STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275020	A. Building B. Wing	02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bella Terra of Billings	1807 24th St W Billings, MT 59102

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 44770 Based on interview and record review, the facility failed to: - Provide ordered dressing changes for 2 (#s 5 and 212) of 3 sampled residents. For #5, the resident missed a wound care appointment, which was not rescheduled, and the wound was not treated as ordered. For resident #212, a wound went untreated, and worsened, requiring antibiotics, and the resident had pain from the wound. - Nursing staff neglected to send 1 (#12) resident to the emergency department when the resident requested to be sent, and the resident was later diagnosed with lower lobe pneumonia and antibiotics to treat the infection. - Failed to protect 1 (#4) of 1 sampled residents from two incidents of verbal abuse by staff. The failure, and action taken by the facility, did not ensure resident protection after the first incident of verbal abuse for resident #4, and it occurred again. Findings include: 1. A record review of a facility reported incident for a neglect allegation, dated 9/19/21, showed, On 9/17/21, it was reported by the wound nurse that the dressing to resident, [#5], was dated 9/9/21. Resident's dressing is scheduled to be changed on Tuesdays and Fridays. Per the schedule the dressing should have been changed on 9/10 and 9/14. The allegation of neglect was substantiated by the facility. During an interview on 2/16/22 at 9:56 a.m., staff member A stated she investigated the incident and found that resident #5 missed her appointment for wound care because she was not ready to go when the bus was ready to take her. The driver had another resident to take to an appointment and did not have time to wait for the nurses to get the resident ready for her appointment. Resident #5 would have had her dressing changed at that appointment, but since she did not go, the dressing was not changed. The TAR did not prompt the nurse to change the dressing. Staff member A stated they have changed the process so that on wound care appointment days it will need to be documented if the clinic does the dressing change or if the nurse does the dressing change. Although the resident did not attend the scheduled appointment, the facility staff did not ensure the resident's skin care needs were addressed related to the dressing change. (continued on next page)

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

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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A record review of resident #5's EMR, Skin Wound Note, dated 9/7/21, showed, Resident right lateral outer and calf are healing with no signs of infection noted, redness is resolved, area is light pink, will continue with current treatment order for protection. This was prior to the event of the resident not attending the scheduled appointment. A record review of resident #5's EMR, Communication with Resident Family, dated 9/17/21, showed, Family was notified of resident missing wound care appointment on 9/14/21. Due to the resident missing her appointment her wound care to the right calf was not completed. 2. During an interview on 2/14/22 at 3:56 p.m., with resident #12 and NF3, resident #12 stated, I needed to go to the hospital (1/16/22) because I couldn't breathe and the nurse (staff member II), told me 'We don't do that here.' NF3 stated she did not get a phone call about it, and that they diagnosed him (resident #12) with left lower lobe pneumonia. NF3 did not find out about it until the next day. Resident #12 stated, The doctor saw me here the next day during his regular rounds. I was given a nebulizer and a steroid. NF3 stated, in November, around the 11th (2021) she saw protective dressings on his feet that had been on since he had been in the hospital. NF3 stated the CNA gave him a shower with the dressings on, and then the water from the wet dressings soaked his socks and shoes. NF3 went to talk to the nurse to see if she could take the dressings off and was told by the nurse, I don't care what you do. During an interview on 2/15/22 at 2:41 p.m., staff member A stated, We follow the resident rights on change in condition, if he (resident #12) wanted to go to the hospital, he should have been sent. During an interview on 2/16/22 at 8:36 a.m., staff member CC stated if a resident tells her they need to go to the hospital, she would check the residents' vitals, call the MD, and provide any interventions needed for the resident. Staff member CC stated, But if the resident is requesting to go to the emergency room then I would send them. A review of resident #12's medical record showed an x-ray, dated 1/17/22, with clear lungs, and the lab testing was negative for influenza and Covid 19. On 1/24/22, a new x-ray showed the resident had left lower lobe pneumonia, and a Z pack (azithromycin) was ordered, along with prednisone 40 mg for 5 days, and Duo Neb three times a day, to be