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	02/02/2023

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 - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 41652 Based on interview and record review, the facility failed to ensure residents were free from any form of abuse for 2 (#s 26 and 430) of 4 sampled residents. Resident #26 stated he felt worthless, and resident #430 was afraid to call for assistance when she needed help. Findings include: 1. Review of a Facility Reported Incident, reported to the State Survey Agency, dated 6/1/22, showed resident #26 reported a CNA yelled at him and had made him feel worthless. Review of the facility investigative file for the incident, which occurred on 6/1/22, and provided by the facility on 1/31/23, showed the facility substantiated the allegation of staff verbal abuse, based on statements by resident #26, the accused CNA, and another unidentified CNA who was present during the interaction. During an interview on 2/1/23 at 4:54 p.m., staff member B stated the accused CNA was immediately suspended, and was going to be allowed to return to the facility, after the investigation, and education was completed. Staff member B stated the CNA did not complete the education and chose not to return to work at the facility after being suspended. 47752 2. Review of a facility reported incident, reported to the State Survey Agency on 6/19/22, showed resident #430 reported a CNA was rude and refused to empty her emesis basin when asked. Also, resident #430 reported the CNA slammed her door whenever she left the room, causing the resident to be tearful, and afraid to ask the CNA for assistance. Review of the 6/19/22 investigation, provided by the facility on 2/1/23, showed the facility substantiated the allegation of abuse based on statements from resident #430, other resident interviews, and staff interviews. The investigation showed the CNA was immediately suspended and terminated after the investigation was completed. The investigation showed the CNA was provided abuse and neglect training at the time of hire. During an interview on 2/1/23 at 9:05 a.m., resident #430 stated she remembered the incident and became tearful. Resident #430 stated she quit asking for help because she was scared the CNA would be mean. Resident #430 was aware the CNA was not longer working at the facility.

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. 40068 Based on interview and record review, the facility failed to investigate a Facility Reported Incident of neglect within the required time frame, for 1 (#400) of 2 sampled residents; failed to thoroughly investigate an allegation of misappropriation of resident property involving a controlled narcotic medication, for 1 (#433) of 1 sampled resident; and failed to provide staff education to address reoccurring allegations of abuse and neglect for 2 (#s 3 and 22) of 2 sampled residents. Findings include: 1. Review of a Facility Reported Incident, sent to the State Survey Agency on 12/20/22, showed: - [Resident #400's] wife spoke with the case manager at [Hospital Name] about concerns she has about her husbands care at [Facility Name]. - Investigation initiated, physician, wife, notified . - What were the results of this investigation? Interview with the nurse on duty 12/18/22 stated she gave morning medications and noon medications and asked, [Resident #400] how he was feeling and resident said he was tired but otherwise felt fine on both occasions. Nurse immediately assessed resident upon wife's request because she thought he was yellow looking and slumped in his chair. The provider was who instructed to send the resident to the ER. The toilet in the residents room has been fixed and was working properly as of 12/27/22. The facility had appropriate staff working the shift. Interviews with other residents indicated there were not times that they were denied use of the bathroom. [sic] -Findings of this investigation were submitted to the State Survey Agency on 12/27/22. The investigation was submitted outside of the five days required for neglect allegations, per CMS regulatory requirements. During an interview on 2/2/23 at 9:10 a.m., staff member A stated the facility needed to work on the facility reported incident investigation process. Staff member A stated there was some confusion on who was supposed to complete investigations. Staff member A stated, Sometimes the DON completes it and sometimes the administrator completes it. My guess is that it just fell by the wayside, when referring to the incident regarding resident #400. 41652 2. Review of a Facility Reported Incident, dated 11/12/22, and reported to the State Survey Agency, showed resident #433 reported a bottle of 8-10 oxycodone tablets, went missing. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the investigative file, provided by the facility on 2/1/23, showed the misappropriation of medications was unsubstantiated due to a lack of evidence. The documents showed five other residents were asked about any missing personal items, and all of them denied having anything missing. The investigation failed to show how the facility addressed the scheduled narcotic being in the resident's possession prior to it being stolen, to prevent similar occurrences in the future. The file failed to show any corrective actions or system changes implemented to prevent this type of incident from happening again. During an interview on 2/1/23 at 4:47 p.m., staff member B stated the person who investigated the misappropriation of medication was no longer employed by the facility, so was not available to interview. Staff member B stated there should have been a belongings list in resident #433's EMR, but it was not found. Staff member B stated she believed the resident was not aware he should not have any medications in his possession. Staff member B stated the investigative file failed to show any documentation regarding the risks associated with the missing item being a controlled narcotic medication. 46400 3. During an interview on 2/1/23 at 1:17 p.m., resident #22 stated the night shift CNA [staff member X] was very dismissive of her. Review of resident #22's written statement, included in the investigation file for the November 2022 verbal abuse allegation, dated 11/8/22, showed, Asked CNA [staff member X] if he could take off my [NAME] Hose . he said I'm not doing this. Anything I do for you you are going to complain about .We clash. He's making me very unhappy. Review of the facility investigative file showed a lack of education or monitoring for staff member X upon his return to work. 4. Review of Facility Reported Incidents, dated 9/16/22 and 10/10/22, showed resident #3 accused staff member X of neglect involving one instance of being left on the bedpan, and another instance of being left without his call light. During an interview on 2/2/23 at 8:52 a.m., staff member C reviewed the facility investigation files for resident #3's allegations of neglect in September and October of 2022; and resident #22's allegation of verbal abuse in November of 2022. Both allegations accused the same staff member. She stated the investigation files did not show if education was done for the staff member accused once he returned to work, but she knew the previous DON had completed education for staff member X.

