauze to prepped skin or cover with a 4x4 gauze and secure with Medipore tape to prepped skin. Change [NAME] and as needed (PRN) every day shift for Wound Care and as needed for Wound Cares. The order discontinued the previous wound treatment. The Wound - Initial (New) Documentation Form dated 3/30/23 at 1:30 PM listed that Resident #16 had a pressure ulcer to her right buttock that measured 1 cm x 1 cm. The nurse notified the Physician on 3/28/23. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Resident #16's March 2023 TAR included an order started on 3/23/23 and discontinued on 3/29/23 to clean with soap and water, dry, apply Aquacel Ag or Calcium Alginate dressing then cover with a border gauze. Change the dressing daily and PRN. The TAR lacked documentation of administration on 3/27/23. The Wound - Weekly Form (One wound per form until healed) dated 4/6/23 at 1:03 PM listed that Resident #16 had a pressure ulcer to her right buttock that measured 1 cm x 1 cm. Documentation indicated the wound had no change. The Wound - Weekly Form (One wound per form until healed) dated 4/12/23 at 2:08 PM listed that Resident #16 had a stage II pressure ulcer to her left buttock that measured 1 cm x 0.9 cm x 0.2 cm. The wound appeared indurated, edematous, and erythema. Documentation list the wound as stable and improved. The Wound Clinic Progress Notes signed by an ARNP dated 4/19/23 identified that the assessment of her wheelchair revealed an appropriate ROHO cushion. The left buttock wound had undermining from 7:00 to 11:00 o'clock with a maximum depth of 0.6 cm. The wound had a medium amount of serous drainage, a thickened wound margin, medium pink granulation in wound bed, small necrotic including adherent slough in wound bed, stage III pressure ulcer that measured 0.3 cm length, 0.7 cm width, 0.3 cm depth. The Care Plan Focus revised 4/5/23 indicated that Resident #16 had a potential for pressure ulcers related to decreased mobility and sleeping her in recliner instead of her bed. On 1/5/23 Resident #16 had a new pressure ulcer to her buttock and gluteal fold (the crease between the buttock and upper thigh). The Care Plan included the following Interventions: a. Initiated 12/8/22: Monitor nutritional status. Serve diet as ordered, monitor intake and record. b. Initiated 12/8/22: Follow facility policies/protocols for the prevention/treatment of skin breakdown. c. Initiated 2/9/23: ROHO cushion. d. Revised 4/5/23: Pressure relieving cushion in her wheelchair ROHO. Resident #16 likes her recliner. The staff discussed shifting her weight every 1-2hrs with her but she often declined. Resident #16 is resistant and non-compliant at times with her care and treatment. The Intervention directed the staff to work one on one (1:1) with her to keep as dry as possible, in addition to turning, repositioning, and pressure reduction interventions. The Pressure Ulcer Risk Assessment Policy revised March 2019 directed to provide guidelines for the assessment and identification of residents at risk for developing pressure ulcers. - General guidelines: a. If treatment of a pressure ulcer does not occur when discovered, they quickly get larger, become painful for the resident, and often become infected. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	b. Continual pressure, heat, moisture, irritating substances on the resident's skin, decline in nutrition and hydration status, acute illness and /or decline in the resident's physical and/or mental conditions make pressure ulcers worse. c. Once a pressure ulcer develops it can be extremely difficult to heal. d. Pressure ulcers are a serious skin condition for residents. e. Routinely assess and document the condition of the resident's skin per facility wound and skin programs for any signs and symptoms of irritation or breakdown. f. Complete comprehensive skin assessments on admission, readmission, annually, and with change in condition or surface. g. Skin checks: Check the skin for the presence of a developing pressure ulcer 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. Notify the nurses to inspect the skin if skin changes identified. Nurses conduct a skin assessment at least weekly to identify changes. - Identifying Resident 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 and time and type of skin care provided. c. Any change in the resident's condition. d. The condition of the skin (size and 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. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	b. Report other information in accordance with the facility policy and professional standards of practice. On 5/4/23 at 1:13 PM when asked about the lack of weekly skin assessments, lack of signed physician notification of the resident's wound, or an order for treatment of the wound, and the delay in obtaining nutritional supplements or wound clinic referral, the Director of Nursing (DON) did not respond and continued to look at the resident's clinical record to find the missing items.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44475 Based on clinical record, facility policy, resident, resident representative, and staff interviews, the facility failed to perform restorative therapy for 2 of 2 residents reviewed (Residents #18 and #27). The facility reported a census of 38 residents. Findings include: 1. Resident #18's Minimum Data Set (MDS) assessment dated [DATE] listed an admitted to the facility of 12/20/22. The MDS identified a BIMS of 3, indicating severely impaired cognition. The MDS indicated that the resident required extensive assistance of two persons with bed mobility, transfers, and toilet use. Resident #18 could be independently mobile while using his manual wheelchair. The MDS included a diagnosis of encephalopathy (disease that affects brain function). On 5/2/23 at 11:48 AM, Resident #18's Wife reported that she would like the resident to do restorative exercises. The undated Restorative Nursing Program form included the following a. Start date listed upon admission. b. Frequency three times per week. c. Exercise plans directed by Physical Therapy and Occupational Therapy. The Care Plan Focus initiated 1/17/23 related to restorative therapy included a Goal to maintain current functional status through the next review date. The Focus included one Invention that directed that Resident #18 has a recommended restorative program, please see point of care. Resident #18's December 2022 Point of Care documentation lacked directions of his restorative therapy. Resident #18's January 2023 Point of Care documentation included an as needed Interventions started 1/18/23 of: a. Seated hamstring stretch for one minute or as Resident #18 tolerates. b. NuStep (stationary bicycle that works the arms and legs) Level 4 for 10-15 minutes. c. Upper Extremity Exercises d. Lower Extremity Exercises The form lacked documentation of completed restorative Interventions. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #18's February 2023 Point of Care documentation included an as needed Interventions of: a. Seated hamstring stretch for one minute or as Resident #18 tolerates. b. NuStep (stationary bicycle that works the arms and legs) Level 4 for 10-15 minutes. c. Upper Extremity Exercises d. Lower Extremity Exercises The form lacked documentation of completion of the restorative Interventions from 2/1/23 - 2/7/23. 2. Resident #27's MDS assessment dated [DATE] identified a BIMS score of 15, indicating intact cognition. The MDS included diagnoses of metabolic encephalopathy (a brain condition that can cause confusion and memory loss) and mental disorder. The MDS indicated that Resident #27 needed extensive assistance from one person with bed mobility and extensive assistance of two persons with transfers and toilet use. On 4/18/23 at 8:44 AM, Resident #27 reported that it felt like the facility gave up on him (for restorative therapy). Resident #27 explained that it could make a difference on well he could tolerate being in the standing lift with his knees. The Occupational Therapy (OT) Discharge Summary dated 1/15/21 recommendations directed the following: a. He will benefit from a restorative program as provided for gentle shoulder ROM (range of motion) and elbow/wrist strengthening to reduce risk for decline in strength/ROM. b. RNP (restorative nursing program) provided and encouraged. c. The IDT (interdisciplinary team) has completed instruction related to helping the patient maintain his current level of performance and to prevent decline, development of, and instruction in the following RNPs with the ROM (active), ROM (passive), and dressing. The Physical Therapy (PT) Discharge Summary dated 1/19/21 revealed: a. Discharge recommendations: Assistance with ADLs (activities of daily living) and RNP. b. RNP: The IDT team received instruction to facilitate the patient maintaining her current level of performance and to prevent decline, development of and instruction in the following RNPs: transfers and ROM (passive). The Care Plan Focus revised 6/3/21 indicated that Resident #27 had an alteration in mobility due to a history of a fall at home with multiple fractures. Resident #27 had a fall on 5/27/21 with no injuries. The Intervention dated 7/14/21 instructed to encourage Resident #27 to participate in the restorative program. (continued on next page)