started 1/24/22. Review of resident #12's MAR showed the medications were not started until 1/25/22. During an interview on 2/16/22 at 2:38 p.m., resident #12 stated, I did tell the CNA and the dayshift nurse that the night nurse told me I couldn't go to the hospital. But nobody did anything about it. 3. A record review of a facility reported incident for a neglect allegation, dated 9/20/21, showed, On 9/20/21, it was reported by night shift that the dressing to resident, [#212], was dated 9/8/21 . An allegation of neglect has been submitted . the allegation of neglect is substantiated. According to the facility reported incident the facility found that a nurse falsified a record, documenting she had changed the dressing on 9/14/21, but she had not, and on 9/17/21 another nurse documented on the TAR that she changed the dressing because she thought that the wound care nurse had done the dressing change, but the dressing was not changed on 9/17/21 either. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview on 2/15/22 at 4:15 p.m., resident #212 stated, the wound was now healed but he remembered the incident. Resident #212 stated, It was very painful. I had a hell of a time for it to heal. It was healed once then it got a blister under the dressing. It took it months for it to heal after they found it like that. During an interview on 2/16/22 at 9:56 a.m., staff member A stated it was her understanding that resident #212's wound was healed and then the nurse placed a dressing on it to protect it. When it was discovered that the protective dressing did not get changed on schedule, when they took the protective dressing off they found a new blister. During an interview on 2/17/22 at 7:55 a.m., staff member A stated, [Staff member HH] was terminated for falsifying documentation. She was educated on wound care. [Staff member HH] admitted that she falsified the document that she had changed the dressing but then didn't do it. That is all I remember about that. A record review of resident #212's TAR, dated August 2021, showed, the protective dressing was changed on 8/4/21, 8/14/21 and 8/18/21, but it was not changed as ordered on 8/7/21 or 8/11/21. The bandage was left on and unchanged for 10 days. A record review of resident #212's TAR, dated September 2021, showed, the protective dressing was changed on 9/3/21, 9/21/21 and 9/24/21, but was not changed as ordered on 9/7/21, 9/10/21, 9/14/21 or 9/17/21. The bandage was left on and unchanged for 14 days. A record review of resident #212's skin/wound note, dated 7/28/21, showed, the left heal wound was healed and a protective dressing applied. A record review of resident #212's skin/wound note, dated 9/20/21, showed, the left heal dressing was not changed per physician order. There was no documentation to reflect any changes in the wound. A record review of resident #212's antibiotic note, dated 9/22/21, showed, Lt (left) heel wound, antibiotics x 5 days, dressing change. Date of infection 9/20/21. The wound required antibiotics at this point. A record review of resident #212's Health Status Note, dated 9/23/21, showed, wound to heel measures 0.5 x 3.5 x 0.1 serosanguinous drainage noted. This wound is due to resident receiving a shower with foam heel protector in place and was not changed per provider orders. There was no documentation to reflect the stage of the wound/ulcer. 32997 4. Review of two facility reported incidents, dated 10/20/21 and 8/2/21, for verbal abuse toward resident #4 were investigated. a. On 8/2/21 an allegation of verbal abuse was reported. A CNA overheard a nurse tell resident #4 Maybe it would be better if you broke something, and we can get rid of you for a few weeks. You don't let me get my work done and I'm going to kill someone. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of resident #4's clinical record showed, at the time of the incident, the resident was moderately cognitively impaired with Alzheimer's Disease, and vascular dementia. The facility did substantiate verbal abuse of resident #4. The nurse was suspended pending investigation. The nurse received a written disciplinary action, and was educated on customer service, and resident rights. b. On 10/20/21 a CNA was overheard saying, Don't you comprehend what I am saying (resident name). This was said in a harsh tone to Resident #4. Resident #4 was heard to respond with I am a pain in the butt. The facility did substantiate verbal abuse of resident #4. The CNA was suspended pending investigation. The CNA was disciplined by the facility, and educated on customer service. A review of the facility's policy, Abuse and Neglect, dated May 2019, reflected: Policy Statement: It is the policy of the facility to provide professional care and services in an environment that is free from . neglect . Neglect is the failure to provide necessary services and adequate (medical, personal or psychological) care . failure to care for a person in a manner, which would avoid harm .Staff may be aware or should have been aware of the service the resident requires, but fails to provide that service.

