STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235719	A. Building B. Wing	04/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeside Manor Nursing and Rehabilitation Center	13990 Lakeside Circle Sterling Heights, MI 48313

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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 - Few	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** 35103 Based on observation, interview, and record review, the facility failed to provide respectful and dignified care during dining assistance and dressing for three Residents (#20, #36, and #43) of 17 residents reviewed for resident rights. This deficient practice resulted in the potential for decreased quality of life, increased depression, and feelings of hopelessness and despair. Findings include: Resident #20 Review of Resident #20's Minimum Data Set (MDS) assessment, dated 9/2/21, revealed Resident #20 was admitted to the facility on [DATE] with diagnoses that included cerebrovascular accident (CVA), hemiplegia, depression, and other muscle spasm. Resident #20 was totally dependent on staff for bed mobility, transfers, dressing, toileting, personal hygiene, and bathing, and scored 15 of 15 on the Brief Interview for Mental Status (BIMS), reflective of intact cognition. On 3/28/22 at 2:20 p.m., Resident #20 was observed lying in bed wearing a hospital gown. During an interview at this same time, when asked if she preferred to wear a hospital gown during the day, Resident #20 stated, No, I would like to be dressed. When asked why the Resident did not get dressed, Resident #20 stated, I don't know. On 3/30/22 at 1:44 p.m., Resident #20 was observed lying in bed wearing a hospital gown. When asked about getting dressed, Resident #20 said she would like to get dressed. On 4/4/22 at 9:07 a.m., Resident #20 was observed lying in bed wearing a hospital gown. When asked about getting dressed, Resident #20 said she never gets dressed, and she never gets up in her wheelchair. Resident #20 said she would like to get dressed and be up in the wheelchair. During a telephone interview on 4/4/22 at 11:25 a.m., the facility documented Durable Power of Attorney (DPOA) DD was asked about Resident #20 being dressed and in the wheelchair. DPOA DD said a request was made to get Resident #20 out of bed everyday, but they leave her in the chair for hours which was painful and unable to be tolerated. DPOA DD said Resident #20 was unable to reposition independently in bed. (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 - Few	Review of the Rights of Residents in [Name of State] Nursing Facilities pamphlet, dated 11/28/16 read, in part: Respect and Dignity: You have the right to be treated with respect and dignity .Privacy and Confidentiality: You have the right to personal privacy and confidentiality .You are entitled to privacy, to the extent feasible, in treatment and in caring for personal needs with consideration, respect, and full recognition of your dignity and individuality. 34276 Resident #43 A review of Resident #43's medical record revealed he admitted to the facility on [DATE] with diagnoses including gastrostomy (feeding tube) status, moderate protein-calorie malnutrition, adult failure to thrive, and dementia. A review of the 3/7/22 MDS assessment revealed she was assessed by staff to be severely impaired for cognition. Per this assessment, Resident #43 was totally dependent on one person for eating, had a feeding tube and mechanically altered diet, and had significant weight loss. On 3/30/22 at 12:05 p.m., Resident #43 was observed seated across from the nurse's station with a rolling table positioned in front of her. On the table was her lunch tray of pureed food and regular fluids. Certified Nurse Aide (CNA) N was observed standing in front of Resident #43 holding a spoon of pureed food in front of her face. CNA N put the spoon down and continued to stand in front of Resident #43 looking down at her with her hands on her hips. CNA N continued to offer the same bite of pureed food without describing what the food was or offering any of the other two pureed foods on the plate. On 3/30/22 at 4:00 p.m., RD T and the Director of Nursing (DON) were notified of the observation of Resident #43 being fed in an undignified manner at lunch. The DON and RD T nodded in affirmation of the concern, but provided no comment.

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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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34276 Based on interview and record review, the facility failed to ensure that residents and their families/representatives were invited to attend quarterly care conference meetings for two Residents (#20 and #40) and four confidential Residents (C#1001, C#1003, C#1004, C#1005). This deficient practice resulted in the potential for uncommunicated concerns and lack of coordination and participation in the care provided. Findings include: On 3/29/22 at 3:08 p.m., C#1005 reported that the facility was not inviting him to the quarterly care conferences. C#1005 reported he had been a resident at other facilities where they did do it, but they were not doing it here currently. C#1003 reported he had also not been to any care conference meetings with the different departments including therapy, dietary, nursing, social work, etc. C#1001 and C#1004 agreed that they had also not been invited to any care conference meetings. A review of the facility policy titled, Resident/Family Participation - Assessment/Care Plans reviewed 3/22/22 revealed, Each resident and his/her family members are encouraged to participated in the development of the resident's comprehensive assessment and care plan . 1. The resident and his/her family, and/or the legal representative (sponsor), are invited to attend and participate in the resident's assessment and care planning conference . 35103 Resident #20 Review of Resident #20's Minimum Data Set (MDS) assessment, dated 9/2/21, revealed Resident #20 was admitted to the facility on [DATE] with diagnoses that included cerebrovascular accident (CVA), hemiplegia, depression, and other muscle spasm. Resident #20 was totally dependent on staff for bed mobility, transfers, dressing, toileting, personal hygiene, and bathing, and scored 15 of 15 on the Brief Interview for Mental Status (BIMS), reflective of intact cognition. Review of Resident #20's Care Conference Report printed 3/30/22 by MDS Coordinator Q revealed Resident #20 had her last care conference on 12/2/21, with the previous held on 6/2/21, five months prior. Review of the 12/2/21 care conference progress note read, in part: IDT (interdisciplinary team) met with resident at bedside for quarterly care conference. IDT then called POA as well. Review of 6/2/21 care conference progress note read, in part: IDT met with resident at bedside for significant change care conference. Resident is her own responsible party and did not wish for family to be called for care conference . Previous IDT notes regarding quarterly care conferences for Resident #20, on 4/21/21, 2/9/21 and 8/7/20 all documented as .spoke to POA / or Responsible Party via phone . IDT members present at bedside for care conferences ranged between eight IDT staff on 2/9/21, to three IDT staff on 8/7/20. Resident #20 shared a room with another resident. (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #40 Review of Resident #40's MDS assessment, dated 3/5/22, revealed Resident #40 was readmitted to the facility on [DATE] with diagnoses that included: diabetes mellitus, muscular dystrophy, contracture of right-hand muscle, and muscle weakness. Resident #49 was totally dependent upon staff for bed mobility, transfers, dressing, toilet use, personal hygiene, and bathing, and had a functional limitation in range of motion on one side of his upper extremity. Resident #40 used a wheelchair for mobility. Resident #40 scored 15 of 15 reflective of intact cognition, shared a room with another resident. Review of Resident #40's Care Conference Report, printed 3/30/22 at 12:57 p.m., by LPN/MDS Q, revealed Resident #40 had his last Quarterly Care Conference on 12/6/21. The previous Quarterly Care Conference was five months previous on 6/25/21. All IDT progress notes revealed the IDT met with Resident #40 at his bedside for the Care Conferences. The Care Conference Report listed the following number of people at his bedside for the IDT conference on the following dates: 12/6/21 - four IDT members 6/25/21 - seven IDT members 3/17/21 - seven IDT members 12/18/20 - seven IDT members 9/21/20 - five IDT members

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35103 Based on interview and record review, the facility failed to promote self-determination through facilitation of a resident's choice to take a temporary Leave of Absence (LOA) outside the facility, resulting in the potential for psychosocial harm based on a reasonable person standard, for three Residents (#18, #25, and #40) of 17 residents reviewed for leave of absences. This deficient practice resulted in infringement of the residents right to participate in activities outside of the facility, and feelings of entrapment and seclusion. Findings include: Resident #18 During an interview on 4/4/22 at 8:58 a.m., Resident #18 said she was very upset because she was denied permission to go LOA to a nearby mall on 4/2/22. Resident #18 said she is her own person and they let another Resident (#25) go LOA but because Resident #18 didn't have a staff member to go along, the LOA was denied. Resident #18 stated, I have to tell you I was mad. I am [AGE] years old, and I am my own guardian, and I don't need a babysitter. Resident #18 wanted to know why she was prohibited from leaving the building over the weekend. Resident #18 stated, The facility required someone pick me up at the (facility) door, and drop me off at the door of my destination. If I didn't have that, I could not go out. I could not go to the mall across the road because they said the road (service drive for the mall) was too busy, and I could not get transportation to go such a short distance . Then they (facility staff) came and told me that I couldn't go (LOA) and they would plan an activity sometime - when they (facility staff) want to go somewhere. Review of Resident #18's Minimum Data Set (MDS) assessment, dated 1/14/22, revealed Resident #18 was admitted to the facility on [DATE], with diagnoses that included: diabetes mellitus, anxiety disorder, depression, and polyneuropathy (malfunction of peripheral nerves throughout the body). Resident #18 required extensive one to two-personal physical assistance with bed mobility, transfers, dressing, toilet use, and personal hygiene. Resident #18 used a motorized wheelchair and required supervision, to limited assistance with locomotion in the electric wheelchair. Resident #18 scored 15 or 15 on the Brief Interview for Mental Status (BIMS) reflective of intact cognition. Review of Resident #18's care plans found no interventions to address the desire to participate in activities outside of the facility, including visitation with friends and family, or shopping. During an interview on 4/4/22 at 9:58 a.m., a copy of the LOA policy was requested from Confidential Administrative Staff C#1008. Staff C#1008 said the current LOA policy was in the process of review and revision. When asked about the current process for resident LOAs, Staff C#1008 said the Director of Nursing (DON) and the front office staff coordinate the LOA, and the resident signs in an out. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility Release of Responsibility for Leave of Absence, undated, received from Staff C#1009 on 4/4/22 at 10:02 a.m., revealed the following signature form explanation, in part: I, the undersigned, hereby accept complete responsibility for (Resident Name) while away from [Facility Name] and absolve the management of said facility, its staff and the attending physician of responsibility for any deterioration in condition, or accident that may happen while the resident/patient is away. I understand that a bed will be reserved for the above-named resident/patient when he/she returns or before the appointed date and time. The resident or resident representative would sign in, out, destination address and expected time of return, telephone number, resident signature or responsible person signature, sign in time, and nurse initials. Resident #40 During an interview on 3/28/22 at 2:45 p.m., Resident #40 said the facility was preventing residents from going out of the building, even if they were their own responsible party. Resident #40 said he didn't think that was right, and felt residents should be able to go out if they want to do that. Review of Resident #40's MDS assessment, dated 3/5/22, revealed Resident #40 was readmitted to the facility on [DATE] with diagnoses that included: diabetes mellitus, muscular dystrophy, contracture of right-hand muscle, and muscle weakness. Resident #40 was totally dependent upon staff for bed mobility, transfers, dressing, toilet use, personal hygiene, and bathing, and had a functional limitation in range of motion on one side of his upper extremity. Resident #40 used a wheelchair for mobility, and scored 15 of 15 on the BIMS, reflective of intact cognition. Review of Resident #40's care plans found no interventions to address Resident #40's desire to participate in activities outside of the facility, including visiting with friends and family or shopping. During an interview on 4/4/22 at 2:50 p.m., Resident #40 approached the survey team and stated, that LOAs had been discontinued again. Resident #40 said residents were not even permitted to leave once a day. If they were allowed to leave the requirements were so stringent if felt like Fort [NAME]. Resident #40 said there was a sign at the front desk regarding the suspension of LOAs. Resident #25 During an interview on 4/4/22 at approximately 11:10 a.m., Resident #25 confirmed he had gone LOA on 4/2/22 with his girlfriend. Resident #25 stated, It was absolutely wonderful. Resident #25 said that all LOAs had been prohibited before the survey team had arrived the previous week. Resident #25 said his girlfriend called the facility that morning (4/4/22) and being told that LOAs were no longer allowed, and informed that she could not take him out of the facility that day (4/4/22). Resident #25 was unsure as to why the LOAs were once again being denied to facility residents. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/4/22 at 11:55 a.m., Receptionist VV was asked if she had spoken with Resident #25's girlfriend via telephone this morning (4/4/22) and told her that LOAs were not taking place at this time because of an event that happened with a resident over the weekend (on 4/2/22). Receptionist VV stated, I told her there was an unpleasant resident event this weekend, and unfortunately because of that, LOA was discontinued at this time. I told her I could not tell her when it would be reinstated, but it should not be very long, and it was due to an unfortunate event that involved residents. During an interview on 4/4/22 at 12:05 p.m., when asked about LOAs, the Nursing Home Administrator (NHA) said that resident's physicians will now have to be involved. The NHA stated, It is getting scary to let residents go LOA. The NHA confirmed facility residents were denied LOA until last week after the recertification survey was initiated, and the facility allowed at least one person LOA over the weekend. The NHA restated, LOA privileges are now not allowed until the physician is more involved in LOA's. Review of the four-page Your Rights and Protections as a Nursing Home Resident, undated, provided by the facility read, in part: .Nursing homes can't keep you apart from everyone else against your will . Leave the Nursing Home: Leaving for visits: If your health allows, and your doctor agrees, you can spend time away from the nursing home visiting family or friends during the day or overnight, called a 'leave of absence.' Talk to the nursing home staff a few days ahead of time so the staff has time to prepare your medicines and write your instructions . Review of the Centers for Medicare & Medicaid Services, QSO-20-39-NH Memo, revised 3/10/22, revealed the following in part: . Facilities must permit residents to leave the facility as they choose. Should a resident choose to leave, the facility should remind the resident and any individual accompanying the resident to follow all recommended infection prevention practices . During an interview on 4/4/22 at 3:15 p.m., Confidential Administrative (Staff) C1008 was asked about any concern with the LOAs being suspended and prohibited for all facility residents at that time. Staff C1008 stated, I do consider it a violation of residents rights.

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents have reasonable access to and privacy in their use of communication methods. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35103 Based on observation, interview, and record review, the facility failed to ensure the resident right to privately and confidentially send and receive mail for five confidential Residents (#C1001, #C1002, #C1003, #C1004, and #C1005) of 17 residents reviewed for mail privacy. This deficient practice resulted in resident letters and packages being opened by the facility prior to delivery to the resident, and a loss of personal privacy and independence. Findings include: Resident #C1002 Review of Resident #C1002's Minimum Data Set (MDS) assessment, dated 1/14/22, revealed Resident #C1002 was admitted to the facility on [DATE], with diagnoses that included: diabetes mellitus, anxiety disorder, depression, and polyneuropathy (malfunction of peripheral nerves throughout the body). Resident #C1002 required extensive one to two-personal physical assistance with bed mobility, transfers, dressing, toilet use, and personal hygiene. Resident #C1002 scored 15 or 15 on the Brief Interview for Mental Status (BIMS) reflective of intact cognition. Review of Resident #C1002's Physician Order report, retrieved on 3/29/2022 at 9:50 a.m., revealed the following Physician Order: Check incoming packages or personal items delivered for sharp objects. Every Shift . Start Date: 12/14/2021, End Date: Open Ended. Review of Resident #C1002's Care Plans found no reference to checking or opening mail being delivered to this Resident. During an interview on 4/4/22 at 8:58 a.m., Resident #C1002 was asked if facility staff opened mail or packages addressed to the Resident. Resident #C1002 confirmed the facility did open her incoming packages to verify the contents. During an interview on 4/4/22 at 4:31 p.m., Confidential Administrative Staff #C1008 was asked about the physician order searching a resident packages. Staff #C1008 stated, I don't think that is right. I think that permission (to open mail/packages) would have to be initiated by the resident. Review of the facility Mail/Package Screening policy, dated 3/6/22, revealed the following, in part: . 5. Opening of Resident Mail: . 5. Mail from federal or state agencies will not be opened. To prevent the spread of contaminated mail reaching our resident population, and only upon the written consent from the residents, suspicious items may be opened. The resident's incoming mail (e.g., letters, handwritten notes, get well cards, insurance papers, gift boxes, etc.) will not be opened before delivery to the resident . Resident #C1005 (continued on next page)

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and observation on 4/4/22 at 2:50 p.m., Resident #C1005 presented a copy of a letter from the Social Security Administration that had been opened by the business office prior to distribution to the Resident. Resident #C1005 said he did not receive the envelope with the letters, which was observed by all members of the survey team. Resident #C1005 stated, The Business Office lady who keeps track of the money gave me the letter with no envelope .(she) said anything from Social Security we open it up. Resident #C1005 appeared upset with animated hand movements and rapid speech. Resident #C1005 said it was not right to open people's mail. During an interview on 4/4/22 at 3:01 p.m., Business Office Manager (BOM) J confirmed she had opened Resident #C1005's confidential mail prior to distributing it to the Resident. The BOM also confirmed there was a physician order to open the Resident's packages. Review of [Facility Name] Residents' Rights policy, undated, revealed the following, in part: .A patient or resident is entitled to .send and receive personal mail unopened on the same day it is received at the health facility or agency, unless medically contraindicated as documented in the medical record by the attending physician .the right to independent personal decisions and the right to knowledge of available choices shall not be infringed . 34276 On 3/29/22 at 3:08 p.m., C#1005 reported that staff had been opening their packages for .security purposes. C#1001, C#1002, C#1003, and C#1004, agreed that they had their packages opened or had witnessed it being done to other residents. On 3/31/22 at 10:05 a.m., Receptionist VV was asked about who delivered the mail and reported it was either the BOM/Staff J or the activities department. On 3/31/22 at 10:06 a.m., Staff J was asked about mail delivery and reported that the business office only got and opened mail related to Resident bills or financial stuff. On 3/31/22 at 10:12 a.m., Activities Director AAA was if any residents were complaining of their mail and packages being opened. Activities Director AAA reported, I don't know a lot about it but the Residents have been telling me that. I'm not doing it. I don't know who is. On 3/31/22 at 10:15 a.m., Activities Aide ZZ was asked about the opened mail and packages and stated, I've never witnessed anybody doing it since I started (in February 2022). They told me it was happening, but I don't know who was doing it. Maybe the Business office.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34276 Based on interview and record review, the facility failed to ensure that 1) Residents/Representatives were offered the opportunity to complete an advanced directive for one Resident (#95) and 2) failed to ensure the advanced directive was completed correctly and signed by the appropriate party for one Resident (#20) out of six residents reviewed for advanced directives. This deficient practice resulted in the potential for undesired outcomes related to code status, hospitalization , and end of life care. Findings include: Resident #95 A review of Resident #95's medical record revealed he admitted to the facility on [DATE] with diagnoses including down syndrome, chronic obstructive pulmonary disease (COPD), viral pneumonia related to COVID-19, and dementia. Resident #95 expired in the facility on [DATE]. A review of Resident #95's record revealed Resident #95's Guardian (Guardian XX) signed a Do Not Resuscitate (DNR) order on [DATE]. There was no Advanced Medical Treatment Directive signed delineating what guidelines of treatment were desired, including the use of antibiotics, IV fluids, Enteral Feeding, hospitalization , Oxygen, Ventilation, or Blood Transfusion. A review of a document included in Resident #95's Electronic Medical Record (EMR) from his previous admission, dated [DATE], revealed that previously Guardian XX had desired all of the above treatments be used. On [DATE] at 3:17 p.m., a phone interview was conducted with Guardian XX. When asked about the desired advanced directives for Resident #95, Guardian XX reported that Resident #95 was put on hospice services when he admitted to the facility and that he (Guardian XX) had signed a DNR order. Guardian XX reported that no staff at the facility had offered for him to make an advance directive to include which treatments (such as hospitalization) he wanted for Resident #95. Guardian XX reported that he was not aware of Resident #95's sudden decline on [DATE] until after Resident #95 had already expired. The facility failed to offer the opportunity for Guardian XX to send Resident #95 to the hospital. A review of the facility policy titled, Advance Directives reviewed on [DATE] revealed, 1. Prior to or upon admission of a resident to our facility, the Social Services Director or designee will provide written information to the resident concerning his/her right to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment, and the right to formulate advance directives . 3. Prior to or upon admission of a resident, the Social Services Director or designee will inquire of the resident, and/or his/her family members, about the existence of any written advance directives . 10. If the Resident or representative refuses treatment, the facility and care providers will: . Document specifically what the resident/representative is refusing . 35103 Resident #20 (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #20's Minimum Data Set (MDS) assessment, dated [DATE], revealed Resident #20 was admitted to the facility on [DATE] with diagnoses that included cerebrovascular accident (CVA), hemiplegia, depression, and other muscle spasm. Resident #20 scored 15 of 15 on the Brief Interview for Mental Status (BIMS), reflective of intact cognition. Review of Resident #20's Face Sheet, retrieved from the EMR on [DATE] at 10:48 a.m., revealed the following, in part: Resident Face Sheet: [Resident #20's Name] (Full Code) at the top of every sheet. The Face Sheet also identified Resident #20 was participating in Hospice services in the facility, with her latest return to the facility on [DATE]. Review of Resident #20's Physician Orders retrieved from the EMR on [DATE] at 10:25 a.m., revealed the following orders, in part: Code Status: FULL CODE, Start Date: [DATE], End Date: Open Ended. Review or Resident #20's Care Plans, Last Reviewed/Revised: [DATE] at 8:01 a.m., by Licensed Practical Nurse (LPN)/MDS Coordinator Q read in part: Care Plan - [Resident #20's Name] (Full Code) . No reference of a change to DNR was noted in the care plan. Review of Resident #20's [State Name] General Procedures, DO-NOT-RESUSCITATE, signed [DATE] by Resident #20's Durable Power of Attorney (DPOA), contained no physician signature or date of physician signature. A copy of this same form was signed by the physician on [DATE], with handwritten instructions of the DPOA to include: Please allow for the following: Antibiotics, IV Fluid, Oxygen, [DPOA Signature], and Date of [DATE]. Review of the facility Advanced Medical Treatment Directive, dated originally [DATE], was absent a physician signature, and included both of the following instructions: A. Cardiopulmonary resuscitation will be performed (checked as requested), and B. DNR/DNI (handwritten on the document) . Review of the Advance Directives policy, dated [DATE], revealed the following, in part: The plan of care for each resident will be consistent with his or her documented treatment preferences and/or advance directive . 12. In accordance with current OBRA (Omnibus Budget Reconciliation Act) definitions and guidelines governing advance directives, our facility has defined advanced directives as preferences regarding treatment options and include, but are not limited to: .l. Do Not Resuscitate - indicates that, in case of respiratory or cardiac failure, the resident, legal guardian .has directed that no cardiopulmonary resuscitation (CPR) or other life-sustaining treatments of methods are used . The Interdisciplinary Team will conduct ongoing review of the resident's decision-making capacity and communicate significant changes to the resident's legal representative. Such changes will be documented in the care plan and medical record. 16. Changes or revocations of a directive must be submitted in writing to the Administrator .The Care Plan Team will be informed of such changes and/or revocations so that appropriate changes can be made in the resident assessment (MDS) and care plan . During an interview on [DATE] at 4:18 p.m., the Nursing Home Administrator (NHA) and Director of Nursing (DON) where asked to review the facility Advanced Medical Treatment Directive where both CPR and DNR are noted on the form. The NHA acknowledged both should not be checked as applicable on the form, and said Social Worker (SW) G was working on correcting the Advanced Directive.

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	235719	A. Building B. Wing	04/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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** 34276 Based on observation, interview, and record review, the facility failed to ensure that the environment was clean and homelike, being cleaned regularly, and well maintained, affecting all 45 residents residing in the facility. This deficient practice resulted in soiled carpeting in the hallways and resident rooms, as well as damaged doors and multiple holes in the carpet. Findings include: On 3/29/22 at 7:55 a.m., Resident #95's room was observed with large areas of food or some gray-brown substance crusted on the floor near the wall and around the bed. On 3/29/22 at 8:13 a.m., a large area of damaged carpet was observed outside of the north medication room. On 3/29/22 at 3:08 p.m., C#1005 reported that since he had been residing in the building (over a year), the floors had only been deep cleaned one time. C#1003 reported that he had never seen the floors being deep cleaned, but when he asked why it wasn't happening, he was told that the floor cleaner was broken. C#1002, C#1004, C#1006, and C#1007 agreed that the floors were not being cleanedand that they were soiled. On 3/29/22 at 5:31 p.m., Resident #15 was observed in bed. The thermometer above her bed was pulled out of the wall and was hanging into her bed. On 3/30/22 at 8:17 a.m., black debris was observed stuck into the carpet outside of room [ROOM NUMBER]. Bleach spots in the carpet and stained areas were observed throughout the north and south hallways, as well as in the resident rooms. There were gouges in the carpet outside of room [ROOM NUMBER]. Red spills on the carpet were observed outside of room [ROOM NUMBER]. Large brown stains were observed on the floor in the hallways between rooms [ROOM NUMBERS]. A review of the facility policy titled, (Name of Facility) Environmental Services Policy and Procedure Manual most recently reviewed on 4/10/2020 revealed, . Carpeting and Cloth Furnishings. A. Vacuum carpeting in public areas of health-care facilities and in general patient-care areas regularly with well-maintained equipment designed to minimize dust dispersion . B. Periodically perform a thorough, deep cleaning of carpeting as determined by facility policy by using a method that minimizes the production of aerosols and leaves little or no residue . C. Avoid use of carpeting in high-traffic zones in patient-care areas or where spills are likely . G. Carpeted areas in patient rooms will be cleaned using Virex (all-purpose disinfecting cleaner) disinfectant on a monthly basis and as needed . 35103 (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 3/30/22 at 9:40 a.m., Housekeeping Aide (Staff) JJ said the facility carpet cleaner was broken when he began work at the facility, about a month ago. Staff JJ was observed as he exited a carpeted North side resident room and moved to the South side with the carpet cleaner machine. Staff JJ said he had just completed cleaning the first room with the repaired carpet cleaner, and he had never completed cleaning all the facility carpets because the carpet cleaner had been broken. He said there was one other room to clean on 3/30/22. Review of the facility Staff List with Hire Dates, received from the facility revealed Staff JJ was hired on 1/26/22 as a Housekeeping Aide. On 3/30/22 at 9:45 a.m., Housekeeping Supervisor (Staff) U approached Staff JJ and this Surveyor. Staff U confirmed the carpet cleaner had been broken and not in use until today, but neither Staff JJ or Staff U had any idea how long the carpet cleaner was broken. When asked what carpet cleaning solution was being used in the machine, Staff U went to get a container of the cleaning product in use in the machine: [Name Brand] Extraction Cleaner. On the carpet cleaner machine was a clear bottle with a pink top that Staff JJ said was the [Name Brand] Extraction Cleaner. The bottle was not labeled or dated when the cleaning product was placed into the bottle. Staff U returned with a one-gallon bottle of the Extraction Cleaner and indicated this was the product used for cleaning the facility carpets. When Staff JJ was asked how much of the Extraction Cleaner was used to clean the carpet, Staff JJ stated, Approximately 3/4 of the (gallon) container, up to the line below the handle of the gallon bottle. Staff JJ' said he used three-quarters of the container that is poured into the machine and adds approximately 4-5 gallons of water. Review of the [Name Brand} Extraction Cleaner product label included the following, in part: For Portable Extractor Use: Dilute 5 oz. of Extraction Cleaner per 5 gallons cold water - always vacuum carpet to remove loose soil and pre-spot carpet prior to cleaning. Review of the Carpet Cleaner Instructions for Use, copyright 2017, received from the facility Director of Facilities (Staff) SS on 3/31/22 at 10:16 a.m., revealed the following, in part: NOTE: Read all instructions before using this machine . Do not use the machine within range of persons unless they wear protective clothing . During an interview on 3/31/22 at 10:16 a.m., Staff SS said he began work at the facility in January (1/13/22) and was unaware of any contracted carpet cleaning that had been performed in the facility since that time. During an interview on 3/31/22 at 10:26 a.m., Staff U said the carpet cleaner had been broken for a long time. Staff U began work January 29th, 2022 and said they did not have the carpet cleaner when she started. Staff U stated, All the rooms need to be cleaned. Staff JJ was the only guy and we were so short-staffed and [Staff JJ] didn't have time to do what he needed to do . [Staff JJ] was getting overwhelmed . If the carpet is not clean - the (resident) room is not clean. Staff U acknowledged Staff JJ had not been given any instruction on how to use the carpet cleaner and said there were no instructions in the back room (by the carpet cleaner). Staff U said the carpet cleaner repair contractor was supposed to bring some material so he (Staff JJ) can read it and get some education on the carpet cleaner. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 3/31/22 at 10:56 a.m., a telephone interview was conducted with janitorial and equipment repair Contractor TT regarding the carpet cleaner. Contractor TT confirmed the broken carpet cleaner was picked up from the facility on February 10th and returned to the facility on [DATE]th. Contractor TT stated, We handle their (facilities) janitorial and environmental equipment. Contractor TT was unaware of how the the carpet cleaner had been broken prior to being picked up February 10th, 2022. Review of the Resident Rights policy, dated 3/11/22, revealed the following, in part: Federal and state laws guarantee certain basic rights to all residents of this facility. These include the following resident's rights: . to a safe, clean, comfortable, and homelike environment, including but not limited to receiving treatment and support for daily living .

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35103 Based on interview and record review, the facility failed to report a fall with major injury (hip fracture) during peri care to the State Agency for one Resident (#20) of two residents reviewed for inadequate supervision to prevent a fall. This deficient practice resulted in the potential for continuation of inadequate supervision during cares. Findings include: Review of a Fall Event Report, dated 12/2/21 at 6:19 p.m., revealed the following in part: CNA reported to writer that in the middle of peri care residents' upper body was too close to the edge of the bed and she was sliding off the bed. CNA lowered resident to the floor and called for help . The progress note said the Physician, family, and DON (Director of Nursing) were notified at that time (12/2/21 at 4:42 p.m.). Notification specified on the Event Report document NO to Attending Faxed, Physician Notified, Resident Representative Notified, and Care Plan Reviewed. The CNA involved was not identified in the report. Review of Resident #20's Minimum Data Set (MDS) assessment, dated 9/2/21, revealed Resident #20 was admitted to the facility on [DATE] with diagnoses that included cerebrovascular accident (CVA), hemiplegia, depression, and other muscle spasm. Resident #20 was totally dependent on staff for bed mobility, transfers, dressing, toileting, personal hygiene, and bathing, and scored 15 of 15 on the Brief Interview for Mental Status (BIMS), reflective of intact cognition. Review of Resident #20's progress notes revealed the following, in part: 12/3/21 5:59 p.m., Received a report resident tested positive for Covid (presumptive) awaiting results for PCR. Patient alert, oriented, weak complains of feeling weak and reports pain (6) on Hip post fall 12/2/2021 . [Physician] notified .Order to send patient out to Hospital. 12/17/21 8:20 p.m., readmitted on 14-day observation post covid and Hemiarthroplasty hip . During an interview on 4/4/22 at 3:15 p.m., the Nursing Home Administrator (NHA) and DON confirmed this fall with major injury (hip fracture) and potential neglect during peri care was not reported to the State Agency because it was observed. Review of the facility Resident Abuse/Neglect policy, revised 3/9/22, revealed the following, in part: Incidents involving alleged, suspected or actual abuse (including misappropriation or exploitation) or resulting in serious bodily injury to the patient (including injuries of unknown origin, shall be reported to the state immediately, but not more than 2 hours after forming the suspicion .

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35103 Based on interview and record review, the facility failed to fully investigate a fall with major injury (hip fracture) during pericare for one Resident (#20) of two residents reviewed for inadequate supervision to prevent a fall. This deficient practice resulted in the potential for continuation of inadequate supervision during cares repeated injury for facility residents. Findings include: Review of a Fall Event Report, dated 12/2/21 at 6:19 p.m., revealed the following in part: CNA reported to writer that in the middle of peri care residents' upper body was too close to the edge of the bed and she was sliding off the bed. CNA lowered resident to the floor and called for help . The progress note said the Physician, family, and DON (Director of Nursing) were notified at that time (12/2/21 at 4:42 p.m.). Notifications specified on the Event Report documented NO to Attending Faxed, Physician Notified, Resident Representative Notified, and Care Plan Reviewed. The CNA involved was not identified in the report. Review of Resident #20's Minimum Data Set (MDS) assessment, dated 9/2/21, revealed Resident #20 was admitted to the facility on [DATE] with diagnoses that included cerebrovascular accident (CVA), hemiplegia, depression, and other muscle spasm. Resident #20 was totally dependent on staff for bed mobility, transfers, dressing, toileting, personal hygiene, and bathing, and scored 15 of 15 on the Brief Interview for Mental Status (BIMS), reflective of intact cognition. Review of Resident #20's progress notes revealed the following, in part: 12/3/21 5:59 p.m., Received a report resident tested positive for Covid (presumptive) awaiting results for PCR. Patient alert, oriented, weak complains of feeling weak and reports pain (6) on Hip post fall 12/2/2021 . [Physician] notified .Order to send patient out to Hospital. 12/17/21 8:20 p.m., readmitted on 14-day observation post covid and Hemiarthroplasty hip . During an interview on 4/4/22 at 3:15 p.m., the Nursing Home Administrator (NHA) and DON were asked for the investigation file, including identification of the staff members involved, witness statements, and an investigative summary of the facilities findings. The NHA and DON confirmed there were no witness statements or investigation documentation for this fall with major injury (hip fracture) and potential neglect during peri care because the incident had been witnessed. Review of the facility Resident Abuse/Neglect policy, revised 3/9/22, revealed the following, in part: ABUSE INVESTIGATIONS: 1. Should an actual, suspected or alleged incident (of) resident abuse, mistreatment, neglect or injury of unknown source be reported, the Administrator, or his/her designee, will initiate investigation of . the incident .6. The individual conducting the investigation will, as a minimum: a. Review the completed documentation forms; b. Reviewed the resident's medical record to determine events leading up to the incident; c. Interview the person(s) reporting the incident; d. Interview any witnesses to the incident; e. Interview the resident . g. Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident . 8. Witness statements will be obtained in writing. Witnesses will be required to sign and date such reports .18. The Administrator will provide a written report of the results of all abuse investigations and appropriate action taken to the state survey and certification agency .