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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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Multidisciplinary Care Conference Summaries dated 5/10/22 listed a restorative plan of seated lower extremity exercises and upper body strengthening with the greed/medium resistant band for 10 to 15 minutes daily to maintain function. The Care Plan Focus initiated on 2/1/23 and cancelled on 4/30/23 related to restorative therapy included a Goal that Resident #27 would maintain his current functional status through the review date. The intervention dated 2/1/23 and cancelled on 4/30/23 directed that Resident #27 has a recommended restorative program to participate three to five times a week. In an interview on 4/26/23 at 9:35 AM, Staff M, Certified Nurse Assistant (CNA), reported that she started working on the restorative program at the facility in January 2023 and that the program became operational in February 2023. On 5/3/23 at 1:21 PM, the [NAME] President of Operations reported that the facility did not have a restorative program prior to January 2023. The Restorative Nursing Program Policy dated March 2019 revealed: a. Restorative Nursing Program refers to nursing interventions that promote the resident's ability to adapt and adjust to living as independently and safely as possible. This concept actively focuses on achieving and maintaining optimal physical, mental and psychosocial functioning. b. A resident may start on a restorative nursing program when he or she admits to the facility with restorative needs, but is not a candidate for formalized therapy, or when restorative needs arise during a longer-term stay, or in conjunction with formalized therapy. Generally restorative nursing programs initiate after a resident discharges from formalized physical, occupational, or speech therapy. c. Restorative nursing includes, but is not limited to: skill practice in walking, dressing, grooming, eating, swallowing, transferring, amputation care, splint care, communication, PROM (passive range of motion) /AROM (active range of motion), scheduled toileting, bladder training, or bed mobility.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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** 44474 Based on clinical record review, staff interviews, facility record review and facility policy review, the facility failed to ensure residents at risk for elopement were unable to exit the facility unattended for 2 of 2 residents reviewed for elopement (Residents #39 and #18). The facility's failure resulted in an Immediate Jeopardy to the health, safety, and security of the residents. The State Agency informed the facility of the Immediate Jeopardy (IJ) that began as of January 17, 23 on April 18, 23 at 12:58 p.m. The Facility Staff removed the Immediate Jeopardy on April 19, 23 through the following actions: a. The facility engaged an additional keypad door alarm on the North Door. The door alarm sound is loud and heard throughout the facility. When the door alarm goes off, staff must enter a code at the door to turn it off. The keypad door alarm activated immediately at 1:30 p.m. on 4/18/23. The [NAME] President of Operations (VPO) and Administrator called a staff meeting to educate all present employees that effective immediately to not use the North door unless taking out trash. The Administrator notified all staff not present by a text message at 1:59pm. b. The Director of Nursing (DON) educated the resident who smoked to no longer use the North Door and if followed by another resident to immediately alert a staff member. The facility moved the designated smoking area to the front of the building at the time. c. The facility contacted the alarm company to verify the installation time of the new alarm system. The company verified the date for the alarm as 4/25/23. d. The facility will educate all staff to respond to all door alarms to ensure that it is not a resident leaving the facility by 4/19/23. f. The facility will educate all staff by 4/19/23 on the risk of elopement for residents, the facilities elopement policy and the importance of responding to door alarms. g. The facility will complete an updated elopement risk assessment on all residents by 4/19/23. h. The facility will educate the staff on the revised elopement book. The elopement book will flag residents at risk for eloping. The Maintenance Director or designee will conduct an audit twice a day to ensure that all door alarms work correctly and that the staff respond to the alarms until the installation of the new door lock system on the north double doors by 4/26/23. The facility will continue to do audits until the installation of the new locking system. The scope lowered from a K to an E at the time of the survey after ensuring the facility implemented education and their policy and procedures. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Findings Include: Resident #39's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. The MDS included diagnoses of diabetes mellitus, Bipolar disorder (mood disorder), and anxiety disorder. Resident #38 completed all her activities of daily living independently. The Social Services Note dated 1/17/23 at 10:51 a.m. indicated that the Social Services Director (SSD) sat and discussed the incident of when Resident #39 decided to take a walk outside without permission. Resident #16 explained that she talked with a cousin friend the day before. They mentioned donuts, so she went out for donuts. But once outside she forgot about the donuts. Resident #16 added that she became confused about her location and her plan. Resident #16 added that she wanted to go outside to get fresh air, as she had not been outside for ages. The SSD reminded her that they had colder weather then when she usually goes out for her walks. The SSD also reminded Resident #39 that when went out for a walk, she usually walked in the front lot area. This allowed the staff to keep an eye on her and know that she is out there. Resident #16 reported that she thought she told another resident. The SSD stated that she could not tell another resident. Resident #16 replied no, she told the Administrator. The SSD planned to investigate her report. The SSD reminded Resident #16 to ask a staff member to go outside with her, if she wanted to get some fresh air. If the floor staff is busy, she could ask the Activity Director (AD) or the SSD, and they would help. The Orders - Administration Note dated 1/30/23 at 12:08 AM indicated that staff completed hourly checks on Resident #16 due to exit seeking behavior that day and the day before. The Behavior Note dated 1/30/23 at 7:18 AM identified that Resident #16 attempted to exit the facility early in the shift. The Behavior Note dated 2/5/23 at 10:00 PM indicated that Resident #16 attempted to go out the front door twice with other residents' visitors as they left. She verbalized that she wanted to go outside because of it being so nice out. The staff explained to Resident #16 that she could only go out with staff for her safety. The remaining of the shift, she remained on one to one (1:1) supervision until she went to her room and got in bed. The facility then completed 15 minutes checks on her. 2. On 4/18/23 at 9:22 a.m. watched Resident #1 exit the building out of the north service entrance to smoke. Exited the building with Resident #1 and heard the door alarm sounded until the door closed. When asked if he needed to enter a code to go back into the building, Resident #1 reported the door did not have a code that worked. He added that someone could just open the door and when they close the door the alarm turns off. Resident #1 remarked that he did that every day. Witnessed Resident #1 reentered the door with the alarm sounding and turned off after entering the building and closing the door. On 4/18/23 at 9:47 a.m. the Maintenance Director reported that he checked the door alarms weekly. When asked about the north service entrance he revealed that the mag lock did not work due to shifting of the door frame. The facility applied a temporary alarm after Resident #39 left the building. The facility is working on getting alarms on the double doors before the exit but are currently waiting on alarm company. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 4/18/23 at 10:52 a.m. Staff C, Licensed Practical Nurse (LPN), reported that the facility has an elopement binder for all the residents at risk for elopement. Upon further examination Staff C, explained that the binder contained all the residents in the facility. Staff C explained that they determined the resident's elopement risk by looking in the computer under the elopement risk form. On 4/18/23 at 11:15 a.m., Staff C explained that he worked at the facility as a Certified Medication Aide (CMA) when Resident #38 left the building. Staff C reported that Resident #38 exited the facility on the north side of the building. He added that the facility did not have an alarm on the door. Staff C explained that after Resident #38 exited the facility, they installed a makeshift alarm on the north exit door. Staff C reported that the staff cannot hear the alarm unless staff members are at or close to the nurses' station. Staff C confirmed that he did not receive education or training after Resident #38 exited the building without staff knowing. The list of residents at risk for elopement dated 4/18/23 listed Resident #33. The Elopement Policy revised March 2019 instructed that the facility nursing personnel must report and investigate all reports of missing residents. On 4/19/23 at 11:23 a.m. the Administrator vocalized that the facility had a different Administrator at the time of the incident but she did review the report and understood that Resident #38 left the building through the north doors. When the police department called Resident #38 gave them a false name. After sometime the police department called back again, then the staff figured out that Resident #38 left the facility. The Administrator reported that she expected the staff to answer a door alarm if the door alarms worked. 44475 3. Resident #18's MDS dated [DATE] identified a BIMS score of 3, indicating severely impaired cognition. The MDS indicated that Resident #18 required extensive assistance from two persons with bed mobility, transfers, toilet use. Resident #18 independently used his manual wheelchair. The MDS including a diagnosis of encephalopathy (disease that affects brain function). The resident's Electronic Health Record (EHR) included a form labeled Identified Wander/Elopement Risk dated 11/19/22. The Emergency Medical Information list that Resident #18 had a diagnosis of dementia. The Elopement Risk Assessments summary question if the resident had an elopement risk, included documentation in each assessment that Resident #18 did not have a risk for elopement on the following dates: 1. 12/21/22 2. 3/27/23 3. 4/19/23 (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 4/17/23 at 1:02 PM observed Resident #18 sit in his wheelchair in front of the nurses' station in between a space of the facility entrance and the North hall. During the observation the resident moved around the space using his feet to propel the wheelchair, looking around as though he needed assistance. During the observation, Resident replied when asked that he wondered where he should go, what he should do, and reported that he wanted to go home. On 4/18/23 at 10:25 AM, Staff M, Certified Nurse Aide (CNA), reported that Resident #18 knew where to find his room, they explained that he wandered the building. Resident #18 has reported to Staff M that he did not know where he's going, that he occasionally reports that he wants to go home, but he did not have exit seeking behaviors and usually congregated towards groups of people. 26527 4. On 4/18/23 at 9:10 a.m. the Marketing/Admissions Director stated if the front door opened without putting in the code the alarm sounded and got louder until somebody checked it and put in the code. The side doors that go out to the dumpsters (alarm) sounded when the door opened, and when the door closed it went off. On 4/18/23 at 9:25 a.m. the Business Office Manager (BOM) stated if the front door opened the alarm sounded and someone needed to go to the alarm and see if a resident went out. They could shut the alarm off by putting in the code. If someone put the code in, the alarm sounded if the door stayed open too long. On 4/18/23 at 9:30 a.m. Staff Q, CNA, said she would need to ask someone what she would do if a door alarm sounded. She went to the nurses' station and asked what they should do. She returned and said if an alarm sounded they went and checked the door. If they did not see a resident they reported it to the nurse so they could check the residents. The BOM reported the alarm sounded if the (alarm) door stayed open more than 19 seconds. On 4/18/23 at 9:35 a.m. Staff T, Dietary Aide, stated they take garbage out the side door and it beeps while open and stops when it shuts. On 4/18/23 at 10:38 a.m. Staff N, Licensed Practical Nurse (LPN), denied knowing if the facility had an elopement risk. She did not really know who was at risk. She said residents with mental impairment would be at risk. She added that she would check on who was at risk. At 10:42 a.m. Staff N explained that they did assessments on residents. She said they did have an elopement binder and she would get it. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 4/18/23 at 11:17 a.m. the Social Services Director stated the day of Resident #39's elopement she came in late. They asked her check Resident #39's BIMS and she scored a 15, indicating no cognitive impairment. Resident #39 said she went to meet her mom, as her mom and dad were going to pick her up in the pickup truck. She went out the side smoking door which didn't have an alarm at that time. She said they put the current alarm in place at that time. She could not even guess how long they didn't have an alarm on that door. They questioned if she followed another resident out. She said Resident #39 used to go out all the time and walk last fall. She said prior to her elopement, Resident #39 started packing up her things and pushed it out in the hall because she was leaving here. But she had never exit seek before. On 4/18/22 at 11:41 a.m. the Administrator at time of Resident #39's elopement stated she stopped working at the facility on 1/20/23. She thought Resident #39 got out and down past the fire department. She thought they went and got her, but not sure. She was tying up loose ends because she was leaving. Resident #39 did like to go out and walk. She knew the passcode to go out the front door. The Administrator thought that she went out there. She said someone called but they did not think anyone was missing. She thought Resident #39 packed her stuff up one time. She did not exit seek. The Administrator at the time said they had someone in the offices that could observe her when she went outside. On the weekend they had a nurse manager who could observe her outside. She said they had never had an elopement before. She thought Resident #39 had something mentally going on. She said that all the door alarms alarmed at that time. If they had a door without an alarm they would have someone watching that door. On 4/18/23 at 12:16 p.m. the BOM stated Resident #39 got out (eloped) before she got to work. She did know for sure what door she went out, but Resident #39 did know the code to the front door. She did not know if all the doors had the same code but she would find out. The BOM came to report all the doors had the same code to get out without alarming. On 4/19/23 at 3:20 p.m. Staff X, CNA, stated she just returned from maternity leave that day. She thought the facility maybe had 1 or 2 residents at risk for elopement. She said residents who were elopement risks would be on 15-minute checks. She said if a door alarm went off she would check where the alarm went off and check to see if anyone went out. If she didn't see anyone outside she would probably check to make sure no one was missing by looking in each resident's room. On 4/19/23 at 3:45 p.m. Staff W, CNA, said she didn't think the facility had anyone at risk for elopement at that time. If a door alarm went off she would go to the nurses' station to see which door it was, and go to the door to check if anyone went out. Then she would go and tell the nurse that no one left. On 4/20/23 1:15 p.m. Staff V, CNA, explained that the facility did tell them what they needed to know about door alarms and any new policies. She said they cannot go out the side door unless taking garbage out. Now the door had an alarm on it with the door code. She said if you hear a door alarm you have check whichever door it was and make sure that no residents went out. If you could not identify who went out, you must go check and make sure everybody's accounted for. She said reported Resident #33 as an elopement risk so they watched her more closely. She'd never actually seen Resident #33 try to go out. Staff V said that she received education about alarms and elopement yesterday. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 4/20/23 at 1:23 p.m. Staff U, CNA, explained that she knew what to do with the alarms and elopements, as they received education. She felt up to date on how to answer the alarms, how to deal with alarms, and the elopement risk. They had received new direction on using the side door, and that they could only use the door to take out the garbage. The door had a full alarm and a keypad. On 4/20/23 at 1:32 p.m. Staff B, CNA, able to tell the new policy with the side door and the alarm for that door, and who could go out that door. She knew of the elopement risk. In addition, Staff B knew how to answer the door alarms and ensure the safety of everyone.