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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. 44770 Based on interview and record review the facility failed to fully investigate alleged neglect for 2 (#s 5 and 212) out of 2 sampled residents. Findings include: 1. A record review of a facility reported incident, dated 9/19/21, showed resident #5 had not had her wound dressing changed for seven days. Resident #5's dressing was scheduled to be changed on Tuesdays and Fridays. Per the schedule, the dressing should have been changed on 9/10/21 and 9/14/21, but was not. The dressing did not get changed because resident #5 missed her wound care appointment as she was not ready to go when the driver arrived, and he had other residents to take to appointments. The nursing documentation did not prompt the nurse to do the dressing change since it otherwise would have been done at the appointment. (See F600 for details.) The nurse on duty failed to ensure measures were taken for the resident's wound treatment that was missed. A review of a facility document titled, Verification of Investigation, dated 9/17/21, showed the form was not filled out completely. There were four areas to fill out, provide a detailed description of event/allegation, assessment of resident/describe injury, resident interview summary, and immediate resident protection initiated. Only the first section, Provide detailed description of event/allegation, had anything written in it. The rest of the form was blank, other than a check mark in the box labeled YES for immediate resident protection initiated, but the form failed to describe the action provided for the resident or other investigation details. 2. A record review of a facility reported incident, dated 9/20/21, showed, resident #212 had not had his protective dressing changed for 14 days causing a wound to develop. A record review of resident #212's TAR, dated September 2021, showed, the protective dressing was changed on 9/3/21, 9/21/21 and 9/24/21 but was not changed as ordered on 9/7/21, 9/10/21, 9/14/21 or 9/17/21. Showing the dressing did not get changed for 14 days. A record review of resident #212's Health Status Note, dated 9/23/21 showed, wound to heel measures 0.5 x 3.5 x 0.1 serosanguinous drainage noted. This wound is due to resident receiving a shower with foam heel protector in place and was not changed per provider orders. (See F600 for details.) There was no Verification of Investigation form completed for this facility reported incident. During an interview on 2/16/22 at 9:49 a.m., staff member A stated, When I do my investigations, we report first then we suspend staff if we need to. We get statements from those involved or from other residents as well. We look at documentation that is pertinent to that investigation, notify family and physician if needed. I'll do the investigation if there is abuse or neglect. [Staff member JJ] was the DON at the time of the incidents, and she was handling those (resident #s 5 and 212's facility reported incident investigations). There is a form that we fill out that guides us through the process [staff member JJ] was not very faithful using those forms. So, the form should guide the process for the follow up. It is a tool that is created for (agency name) so you get to the resolution to the problem. But [staff member JJ] never finished them. Staff member A stated she looked at her QAPI notes for that time frame and there was nothing specific in them that showed the facility talked about the incidents or how to change the process to ensure investigations were completed.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 45448 Based on interview and record review, the facility failed to complete accurate assessments for 1 (13) of 4 sampled residents. This deficient practice had the potential to affect resident care and safety as it inaccurately depicted the residents' care needs. Findings include: During an interview on 2/15/22 at 1:17 p.m., resident #13 stated his pressure ulcer was healed sometime in January 2021. He was no longer going to the wound clinic. During an interview on 2/16/22 at 12:37 p.m., staff member EE said, I spoke with the wound nurse, and the resident still has a small open wound, it is not fully healed. The wound clinic said the wound is healed. A record review of resident #13's care plan,with an initiation date of 5/20/21, showed: . Weekly monitoring of wounds by wound nurse or designee -assessment -recommendations -measurement Date Initiated 7/23/21 . A review of the facility's LGHC Skin Evaluation, completed by staff member GG, for resident #13 on 1/12/22 and 1/19/22, showed: .6. Pressure Ulcer site; 55) Right gluteal fold, Type; Pressure. The area for measurement was left blank. Staff member GG did not document measurements for resident #13's pressure ulcer or recommendations for treatment as ordered by the physician. A review of the facility's LGHC Skin Evaluation, done by staff member GG, for resident #13 on 2/4/22 and 2/12/22 showed: . 5. Resident has alteration in skin integrity: No Staff member GG's documentation showed resident #13 no longer had an alteration of skin integrity. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's Wound Assessment Detail Report, dated 2/14/22, completed by staff member MM, showed a picture of a right gluteal upper posterior thigh wound with measurements of 0.3 X 0.4 X 0.1 (L x W x D). A review of staff member MM's progress note, dated 2/16/22 at 12:56 p.m., showed, Upon wound assessment today writer measured a small opening of 0.2cm (L) x 0.2cm (W). Scar tissue noted around previous wound. No exudate. Will continue with current treatment.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 40068 Based on interview and record review, the facility failed to shower residents timely, due to short staffing, to promote cleanliness and comfort for 5 (#s 9, 13, 24, 56, and 60) of 15 sampled residents; and failed to: provide enough staff to assist residents with their needs in a timely manner, chart daily food intake, assist with incontinence care as needed, assist with resident transfers safely, and order needed supplies for the resident, for 6 (#s 3, 4, 5, 27, 51, and 57) of 15 sampled residents. Findings include: During an interview on 2/16/22 at 9:30 a.m., staff member L stated she used to help with bathing residents in November and December of 2021, as well as January of 2022. Staff member L stated up until recently, the facility did not have a bath aide. Staff member L stated during that time, the facility was very short staffed, and bathing was not getting done if there were other CNA tasks. Staff member L stated there were quite a few days when residents were not getting bathed due to not having staff. 