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prepare residents for a safe transfer or discharge from the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38328 Based on interview and record review the facility failed to ensure a safe discharge was provided for one Resident (#45) of one resident reviewed for discharge/transfers. This deficient practice had the potential to disrupt the necessary care and services and the potential for re-hospitalization . Findings include: A review of the face sheet for Resident #45 revealed admission to the facility on [DATE] at 5:03 p.m. Resident #45 was discharged from the facility on 1/17/22 at 5:00 p.m. Diagnoses included cerebral infarction (stroke) due to thrombosis (clot) of left posterior cerebral artery, hypertensive heart disease without heart failure, polyneuropathy (damage or disease of nerves), dysarthria (speech and sound disorder), and hemiplegia (paralysis of one side of the body). Resident #45 had an approximate 6-day stay at the facility. On 3/31/22 at 10:30 a.m. during an interview, Licensed Practical Nurse (LPN) A stated Resident #45 was really doing well and had no issues he was aware of during their stay. On 3/31/22 at 11:16 a.m., during an interview, LPN E stated before Resident #45 admitted to the facility, he remembered the family expressed to him they wanted a facility closer to the family. When asked if LPN E had any involvement in the discharge or the Against Medical Advice (AMA) process done for Resident #45, LPN E stated former Social Worker (SW) K was the one who had gone through the AMA process with Resident #45 and her family. On 3/31/22 at 11:24 a.m., during an interview, the Director of Nursing (DON) stated the Durable Power of Attorney (DPOA) was the one who had taken Resident #45 to another facility. The DON stated the transfer to the (named) facility was the DPOA's choice. The DON stated, It wasn't supposed to be an AMA discharge, it was supposed to be a planned discharge., The DON stated the DPOA obtained her own transport van and showed up at the facility to transfer Resident #45. The DON stated the DPOA told the facility she wanted Resident #45 transferred to another facility and she was not willing to wait until the planned discharge which would have occurred on approximately 1/19/22. The DON stated the facility offered to provide paperwork and medications and the family didn't want to wait. On 3/31/22 at 12:11 p.m. during a follow-up interview, the DON was asked to confirm if medications were offered to be sent with Resident #45 upon discharge. The DON confirmed medications were offered, but the DPOA refused to take them. The Electronic Medical Record (EMR) was devoid of any documentation relating to this or any other details leading up to the discharge on 1/17/22, except as below. A review of the Progress Notes for Resident #45 revealed the following: (continued on next page)

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/17/2022 03:56 PM Sw (social worker) received call from DPOA at 4:00 p.m. stating she is transferring resident to (Named facility) today at 4:30- sw (social worker) explained that there is a process to transferring resident's to other facilities and a referral needs to be sent to that facility, sw and their admissions need to communicate to be assured that they were actually accepted and can provide appropriate care for the resident. Admin (Nursing Home Administrator (NHA)), DON and sw discussed and due to not being notified of transfer until now, this will be an AMA discharge. AMA fully explained to DPOA and we explained why this is an AMA discharge. DPOA voiced understanding. AMA paper provided to nurse and nurse made aware of AMA transfer. Social Services (SW K) On 3/31/22 at 12:14 p.m., during an interview, SW K stated Resident #45 gave them little notice of the desired transfer and stated the family indicated they would be picking up Resident #45 in approximately 30 minutes. SW K stated she was instructed not to send any information or medications to the receiving facility by the Nursing Home Administrator (NHA). SW K stated she was instructed by the NHA to treat the discharge as an AMA. When asked if attempts were made to contact the receiving facility to ensure a safe discharge, SW K stated she did not recall if she had done so. When asked if this AMA discharge was then reported to Adult Protective Services (APS), SW K did not respond. On 3/31/22 at 12:37 p.m., during an interview, the NHA denied directing SW K to discharge the resident AMA and stated she did not find out about the discharge until after Resident #45 had left. The NHA stated SW K was terminated due to lack of communication on family needs and other aspects of social work including discharge planning. The NHA stated there would not be a recapitulation of stay because Resident #45 was considered discharged AMA. On 3/31/22 at 7:30 p.m., during a phone interview, DPOA L made the following pertinent statements: DPOA L stated she had communicated with SW K about the family wanting to move Resident #45 on several occasions prior to discharge and asked SW K how the process worked. DPOA L stated SW K informed her of the need for a referral to be sent to the receiving facility, and asked SW K to do so for (Named Facility). DPOA L was informed there was not a bed available at (Named Facility) and then decided on (Current Facility) and communicated this to SW K. DPOA L stated she assumed SW K would have sent the referral to (Current Facility) she had selected and then called the facility approximately 2 hours prior to coming to pick up Resident #45 for the transfer to the new facility. The floor nurse stated Resident #45 would be ready and indicated no problem with the discharge at that time. A transport vehicle had to be rented because the facility did not have transportation available, and DPOA L arrived at the facility sometime after 4:00 p.m. DPOA L was denied entry to the facility and the (unidentified) staff member who denied her entry called SW K to discuss the transfer of Resident #45 because SW K had already left for the day. The unidentified staff member returned and told DPOA L she would have to sign out Resident #45 AMA. DPOA L stated she refused to sign the AMA form and the unidentified staff member informed DPOA L, since she would not sign it (paperwork), someone at the facility would. She took her family member to (Current Facility) and stated no paperwork or medications were offered or received on discharge from the facility. The main issue at the facility was a lack of communication. On 4/4/22 at 5:00 p.m., during a follow-up interview, the NHA was asked to provide the AMA form for Resident #45 referred to in the EMR. The NHA stated the AMA form could not be found. (continued on next page)

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN E and SW K were aware of the DPOA for Resident #45's wishes to move to an alternative facility. No discharge planning, documentation of contacting prospective facilities, evaluation of transfer to another facility being an unsafe discharge, or contact with Adult Protective Services (APS) regarding facility's determination of an unsafe discharge was documented as required in the policy below. A review of the facility policy Discharge Planning, with a review date of 3/11/22 read in part: It is the policy of this facility to develop and implement an effective discharge planning process that focuses on the resident's discharge goals . . 3. If discharge to community is determined to not be feasible, the facility will document in the clinical record who made the dete1mination (sic) and why. 4. In cases where the resident wishes to be discharged to a setting that does not appear to meet his or her post -discharge needs, or appears unsafe, the interdisciplinary team will treat this situation similarly to refusal of care: a. Discuss with the resident, (and/or his or her representative, if applicable) and document the implications and/or risks of being discharged to a location that is not equipped to meet his/her needs and attempt to asce1tain (sic) why the resident is choosing that location. b. Offer other, more suitable, options of locations that are equipped to meet the needs of the resident. Document any discussions related to the options presented. c. Document refusals of other options that could meet the resident's needs. d. At the time of discharge, follow policies regarding discharges Against Medical Advice, and refer to Adult Protective Services (or other state entity charged with investigating abuse and neglect), as necessary . . 8. The facility will document any referrals to local contact agencies or other appropriate entities made for the purpose of the resident's interest in returning to the community . . 10. The facility will assist residents and their representatives in choosing an appropriate post acute provider . that will meet the resident's needs, goals, and preferences . . 12. The evaluation of the resident's discharge needs and discharge plan will be completely documented on a timely basis in the clinical record . . 14. Education needs; as identified in the discharge plan, will be provided to the resident and/or family member prior to discharge. 15. Prior to discharge, an order to discharge will be obtained from the resident's attending physician .

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34276 Based on interview and record review, the facility failed to ensure that one newly admitted Resident (#95) had an appropriate physician ordered diet out of 17 residents reviewed for physician orders. This deficient practice resulted in the resident receiving the wrong level of thickened liquids for his diet resulting in aspiration pneumonia. Findings include: On [DATE] at 10:32 a.m., Resident #95 was observed in bed in his room with the blanket over his head. Resident removed the blanket from his head and took a sip from the pre-packaged cup of nectar thick juice from his bedside table. After drinking the juice Resident #95 began to cough and struggle to clear his throat. A review of Resident #95's medical record revealed he admitted to the facility on [DATE] with diagnoses including down syndrome, chronic obstructive pulmonary disease (COPD), viral pneumonia related to COVID-19, and dementia. Resident #95 expired on [DATE] before a comprehensive MDS could be completed. A review of Resident #95's physician order for diet dated [DATE] revealed, Diet: Puree with thick liquids and NO STRAW. This diet order did not indicate what the level of thickness should be for the fluids. This order was documented by RN BBB On [DATE] at 4:00 p.m., Resident #95's diet order for thickened liquids was reviewed with RD T and the Director of Nursing (DON). When asked about the diet order stating just thickened liquids and not specifying honey thick or nectar thick, RD T reported she would review the issue and follow up. The DON was asked what the process was if the facility was unsure of a diet order. The DON reported they would call the discharging facility or do a speech therapy screen. On [DATE] at 1:07 p.m., an interview was conducted with Speech Language Pathologist (SLP) WW. When asked if he had evaluated Resident #95 for his diet and liquids, SLP WW reported he had not, as Resident #95 was on hospice. SLP WW' reported when residents admit to the facility on hospice speech therapy staff usually just does a screen. SLP WW could not say why a screen had not been ordered for Resident #95. On [DATE] at 4:50 p.m., RD T reported that previously, Resident #95 was on honey thickened liquids during his summer 2021 admission, and she had downgraded him to honey thickened liquids until he could be seen by Speech therapy. A review of a hospital discharge document for Resident #95 prior to his admission to the facility (dated [DATE]) revealed .Adult diet: . Pureed; Fluid Consistency: Honey Thick; Additional Restrictions: No Straws, 1:1 Feed . This document revealed Resident #95 should have been on a honey thick consistency for liquids and not nectar thickened for his entire admission. On [DATE] at 2:52 p.m., an interview was conducted with SLP WW who reported he had evaluated Resident #95 on [DATE] and that Resident #95 required a Pureed and honey thick liquid diet. SLP WW also reported the Resident did require supervision for feeding. (continued on next page)

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 3:24 p.m., a phone interview was conducted with RN P regarding Resident #95's admission. RN P reported she was just the charge nurse that helped with the admission. When asked where his diet order came from, RN P reported she assumed it came from the discharge paperwork. RN P reported if they don't get a diet from the discharging hospital they put in an order for a swallowing evaluation. On [DATE] at 3:43 p.m., a phone interview was conducted with RN BBB who reported it she was on the unit Resident #95 admitted to. RN BBB reported that she normally gets the diet orders from the hospital records, but if it's not there they would request a speech evaluation. RN BBB reported she didn't remember putting his orders in. On [DATE] at 4:18 p.m., the Administrator and the DON were asked about Resident #95 receiving nectar thick liquids when his discharge orders were for honey thickened. The DON then stated, Nurses can do swallow evals . It's a standard of practice. When asked to clarify, the Administrator reported the staff should have called the doctor or speech therapy staff if they weren't sure on the diet orders. A review of the facility policy titled, Admissions/Physician Role reviewed by the facility on [DATE] revealed, . 16. The nursing staff will obtain all orders needed at the time of admission from the attending physician . A review of the facility policy titled, Admission Assessment last reviewed by the facility on [DATE] revealed, 1. When a resident is admitted to the nursing unit, the admitting Nurse must document the following information . in the nurses' notes, admission form, or other appropriate place . k. The time the Dietary Department was notified of the diet order; .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 35103 Based on interview and record review, the facility failed to implement comprehensive person-centered care plans with measurable objectives and timeframes for four Residents (#18, #19, #43, and #95) of 17 residents reviewed for a comprehensive care plan. This deficient practice resulted in the potential for unaddressed resident needs, preferences, and goals to promote the highest practicable physical, mental, and psychosocial well-being. Findings include: Resident #18 Review of Resident #18's Minimum Data Set (MDS) assessment, dated [DATE], revealed Resident #18 was admitted to the facility on [DATE], with diagnoses that included: diabetes mellitus, anxiety disorder, depression, and polyneuropathy (malfunction of peripheral nerves throughout the body). Resident #18 required extensive one to two-personal physical assistance with bed mobility, transfers, dressing, toilet use, and personal hygiene. Resident #18 used a motorized wheelchair and required supervision to limited assistance with locomotion in the electric wheelchair. Resident #18 scored 15 or 15 on the Brief Interview for Mental Status (BIMS) reflective of intact cognition. During an interview on [DATE] at 8:58 a.m., Resident #18 said she was very upset because she was denied permission to go LOA (Leave of Absence) to a nearby mall this weekend. Resident #18 said she is her own person and they let another Resident (#25) go LOA but because Resident #18 didn't have a staff member to go along, the LOA was denied. Resident #18 stated, I have to tell you I was mad. I am [AGE] years old, and I am my own guardian, and I don't need a babysitter. Review of Resident #18's care plans found no interventions to address the desire to participate in activities outside of the facility, including visitation with friends and family or shopping. Review of Resident #18's Activity Care Plan revealed all documentation including interventions within the care plan were initiated, and last reviewed/revised on [DATE]. The following Approaches (interventions) were never completed to specify Resident #18's goals, preferences, and desires: Activities of Choice - none identified. Arrange visits by staff - none identified, and no timeframe provided. Encourage resident to become involved with activities _____ (special events and social gatherings) - not completed with Resident #18's preferences. Inform resident of upcoming activities by: _____ . - not completed with Resident #18's preferences. Involved residents with those who have shared interests - interests not identified. Provide opportunity for resident's expression of individuality - not specified or identified. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide setting in which activities are preferred: _____ - not completed with Resident #18's preference. All other care plan Problems and Approaches were initiated on [DATE] prior to Resident #18's admitted listed on the Care Plans as [DATE]. Resident #19 Review of Resident #19's Minimum Data Set (MDS) assessment, dated [DATE], revealed Resident #19 was admitted to the facility on [DATE], with diagnoses that included: stroke, deep vein thrombosis (DVT), cerebrovascular accident (CVA), hemiplegia (paralysis of one side of the body), depression, and dysarthria (unclear articulation of speech) and dysphagia (difficulty swallowing). Resident #19 required extensive one-person assistance with bed mobility, transfers, walking in room, dressing, toilet use, personal hygiene, and was totally dependent upon staff for bathing. Resident #19 scored 13 of 15 on the BIMS reflective of intact cognition. Resident #19's ADL Functional/Rehabilitation Potential care plan was started on [DATE], after admission on [DATE]. The Admission MDS assessment was completed [DATE]. The comprehensive MDS assessment findings were not consistent with the initial care plan provided for Resident #19. And it appeared the Care Plans were not based on the MDS comprehensive assessment. Resident #19 had no Activity Care Plan present in the medical record, and review of the [DATE] Admission MDS assessment revealed Section F Preferences for Customary Routine and Activities was documented as 0 NO (for completion), (resident is rarely/never understood and family/significant other not available). Review of Resident #19's [DATE] Communication Care Plan read, in part: Resident has unclear speech d/t (due to) CVA; is able to communicate but has some difficulty. During an interview on [DATE] at 9:01 a.m., Resident #19 said he made a mess of breakfast, and stated, It is nice to see you. Communication was slow, but he was able to understand others and be understood. The MDS assessment (referred to above) documented Resident #19 was totally dependent upon one person for bathing which the [DATE] Care Plan said ,d+[DATE] person assist as needed; MDS bed mobility was extensive one-person assist, Care Plan was one to two assist; and MDS transfers were extensive one-person assist, Care Plan was one to two assist. Review of Resident #19's ADL (Activities of Daily Living) Functional/Rehabilitation Potential care plan, initiated [DATE] revealed the following intervention: Approach Start Date: [DATE], range of motion with adls. No individualized, person-centered Restorative care plan interventions were identified in the care plan for Resident #19, including the type, amount, and duration of the range of motion exercises with ADLs. Review of the facility Care Plans - Baseline policy, dated [DATE], revealed the following, in part: .3. The baseline care plan will be used until the staff can conduct the comprehensive assessment and develop an interdisciplinary care plan. 34276 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #43 A review of Resident #43's medical record revealed she admitted to the facility on [DATE] with diagnoses including gastrostomy (feeding tube) status, moderate protein-calorie malnutrition, adult failure to thrive, dementia. A review of the [DATE] Minimum Data Set (MDS) assessment revealed she was assessed by staff to be severely impaired for cognition. Per this assessment Resident #43 was totally dependent on one person for eating, received more than 51% of her nutritional needs from a tube feeding but also consumed a mechanically altered diet, and was marked for having significant weight loss. A review of Resident #43's care plan titled, Nutrition initiated on [DATE] revealed, Resident has potential alteration in nutritional status R/T (related to) malnutrition, cognitive and communicate deficits, assist with adl (activities of daily living) tasks needed, peg tube placement and use for nutrition . Administer tube feeding and water flushes per MD (Medical Doctor) orders (initiated [DATE]) .Elevate HOB (head of bed) ,d+[DATE] degrees during tube feeding administration (initiated [DATE]) . Obtain dietary consult and follow recommendations (initiated [DATE]). This care plan was not developed with the collaboration of any qualified nutrition staff, nor did it contain resident specific interventions regarding her tube feeding boluses or significant weight gain. Resident #46 A review of Resident #46's medical record revealed he admitted to the facility on [DATE] with diagnoses including gastrostomy (feeding tube) status, COVID-19, stroke, protein-calorie malnutrition, other nutritional anemias. A review of the [DATE] Minimum Data Set (MDS) assessment revealed he scored ,d+[DATE] on the Brief Interview for Mental Status (BIMS) assessment, indicating moderately impaired cognition. A review of Resident #46's care plan revealed the following: The Nutritional Status care plan was initiated on [DATE] by CDM UU but contained only one approach dated [DATE], obtain weekly weights x 4 weeks, then monthly if stable. On [DATE] Consultant RD T initiated the other 13 approaches, including: Check for tube placement and residuals per facility parameters, Elevate HOB (head of bed) ,d+[DATE] degrees during tube feeding administration, Observe and report to physician PRN (as needed): s/sx (signs and symptoms) of Aspiration, and RD to evaluate monthly and PRN. Make recommendations for changes to tube feeding as needed. This full care plan was not developed until six days prior to Resident #46's expiration on [DATE]. Resident #95 A review of Resident #95's medical record revealed he admitted to the facility on [DATE] with diagnoses including down syndrome, chronic obstructive pulmonary disease (COPD), viral pneumonia related to COVID-19, and dementia. Resident #95 expired on [DATE] before a comprehensive MDS could be completed. A review of Resident #95's care plan in the Electronic Medical Record revealed they were dated 2021 despite the Resident being admitted in 2022. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 12:42 p.m., LPN/MDS Coordinator Q was asked about why some Residents had care plans dated prior to their admission. LPN Q reported it was because the old care plans (from a previous admission) were being reactivated instead of a new care plan being formed. LPN Q reported that a new care plan should be built for each admission. When asked about Resident #95's care plan containing treatments and plans from Summer of 2021, LPN Q reported she had been hired in March and wasn't able to answer that question. On the following dates and times, the care plan for Resident #95 was requested but was not received: [DATE] at 12:42 p.m. and [DATE] at 9:55 a.m. The facility was asked to provide the policy for Comprehensive Care Plans on [DATE] at 5:32 p.m., but the policy was not provided.

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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** 35103 Based on interview and record review, the facility failed to review and/or revise resident care plans after each comprehensive and quarterly review assessment as determined by the resident's needs for four Residents (#C1002, #19, #20, and #40) of 17 residents reviewed for care plan revisions. This deficient practice resulted in the potential for inadequate or inappropriate care. Findings include: Resident #C1002 Review of Resident #C1002's Minimum Data Set (MDS) assessment, dated 1/14/22, revealed Resident #C1002 was admitted to the facility on [DATE], with diagnoses that included: diabetes mellitus, anxiety disorder, depression, and polyneuropathy (malfunction of peripheral nerves throughout the body). Resident #C1002 required extensive one to two-personal physical assistance with bed mobility, transfers, dressing, toilet use, and personal hygiene. Resident #C1002 used a motorized wheelchair and required supervision to limited assistance with locomotion in the electric wheelchair. Resident #C1002 scored 15 or 15 on the Brief Interview for Mental Status (BIMS) reflective of intact cognition. Review of Resident #C1002's Physician Order report, retrieved on 3/29/2022 at 9:50 a.m., revealed the following Physician Order: Check incoming packages or personal items deliver for sharp object. Every Shift . Start Date: 12/14/2021, End Date: Open Ended. Review of Resident #C1002's Care Plans found no reference to checking or opening mail being delivered to this Resident. During an interview on 4/4/22 at 8:58 a.m., Resident #C1002 was asked if facility staff opened mail or packages addressed to the Resident. Resident #C1002 confirmed the facility did open packages that were addressed to her to verify the contents of the packages. Resident #19 Review of Resident #19's MDS assessment, dated 1/18/22, revealed Resident #19 was admitted to the facility on [DATE], with diagnoses that included: stroke, deep vein thrombosis (DVT), cerebrovascular accident (CVA), hemiplegia (paralysis of one side of the body), depression, and dysarthria (unclear articulation of speech) and dysphagia (difficulty swallowing). Resident #19 required extensive one-person assistance with bed mobility, transfers, walking in room, dressing, toilet use, personal hygiene, and was totally dependent upon staff for bathing. Resident #19 scored 13 of 15 on the BIMS reflective of intact cognition. Resident #19 could understand others, be understood, and make his needs known. Resident #19's ADL Functional/Rehabilitation Potential care plan was started on 1/14/22, after admission on 1/12/22. The Admission MDS assessment was completed 1/25/22. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #19's ADL (Activities of Daily Living) Functional/Rehabilitation Potential care plan, initiated 1/14/22 revealed the following intervention: Approach Start Date: 02/15/2022, range of motion with adls. Restorative therapy was ordered for Resident #19 on 2/3/22 for 12 weeks. No individualized, person-centered Restorative care plan or Restorative interventions were identified in the care plan for Resident #19, including the type, amount, and duration of the range of motion exercises with ADLs. During an interview on 4/4/22 at 8:33 a.m., MDS Coordinator Q reviewed Resident #19's care plans and confirmed there was not a specific restorative care plan . Resident #19's Nutritional Baseline Care Plan, initiated 1/14/22, had an Approach Start Date: 01/14/2022 to OBTAIN FOOD PREFERENCES FROM RESIDENT/FAMILY. Review of Resident #19's breakfast meal tray card on 3/29/22 at 8:12 a.m., found no Allergies, Dislikes, or Preferences documented for this Resident. During an interview at this same time, when asked if he had told the facility what he liked to eat, Resident #19 stated, Nobody asked me. No revision to Resident #19's care plan regarding food preferences had been documented between 1/14/22 and 3/29/22. Resident #20 Review of Resident #20's MDS, dated [DATE], revealed Resident #20 was admitted to the facility on [DATE], and readmitted to the facility on [DATE] with diagnoses that included cerebrovascular accident (CVA), hemiplegia, depression, and other muscle spasm. Resident #20 was totally dependent on staff for bed mobility, transfers, dressing, toileting, personal hygiene and bathing, and scored 15 of 15 on the Brief Interview for Mental Status (BIMS), reflective of intact cognition. Resident #20 had a Significant Change MDS assessment completed on 6/7/21. Review of Resident #20's Care Plans revealed the following care plans were implemented from her 8/7/2020 the original facility admitted , not specific, person-centered interventions directly related to the 6/1/21 readmission: 1. ADL Function/Rehabilitation Potential with 11 Approaches (interventions) dated 8/7/2020. 2. Diagnosis/History of CVA with all four interventions dated 8/7/2020. 3. Risk for Respiratory Complications with six of 10 interventions dated 8/7/2020. 4. Risk for Bleeding with all six interventions dated 8/7/2020. 5. Risk for Social Isolation with all four interventions dated 8/7/2020. 6. Resident to Remain in facility with both interventions dated 8/7/2020, including Arrange for discharge planning conference. 7. Activities with all five interventions dated 8/7/2020. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8. Skin Alteration with eight of 10 interventions dated 8/7/2020. 9. Falls with 10 of 11 interventions dated 8/7/2020. 10. Pain with all seven interventions dated 8/7/2020. Review of Resident #20's Care Plans provided by paper copy, revealed three Care Plans were modified by the facility on 3/29/22, following the start of the survey on 3/28/22, including: Psychosocial Well-Being, with a problem start date and interventions all dated for 3/8/2022, and last reviewed/revised by the facility on 3/29/22 at 5:33 p.m. by MDS Coordinator Q. This Care Plan was not present in Resident #18's Care Plans retrieved electronically by this Surveyor via the Electronic Medical Record on 3/29/22 at 10:33 a.m. The Nutritional Status Care Plan was Revised on 3/29/22 at 5:28 p.m., to add hospice status on readmit, and the Functional Urinary Incontinence Care Plans was revised on 3/29/22 at 5:28 by MDS Coordinator Q to remove the following New Dx (diagnosis) of Kidney Stone; Surgery is scheduled for May 25, 21which were changes from the original care plans retrieved from the EMR. During interviews on 4/4/22 at 8:21 a.m. and 8:30 a.m., MDS Coordinator Q was asked about the process of care plan revisions following hospital discharges or discharges with anticipated return. MDS Coordinator Q said there should be an IDT (interdisciplinary team meeting) after resident hospitalization to review and revise interventions as appropriate. MDS Coordinator Q was asked to review Resident #20's care plans revised during the recertification survey on 3/29/22. MDS Coordinator Q reviewed Resident #20's Psychosocial Well-Being care plan and confirmed the entire care plan had been added on 3/29/22 following the start of the survey. The Start and Approach Dates were added by MDS Coordinator Q, and not indicative of the start of the care plan or interventions. MDS Coordinator Q also confirmed she had added Hospice Status on Readmit to the Nutritional Status care plan, and deleted information that was old on the Urinary Care Plan. MDS Coordinator Q said she just started in March, so she did not have time to go through a full cycle of care plan reviews. MDS Coordinator Q agreed that when a person is readmitted , the care plan should reflect current needs and necessary revisions. Resident #40 Review of Resident #40's MDS assessment, dated 3/5/22, revealed Resident #40 was readmitted to the facility on [DATE] with diagnoses that included: diabetes mellitus, muscular dystrophy, contracture of right-hand muscle, and muscle weakness. Resident #49 was totally dependent upon staff for bed mobility, transfers, dressing, toilet use, personal hygiene, and bathing, and had a functional limitation in range of motion on one side of his upper extremity. Resident #40 used a wheelchair for mobility and scored 15 of 15 on the BIMS, reflective of intact cognition. Review of Resident #40's care plans found no interventions to address Resident #40's desire to participate in activities outside of the facility, including visiting with friends and family, or shopping. Review of Resident #40's Activity care plan, dated 4/21/21 found all six interventions dated 4/21/21 with three of the interventions incomplete, including how to inform the resident of upcoming activites, what materials of interest could be provided, and where Resident #20 preferred to participate in activities. The care plan was last reviewed on 3/15/22 by MDS Coordinator Q, with no documented changes to the incomplete interventions. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #40's Care Plans found a Restorative care plan with all interventions dated 2/1/21 (over a year ago) with physical therapy orders that did not match the current Restorative Care Program for Resident #40. Resident #40 still retained a Risk for Social Isolation care plan, started 9/22/20, due to visitor restrictions for COVID-19 pandemic. No revisions to address current visitor guidelines have been added since 9/2020. Review of the facility Care Plans - Baseline policy, dated 3/22/22, revealed the following, in part: .3. The baseline care plan will be used until the staff can conduct the comprehensive assessment and develop an interdisciplinary care plan.

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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** 38328 Based on interview and record review, the facility failed to develop a discharge summary for one Resident (#45) of one resident reviewed for discharge summary. This deficient practice resulted in the potential for maladjustment in the new living environment. Findings include: A review of the face sheet for Resident #45 revealed admission to the facility on [DATE] at 5:03 p.m. Resident #45 was discharged from the facility on 1/17/22 at 5:00 p.m. Diagnoses included Cerebral infarction (Stroke) due to thrombosis (clot) of left posterior cerebral artery, hypertensive heart disease without heart failure, polyneuropathy(disease affecting peripheral nerves), dysarthria (speech/sound disorder), ataxia (lack of muscle coordination), hemiplegia (paralysis on one side of the body). Resident #45 had an approximate 7-day stay at the facility. On 3/31/22 at 11:24 a.m., during an interview, the Director of Nursing (DON), referring to the discharge of Resident #45, stated, It wasn't supposed to be an AMA (Against Medical Advice) discharge, it was supposed to be a planned discharge. The DON stated the DPOA (Durable Power of Attorney) told us she wanted Resident #45 transferred to another facility and she would not wait until the planned discharge which was to occur on approximately 1/19/22. The DON stated the facility offered to provide paperwork and medications and the family didn't want to wait. A review of the Electronic Medical Record (EMR) revealed no recapitulation of stay present in the chart. On 3/31/22 at 12:11 p.m., during a follow-up interview, the DON stated she could not see a recapitulation of stay for Resident #45 in the EMR and stated there was no recapitulation of stay form or process designed for the facility's EMR system. The DON also acknowledged the facility Discharge Policy provided no guidance or reference to the requirement of a recapitulation of stay. The EMR was devoid of any documentation relating to this or any details leading up to the discharge. On 3/31/22 at 12:37 p.m., during an interview, the Nursing Home Administrator (NHA) stated she did not direct the social worker (SW) K to discharge the resident AMA and did not find out about this until after Resident #45 discharged . The NHA stated there would not be a recapitulation of stay because Resident #45 was considered discharged AMA. On 4/4/22 at 5:00 p.m., during a follow-up interview, the NHA was asked to provide the AMA form for Resident #45. The Administrator stated the AMA form referred to in the progress notes of the EMR could not be found. A review of the facility policy Discharge Planning, with a review date of 3/11/22 read in part: . 13. The results of the evaluation and the final discharge plan will be discussed with the resident or resident's representative. All relevant information will be provided in a discharge summary to avoid unnecessary delays in the resident's discharge or transfer, and to assist the resident in adjustment to his or her new living environment.

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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 0675 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor each resident's preferences, choices, values and beliefs. 35103 Based on observation, interview, and record review, the facility failed to provide communal dining services to promote the highest practicable physical, mental, and psychosocial well-being of four Residents (#17, #18, #27, and #40) of 17 residents reviewed for dining. This deficient practice resulted in the potential for increased depression, isolation, loneliness, and the inability to form and maintain social bonds with facility residents. This deficient practice had the potential to affect all facility residents who consumed food orally. Findings include: Facility observation on 3/28, 3/29, 3/30, 3/31, 4/4 and 4/5/22 showed all facility residents received meal trays in their rooms, or hallways for all regularly scheduled meals. No communal dining was implemented prior to or during the recertification survey. During an interview on 03/28/22 at 03:57 p.m., Resident #27 was asked where the Resident preferred to eat her meals. Resident #27 said residents in the facility did not have a option to eat in the dining room, but only received meals in their rooms. Resident #27 stated, I would like to eat in the dining room, because it gets a little lonely down here (in room alone) During interview on 4/5/22 at 11:05 a.m., 11:10 a.m., 11:15 a.m., and 11:20 a.m., with Resident #40, #27, #18, and #17 respectively, all residents confirmed they would like to eat in the dining room for communal meals. Resident #40 stated, We have not eaten meals in the dining room, other than birthday parties or things like that. We all eat in our rooms. Resident #27 stated, I want to eat in the dining room, but they (facility staff) said that we could not eat there because of the pandemic. It gets lonely in the rooms alone for meals every day. Resident #18 stated, Absolutely I would like to eat in the dining room. Resident #17 stated, I would prefer to eat in the dining room. They said because of the pandemic we could not eat in the dining room. During an interview on 4/5/22 at 4:22 p.m., the Director of Nursing (DON) was asked about the lack of communal dining in the facility. The DON said residents have the option to eat in the dining room, but none of the Residents interviewed expressed any knowledge regarding optional dining room meal service. Review of the Centers for Medicare & Medicaid Services, QSO-20-39-NH Memo, revised 3/10/22, revealed the following in part: . Communal Activities, Dining and Resident Outings: While adhering to the core principles of COVID-19 infection prevention, communal activities and dining may occur . During an interview on 03/31/22 at 08:18 a.m., Confidential administrative staff C1008 was asked why there was no communal dining. Staff C1008 stated, I don't know why it is not communal dining. Of course, it is a positive environment. There is tremendous benefit in socialization, engagement, conversation, and interpersonal relationship fostering when people eat together. You see bonding. It is so important.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34276 Based on observation, interview, and record review, the facility failed to ensure that dependent residents were provided Activities of Daily Living (ADL) care related to grooming and hygiene for four Residents (#6, #15, #43, and #95) out of 14 reviewed for ADL care. This deficient practice resulted in residents appearing disheveled and ungroomed with the potential for feelings of insecurity. Findings include: Resident #6 On [DATE] at 5:53 p.m., Resident #6 was observed in the hallway wearing a dirty shirt. Resident #6's hair was long and disheveled, and his facial hair was grown out to approximately ,d+[DATE] centimeters long. A review of Resident #6's medical record revealed he admitted to the facility on [DATE] with diagnoses including vascular dementia, stroke, and diabetes type 2. A review of his [DATE] Minimum Data Set (MDS) assessment revealed he scored ,d+[DATE] on the Brief Interview for Mental Status (BIMS) assessment indicating severely impaired cognition and required the extensive assistance of one staff person for hygiene and dressing. On [DATE] at 11:54 a.m., Resident #6 was observed across from the nurse's station. There was orange residue around his mouth and in his mustache and beard. A review of Resident #6's care plan for ADL Functional/ Rehabilitation Potential initiated [DATE] revealed, Resident has a self care deficit . Bathing: ,d+[DATE] person assist as needed, weekly per facility schedule . Hygiene/oral care: 1 person assist . Offer shave daily. Resident #15 On [DATE] at 3:50 p.m., Resident #15 was observed in bed. Resident #15 had facial hair growing from her chin approximately ,d+[DATE] centimeters long and had white residue at the corners of her mouth. A review of Resident #15's medical record revealed she admitted to the facility on [DATE] with diagnoses including stroke, nutritional deficiency, gastrostomy (feeding tube) status, and diabetes type 2. A review of the [DATE] MDS assessment revealed she was assessed by staff to be severely cognitively impaired and relied on tube feeding to meet her nutritional needs. This MDS also revealed she was totally dependent on staff for hygiene. On [DATE] at 9:51 a.m., Resident #15 was observed in bed still with the long facial hair on her chin. On [DATE] at 11:57 a.m., Resident #15 had white liquid dried coming out the corners of her mouth. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #15's care plan for ADL Functional/Rehabilitation Potential initiated [DATE] did not contain any interventions regarding the level of assistance she required with any ADL's. The care plan stated at the bottom, Last reviewed/revised: [DATE]. Resident #43 On [DATE] at 2:10 p.m., Resident #43 was observed lying in bed with approximately ,d+[DATE] centimeter-long hairs growing from her chin. A review of Resident #43's medical record revealed she admitted to the facility on [DATE] with diagnoses including gastrostomy (feeding tube) status, moderate protein-calorie malnutrition, adult failure to thrive, and dementia. A review of the [DATE] Minimum Data Set (MDS) assessment revealed she was assessed by staff to be severely impaired for cognition. Per this assessment Resident #43 was totally dependent on one person for eating and required total dependence of one staff for hygiene. On [DATE] at 8:20 a.m., Resident #43 was observed still with long hairs on her chin. A review of Resident #43's care plan for ADL's initiated on [DATE] revealed, Bathing: dependent assist, weekly per facility schedule .offer shave daily Resident #95 On [DATE] at 3:47 p.m., Resident #95 was observed sitting in a chair across from the nurse's station. Resident #95 has facial hair growth approximately ,d+[DATE] centimeters long and disheveled hair. A review of Resident #95's medical record revealed he admitted to the facility on [DATE] with diagnoses including down syndrome, chronic obstructive pulmonary disease (COPD), viral pneumonia related to COVID-19, and dementia. Resident #95 expired on [DATE] before a comprehensive MDS could be completed. On [DATE] at 1:15 p.m., Resident #95 was observed wearing a sweatshirt and sweatpants. On the front of his sweatshirt and the inner leg area of his sweatpants there were white dried stains of either food or sputum. A review of Resident #95's Point of Care documentation for hygiene revealed no documentation was completed that hygiene care was provided from his admission on [DATE] until five days later on [DATE] at 6:22 a.m. There was also no documentation that hygiene care was provided on [DATE] and [DATE]. A review of Resident #95's Point of Care documentation for bathing revealed during his admission from [DATE] until he expired on [DATE] he received only one shower (on [DATE]) and no bed baths had been provided. On the following dates and times the care plan for Resident #95 was requested but was not received: [DATE] at 12:42 p.m. and [DATE] at 9:55 a.m. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility policy titled, Activities of Daily Living revised ,d+[DATE] revealed, .13. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene .

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34276 Based on observation, interview, and record review, the facility: 1) Failed to ensure that one Resident (#46) was assessed and monitored for change in condition and sent to the hospital per his advance directives; and 2) Failed to ensure that one Resident (#95) was monitored for signs and symptoms of aspiration after being placed on the wrong modified diet and failed to administer oxygen timely during respiratory distress, out of 17 residents reviewed for quality of care. This deficient practice resulted in Resident #46 not being hospitalized per his advance directive, and Resident #95 developing aspiration pneumonia and not being administered oxygen treatment timely, contributing to his death. Findings include: Resident #46 A review of Resident #46's medical record revealed he admitted to the facility on [DATE] with diagnoses including gastrostomy (feeding tube) status, COVID-19, stroke, protein-calorie malnutrition, and other nutritional anemias. A review of the [DATE] Minimum Data Set (MDS) assessment revealed he scored , d+[DATE] on the Brief Interview for Mental Status (BIMS) assessment, indicating moderately impaired cognition. A review of Resident #46's Advanced Medical Treatment Directive signed [DATE] by the Resident, who was his own responsible party, revealed he chose to have NO CARDIOPULMONARY RESUSCITATION (DNR). This document also included the section as follows: The following additional guidelines for treatment have been agreed upon: Not to be used - Oxygen; To be used: Antibiotics, IV fluid, Enteral Feeding/Peg Tube, hospitalization , Ventilation, and Blood transfusion. A review of Resident #46's vital signs revealed abnormal vital signs starting on [DATE], indicating a possible change in condition, as follows: [DATE] 3:06 p.m. Pulse 92 per minute ,d+[DATE] 4:30 p.m. Respirations 22 per minute, Pulse 99 per minute [DATE] 6:07 a.m. Respirations 28 per minute, Pulse 120 per minute A review of Resident #46's progress note dated [DATE] revealed, .Resident alert, verbal able to make needs known with confusion. Writer noticed vitals unstable. had fever of 100.8 (degrees Fahrenheit) Temporal. W (with) oxygen saturation fluctuated between ,d+[DATE] (%) new order by NP (Nurse Practitioner Y) to put on 2L (liters of oxygen) nasal cannula, Motrin Q (every) 6hrs, Tylenol Q6hrs X2days. Albuterol . STAT CXR (chest xray) 2View ordered. At 2pm resident was afebrile (without fever) post Tylenol and motrin doses . Notified NP of lab results and CXR. New order to start one time order of 0.9% NS 65ml/hr (Intravenous hydration). Levaquin(antibiotic) 500 (mg) Q daily (every day). When writer administered medication via peg, noticed resident overflow of coffee ground color residuals. Notified family and family wants to keep resident inhouse and not send out to the ER. NP ordered STAT KUB. order in place. Will cont.(continue) to monitor patient oxygen level . There was no documentation or evidence showing Resident #46's advance directive to be hospitalized was followed. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	A review of Resident #46's progress note dated [DATE] 3:06 p.m. revealed, Notified (NP Y) of residents status. Verbal order to speak with family and ask son if it is okay to have residents placed on Hospice. Notified (Son of Resident #46) of doctors request. (Son of Resident #46) stated that he would call his older brother and will call back later about resident being on hospice . A review of Resident #46's progress note dated [DATE] at 4:06 p.m. revealed, Resident was observed in bed with no respirations. Non responsive when called by name. Vitals were unable to be obtained. Notified attending physician of residents status, Notified Family . On [DATE] at 9:55 a.m., an interview was conducted with the Director of Nursing (DON). When asked why Resident #46 was not hospitalized per his signed advanced directives when he started to have a change in condition on [DATE], the DON stated that they did a courtesy call to family. When asked to explain, the DON first stated, At this point I think they chose hospice. When asked where the hospice order and evaluation was, the DON reported she called the hospice and asked for notes. The DON stated, The doctor said we needed to call family to start hospice. When asked if it was what the family wanted, as the last note dated an hour before Resident #46 expired stated they still needed to discuss it with family, the DON stated, He (Resident #46) was declining. The DON could not explain why Resident #46's advance directive wishes of being hospitalized were not followed. Further review of Resident #46's medical record revealed no order for a hospice consult or admission. Resident #46's medical record contained no information about Resident #46 being on hospice, or why his advanced directives were not followed. On [DATE] at 1:51 p.m., the DON reported she had a note from the hospice nurse who did the evaluation for Resident #46. When asked if the facility had family approval to have the resident evaluated for hospice, or if there was a physician order to do so, the DON reported that normally the facility does but she was unable to find any documentation that it occurred. The DON asked why the progress note dated [DATE] at 4:06 p.m. did not include who called the time of death and when, the DON reported she did not know. On [DATE] at 4:18 p.m., an interview was conducted with the Administrator. When asked at what point a resident's family can override their advanced directives if they are their own person, the Administrator stated, When they can no longer make their own decisions. When asked if that would be when they were deemed incompetent by two physicians, the Administrator said yes. A review of a Communication Note on hospice letter head (provided by the DON) regarding Resident #46 revealed the following, Reg: (Name of Resident #46). On [DATE], (Name of Hospice) Hospice RN (unidentified) was in the vicinity of (Name of Facility) visiting hospice patients. A facility staff approached Hospice RN (unidentified) regarding a probable referral for Hospice care and request that RN (unidentified) see if patient would qualify under hospice. Upon seeing the patient and obtaining a brief medical history, patient qualified for hospice care. Informed facility that a Hospice referral and order will be required prior to admission under hospice care and before a full assessment can be done. Unfortunately, patient had passed the same day and was not admitted under Hospice care. (Name of Hospice RN GGG). This documented was undated and unsigned by the author. This document was also not in the medical record. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	A review of Resident #46's death certificate revealed, .date of death : [DATE] . Time of death: 4:20 PM . date signed: [DATE] (by the Medical Director) .Enter the chain of events: 2019-nCov (sic) acute respiratory disease, cerebral infarct, unspecified; other specified nutritional anemias; Peg tube status with dysphagia . The facility was asked to provide the physician statement/recapitulation regarding the death of Resident #46 (per the facility policy) on [DATE] at 3:44 p.m., and on [DATE] at 11:15 a.m. and 3:31 p.m. The physician statement was never provided. A review of the facility policy titled, Transfers and Discharges/Physician role last reviewed [DATE] revealed, . 10. If the individual has diet, the final summary will review the individuals stay and identify factors contributing to death . Resident #95 On [DATE] at 8:15 a.m., Resident #95 was observed in his room, rocking on his bed with a wet, congested cough. Resident #95's oxygen concentrator was turned off with the tubing and nasal cannula lying on the floor and filter on the concentrator was dusty. Resident #95 had two empty pre-packaged cups of nectar thick juice on his bedside table. Resident #95 had eaten his meal unsupervised in his room. A review of Resident #95's medical record revealed he admitted to the facility on [DATE] with diagnoses including down syndrome, chronic obstructive pulmonary disease (COPD), viral pneumonia related to COVID-19, and dementia. No comprehensive MDS was completed for Resident #95. On [DATE] at 10:32 a.m., Resident #95 was observed in bed in his room with the blanket over his head. Resident #95 removed the blanket from his head and took a sip from a pre-packaged cup of nectar thick juice from his bedside table. After drinking the juice Resident #95 began to cough and struggle to clear his throat. On [DATE] at approximately 10:33 a.m., Certified Nurse's Aide (CNA) N was outside of Resident #95's room. When asked why Resident #95 had been eating breakfast in his room with the door closed, CNA N reported that Resident #95 had behaviors or disrobing and wouldn't keep his mask on so she told him to stay in his room. On [DATE] at approximately 10:34 a.m., Licensed Practical Nurse (LPN) A was notified of Resident #95's cough by this surveyor and LPN A reported he would go assess him. LPN A assessed Resident #95's oxygen saturation and found it to be 81%. LPN A reported that the reading couldn't be accurate and went to find another pulse oximeter. The second pulse oximeter gave a result of 87%. When asked what he would do, LPN A reported he could provide a breathing treatment or an inhaler as well as oxygen. LPN A reported he would need to get new oxygen tubing as the current tubing had been lying on the floor. On [DATE] at 5:35 p.m., Resident #95 was observed rocking in bed. His meal tray was at his bedside with 100% of his food and fluids consumed. Resident #95 continued with a congested cough and slight wheeze. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 5:37 p.m., LPN A was asked about Resident #95's congestive cough and oxygen saturation. LPN A reported that when he checked Resident #95's lungs he heard some crackles so he had notified the Nurse Practitioner and she had ordered an Xray. A review of NP Y progress note on [DATE] revealed, .S: Following for treatment of pneumonia. Laying in bed, is alert and awake, answer to his name. Patient is laying comfortably, no cough and congestion noted no wheezing, no shortness of breath or respiratory distress . ,d+[DATE] chest x-ray .Pneumonic process in the right suprahilar region and in the right infrahilar region medially . shadow and appearing to be portions of the right upper and lower lobes better seen in right lower lobe .Pneumonia. Continue moxifloxacin . A review of Resident #95's physician order for diet dated [DATE] revealed, Diet: Puree with thick liquids and NO STRAW. This diet order did not indicate what the level of thickness should be for the fluids. There were no dietary or nutritional assessments in Resident #95's record to reflect the correct diet. On [DATE] at 9:52 a.m. and 11:53 a.m Resident #95 was observed in bed, with no fluids at bedside, with audible chest congestion. On [DATE] at 4:00 p.m., RD T and the Director of Nursing (DON) were asked to observe Resident #95. When asked if there was anything missing from Resident #95's room, the DON and RD T confirmed that Resident #95 did not have any beverages or hydration available to him in his room. When asked about Resident #95's diet order being Thick Liquids and whether he had been assessed, RD T reported that CDM S was supposed to do his nutritional assessment. RD T reported she would investigate the issue. A review of a new physician orders for Resident #95 dated [DATE] revealed RD T had downgraded Resident #95 to a Regular diet puree with honey thick liquids and no straw after the conversation on [DATE]. On [DATE] at 12:45 p.m., Resident #95 was observed curled up in blankets in his bed. There were no liquids or beverages in his room. On [DATE] at approximately 1:00 p.m., CDM S confirmed that Resident #95 had been on a nectar thick liquids prior to [DATE]. A review of NP Y progress note on [DATE] revealed, .S: Following for treatment of pneumonia. Laying in bed, . Patient is laying comfortably, no cough and congestion noted no wheezing, no shortness of breath or respiratory distress . ,d+[DATE] chest x-ray .Pneumonic process in the right suprahilar region and in the right infrahilar region medially . appearing to be portions of the right upper and lower lobes better seen in right lower lobe .Pneumonia. Continue moxifloxacin .#Dysphagia. Dietitian follows, optimize nutrition, monitor weight . A review of a hospital discharge document for Resident #95 prior to his admission to the facility dated [DATE] revealed .Adult diet: . Pureed; Fluid Consistency: Honey Thick; Additional Restrictions: No Straws, 1:1 Feed . This document confirmed that Resident #95 was supposed to admit to the facility on honey thickened liquids. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 2:52 p.m., an interview was conducted with SLP WW who reported that he had evaluated Resident #95 on [DATE] and that Resident #95 required a Pureed and Honey Thickened liquid diet. SLP WW also reported that the Resident did require supervision. On [DATE] at 3:24 p.m., a phone interview was conducted with RN P regarding Resident #95's admission. RN P reported she was just the charge nurse that helped with the admission. When asked where his diet came from, RN P reported she assumed it came from the discharge paperwork. RN P reported if they don't get a diet from the discharging hospital they put in an order for a swallowing evaluation. On [DATE] at 3:43 p.m., a phone interview was conducted with RN BBB who reported it she was on the unit Resident #95 admitted to. RN BBB reported that she normally gets the diet orders from the hospital records, but if it's not there they would request a speech evaluation. RN BBB reported that she didn't remember putting Resident #95's orders in. When informed her name was on the admission diet order, RN BBB reported she didn't know. On [DATE] at 1:07 p.m., Speech Language Pathologist (SLP) WW was asked if he had evaluated Resident #95 for the appropriate diet consistency. SLP WW reported that he had not because as far as he was aware Resident #95 admitted on hospice services. SLP WW stated, When they (residents) come in on hospice we usually just do a screen., Per SLP WW, Resident #95 had not been screened on admission. When asked what diet order the facility was supposed to follow, SLP WW reported the Resident should be on whatever diet his was discharged from the hospital on. A review of Resident #95's Admission Nursing Comprehensive Evaluation dated [DATE] revealed the following, .swallowing difficulty: yes. Thickened liquids: yes (consistency blank) . fluid restrictions: no . On [DATE] at 1:15 p.m., Resident #95 was observed up in a chair across from the nurses station with a rolling tray in front of him with a larger Styrofoam cup of honey-thickened juice, and a smaller cup that had the label torn off. Resident was observed to be raising and lowering his shoulders while he was breathing, was rubbing his face, and had a productive wet cough and wheeze. On [DATE] at 1:27 p.m., this surveyor was notified Resident #95 was having respiratory distress. On [DATE] at 1:30 p.m., Resident #95 was observed across from the nurse's station struggling to breath and clear his airway. Hospice Registered Nurse (RN) II was observed trying to get a portable oxygen tank working. Hospice RN II was asked about Resident #95's Spo2 and stated it was In the 40's. Hospice RN II attempted to get another reading of Resident #95's SPO2 which revealed 35% read on his right-hand finger and read 47% on his left great toe. LPN AA reported it was hard getting a reading because his extremities were so cold. Hospice RN II and LPN AA continued to struggle with getting a second portable oxygen tank to function. On [DATE] at 1:40 p.m., CNA V was observed brining an oxygen concentrator down from Resident #95's room to the nurses station. LPN AA obtained clean oxygen tubing and the oxygen cannula was placed on Resident #95. On [DATE] at 1:42 p.m., LPN AA rechecked Resident #95's Spo2 which read 43% oxygen saturation with a heart rate of 128 beats per minute. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 2:35 p.m., Hospice RN II was asked about Resident #95 and reported his oxygen saturation was now between ,d+[DATE]% on oxygen. Hospice RN II reported that the Resident had also received a breathing treatment, Albuterol, and that NP Y had been notified and they were discussing whether to send the Resident to the hospital for evaluation. On [DATE] at 3:54 p.m., Hospice RN II followed up to report they were holding fluids for Resident #95 because it seemed he was struggling to breath after drinking liquids. When asked about the liquids he had been consuming at lunch, Hospice RN II reported that he had a thicker liquid in a cup and then a thinner liquid in the little cup. On [DATE] at 11:23 a.m., a phone interview was conducted with NP Y. When asked about Resident #95, NP Y reported she had seen the Resident on [DATE] and didn't hear any appreciable crackling or wheezing and that the resident wasn't coughing or struggling to breath. When asked if Resident #95's death on [DATE] had been anticipated, NP Y reported that the resident was compromised and declined to provide further comment. NP Y further reported that they had thought Resident #95 was a full code at first and were planning to send him to the hospital. When asked what her expectations of staff were if a resident was in respiratory distress with oxygen saturation ,d+[DATE]%, NP Y stated, Bring them back to their room. Administer oxygen. Give maximal oxygen you could give. When asked if the Guardian of Resident #95 was notified when Resident #95 started to decline, NP Y reported that she did not know. A review of a progress note written by Hospice RN II and emailed on the DON on [DATE] at 10:24 a.m., reveal in part, Routine hospice visit around 1400 (2:00 p.m.), patient is seen sitting up on wheelchair at nurses' station, alert, drinking thickened liquids. Patient's skin and lips appear pale, with productive cough . crackles noted on bilateral lungs. Unable to obtain accurate oxygen saturation on upper extremities due to pale & cold skin. Facility nurse then obtained oxygen saturation @ (at) 82% on left foot second toe on room air .Hospice RN educated facility staff regarding risk for aspiration due to current condition . Started non-rebreather mask @ 10LPM (liters per minute). Albuterol neb given then every ,d+[DATE] hrs as needed. Monitor patient closely . (NP Y) seen and assessed the patient with no further orders made . At around 1600, Hospice nurse and facility staff seen (sic) patient on bed, unresponsive, with no BP (blood pressure), no HR (heart rate), no RR (respirations). Patient time of death is 1615 (4:15 p.m.) . On [DATE] at 4:18 p.m., the Administrator and the DON were asked about Resident #95 receiving nectar thick liquids when his discharge order from the hospital was for honey thickened liquids. The DON then stated, Nurses can do swallow evals . It's a standard of practice When asked to clarify, the Administrator reported the staff should have called the doctor or speech if they weren't sure on the diet orders. The DON was asked what the time expectation was for staff to administer oxygen if a Resident is experiencing respiratory distress. The Administrator stated, Immediately. Within seconds. A review of Resident #95's [DATE] MAR from [DATE] through [DATE] revealed: The order for Albuterol Sulfate Inhale 2 puffs every 4 hours as needed for DOB(Sic - SOB - shortness of breath) was never given. The order for budesonide-formoterol inhaler twice per day was missed three times. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	A review of the facility policy titled, Pneumonia, Bronchitis, Lower Respiratory Infections reviewed [DATE] revealed, .2. The staff will identify residents with symptoms that suggest possible bronchitis or pneumonia . 3. The staff and physician will identify residents with risk factors that may predispose them to pneumonia, such as . clinically significant dysphagia . 4. The physician will identify individuals who may need hospitalization because of the severity of pneumonia or the presence of complications .

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 38328 Based on observation, interview, and record review, the facility failed to maintain implemented care plan measures to prevent pressure injuries for one Resident (#145) of 3 reviewed for pressure injuries. This deficient practice resulted in potential for pressure injuries and likely contributed to the open skin areas. Findings include: On 3/28/22 at 1:53 p.m., Resident #145 was observed laying in a bed with a pressure reduction air mattress in place. The electrical unit at the end of the bed designed to inflate the bed was observed with the switch in the on position but was observed not functioning. The power cord for the electrical unit designed to inflate the mattress was noted laying on the floor and unplugged. Resident #145 was visibly sunken into the mattress with the edges of the mattress around her sticking up past her body. Resident #145's body was observed resting on the metal part of the bed frame and the mattress was completely deflated. Resident #145 was positioned resting on her back during this observation. On 3/28/22 at 2:10 p.m., PM Licensed Practical Nurse (LPN) B entered the room to assist Resident #145 with drinking some water. LPN B failed to notice the air mattress was not plugged in and functioning. Resident #145 remained in the position first observed at 1:53 p.m. and remained completely sunken into the mattress with her body resting on the bed frame. On 3/28/22 at 2:32 p.m., LPN B returned to inform Resident #145 when family would be in to visit. LPN B did not recognize or correct the issue of the air mattress not functioning. Resident #145 remained resting on her back. On 3/28/22 at 2:54 p.m., the door to Resident #145's room was closed by an unknown staff member. Upon knocking and entering the room, only Resident #145 was observed in the room resting in bed. Resident #145 remained in the same position resting on her back with the mattress deflated and the electrical unit remained unplugged. Resident #145 remained visibly sunken into the bed frame with no support under her. On 3/28/22 at 4:30 p.m., LPN A was alerted to the concern of the air mattress not functioning. LPN A acknowledged the issue and noted the air mattress unit was not plugged in. LPN A acknowledged the mattress was completely deflated and that Resident #145's body had been resting completely on the bed frame with no mattress support. Resident #145 was observed resting on her back during this observation. On 3/29/22 at 3:29 p.m., during an interview, LPN AA stated Resident #145 had received a shower that afternoon and a shower sheet was completed. LPN AA proceeded to show this Surveyor a shower sheet dated 3/29/22 indicating there were no skin issues. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/31/22 at 9:55 a.m., Activities of Daily Living (ADL) care was observed being provided by Certified Nurse Aide (CNA) C. Upon turning Resident #145 to the side, the coccyx, sacrum and buttock area was observed with a large red blanchable area with what appeared deep purple/black and looked like a suspected deep tissue injury (DTI) area in the center of the coccyx. CNA C was asked to press and release her finger over the Suspected DTI and the area appeared non-blanchable. The Suspected DTI area measured approximately 0.5 centimeters (cm) by 3 cm. At 9:58 a.m., LPN AA entered the room and observed the area. LPN AA agreed the wound appeared non-blanchable at the purple/black spot in the center of the redness after she assessed the area. LPN AA confirmed the area assessed appeared as a suspected deep tissue injury. At 10:03 a.m., LPN B came in to assessed the wound and brought in the Nurse Practitioner (NP) Y. NP Y acknowledged the purple area appeared to be a suspected deep tissue injury. LPN B stated the wound was not present when she admitted to the facility. LPN B stated she was unsure of who worked yesterday, but stated the CNA should have reported this skin issue. CNA C stated Resident #145 had this area on 3/29/22, but it was was not as red. On 4/4/22 at 12:50 p.m., during an interview, Family Member (FM) BB stated the facility notified her of Resident #145's skin issue and had changed the skin issue to contact dermatitis. A review of an Electronic Medical Record (EMR) for Resident #145, dated 4/4/22, revealed a note indicating a Wound NP, (NP Y) directed the facility staff to remove the diagnosis of Stage I with a Suspected DTI in the center of the wound and change it to contact dermatitis. On 4/4/22 at 4:44 p.m., CNA CC and LPN B were observed performing personal care of Resident #145. The buttocks, coccyx, and sacral areas all appeared blanchable. The suspected DTI area no longer had the purple/black area present. However, there were two stage two appearing areas noted within the red area on the right and left buttock. A review of the EMR care plans for Resident #145 accessed on 4/4/22 at 5:00 p.m., read in part: Resident (#145) has a pressure ulcer; due to multiple underlying health conditions, wounds may not heal and formation of new wounds may be unavoidable: Resident (#145) is hospice status . .Low air loss mattress; monitor for inflation and function every shift Start date: 3/31/22 The air mattress was in place since the start of the survey on 3/28/22. The care plan intervention for the air mattress was not initiated in the care plan for Resident #145 until 3/31/22 after the concern with the air mattress not functioning was brought to the attention of facility leadership.

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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** 35103 Based on interview and record review, the facility failed to ensure restorative services were provided to increase range of motion (ROM) and/or to prevent further decrease ROM for three Residents (#19, #36, and #40) of 17 residents reviewed for ROM. This deficient practice resulted in the lack of ROM services to residents with written restorative orders, and a potential deterioration of condition due to inactivity. Findings include: Resident #19 Review of Resident #19's Minimum Data Set (MDS) assessment, dated 1/18/22, revealed Resident #19 was admitted to the facility on [DATE], with diagnoses that included: stroke, deep vein thrombosis (DVT), cerebrovascular accident (CVA), hemiplegia (paralysis of one side of the body), depression, and dysarthria (unclear articulation of speech) and dysphagia (difficulty swallowing). Resident #19 required extensive one-person assistance with bed mobility, transfers, walking in room, dressing, toilet use, personal hygiene, and was totally dependent upon staff for bathing. Resident #19 scored 13 of 15 on the Brief Interview for Mental Status (BIMS) reflective of intact cognition and was not identified as participating in the Restorative Program on the 1/18/22 MDS assessment. Resident #19's Restorative Care Program form, signed by a Therapist and Restorative Nurse/Aide on 2/3/22, revealed the following: Goals for Restorative Program: To maintain B (bilateral) UE/LE (upper extremity/lower extremity ROM and strength. Approach: Nu-step/sci-fit. 15 mins. Level 2/3 with any s/s (signs/symptoms) SOB (shortness of breath, and other illegible instructions for bilateral upper extremity strength, and ambulation. Time: 3 x (times)/wk (week) x 12 weeks. Review of Resident #19's ADL (Activities of Daily Living) Functional/Rehabilitation Potential care plan, initiated 1/14/22 revealed the following intervention: Approach Start Date: 02/15/2022, range of motion with adls. No individualized, person-centered Restorative care plan interventions were identified in the care plan for Resident #19, including the type, amount, and duration of the range of motion exercises with ADLs. No documentation in Resident #19's electronic medical record (EMR) was present to show completion of any restorative care based on the physical therapy orders. Resident #36 (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #36's MDS assessment, dated 2/17/22, revealed Resident #36 was admitted to the facility on [DATE] with diagnoses that included: seizure disorder, anxiety disorder, polyneuropathy, and syncope and collapse. Resident #36 was independent in all ADLs other than walking in the corridor and bathing which were documented as Activity did not occur. Resident #36 scored 15 of 15 on the BIMS, reflective of intact cognition. The 2/17/22 Section O - Special Treatments, Procedures and Programs did not document Resident #36 participating in the Restorative program. Resident #36's Restorative Care Program form, signed by a Therapist and Restorative Nurse/Aide on 3/15/22, revealed the following: Goals for Restorative Program: To maintain ROM and decrease tone with right 4-5th digits. Approach: Pt (patient) to don Rt (right) inflatable carrot splint for up to 6 hours without any changes with skin integrity or increased pain. PROM (passive range of motion) with Rt hand/digit 4th-5th prior to donning Rt inflatable carrot. Time: 7x/wk x 12 wks Review of Resident #36's EMR and documents provided by the facility found no individualized, person-centered Restorative care plan. No documentation in Resident #36's electronic medical record (EMR) was present to show completion of any restorative care based on the physical therapy orders. Resident #40 Review of Resident #40's MDS assessment, dated 3/5/22, revealed Resident #40 was readmitted to the facility on [DATE] with diagnoses that included: diabetes mellitus, muscular dystrophy, contracture of right-hand muscle, and muscle weakness. Resident #49 was totally dependent upon staff for bed mobility, transfers, dressing, toilet use, personal hygiene, and bathing, and had a functional limitation in range of motion on one side of his upper extremity. Resident #40 scored 15 of 15 on the BIMS, reflective of intact cognition. Section O - Special Treatments, Procedures, and Programs of the 3/5/22 MDS assessment did not document Resident #40's participation in the Restorative Program. Resident #40's Restorative Care Program form, signed by a Therapist and Restorative Nurse/Aide on 10/11/21 and 11/10/21, revealed the following: Goals for Restorative Program: To maintain B (bilateral) LE (lower extremity) ROM and MS (muscle) strength. Approach: PROM . on B LE in all planes. 10 reps x 2. Time: 3x/wk x 8 weeks. No documentation was present showing Resident #40 was discharged or had a program change to his restorative program. Review of Resident #40's Care Plans found a Restorative care plan with all interventions dated 2/1/21 (over a year ago) with physical therapy orders that did not match the current Restorative Care Program for Resident #40 dated. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No documentation in Resident #40's electronic medical record (EMR) was present to show completion of any restorative care based on the physical therapy orders. Review of the Restorative Services - Goals and Objectives policy, dated 3/16/22, and received from the Director of Nursing (DON) on 3/29/22 at 5:15 p.m., revealed the following in part: Specialized rehabilitative service goals and objectives shall be developed for problems identified through resident assessments . 1. Rehabilitative goals and objectives are developed for each resident and are outlined in his/her plan of care relative to therapy services. The Restorative Services policy provided did not address who may provide specific treatments, nor did it address equipment use, cleaning, and storage. The policy did not delineate the need to include specific care plan interventions, exercises and/or therapy to maintain or improve the ROM or mobility or to prevent, to the extent possible, further declines in the resident's ROM or mobility. During an interview on 3/29/22 at 5:05 p.m., the Director of Nursing (DON) was asked for any Restorative documentation including therapy orders, progress notes specific to restorative function, and documentation of completion of the range of motion exercises ordered by therapy. The DON said the Restorative program had just been started and all documentation was on paper. The DON said she had just met with the Restorative Certified Nurse Aide (CNA) who would work Monday through Friday and had started working with the Restorative program on Monday (3/28/22). When asked for the location of Restoration task documentation, the DON acknowledged the Restorative activities were not documented, and there were no Restorative progress notes. The DON agreed that if the documentation was not completed, it would be considered as not done, as no evidence was present to show the Restorative program participation with each resident.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38328 Based on observation, interview, and record review, the facility failed to provide adequate supervision and/or fall interventions to prevent falls, including a fall with major injury (fracture) resulting in harm, for four Residents (#6, #20, #27, and #145) of six residents reviewed for falls. This deficient practice resulted in a hip fracture for Resident #20 with continued sequalae following surgical repair, and the potential for injury for the other residents. Findings include: On 3/28/22 1:53 p.m., Resident #145 was observed resting in a bed with a metal bed frame and an air mattress in place and not functioning (unplugged). Three half rails were noted in place on the bed; two rails on the right side at the foot and head with a space in between, and a half rail on the left side at the head of the bed. In between the rails on the right hand side, a dark blue cushion was uncovered, unsecured and tucked in the space between these rails. There were two fall mats located in the room which were folded up and resting against a chair at the foot of the bed. A review of the hospital History and Physical, dated 3/24/2022 at 11:38 p.m. [Recorded as Late Entry on 3/25/2022 at 11:38 p.m.], read in part: HPI (History of Present Illness): (Resident #145) was transferred for continued medical management and rehab care from (local hospital) where she was hospitalized for inpatient hospice care after a traumatic fall . PMH (Past Medical History): COPD (Chronic Obstructive Pulmonary Disease), traumatic fall, nasal bone fx (fracture), acute respiratory failure, intracranial hemorrhage w (with)/thalamic bleed, acute UTI (Urinary Tract Infection), asthma, pediculosis (lice infestation), generalized anxiety disorder, Alzheimer's dementia, multilevel C-spine degenerative disk disease, chronic debility . A review of the progress notes section for Resident #145 revealed the following: 03/24/2022 06:30 AM . bed left in lowest position with safety mat present @bedside . 03/25/2022 07:58 AM . bed left in lowest position with safety mat present @bedside . On 3/29/22 at 3:09 p.m., the floor mats were observed folded up and leaning against the wardrobe located near the room door. Resident #145 was resting in her bed. On 3/30/22 at 8:09 a.m., upon entering Resident #145's room, two floor mats were located in the room folded up and leaning against furniture. Resident #145 was resting in her bed. On 3/30/22 at 5:21 p.m., Resident #145 continued to have three side rails observed in place on the Resident's bed. There were no orders, measurements, assessment, or consent for the three half rails. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 3/31/22 at 01:00 PM an observation was made of Resident #145's bed with rails remaining in place and no assessment, consent, or orders provided by the facility at the time of exit. The Director of Nursing (DON) and Nursing Home Administrator (NHA) were asked to provide evidence of the order, measurements, assessment, and consent for the half rails. On 4/4/22 at 1:08 p.m., a review of the Electronic Medical Record (EMR) Progress Notes for Resident #145 revealed the facility had the bed with side rails changed out and Resident #145 was currently resting in a bariatric bed. On 4/4/22 at 2:10 p.m., during an interview, the NHA was asked why the bed and bed rails were removed from Resident #145. The NHA stated they were starting the process over and removing the bed with bed rails until the required items for bed rail use could be completed. The NHA acknowledged the facility was out of compliance with regard to the use of bed rails on Resident #145. The NHA was asked for the facility policy for bedrails. On 4/4/22 at 2:20 p.m., the floor mats in the room were noted in place on the left hand side of the bed. A review of the EMR care plan on 4/4/22 at 2:54 p.m. revealed no floor mats used as an intervention for any precautions. On 4/4/22 at 3:00 p.m., One of the floor mats was observed leaning up against a chair in the room and the other floor mat was folded up into thirds on the floor and located approximately 2-3 feet from the edge of the bed. Resident #145 would likely have struck the floor versus landing on the floor mat if she were to have fallen out of bed. On 4/4/22 at 03:02 p.m., during an interview, Licensed Practical Nurse (LPN) AA was asked if floor mats were supposed to be in place for Resident #145 when she was in her bed. LPN AA confirmed the floor mats were supposed to be in place. This surveyor accompanied LPN AA to the room and showed her the floor mats as observed above. LPN AA agreed the floor mat should not have been folded up and not in the correct place. On 4/4/22 at 4:00 p.m., during an interview, the DON provided a policy on restraints and stated this was the closest policy she could find relating to the use of bed rails. The DON stated they follow Centers for Medicare/Medicaid guidelines for bedrail use. A review of the policy Assessing Falls and Their Causes, with a revised date of 8/1/2016, read in part: 2. Identify the resident's current medications and active medical conditions . There was no guidance within the facility policy for staff to assess for the risk of falls when admitting and/or initiating appropriate interventions to prevent falls for a resident with a significant fall history. 34276 Resident #6 (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeside Manor Nursing and Rehabilitation Center	13990 Lakeside Circle Sterling Heights, MI 48313