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44475 Based on clinical record, facility policy, and staff interview, the facility failed to notify a physician that a resident had a new pressure ulcer for 1 of 1 residents reviewed (Resident #16). The facility reported a census of 38 residents. Findings include: Resident #16's Minimum Data Set (MDS) dated [DATE] identified a Brief Interview of Mental Status (BIMS) score of 13, indicating intact cognition. The MDS included diagnoses of medically complex conditions of major depression, diabetes mellitus, and cellulitis. The MDS listed that Resident #16 had a pressure ulcer and infection in his foot (such as cellulitis skin infection or purulent drainage infection related drainage). The Wound - Initial (New) Documentation Form dated 1/5/23 revealed: 1. Unstageable pressure ulcer to the left buttock measuring 0.7 centimeters (cm) x 0.5 cm. 2. Unstageable pressure ulcer to the right buttock measuring 0.3 cm x 0.3 cm. 3. The physician received notification of the wounds and to request treatment orders. The Clinical Record lacked signed physician orders when the physician received notification of the pressure ulcers. In an interview on 5/3/23 at 1:13 PM, the [NAME] President of Operation (VPO) reported that the facility may not have documentation that the physician received notification of the wound due to an issue with a staff member destroying resident clinical record information.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44475 Based on clinical record, facility policy, resident interview, and staff interview, the facility failed to answer a resident's call light in a timely manner for 1 of 19 residents reviewed (Resident #4). The facility reported a census of 38 residents. Findings include: Resident #4's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS included diagnoses of multiple sclerosis and paraplegia. The MDS indicated that Resident #4 required extensive assistance of two persons with bed mobility and total assistance from two persons with transfers. The MDS identified Resident #4 with a risk of developing pressure ulcers/injuries. On 4/26/23 at 11:48 AM, Resident #4 reported that on 4/25/23 she laid in her bed on her back from 1:30 PM to 4:30 PM without having a position change. Resident #18 explained that she put her call light on at 3:30 PM. Someone answered the call light and told her that another staff person would need to be located to assist with the transfer. After 30 minutes, Resident #4 put back on her call light. Someone told her that they needed to locate another staff person to assist with her transfer. Resident #4 reported that at 4:30 PM, they transferred her from her bed to her wheelchair. The Call Light Accessibility and Timely Response Policy and Procedure policy dated October 2022 directed: 1. The process for responding to call lights: Answer the call light as soon as possible. 2. If the resident needs assistance with a procedure, summon help by using the call light, and stay with the resident until help arrives.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 44475 Based on facility nursing schedule reviews and staff interviews, the facility failed to assure a registered nurse (RN) on duty for 8 hours a day, 7 days per week. The facility reported a census of 38 residents. Findings include: Review of the facility's nursing staff schedule dated 10/01/22 through 12/05/22 revealed the following days lacked a RN on duty for 8 hours 10/3/22 10/12/22 10/13/22 10/26/22 11/4/22 11/19/22 11/20/22 11/24/22 11/26/22 11/27/22 12/4/22 On 4/24/23 at 3:50 p.m. the Director of Nursing (DON) reported she was the only RN on the schedule when she started PRN (as needed) in October 2022. On 4/25/23 at 7:35 a.m. the DON verified the lack of RN coverage in October and November 2022. The DON stated she would expect to have 8 hours of RN coverage every day. On 4/25/23 at 7:55 a.m. the DON reported the facility does not have a policy on RN coverage.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785 Based on policy and chart review, and interviews the facility failed to accurately document the use of narcotic medications for 1 of 3 residents reviewed. The facility reported a census of 38 residents. Findings include: Resident #40's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) of 00, indicating severe cognitive impairment. The MDS listed that Resident #40 received Hospice services. The MDS included diagnoses of type II diabetes mellites, anxiety disorder, and urinary tract infections. The Order details dated 1/18/22 at 10:53 PM listed an order for hydrocodone-acetaminophen (pain medication narcotic) tablet 5-325 milligrams (MG). The order directed to give one tablet two times a day for breakthrough pain and one tablet every 4 hours as needed (PRN) for pain. The Controlled Medication Utilization Record for 7/21/22 through 7/31/22 had documentation to indicate that Resident #40 received three doses of hydrocodone-acetaminophen tablet 5-325 milligrams (MG) on 7/28/22. Resident #40's July 2022 Medication Administration Record (MAR) received her scheduled dose of hydrocodone-acetaminophen tablet 5-325 milligrams (MG) twice that day. The PRN dose lacked documentation that Resident #40 ever received a dose. A bound book used for documentation of the utilization of narcotics showed that on 11/23/22 Resident #40 had 29 hydrocodone pills left. On the bottom of the form it had documentation indicating the destruction of the medication on 1/23/23. The document lacked signatures. On 4/26/23 at 4:24 PM, the Director of Nursing (DON) said that she and the previous administrator destroyed the remaining 29 tablets of hydrocodone on 1/23/23. She acknowledged that they failed to sign the document and she understood that the policy instructed to have two nurse signatures for the destruction of controlled substances. On 4/27/23 at 1:00 PM the Administrator said they expected the staff to have two signatures when destroying controlled substances. The Narcotics-Counting and Destruction policy dated March 2019 directed to provide accurate regulation and maintenance of controlled substances. The narcotic record number should correspond with the number in the index. Staff were to chart the disposal of controlled substances from in the resident chart and the narcotic book with two nurse's signatures. Medication destruction on controlled substances needs completed by DON/license nurse designee and a second license nurse.

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785 Based on observation, interview, and policy review the facility failed to serve food at the recommended temperatures to ensure palatability for 38 residents. The facility reported a census of 38 residents. Findings include: 1. On 4/20/23 from 11:00 through the end of the lunch service, observed the fruit ambrosia salad left sitting out without a cooling method in place. At the end of service at 12:09 PM the temperature of the salad was 61 degrees Fahrenheit. The Healthcare Services Group Dining Service Department Policy and Procedure Manual last revised on September 2017, the section titled; Food Storage; Cold Food instructed that all perishable foods would maintain a temperature of 41 degrees or below. 26527 2. On 4/20/23 at 7:25 a.m. observed glasses of liquids (including milk) sitting on tables with no residents in the dining room. At 7:50 a.m. Resident #22 came to the breakfast table (liquids had been sitting out since 7:25 a.m.). At 8 a.m. another resident had milk sitting out in lidded cups came to the table, and another resident came to the dining room, both liquids sat out since 7:25 a.m. At 8:48 a.m. Resident #20 came to the dining room and sat at a table with liquids including milk sitting out. The staff pushed the milk up to the resident and asked the kitchen for her food. When asked, the Dietary supervisor temped the milk at 67.8 degrees, said it was too warm, and removed it from the table. 44474 3. Resident #8's Minimum Data Set (MDS) assessment dated [DATE] identified a BIMS score of 13 indicating moderate cognitive impairment. The MDS included diagnoses of heart failure, anxiety and arthritis. On 4/18/23 at 3:22 p.m., Resident #8 remarked that she eats in her room and the dining room. She explained that she receives many of her meals cold. Resident #8 added that it does not make a difference if she eats in the dining room or in her room for the temperature of the food. A test tray received on 4/26/23 at 9:12 a.m. consisting of scrambled eggs, oatmeal, and bacon. The temperature of the food assessed revealed the temperature of the eggs at 118 degrees Fahrenheit (F), oatmeal at 128.9 F, and bacon warm to the touch A second test tray received on 4/26/23 at 1:01 p.m. consisted of a meal of ham, cooked cabbage, and sweet potatoes. The temperature of the food assessed identified a temperature for ham at 133 F, cabbage at 119.7 F, and sweet potatoes at 137.4 F. 44475 (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Resident #24's MDS assessment dated [DATE] identified a BIMS score of 15, indicating intact cognition. The MDS listed Resident #24 as independent with eating with set up assistance only. The MDS included diagnoses of unspecified vision loss, vitamin d deficiency, and alcohol use, unspecified with other alcohol-induced disorder. On 4/17/23 at 1:30 PM Resident #24 reported that she gets her food served cold sometimes. The Food: Quality and Palatability policy revised September 2017 revealed food will be palatable, attractive, and served at a safe and appetizing temperature.