1. Review of resident #24's bathing documentation showed the resident did not receive a shower from: 11/4/21 - 11/22/21 (18 days) 12/16/21 - 12/30/21 (14 days) 2. Review of resident #56's bathing documentation showed the resident did not receive a shower from: 12/9/21 - 12/30/21 (21 days) During an interview on 2/16/22 at 8:43 a.m., staff member K stated if the shower sheet said 'non-applicable,' that meant the shower did not get done. Staff member K stated, Back in December 2021 showers were not getting done, we were busy doing CNA duties, and we did not have a bath aide. 45447 3. During an interview on 2/14/22 at 4:10 p.m., resident #3 stated he had to wait a while, sometimes hours, when he rang the bell for assistance because the facility was shorthanded with staff, especially on the weekends. 4. During an interview on 2/14/22 at 4:31 p.m., resident #27 stated the facility had light staffing on weekends, he had to wait a while when he needed assistance. Resident #27 stated it was dangerous that the facility was short staffed, because people could fall. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	5. During an interview on 2/16/22 at 8:29 a.m., staff member O stated the nursing staff were not charting daily intakes and outputs of food and fluid because the facility was short staffed. Staff member O stated it was difficult to determine what resident #51 needed nutritionally when she could not tell what he had been eating. 6. During an interview on 2/16/22 at 9:43 a.m., staff member N stated it was typical for one nurse to oversee 20 residents, and there had been several nights where one nurse oversaw 47 residents. Staff member N stated one of those nights was on 2/14/22, where she worked midnight to 6:00 a.m., otherwise the nurse that night would have had 47 residents to oversee. Staff member N stated weekend staffing had been short since November (2021). Staff member N stated because of the short staffing, the staff would perform a one person assist when a resident required a two person assist with a lift, and this was dangerous because a resident could fall. Staff member N stated she had told her managers about the staffing concern, but it seemed like no one had done anything to remedy it, and she did not see anyone from management help on the floor. Staff member N stated that staff were leaving, and the agency staff hardly showed up for work. Staff member N stated resident brief changes were not getting done due to short staffing, and because of this, resident #5 and 57's incontinence briefs were not changed during the night shift on 2/15/22. During an interview on 2/16/22 at 9:59 a.m., staff member N stated that on 2/12/22, the unit ran out of catheter bags, gloves, and insulin syringes. Staff member N stated that staff member P oversaw supply ordering, but was doing three other jobs: reception, staff coordinator, and scheduling, because the facility was short staffed, and she had been unable to keep up with the supply needs of the facility. Staff member N also stated because of short staffing, the residents received breakfast late, at 8:30 a.m., on 2/12/22. 45448 7. During an interview on 2/15/22 at 1:17 p.m., resident #13 said, In January, I didn't have a shower for 2 weeks. They didn't have staffing to provide a shower. A record review of a facility document for bathing tasks, dated 1/17/22 through 1/26/22, showed resident #13 peferred to shower twice weekly. Resident #13 received a shower on 1/17/22 and 1/26/22, nine days apart. A record of resident #13's bathing task documentation for 1/1/22 through 1/16/22 was not provided prior to the end of the survey. 8. During an interview on 2/15/22 at 8:15 a.m., resident #60 stated, night shift was often short staff, and she had gone seven to nine days without a shower. Resident #60 said she had talked and sent notes to staff member A about showering. A record review of a facility document for bathing tasks, dated 1/17/22 through 1/31/22, reflected, resident #60 received a shower on 1/17/22 and 1/30/22, with 18 days between showers. A record of resident #60's bathing task documentation for 1/1/22 through 1/16/22 was not provided prior to the end of the survey. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	9. During an interview on 2/15/22 at 10:45 a.m., resident #9 stated, last month she went without showers. Resident #9 said she needed to have her pannus cleaned daily and the facility had run out of wipes. Resident #9 said, when that happened, she could smell herself and hated it. Resident #9 also stated, staffing was difficult, staff called in or did not show up, the facility would have to find someone emergently. The CNA would come to the call light to assist and tell resident #9 that they would be back after assisting others or finding help and turned the call light off. The CNA would forget or get busy, and not return, so resident #9 had to turn her call light back on. A record review of facility document for bathing tasks, dated 1/17/22 through 1/31/22, reflected, resident #9 preferred bathing two times a week. Resident #9 received only one shower between 1/17/22 and 1/31/22. During an interview on 2/16/22 at 7:43 a.m., staff member S stated, When I need help with a Hoyer lift, I need to find someone to help, and I can't always find someone. I have let scheduling know we need help due to resident #4. I don't have time to take proper care of the residents. Staff member S said she spent five hours one day just attending to resident #4, to keep her from running into walls and to keep her safe. Staff member S said the unit had ten residents, with five residents requiring a two person assist. Currently the Copper Crest [NAME] Unit was staffed with one CNA for the ten residents, resident #4 resides on this unit. During an interview on 2/16/22 at 11:28 a.m., staff member B stated the Copper Crest [NAME] and Rim View [NAME] were considered all one unit. The facility staffing standard was four CNAs and two bath aides. When staff called off, the facility attempted to get the shift covered with prn and on call staff. One staff member carried an on-call phone. Sometimes, it would require a manager to cover the shift. A record review of the Facility Assessment, dated December 2021- November 2022, reflected: . Our staffing plan is exclusively based on keeping the continued needs of our resident in focus and providing adequate staffing levels at all times so that their basic, individualized needs are met. Nursing services . Staffing levels appointed given the unique needs of the residents and the units they reside on.