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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 0689 Level of Harm - Actual harm Residents Affected - Few	On 3/30/22 at 11:54 a.m., Resident #6 was observed walking around near the nurse's station near the door of his room. Resident #6 was unsteady on his feet, wearing only regular socks, and started to reach out looking for something to steady his balance. Resident #6 was assisted to steady himself when LPN A offered him a hand. A review of Resident #6's medical record revealed he admitted to the facility on [DATE] with diagnoses including vascular dementia, stroke, and diabetes type 2. A review of his 1/2/22 MDS assessment revealed he scored 1/15 on the BIMS assessment, indicating severely impaired cognition, had a fall in the month prior to his admission, and had one fall since his admission to the facility. On 4/4/22 at 4:05 p.m., Resident #6 was observed up walking in the hallway with his Family Member (FM) HHH. Resident # 6 had a slipper on his left foot and a regular sock on his right foot. FM HHH reported that his father liked to walk but was at risk for falls. A review of Resident #6's care plan for Falls initiated 12/29/21 revealed the following: Resident is at risk for falling R/T: mobility and cognitive limits . Provide proper, well-maintained footwear . 35103 Resident #20 During interview on 3/28/22 at 2:25 p.m. and 3/30/22 at 1:43 p.m., Resident #20 was interviewed regarding falls in the facility. Resident #20 said facility staff had dropped her and she had a broken hip. Resident #20 was unsure what staff member was present when she fell and broke hip on 12/2/22. Review of Resident #20's MDS assessment, dated 9/2/21, revealed Resident #20 was admitted to the facility on [DATE] with diagnoses that included cerebrovascular accident (CVA), hemiplegia, depression, and other muscle spasm. Resident #20 was totally dependent on staff for bed mobility, transfers, dressing, toileting, personal hygiene, and bathing, and scored 15 of 15 on the Brief Interview for Mental Status (BIMS), reflective of intact cognition. Review of a Fall Event Report for Resident #20, dated 12/2/21 at 6:19 p.m., revealed the following in part: CNA reported to writer that in the middle of peri care residents' upper body was too close to the edge of the bed and she was sliding off the bed. CNA lowered resident to the floor and called for help . The progress note said the Physician, family, and DON (Director of Nursing) were notified at that time (12/2/21 at 4:42 p.m.). Notification specified on the Event Report documented NO to Attending Faxed, Physician Notified, Resident Representative Notified, and Care Plan Reviewed. The CNA involved was not identified in the report. Review of Resident #20's progress notes revealed the following, in part: 12/2/21 4:42 p.m., CNA reported to writer that in the middle of peri care residents' upper body was too close to the edge of the bed and she was sliding off the bed, CNA lowered resident to the floor and call for help . (Authored by LPN B) (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	12/3/21 5:59 p.m., Received a report resident tested positive for Covid (presumptive) awaiting results for PCR. Patient alert, oriented, weak complains of feeling weak and reports pain (6) (6 out of 10 on pain scale) on Hip post fall 12/2/2021 .[Physician] notified .Order to send patient out to Hospital. 12/17/21 8:20 p.m., readmitted on 14 day observation post covid and Hemiarthroplasty hip . Review of a [Name] Therapy Screen, for Resident #2 by Occupational Therapy (OT) staff on 12/16/21 revealed the following, in part: Reason for Screen . Resident had a fall 12/2 . Therapy was told on 12/6/21 . Change from baseline (Circle): Falls (circled) . Educate staff on [illegible word, appears to be 'proper'] bed mobility. Pt (patient) had covid 19 and sent out to hospital on 12/2 . Review of Resident #20's acute care hospital History of Present Illness, admitted : 12/3/2021 revealed the following, in part: .bed bound needs hoyer lift/wheelchair for mobilization . present from [Facility Name] nursing home due to a fall. Per patient she is a 2 person assist for movement. She says only one person moving her at nursing home and she fell on to wheelchair, had left hip pain . Review of Resident #20's acute care hospital After Visit Summary, for the 12/4/21 - 12/17/21 hospital stay, revealed the following, in part: Current Visit, Past Procedures, 12/5/2021 Hemiarthroplasty hip . During an interview on 4/4/22 at 10:05 a.m., Licensed Practical Nurse (LPN) B said she did not recall who the CNA was that reported Resident #20 slipped from bed during pericare on 12/2/21. When asked about the provision of pericare by one CNA, for a resident with left-sided paralysis, LPN B acknowledge surprise that the CNA had done pericare alone for Resident #20. LPN B agreed it would be unsafe to roll Resident #20 alone (to clean the buttocks), and also agreed you would not complete pericare from the front position only - rolling would be necessary. LPN B confirmed she was called for assistance by the unidentified CNA, and found Resident #20 on the floor. During a telephone interview on 4/4/22 at 11:25 a.m., Resident #20's Durable Power of Attorney (DPOA) DD was asked about Resident #20's 12/3/22 hospitalization . DPOA DD said Resident #20 had a significant decline in her condition since the broken hip in early December 2021. When asked about notification from the facility, related to a fall for Resident #20, DPOA DD said Resident #20 was not able to reposition in bed due to left sided paralysis from a stroke in 2019. DPOA DD stated, I do not believe that they lowered her to the ground. She is not even able to turn herself in bed. I was heartbroken when I heard about it. I was very upset when they did not take her to the hospital (right away). I did not find out that she had gone to the hospital until the doctor called and said she was going to have surgery . The nurse called me and said we dropped her . said she (Resident #20) slipped . and she went down to the floor and she called for help . DPOA DD said that she believed the decline in Resident #20's current condition was a result of the fall with resulting hip fracture in December 2021. During a telephone interview with Confidential Witness #C1009 on 4/5/22 at 2:20 p.m., Resident #20's fall in the facility on 12/2/21 was discussed. Witness #C1009 said they were sad and unconsionably upset by the multiplicity of things that transpired with Resident #20's care. Witness #C1009 said the facility administration said Resident #20 did not have a fall, but nursing staff said there was a problem with the transfer from the bed to the wheelchair. Witness #C1009 stated, To be honest with you, a lot of that (fall information) was a little convoluted and camouflaged . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 4/4/22 at 3:15 p.m., the Director of Nursing (DON) and Nursing Home Administrator (NHA) confirmed there was no investigation completed and no witness statements obtained for Resident #20's fall resulting in a broken hip (major injury). The CNA involved in Resident #20's 12/2/21 fall from bed was unable to be identified, and therefore unable to be interviewed. The facility was unable to provide staff schedules showing which nursing staff worked in the facility on 12/2/21 and 12/3/21 at the time of, and following Resident #20's fall with left hip fracture. Review of the facility Resident Abuse/Neglect policy, revised 3/9/22, revealed the following, in part: Incidents involving alleged, suspected or actual abuse (including misappropriation or exploitation) or resulting in serious bodily injury to the patient (including injuries of unknown origin), shall be reported to the state immediately, but not more than 2 hours after forming the suspicion .

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 38328 Based on observation, interview and record review, the facility failed to prevent the unnecessary use of a catheter for one Resident (#145) of one resident reviewed for catheter use. This deficient practice resulted in the potential for complications related to catheter use including complications associated with urinary tract infection. Findings include: On 3/28/22 at 2:00 p.m., Resident #145 was observed with a catheter bag in place on the window side of the bed. The urine in the catheter bag and tubing was clear yellow. On 3/31/22 at 9:55 a.m., Certified Nurse Aide (CNA) C was observed providing pericare and catheter care. The catheter bag and tubing was observed with yellow urine and significant sediment in the urine. On 4/4/22 at 2:20 p.m., the Director of Nursing (DON) was asked for a qualifying diagnosis for catheter use on Resident #145. A review of the face sheet in the Electronic Medical Record (EMR) accessed on 4/4/22 at 2:30 p.m., revealed the only diagnosis associated with catheter use for Resident #145 was N39.0 History of Urinary Tract Infection. On 4/4/22 at 2:35 p.m., the urine in the catheter tubing was observed filled with sediment. On 4/5/22 at 10:20 a.m., during an interview, the DON stated there was not a qualifying diagnosis for the catheter use so it was removed the morning of 4/5/22. The facility provided policies for catheter use including Foley Catheter Insertion, Female, revised date 3/16/22, and Foley Catheter Removal, revised date 3/15/22. The policies provided had no guidance on the appropriate use of a catheter including making sure there was an appropriate diagnosis.

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F 0692 Level of Harm - Actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34276 Based on observation, interview, and record review, the facility failed to ensure that Residents were: 1) provided feeding assistance and supervision per assessment; 2) Provided fluids of appropriate consistency to prevent dehydration; 3) assessed and monitored by a qualified nutritional professional to maintain adequate nutritional parameters and to address significant weight loss, and; 4) were weighed per physician order to monitor weight status for seven Residents (#6, #27, #43, #95, #145, #902, and #903) out of 17 reviewed for nutrition and hydration. This deficient practice resulted in significant weight loss, a lack of weight monitoring, and a lack of assessment with the potential for dehydration, tube feeding intolerance, and overall decline. Findings include: Resident #6 On 3/30/22 at 8:20 a.m., Resident #6 was observed laying in bed sleeping with his untouched breakfast tray on the overbed table with his door closed. A review of Resident #6's medical record revealed he admitted to the facility on [DATE] with diagnoses including vascular dementia, stroke, and diabetes type 2. A review of his 1/2/22 Minimum Data Set (MDS) assessment revealed he scored 1/15 on the Brief Interview for Mental Status (BIMS) assessment indicating severely impaired cognition and required supervision and one staff physical assistance for eating. A review of Resident #6's weight log revealed the following: 12/28/21: 138.7 pounds 2/12/22: 136.2 pounds 2/17/22: 137.8 pounds 2/21/22: 139 pounds 3/10/22: 139.9 pounds Resident #6 was not weighed for over a month after his first admission weight. On 3/31/22 at 10:59 a.m., Resident #6 was observed being weighed by Licensed Practical Nurse (LPN) A. Resident #6 was found to be 128.6 pounds, revealing a loss of -11.3 pounds in 3 weeks or -8.0% body weight loss. On 4/4/22 a review of Resident #6's record revealed the weight that was taken on 3/31/22 had not been logged, no repeat weight had been taken, and no dietary assessment had been conducted regarding the weight loss. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Some	On 4/4/22 at 1:51 p.m., an interview was conducted with the Director of Nursing (DON). When asked about why the weight taken on 3/31/22 wasn't logged and the weight loss was not addressed, the DON called LPN A by telephone. The DON reported that LPN A couldn't remember if he had logged the weight or not. When asked if weights should be documented in the medical record, the DON reported they should be. On 4/4/22 at 4:05 p.m., Resident #6 was observed up walking in the hallway with his Family Member (FM) HHH. FM HHH was asked if he had any concerns regarding his father's care and stated, Do you know how they are feeding him? FM HHH reported his father needed extensive encouragement and cueing with eating. When asked if he felt his father had lost weight since being at the facility, FM HHH reported his father looked like he had lost a lot of weight. A review of Resident #6's care plan for Nutrition initiated on 12/29/21 revealed, Resident has potential alteration in nutritional status .monitor for chewing/swallowing difficulty Monitor/record and report to MD (medical doctor) any S/S (signs and symptoms of) malnutrition; emaciation, muscle wasting, weight loss . Obtain dietary consult and follow recommendations On 3/30/22 at 10:24 a.m., a phone interview was conducted with Consultant Registered Dietitian (RD) T. When asked how many hours she was working in the building or how many Residents she was reviewing at the facility, RD T stated, There's no way to report anything. I'd have to go into each record to figure that out. RD T reported she was just helping the building out until they hired an RD. RD T was asked about the lack of weighing residents per the policy and reported she had no comment on the issue. On 3/30/22 at 4:46 p.m., during an interview Certified Dietary Manager (CDM) S reported she started as the CDM in September of 2021 along with another CDM. When asked which Residents she provided nutritional monitoring and care for, CDM S reported all the Residents except for those on tube feeding, with wounds, with weight loss, and dialysis patients. CDM S was asked if she obtained Resident preferences and stated that she was, and that they were supposed to be done within 72 hours of admission. CDM S reported she usually worked four to five days a week in the afternoons, from 4:00 p.m., until whenever she's done. CDM S admitted that she was working a full-time job elsewhere and was just carrying the load until they hired someone full time. Resident #43 On 3/29/22 at 8:29 a.m., Resident #43's tray was observed in the cart to go back to the kitchen with the other trays after the meal. A review of her plate of pureed food revealed none of it had been consumed. LPN A reported that Resident #43 only ate about 10% at each meal and received a bolus of tube feeding if she didn't eat much. A review of Resident #43's medical record revealed she admitted to the facility on [DATE] with diagnoses including gastrostomy (feeding tube) status, moderate protein-calorie malnutrition, adult failure to thrive, and dementia. A review of the 3/7/22 Minimum Data Set (MDS) assessment revealed she was assessed by staff to be severely impaired for cognition. Per this assessment Resident #43 was totally dependent on one person for eating, received more than 51% of her nutritional needs from a tube feeding but also consumed a mechanically altered diet, and was marked for having significant weight loss. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Some	A review of Resident #43's medical record revealed no nutritional assessments, evaluations, or progress notes. A review of Resident #43's weight log revealed the following: 3/1/22 125.6 pounds 3/24/22 133.4 pounds (+7.8 pounds or 6.2% gain x 3 weeks) 3/28/22 133.6 pounds 3/28/22 134.1 pounds Resident #43 was not weighed weekly after her admission, so it is unclear if there was significant weight gain, or if the admission weight was inaccurate. On 3/30/22 at 8:20 a.m., Resident #43's tray was again observed in the dirty tray cart with no bites taken from any of the food. On 3/30/22 at 8:28 a.m., CNA N was asked if she had assisted resident #43 with eating. CNA N reported that she had. When asked how long she had assisted the resident, CNA N stated, About five minutes the first time, and then someone else tried, and I went back again. CNA N reported Resident #43 had eaten a few bites, despite the meal tray showing no bites had been taken. On 3/30/22 at 10:24 a.m., RD T was asked why Resident #43 had no nutritional notes or assessments conducted. RD T reported she had been following the resident for a few weeks but had not documented anything. When asked if she had ever met the Resident, RD T reported she had not. On 3/30/22 at 12:05 p.m., Resident #43 was observed seated across from the nurse's station with a rolling table positioned in front of her. On the table was her lunch tray of pureed food and regular fluids. CNA N was observed standing in front of Resident #43 holding a spoon of pureed food in front of her face. CNA N put the spoon down and continued to stand in front of Resident #43 looking down at her with her hands on her hips. CNA N continued to offer the same bite of pureed food without describing what the food was or offering any of the other two pureed foods on the plate. On 3/31/22 at 8:00 a.m., Resident #43 was in bed and CNA YY was seated in a chair beside her bed. A spoon was in the meat portion of the plate, but the other two unidentified pureed foods were untouched. When CNA YY was asked what was on the plate, she said Oatmeal and I don't know what else. A review of Resident #43's care plan titled, Nutrition initiated on 3/2/22 revealed, Resident has potential alteration in nutritional status R/T malnutrition, cognitive and communicate deficits, assist with adl tasks needed, peg tube placement and use for nutrition . Administer tube feeding and water flushes per MD orders (initiated 3/30/22) .Elevate HOB 30-45 degrees during tube feeding administration (initiated 3/30/22) . Obtain dietary consult and follow recommendations (initiated 3/2/22). Resident #95 (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Some	On 3/30/22 at 8:26 a.m., Resident #95 was observed in bed with just a brief on and a thin white blanket covering his head. Resident #95 had consumed 100% of his food, but had no beverages on his meal tray or at his bedside. A review of Resident #95's medical record revealed he admitted to the facility on [DATE] with diagnoses including down syndrome, chronic obstructive pulmonary disease (COPD), viral pneumonia related to COVID-19, and dementia. Resident #95 had no completed MDS assessments in his record. A review of Resident #95's record revealed he had not been assessed by the CDM or the RD since his admission to review his nutrition and hydration needs. A review of Resident #95's physician order for diet dated 3/24/22 revealed, Diet: Puree with thick liquids and NO STRAW. This diet order did not indicate what the level of thickness (nectar, honey, or pudding) should be for the fluids. On 3/30/22 at 9:52 a.m., Resident #95 was observed in bed. Resident #95 has no fluids at bedside or in his room at all. On 3/30/22 at 11:53 a.m., Resident #95 was observed with no liquids in his room. Resident #95 was noted to have a continued congestive cough. On 3/30/22 at 3:50 p.m., Resident #95 still had no liquids in his room. On 3/30/22 at 4:00 p.m., RD T and the Director of Nursing (DON) were asked to observe Resident #95. When asked if there was anything missing from Resident #95's room, the DON and RD T confirmed that Resident #95 did not have any beverages or hydration available to him. When asked about Resident #95's diet order being Thick Liquids and whether or not he had been assessed by a Speech Therapist, RD T reported that CDM S was supposed to do his assessment. On 3/30/22 at 5:35 p.m. and 3/31/22 at 12:45 p.m., Resident #95 was observed still with no liquids or beverages in his room. A review of the facility policy titled, Resident Hydration and Prevention of Dehydration last reviewed by the facility on 3/16/22 revealed, 1. The dietitian will assess all residents for hydration adequacy at least quarterly, and more often as necessary per resident need . 6. Nurses' aides will provide and encourage intake of bedside, snack and meal fluids, on a daily and routine basis as part of daily care. Resident #902 A review of Resident #902's medical record revealed he admitted to the facility on [DATE] with diagnoses including protein-calorie malnutrition, gastrostomy status, tracheostomy status, and pneumonia. A review of the 11/15/21 Minimum Data Set (MDS) assessment revealed he was Severely Impaired per staff assessment and received tube feeding to meet his nutritional needs. A review of Resident #902 weight log revealed he was never weighed during his admission. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Some	A review of Resident #902's record revealed no nutrition or dietary notes. Resident #903 was never seen by the CDM or the RD. The facility was asked to provide the November and December 2021 MAR and TAR. The facility only provided the November 2021 MAR that included December 1. This MAR did not show that any tube feeding were documented as administered during his stay. A review of Resident #902's progress notes revealed, 11/29/21 . Resident received peg tube feeding, during feeding machine malfunctioned. Writer called RD, and Acting D.O.N (Director of Nursing) no answer, awaiting return phone call for bolus order . A review of Resident #902's Nutritional Status care plan initiated on 11/12/21 revealed, Resident has potential alteration in nutritional status R/T PMH of: malnutrition, cardiac disease, tubefeeder . This care plan contained only 4 interventions, including 11/12/21 Obtain dietary consult and follow recommendations. There were no interventions regarding weighing the resident, monitoring for signs or symptoms of aspiration, or to keep the head of the bed elevated to prevent aspiration. Resident #903 A review of Resident #903's medical record revealed she admitted to the facility on [DATE] with diagnoses including gastrostomy status, protein-calorie malnutrition, diabetes type 2, and pneumonia. A review of the 11/17/21 MDS assessment revealed she scored 9/15 on the BIMS assessment indicating moderately impaired cognition. Per this MDS, Resident #903 had two unhealed stage three pressure ulcers and relied on tube feeding to meet her nutritional needs. A review of Resident #903's face sheet revealed she discharged to the Emergency Department on 12/9/21 and did not return to the facility. A review of Resident #903 dietary notes revealed she was evaluated by former CDM UU on 9/18/21, 9/26/21, 10/5/21, 10/11/21, and 12/8/21. Resident #903 was never seen by a RD during her admission. A review of Resident #903's weight record revealed the following: 9/16/21 172.6 pounds 11/18/21 147.2 pounds (-25.4 pounds or -14.7% weight loss in 2 months.) 11/19/21 147.2 pounds Resident #903 was not weighed for almost two months between September and November of 2021. Resident #903 was only weighed three times during her admission, despite receiving tube feeding, having pressure ulcers, and having significant weight loss. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Some	A review of Resident #903's care plan for Nutritional Status initiated 9/10/21 revealed, Resident has potential alteration in nutritional status R/T PMH of: gerd (gastroesphogeal reflux), diabetes, is a tube feeder; had peg placed July 14, 2021 .Obtain dietary consult and follow recommendations . tube feeding per order . This care plan had no interventions regarding weight monitoring or to keep the head of bed elevated to prevent aspiration. There were no updates to this care plan since 9/13/21. A review of the facility policy titled, Nutritional Assessment last reviewed by the facility on 3/16/22 revealed, 1. The Dietitian, in conjunction with the nursing staff and healthcare practitioners, will conduct a nutritional risk assessment for each resident upon admission (within current initial assessment timeframes) and as indicated by a change in condition that places the resident at risk for or with impaired nutrition . identify at least the following components: . usual body weight . a description of the resident's usual intake and appetite . general appearance . the residents usual route(s) of intake . food preferences and dislikes (including flavors, textures, and forms . food restrictions .an estimate of calorie, protein, nutrient and fluid needs . special food formulations . Individualized care plans shall address, to the extent possible: a. The identified causes of impaired nutrition; b. the resident's personal preferences . time frames and parameters for monitoring and reassessment . A review of the facility policy titled, Weight Assessment & Intervention last reviewed by the facility on 3/16/22 revealed, 1. The nursing staff will measure resident weights on admission, and weekly for three weeks thereafter. If no weight concerns are noted at this point, weights will be measured monthly thereafter. 2. Weights will be recorded in each unit's Weight Record chart or notebook and in the individual's medical record. 3. [NAME] weight change of 5% or more since the last weight assessment will be retaken. If the weight is verified, nursing will immediately notify the Dietitian in writing. Verbal notification must be confirmed in writing. 4. The Dietitian will respond within 24 hours of receipt of notification . 6. The threshold for significant unplanned and undesired weight loss will be based on the following criteria: . a. 1 month - 5% weight loss is significant; greater than 5% is severe. 3 months - 7.5% weight loss is significant . 6 months - 10% weight loss is significant . 35103 Resident #27 During an observation and interview on 03/28/22 at 3:59 p.m., a white styrofoam cup with a straw was observed on Resident #27's overbed table. When asked about replenishment of fresh water, Resident #27 stated, This (water) is from the midnight shift last night. We did not get any fresh water on day shift - none this morning - this (water) is old. During an observation and interview on 03/30/22 at 3:59 p.m., a white syrofoam cup with a straw was observed on Resident #27's overbed table. The cup was dated with pen for 3/29/22 near the rim, just below the cup cover. Resident #27 said the water was from the night shift staff the previous nice and day shift did not bring her fresh water that day. Resident #27 stated, They facility staff) didn't offer water today. Resident #27 stated, When they (facility staff) get me up, they don't have to do anything for me the rest of the day. They don't come to do anything for me. Resident #16 (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Some	During an observation on 03/28/22 at 3:34 p.m., Resident #16 was observed asleep in bed with a red blanket pulled up over his head. During an interview at this same time CNA NN said she was assigned to Resident #16's care and had assisted him with breakfast, but he did not eat anything for lunch. The meal tray was still present in his room, with pureed food underneath the insulated lid, and pudding, milk, and juice on the tray as well. Nothing appeared eaten. CNA NN said the lunch tray would remain in his room until dinner. No water for hydration was visible within reach of Resident #16 in the room. During an interview on 03/30/22 at 05:06 p.m. CDM S said water was provided to the residents on every shift. CDM S stated, They should have fresh water in the room, so it is easier for staff to assist the resident (who may need dining assistance). 38328 Resident #145 On 3/28/22 at 2:04 p.m., during an interview, Resident #145 stated she needed some help and at first stated she did not know why. Resident #145 then stated she needed something to drink and began to ask for Agua meaning water in Spanish. This Surveyor informed Resident #145 staff would be alerted to her need. The water was observed on a bedside table which was positioned against the adjacent bathroom wall approximately six feet away and out of reach of the Resident. On 3/28/22 at 2:10 p.m., Licensed Practical Nurse (LPN) B was notified of Resident #145's water needs. Resident #145 was heard calling out Agua (Water in Spanish) several times while LPN B and this Surveyor were walking back to Resident#145's room. LPN E assisted Resident #145 with drinking several sips of water from a straw and then placed the water back on the tray table within reach of Resident #145. LPN B was asked if Resident #145 was able to drink independently. LPN B stated, Yes, she can. LPN B stated Resident #145 was at the facility for hospice services and had been at the facility for approximately one week. On 3/30/22 at 8:09 a.m., there were no fluids available to Resident #145 and the bedside table was observed out of reach sitting against the adjacent bathroom wall approximately six feet away.

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34276 Based on observation, interview, and record review, the facility was placed in Immediate Jeopardy (IJ) related to failing to ensure that medically complicated residents receiving enteral nutrition (tube feeding) and at risk for weight loss, dehydration, and aspiration (inhalation of foods/fluids into the lungs) were thoroughly assessed, evaluated, and monitored by a Registered Dietitian (RD) as well as provided care by competent staff to prevent complications, effecting six Residents (#15, #43, #46, #901, #902, #903) out of six Residents reviewed for enteral nutrition. This deficient practice resulted in: 1) Resident #902 receiving no enteral assessment or monitoring by an RD or other qualified health practitioner, was never weighed during his admission, did not have appropriate tube feeding orders or documentation of administration, and was found unresponsive with cause unknown and expired [DATE] while in transport to the Emergency Department.; 2) Resident #46 failed to receive a timely RD consult for tube feeding intolerance, did not have appropriate water flush orders or documentation of administration, started to exhibit signs of intolerance (emesis of coffee ground-like substance) post feeding, and was found unresponsive and expired the following day on [DATE]; 3) Resident #903's tube feeding and orders were not monitored by an RD and weights were not consistently taken which resulted in a significant weight loss of 25.4 pounds in two months; 4) Resident #15 was observed receiving the wrong tube feeding formula on [DATE] and [DATE] during the annual survey, with the potential for significant weight change and nutritional inadequacy; 5) Resident #43's bolus tube feeding administration was observed where staff used ice water to flush and dilute the tube feeding, resulting in discomfort and the potential for clogging and intolerance. The IJ began on [DATE], when the RD failed to assess and provide tube feeding order recommendations, the physician order for tube feeding was not written correctly and, there was no documentation of the tube feeding being administered, which likely contributed to Resident #902's hospitalization on [DATE]. As of [DATE] the facility still had no RD providing nutritional care on a consistent basis to ensure Residents receiving tube feeding were being assessed, monitored for tolerance, weighed appropriately, and had correct tube feeding orders consistently to prevent significant weight loss, tube feeding intolerance, and malnutrition. The IJ notification was communicated verbally to the Administrator and Director of Nursing (DON) on [DATE] at 6:23 p.m. and was followed with an email copy with request for an abatement plan. The IJ was removed on [DATE] when the facility abatement plan was accepted. The deficient practice continued at a pattern level of potential for more than minimal harm until onsite review and confirmation of the completion of the full plan of correction. Findings include: Resident #902 A review of Resident #902's medical record revealed he admitted to the facility on [DATE] with diagnoses including protein-calorie malnutrition, gastrostomy status, tracheostomy status, and pneumonia. A review of the [DATE] Minimum Data Set (MDS) assessment revealed he was Severely Impaired in cognition per staff assessment and received tube feeding to meet his nutritional needs. A review of Resident #902 weight log revealed he was never weighed during his admission. (continued on next page)

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A review of Resident #902's record revealed no nutrition or dietary notes. Resident #902 was never seen by an RD or by a Certified Dietary Manager (CDM). The facility was asked to provide the November and [DATE] MAR and TAR. The facility only provided the [DATE] MAR/TAR that included [DATE]. These Administration records did not show that any tube feedings were documented as administered during his stay, as the orders were not translated to any of the administration records. A review of Resident #902's physician order dated [DATE] revealed . Glucerna 1.5 @ 50 hr 1800 total water 100ml/hr total 1115mL . This order was discontinued on [DATE] when Resident #902 was admitted to the hospital. This order was not clearly or correctly written, as the maximum tube feeding that could be administered at a rate of 50mL/hr in 24 hours would be 1200 mL, not 1800. A review of Resident #902's physician order dated [DATE] revealed, . Glucerna 1.5 @ mL water bolus @ 10mL/hr 1800 kcal 99g ppot. 1151mL . and was discontinued on [DATE]. This tube feeding order does not provide the rate per hour, the total mL of tube feeding to be dispensed. Further review revealed the flush order of 10mL per hour could never amount to 1151mL in a 24 hour period. Further review of Resident #902's physician orders revealed no other orders for tube feeding, or documentation as to what his tube feeding order was from [DATE] through [DATE] when he was found unresponsive. This suggests he did not receive any tube feeding during this time period as there was no physician order nor any record showing anything was administered. A review of Resident #902's progress notes revealed the following: [DATE] .(tube feeding) Formula infusing per orders . [DATE] . Pt (patient) displayed using accessory muscle and flushed face along with diaphoresis when checked vitals SPO2 was 80% . 911 called . A review of the [DATE] History & Physical from the hospital reveled, Chief complaint: Sepsis On the day of ED (Emergency Department) admission, patient was noted to be hypoxic with noted bradycardia prompting EMS (Emergency Medical Services) . Chest x-ray revealed right lower lobe pneumonia. admitted to the ICU (Intensive Care Unit) for severe sepsis management . Active Problem List: Severe sepsis likely source pneumonia . Severe protein calorie malnutrition . A review of the [DATE] Discharge Summary for Resident #902 revealed, . Severe protein calorie malnutrition. PEG tube in place. Nutrition consult .Will start trickle feeds. Monitor lytes (electrolytes) closely for refeeding syndrome . A review of the Plan of Care discharge document by Hospital RD NNN revealed, . evident muscle and body fat losses . TF started ,d+[DATE], trickle feedings. Pt has been tolerating Glucerna 1.5 at 15 mL/hr. Electrolytes have been replaced . Interventions: 1. Increase Glucerna 1.5 10ml q 4 hours to eventual goal rate of 50 ml/hr x 24 hr via PEG . will provide 1800 kcals, 99 grams protein, in 910 ml free water. 2. Flush 120 ml H20 via PEG . 3. Ongoing electrolyte monitoring as needed. 4. Weekly weight . Further review of Resident #902's progress notes after he readmitted to the facility on [DATE] revealed the following: (continued on next page)

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	[DATE] . Resident readmitted with a DX (diagnosis) of post sepsis, post RT lower lobe pneumonia (suggestive of aspiration pneumonia), and chronic respiratory failure w/ (with) hypoxia . [DATE] . Resident received peg tube feeding, during feeding machine malfunctioned. Writer called RD, and Acting D.O.N (Director of Nursing) no answer, awaiting return phone call for bolus order . [DATE] Resident is observed in bed with head elevated not breathing. Code Blue Initiated. 911 services notified and arrived after 10 minutes of CPR initiated. Will continue to monitor. [DATE] Resident is expired (deceased) 1608 (at 4:08 p.m.) by (Hospital Doctor) . A review of Resident #902's Nutritional Status care plan initiated on [DATE] revealed, Resident has potential alteration in nutritional status R/T PMH (past medical history) of: malnutrition, cardiac disease, tubefeeder . This care plan contained only 4 interventions, including [DATE] Obtain dietary consult and follow recommendations. There were no interventions regarding weighing the resident, monitoring for signs or symptoms of aspiration, or to keep the head of the bed elevated to prevent aspiration. On [DATE] at 11:23 a.m., a phone interview was conducted with NP Y who reported she was aware the facility had no full time RD or CDM. NP Y reported that she thought that the RD from another building was coming on a set schedule. When asked about resident #902's tube feeding issues, NP Y reported that she usually works with RD but could not remember this resident. When asked about what her expectations are if there are issues with tube feeding, NP Y reported the staff should call her. When asked if not having an RD available to address nutrition and tube feeding concerns impacts the care, NP Y stated, It does. NP Y also reported that residents should be weighed regularly. Resident #46 A review of Resident #46's medical record revealed he admitted to the facility on [DATE] with diagnoses including gastrostomy (feeding tube) status, COVID-19, stroke, protein-calorie malnutrition, and other nutritional anemias. A review of the [DATE] MDS assessment revealed he scored ,d+[DATE] on the Brief Interview for Mental Status (BIMS) assessment, indicating moderately impaired cognition and relied on a feeding tube to meet his nutritional needs. A review of the nutritional assessments completed for Resident #46 dated [DATE], [DATE], and [DATE] revealed they were all completed by Certified Dietary Manager (CDM) UU. A review of the [DATE] Nutritional Assessment revealed Resident #46's estimated caloric needs were ,d+[DATE] kcals (calories) based on his current body weight. Resident #46 weighed 101 pounds with a Body Mass Index (BMI) of 17.33 (BMI < 18.5 is underweight). This assessment also revealed, No referrals necessary . Resident may benefit from planned weight gain program A review of Resident #46's weight log revealed that he was weighed only three times between his admission on [DATE] through his expiration on [DATE], and had significant weight loss. The weight log revealed: [DATE] 101 lbs (pounds) [DATE] 94.2 lbs (-6.8 pounds/ -6.7% weight loss x 1 month - Significant) (continued on next page)