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785 Based on observations, clinical record review, resident and staff interviews and facility policy review the facility failed to assure that resident received the recommended therapeutic menu for residents at risk for choking for 5 of 5 residents reviewed (Residents #8, #6, #13, #22, and #27). This failure increased the risk of residents choking or aspirating (something entering the lungs), therefore causing an Immediate Jeopardy to the health, safety, and security of the resident. The State Agency informed the facility of the Immediate Jeopardy (IJ) that began as of April 24th at 3:45 P. M. The Facility Staff removed the Immediate Jeopardy on April 25, 2023 through the following actions: 1. [NAME] President of Operations, Nurse Consultant, Director of Nursing, Administrator, and Dietary Manager met at 3:20 PM on 4/24/23 to discuss Therapeutic Diets to gain understanding of problem areas. 2. The facility educated the Dietary Manager on subject of diet types, mechanically altered, additives, and consistencies on 4/24/2023 at 4:40PM. 3. The facility instructed the Dietary Manager to oversee all special instruction diets that came out of the kitchen from 4:40 PM on 4/24/23 to lunchtime on 4/25/23 to ensure the staff follow the resident's diets according to the physician's order. The facility instructed the Dietary Manager on specific instructions in the case that a resident refused the diet as ordered on 4/24/23. 4. The facility planned a meeting for on 4/25/23 at 9:30 AM between dietary cooks, Speech Therapy, management crew and a representative from their consulting company to provide education. The staff received education on following diet orders, communication to Speech Therapy and their involvement, and steps to ensure staff followed the physician's orders. 5. The facility created audits to ensure regular compliance weekly for one month and once a month for one year to follow. The Dietary Manager will complete the audits beginning the week ending 4/28/23. The scope lowered from a K to an E at the time of the survey after ensuring the facility implemented education and established procedures to ensure resident safety at meal time. Findings Include: (continued on next page)

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	1. Resident #13's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 10, indicating moderately impaired cognition. The MDS indicated that Resident #13 only required set up assistance for eating. The MDS included diagnoses of heart failure, renal insufficiency, diabetes mellitus and seizure disorder. The MDS listed that Resident #13 had a mechanically altered diet (thickened liquids, ground, or pureed food). The Care Plan Focus revised 6/15/22 indicated that Resident #13 ate independently but had dietary restrictions due to his diagnosis of diabetes. The Interventions directed the following a. Revised 4/1/21: Speech Therapy (ST) evaluate and treat him as needed. b. Staff to give him, his diet as ordered and monitor him for the need to change his diet and/or texture. The Order Details dated 9/22/22 listed an order for dysphagia advanced diet texture with regular fluid consistency. On 4/24/23 at 12:50 PM, observed Resident #13 receive a hamburger patty on a bun. He took one bit of the sandwich and chewed for a long period of time. He then removed the top of the bun and with his fork pulled pieces of meat apart to eat in smaller bites. 2. Resident #6's MDS assessment dated [DATE] identified a BIMS score of 11, indicating moderately impaired cognition. The MDS included a diagnosis of cerebral palsy. The MDS indicated that Resident #6 required supervision with set-up assistance with meals. The MDS listed that Resident #6 received a mechanical altered diet. The Speech Therapy Evaluation and Plan of Treatment dated 11/10/22 identified that the ST saw Resident #6 due to her having an increased dislike of her current diet of mechanical soft textures. Resident #16 warranted an analysis of her diet textures and liquid consistencies to ensure safe swallowing and her risk for aspiration. Resident #6 had a risk for aspiration, a further decline in function, and pneumonia. The documentation indicated that Resident #16 tolerated her mechanical soft diet with no signs or symptoms of aspiration. She required moderate verbal and visual cues to use safe swallow strategies. Resident #16 demonstrated the highest level of safe intake with the mechanical soft textures. The ST recommended that Resident #16 continued her diet texture. Resident #16 had inadequate mastication (rotary chew pattern) and poor attention to task decreased self-monitoring. The Order Details dated 4/6/22 listed an order for dysphagia advanced diet texture with regular fluid consistency. On 4/24/23 at 12:50 PM, observed the staff serve Resident #6 a hot dog cut into bite sized pieces. She ate the pieces without assistance with several staff members in the dining area. On 4/24/23 at 2:17 PM the Dietary Manager (DM) said that the residents get a list of food options. At the bottom of the list had options classified as always available which included a hot dog and a hamburger on a bun. She said that a resident on the dysphasia advanced diet would need to have the hamburger and/or hot dog ground before they received it. (continued on next page)

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 4/24/23 at 2:24 PM Staff R, Dietary Aide, said that none of the residents with a mechanical soft diet chose a hamburger or hot dog for lunch that day. She said that she did not grind any hamburger patties or hot dogs for lunch. On 4/27/23 at 11:52 AM the DM looked at the list of education for the kitchen staff and verified that only 1 of the 4 current dietary staff received education on texture modification. She said that the company provided the education on a rotation basis. The DM reported September 2022 as the last time the education module offered and 3 of the 4 current staff did not start until after that date. According to the Diet and Nutritional Care Manual dated 2019, the National Dysphagia Diet Levels were as follows: a. Level 1: Dysphagia Pureed b. Level 2: Mechanically Altered c. Level 3: Dysphagia Advanced d. Regular Diet. The allowed Dysphagia Advanced foods included moistened meats with sauce or gravy, must be tender, fruits without skins and moistened breads. The Dysphagia Advanced foods not allowed included dry tough meat, grapes, corn, potato skins, dry, tough, or crusty bread. On 4/24/23 at 5:08 PM the Registered Dietician (RD) for the facility said that the DM had the responsibility to educate new staff and make sure they understand the diets they serve. She agreed that the always available listed on the bottom of a resident's menu may be confusing if staff do not understand that they need to grind these meats for an Advanced Dysphasia diet. On 4/25/23 at 9:26 AM the ST reported that she gave a very specific description of diets to include meat textures, veggies, and fruits. She then sends these recommendations to the doctor for the orders. She agreed that an Advanced Dysphagia diet must have the meats ground. 44474 3. Resident #8's MDS assessment dated [DATE] identified a BIMS score of 13, indicating intact cognition. The MDS included diagnoses of heart failure, anxiety and arthritis. The General Note dated 2/17/23 at 12:50 p.m. indicated that Resident #8 had a choking episode out of the facility. The provider indicated they would send over orders for ground meat. The General Note dated 2/17/23 at 3:33 p.m. listed the facility received the ground meat order. The Health Status Note dated 4/20/23 at 1:21 p.m. identified that the facility received an order by fax from the primary care physician for Resident #8's diet to change to a regular consistency, carbohydrate-controlled diet. (continued on next page)