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F 0744 Level of Harm - Actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32997 Based on observation, interview, and record review, the facility failed to ensure necessary services were provided for a resident who displayed behavioral outbursts, wandering, intruding on others, and calling out, and the resident had a diagnosis of Alzheimer's/dementia, for 1 (#4); and resident #4's behavior affected other residents, to include 2 (#s 9 and 16) of 4 sampled residents. The facility also failed to use available medication to treat and attempt to decrease resident #4's agitation/behavior if there was no improvement shown after an antipsychotic medication was started. Resident #4's care plan lacked non-pharmacological interventions for the resident's behavioral needs. These failures continued over an extended period of time, without timely action taken to address the concerns, which affected the residents quality of life on a regular basis. Findings include: Resident #4 was admitted to the facility on [DATE] with diagnoses including: mixed Alzheimer's and vascular dementia with behavioral disturbance, Anton's syndrome, anxiety, major depression, and conduct disorder. During an interview on 2/14/22 at 3:53 p.m., Resident #16 said resident #4 wandered all around and would yell for help. The resident went into everyone's room at all times of the day and night, and resident #16 said that caused a huge lack of privacy. Resident #16 said she had filed a grievance report with the facility due to resident #4's wandering, and entering resident rooms. During an observation on 2/15/22 at 9:37 a.m., resident #4 was going down the hall calling hello. The resident rolled into a wall calling out Hello, I am here. I am coming in. Hello, hello, hello. A staff member came out of room [ROOM NUMBER], saw resident #4 and wheeled her back to her room. During an interview on 2/15/22 at 10:45 a.m., resident #9 said resident #4 always entered her room at night when she was sleeping and woke her up. Resident #9 said she did not sleep well. (continued on next page)

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	275020	A. Building B. Wing	02/17/2022

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Bella Terra of Billings	1807 24th St W Billings, MT 59102

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F 0744 Level of Harm - Actual harm Residents Affected - Few	During an interview on 2/16/22 at 9:11 a.m., NF2 said the facility did not provide adequate care for resident #4. NF2 said the resident had a diagnosis of Anton's syndrome - which was cortical blindness. She said resident #4 would confabulate, which was part of the syndrome, and convince people she could see. The expectations of the facility staff were for resident #4 to be able to do the same things as a sighted person. NF2 said resident #4 had seen a neuropsychologist several times in the last couple of months. NF2 said the neuropsychologist told her that resident #4's short-term memory was to the point where it reset every 3-5 minutes. [Resident #4] can be combative, but if you let her know you are there and will be touching her she is calm. If you just walk up to her and she doesn't know you are there, it scares her and she will become combative. NF2 said given the limitations imposed by resident #4's short term memory problems, she felt resident #4 viewed the facility as her home, and therefore could not understand why she could not go into any room she chose, and when in those rooms perhaps she saw the other residents as intruders. NF2 said the facility had a recent care plan meeting for resident #4, and all disciplines were supposed to attend. NF2 said, It was me, the activity director, social services, and the ombudsman. NF2 said nursing should have been in attendance since resident #4's behaviors were all related to her medical problems. NF2 said she knew the facility did not want resident #4 in the facility due to all the behavior problems, but nursing would not document her behaviors consistently, good and bad, so the neuropsychologist could make a determination on the approaches and medications for the resident to improve her quality of life. NF2 said when she was at the care plan meeting she had specifically requested the facility come up with some kind of behavior tracking so the information could be provided to the neuropsychologist. During an interview on 2/16/22 at 11:28 a.m., staff member B said the facility staff were trying to track and document resident #4's behaviors to see what triggers her behaviors. She said staff member I was involved with this. Staff member B said the facility was working on education and plans were developed last week for resident #4, although the resident had admitted to the facility in early 2021. Review of a social service progress note, dated 2/11/22 at 2:48 p.m., showed: A quarterly care conference was held today, 2/11/22 @ 10:30 a.m. The following were present: daughter, Ombudsman, Activities, and Social Services. SS went through information that was on Multidisciplinary Care Conference UDA. Daughter had some concerns. SS spoke to Administrator and DON about those concerns. DON put behavior charting in MAR so that the nurses would have to progress note each shift and mark it off that it was done. Code status reviewed.Appointment scheduled next Thursday, 2/17/22 @ 1pm with [neuropsychologist's name]. SS will send updated progress notes early next week. SS will send a referral to [Hospital name] in [NAME]. SS will continue to follow resident. (continued on next page)