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	[DATE] 91.4 lbs (-9.6 pounds/-9.5% weight loss x 2 months) A review of Resident #46's [DATE] Medication Administration Record (MAR) and Physician orders revealed: [DATE] Consult Dietitian r/t (related to) enteral tube feeding evaluation and loose stools. This was marked as completed on the MAR, but the review of the record revealed it was not completed. [DATE] RD consult re: (regarding) eval (evaluation) formula pt (patient) with diarrhea. This order did not translate to the MAR but review of the record revealed it was not completed. [DATE]-[DATE] diabetisource 1 can 250 cc (cubic centimeters) five times daily which would provide 1500 calories per day. The administration of this bolus (a single dose of tube feeding given all at once) order was documented as charted late 24 times. Late boluses of tube feeding can result in intolerance, high residuals, and refusal of subsequent scheduled boluses due to the patient still feeling too full. [DATE] - [DATE] ok to use Glucerna 1.2 for bolus 250cc five times a day which would provide 1500 calories per day. This order ran concurrently to the order for diabetisource, and staff documented on multiple days that they gave boluses of both tube feeding formulas. A physician's order dated [DATE] through [DATE] for 1550 cc QID (four times per day) water flushes Four times a day was not translated to the MAR or any other administration record provided, and therefore there was no documentation to show it was administered. Furthermore, this order of flushing 1550 cc four times per day would equal to 6,200 cc of free water or 209 fluid ounces in 24 hours. This would grossly exceed the 1377cc fluid needs estimation by CDM UU, and would likely result in high gastric residuals, intolerance, and overhydration/water toxicity. A review of Resident #46's progress note dated [DATE] revealed, Resident had multiple episodes of loose stool. Writer spoke with NP (Nurse Practitioner Y) and orders were for monitoring resident for more loose stool x 2 days every shift, Imodium (antidiarrheal medication) 2mg (milligrams) ,d+[DATE] tabs . and consult to dietitian r/t (related to) enteral feeding formula . A review of Resident #46's progress notes revealed he had refused his bolus tube feeding on [DATE], [DATE], and [DATE]. A review of an [DATE] progress note revealed, .Resident continues to be aggressive verbally and requesting to go to hospital for evaluation and treatment. Resident #46 was transferred to the Emergency Department for evaluation and treatment on [DATE]. A review of Resident #46's progress notes revealed he readmitted to the facility on [DATE]. The progress notes revealed: [DATE] Called Hospital for clarification of feeding intake. Nurse on duty said that Jevity 1.2 50cc/hr to be infuse (sic) up to 1200cc. Notified NP and she order (sic) to continue Jevity 1.2@50cc/ph (per hour) until seen by dietitian. Order carries on. [DATE] H/o (history of) refusing tubefeeding, likely d/t h/o UTI (Urinary Tract Infection) . (continued on next page)

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A review of the only documentation by Consultant RD T for Resident #46 on [DATE] revealed, . Nutritional status Underweight . TF (tube feeding) is being tolerated . Resident has lost 10# (pounds) since admission. Weight loss as unplanned, unavoidable and likely r/t resident refusal of TF at times and diarrhea in November .CBW of 91.4# (pounds) is 67% of IBW (Ideal Body Weight) and 65% of UBW (Usual Body Weight) . POC (plan of care) goal for weight gain to reach 136#. Current TF is Jevity 1.5 55cc x 20 hours and flush of 205cc q 6 hours to provide 1706ml, 1650kcal, and 61g protein; which is above estimated needs for fld/kcal/pro (fluid/calories/protein) . Further review of Resident #46's progress notes revealed: [DATE] . non-compliant elevating HOB (head of bed) at 30 degrees during tube feeding. Resident will lower HOB flat despite education . Tubefeeding is continuing with no problems . [DATE] Writer received order from outgoing nurse to change current tube feeding order to bolus feed of Jevity 1.5 220 cc Q4h; tube feeding order to be re-instated pending delivery. [DATE] Resident was given a bolus feeding at 0430 (4:30 a.m.). residuals were check (sic) prior to feeding and the head of the bed was 30 degrees. The resident vomited stomach content and is noncompliance (sic) with keeping the head of the bed to at least 30 degrees. On coming nurse was notified NP was called no respond (sic). [DATE] .Resident alert, verbal able to make needs known with confusion .Writer noticed vitals unstable. had fever of 100.8 Temporal. w (with) oxygen saturation fluctuated between ,d+[DATE] (percent) new order by NP to put on 2L (of oxygen) nasal cannula . At 2pm resident was afebrile post Tylenol and motrin doses. Labs CBC (complete blood count) and BMP (basic metabolic panel) ordered STAT (immediately). Notified NP of lab results and CXR (chest xray). New order to start one time order of 0.9% NS 65ml/hr (Intravenous hydration). Levaquin (antibiotic) 500Q daily. When writer administered medication via peg, noticed resident overflow of coffee ground color residuals. Notified family and family wants to keep resident inhouse and not send out to the ER (emergency room). Np ordered STAT KUB (an xray of the kidney, ureter, and bladder). order in place . Review of Resident #46's physician orders revealed there was no order for a STAT KUB nor an indication of why it was ordered. Review of Resident #46's Advanced Directives signed by himself on [DATE] revealed yes to being hospitalized , and Resident #46 was legally his own decision maker. A review Resident #46's progress notes dated [DATE] revealed, 3:06 PM . Verbal order to speak with family and ask son if it is okay to have residents placed on Hospice. Notified son of doctors request. (Son of Resident #46) stated that he would call his older brother and will call back later about resident being on hospice . and 4:06 PM Resident was observed in bed with no respirations. Non responsive when called by name. Vitals were unable to be obtained . A review of Resident #46's care plan for Nutritional Status initiated on [DATE] by CDM UU revealed it contained only one approach dated [DATE], obtain weekly weights x 4 weeks, then monthly if stable. On [DATE] Consultant RD/RD T initiated the other 13 approaches, including: Check for tube placement and residuals per facility parameters, Elevate HOB (head of bed) ,d+[DATE] degrees during tube feeding administration, Observe and report to physician PRN(as needed): s/sx (signs and symptoms) of Aspiration, and RD to evaluate monthly and PRN. Make recommendations for changes to tube feeding as needed. (continued on next page)

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On [DATE] at 10:24 a.m., a phone interview was conducted with RD T. RD T reported that she was just helping out in the building until they found a dietitian and had been coming since [DATE]. RD T reported she just did the high-risk Residents as the CDM (CDM S) evaluated and assessed the other Residents. RD T reported that residents on enteral nutrition were supposed to be seen by the RD at least once per month. RD T reported she hadn't been in to do her visits for the month (of March) yet. When asked if she was aware of any issues with the Residents' tube feeding orders or administration, RD T reported she was not. On [DATE] at 12:50 p.m., the Administrator provided the hours the Dietitian had been in the building for the previous three months which revealed, [DATE]. 6.5 hours. [DATE] = 6 Hours. [DATE] = 7 hours. On [DATE] at 4:40 p.m., RD T reported that she had documented on Resident #46 on [DATE], and that he had lost some weight but also sometimes refused his tube feeding. RD T reported she could see that a few days later he was changed from the continuous recommendation that she wrote to a bolus regimen. When asked if she would have recommended the bolus for him, RD T stated, No. He had been tolerating it (continuous tube feeding). When asked if the CDM should be writing or recommending Tube feeding orders, RD T stated, No, that should typically be me. On [DATE] at 9:55 a.m., an interview was conducted with the Director of Nursing (DON). When asked why Resident #46's tube feeding was changed from a continuous feed to a bolus feed on [DATE], the DON could not say. When asked if it was appropriate for a nurse to change a tube feeding without an RD consult, for convenience, or without documenting the reason for the change, the DON stated No. On [DATE] at 11:23 a.m., a phone interview was conducted with NP Y. When asked about Resident #46's tube feeding being held because a KUB was ordered, NP Y reported that tube feeding is not normally held for that procedure. NP Y made no comment as to why the documentation stated that tube feeding and medications were held for a KUB. When asked if a Resident who is his own person and has an advanced directive to be hospitalized can be overruled by family, NP Y stated, The patient goes with his choice. If he wants to be hospitalized , then he (has the) right to go. A review of Resident #46's death certificate revealed, .date of death : [DATE] . Time of death: 4:20 PM . date signed: [DATE] (by the Medical Director) .Enter the chain of events - disease, injuries or complications - that directly caused the death: 2019-nCov acute respiratory disease, cerebral infarct, unspecified; other specified nutritional anemias; Peg tube status with dysphagia . Resident #15 A review of Resident #15's medical record revealed she admitted to the facility on [DATE] with diagnoses including stroke, nutritional deficiency, gastrostomy (feeding tube) status, and diabetes type 2. A review of the [DATE] MDS assessment revealed she was assessed by staff to be severely cognitively impaired and relied on tube feeding to meet her nutritional needs. On [DATE] at 3:50 p.m., Resident #15 was observed in bed with Glucerna 1.2 running at 70 mL/hr. Per the tube feeding pump display it had already dispensed 1210 mL of tube feeding. The bottle was labeled that it had been hung on ,d+[DATE] (2022) but did not have a time that it was hung. (continued on next page)

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A review of Resident #15's physician orders revealed an active order initiated [DATE] for Glucerna 1.5 via peg tube @ 70cc/hr x 20 hours for a total of 1400 cc and 2250kcal. On [DATE] at 7:57 a.m., Resident #15 was observed lying in bed with Glucerna 1.5 running at 70 mL per hour with a total of 540 mL of tube feeding dispensed. On [DATE] at 10:24 a.m., a phone interview was conducted with RD T. When asked about the last time she had assessed Resident #15, RD T reported she was on the schedule for her to see. When notified that Resident #15 had no nutritional notes since [DATE], RD T had no comment. RD T reported she wasn't aware of any issues with the staff not administering the correct tube feeding. On [DATE] at 3:53 p.m., Resident #15 was observed in bed and Glucerna 1.2 was again hanging and dispensing at 70 mL/hr. At 4:00 p.m., RD T and the DON were asked to observe Resident #15. RD T was asked if the correct tube feeding was hanging and reported that the wrong tube feeding formula was being dispensed. On [DATE] at 4:40 p.m., RD T reported that Resident #15 was supposed to be receiving Glucerna 1.5 and that the nurses reported it was likely due to a supply issue that the Glucerna 1.2 was being used. RD T confirmed that Glucerna 1.2 provided less calories per milliliter than Glucerna 1.5 and therefore it could not be substituted at the same rate. Resident #43 A review of Resident #43's medical record revealed she admitted to the facility on [DATE] with diagnoses including gastrostomy (feeding tube) status, moderate protein-calorie malnutrition, adult failure to thrive, and dementia. A review of the [DATE] MDS assessment revealed she was assessed by staff to be severely impaired for cognition. Per this assessment Resident #43 was totally dependent on one person for eating, received more than 51% of her nutritional needs from a tube feeding but also consumed a mechanically altered diet, and was marked for having significant weight loss. A review of Resident #43's medical record revealed she had no admission nutrition or enteral assessment and had no dietary progress notes documented. On [DATE] at 4:21 p.m., Resident #43 was observed in bed with a bottle of Glucerna 1.2 sitting on her bedside table that was three quarters full of tube feeding and was undated and unlabeled. On [DATE] at 10:24 a.m., a phone interview was conducted with RD T. When asked why Resident #43 who was on a tube feeding and had admitted on [DATE] had not yet been assessed, RD T reported she had been following her but had not documented anything. RD T reported that she had not yet been into the building during the month of [DATE]. (continued on next page)

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On [DATE] at 9:00 a.m., Resident #43's bolus tube feeding administration by LPN A was observed. During the administration, LPN A used a measuring cylinder to measure out 350 mL of Glucerna 1.2 out of the 1000 mL ready to hang bottle. LPN A used a Styrofoam cup of ice water to flush the peg tube prior to starting the tube feeding. Upon administering the ice water flush, Resident #43 quivered in discomfort. LPN A then started to administer the tube feeding in portions, and when it did not go through quickly, he added ice water to the syringe to dilute it. LPN A then added ice water directly into the portioned tube feeding container and continued to administer the bolus. LPN A was observed squeezing the tubing and flicking the syringe to get the tube feeding to administer faster. When asked how long they would keep a bottle of tube feeding open for, LPN A reported it was 24 hours but that he threw away and got a new bottle every morning. LPN A left the bottle of tube feeding on Resident #43's bedside table. A review of Resident #43's physician order dated [DATE] revealed, Glucerna 1.2 via Peg Tube bolus 350 mL QID (four times per day) until 1400 mL and 1680kcal infused. Until Glucerna 1.5 comes in the (sic) contact Rd. On [DATE] at 12:42 p.m., Nurse Educator/RN D reported she had completed LPN A's nurse skills competency evaluation on [DATE]. RN D was then asked about the tube feeding administration observation of LPN A and the use of ice water to flush and dilute the tube feeding. RN D reported that when she had observed him just weeks before he had done it correctly. RN D reported she would re-educate LPN A Resident #901 A review of Resident #901's medical record revealed she admitted to the facility on [DATE] with diagnoses including gastrostomy status, tracheostomy status, and pneumonia. Resident #901 had no completed MDS in her chart. A review of Resident #901's progress notes revealed the following: [DATE] 2:34 AM Resident arrived in the building . at approximately 8:15 pm . Has trach in place with 6L (liters) oxygen . Resident has Peg tube in place and is NPO (nothing by mouth). Resident has a LUQ (left upper quadrant) nickel size opening covered with colostomy bag and has small amount of greenish drainage in bag . [DATE] 2:34 AM .Orders to give 250cc bolus (of) Jevity 1.5 along with 250 cc water flush every four hours. [DATE] 5:58 AM Pt was given 250cc bolus of Javity (sic) 1.5 noted tube feed coming out of LUQ open area and collecting in the colostomy bag covering the wound. Bolus was stopped. Area was cleaned new bag was applied and monitored. Notified NP, waiting for further orders. There were no progress notes following the [DATE] 5:58 AM progress note, even though per the Resident Census sheet Resident #901 was not transferred back to the hospital until [DATE] at 6:09 p.m., almost 12 hours later. A review of Resident #901's chart revealed no documentation from any Physician or Nurse Practitioner. (continued on next page)

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A Resident #901's MAR and TAR for [DATE] revealed, Enteral Feeding: Formula Jevity 1.5 bolus 250cc Q4hours with 250 water flush was documented as being on hold for the [DATE] 4:00 AM and 8:00 AM dose, given late for the 12:00 PM dose, and not given for the 4:00 PM dose. A review of a Resident Transfer to the Hospital/Other Care Facility form dated [DATE] 3:49 p.m. for Resident #901 revealed Resident #901 was sent to the hospital, but was not complete and did not entail why the Resident was being sent out. A version of this form that was marked as in progress and was not fully completed contained the paragraph: Resident has an old peg site, that when bolus is administered through new peg site, all the formula passes through and into the old peg tube bag. Resident #903 A review of Resident #903's medical record revealed she admitted to the facility on [DATE] with diagnoses including gastrostomy status, protein-calorie malnutrition, diabetes type 2, and pneumonia. A review of the [DATE] MDS assessment revealed she scored ,d+[DATE] on the Brief Interview for Mental Status (BIMS) assessment indicating moderately impaired cognition. Per this MDS, Resident #903 also had two unhealed stage three pressure ulcers. A review of Resident #903's face sheet revealed she discharged to the Emergency Department on [DATE] and did not return to the facility. A review of Resident #903 dietary notes revealed she was evaluated by former CDM UU on [DATE], [DATE], [DATE], [DATE], and [DATE]. Resident #903 was never seen by a RD during her admission, despite receiving tube feeding, having pressure ulcers, and having significant weight loss. A review of Resident #903's weight record revealed the following: [DATE] 172.6 pounds [DATE] 147.2 pounds (-25.4 pounds or -14.7% weight loss in 2 months.) [DATE] 147.2 pounds Resident #903 was not weighed for almost two months between September and November of 2021. Resident #903 was only weighed three times during her admission, despite receiving tube feeding and having significant weight loss. A review of Resident #903's Medication Administration Record (MAR) from [DATE] through [DATE] revealed the following: From [DATE] through [DATE], Resident #903's diet order read, Pt (patient) to receive Glucerna bolus 237ml for 4x day (4 times a day) with 375 cc H20 flush with each bolus which did not indicate the type of Glucerna (1.0, 1.2, or 1.5 calories/mL). Resident #903 received the correct number of boluses only four days out of those eight days it was ordered. On [DATE] and [DATE], Resident #903 received only a single bolus of .Glucerna 1.2. Administer 474 mL, providing only 568 calories per day. (continued on next page)

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On [DATE], [DATE], and [DATE], the ordered Glucerna 1.2 was not available per the MAR. On [DATE] no substitute was documented as given. On [DATE] there is nothing charted on the MAR, but the progress note for that day stated, .MD stated that if facility is out of Glucerna, use whichever supplement in house that is lowest in glucose, highest in protein. On [DATE] nothing is documented on the MAR but the progress note for that day revealed, .TF jevity 1.0 cal received r/t no glucerna 1.2 . This did not indicate at what rate it was administered, and did not note whether the tube feeding was adjusted due to the facility using a lower calorie tube feeding product. There are no notes that the RD or CDM were notified or consulted. On [DATE], [DATE], and [DATE] there was no documentation that Resident #903 received any tube feeding. On [DATE], just prior to Resident #903's transfer to the hospital, an order was written and administered for 500mL bolus via peg x 1 now, but did not entail what the bolus was. The progress note for this day did not indicate if the bolus was tube feeding or a bolus of water. A review of Resident #903's progress notes revealed the following: [DATE] . patient had an increase in blood pressure and heartrate . writer observed patient sweating cool and clammy. BS (blood sugar) 249. Abdominal (sic) extended and round . audible wheezing noted . patient awaiting to be transported to (Name of Emergency Department) . [DATE] .Readmit from (Name of Hospital) via stretcher. Admission diagnosis severe sepsis . A review of Resident #903's care plan for Nutritional Status initiated [DATE] revealed, Resident has potential alteration in nutritional status R/T PMH of: gerd (gastroesphogeal reflux), diabetes, is a tube feeder; had peg placed [DATE] .Obtain dietary consult and follow recommendations . tube feeding per order . This care plan had no interventions regarding weight monitoring or to keep the head of bed elevated to prevent aspiration. There were no updates to the care plan since [DATE]. A review of the facility policy titled, Enteral Nutrition reviewed [DATE] revealed, 1. The interdisciplinary team, including the Dietitian, will conduct a full nutritional assessment within current initial assessment timeframes to determine the clinical necessity of enteral feedings . 3. The Dietitian, with input from the Physician and Nurse, will: a. Estimated calorie, protein, nutrient and fluid needs; . c. Recommend special food formulations . 4. Enteral nutrition will be ordered by the Physician based on recommendations of the Dietitian . 7. The Dietitian will monitor residents who are receiving enteral feedings, and will make appropriate recommendations for interventions to enhance tolerance and nutritional adequacy of enteral feedings . 12. Staff caring for residents with feeding tubes will be trained on how to recognize and report complications associated with insertion and/or use of a feeding tube, such as: a. Aspiration; . 14. Risk of aspiration will be assessed by the Nurse and Physician and addressed in the individual care plan . A review of the facility policy titled, Enteral Feedings-Safety Precautions reviewed [DATE] revealed, .1. Maintain strict aseptic technique at all times when working with enteral nutr[TRUNCATED]

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F 0695 Level of Harm - Actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34276 Based on observation, interview, and record review, the facility failed to provide timely oxygen care, tracheostomy care, and maintain oxygen concentrators in a sanitary manor for three Residents (#15 and #95 and #902) out of five reviewed for oxygen care. This deficient practice resulted in a Resident (#95) not receiving timely oxygen support during respiratory distress, potentially contributing to his expiration, and the potential for further respiratory distress and infection. Findings include: Resident #95 On [DATE] at 8:15 a.m., Resident #95 was observed in his room. His oxygen concentrator was turned off with the tubing and nasal cannula lying on the floor. The filter on the concentrator was dusty. Resident #95 was rocking in his bed and had a congestive cough. A review of Resident #95's medical record revealed he admitted to the facility on [DATE] with diagnoses including down syndrome, chronic obstructive pulmonary disease (COPD), viral pneumonia related to COVID-19, and dementia. Resident #95 did not have a completed Minimum Data Set (MDS) assessment completed. On [DATE] at 10:32 a.m., Resident #95 was observed in bed in his room with a blanket over his head. Resident removed the blanket from his head and took a sip from the pre-packaged cup of nectar thick juice from his bedside table. After drinking the juice Resident #95 began to cough and struggle to clear his throat. On [DATE] at approximately 10:33 a.m., Certified Nurse Aide (CNA) N was observed in the hall outside Resident #95's room. When asked why Resident #95 had been eating breakfast in his room with the door closed, CNA N reported that Resident #95 had behaviors of disrobing and wouldn't keep his mask on so she told him to stay in his room. On [DATE] at approximately 10:34 a.m., Licensed Practical Nurse (LPN) A was notified of Resident #95's cough by this surveyor and reported he would go assess him. LPN A assessed Resident #95's oxygen saturation with a pulse oximeter and found it to be 81%. LPN A reported that the reading couldn't be accurate and went to find another pulse oximeter. The second pulse oximeter gave a result of 87%. When asked what he would do, LPN A reported he could provide treatments and inhalers as well as oxygen. On [DATE] at 5:35 p.m., Resident #95 was observed rocking in bed. His meal tray was at his bedside with 100% of his food and fluids consumed. The pre-packaged juice cups were noted to be nectar-thick consistency per the label. Resident #95 continued to struggle with a congested cough and slight wheeze. On [DATE] at 5:37 p.m., LPN A was asked about Resident #95's congestive cough and oxygen saturation. LPN A reported that when he checked Resident #95's lungs he heard some crackles so he had notified the Nurse Practitioner (NP Y) and she had ordered a chest X-ray. (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Few	A review of NP Y progress note on [DATE] revealed, .S: Following for treatment of pneumonia. Laying in bed, is alert and awake, answer (sic) to his name. Patient is laying comfortably, no cough and congestion noted no wheezing, no shortness of breath or respiratory distress . ,d+[DATE] chest x-ray .Pneumonic process in the right suprahilar region and in the right infrahilar region medially . shadow and appearing to be portions of the right upper and lower lobes better seen in right lower lobe .Pneumonia. Continue moxifloxacin (antibiotic) . On [DATE] at 1:15 p.m., Resident #95 was observed up in a chair across from the nurse's station with a rolling tray in front of him with a larger Styrofoam cup of honey-thickened juice, and a smaller pre-packaged juice cup that had the label torn off. Resident was observed to be raising and lowering his shoulders while he was breathing, was rubbing his face, and had a productive wet cough and wheeze. On [DATE] at 1:27 p.m., this Surveyor was notified by another member of the Survey team that Resident #95 was having respiratory distress. On [DATE] at 1:30 p.m., Resident #95 was observed across from the nurse's station struggling to breath and clear his airway. Hospice Registered Nurse (RN) II was observed trying to get a portable oxygen tank to work. LPN AA and LPN FFF were also observed around Resident #95. Hospice RN II was asked about Resident #95's Spo2 and stated it was in the 40's. Hospice RN II attempted to get another reading of Resident #95's SPO2 which revealed 35% read on his right-hand pointer finger and read 47% on his left great toe. LPN AA reported it was hard getting a reading because his extremities were so cold. Hospice RN II and LPN AA continued to struggle with getting a second portable oxygen tank to work. On [DATE] at 1:40 p.m., CNA V was observed bringing down an oxygen concentrator from Resident #95's room down to the nurses station. LPN AA obtained clean oxygen tubing and the oxygen cannula was placed on Resident #95. On [DATE] at 1:42 p.m., LPN AA rechecked Resident #95's Spo2 which read 43% oxygen saturation with a heart rate of 128 beats per minute. On [DATE] at 2:35 p.m., Hospice RN II was asked about Resident #95 and reported his oxygen saturation was now between ,d+[DATE]% on oxygen. Hospice RN II reported that the Resident had also received a breathing treatment, Albuterol, and that NP Y had been notified and they were discussing whether to send the Resident to the hospital for evaluation. On [DATE] at 3:54 p.m., Hospice RN II followed up to report they were holding fluids for Resident #95 because it seemed he was struggling to breath after drinking liquids. When asked about the liquids he had been consuming at lunch, Hospice RN II reported that he had a thicker liquid in a cup and then a thinner liquid in the little cup. Hospice RN II reported that NP Y had told them to continue monitoring his breathing. (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 11:23 a.m., a phone interview was conducted with NP Y, who reported she had been working in the building for over a year. When asked about Resident #95, NP Y reported she had seen the Resident on [DATE] and wrote a progress note. NP Y reported she didn't hear any appreciable crackling or wheezing and that Resident #95 wasn't coughing or struggling to breath. When asked if Resident #95's death on [DATE] had been anticipated, NP Y reported that the resident was compromised. NP Y provided no further comment on Resident #95's death. NP Y further reported that they had thought Resident #95 was a full code at first and were planning to send him to the hospital. When asked what her expectations of staff were if a resident was in respiratory distress with oxygen saturation in the ,d+[DATE]'s, NP Y stated, Bring them back to their room. Administer oxygen. Give maximal oxygen you could give. When asked if the Guardian of Resident #95 was notified when Resident #95 started to decline, NP Y reported that she did not know. On [DATE] at 4:18 p.m., the Administrator and the DON were asked what the time expectation was for staff to administer oxygen if a Resident is experiencing respiratory distress. The Administrator stated, Immediately. Within seconds. A review of a progress note written by Hospice RN II and emailed to the Director of Nursing (DON) on [DATE] at 10:24 a.m., revealed in part, Routine hospice visit around 1400 (2:00 p.m.), patient (Resident #95) is seen sitting up on wheelchair at nurses' station, alert, drinking thickened liquids. Patient's skin and lips appear pale, with productive cough . crackles noted on bilateral lungs. Unable to obtain accurate oxygen saturation on upper extremities due to pale & cold skin. Facility nurse then obtained oxygen saturation @ (at) 82% on left foot second toe on room air .Hospice RN educated facility staff regarding risk for aspiration due to current condition . Started non-rebreather mask @ 10LPM (liters per minute). Albuterol neb given then every ,d+[DATE] hrs as needed. Monitor patient closely . (NP Y) seen and assessed the patient with no further orders made . At around 1600, Hospice nurse and facility staff seen patient on bed, unresponsive, with no BP (blood pressure), no HR (heart rate), no RR (respirations). Patient time of death is 1615 (4:15 p.m.) . Resident #15 On [DATE] at 3:50 p.m., Resident #15 was observed in bed with a nasal cannula in her nose. Observations of her oxygen concentrator revealed that the filter was very dusty and there was a dried black residue spilled on the concentrator. A review of Resident #15's medical record revealed she admitted to the facility on [DATE] with diagnoses including stroke, nutritional deficiency, gastrostomy (feeding tube) status, and diabetes type 2. A review of the [DATE] Minimum Data Set (MDS) assessment revealed she was assessed by staff to be severely cognitively impaired and relied on tube feeding to meet her nutritional needs. On [DATE] at 7:55 a.m., Resident #15's oxygen concentrator was observed to still have black residue spilled on it and the filter was still full of dust. On [DATE] at 4:00 p.m., the Director of Nursing (DON) was shown Resident #15's oxygen concentrator and she confirmed that the filter was dusty and the concentrator was dirty. Resident #902 (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Few	A review of Resident #902's medical record revealed he admitted to the facility on [DATE] with diagnoses including protein-calorie malnutrition, gastrostomy status, tracheostomy status, and pneumonia. A review of the [DATE] Minimum Data Set (MDS) assessment revealed he was Severely Impaired per staff assessment and received tube feeding. A review of Resident #902's Medication Administration Record (MAR) and Treatment Administration Record (TAR) revealed the following: An order dated [DATE] for (Tracheostomy) Suction Q (every) 4 hours and PRN was discontinued on [DATE], and was only completed 4 times on [DATE] and not at all on [DATE]. An order dated [DATE] for Tracheostomy care . with NS (normal saline) Q shift and PRN discontinued [DATE] had only been completed one time on [DATE]. Further review of this MAR and TAR revealed that despite the Resident being admitted on [DATE], there were no orders for trach care or suctioning until [DATE], and there was no evidence it was being done prior to [DATE]. A review of the facility policy titled, Oxygen Administration most recently reviewed [DATE] revealed, 1. Review the physician's orders for facility protocol for oxygen administration E. Concentrator exteriors will be cleaned weekly; associated filters will be cleaned weekly . Before administering oxygen, and while the resident is receiving oxygen therapy, assess for the following: 1. Signs of symptoms of hypoxia (cyanosis, tachycardia, tachypnea, diaphoresis, restlessness or confusion, dyspnea). 2. Vital signs. 3. Auscultate lungs. 4. Oxygen Saturation .6. Connect the delivery device to the oxygen source, date the tubing, and turn on the concentrator. NOTE: concentrators take ,d+[DATE] minutes to produce oxygen . A review of the facility policy titled, Pulse Oximetry (Assessing Oxygen Saturation) last reviewed [DATE] revealed, The purpose of this procedure is to monitor arterial blood oxygen saturation (SaO2) without the use of invasive devices . b. placement of oximeter. Impaired circulation . to the area in which the oximeter probe is placed will provide inaccurate data. Since the elderly often have impaired peripheral circulation, an ear probe may be used . 2. Normally SpO2 is between 9- and 100 percent; Sustained SpO2 below 70 percent requires immediate intervention Documentation. The date, and time that the procedure was performed, the value of the reading. 1. Any unusual findings and action taken .