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident #8's medical chart lacked documentation of a Speech Evaluation to assess for safety to advance her diet. 26527 4. On 4/19/23 at 1:12 p.m. Resident #22 sat in the dining room. He stated he finished his lunch. Meat remained on the plate, splayed out. Resident #22 stated they didn't have any mashed potatoes. Resident #22's menu showed garlic mashed potatoes circled. His tablemate, Resident #27 said they didn't have any mashed potatoes, they got stir fry instead. There were red skinned potatoes on Resident #27's plate. Resident #22 and Resident #27's menus both showed Regular-Dysphagia Advanced diet. The menus did not have the option for red skinned potatoes. A menu indicating Regular diet had garlic roasted red skinned potatoes on the menu. The Dietary Manager (DM) checked the menus and said Resident #22 and Resident #27 received the wrong food items. She thought that they were the only ones. On 4/20/23 at 10:02 a.m. Resident # 24 stated she was on a special diet because of difficulty swallowing. She said sometimes they ground the meat and sometimes they didn't. She said she couldn't eat the ground sometimes because it was so dry. Some broth or gravy on it would help. She said she had been eating the meat when they didn't grind it. At 10:08 a.m. Resident #6 said they did not grind her meat. On 4/20/23 at 12:35 p.m. staff delivered resident noon meals. Residents on dysphagia advanced diets, and requested a sandwich received the contents ground including the bread. Two residents pushed it away and asked where their sandwich was. At 1:20 p.m. the DM stated she would have to get a therapeutic menu they didn't have one in the kitchen and they should have. At 2 p.m. the Dietician stated residents should receive their diets as ordered. She stated she knew some of the residents were on mechanical soft due to the status of their teeth. At 2:45 p.m. the DM pulled up the therapeutic menu dysphagia advanced and it showed ground meat went on the bun. Looked at other menus and they called for ground meat on bread (not a ground meat sandwich). On 4/24/23 at 12:49 p.m. Resident #24 received the casserole, carrots and cauliflower, bread and cake. Resident #24's menu called for no peas. The casserole had both peas and corn in it. Resident #24 stated she received the carrots not entirely cooked and were too hard to eat. She could not eat peas because if the skin sloughed off it could get stuck in her throat. Resident #22 received the casserole, cauliflower and carrots, bread and pineapple. Resident #27 received the same, and said she received carrots not fully cooked enough and hard to eat. On 4/24/23 at 1:17 p.m. the DM confirmed Resident #24 should not have received the casserole with peas in it, and those on advanced dysphagia diets should not have received corn. The resident should have completely cooked carrots and soft for dysphagia advanced diets. (continued on next page)

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	44475 5. The MDS dated [DATE] for Resident #27 revealed a BIMS of 15 which indicated intact cognition. The same MDS revealed the resident had diagnoses of metabolic encephalopathy (a brain condition that can cause confusion and memory loss), anemia (low amount of iron in blood, iron found in meat), and mental disorder. The MDS revealed the resident was independent with eating, had speech therapy service from 12/2/22 to 12/23/22, and had a mechanically altered diet - require change in texture of food or liquids (e.g., pureed food, thickened liquids). The SPL (Speech Language Pathologist) Evaluation and Plan of Treatment with a start of care date of 12/6/22 revealed: 1. Reason for referral: Resident #27 referred to Speech Therapy (ST) by dietary due to their reports of difficulty with mastication (chewing) of meats/harder textures. The ST recommended Skilled ST to evaluate for analysis of diet texture and liquid consistencies to determine least restrictive diet and implement preventative strategies for decreased risk of aspiration. Without skilled ST Resident #27 has at risk for aspiration and malnutrition due to their inability to safely consume regular textures. 2. Intake recommendations mechanical soft/ground textures. The Order dated 12/6/22 signed by a physician revealed per speech therapy, may we have an order for diet change to mechanical soft, ground meat, soft veggies, soft bite sized bread, and purred fruits with the physician response as yes. On 4/17/23 at 12:37 PM observed Resident #27 receive a formed meat patty. Resident #27 left the meat patty uneaten. In an interview on 4/17/23 at 12:37, the resident reported he should have ground meat and pointed out the ground meat only wording on his menu slip that came with his noon meal. The resident reported he receives the incorrect texture for foods often. On 4/19/23 at 1:33 PM, Resident #27 reported that he received soft roast beef for lunch that he could, but the meat did not get ground. In addition, he received potatoes with the skin on them.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44475 Based on observations, facility policy, and staff interview, the facility failed to store kitchen ware in a way to protect it from contaminants, seal and date opened food, and failed to provide a sanitary kitchen environment. The facility reported a census of 38 residents. Findings include: 1. On 4/17/23 at 10:34 AM observed the following: a. Silverware divider open to air with adaptive silverware including regular forks and knives. b. Container of spoons open to air. c. Open bag of potato flakes not sealed. d. Open bag of corn starch not sealed. e. Microwave with dried brown substance splattered on inner door, bottom, and sides. f. Drawer in stainless steel unit that contained a two basin sink with brown and red dried substance. g. Undated orange, apple, and cranberry juice bags fed into a serving unit. h. Serving table with dishes serving side up. i. Storage and mixing bowls not inverted. j. Dried brown substance on serving table unit. k. Dried brown substance and brown dried debris in two drawers in stainless steel food preparation table. l. Open and undated hardboiled eggs in a clear plastic bag in the refrigerator. The Food Storage: Cold Foods policy revised April 2018 instructed to store all foods wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination. The Environment policy revised September 2017 directed that the Dining Services Director would ensure that a routine cleaning schedule is in place for all cooking equipment, food storage areas, and surfaces. On 5/4/23 at 12:48 PM the Dietary Manager (DM) reported that she expected the kitchen to be clean, open foods sealed and dated, and kitchenware to be stored in a manner to prevent contamination. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	41785 2. The continuous observation of the lunch service on 4/20/23, witnessed Staff S, Dietary Aide, wear the same gloves throughout the meal service (at 12:20, 12:24, 12:25, 12:26, 12:40 and 12:45). Staff S touched many surfaces, utensils, bread bags, then touched the pizza, and handled buns with same pair of gloves. On 4/20/23 at 1:53 PM the Dietary Manager said that she expected staff to use tongs to handle food, not gloved hands, and that she expects them to change their gloves after staff had touched potentially contaminated surfaces. The Healthcare Services Group Dining Service Department Policy and Procedure Manual revised September 2017 instructed all staff to practice proper hand hygiene and glove use. The staff would adhere (follow) to proper utensils or clean gloved hands for food handling. The section titled; Food Storage; Cold Food directed that all perishable maintain a temperature of 41 degrees or below.