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F 0744 Level of Harm - Actual harm Residents Affected - Few	During an interview on 2/16/22 at 2:12 p.m., staff member S said she had not received any behavioral or dementia training for resident #4. The staff member said the social worker was going to provide training specific to resident #4's behavioral concerns, but it never happened. She said she would dump towels on the table for resident #4 to fold or she would call the activity staff to have someone take resident #4 to the activity room. Staff member S said there were some things she had shared with other staff to help intervene with resident #4's behaviors. Staff member S stated, We've just recently started documenting on resident #4's behaviors. Resident #4 wanders, and she goes into other resident rooms frequently. The other residents understand she can't see, and she has dementia, but they get upset with her coming in their rooms. Especially at 2 or 3 o'clock in the morning. Staff member S said resident #4 would be up for 36 to 48 hours at a time and then crash for a day. She said the other residents on Copper Crest [NAME] would get upset because when resident #4 is on the go, she needed constant supervision, and the other residents did not get their needs addressed. Staff member S stated, On this unit it's me . and the nurse to provide care for the residents. During an interview on 2/16/22 at 2:18 p.m., staff member FF said she had not received any education or training on minimizing or limiting resident #4's behaviors. Review of resident #4's neuropsychologist's report, dated 12/28/2021, showed, Plan: . - start risperidone 0. 5mg BID, after 2 days if no improvement in behavior increase to 1mg BID . During an interview on 2/16/22 at 3:16 p.m., staff member B said she was not aware the neuropsychologist had written, If no improvement in behaviors increase risperdone to 1 mg BID. During an interview on 2/16/22 at 3:26 p.m., staff member I said she had not provided actual training to facility staff in regards to resident #4's diagnoses and behaviors. Staff member I said the DON told her last week she needed to do a huddle with the nursing staff for resident #4's diagnosis and behavior management. Staff member I said she was not the person responsible for writing dementia and behavior care plans for the residents. She said the nursing staff wrote the majority of the care plans for each resident. Review of the facility's Grievance and Satisfaction Form, dated 2/7/22, showed resident #16 had filed a grievance with the facility regarding resident #4's behaviors. Resident #16 wrote, [resident name] was being loud and disruptive all night 2/5 claiming there was fire. Approx. 5am 2/6 [resident name] opened my door and walked in while I was partially naked during check & change. [Staff name] removed her but my privacy was violated & I wanted it on the rec. The facility's resolution for this grievance showed, 1. Resident evaluated by physician. 2. Stop sign placed on door. The facility's investigation for this grievance showed, Residents upset c [with] other resident A [resident #4]. Resident A wanders & is blind. Resident A wandered into resident B room. Attempted re-direction unsucessful [sic]. Review of resident #4's nursing progress notes showed: - 1/27/22 at 9:47 p.m.: Continues to have adverse behaviors. Goes into other resident's [sic] rooms, continuously asks to go to the restroom when she has just been, asks to lay down and gets right back up, runs into staff and walls with wheelchair, constant yelling and screaming, and wanders the halls . Has not slept thus far this shift. will continue to monitor. No nonpharmacological or pharmacological interventions were documented at that time. (continued on next page)

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F 0744 Level of Harm - Actual harm Residents Affected - Few	- 2/4/22 at 12:27 a.m.: Resident continues with behaviors. Enters other resident's [sic] rooms, runs into staff with wheelchair, goes to bed and gets right back up, runs into walls ad [sic] equipment, and constantly yelling. Is very difficult to redirect. Denies any pain at this time. Will continue [sic] to monitor. No nonpharmacological or pharmacological interventions were documented at that time. - 2/9/22 at 10:26 p.m.: Resident was running chest into the table in the dinning [sic] room on the west unit. Non-Pharmacological Interventions: Redirected, resident stated that she did not know she was doing it. - 2/14/22 at 6:14 a.m.: Late note for 2/13/22, resident slept on and off throughout the morning. Up late afternoon with calling out help me, help me. The resident had snacks and a diet soda. She wandered around trying to get into other residents' rooms. Had to one on one to keep her from