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 38328 Based on observation, interview and record review, the facility failed to ensure adequate pain management was provided for one Resident (#30) of two residents reviewed for pain. This deficient practice resulted in the potential for continued uncontrolled pain and poor quality of life. Findings include: On 3/29/22 at 8:36 a.m., during an interview, Resident #30 stated he experienced chronic pain mostly in the posterior neck area and the left hand. Resident #30 stated he received pain medication for this but expressed concern with his pain medication running out approximately two months ago. Resident #30 stated Licensed Practical Nurse (LPN) B was the one who was aware of the issue and was the one who called the pharmacy to get more. Resident #30 stated it took approximately 8 hours to get the medication from the pharmacy after it was addressed by LPN B. Resident #30 stated his pain had increased while having to wait for pain medication. When asked to describe the pain progression while waiting for pain medication, Resident #30 stated his pain started at about a 6 (0 [No Pain] to 10[Severe Pain] pain scale) and it got to an 11 or 12. A review of Medication Administration Records (MAR's) for September 2021 through March 2022 revealed the following: Percocet 10/325 mg (milligram) two (2) tablets was twice daily in September 2021. There were 23 pain ratings observed at 7 or greater (moderate/severe to severe pain). This demonstrated a trend of frequent moderate to severe pain for Resident #30. The Percocet 10/325 mg two tablets twice daily was changed to three times daily October 1st, 2021, and then back to twice daily October 22nd, 2021. There were 22 pain ratings observed at 7 or greater after the pain medication increase. This demonstrated an overall decrease in pain after increase in pain medication frequency. There were 30 additional pain rating observations and essentially the same amount of pain ratings at 7 or greater. This demonstrated an increase in pain for Resident #30 from the previous month and the pain medication appeared to be increased in frequency in response the following month below. Percocet 10/325 mg two tablets was changed from twice a day to three times a day on November 2nd, 2021 and then back again to twice daily on 11/17/21. The Percocet 10/325 mg two tablet 9:00 p.m. dose was not charted as given on 11/24/21 and 9:00 a.m. dose was not charted as given on 11/26/21. There were no explanations offered in the reason/comments section. There were three pain ratings at 7 or greater during the first few days in the beginning of November 2021, and the pain medication frequency appeared to be increased in response to this. There were only six pain ratings of 7 or greater when the pain medication was increased to three times daily. Then when the pain medication frequency was reduced again to twice daily, there were 9 pain ratings observed at 7 or greater. It was unclear the reason for reducing the frequency of the pain medication to twice daily but pain levels for Resident #30 appeared to be once again trending up after reducing the pain medication frequency. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Percocet 10/325 mg two tablets remained twice daily for December 2021 and there was a 9:00 p.m. dose not charted as given on 12/7/21. There was no explanation offered in the reason/comments section. There were a total of 17 observed pain ratings of 7 or greater. This appeared to demonstrate pain levels for Resident #30 were trending upward further with no response in adjusting the pain medication. Percocet 10/325 mg two tablets twice daily remained in place for January 2022 with a total of 8 observed pain ratings of 7 or greater. The 1/16/22 9:00 p.m. dose was charted as Not Administered: Drug/Item unavailable . and the 1/17/22 9:00 a.m. dose was charted as Not Administered: Other; Comment: just received from pharmacy. Pain ratings appeared to stabilize for this month, although Resident #30 experienced a documented increase in pain around the time of pain medication not being administered because it was unavailable. The Percocet 10/325 mg two tablets twice daily remained in place for February 2022 with a total of 19 pain ratings at 7 or greater. Pain ratings for Resident #30 appeared to further trend upwards with no response in adjusting the pain medication. The Percocet 10/325 mg two tablets twice daily remained in place for March 2022. There were a total of 20 pain ratings at 7 or greater. Pain ratings for Resident #30 appeared to further trend upwards, with no response in adjusting the pain medication. The pain control ratings based on review of the MAR's from October 2021 through March 2022 demonstrated an overall increase in effectiveness when Resident #30 was receiving Percocet 10/325 mg two tablets three times daily compared with two times daily. A review of the progress notes from Nurse Practitioner (NP) Y revealed no explanation for the increases and subsequent decreases in the Percocet 10/325 mg two tablets twice daily. A review of the progress notes, physician progress notes, and MAR's from October 2021 through March 2021, revealed no evidence of excess sedation or negative effect for Resident #30 during administration of Percocet 10/325 mg three times daily. On 4/5/22 at 11:14 a.m., during a follow-up interview, Resident #30 stated his pain was much more manageable when he was getting his pain medication three times daily. On 4/5/22 at 11:20 a.m., during an interview, NP Y was asked if she could explain why Resident #30's pain medication orders had been increased and decreased several times without explanation in the progress notes section. NP Y stated she had just seen Resident #30 and he did not say that his pain medication was an issue. NP Y stated she would re-approach Resident #30 to discuss his concerns with pain medication and talk with the nurse taking care of him. On 4/5/22 at 11:42 a.m., during a follow-up interview, when asked Resident #30 had communicated his pain medication issues to NP Y when he was seen on 3/31/22, Resident #30 stated he felt like he could not complain because (NP Y) was the one who put the pain medication back to twice daily and (NP Y) knew I wasn't happy with that. I felt like there was no point in complaining because she changed it to twice daily for whatever reason and I didn't think she would change it back. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/5/22 at 10:20 a.m., during an interview, the Director of Nursing (DON) and Nursing Home Administrator (NHA) were asked to provide narcotic drug reconciliation documentation for Resident #30 to further investigate the omitted doses of pain medication above. The DON and NHA stated the facility does not have any controlled medication administration reconciliation they could find prior to them starting at the facility in December 2021. The omitted doses were noted before December 2021 as noted above. A review of the facility policy Pain Assessment and Management, with a revised date of 3/21/22 read in part: The purpose of this procedure are to help the staff identify pain in the resident, and to develop interventions that are consistent with the resident's goals and needs and that address the underlying causes of pain . . 3. Pain management is a multidisciplinary care process that includes the following: . b. effectively recognizing the presence of pain . . g. Monitoring for the effectiveness of interventions; and h. Modifying approaches as necessary . 3. Review the medication administration record to determine . to what extent the administered medications relieve the resident's pain . . 4. The physician and staff will establish a treatment regimen based on consideration of the following: a. The resident's medical condition; b. Current medication regimen; c. Nature, severity, and cause of the pain; d. Course of the illness; and e. Treatment goals. 5. Strategies that may be employed when establishing a treatment regimen include: a. Starting with lower doses and titrating upwards as necessary; c. Combining long-acting medications with PRN's (as needed) for breakthrough pain; . 6. Implement the medication as ordered, carefully documenting the results of the interventions . . 2. Monitor the following factors to determine if the resident's pain is being adequately controlled. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. The resident's response to interventions and level of comfort over time; . . c. The presence of adverse consequences to treatment . . 4. If the pain has not been adequately controlled, the multidisciplinary team, including the physician, shall reconsider approaches and make adjustments as indicated . . 1. Document the resident's reported level of pain with adequate detail (i.e. enough information to gauge the status of pain and the effectiveness of interventions for pain) as necessary and in accordance with the pain management program . . Report the following information to the physician or practitioner: 1. Significant changes in the level of the resident's pain; . . 3. Prolonged, unrelieved pain despite care plan interventions.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. 38328 Based on observation, interview and record review, the facility failed to ensure appropriate assessment, measurements, consent, and order for bedrails was completed for one Resident (#145) of one resident reviewed for bedrails. This deficient practice resulted in the potential for entrapment and injury. Findings include: On 3/28/22 1:53 p.m., Resident #145 was observed resting in a bed with three half rails noted in place. Two rails on the right side at the foot and head with a space, and a half rail on the left side of the bed at the head. In between the rails on the right hand side, a dark blue cushion was uncovered, unsecured and tucked in the space between these rails. A review of the hospital History and Physical, dated 3/24/2022 at 11:38 p.m., read in part: HPI (History of Present Illness): (Resident #145) was transferred for continued medical management and rehab care from (local hospital) where she was hospitalized for inpatient hospice care after a traumatic fall . PMH (Past Medical History): COPD (Chronic Obstructive Pulmonary Disease), traumatic fall, nasal bone fx (fracture), . intracranial hemorrhage w (with)/thalamic bleed, acute UTI (Urinary Tract Infection), . multilevel C-spine degenerative disk disease, chronic debility . On 3/30/22 at 5:21 p.m., Resident #145 continued to have three half side rails in place. A review of the Electronic Medical Record (EMR) revealed no evidence of a physician's order, gap measurements, assessment, or consent for the three half rails. The Director of Nursing (DON) and Nursing Home Administrator (NHA) were asked to provide evidence of these items and the policy for bedrail use. On 3/31/22 at 1:00 p.m., bedrails remained in place for Resident #145 and no assessment, consent, or orders were provided by the facility at the time of exit on 3/31/22. On 4/4/22 at 1:08 p.m., a review of the EMR Progress Notes for Resident #145 revealed the facility had the bed with bedrails changed out and Resident #145 was currently resting in a bariatric bed without bedrails. On 4/4/22 at 2:10 p.m., during an interview, the NHA was asked why the bed and bed rails were removed from Resident #145. The NHA stated they were starting the process over and removing the bed with bed rails until the required items for bed rail use could be completed. The NHA acknowledged the facility was out of compliance with regard to the use of bed rails on Resident #145. The NHA was asked for the facility policy for bedrails. On 4/4/22 at 4:00 p.m., during an interview, the DON provided a policy on restraints and stated this was the closest policy she could find relating to the use of bed rails. The DON stated they follow Centers for Medicare/Medicaid guidelines for bedrail use. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility policy Use of Restraints, with a revised date of 3/15/22, read in part: Restraints will only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully. Restraints shall only be used to treat the resident's medical symptom(s) and never for discipline or staff convenience, or for the prevention of falls. 1. Physical Restraints are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body . 2. The definition of a restraint is based on the functional status of the resident and not the device. If the resident cannot remove a device in the same manner in which the staff applied it given that resident's physical condition (i.e., side rails are put back down, rather than climbed over) , and this restricts his/her typical ability to change position or place, that device is considered a restraint . . 4. Practices that inappropriately utilize equipment to prevent resident mobility are considered restraints and are not permitted, including: a. Using bedrails to keep a resident from voluntarily getting out of bed as opposed to enhancing mobility while in bed . 5. Restraints may only be used if/when the resident has a specific medical symptom that cannot be addressed by another less restrictive intervention AND a restraint is required to: a. Treat the medical symptom; b. Protect the resident's safety; and c. Help the resident attain the highest level of his/her physical or psychological well-being. 6. Prior to placing a resident in restraints, there shall be a pre-restraining assessment and review to determine the need for restraints. The assessment shall be used to determine possible underlying causes of the problematic medical symptom and to determine if there are less restrictive interventions (programs, devices, referrals, etc.) that may improve the symptoms . . 9. Restraints shall only be used upon the written order of a physician and after obtaining consent fro the resident and/or representative (sponsor) . . 14. Residents and/or surrogate/sponsor shall be informed about the potential risks and benefits of all options under consideration, including the use of restraints, not using restraints, and the alternatives to restraint use.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 34276 Based on interview and record review, the facility failed to ensure that licensed nurses and Certified Nurse Aides (CNAs) were reviewed for competency annually, with the potential to affect all 45 residents residing in the building. This deficient practice resulted in the potential for inappropriate or unmet care needs and injury. Findings include: On 3/29/22 at approximately 1:30 p.m., annual competencies were requested for CNA C, CNA CCC, CNA DDD, and CNA EEE. On 3/29/22 at 4:30 p.m., a review of the four CNA records revealed no annual competencies had been conducted. On 3/30/22 at 9:00 a.m., Resident #43's bolus tube feeding administration by LPN A was observed. During the administration, LPN A used a measuring cylinder to pour the 350 ml of Glucerna 1.2 (a diabetic tube feeding forumla) out of the 1000 mL ready to hang bottle. LPN A used a Styrofoam cup of ice water to flush the peg tube prior to starting the tube feeding. Upon administering the ice water flush, Resident #43 quivered in discomfort. LPN A then started to administer the tube feeding in portions, and when it did not go through quickly, he added ice water to the syringe to dilute it. LPN A then added ice water directly into the portioned tube feeding measuring container and continued to administer the bolus. LPN A was observed squeezing the tubing and flicking the syringe to get the tube feeding to administer faster. On 3/31/22 at 12:01 p.m., LPN/Unit Manager E was asked to provide Staff Education/RN D the request for nurse competencies for LPN A, LPN R, RN P, LPN O, and RN BBB. On 3/31/22 at 12:34 a.m., RN D was asked about the nurse competencies and reported that she had one for LPN A that was completed in March of 2022. RN D reported she thought she also had done one for LPN O but did not have them for the other three staff as they worked night shift and she hadn't gotten to them yet. When asked why she had no evidence of annual competencies, RN D reported that when she started in December 2021 she was not able to find any of the competencies for any of the staff. RN D reported that she was in the process currently of going through all the staff and doing competency evaluations. On 3/31/22 at 12:42 p.m., RN D was asked about the tube feeding administration observation of LPN A and the use of ice water to flush and dilute the tube feeding. RN A reported that when she had observed LPN A just a few weeks before (3/9/22) he had done it correctly. A review of the facility policy titled, Competency Evaluations reviewed 3/21/22 revealed that it pertained to the State Nurse Aide Licensing exam and was not related to the facility evaluation of licensed staff performance.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. 35103 Based on interview, and record review, the facility failed to assure a Registered Nurse (RN) was on duty eight consecutive hours a day, seven days a week. This deficient practice resulted in the potential for inadequate coordination of care and negative clinical outcomes with the potential to affect all 45 residents currently residing in the facility. Findings include: During an interview on 3/29/22 at 5:05 p.m., the Director of Nursing (DON) was asked how many RNs were on staff (employees or agency contract staff) in the facility. The DON said there were three RNs currently on the staff list, not including administrative RNs. The DON acknowledged it had been difficult filling the RN positions and confirmed she had last worked providing direct care services to residents in December of 2021. When asked how many of the three nurses listed on the 3/29/22 Daily Staffing were administrative RNs, the DON said that number (three) included the DON and the RN Education Director. When asked if she provided direct care that day, the DON acknowledged she did not, but did not feel that the staff posting was to reflect direct care staff only. Review of the Daily Staffing posting forms for February and March 2022 revealed no RNs were documented as working on either the 7:00 a.m. to 7:00 p.m., or the 7:00 p.m. to 7:00 a.m. shifts on 2/10, 2/12, 2/13, 2/18, 2/19, 2/20, 2/26, 2/27, 3/11, 3/12, and 3/20/22. Review of an email from the Survey Team to the Nursing Home Administrator (NHA) and DON, requesting the Nurse Staffing Posting Policy - revealed handwritten documentation of We don't have this from the facility administration.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Post nurse staffing information every day. 35103 Based on interview and record review, the facility failed to post Nurse Staffing Information daily that included the total number and the actual hours worked by licensed and unlicensed nursing staff directly responsible for resident care per shift including Registered Nurses (RNs), Licensed Practical Nurses (LPNs), and Certified Nurse Aides. This deficient practice resulted in the potential for unmet resident care needs. Findings include: Review of the Daily Staffing posting forms for February and March 2022 revealed all documentation for the evening shift from 7:00 p.m. to 7:00 a.m. was absent any information on the following dates: 2/1, 2/4, 2/7, 2/8, 2/10, 2/22, 2/18, 2/22, 2/25, 3/4, 3/9, 3/11, and 3/18/22. No Daily Staffing forms were present and available for review for the following days: 2/5, 2/6, 2/11. During an interview on 3/29/22 at 5:05 p.m., when asked how many of the three nurses listed on the 3/29/22 Daily Staffing were administrative RNs, the Director of Nursing (DON) said that number (three) included the DON and the RN Education Director. When asked if she provided direct care that day, the DON acknowledged she did not, but did not feel that the staff posting was to reflect direct care staff only. Review of an email from the Survey Team to the Nursing Home Administrator (NHA) and DON, requesting the Nurse Staffing Posting Policy - revealed handwritten documentation of We don't have this from the facility administration. The Nurse Staffing Posting policy had been requested multiple times prior to the end of the survey, and both the NHA and DON confirmed they did not have a policy to address this deficiency concern.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 35103 Based on interview and record review, the facility failed to ensure the timely dispensing, administration, and document of medications administered, and maintain an account of all controlled drugs for four Residents (#30, #43, #46, and #24) of 17 residents reviewed for medication administration. This deficient practice resulted in the potential for late medication administration, reduced efficacy of time sensitive medications, and the potential for drug diversion. Findings include: Resident #44 A review of Resident #4's medical record revealed she admitted to the facility on [DATE] with diagnoses that included hypertension, cerebrovascular accident (CVA/Stroke), and chronic obstructive pulmonary disease (COPD). Resident #44 scored 15 of 15 on the Brief Interview for Mental Status (BIMS) reflective of intact cognition. A review of Resident #44's March 2022 MAR revealed the following medication orders and the number of times they were documented late: Albuterol sulfate (used to treat COPD), HFA (propellant) aerosol inhaler; 90 mcg/actuation; Amount to Administer: 1 puff; inhalation, Twice a Day, Start Date 1/27/2022. This medication was charted as Late Administration Charted Late Comment: Administered on Time, when scheduled to be administered between 7:00 a.m. and 11:00 a.m., and 7:00 p.m. and 11:00 p.m., on six (6) different days. Amlodipine (used to treat high blood pressure and/or heart failure) tablet, 10 mg; Amount to Administer: 10 mg; oral Once a Day, Start Date 12/18/21, Time 7:00 a.m. to 11:00 a.m. This medication was charted as Late Administration: Charted late Comment: Administered on time 16 times. Labetalol (used to treat blood pressure), 300 mg; Amount to Administer; 1 tablet; oral, Twice a Day, Start Date 12/23/2021, Time: 9:00 AM and 9:00 PM. This medication was charted as Late Administration: Charted late Comment; Administered on time18 times. During an interview on 03/31/22 at 9:55 a.m. Licensed Practical Nurse (LPN) KK explained the process of recording the time of medication administration. LPN KK said she has never been more than one hour late with documentation of her medication administrations. She said she would never go greater than one hour late usually (the acceptable practice), unless there was an emergency that prevented her from giving/documenting medication administration. Review of the Administering Medications policy, dated 3/16/22, revealed the following, in part: Medications will be administered in a safe and timely manner, and as prescribed .Medications must be administered in accordance with the orders, including a required time frame. 4. Medications must be administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders) . The individual administering the medication must initial the resident's MAR on the appropriate line after giving each medication and before administering the next ones . (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/5/22 at 9:11 a.m., LPN A was asked about multiple medication documentations that recorded Late Administration: Charted Later Comment: Administered on Time. LPN A stated, There are a lot of interruptions. When asked when documentation of a medication administration should be completed, LPN A stated, It (documentation) should be immediately after (administration to the resident). 34276 Resident #43 A review of Resident #43's medical record revealed she admitted to the facility on [DATE] with diagnoses including gastrostomy (feeding tube) status, moderate protein-calorie malnutrition, adult failure to thrive, and dementia. A review of the 3/7/22 MDS assessment revealed she was assessed by staff to be severely impaired for cognition. A review of Resident #43's March 2021 MAR revealed the following medication orders and the number of times they were documented late: Banatrol Plus (used to treat diarrhea) . powder in packet; every 8 hours . (started) 3/1/22 (discontinued 3/16/22). This medication was charted as not given due to Drug/Item unavailable 27 times. It was charted as given or given late 14 times, despite not having the product available. Lithium carbonate (medication used to treat bipolar disorder) capsule; 150 mg. twice per day . (started) 3/1/22 This medication was documented as Charted late 27 times. Metoprolol tartrate (a blood pressure medication) tablet; 25 mg .half tablet . every 12 hours . started 3/1/22. This medication was documented as Charted late 15 times. Resident #46 A review of Resident #46's medical record revealed he admitted to the facility on [DATE] with diagnoses including gastrostomy (feeding tube) status, COVID-19, stroke, protein-calorie malnutrition, and other nutritional anemias. A review of the 12/17/21 MDS assessment revealed he scored 9/15 on the Brief Interview for Mental Status (BIMS) assessment, indicating moderately impaired cognition. A review of Resident #46's November 2021 MAR revealed the following: amlodipine (blood pressure medication) tablet; 10 mg . once a day (started) 10/25/21 was documented as charted late 12 times. enoxaparin (an anticoagulant medication) syringe; 30 mg/ml . once a day (started) 10/25/21) was documented as charted late 11 times. 38328 Resident #30 (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/29/22 at 8:36 a.m., during an interview, Resident #30 stated he experienced chronic pain mostly in the posterior neck area and the left hand. Resident #30 stated he received pain medication for this but expressed concern with his medication for pain running out approximately two months ago. Resident #30 stated Licensed Practical Nurse (LPN) B was the one who was aware of the issue and was the one who called the pharmacy to get more. Resident #30 stated it took approximately 8 hours to get the medication from the pharmacy after it was addressed by LPN B. Resident #30 stated his pain had increased while having to wait for pain medication. When asked to describe the pain progression while waiting for pain medication, Resident #30 stated his pain started at about a 6 (0 [No Pain] to 10[Severe Pain] pain scale) and it got to an 11 or 12. A review of Medication Administration Records (MAR's) for September 2021 through March 2022 for Resident#30, revealed the following: Percocet 10/325 mg two tablets was changed from twice a day to three times a day on November 2nd, 2021 and then back again to twice daily on 11/17/21. The Percocet 10/325 mg two tablet 9:00 p.m. dose was not charted as given on 11/24/21 and 9:00 a.m. dose was not charted as given on 11/26/21. There were no explanations offered in the reason/comments section. There were three pain ratings at 7 or greater at the beginning of November 2021 before the frequency of the pain medication was increased. There were six pain ratings of 7 or greater when the pain medication was increased to three times daily. There were 9 pain ratings observed at 7 or greater after the pain medication was reduced to twice daily. The Percocet 10/325 mg two tablets remained twice daily for December 2021 and there was a 9:00 p.m. dose not charted as given on 12/7/21. There was no explanation offered in the reason/comments section. There were a total of 17 observed pain ratings of 7 or greater. The Percocet 10/325 mg two tablets twice daily remained in place for January 2022 with a total of 8 observed pain ratings of 7 or greater. The 1/16/22 9:00 p.m. dose was charted as Not Administered: Drug/Item unavailable . and the 1/17/22 9:00 a.m. dose was charted as Not Administered: Other; Comment: just received from pharmacy. On 4/5/22 at 10:20 a.m., during an interview, the Director of Nursing (DON) and Nursing Home Administrator (NHA) were asked to provide narcotic drug reconciliation documentation for Resident #30 to further investigate the omitted doses of pain medication above. The DON and NHA stated the facility does not have any controlled medication administration reconciliation they could find prior to them starting at the facility in December 2021. The omitted doses were noted on or before December 7th, 2021 as noted above. The NHA stated there was no narcotic drug reconciliation documentation available for the December 7th, 2021 omitted dose. The first accessible date was 12/15/21 per an email received from the NHA on 4/5/22 at 12:41 p.m. Further review of Medication Administration Records (MAR's) for September 2021 through March 2022 for Resident #30, revealed the following: Multiple medications are charted as late or not administered throughout the six month period were as follows: Aspirin OTC (Over the Counter[Anticoagulant]) tablet, chewable 81 mg one tablet daily (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Colace (docusate soduim[Bowel]) [OTC] capsule; 100 mg, two capsules daily Linzess (linaclotide [Bowel]) capsule, 72 mcg, 1 cap oral daily Macrobid (nitrofurantoin monohyd/m-cryst [Urinary Tract Infection]) capsule, 100 mg, 1 capsule daily Metoprolol tartarate (Blood Pressure) tablet, 25 mg, 1 tablet every 12 hours Percocet (oxycodone-acetaminophen [pain]) - Schedule II tablet, 10/325 mg, 2 tablets oral, twice daily polyethylene glycol (bowel)3350 [OTC] powder, 17 gram/dose, 17 gm (gram), oral tamsulosin (prostate) capsule, 0.4 mg, 1 capsule daily Each of the above medications had multiple instances of Late Administration documented. The Reasons/Comments charted included the following: . Late Administration: Charted late Comment: administered late . . Late Administration: Other Comment: late chart . . Not Administered: Drug/Item unavailable . . Late Administration: Other Comment: pt (patient) care . . Late Administration: Drug/Item unavailable Comment: refused x (times) 3 . . Not Administered: Other Comment: just received from pharmacy . . Late Administration: Administered late

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35103 Based on interview and record review, the facility failed to ensure medical irregularities were review and documented timely by the physician for three Residents (#18, #27, and #6) of five Medication Regimen Reviews (MRRs) performed. This deficient practice resulted in the potential for unmet medical care needs. Findings include: Resident #18 Review of Resident 18#'s Minimum Data Set (MDS) assessment, dated 1/14/22, revealed Resident #18 was admitted to the facility on [DATE]/21 with diagnoses that included diabetes mellitus, hyperlipidemia, hypothyroidism, and polyneuropathy. Resident #18 scored 15 of 15 on the Brief Interview for Mental Status (BIMS), reflective of intact cognition. A review of the MMRs for Resident #18 revealed the Pharmacist made a two recommendations on 3/1/22. A review of the 3/1/22 MRR reports revealed the recommendations of: 1. Recommend a baseline thyroid function test (TSH, T3, T4) and repeat yearly while resident is taking Synthroid 125mcg (micrograms) daily. NONE CURRENTLY FOUND IN CHART. No Response was documented and the Note to Attending Physician/Prescriber was signed on 4/4/22 (during the facility recertification survey) with an illegible signature per the [Physician Name]. 2. This resident is taking the following statin drug. Atorvastatin 20 mg QD (daily). Suggest obtaining LIPID PANEL routinely for progression monitor. No Response was documented and the Note to Attending Physician/Prescriber was signed on 4/4/22 with an illegible signature per the [Physician Name]. Resident #27 Review of Resident #27's MDS assessment, dated 4/26/21, revealed Resident #27 was admitted to the facility 4/20/2020, with diagnoses that included coronary artery disease, heart failure, hypertension, diabetes mellitus, hyperlipidemia, and cerebrovascular accident (CVA/Stroke). Resident #27 score 15 of 15 on the BIMS reflective of intact cognition. A review of the MMR for Resident #27 revealed the Pharmacist made a recommendation on 3/1/22. A review of Resident #27's 3/1/22 MRR report revealed the recommendation of: Patient is currently taking Atorvastatin 10 mg (milligrams) QD (every day) and there are no labs on (sic) the chart. Please consider ordering a current lipid panel and TSH levels. There was no Response section on the form, and the form was signed on 3/29/22 (during the recertification survey). The Physician had agreed with the recommendation, but no order was designated on the form. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/5/22 at 4:39 p.m., the Director of Nursing (DON) was asked about the timing of physician review and signature of the MRRs completed by the facility Pharmacist. The DON stated, From my experience, they (pharmacy MRR recommendations) are usually addressed within three days, and then you would have the (physician) orders. 34276 Resident #6 A review of Resident #6's medical record revealed he admitted to the facility on [DATE] with diagnoses including vascular dementia, stroke, and diabetes type 2. A review of his 1/2/22 MDS assessment revealed he scored 1/15 on the Brief Interview for Mental Status (BIMS) assessment indicating severely impaired cognition. A review of the MMR for Resident #6 revealed the Pharmacist made a recommendation on 2/1/22. A review of this 2/1/22 MRR report revealed the recommendation of Recommend discontinue PRN (as needed) use of Lorazepam (anti-anxiety drug) 1 mg (milligram) . This document was not signed by any physician and did not indicate whether the physician agreed or disagreed with the recommendation.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35103 Based on interview and record review, the facility failed to ensure no significant medications errors occurred for one Resident (#20) of five residents reviewed for medication administration. This deficient practice resulted in a significant medication error for Resident #20, and the potential for hemorrhage (excessive bleeding) and deterioration of condition with dual administration of anticoagulant medications contrary to physician orders. Findings include: Review of Resident #20's Minimum Data Set (MDS) assessment, dated 9/2/21, revealed Resident #20 was admitted to the facility on [DATE] with diagnoses that included cerebrovascular accident (CVA), hemiplegia, depression, and other muscle spasm. Resident #20 was totally dependent on staff for bed mobility, transfers, dressing, toileting, personal hygiene, and bathing, and scored 15 of 15 on the Brief Interview for Mental Status (BIMS), reflective of intact cognition. Review of Resident #20's progress notes revealed the following, in part: 2/1/22 - 11:16 PM Positive venous doppler results received verbally from [Laboratory Name], [Physician EE] notified of verbal report. No new orders at this time. 2/2/22 7:33 AM - [Physician EE] notified of residents venous doppler results. [Physician EE] stated that she is on the highest dose of Lovenox and all to continue with current treatment. Will continue to monitor. Licensed Practical Nurse (LPN) A authored. 2/3/22 - 11:02 AM - Received verbal order for Eliquis 5 mg tablet, PO, twice daily from MD for DVT [deep vein thrombosis (blood clot)]. Lovenox to be discontinued after the first dose of Eliquis is given for bridging. Resident and staff nurse all made aware of prescription changes. Will continue to moitor. Director of Nursing (DON) authored. Review of Resident #20's February Medication Administration Records (MARs), revealed the following orders and subsequent administrations: 1. Order: Eliquis tablet; 5 mg; Amount to Administer: 5 mg; oral, Twice a Day. Special Instructions: Discontinue Lovenox after the first dose of Eliquis is given for bridging per MD (EE). Start/End Date: 2/3/22 - 3/4/22 [(DC) Discontinue Date]. 2. Order: Enoxaparin syringe; 80 mg (milligrams)/0.8 mL (milliliter), Amount to Administer: one injectable; subcutaneous every 12 hours, Start/end Date: 1/1822 - 2/17/22 (DC Date). 3. Administrations: Both Eliquis, 5mg Twice a Day, and Enoxaparin, 80mg/0.8 mL Every 12 hours, were administered on 2/4, 2/5, 2/6, 2/7, 2/8, 2/9, 2/10, 2/11, 2/13, 2/14, 2/15 and 2/16/22. Administration on 2/12 - did not include the evening dosage of Enoxaparin. The dual dosing of these medications occurred for 13 days after the physician had ordered discontinuation of the Lovenox (Enoxaparin). (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/5/22 at 2:20 p.m., when asked about concerns with dual administration of both Eliquis and Lovenox, when specific instructions to discontinue lovenox were ordered [Physician EE] stated, When you are giving dual antiplatelet agents .they have a higher incidence of bleeding. When you talk about anti-clotting agents - the fact that she didn't bleed out was a miracle. During an interview on 4/5/22 at 4:47 p.m., the Nursing Home Administrator (NHA who is alo a nurse) and DON were asked to review and comment on the dual administration of Eliquis and Lovenox to Resident #20 in February of 2022. The DON reviewed the eMAR documentation and confirmed it was a medication error with the potential for bleeding, and said she agreed this would be considered a substantial medication error.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 35103 Based on observation, interview, and record review, the facility failed to properly store and label drugs and biologicals in one medication cart of two medication carts reviewed and maintain proper temperature controls in one medication refrigerator of one medication room refrigerator reviewed. This deficient practice resulted in the potential for administration of medication with reduced efficacy, the potential for drug diversion with the potential to affect all 45 facility residents. Findings include: On 03/30/22 at 8:55 a.m., Observation of the South 1 medication cart with Licensed Practical Nurse (LPN) KK found 12 loose pills on the bottom of the top resident medication drawer that were not contained in the medication blister packs. LPN KK said she had no idea what the pills were, or if the residents who were to receive those specific medications had received the dose, or the dose was omitted because it ended up in the bottom of the medication drawer. In the 3rd medication drawer LPN KK confirmed there were multiple spills that appeared to be dry and sticky on the bottom of the drawer in approximately 8 spots. LPN KK attempted to clean the bottom of the drawer, but the liquid spills were dry and needed to be soaked. Continued observation with LPN KK, of the South 1 Medication cart on 3/30/22 at 9:05 a.m., found two controlled medications that were taped back into the blisterpacks for the following residents: 1. [Resident #40], Hydrocodone/APAP 10/35 mg Tab - package 2 of 3, Tape covered the tablet back covers for pills 11 and pill 21. Pill 21 was used, but pill 11 remained with tape covering the back of the foil blister pack. 2. [Resident #23], Alprazolam 0.25 mg tab, pill number 15 was broken open, still present in the blister pack, and tape covered the back of the pill 11 in the blister pack. Copies of blister packs received from LPN KK for both the Blister packs for Resident #40 and Resident #23. Observation with LPN KK on 3/30/22 at 8:57 a.m., found the South 1 medication cart small, bottom drawer contained a dirty, stained with what appeared to be food, Restorative Kentucky Collar (brace). The previously used collar was visibly soiled with what appeared to be food. When asked about the appropriateness of storing dirty medical equipment in the medication cart, LPN KK said it would be an infection control issue. During an observation on 3/30/22 at 9:30 a.m., the North medication cart was reviewed with LPN LL. A bottle of Morphine Sulfate with 25 mg of liquid medication in a plastic bottle was observed with no open date on the bottle or on the box of the morphine sulfate for Resident #145. LPN LL confirmed the morphine sulfate should have been labeled with the date when originally opened. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 03/30/22 at 11:45 a.m., of the medication room refrigerator with LPN A found the Medication Room Daily Refrigerator Logs for March 2022 absent temperature documentation between March 7th through the 20th, and 24th through the 30th. LPN A stated, They (nursing staff) usually check the temps (refrigerator temperatures) at midnight and only one check is done on the refrigerator every 24 hours The refrigerator temperature was found to be 34 degrees. The Tuberculin purified protein derivative (PPD) (used for TB testing) bottle was open and undated. The absence of a date on the PPD box or vial was confirmed by LPN A. A copy of the March 2022 refrigerator logs were requested from LPN A. LPN A looked at the March 2022 refrigerator temperature log and stated, This is terrible .they (nursing staff) are slipping, and they need to get back on to recording the temperatures. The Daily Refrigerator/Freezer Temperature Log only had space for documentation of one Refrigerator and one Freezer temperature daily. During an interview on 03/30/22 at 1:09 p.m., the Director of Nursing (DON) was asked if the facility would be able to determine if medications and vaccines were stored under appropriate temperatures and conditions with the absence of temperature documentation. The DON said she would not be able to tell if the temperatures were not recorded. When asked if there were vaccines in the refrigerator the DON stated both influenza vaccine and undated Tuberculin PPD were present in the medication room refrigerator. Review of the Storage of Medications policy, dated 3/17/22, revealed the following, in part: .1. Drugs and biologicals will be stored in the packaging, containers, or other dispensing systems in which they are received .2. The nursing staff will be responsible for maintaining medication storage AND preparation areas in a clean, safe, and sanitary manner. 3. Drug containers that have missing, incomplete, improper, or incorrect labels will be returned to the pharmacy for proper labeling before storing .8. Drugs will be stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing systems. Each resident's medications will be assigned to an individual cubicle, drawer, or other holding area to prevent the possibility of missing medications of several residents. 9. Medications requiring refrigeration must be stored in a refrigerator located in the drug room at the nurses' station or other secured location. Medications must be stored separately from food and must be labeled accordingly .

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F 0801 Level of Harm - Actual harm Residents Affected - Some	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 34276 Based on observation, interview, and record review, the facility failed to ensure they had qualified dietary staff, to include a full time Certified Dietary Manager (CDM) or Registered Dietitian (RD), to oversee the nutritional care of all 45 Residents residing in the building. This deficient practice resulted in the lack of nutritional assessment and care for facility residents. Findings include: On 3/29/22 at 3:08 p.m., C#1003 reported he had not seen the Dietitian even one time since he had been admitted , and no one came to ask him what his food preferences were. C#1002 reported she has only seen a Dietary person one time. C#1006 reported that the meals served were not diabetic friendly, and the Dietitian never came down to talk to her about it. C#1007 reported she voiced concerns that her diet was elevating her blood sugars and staff told her to relax and let it be. C#1007 reported the staff told her she could move to another facility if she didn't like the kind of food that was being served. On 3/30/22 at 10:24 a.m., a phone interview was conducted with consultant RD T, who reported she had been filling in since December 2021 until the facility could hire a dietitian. RD T reported she was only responsible for the high-risk residents, including those on tube feeding, with wounds, and with significant weight loss. On 3/30/22 at 11:50 a.m., the Administrator was asked how often CDM S was in the building. The Administrator stated, She's not here 40 hours (a week). The Administrator reported the CDM was not full time, but that the facility had an ad out to hire a full time CDM and an RD. On 3/30/22 at 12:50 p.m., the Administrator provided the hours the RD had been in the building for the previous three months which revealed, 1/31/2022. 6.5 hours. 2/23/2022 = 6 Hours. 2/25/2022 = 7 hours. On 3/30/22 at 4:46 p.m., CDM S reported she started as a CDM in September of 2021 along with another CDM who was no longer at the facility. When asked which Residents she provided nutritional monitoring and care for, CDM S reported all the Residents except for those on tube feeding, with wounds, with weight loss, and dialysis patients. CDM S was asked if she obtained Resident preferences and stated that she was, and that they were supposed to be done within 72 hours of admission. CDM S reported she usually worked four to five days a week in the afternoons, from 4:00 p.m., until whenever she's done. CDM S admitted that she was working a full-time job elsewhere and was just carrying the load until they hired someone full time.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 35103 Based on interview and record review, the facility failed to provide food that accommodated resident preferences for seven Residents (R#19, R#27, and Confidential Residents #C1001, #C1002, #C1003, #C1004, and #C1005) of 17 residents reviewed for dining. This deficient practice resulted in resident dissatisfaction with food provided, and the potential for decline in condition for residents with inappropriate provision of medical diets (e.g. diabetics). Findings include: Resident #19 During an interview and observation on 3/28/22 at 1:45 p.m., Resident #19 reported he had not been provided a meal tray for lunch that day. Resident #19's Friend OOO confirmed Resident #19 had not been delivered a meal tray for lunch that day. No meal tray was present in Resident #19's room. On 3/28/22 at approximately 1:45 p.m., Dietary Staff PPP delivered a plate with an insulated cover that contained one grilled cheese sandwich, that covered approximately 1/2 of the plate. Friend OOO, looked at the plate and complained that Resident #19 needed more than one grilled cheese sandwich for lunch. Friend OOO asked where the fruit and vegetables were, where the beverages were, and said for the money he (Resident #19) pays to live there he should have a decent meal when they forgot to give him one in the first place. Dietary Staff PPP said he was unaware that the entire meal tray had been omitted and returned to the kitchen with the single grilled cheese sandwich. On 3/28/22 at 2:00 p.m., Social Worker G confirmed she was aware that Resident #19 did not receive a lunch meal tray. Review of Resident #19's 3/29/22 Breakfast meal tray card revealed no foods listed under Allergies, Dislikes, or Preferences. During an interview on 3/29/22 at 8:12 a.m., when asked about the absence of food preferences on the breakfast meal tray card, Resident #19 stated, Nobody asked me (about preferences). Review of Resident #19's Care Plans revealed the following, in part: Nutritional Status: Approach Start Date: 01/14/2022, Obtain Food Preferences From Resident/Family. Resident #27 Review of Resident #27's 4/4/22 Lunch meal tray card documented the following food preferences: No Bread, No Sugar, No Sweets. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and observation on 4/4/22 at 12:25 p.m., Resident #27 was asked for permission to review the food preferences on the lunch meal tray card. Resident #27 held up a small container of ice cream, and a glass of lemonade, pointed to the meal tray card and stated, No sugar. No sweets, with a facial grimace. Resident #27 said she had provided those preferences and continued to get foods that she has requested not to receive. Resident #27 said she was a diabetic and needed to watch her carbohydrate intake. Resident #27 was documented with CCHO (controlled carbohydrate) and NAS (no added salt) diet. Review of the facility Resident Food Preferences policy, dated 3/17/22, revealed the following, in part: Nutritional assessments will include an evaluation of individual food preferences . 1. Upon the resident's admission, or within twenty-four (24) hours after his/her admission, the Dietitian or nursing staff will identify a resident's food preferences. When possible, this will be done by direct interview with the resident . The resident's clinical record (orders, care plan. or other locations) will document the resident's likes and dislike and special dietary instructions or limitations . 34276 On 3/29/22 at 3:08 p.m., C#1003 reported that no one came down from the kitchen to ask him about his meal preferences. C#1005 reported that a long time ago the Dietitian used to do that, but it hadn't been happening for a long time. C#1001, C#1002, and C#1004 agreed that the dietary staff were not obtaining and following their preferences. On 3/30/22 at 4:46 p.m., Certified Dietary Manager (CDM) S reported she was responsible for obtaining food preferences and that they were supposed to be done within 72 hours of admission. CDM S acknowledged she had not been able to obtain dietary preferences on all residents, as she was not working in the position full time.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34276 Based on observation, interview, and record review, the facility failed to ensure that a correct therapeutic diet was prescribed for one Resident (#95) out of 17 residents reviewed for physician orders. This deficient practice resulted in Resident #95 receiving the wrong therapeutic diet resulting in aspiration pneumonia. Findings include: Resident #95 On 3/29/22 at 10:32 a.m., Resident #95 was observed in bed in his room with the blanket over his head. Resident #95 removed the blanket from his head and took a sip from the pre-packaged cup of nectar thick juice from his bedside table. After drinking the juice Resident #95 began to cough and struggle to clear his throat. A review of Resident #95's medical record revealed he admitted to the facility on [DATE] with diagnoses including down syndrome, chronic obstructive pulmonary disease (COPD), viral pneumonia related to COVID-19, and dementia. Resident #95 did not have a completed Minimum Data Set (MDS) assessment in his record. A review of Resident #95's physician order for diet dated 3/24/22 revealed, Diet: Puree with thick liquids and NO STRAW. This diet order did not indicate what the level of thickness (nectar, honey, or pudding thick) should be for the fluids. On 3/30/22 at 1:07 p.m., an interview was conducted with Speech Language Pathologist (SLP) WW. SLP WW reported that he had not evaluated Resident #95 because he was on hospice. SLP WW' reported that when residents admit on hospice services speech therapy staff usually just does a screen for diet appropriateness. SLP WW could not say why a screen had not been ordered for Resident #95. On 3/30/22 at 4:00 p.m., Resident #95's diet order for thickened liquids was reviewed with RD T and the Director of Nursing (DON). When asked about the diet order stating just thickened liquids and not specifying honey thick or nectar thick, RD T reported she would review the issue and follow up. The DON was asked what the process was if the facility was unsure of a diet order upon a residents admission. The DON reported they would call the discharging facility or do a speech screen. On 3/30/22 at 4:50 p.m., RD T reported that on a previous admission (Summer 2021) Resident #95 was had been receiving honey thickened liquids. RD T reported she had downgraded him to honey thickened liquids until he could be evaluated by Speech Therapy. On 4/5/22 at 2:52 p.m., a second interview was conducted with SLP WW who reported that he had evaluated Resident #95 on 3/31/22 and that Resident #95 required a Pureed and Honey Thickened liquid diet. SLP WW also reported that Resident #95 did require supervision for feeding. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a hospital discharge document for Resident #95 prior to his admission to the facility dated 3/24/22 revealed .Adult diet: . Pureed; Fluid Consistency: Honey Thick; Additional Restrictions: No Straws, 1:1 Feed . This document revealed that Resident #95 should have been on a honey thickened diet for his entire admission. A review of the facility policy titled, Therapeutic Diets last reviewed by the facility on 3/16/22 revealed, 1. Mechanically altered diets, as well as diets modified for medical or nutritional needs, will be considered therapeutic diets. 2. A therapeutic diet must be prescribed by the resident's Attending Physician. The Physicians diet should match the terminology used by Food Services .