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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 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** 44475 Based on observation, facility policy, and staff interview, the facility failed to protect health information for 1 of 19 residents reviewed (Resident #16). The facility reported a census of 38 residents. Findings include: Resident #16's Minimum Data Set (MDS) dated [DATE] identified a Brief Interview of Mental Status (BIMS) score of 13, indicating intact cognition. The MDS included diagnoses of medically complex conditions of major depression, diabetes mellitus, and cellulitis. The MDS listed that Resident #16 had a pressure ulcer and infection in his foot (such as cellulitis skin infection or purulent drainage infection related drainage). On 4/17/23 at 11:33 AM observed a sign posted on Resident #16's room door that listed Infections or Conditions Requiring Contact Precautions. The sign listed 38 different infections or conditions, including major wound infections. The Health Status note dated 3/27/23 at 10:56 PM revealed Resident #16 had a wound to his left leg that tested positive for VRE (bacteria resistant to some antibiotics). On 4/20/23 at 11:09 AM, the Director of Nursing (DON) reported that the sign displayed on the door had the incorrect side facing out. The DON explained that the side facing out listed all the infections or conditions that required contact precautions and anyone could see the list indicating the resident in that room had one of those infections or conditions. The Notice of Privacy Practices policy dated 8/1/18 revealed that the facility had responsibilities required to maintain the privacy of their health information.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 44475 Based on facility records, facility policy, and staff interview, the facility failed to have the required members present for their Quality Assurance and Performance Improvement (QAPI) meetings. The facility reported a census of 38 residents. Findings include: The 7/26/22 QAPI sign in sheets lacked the Director of Nursing (DON) present. The following QAPI sign in sheets reviewed since June 2022 lacked a present Medical Director: 1. 6/15/22 2. 10/31/22 3. 11/30/22 4. 12/21/22 5. 1/18/23 The QAA (Quality Assessment and Assurance) and QAPI Policy and Procedure effective August 2019 instructed the following: 1. The QAA Committee shall be interdisciplinary and shall: a. Consist at a minimum of: i. The Director of Nursing Services (DON); ii. The Medical Director or his/her designee; iii. At least 3 other members of the facility's staff, at least one of which must be the Administrator, an owner, a board member or another individual in a leadership role; and iv. The Infection Preventionist. b. Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects under the QAPI program are necessary. (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 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/25/23 at 8:53 AM, the [NAME] President of Operations (VPO) reported that he supplied all the QAPI sign in sheets since May 2022, the Medical Director attended meetings every other month, and that he noticed incorrect dates on the preprinted sign in sheets. The VPO reported that he reconciled the sign in sheets with the corresponding QAPI meeting agenda dates, crossed out the incorrect date, and handwrote the correct date on the sign in sheets. On 4/25/23 at 8:58 AM, the VPO reported that the DON is a required QAPI meeting member and listed the required QAPI meeting members to include the Medical Director.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785 Based on observations, interviews, record, and policy review the facility failed to establish and implement effective infection control practices. The staff failed to review the infection control policies annually and failed to establish a process for monitoring the threat of water borne pathogens. In addition, the staff failed to use proper personal protective equipment (PPE) while caring for a resident in transmission-based precautions (Resident #16), and the staff failed to use proper hand hygiene and PPE during care for 1 resident, (Resident #4). The facility reported a census of 38 residents. Findings include: 1. On [DATE] at 3:49 PM the Maintenance Manager (MM) said that when first started at the facility, he had some education on the management of water borne pathogens but they last tested the water for legionella three years before. He said that the facility had some test strips on the shelf but they already expired. He acknowledged that they hadn't established a process for monitoring for water borne pathogens and they did not flush the lines in the building. On [DATE] at 1:00 PM the Administrator said that she consulted with someone at the corporate office that said there weren't any tests to monitor for legionellae. She said they would do some further research. The facility provided a copy of a handbook developed by the Centers for Disease Control (CDC) titled: Developing a Water Management Program to Decrease Legionella Growth and Spread in Building dated [DATE]. The handbook directed staff to actively identify and manage hazardous conditions that support growth and spread of Legionella. Staff need to identify and control hazardous conditions that increase the chance of Legionella growth and spread. A workbook tool provided by the facility titled: Legionella Water Management Plan included a step by step process for monitoring. The purpose of the tool was to promote proactive steps to establish healthy, infection-free environments for residents, staff and visitors. When residents contract Legionnaires' disease, it is often the result of exposure to inadequately managed building water systems, that is preventable. The document remained incomplete. 2. A review a policy titled: Infection Prevention and Control Program Overview Policy reviewed in March of 2019. The Policy lacked additional documentation of reviews after [DATE]. On [DATE] at 11:09 AM the Director of Nursing (DON) and Assistant Director of Nursing ADON confirmed that the last update of the infection control policy happened in 2019. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. On [DATE] at 1:48 PM Staff P, Certified Nurse Aide (CNA), came in the front door and said she was just beginning her shift. She explained that due it being the beginning of her work week she took the COVID-19 test. She said that the facility tested on ce a week, or twice a week if someone tests positive. Staff P swabbed her nose without using gloves or completing hand hygiene after doing the test. She laid the test on the table without barrier, grabbed a pen off the table, and wrote her name on the sheet. She then grabbed some things in her purse, waited seven minutes, and documented that the test as negative. Two more staff members came in the door and started to get tests out of the box without the use of gloves. Staff P put the pen down on the notebook and invited the other staff members to use it if they needed. She then entered the facility without completing any hand hygiene. 44475 4. Resident #16's Minimum Data Set (MDS) dated [DATE] identified a Brief Interview of Mental Status (BIMS) score of 13, indicating intact cognition. The MDS included diagnoses of medically complex conditions of major depression, diabetes mellitus, and cellulitis. The MDS listed that Resident #16 had a pressure ulcer and infection in his foot (such as cellulitis skin infection or purulent drainage infection related drainage). The Microbiology Routine Culture laboratory report dated [DATE] indicated that Resident #40's wound had resistance to vancomycin. The Health Status note dated [DATE] at 10:56 PM revealed Resident #16 had a wound to his left leg that tested positive for VRE (bacteria resistant to some antibiotics). The note indicated the next shift received notification of the infection. The note included that the facility initiated and followed isolation precautions. The Order signed [DATE] by a physician revealed left buttock wound: cleanse with soap and water, dry, apply Aquacel Ag or calcium alginate and cover with border gauze. Change daily and PRN (as needed) for wound care and every day shift for wound care. On [DATE] at 2:00 PM observed Staff N, Licensed Practical Nurse (LPN), with the Director of Nursing (DON) present perform a dressing change procedure to Resident #16's pressure ulcer to her left buttock. After cleansing the wound with soap, Staff N changed her gloves without performing hand hygiene. In addition, Staff N failed to wear a face shield during the procedure. On [DATE] at 2:23 PM the DON agreed that the staff needs to complete hand hygiene with glove changes and educated Staff N during the interview. Staff N reported that she needed to hurry the procedure because Resident #16 made her feel rushed when she called out for her to complete the procedure quickly. Staff N reported that she usually performed hand hygiene with glove changes. During the interview both the DON and Staff N acknowledged that they knew Resident #16's wound had an infection. When asked how the staff know when to apply all the PPE or only part of the PPE required for contact precautions as listed on the sign on the resident's room door, the DON responded that she personally always puts on all the required PPE because she never knows for sure if the resident will need help going to the bathroom or if body fluids could splash. The DON reported that PPE for contact precautions did not require a face shield. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 2:27 PM the DON reported that the facility had issues with communication of resident information from the wound clinic. The facility explained that due to the issues with communication, they did not know Resident #16 had VRE (bacteria resistant to the vancomycin antibiotic) for two days. The Centers for Disease Control and Prevention (CDC) article Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) reviewed [DATE] directed that with contact precautions, the staff may need face protection if performing an activity with risk of splash or spray. The VRE policy revised [DATE] directed that 1. Enterococci are bacteria that are normally present in the human intestines and in the female genital tract. 2. They can cause urinary tract, bloodstream, wound infections, or other infections. 3. Caregivers can pass VRE from person to person by their hands following contact with a resident or contaminated surfaces. 5. Resident #4's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS included diagnoses of multiple sclerosis and paraplegia. The MDS indicated that Resident #4 required extensive assistance of two persons with bed mobility and total assistance from two persons with transfers. The MDS identified Resident #4 with a risk of developing pressure ulcers/injuries. The Medication Review Report dated [DATE] signed by a physician revealed an order to change urostomy every week every evening shift every Wednesday. Observation on [DATE] at 2:01 PM of Staff C, Licensed Practical Nurse (LPN), perform a urostomy appliance change procedure with the ADON present. During the procedure, Staff C removed his gloves, and without performing hand hygiene, looked through supplies in the resident's drawers to find a new extension piece for the catheter tubing, scratched his face under his face mask, and failed to perform hand hygiene before putting on gloves. Staff C then applied the tubing extension to the catheter bag and tubing. On [DATE] at 2:26 PM, the ADON agreed that staff need to do hand hygiene in between glove changes and after touching their face. The Handwashing/Hygiene policy revised [DATE] instructed the following 1. Handwashing, being the single most effective way of controlling the spread of infection, staff to perform routine and thorough hand hygiene to protect residents from the spread of infection. 2. The staff are to complete hand hygiene before donning (putting on) and after the removal of gloves and/or other PPE (such as a gown, facemask, etc.) 3. The use of gloves does not replace handwashing/hand hygiene.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785 Based on policy and chart review, and interviews the facility failed to offer the pneumococcal vaccine to 1 of 5 residents reviewed for immunizations (Resident #31). On 9/16/21 Resident #31 admitted to the facility with admission orders that included an order to administer the pneumococcal vaccine. The clinical record lacked documentation of a completed pneumococcal vaccine. The facility reported a census of 38 residents. Findings include: Resident #31's Minimum Data Set (MDS) assessment dated [DATE] listed an admitted [DATE]. The MDS identified a Brief Interview for Mental Status (BIMS) score of 5, indicating severely impaired cognition. The MDS included diagnoses of acidosis (an excess amount of acid in the body), hypertension (high blood pressure), dehydration (abnormal loss of water from the body), and bacteremia (infection of the blood). The MDS lacked documentation that Resident #31 received a pneumococcal vaccine. The Clinical Record lacked documentation that Resident #31 received or refused a pneumococcal vaccine. A signed admission order dated 9/20/21 included directives to administer the pneumococcal vaccine. Resident #31's September 2021 Medication Administration Record (MAR) listed an order on 9/21/21 at 6:00 AM of a pneumonia vaccine. The MAR lacked documentation to indicate she received the vaccine. The Pneumococcal Vaccination for Residents policy March 2019 directed that the facility offers and encourage all residents to receive the pneumococcal vaccine. According to the Centers for Disease Control (CDC) reviewed on 5/1/23 from https://www.cdc.gov/vaccines/vpd/pneumo/hcp/who-when-to-vaccinate.html instructed that all adults aged [AGE] years or older who have not previously received a pneumococcal vaccine or those whose previous vaccination history is unknown should receive a single dose of the pneumococcal vaccine; PCV13.