bothering others. No nonpharmacological or pharmacological interventions were documented. - 2/14/22 at 7:19 p.m.: Resident continuously wondering [sic] while she is awake. wanders into other rooms. constantly wanting someone by her side to talk to. A review of resident #4's monitoring record, dated 2/1/2022 to 2/28/2022 with a start date of 2/11/2022, showed, Nurse must enter progress note every shift regarding residents [sic] behavior. Identify wandering into rooms, yelling out, repetitive statements, or others, every shift for Behavior - 2/11/22 evening staff documented the resident was voicing repetitive statements and wandering. - 2/12/22 day staff documented the resident was voicing repetitive statements and wandering. - 2/12/22 evening staff failed to document the resident was exhibiting any behaviors. - 2/13/22 day staff documented the resident was wandering. - 2/13/22 evening staff documented the resident was voicing repetitive statements, wandering, and yelling all night. - 2/14/22 day staff documented the resident was voicing repetitive statements, and wandering. - 2/14/22 evening staff documented NA for repetitive statements, wandering, and yelling. Review of resident #4's Minimum Data Sets (MDS) from 2/25/21 to 2/2/22 showed the following: - Significant Change MDS, with an ARD of 8/2/21, showed resident #4 had wandered 4-6 days of the seven-day look-back period. The impact of the wandering behavior showed the behavior placed the resident at risk of getting into a potentially dangerous place and had a significant potential to affect other residents by intruding on their privacy. - The Quarterly MDS, with an ARD of 11/2/21, showed resident #4 had wandered daily during the 7-day look-back period. The impact of the wandering behavior to the resident and other residents was not completed. (continued on next page)

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F 0744 Level of Harm - Actual harm Residents Affected - Few	- The Quarterly MDS, with an ARD of 2/2/22, showed resident #4 had a severe cognitive deficit. The resident had wandered 4-6 days of the 7-day look-back period. The impact of the wandering behavior of the resident and other residents was not completed. A review of resident #4's Behavioral Symptoms CAA, with an ARD of 8/2/21, showed the resident was wandering 4-6 days of a 7-day look-back period, and the resident's wandering behavior had worsened since the last assessment. The seriousness of the resident's behavioral symptoms indicated she was an immediate threat to herself. A review of resident #4's current care plan showed: a. - Focus: anxiety: I have had medication changes, I are [sic] to revisit on [DATE]rd. The medication change [sic] helped maybe a couple of days. since then I am very restless, my behavior os [sic] becoming demanding, I am wandering all over, I am bumping into others. I am asking excessively for diet coke. nursing to keep in touch with my providers Date Initiated: 12/15/2021 - Goal: I will remain safe throughout my stay at [Facilty name] with the assistance of the staff. Date Initiated: 12/15/2021 Target Date: 03/31/2022 - Interventions: I need constant supervision when I am out of bed. I wander through the facility, and into others rooms. I ask for things nonstop, please monitor that I do not overeat, or drink too much at one time. toilet me often. Please have patience, as I just do not understand, I cannot sit still when IO [sic] am up. I do get very upset and can [sic] verbally abusive to others Date Initiated: 12/15/2021 b. - Focus: MOOD/DEPRESSION- My PHQ severity score was 7/27. Depression causal factors include Diagnosis and history of depression; Reaction to multiple losses and increased dependency; Anger management and emotional distress. I presented with symptoms of depression during the PHQ interview including being so fidgety or restless that I have been moving around a lot; Feeling down, depressed, or hopeless; Feeling tired, or having little energy. Date Initiated: 02/08/2022 - Goal: I will engage in mental health treatment and work on improving mood state and outlook, through my next review date. Date Initiated: 02/08/2022 Target Date: 03/31/2022 (continued on next page)

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F 0744 Level of Harm - Actual harm Residents Affected - Few	- Interventions: I will talk to staff that I feel comfortable with about ideas to moderate and reduce my mood distress symptoms such as: sharing thoughts and feelings that have contributed to depression. Staff will notify my Provider and Social Services if they see an increase in any signs and/or symptoms of depression. Date Initiated: 02/08/2022 During an interview on 2/17/22 at 8:03 a.m., staff member D said she did not write care plans. She said the unit managers did that. Staff member D said staff member C wrote the care plans for the unit the resident resided on. During observation and attempted interview on 2/17/22 at 8:06 a.m., staff member C was working at a medication cart. Staff member C verified she would have written the majority of resident #4's care plan. Staff member C was not available for further interviews prior to the survey team exiting the facility.