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 35103 Based on interview and record review, the facility failed to provide a nourishing snack at bedtime for four Confidential Residents (#C1002, #C1004, #C1005, and #C1006) of 17 sample residents reviewed for snacks at bedtime. This deficient practice resulted in resident dissatisfaction, hunger, and potential decline in condition for diabetic residents. Findings include: Resident #C1002 During an interview on 4/5/22 at 11:15 a.m., Confidential Resident #C1002 was asked if a bedtime snack was provided at bedtime. #C1002 stated, No, only if you ask (for a snack). If you forget to ask, you don't get any. Resident #C1002 confirmed she had forgotten to ask for a snack in the past and had not received a snack and wished to receive a consistent bedtime snack. Review of Resident #C1002's Minimum Data Set (MDS) assessment, dated 1/14/22, revealed diagnoses that included diabetes mellitus. Resident #C1002 scored 15 or 15 on the Brief Interview for Mental Status (BIMS) reflective of intact cognition. Review of Resident #C1002's Physician Orders, revealed the following, in part: Offer QHS (every hour of sleep) snack Special Instructions: Offer bedtime snack, At Bedtime 09:00 PM, Start Date: 10/8/2021 - Open Ended . Review of Resident #C1002's Care Plans revealed the following interventions, in part: 1. Start Date 10/7/21, Provide diabetic snacks. 2. Start Date 10/7/21, Provide HS (Hour of Sleep) snack. Resident #C1006 Review of Resident #C1006's Minimum Data Set (MDS) assessment, dated 4/26/21, revealed diagnoses that included diabetes mellitus. Resident #C1002 scored 15 or 15 on the Brief Interview for Mental Status (BIMS) reflective of intact cognition. During an interview on 4/5/22 at 11:10 a.m., Resident #C1006 was asked about snacks at bedtime. Resident #C1006 said she did not always get a bedtime snack, and commented she was a diabetic and was supposed to be getting one all the time. Review of Resident #C1006's Physician Orders, revealed there was no physician order addressing Resident #C1006's need for a HS snack. Review of Resident #C1006's Care Plans, revealed the following intervention, in part: Approach Start Date: 08/10/2020, Provide HS snack. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	34276 On 3/29/22 at 3:08 p.m., a group interview was conducted: C#1005 reported residents were not consistently getting snacks at night. C#1005 reported that it depended on who was working during the night shift, and that often staff just left the tray of snacks at the nursing station at dinner time, and, If you don't get up their fast you won't get anything. C#1002 reported that she had offered ways to help the facility ensure that all the residents were getting snacks but was told by staff that it was their job to do. C#1002 reported that the snacks were often very sugary in nature or like candy and were not suitable for diabetics. C#1006 agreed that the snacks offered were not good for her since she has diabetes and often did not get any snacks at all. C#1004 and C#1005 agreed that they were not consistently getting offered nighttime snacks. A review of the facility policy titled, Snacks (Between Meal and Bedtime), Serving reviewed 3/17/22 revealed, The purposed of this procedure is to provide the resident with adequate nutrition . 1. Place the snack on the over bed table or serving area . 4. Place beverages within easy reach . The person performing this procedure should record the following information in the resident's medial record: 1. The date and time the snack was served . 3. The amount of snack eaten by the resident . 2. Report any problems or complaints made by the resident related to the snack .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 22960 Based on observation, interview, and record review, the facility failed to ensure resident food items were dated, and failed to store the ice scooper in a sanitary manner, resulting in the increased potential for foodborne illness and cross contamination. This deficient practice had the potential to affect all residents that consume food orally. Findings include: On 3/38/22 at 1:15 PM, the resident refrigerator located in the nourishment room, which is utilized for the storage of resident food brought in from the outside, was observed with Assistant Dietary Manager (ADM) W. There were 2 undated plates of meat and rice, 3 undated containers of Chinese food, an undated rotisserie chicken, a bag with moldy cucumbers and tomatoes, and a pan of ham and turkey deli sandwiches with a use by date of 3/24. In addition, the ice machine inside the nourishment room was observed with the ice scooper handle resting directly in contact with the ice. ADM confirmed that all the food in the resident refrigerator should have been dated, and that the ice scooper should not have been stored inside the ice. The policy for the safe storage of resident food brought in from the outside was requested from the Administrator on 3/29/22 at 9:15 AM, but was not provided by the end of the survey. According to the 2013 FDA Food Code section 3-304.12 In-Use Utensils, Between-Use Storage, During pauses in FOOD preparation or dispensing, FOOD preparation and dispensing UTENSILS shall be stored: . (B) In FOOD that is not TIME/TEMPERATURE CONTROL FOR SAFETY FOOD with their handles above the top of the FOOD within containers or EQUIPMENT that can be closed.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 35103 Based on observation, interview, and record review the facility failed to provide effective and efficient administration as evidenced by failure to ensure: 1. Transportation expenses were paid, ensuring resident transportation to medical appointments. 2. Dietitian services were provided to ensure tube-feeding residents dietary needs were appropriately assessed and provided. This deficient practice resulted in the failure to maintain the highest practicable physical, mental, and psychosocial well-being of each resident, and had the potential to affect all 45 facility residents. Findings include: During an interview on 03/28/22 at 4:03 p.m., Resident #36 requested to speak to this Surveyor regarding concerns he had with care at the facility. Resident #36 said there was not a dietitian providing care in the facility, and said he had an appointment with a hand surgeon scheduled and provided the facility with four-days notice for transportation. The facility had said transportation was set, and the day he was supposed to go a staff member came and told him someone messed up with the transportation appointment. Resident #36 said he called the [Company Name] transportation service and the owner said he no longer provided transportation for the facility due to non-payment for services provided. Resident #36 said the appointment was rescheduled, and the facility rescheduled transportation with four-days notice again, and the facility told him they would only transport one resident to an appointment per day. Resident #36 called Medicaid and said they finally got him transportation to the appointment. Review of the facility Transportation Log January 2022 through March of 2022, revealed the following entries, 1. [Resident #36], Hand Clinic, 3/25/22 . appointment time 9:00 a.m., OWN TRANSPORTATION. 2. [Resident #36], foot doctor, 3/11/22 . appointment time 4:30 p.m., RESCHEDULE. Handwritten in the Transportation column documented, Made appt (appointment) on his own did not tell us. Van was not available at this appointment time. No other appointment was documented on the facility Van transportation schedule for 3/11/22. During a telephone interview on 3/31/22 at 9:00 a.m., Owner QQ of [Company Name] Transportation Services confirmed he had previously provided transportation services several nursing home facilities owned by Facility Owner FF. Owner QQ' said he would no longer provide transportation services for Facility Owner FF because he was still owed $6,415 for previous facility transportation services provided to the facility. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a telephone interview on 03/31/22 at 12:20 p.m., Corporate Accounts Payable (Staff) RR was asked why the nursing home facility had discontinued transportation services with [Company Name] Transportation Services. Staff RR said she was unaware of the reason and would call back with the information. On 3/31/22 at 12:25 p.m., the Facility Owner FF telephoned this Surveyor, and said they had purchased a van for the facility probably 2-3 weeks ago. When asked if there was an outstanding balance due to [Company Name] Transportation Services, Owner FF emphatically, with a loud voice, said there was no outstanding balance. Owner FF said there was nothing (owed) and he had no knowledge of any bill from that transportation company. On 03/31/22 at 12:31 p.m., [Company Name] Transportation Services Owner QQ was contacted by telephone. This surveyor requested copies of any outstanding invoices to the nursing home facility for January 2022 through March 2022. The invoices were received via email, which totaled $6415 for the three-month period. During a telephone interview on 03/31/22 at 12:45 p.m., Account Payable Staff RR said a check had been mailed for January for $3,897, dated 3/11/22, $2,518 was owed for February and a bill had not been received for March of 2022. Staff RR said the total that was owed was $6,415, the same amount as provided by Owner QQ of the [Company Name] Transportation Services company. 34276 A review of the facility policy titled, Job Description: Title: Nursing Home Administrator reviewed 10/2019 revealed, As the leader of the facility, the Nursing Home Administrator (NHA) is expected to assure that the facility operates in compliance with all state and federal regulations at all times while providing person-centered care . Monitors facility processes, practices, physical plant condition, and resource availability to assure that the facility is in a state of continuous compliance. Establish and maintain facility committees to implement policies, assure compliance with regulations, and provide safe and high-quality care to the facility ' s residents . Assure that facility staff members receive training necessary to perform their duties in a safe, effective and compliant manner .

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 34276 Based on interview and record review, the facility failed to ensure that they were able to provide all services outlined in their facility assessment, including nutritional servces, with the potential to effect all 45 Residents residing in the facility. This deficient practice resulted in high nutritional risk residents and residents on tube feeding not being assessed or monitored by a Registered Dietitian (RD). Findings include: On 3/30/22 at 10:24 a.m., a phone interview was conducted with consultant RD T. When asked about her role, RD T reported she had been filing in since December 2021 until the facility could hire a dietitian. RD T reported she was only responsible for the high-risk residents, including those on tube feeding, with wounds, and with significant weight loss. RD T reported she had not been in the building since February 2022. On 3/30/22 at 11:50 a.m., the Administrator was asked how often Certified Dietary Manager (CDM) S was in the building. The Administrator stated, She's not here 40 hours (a week). The Administrator reported the CDM was not full time, but that the facility had an ad out to hire a CDM and an RD. On 3/30/22 at 4:46 p.m., CDM S was asked about how long she had been working at the building and reported she started as the CDM in September of 2021 along with another CDM who was no longer working at the building. When asked which Residents she provided nutritional monitoring and care for, CDM S reported all the Residents except for those on tube feeding, with wounds, with weight loss, and dialysis patients. CDM S was asked if she was responsible for obtaining Resident preferences and stated that she was, and that they were supposed to be done within 72 hours of admission. CDM S acknowledged that aspects of the nutritional care program were being missed. CDM S admitted that she was working a full-time job elsewhere and was just carrying the load until they hired someone full time. A review of the Facility Assessment updated 3/8/22 revealed the following, The intent of the facility assessment is for the facility to evaluate its resident population and identify the resources needed to provide necessary care and services the residents require . Facility provides all care/services ROP (Residents of Population?) requires us to provide: Nutrition: individualized dietary requirements, liberal diets, specialized diets, IV nutrition, tube feeding, cultural or ethnic dietary needs, assistive devices, fluid monitoring or restrictions, hypodermoclysis . Staff planning: .1 dietitian, 1 PRN (as needed) Certified Dietary Manager .

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F 0841 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a physician to serve as medical director responsible for implementation of resident care policies and coordination of medical care in the facility. 34276 Based on interview and record review, the facility failed to ensure that the medical director was providing oversight and support to the facility effecting all 45 Residents residing in the facility. This deficient practice resulted in a lack of nutritional care, respiratory care, and infection control concerns. Findings include: On 4/5/22 at 3:31 p.m., the Medical Director was asked about how often he comes into the building and stated, Every week or two. The Medical Director then stated he had been on vacation in March 2022, and was not aware the facility had received an Immediate Jeopardy (IJ) related to tube feeding. The Medical Director was asked if it was concerning that a Resident (#95), who was at high risk for aspiration, received the wrong consistency of liquids and aspirated and stated, Yes. If they (staff) aren't checking the orders. The Medical Director reported he was aware that the facility did not have a Registered Dietitian RD) or full time Certified Dietary Manager (CDM) but thought that maybe the issue had resolved. On 4/5/22 at 3:34 p.m., a review of the Quality Assurance (QA) meeting documentation revealed the Medical Director was not attending quarterly QA meetings. A review of the facility policy titled, Admissions/Physician Role reviewed 3/23/22 revealed, .3. The medical director shall help guide the facility's admission policies and procedures . 10. The medical director will give input into the facility's admissions and discharge process and policies to help ensure that the facility has the appropriate programs and services to meet the needs of the residents/patients it admits . A review of the facility policy titled, Medical Director revised on 3/23/22 revealed, 1. Physician services are under the general supervision of the Medical Director. 2. The Medical Director is a licensed physician in this state and responsible for: a. Coordination of medical care and services for the residents of the facility . 3. The Medical Director functions also include, but at not limited to: . Acting as a consultant to the director of Nursing Services in matters relating to resident care services; c. Helping assure the residents receive adequate services appropriate to meet their needs; d. Helping assure that the resident care plan accurately reflects the medical regimen; e. Participating in staff meetings concerning infection control, quality assurance, pharmaceutical services, resident care policies, etc; .

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 38328 Based on interview and record review, the facility failed to ensure a complete medical record was maintained for 5 Residents (#15, #20, #45, #46, & #901) of 18 residents reviewed for a complete medical record. This deficient practice resulted in the potential for unmet physical/psychosocial needs and the potential to disrupt the continuum of care. Findings include: Resident #45 On 3/31/22 at 8:45 a.m., a review of the Electronic Medical Record (EMR) face sheet revealed Resident #45 admitted to the facility on [DATE] with diagnoses including acute neurologic, cerebral infarction (stroke) due to thrombosis (clot) of left posterior cerebral artery, hypertensive heart disease without heart failure, polyneuropathy (damage or disease affecting peripheral nerves), hyperlipidemia (high cholesterol), anemia (low red blood cells, dysarthria (speech sound disorder resulting from neurological injury), ataxia (impaired coordination), hemiplegia (paralysis of one side of the body). Resident #45 had an approximate a 7-day stay at the facility with a discharge date of [DATE] at 5:00 p.m. A review of the Point of Care (POC) responses for 1/11/22 through 1/17/22 for Resident #45 revealed documentation for only one day on 1/15/22 at 4:39 p.m. and 4:40 p.m., charted by Certified Nurse Aide (CNA) C. On 3/31/22 at 10:23 a.m., during an interview, CNA C stated she was aware of the issue of other CNA's not documenting and acknowledged she was probably the only one charting on Resident #45. CNA C stated there were times where she would have to document for CNA's who could not get into the EMR to document. On 3/31/22 at 12:37 p.m., during an interview, the Nursing Home Administrator (NHA) was asked why there was only POC documentation for a partial day out of the entire stay for Resident #45. The NHA stated the facility was aware of the issue and indicated that many of the CNA's did not have access to the EMR for charting when they got here (new hires). The NHA stated the facility's focus was on getting staffing because that was the priority. The NHA stated the facility has been working on making sure the CNA's have access. The NHA stated the lack of CNA documentation was being worked on in Quality Assurance Process Improvement (QAPI). 34276 Resident #15 A review of Resident #15's medical record revealed she admitted to the facility on [DATE] with diagnoses including stroke, nutritional deficiency, gastrostomy (feeding tube) status, diabetes type 2. A review of the 1/3/22 Minimum Data Set (MDS) assessment revealed she was assessed by staff to be severely cognitively impaired and relied on tube feeding to meet her nutritional needs. Per this assessment, Resident #15 was on hospice services. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #15's medical record revealed no hospice notes since November of 2021. On 3/31/22 at 2:00 p.m., the facility provided the missing notes that they had just received via fax from the hospice provider. These notes and assessments were not readily available to facility staff for collaboration and coordination of care. Resident #43 A review of Resident #43's medical record revealed she admitted to the facility on [DATE] with diagnoses including gastrostomy (feeding tube) status, moderate protein-calorie malnutrition, adult failure to thrive, dementia. A review of the 3/7/22 Minimum Data Set (MDS) assessment revealed she was assessed by staff to be severely impaired for cognition. A review of Resident #43's March 2021 MAR revealed the following: Banatrol Plus (used to treat diarrhea) . powder in packet; every 8 hours . (started)3/1/22 (discontinued 3/16). This medication was noted as Drug/Item unavailable 27 times. It was charted as given or given late 14 times, despite not having the product available for dispensing per the progress notes. Resident #46 A review of Resident #46's medical record revealed he admitted to the facility on [DATE] with diagnoses including gastrostomy (feeding tube) status, COVID-19, stroke, protein-calorie malnutrition, other nutritional anemias. A review of the 12/17/21 Minimum Data Set (MDS) assessment revealed he scored 9/15 on the Brief Interview for Mental Status (BIMS) assessment, indicating moderately impaired cognition. A review of Resident #46's progress note dated 12/27/21 at 4:06 p.m. revealed, Resident was observed in bed with no respirations. Non responsive when called by name. Vitals were unable to be obtained. Notified attending physician of residents status, Notified Family . This progress note was written by LPN A. On 4/4/22 at 1:51 p.m., when asked why the progress note dated 12/28/22 at 4:06 PM did not include who called the time of death and when, the DON reported she did not know. The facility was asked to provide the physician statement/recapitulation regarding the death of Resident #46 on 4/4/22 at 3:44 p.m., and on 4/5/22 at 11:15 a.m. and 3:31 p.m. The physician statement was never provided. A review of the facility policy titled, Transfers and Discharges/Physician role last reviewed by the facility 3/23/22 revealed, .10. If the individual has diet, the final summary will review the individuals stay and identify factors contributing to death. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility policy titled, Death of a Resident, Documenting last reviewed by the facility on 3/16/22 revealed, Appropriate documentation shall be made in the clinical record concerning the death of a resident . 1. A resident may be declared dead by a Licensed Physician or Registered Nurse with physician authorization in accordance with state law. 2. All information pertaining to a resident's death (i.e., date, time of death, the name and title of the individual pronouncing the resident dead, etc.) must be recorded on the nurses' notes. 3. The Attending Physician must record the cause of death in the progress notes, and must complete and file a death certificate with the appropriate agency within twenty-four (24) hours of the resident's death or as may be prescribed by state law . Resident #901 A review of Resident #901's medical record revealed he admitted to the facility on [DATE] with diagnoses including gastrostomy status, tracheostomy status, and pneumonia. Resident #901 discharged to the hospital on 12/31/21 and therefore had no completed MDS assessment. A review of Resident #901's last documented progress note revealed, 12/31/21 5:58 AM Pt (patient) was given 250 cc bolus of Javity (sic - Jevity a tube feding formula) 1.5 noted tube feed coming out of LUQ (Left upper quadrant) open area and collecting in the colostomy bag covering the wound. Bolus (tube feeding) was stopped. Area was cleaned new bag was applied and monitored. Notified NP (Nurse Practitioner), waiting for further orders. There were no progress notes following the 12/31/21 5:58 AM progress note, even though per the Resident Census sheet the Resident was not transferred back to the hospital until 12/31/21 at 6:09 p.m., almost 12 hours later. A review of Resident #901's chart revealed no documentation from any Physician or Nurse Practitioner. A review of a Resident Transfer to the Hospital/Other Care Facility form dated 3:49 p.m. for Resident #901 revealed the Resident was sent to the hospital, but was not complete and did not entail why the Resident was being sent out. A version of this form that was marked as in progress and was not fully completed contained the paragraph: Resident has an old peg site, that when bolus is administered through new peg site, all the formula passes through and into the old peg tube bag. 35103 Resident #20 Review of Resident #20's Minimum Data Set MDS assessment, dated 9/2/21, revealed Resident #20 was admitted to the facility on [DATE] with diagnoses that included cerebrovascular accident (CVA), hemiplegia, depression, and other muscle spasm. Resident #20 was totally dependent on staff for bed mobility, transfers, dressing, toileting, personal hygiene and bathing, and scored 15 of 15 on the Brief Interview for Mental Status (BIMS), reflective of intact cognition. Review of Resident #20's Electronic Medical Record (EMR) revealed the absence of physician visit documentation from December 2021 through April of 2022. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/4/22 at 12:00 p.m., the Director of Nursing (DON) was asked for the dates and times Physician EE was in the building and provided a physician visit for Resident #20. The DON said she and would have to ask Physician EE but confirmed the Physician should have documented physician visits in the medical record. During an interview on 4/4/22 at 2:15 p.m., the DON confirmed she was unable to find any physician visit documentation in Resident #20's EMR between December 2022 and March 2022 and provided a telephone number for Physician EE. During an interview on 4/4/22 at approximately 5:15 p.m., the Director of Nursing (DON) was again asked for the dates and times of Resident #20's physician documentation of physician visits December through March of 2022. The DON said Physician EE had all the notes from his physician visits with [Resident #20] and would put them into the EMR that day. Review of the facility Medication Orders Level III policy, dated 3/16/22, revealed the following, in part: Each resident must be under the care of a Licensed Physician authorized to practice medicine in this state and must be seen by the Physician at least every sixty (60) days . Progress Notes must be signed and dated every thirty (30) days. (Note: This may be changed to every sixty (60) days after the first ninety (90) days of the resident's admission . Review of the facility Initial Assessment/Physician Role policy, dated 3/15/22, revealed the following, in part: Physicians shall perform an appropriate medical assessment upon admission and periodically thereafter . Facility staff will have reliable medical information to identify and implement pertinent interventions . If the physician does not write an admission history and physical in the medical record at the time of the initial visit (for example, because it is dictated and typed at the office), he/she will submit the history and physician within one (1) week of the admission visit.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38328 Based on observation, interview and record review, the facility failed to coordinate care with hospice services for three residents (#15, #46, & #145) of four residents reviewed for hospice services. This deficient practice resulted in the potential for lack of coordination of care to meet the needs of residents on hospice services. Findings include: On [DATE] at 2:17 p.m., during an interview, Licensed Practical Nurse (LPN) A stated (Hospice Provider) was the provider who admitted Resident #145 to the facility. LPN A was asked where to find documentation for the hospice service provided and directed this Surveyor to a binder for Resident #145 located at the nurses station. A review of the face sheet for Resident #145 revealed admission to the facility on [DATE]. A review of the hospice provider notebook revealed an Admission Note on [DATE] and a Visit Note dated [DATE]. There were no other notes available in the note book. There was no hospice plan of care and no hospice orders in the binder. On [DATE] at 2:19 p.m., LPN A was asked to locate a care plan from the hospice provider. On [DATE] at 05:13 p.m., an email was received from the Nursing Home Administrator (NHA) which contained a plan of care from the hospice provider and had a start date of [DATE]. On [DATE] at 8:21 a.m., a review of the hospice provider book located at the nurses station revealed there remained no care plan posted for staff to be able to review to ensure coordination of care with the hospice provider. A review of the Electronic Medical Record revealed no plan of care from the hospice provider in the scanned in documents section. On [DATE] at 12:37 p.m., during a follow-up interview, the NHA was asked how the facility staff would be able to coordiate care with the facility provider without having access to the care plan from the hospice provider. The NHA acknowledged and agreed with the concern. 34276 Resident #15 A review of Resident #15's medical record revealed she admitted to the facility on [DATE] with diagnoses including stroke, nutritional deficiency, gastrostomy (feeding tube) status, diabetes type 2. A review of the [DATE] Minimum Data Set (MDS) assessment revealed she was assessed by staff to be severely cognitively impaired and relied on tube feeding to meet her nutritional needs. Per this assessment, Resident #15 was on hospice services. A review of Resident #15's medical record revealed she admitted to hospice on [DATE]. A review of Resident #15's medical record revealed no hospice notes since November of 2021. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 2:00 p.m., the facility provided the missing notes that they had just received via fax from the hospice provider. These notes and assessments were not readily available to facility staff for collaboration and coordination of care. Resident #46 A review of Resident #46's medical record revealed he admitted to the facility on [DATE] with diagnoses including gastrostomy (feeding tube) status, COVID-19, stroke, protein-calorie malnutrition, other nutritional anemias. A review of the [DATE] Minimum Data Set (MDS) assessment revealed he scored ,d+[DATE] on the Brief Interview for Mental Status (BIMS) assessment, indicating moderately impaired cognition. Per the face sheet, Resident #46 expired on [DATE]. A review of Resident #46's progress note dated [DATE] 3:06 p.m. revealed, Notified (NP Y) of residents status. Verbal order to speak with family and ask son if it is okay to have residents placed on Hospice. Notified (Son of Resident #46) of doctors request. (Son of Resident #46) stated that he would call his older brother and will call back later about resident being on hospice . A review of Resident #46's progress note dated [DATE] at 4:06 p.m. revealed, Resident was observed in bed with no respirations. Non responsive when called by name. Vitals were unable to be obtained. Notified attending physician of residents status, Notified Family . Further review of Resident #46's medical record revealed no order for a hospice consult or admission to hospice services. Resident #46's medical record contained no information about Resident #46 being on hospice, or why his advanced directives were not followed. On [DATE] at 1:51 p.m., the DON reported that she had a note from the hospice nurse who did the evaluation for Resident #46. When asked if the facility had family approval to have the resident evaluated for hospice, or if there was a physician order to do so, the DON reported that normally the facility does (get the order first) but she was unable to find any documentation that it occurred. When asked why the progress note dated [DATE] at 4:06 PM did not include who called the time of death and when, the DON reported she did not know. On [DATE] at 4:18 p.m., an interview was conducted with the Administrator. When asked at what point a Residents family can override their advanced directives if they are their own person, the Administrator stated, When they can no longer make their own decisions. When asked if that would be when the resident were deemed incompetent by two physicians, the Administrator said yes. A review of a Communication Note on hospice letter head regarding Resident #46 revealed the following, Reg: (Name of Resident #6). On [DATE], (Name of Hospice) Hospice RN (unidentified) was in the vicinity of (Name of Facility) visiting hospice patients. A facility staff approached Hospice RN (unidentified) regarding a probable referral for Hospice care and request that RN (unidentified) see if patient would qualify under hospice. Upon seeing the patient and obtaining a brief medical history, patient qualified for hospice care. Informed facility that a Hospice referral and order will be required prior to admission under hospice care and before a full assessment can be done. Unfortunately, patient had passed the same day and was not admitted under Hospice care. (Name of Hospice RN GGG). This documented was undated and unsigned by the author. This document was also not in Resident #46's medical record. This document indicated that Resident #46 was assessed by hospice without a physician order or families consent. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility policy titled, Hospice Program last reviewed by the facility on [DATE] revealed, .3. 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. The care plan shall be revised and updated as necessary to reflect the resident's current status .