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F 0886 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Perform COVID19 testing on residents and staff. 41785 Based on observations, interviews, and chart review the facility failed to adequately communicate and implement consistent staff testing for the COVID-19 virus. The facility reported a census of 38 residents. Findings include: On 4/19/23 at 1:48 PM Staff P, Certified Nurse Aide (CNA), came in the front door and said she was just beginning her shift. She explained that due it being the beginning of her work week she took the COVID-19 test. She said that the facility tested on ce a week, or twice a week if someone tests positive. After seven minutes, Staff P documented the test as negative. On 4/18/23 at 3:29 PM Staff P explained that she had a religious exemption. She said that she filled something out and put it in her file upon hire. Staff P added that she did not do anything different than the rest of the staff and tests once or twice a week depending on what the positivity rate is. Staff P remarked that she did not do anything different from the rest of staff as far as personal protective equipment (PPE). On 4/18/23 at 3:00 PM Staff Y, CNA, explained that she had a medical exemption from the COVID-19 vaccine because she had a reaction to the meningitis vaccine and spent five days in the hospital. She said that she watched a video about infectious diseases after refusing the vaccine. Staff Y reported that she never had a test at the facility and she started working there in December of 2022. She said that she did not get communication from the facility regarding outbreak status, she did not know when they are in outbreak status, or when she they expected to have a COVID-19 test. She knew the facility had tests in the front lobby but she never used them. On 4/20/23 at 8:27 AM the Physical Therapist (PT) reported that he works at the facility as contracted staff and has not received the COVID-19 vaccine. The PT explained that he just wears a mask all the time and tests one time a week. He added other than that, he did not do anything different with his interaction with residents. He expressed that the facility did not ask for proof of testing. On 4/18/23 at 3:33 PM the Minimum Data Set (MDS) nurse, the Assistant Director of Nursing (ADON), and the Director of Nursing (DON) came in the front door. When asked about the process for testing, they replied that they expected the staff to check the kiosk in the entry that would tell them of the positivity level in the community and if they needed to test or not. On 4/20/23 at 11:09 AM the DON and ADON said that they never received a text message regarding new COVID-19 cases. They acknowledged inconsistency of the COVID testing. They agreed that use of the Kiosk and testing conducted in the lobby is unsanitary. They explained that the staff always tested themselves and they knew that staff did not always use the Kiosk or paying attention to the community's positivity status. (continued on next page)

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F 0886 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Employee/Contractor Health Infection Control policy revised 1/6/22 instructed that any new cases of COVID-19 in the facility would constitute an outbreak status. The policy directed that testing occur for all staff and residents twice a week during an outbreak, regardless of their vaccination status, until testing revealed no new cases. The policy indicated that the Centers for Medicare and Medicaid Services (CMS) directed that vaccinated staff did not have to receive routine testing. The company's policy, however, required that the facility test all staff regardless of their vaccine status. Per CMS regulation, Facility staff includes employees, consultants, contractors, volunteers, and caregivers who provide care and services to the residents on behalf of the facility.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785 Based on interviews, policy and chart review the facility failed to offer the COVID-19 booster immunizations to 3 of 5 residents reviewed (Residents #31, #14, and #16). Findings include: 1. Resident #31's Minimum Data Set (MDS) assessment dated [DATE] listed an admitted [DATE]. The MDS identified a Brief Interview for Mental Status (BIMS) score of 5, indicating severely impaired cognition. Resident #31's Immunization Record listed that she received her first dose of COVID-19 vaccine on 11/10/21 and the second dose on 12/6/21. The Immunization Record lacked documentation of other COVID-19 vaccines. Resident #31's clinical record lacked documentation that the facility offered or gave her a COVID-19 booster vaccine. 2. Resident #14's MDS assessment dated [DATE] listed an admitted [DATE]. The MDS identified a BIMS score of 15, indicating intact cognition. Resident #14's Immunization Record listed that she received her first dose of COVID-19 vaccine on 1/15/21 and the second dose on 2/26/21. The Immunization Record lacked documentation of other COVID-19 vaccines. Resident #14's clinical record lacked documentation that the facility offered or gave her a COVID-19 booster vaccine. 3. Resident #16 Minimum Data Set (MDS) dated [DATE] identified a Brief Interview of Mental Status (BIMS) score of 13 which indicated intact cognition. The MDS listed Resident #16's admitted as 11/30/22. Resident #16's Immunization Record listed that she received her first dose of COVID-19 vaccine on 6/4/21, a second dose on 2/26/21, and a third dose on 1/6/22. The Immunization Record lacked documentation of other COVID-19 vaccines. Resident #16's clinical record lacked documentation that the facility offered or gave her an additional COVID-19 booster vaccine. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/20/23 at 11:09 AM, The Director of Nursing (DON) and the Assistant Director of Nursing (ADON) said that they did not know why the residents did not receive an offer to have the COVID-19 booster but they thought it had something to do with the pharmacy's availability to come to the facility to provide the immunizations. They remarked that the residents could get their booster vaccines from their primary care doctor as the only other option when the residents went to their appointments. They acknowledged that the facility lacked an established system or process to ensure that the residents received the opportunity to have the COVID-19 boosters. The COVID-19 Vaccination Policy and Procedure dated October 2022 instructed the staff to offer the COVID-19 vaccination to residents when supplies were available, and as recommended by the Centers for Disease Prevention and Control.

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 44475 Based on personnel file review, facility policy review and staff interview, the facility failed to provide the required 2-hour dependent adult abuse training within 6 months of hire for 1 of 5 employees reviewed (Staff B, Certified Nurse Aide CNA). The facility reported a census of 38 residents. Findings include: The facility provided untitled facility form with a list of new hires listed Staff B's hired date as 6/30/22. Staff B's Personnel File lacked documentation of a completed Dependent Adult Abuse training. The Abuse Prevention Plan policy dated February 2023 requires that each employee complete the two hours of training provided by the Department of Human Services related to the identification and reporting of dependent adult abuse. On 4/25/23 at 11:28 a.m. the Director of Nursing (DON) verified that Staff B did not complete their dependent abuse training.