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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. 45447 Based on interview and record review, the facility failed to ensure nursing staff input the correct medication orders for 2 (#s 38 and 262) of 2 sampled residents. These deficient practices had the potential to increase the potential of a blood clot and stroke for resident #262, and delay healing for resident #38. Findings include: 1. During an interview on 2/16/22 at 10:30 a.m., staff member M stated there was a different process for entering Coumadin orders, compared to other orders, and the Coumadin orders were to be checked by two nurses. One nurse was to input the orders into the EMR, and those orders were to be checked by a second nurse right after they were entered. During an interview on 2/16/22 at 10:33 a.m., staff member B stated the expectation for nursing staff, when entering an order for Coumadin, was to enter the order with an end date, the correct dose from the order, and to enter the order on the facility's Coumadin tracking sheet. Staff member B stated the facility had two nurses assess the order, and there were clinic meetings in the mornings where orders were also reviewed. During an interview on 2/16/22 at 1:37 p.m., staff member B stated the facility was working on creating a policy and system for double checking all medication orders that were entered in the facility's EMR. On 2/16/22 at 2:12 p.m., a request was given to staff member A for the facility's Coumadin order entering policy. During an interview on 2/16/22 at 4:45 p.m., staff member A stated the facility did not have a policy for entering coumadin orders into the EMR. A review of the facility's investigation notes for a facility reported incident, regarding resident #262, submitted 8/13/21, reflected, On 8/12/21 the facility was notified of a significant medication error regarding Coumadin that resulted a critical PT/INR on resident, [#262]. The resident's Coumadin order .was Coumadin 4 mg to be given on 8/7 and 8/8. The nurse working the floor [staff member LL] had entered to [sic] Coumadin order into the EMAR but put the discontinue date as 8/7 resulting in a missed dose on 8/8/21. Review of resident #262's Order Details, dated 8/6/21, reflected, Give 4 mg [Coumadin] by mouth at bedtime every Tue, Sat, Sun for Long term anticoagulant use until 08/07/2021 23:59. The date was circled, and written next to it was, Should have been 8/8/21. Review of the facility's Education/Training sheet, Subject: Coumadin Orders/Process, dated 7/21/21, reflected staff member LL and other staff members received training on the subject, prior to the incident with resident #262, on 8/6/21. A review of the facility's Coumadin checklist reflected there was two spaces for two nurses to verify Coumadin orders, with signatures. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of resident #262's Coumadin checklist reflected one signature by staff member LL, with no other space for a second nurse to verify and sign. 2. Review of resident #38's After Visit Summary, dated 1/7/22, reflected: Patient Medication List Cephalexin 500mg capsule . Dose: 1,000 mg . Take 2 capsules (1,000 mg total) by mouth three times a day for 7 days Indications: Skin and Soft Tissue Infection Received morning dose prior to discharge 01/07/2022. Review of resident #38's Order Note, dated 1/13/22 at 12:00 p.m., reflected, Data: Resident was d/c on 1/7/22 and ordered Cephalexin 1000 mg three times daily for seven days. Comments: However, he was only receiving 500 mg three times daily. Review of resident #38's MAR, dated 1/1/22 - 1/31/22, reflected, Cephalexin Tablet 500 MG Give 500 mg by mouth three times a day for infection until 01/14/2022 23:59 -Start Date- 01/08/2022 0600. The MAR reflected this ordered medication regimen was administered from 1/8/22 - 1/14/22. The order for Cephalexin entered was incorrect when compared to the After Visit Summary, and the dose administered was incorrect. A review of the facility's policy, 6.0 General Dose Preparation and Medication Administration, revised 1/1/22, reflected: 4. Prior to administration of medication . 4.1 Facility staff should: 4.1.1 Verify each time a medication is administered that it is the correct medication, at the correct dose . 4.1.2 Confirm that the MAR reflects the most recent medication order .