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 35103 Based on interview and record review, the facility failed to consistently ensure the medical director attended quality assessment and assurance meetings quarterly as required. This deficient practice resulted in the potential for impaired resolution of identified issues or decreased quality of care with the potential to affect all 45 residents in the facility. Findings include: On 4/5/22 at 3:34 p.m., the Nursing Home Administrator (NHA) provided quality assurance performance improvement attendance forms, dated January 2022 through March 2022, for the quality assurance meeting. There was no documentation that the Medical Director attended any of the quality assurance meetings, and the sign-in sheets did not contain the Medical Directors name. The NHA stated, He (Medical Director) was not here in January, February, or March. When asked how the facility planned to ensure participation by the Medical Director in the quality assurance committee meetings, the NHA stated, We will have to be creative. The NHA confirmed the Medical Director had not attended the quarterly meetings since the new administrative staff had been employed by the facility in December 2021 and January 2022. Review of the facility Medical Quality Assurance/Performance Improvement Program, dated 3/23/22, revealed the following, in part: 1. Physician will be part of the development and use a quality assurance/performance improvement (QA/PI) program to monitor and improve practitioner performance and care practices .4. The medical director will periodically summarize is/her evaluations of healthcare practitioner performance and practices for the facility' quality assurance/performance improvement committee .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38328 Based on observation, interview, and record review, the facility failed to: 1. Maintain an infection prevention and control program; 2. Maintain facility infection surveillance; 3. Ensure proper Personal Protective Equipment (PPE) for source control was worn in resident care areas. 4. Utilize a system for tracking COVID-19 infections for staff and residents; 5. Document the response to a COVID-19 outbreak; 6. Perform reporting to the local health department for COVID-19; 7. Perform proper hand hygiene during dressing changes; 8. Perform hand hygiene during medication; 9. Maintain clean medication carts; 10. Ensure medication carts were free of soiled medical equipment; 11. Properly clean and disinfect reusable medical equipment; 12. Utilize medical equipment that could be properly cleaned and disinfected; 13. Utilize proper infection control practice while performing bolus tube feeding administration; 14. Ensure single use items were no to used for multiple residents. These deficient practices led to the potential for the spread of infectious agents and the potential for communicable diseases like COVID-19 to spread undetected. Findings include: An appointment was made on 3/29/22 at 4:30 p.m., to meet with the facility to review the infection prevention and control program on 3/30/22 at 9:30 a.m. The meeting was delayed by the facility Infection Preventionist (IP), RN D stating more time was needed to gather information for the meeting. On 3/30/22 at 11:15 a.m., this Surveyor met with the Director of Nursing (DON) and Registered Nurse D (Infection Preventionist) to review the facility infection surveillance and program. When asked how staff are monitored for work exclusion related to COVID-19, the DON presented logs for staff entrance screening. The DON stated the facility only had staff screening logs for December 30th, 2021 to present 03/30/22. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Additional staff entrance screening logs were presented later showing staff screening was being done from January 2021 through August 2021. The facility was unable to show staff screening for the months of September 2021, October 2021 and November 2021. The DON and RN D stated the facility was currently being testing weekly for staff and residents and was based on a low transmission rate in the community. The DON and RN D acknowledged the prior facility leadership (Prior to December 2021) was not looking up the positivity rate or testing staff and residents based on community transmission. A Review of the facility surveillance data for resident infections showed no information available prior to December 2021. Line listings for December 2021, January 2022, and February 2022 had multiple areas of missing information for columns, including, admitted , Sx (symptoms) Onset Date, Site/Dx (diagnosis), Risk Factors, McGeers (Antibiotic Stewardship Tool) Criteria Sx Met?, Culture/XR (X-ray) Date, and Organism/Result. March 2022 was missing a facility summary of infections for the month with a completed line listing and a facility map. There were no monthly facility summaries or mapping of infections for December 2021, January 2022, or February 2022. No McGeers criteria were documented as reviewed for any infections in January 2022 or December 2021, and no McGeers was documented prior to December 2021. When asked if the facility had any residents who were being tracked after testing positive for COVID-19, the DON stated Resident #25 tested positive on 12/8/21 via a rapid antigen test twice. The DON stated Resident #25 was placed in an isolation room on that day. Both the DON and RN D acknowledged the facility had a COVID-19 outbreak amongst the residents and sent multiple residents to acute care hospitals during a November 2021 outbreak and stated they could not provide any documentation of Health Department notification. There was no data available for residents who tested positive for the November 2021 COVID-19 outbreak because staff could not find any data completed by previous staff. The DON and RN D stated there was no outbreak summary available and no record of which residents tested positive prior to Resident #25 on December 8th, 2021. The stated DON and RN D could not answer on whether or not there were any resident deaths associated with the outbreak because there was no documentation available for tracking the COVID-19 infections for staff or residents. The DON and RN D stated there were no documented staff COVID-19 infections since December 2021. The DON and RN D stated there was no record of staff who were tested during the outbreak or test results available during the November 2021 outbreak. The DON stated there was no line listing for staff prior to December 2021, but she was told staff were out for COVID-19 in November 2021. The DON stated she was at the facility for an interview and at the time, sometime in late November 2021 she saw a resident being picked up by Emergency Medical Services (EMS). The DON state she had asked why the resident unidentified was being sent to the hospital, and was told by the former NHA/DON the resident unidentified had a COVID-19 positive antigen test. The DON stated she was unable to locate any outbreak testing information for the November 2021 outbreak, but acknowledged there was an outbreak at that time. available prior to December when she started but acknowledged there were positive residents in November. The DON stated there were no positive staff since December 2021, so there was no line listing for staff. The DON and RN D stated they had to start the infection control program from nothing when they got here in December 2021 as there was no surveillance or tracking of infections able to be located. On 3/30/22 at 1:25 p.m., during an interview, CNA I stated he was in charge of keeping track of staff illnesses. CNA I presented tracking of staff illnesses from January 26th 2022 forward. CNA I stated the facility had no documentation prior to this for staff illness tracking. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 3/30/22 at 1:16 p.m., during an interview, LPN E stated the facility does not have any data for staff call in's (illnesses) until 1/26/22 because they cannot find any data prior to CNA I starting the log. On 4/4/22 at 4:13 p.m., RN D was asked who handled COVID-19 testing for staff. RN D stated she had not had time to put the documentation in order or fill out a line listing for tracking of COVID-19 illness. RN D handed this surveyor a folder with November 2021 - March 2021 of staff and resident testing for COVID-19. There was no discernable order to the documentation and no way to efficiently use the information to perform contract tracing. No documentation of testing for staff or residents beyond November 14th, 2021 was available. On 3/29/22 at 11:35 a.m. Licensed Practical Nurse (LPN) A and LPN AA were observed with face masks not covering the mouth and nose at the nurses station with unidentified residents self propelling around them within 6 feet. On 3/29/22 at 2:45 p.m., LPN A and LPN AA were observed with face masks not covering the mouth and nose at the nurses station with unidentified residents self propelling around them within 6 feet. On 3/29/22 at 5:34 p.m., LPN A and LPN AA were observed with face masks not covering the mouth and nose at the nurses station with unidentified residents self propelling around them within 6 feet. When asked if LPN A and LPN AA were aware of the current guidance from the CDC continued to be the use of a face mask for source control when in resident care areas. LPN A and LPN AA acknowledged the concern and placed their face masks over their mouth and nose. On 4/4/22 at 3:15 p.m., Certified Nurse Aide (CNA) F was observed near the nurses station where she had her mask not covering her mouth or nose. There were several unidentified residents in the area within six feet of CNA F. This Surveyor observed CNA F move the mask over her nose and mouth once eye contact was made. On 3/30/22 at 12:44 p.m., during an interview, the Director of Nursing (DON) and Nursing Home Administrator (NHA) were asked if staff should be wearing masks for source control at the nurses stations with residents wandering close by. Both the DON and NHA confirmed masks should be worn at the nurses stations. Resident #14 On 3/30/22 at 10:54 a.m. wound dressing care was observed for Resident #14 on right anterior foot and heel areas. LPN B performed the wound care with assistance from CNA YY. LPN B changed her gloves after removal of the old dressings for the anterior (front) of the foot and heel of Resident #14. LPN B failed to change her gloves between wound sites. LPN B failed to complete the care for one wound site before moving to the next wound site. LPN B also failed to perform hand hygiene before donning new gloves and continuing care. LPN B changed gloves after cleansing the wounds and failed to perform hand hygiene. LPN B changed her gloves and proceeded to a wound on the right shin without performing hand hygiene. LPN B removed the old dressing and changed her gloves without performing hand hygiene. LPN B cleansed the wound, changed her gloves, and failed to perform hand hygiene. LPN B then completed the dressing change. Resident #145 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 3/31/22 at 10:19 a.m. CNA C was observed bringing a soap bottle from a cart located in the hallway housing multiple various supplies into Resident #145's room for use. CNA C then prepared soapy water for Resident #145 and proceeded to perform incontinence care. When CNA C had completed the task, she brought the soap bottle back out to the supply cart for storage without sanitizing the exterior in any way. When asked about whether or not the soap was for multiple resident use, CNA C confirmed staff use the soap bottles for multiple residents. When this Surveyor voiced concern of cross contamination, CNA C acknowledged the concern. Resident #20 On 4/4/22 at 1:30 p.m., a fell ow Surveyor indicated she found information showing Resident #20 had tested positive on 12/2 or 12/3 of 2021. Resident # 20 Progress Notes: 12/02/2021 07:54 AM During morning medication rounds resident notice dry cough and runny nose . Resident stated i do not feel good since yesterday . (Physician EE) order . PCR (Polymerase Chain Reaction [COVID-19]) test. Nursing (Licensed Practical Nurse [LPN] B) 12/03/2021 05:59 PM Received a reoport (sic) resident tested positive for Covid (presumptive) awaiting results for PCR. Patient . weak complains of feeling weak and reports pain (6) on Hip post fall 12/2/2021. Lungs diminished on Upper and Mid and lower Left lung . O2 (oxygen) Sat (saturation) 85% (Normal Range 95-100%) . (Physician EE) notified with order to give O2 via NC at 3L (liters) . Order to send patient out to Hospital. Nursing (RN GGG) 12/17/2021 08:20 PM [Recorded as Late Entry on 12/18/2021 04:56 AM] readmitted on 14 day observation post covid . (LPN R) On 4/05/22 at 2:27 p.m., during an interview, Physician EE confirmed Resident #20 had to be sent out to the hospital for COVID-19 on December 3rd, 2021. Additional Residents (#13, #15 #16, #24, #28, #33) discovered in the Electronic Medical Record (EMR) who had tested positive for COVID-19. Resident #28 Progress Notes 11/24/2021 07:16 PM Resident tested for COVID 19 by nasal swab . Nursing (RN III) 11/25/2021 08:25 AM Received resident . noticed audible wheezing. Resident stated I have been like this for 3 days and i told and told and told the nurse but nothing was done. VS (Vital Signs) BP (Blood Pressure) 171/100, HR (Heart Rate) 136, T (Temp) 99.2 and Oxygen 89 RA (Room Air). Breathing tx (treatment) given per order. Covid tested w (with)/ positive result. Contacted NP (Nurse Practitioner) and she order to send resident out to ER (emergency room) and to be admitted . 911 Called . Attempted to Notify Administration but No answer . Nursing (LPN B) Resident #24 Progress Notes (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	11/30/2021 07:41 AM residents skin was warm to touch, resident temp was between 100.7-100.9, given scheduled ibuprofen (Motrin-pain/fever reducer). No success of breaking the fever, given 500 mg (milligrams) Tylenol and ice packs, which was successful . monitored throughout the nigh (sic), the temp dropped to 98 last temp taken at @ (at) 6:30 am was 98.5. Nursing (Former Nurse JJJ credential not identified) 12/05/2021 11:02 AM F/U (follow-up) with last night complaints of poor appetite, coughing without secretion, weakness and not feeling well. Administer 2x (times) rapid test and it shows positive . Notified D.O.N (Director of Nursing) and she order to get PCR (Polymerase chain reaction [COVID-19]) test order . Notified NP and waiting for her response. Resident in isolation room until further notice. Nursing (LPN B) Resident #33 Progress Notes 11/27/2021 07:26 AM (Resident #33) was reporting that she was feeling sick with cough and feeling warm. temp was 97.8 and she was covid tested on 11.26 at 9pm with a negative result. cough is dry and non productive Nursing (Former Nurse JJJ credential not identified) 11/28/2021 09:37 AM During morning round resident (#33) noticed coughing. Resident (#33) stated she feels sick all night long with constant coughing . Covid-19 tested with negative result. Notified NP and she order a cough medicine prn (as needed) and chest X-Ray 2 views to r (rule)/o (out) pneumonia. Order in place and cough medicine Robitussin administered with pending result. Nursing (LPN B) No other notes indicated Resident #33 tested positive for COVID-19 until Physician EE acknowledged Resident #33's COVID-19 positive status below. 11/29/2021 10:20 AM . Internal medicine progress note Patient Name: (Resident #33) DOB: 06/30/1926 Pcp (Primary Care Physician): (Physician EE) S: Following this patient for positive result for COVID-19 . PA (Physician Assistant Y) Resident #16 Progress Notes 12/07/2021 02:00 PM Resident noted O2 at 85% MD notified to start O2 at 2L (liters) . (Resident #16) tested for COVID (presumptive) came with positive results . fine crackles heard on auscultation. (Hospice Provider) notified. Facility to manage patient symptoms in house in the facility COVID Unit . Nursing (RN GGG) Resident #13 Progress Notes (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	12/06/2021 06:07 PM Resident (#13) with positive COVID rapid test, resident with no s (signs)/s (symptoms) observed at this time. Resident (#13) transferred to room [ROOM NUMBER]-P (Private), family made aware . Nursing (LPN LLL) Resident #15 Progress Notes 11/29/2021 02:17 PM PRN (as needed) Covid-19 test, positive. NP (Y) made aware, ordered to transfer to (local hospital). (Ambulance Service) phoned for transfer . ETA (estimated time of arrival) of 3 hrs (hours). DON Hospice (Provider) made aware . Nursing (LPN MMM) On 4/5/22 at 4:50 p.m., the NHA stated the NHSN (National Health and Safety Network) reporting for infection control was non-existent for a period of time prior to her starting on 12/21/21. The NHA stated she did not have access to NHSN until January 10th, 2022. When asked if there were COVID-19 related deaths from the outbreak in November 2021, the NHA stated she was able to see from previous data there were COVID-19 related deaths, but she was not sure who. The NHA stated she would attempt to gather that data. No data on Resident COVID-19 deaths was received from the NHA at the time of exit on 4/5/22 at 8:00 p.m. A review of the policy Isolation-Categories of Transmission-Based Precautions, with a revised date of 1/19/21 read in part: Standard Precautions will be used when caring for residents at all times regardless of their suspected or confirmed infection status . f. Resident-Care Equipment (1) When possible, dedicate the use of non-critical resident-care equipment items such as a stethoscope, sphygmomanometer . or electronic thermometer to a single resident (or cohort of residents) to avoid sharing between residents. (2) If use of common items is unavoidable, then adequately clean and disinfect them before use for another resident. A review of the facility policy Standard Precautions, with a revised date of 3/15/22, read in part: . Standard Precautions presume that all blood, body fluids, secretions, and excretions (except sweat), non-intact skin and mucous membranes may contain transmissible infectious agents . . 1. Hand Hygiene a. Hand hygiene refers to handwashing with soap . or using alcohol-based hand rubs . b. Hands shall be washed with soap and water whenever visibly soiled with dirt, blood, or body fluids, or after direct or indirect contact with such . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	c. In the absence of visibly soiling of hands, alcohol-based hand rubs are preferred for hand hygiene. d. Wash hands after removing gloves . . 2. Gloves . . e. Change gloves as necessary, during the care of a resident to prevent cross-contamination from one body site to another . . g. Remove gloves promptly after use, before touching non-contaminated items and environmental surfaces, and before going to another resident and wash hands immediately to avoid transfer of microorganisms to other residents or environments . . 5. Resident-Care Equipment . . b. Ensure that reusable equipment is not used for the care of another resident until it has been appropriately cleaned and reprocessed and single use items are properly discarded. 6. Environmental Control a. Ensure that environmental surfaces, beds, bedrails, bedside equipment and other frequently touched surfaces are appropriately cleaned. A review of the facility policy COVID-19 Preparation and Prevention, dated 12/9/20, read in part: . Our center will implement procedures and practices in accordance with recommendations from the CDC (Centers for Disease Control), directives from State and Federal Executives and Agencies, and evidence-based practices in order to maintain the safety of our residents during the COVID-19 pandemic. Our center will have access to at least one individual with training in IPC (Infection Prevention and Control) to provide management of our COVID-19 prevention and response activities, including developing policies and procedures, performing infection surveillance, . and auditing adherence to recommended IPC (Infection Prevention and Control) practices. Our center will maintain vigilance for COVID-19 among residents and HCP (Health Care Personnel) in order to prevent spread and protect residents and HCP from severe infections, hospitalization s, and death. Personal protective equipment will be available and will be used and conserved in accordance with CDC recommendations. Definitions: . Outbreak - one laboratory confirmed occurrence of COVID-19 of new onset. Source Control - Use of a cloth face covering or face mask to cover a person's mouth and nose to prevent spread of respiratory secretions when they are talking, sneezing, or coughing . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1. The Infection Control Committee shall take an active and effective role in preventing and managing communicable illnesses within our facility. Composition of the Committee 1. The Infection Control Committee shall oversee the surveillance, investigation, reporting, control and prevention of infections; . and monitoring for proper implementation of and adherence to infection control policies and procedures . . Duties and Responsibilities . 3. Develop written policies and procedures to identify and address infections within the facility; 4. Notify appropriate government agencies of reportable contagious or infectious diseases; . . 11. Provide guidance for and help monitor the health status of all employees . 12. Provide guidance for maintaining the facility in a sanitary fashion; . . 14. Maintain written accounts of meetings conducted and action taken by the committee . . 21. Monitor all findings from any resident care quality assessment activities that relate to infection control; . A review of the facility policy, Policies and Practices-Infection Control, with a revised date of 3/19/22, read in part: Policy Statement This facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections. Policy Interpretation and Implementation . 2. The objectives of our infection control policies and practices are to: a. Prevent, detect, investigate, and control infections in the facility; b. Maintain a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the general public; . . e. Maintain records of incidents and corrective actions related to infections; f. Provide guidelines for the safe cleaning and reprocessing of reusable resident -care equipment . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the facility policy, Infection Preventionist, with a revised date of 3/15/22, read in part: .The infection Preventionist will collect, analyze, and provide infection and antibiotic usage data and trends to nursing staff and health care practitioners; consult on infection risk assessment and prevention control strategies; provide education and training; and implement evidence-based infection prevention and control practices. A review of the facility policy, Infection Control: Identifying Infections, with a revised date of 3/15/22, read in part: Policy Statement 1. Physicians will help in identifying the presence of infections and distinguish infection from colonization . . 3. Antibiotics will be used judiciously. Outcomes 1. Clinically significant infections will be identified and managed appropriately. 2. Antibiotics will be used appropriately . Procedure 1. Based on appropriately detailed assessment of the resident/patient and matching results with established criteria, the physician and staff will identify current infections and distinguish them from colonization . .The staff and practitioners will utilize recommendations from widely recognized sources of infection control practices and standards (i.e., CDC, HICPAC [Healthcare Infection Control Practices Advisory Committee], [NAME] [Society for Healthcare Epidemiology of America], APIC [Association for Professionals in Infection Control and Epidemiology], etc.) When signs or symptoms of possible infection are present, the physician and nursing staff will collaborate to evaluate the resident/patient and identify appropriate tests to try to confirm and characterize any infection. 2. The attending physician and staff will attempt to distinguish facility-acquired from community acquired infections . A review of the facility policy, Infections Outbreaks, with a revised date of 3/15/22, read in part: Policy Statement (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Infectious Outbreaks will be identified and managed promptly in order to prevent the spread of infections to non-infected residents/patients as effectively as possible. Infection management and prevention will be consistent with related standards and will comply with applicable laws and regulations. Procedure 1. The nursing staff and infection control coordinator will identify suspected infectious outbreaks, especially monitoring for respiratory . infections. 2. The DON or infection control coordinator will report a suspected outbreak to the medical director and local health department, and nursing staff and/or infection control coordinator will report the information to the attending physicians of affected and at-risk residents/patients . 34276 Resident #43 On 3/31/22 at 9:00 a.m., the bolus tube feeding administration for Resident #43 was observed. Licensed Practical Nurse (LPN) A was observed to wash his hands and don gloves. LPN A reported he just needed to check the tube feeding order one more time and proceeded to deglove and leave the room. LPN A re-entered the room less than a minute later and put another pair of gloves on without washing his hands. LPN A proceeded to start administering the tube feeding. LPN A checked for placement and for residuals, and then proceeded to use the bedside remote to raise the bed. LPN A then continued to administer the bolus tube feeding, without washing his hands or changing gloves. 35103 During a medication pass observation on 3/30/22 at 8:09 a.m., LPN KK placed all medication for Resident #24 on a pink personal clipboard, placed on top of the medication cart. LPN KK took the clipboard and medications into Resident #24's room, placed them on Resident #24's partially eat breakfast tray on the overbed table and donned gloves. LPN KK used a fabric wrist blood pressure cuff to measure Resident #24's blood pressure. LPN 'KK then touched the residents previously used personal water mug, and the inhalers handled by Resident #24 and placed all used medications and medication cups back on top of the clipboard. LPN KK exited the room and placed the potentially contaminated clipboard on top of the medication cart. The clipboard and blood pressure cuff were not cleaned and disinfected following exit from Resident #24's room. During a medication pass observation on 3/30/22 at 8:45 a.m., LPN KK placed Resident #25's medications in a cup on top of the personal pink clipboard and entered Resident #25's room. LPN KK set the pink clipboard on resident #25's overbed table without cleaning or disinfection of the table. LPN KK used the previously used cloth blood pressure cuff to measure Resident #25's blood pressure and placed the potentially contaminated blood pressure cuff into her scrub top pocket. LPN KK touched Resident #25's clothes cupboard, and donned gloves with no performance of hand hygiene prior to administration of Resident #25's medications. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 3/30/22 at 8:49 a.m., LPN KK confirmed infection control was the concern with potential contamination the pink binder brought into each Resident room and the return of the binder to the top of the medication cart. LPN KK acknowledged the same infection control concerns with use of a multi-use wrist blood pressure cuff without cleaning and disinfection and performance of hand hygiene, and touching the environment in a resident room without hand hygiene prior to donning gloves. During an observation on 3/30/22 at 9:12 a.m., LPN LL touched Resident #21's skin and clothing with bare hands and did not perform hand hygiene prior to opening and handling a nicotine patch for Resident #21 with scissors. Following exit from Resident #21's room, LPN LL did not clean and disinfect the scissors prior to placing them back into the medication cart after use in Resident #21's room. During an interview at this same time, LPN LL confirmed she had touched Resident #21's skin and clothing while checking for a nicotine patch and had not cleaned the scissors following use, which would be an infection control concern. Review of the facility Cleaning and Disinfection of Resident-Care Items and Equipment policy, dated 3/19/22, revealed the following, in part: .d. Reusable items are cleaned and disinfected or sterilized between residents (e.g., stethoscopes, durable medical equipment) . durable medical equipment (DME) must be cleaned and disinfected before reuse by another resident . A review of the facility policy Standard Precautions, with a revised date of 3/15/22, read in part: . Standard Precautions presume that all blood, body fluids, secretions, and excretions (except sweat), non-intact skin and mucous membranes may contain transmissible infectious agents . . 1. Hand Hygiene a. Hand hygiene refers to handwashing with soap . or using alcohol-based hand rubs . b. Hands shall be washed with soap and water whenever visibly soiled with dirt, blood, or body fluids, or after direct or indirect contact with such . c. In the absence of visibly soiling of hands, alcohol-based hand rubs are preferred for hand hygiene. d. Wash hands after removing gloves . 2. Gloves . e. Change gloves as necessary, during the care of a resident to prevent cross-contamination from one body site to another . g. Remove gloves promptly after use, before touching non-contaminated items and environmental surfaces, and before going to another resident and wash hands immediately to avoid transfer of microorganisms to other residents or environments . 5. Resident-Care Equipment . b. Ensure that reusable equipment is not used for the care of another resident until it has been appropriately cleaned and reprocessed and single use items are properly discarded. 6. Environmental Control a. Ensure that environmental surfaces, beds, bedrails, bedside equipment and other frequently touched surfaces are appropriately cleaned.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38328 Based on interview and record review, the facility failed to maintain an antibiotic stewardship program. This deficient practice led to the potential for administration of unnecessary antibiotics, antibiotic resistance, and potential development of Multi-Drug Resistant Organisms (MDRO's). Findings Include: An appointment was made on 3/29/22 at 4:30 p.m., to meet with the facility to review the infection prevention and control program on 3/30/22 at 9:30 a.m. The meeting was delayed by the facility Infection Preventionist (IP), RN D stating more time was needed to gather information for the meeting. On 3/30/22 at 11:15 a.m., this Surveyor met with the Director of Nursing (DON) and Registered Nurse D (Infection Preventionist) to review the facility infection surveillance and program. A Review of the facility surveillance data for resident infections showed no information available prior to December 2021. Line listings for December 2021, January 2022, and February 2022 had multiple areas of missing information for columns, including, admitted , Sx Onset Date, Site/Dx, Risk Factors, McGeers Criteria Sx Met?, Culture/XR Date, and Organism/Result. No McGeers criteria were documented as reviewed for any infections in January 2022 or December 2021, and no McGeers was documented prior to December 2021. The DON and RN D stated they had to start the infection control program from nothing when they got here in December 2021 as there was no surveillance or tracking of infections able to be located. A review of the facility policy, Infection Control: Identifying Infections, with a revised date of 3/15/22, read in part: Policy Statement 1. Physicians will help in identifying the presence of infections and distinguish infection from colonization . . 3. Antibiotics will be used judiciously. Outcomes 1. Clinically significant infections will be identified and managed appropriately. 2. Antibiotics will be used appropriately . Procedure 1. Based on appropriately detailed assessment of the resident/patient and matching results with established criteria, the physician and staff will identify current infections and distinguish them from colonization . (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	.The staff and practitioners will utilize recommendations from widely recognized sources of infection control practices and standards (i.e., CDC, HICPAC [Healthcare Infection Control Practices Advisory Committee], [NAME] [Society for Healthcare Epidemiology of America], APIC [Association for Professionals in Infection Control and Epidemiology], etc.) When signs or symptoms of possible infection are present, the physician and nursing staff will collaborate to evaluate the resident/patient and identify appropriate tests to try to confirm and characterize any infection. 2. The attending physician and staff will attempt to distinguish facility-acquired from community acquired infections . A review of the facility policy, Antibiotic Stewardship, with a revised date of 3/15/22, read in part: . c. As a team they will: i) Review infections and monitor antibiotic usage patterns on a regular basis ii) Obtain and review antibiograms for institutional trends of resistance iii) Monitor antibiotic resistance patterns . iv) Report on number of antibiotics prescribed . . 4) Tracking a) Infection Control Nurse will be responsible for infection surveillance and MDRO tracking . b) Infection Control Nurse will collect and review data such as: i) Type of antibiotic ordered, route of administration . iii) Whether appropriate tests such as cultures were obtained before ordering antibiotic iv) Whether the antibiotic was changed during the course of treatment v) Pharmacy consultant will review and report antibiotic usage data including numb (cut-off) residents treated each month. 5) Reporting: a) Infection Control Nurse and/or other members of the ASP team will review and report (cut-off) to facility staff. b) Feedback will be given to physicians by the ASP team on their individual prescribing [NAME] (cut-off)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. 38328 Based on interview and record review, the facility failed to ensure eight Residents (#13, #18, #30 , #31, #34, #36, #44, & #295) were offered and/or received influenza (flu) and pneumococcal (pneumonia) vaccines as requested. This deficient practice resulted in the potential for the spread of communicable diseases, and the potential for hospitalization . Findings include: An appointment was made on 3/29/22 at 4:30 p.m., to meet with the facility to review the infection prevention and control program on 3/30/22 at 9:30 a.m. The meeting was delayed by the facility Infection Preventionist (IP), RN D stating more time was needed to gather information for the meeting. On 3/29/22 at 8:36 a.m., during an interview, Resident #30 confirmed being asked if he wanted his flu and pneumonia vaccines. Resident #30 asked why he was just now being offered the flu vaccine. Resident #30 stated he felt they forgot him and they are trying to catch up with those who have not received their vaccines yet. Resident #30 stated he signed to get the flu vaccine months ago. A review of the Electronic Medical Record for Resident #30 revealed a consent dated 11/9/22, where Resident #30 had consented to receive flu and pneumonia vaccines. On 3/30/22 at 11:15 a.m., the Director of Nursing (DON) and Infection Preventionist (IP) RN D met with this Surveyor to review the infection control program for the facility. RN D was informed Resident #30 had agreed to have flu and pneumonia vaccines on November 9th, 2021. RN D confirmed Resident #30 had not received vaccines he had consented to. RN D stated she was working on getting the immunizations requested caught up and showed this Surveyor a hand written list she had started. RN D was asked to provide a complete list of all residents who had consented to and were eligible for receiving and/or pneumonia vaccines, but had not yet received the vaccines. On 3/31/22 at 9:00 a.m. a copy of a completed list was received from RN D for residents who had consented to and qualified for flu and/or pneumonia vaccines. There were a total of eight Residents (#13, #18, #30 , #31, #34, #36, #44, & #295) who had consented to receiving the flu and/or pneumonia vaccine. RN D stated she had to go through the entire facility population because there were no records from the previous IP to determine if residents were eligible and consented to receiving the vaccine. A review of the facility policy Immunization and Vaccination, dated 7/1/16, read in part: Policy Statement The facility will strive to administer influenza and pneumococcal vaccines in accordance with Centers for Disease Control and Prevention (CDC) recommendations. Outcomes 1. Residents/patients will receive recommended immunizations . (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	. 3. The facility's care will be consistent with related standards and will comply with applicable laws and regulations. Procedure 1. Soon after admission, the staff will review each resident/patient's immunization status. 2. Based on appropriate assessment of the resident/patient and relevant information, the physician will order appropriate immunizations .

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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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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** 38328 Based on interview and record review, the facility failed to implement policies and procedures maintaining COVID-19 vaccination history. This deficient practice led to the potential for staff and residents to be unvaccinated and unprotected from COVID-19. Findings include: On 3/30/22 at 8:43 a.m., a review of the facility staff vaccine documentation provided by the facility revealed multiple staff who had been indicated as being fully vaccinated. There were no recorded dates of vaccinations, no documentation to ensure a series if indicated was completed, no evidence of boosters provided, and no documentation of vaccine manufacturer. There were seven staff names with dates next to them, hand written in at the bottom of the document. The staff list was not complete with newer staff present on the list. CNA YY in particular was not noted on the list of staff vaccinated. An appointment was made on 3/29/22 at 4:30 p.m., to meet with the facility to review the infection prevention and control program on 3/30/22 at 9:30 a.m. The meeting was delayed by the facility Infection Preventionist (IP), RN D stating more time was needed to gather information for the meeting. On 3/30/22 at 11:15 a.m., the Director of Nursing (DON) and Infection Preventionist (IP) RN D met with this Surveyor to review the infection control program for the facility. RN D stated staff vaccinations were as follows: Total staff: 62 Fully Vaccinated: 50 Medical Exemption: 6 Non-Medical: 7 Temporary Delay: 0, No Unvaccinated: The DON stated stated they have copies of staff vaccination cards but the facility did not have it on a spreadsheet yet. The DON and RN D stated they didn't have any records when they started, so they had had to start from the bottom up. The DON and RN D stated they also get the information from the pharmacy to obtain accurate vaccination records for the residents, but did not have it all in the Electronic Medical Record (EMR) yet. When asked why CNA YY was not included on the list of staff vaccinations, the DON and RN D looked through the copies of vaccine cards and could not locate vaccine information for CNA YY. The DON and RN D had to call Human Resources (HR) to see if a copy of vaccinations could be located for CNA YY. An HR representative brought a copy of the vaccination card for CNA YY during the interview. There still remained no explanation for why CNA YY was not listed as an employee on the staff vaccination list. The DON and RN D stated the start date for CNA YY was 12/22/21. The DON and RN D indicated the facility vaccination rate was 81%. A review of the NHSN (National Health and Safety Network) report dated 3/13/22 indicated the vaccination rate for the facility was 92.473%. When asked if the therapy staff and physician staff vaccinations were included in the vaccination data for staff, the DON and RN D stated they had not had the opportunity to add them to the list yet. The DON stated that may be the reason the data from NHSN was a greater than 10% variant from the facility vaccination rate. The DON and RN D stated the therapy department gave the vaccination information to HR on 3/28/22 so they could be added to the list. On 4/5/22 at 4:50 p.m., the Nursing Home Administrator (NHA) stated the NHSN reporting for infection control was non-existent for a period of time prior to her starting on 12/21/21 and she did not get access to NHSN reporting until January 10th, 2022. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235719	A. Building B. Wing	04/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the facility policy, COVID-19 Preparation and Prevention, dated 12/9/20, read in part: .Our center will implement procedures and practices in accordance with recommendations from the CDC, directives from State and Federal Executives and Agencies, and evidence-based practices in order to maintain the safety of our residents during the COVID-19 pandemic. Our center will consider the current situation in our facility and community and refer to that guidance as well as direction from state and local officials when making decisions about relaxing restrictions. Our center will maitain vigilance for COVID-19 among residents and HCP (Healthcare Personnel) in order to prevent spread and protect residents and HCP from sever infections, hospitalization s and death . Reporting: Report COVID-19 cases, facility staffing, and supply information to the National Helatcare Safety Network (NHSN) Long-Term Care Facility (LTCF) COVID-19 Module weekly A review of the facility COVID-19 Vaccination Policy, dated 11/8/21, had no guidance for maintaining accurate, consice, and complete COVID-19 vaccination records for facility staff and residents. The facility was asked to provide a policy on how they kept track of COVID-19 vaccination history for staff and residents on 3/30/22 at 11:15 a.m. during the infection control interview. No policy was provided by the time of exit on 4/5/22 at 8:00 p.m. 34276 Resident #46 A review of Resident #46's medical record revealed he admitted to the facility on [DATE] with diagnoses including gastrostomy (feeding tube) status, COVID-19, stroke, protein-calorie malnutrition, other nutritional anemias. A review of the 12/17/21 Minimum Data Set (MDS) assessment revealed he scored 9/15 on the Brief Interview for Mental Status (BIMS) assessment, indicating moderately impaired cognition. A review of Resident #46's record revealed no documentation regarding his COVID-19 vaccination status. On 3/31/22 at 9:55 a.m., an interview was conducted with the DON. When asked to provide the COVID-19 vaccination consent/declination form for Resident #46, the DON reported that she could not find it. The DON sated, I couldn't find anything on admission that it was offered. (There is) no paperwork. The DON reported that she did not believe that Resident #46 had tested positive for COVID-19 in December, and that the notes regarding his isolation were incorrect and should have stated that he was on observation for COVID-19. The DON could not explain why Resident #46 had a primary diagnosis of COVID-19 in his record. The DON could not show evidence that Resident #46 was ever offered the COVID-19 vaccination.

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F 0888 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure staff are vaccinated for COVID-19 38328 Based on interview and record review, the facility failed to ensure accurate, consice, and complete COVID-19 vaccination records were kept for facility staff. This deficient practice resulted in the potential for unvaccinated staff to have exposure to the entire facility resident population and potentially spread COVID-19. Findings include: On 3/30/22 at 8:43 a.m., a review of the facility staff vaccine documentation provided by the facility revealed multiple staff who had been indicated as being fully vaccinated. There were no recorded dates of vaccinations, no documentation to ensure a series (if indicated) was completed, no evidence of boosters provided, and no documentation of vaccine manufacturer. There were seven staff names with dates next to them, hand written in at the bottom of the document. The staff list was not complete with newer staff present on the list. CNA YY in particular was not noted on the list of staff vaccinated. An appointment was made on 3/29/22 at 4:30 p.m., to meet with the facility to review the infection prevention and control program on 3/30/22 at 9:30 a.m. The meeting was delayed by the facility Infection Preventionist (IP), RN D stating more time was needed to gather information for the meeting. On 3/30/22 at 11:15 a.m., the Director of Nursing (DON) and Infection Preventionist (IP) RN D met with this Surveyor to review the infection control program for the facility. RN D stated staff vaccinations were as follows: Total staff: 62 Fully Vaccinated: 50 Medical Exemption: 6 Non-Medical: 7 Temporary Delay: 0, No Unvaccinated: The DON stated stated they have copies of staff vaccination cards but the facility did not have it on a spreadsheet yet. The DON and RN D stated they didn't have any records when they started, so they had had to start from the bottom up. The DON and RN D stated they also get the information from the pharmacy to obtain accurate vaccination records for the residents, but did not have it all in the Electronic Medical Record (EMR) yet. When asked why CNA YY was not included on the list of staff vaccinations, the DON and RN D looked through the copies of vaccine cards and could not locate vaccine information for CNA YY. The DON and RN D had to call Human Resources (HR) to see if a copy of vaccinations could be located for CNA YY. An HR representative brought a copy of the vaccination card for CNA YY during the interview. There still remained no explanation for why CNA YY was not listed as an employee on the staff vaccination list. The DON and RN D stated the start date for CNA YY was 12/22/21. The DON and RN D indicated the facility vaccination rate was 81%. A review of the NHSN (National Health and Safety Network) report dated 3/13/22 indicated the vaccination rate for the facility was 92.473%. When asked if the therapy staff and physician staff vaccinations were included in the vaccination data for staff, the DON and RN D stated they had not had the opportunity to add them to the list yet. The DON stated that may be the reason the data from NHSN was a greater than 10% variant from the facility vaccination rate. The DON and RN D stated the therapy department gave the vaccination information to HR on 3/28/22 so they could be added to the list. On 4/5/22 at 4:50 p.m., the Nursing Home Administrator (NHA) stated the NHSN reporting for infection control was non-existent for a period of time prior to her starting on 12/21/21 and she did not get access to NHSN reporting until January 10th, 2022. (continued on next page)

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F 0888 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the facility COVID-19 Vaccination Policy, dated 11/8/21, had no guidance for maintaining accurate, consice, and complete COVID-19 vaccination records for facility staff and residents. The facility was asked for a policy pertaining to record keeping for staff and resident COVID-19 vaccines during the infection control interview on 3/30/22 at 11:15 a.m. No policy was provided by the time of exit on 4/5/22 at 8:00 p.m.