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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** 41652 Based on observation, interview, and record review, the facility failed to provide ADL assistance to residents who required staff assistance with bathing, for 6 (#s 2, 12, 26, 60, 72, and 254) of 11 sampled residents; and failed to provide necessary assistance with eating, for 1 (#23), of 1 sampled resident. The deficient practice resulted in residents not receiving a minimum of a weekly shower. Findings include: 1. During an interview on 1/31/23 at 11:31 a.m., NF2 stated she visited the resident every day. NF2 stated resident #12 needed assistance with bathing. NF2 stated she had requested resident #12's hair be washed so it could be fixed. NF2 stated resident #12 got a bed bath on 1/30/23, but her hair was not washed as requested. NF2 stated she had to wash her hair on 1/31/23 so it could be fixed. Review of resident #12's care plan, dated 1/10/23, showed the resident was to receive assistance with bathing up to twice a week. Review of resident #12's bathing records, dated from 12/27/22 through 2/1/23, showed the resident had been showered once on 1/15/23, and there was one refusal on 12/28/22. The record showed resident #12 had only been offered a shower twice in approximately 30 days, rather than twice per week per her preference. 2. During an interview on 1/31/23 at 12:41 p.m., resident #26 stated he was told by the facility he would be getting two showers a week. Resident #26 stated he got one a week, and said the second shower never happens. Review of resident #26's care plan, dated 8/4/22, showed the resident required assistance with bathing, and he preferred showering twice per week. Review of resident #26's bathing records, dated from 11/1/22 through 1/31/23, showed the resident had 23 opportunities for a shower, and received 11 showers during the months of November and December of 2022, and January of 2023. Based on the information received, resident #26 went without a shower or a bath for more than seven days five times during the timeframe, with the maximum being 13 days between showers. 3. During an interview on 1/31/23 at 11:57 a.m., resident #60 stated she liked having a shower every other day, but the facility told her she would receive two showers per week. Review of resident #60's care plan, dated 12/14/22, showed the resident required assistance with bathing and was to be offered a shower up to twice a week. Review of resident #60's bathing records, dated from November of 2022 through January of 2023, showed the resident had 19 opportunities to shower. The bathing records showed eight showers total were given during the months of November and December 2022, and January 2023. Based on the documentation provided by the facility, resident #60 went 11 days in November 2022 without a shower, and 22 days in late December 2022 and early January 2023 between showers. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/1/23 at 1:35 p.m., staff member J stated she worked on Monday, Tuesday, and Wednesday as a bath aide. Staff member J stated she had a resident list which showed each resident's (bathing/shower) preference, and most residents wanted at least two showers per week. Staff member J stated there was not a bath aide scheduled on the days she was not working, so most of the residents only got one shower per week. Staff member J stated the CNA assigned to a resident could try to get a shower or bath done, if she (staff member J) was not able to get at least one done per week. 46400 4. During an observation and interview on 2/1/23 at 1:17 p.m., resident #2 stated it was going on her second week without a shower. Review of resident #2's care plan, dated 10/13/22, showed, I require staff to assist me with 1 to 2 showers per week. Review of resident #2's ADL task Bathing, dated January - February 2023, showed resident #2 had received two showers out of a minimum five opportunities. 5. During an observation and interview, on 2/2/23 at 9:21 a.m., resident #72 stated he was feeling, . miserable. You can't get a shower around here, they keep giving excuses. Resident #72 was wearing sweatpants, and a T-shirt, which had various food and liquid stains on the front of it. Review of resident #72's Bathing Preference Questionnaire, no date, showed, We offer routine bathing two times per week. In the space provided for the resident to detail their bathing preferences, resident #72 wrote: Monday, Wednesday, and Friday is when I like showers. Review of resident #72's ADL task Bathing, for the dates of January - February 2023, showed his last shower was on 1/22/23, 11 days prior. There were no documented shower refusals. 6. During an observation on 2/2/23 at 9:38 a.m., resident #23 was in the dining room eating breakfast. She was alone, with no other residents, or staff, in the dining room to assist her. Review of resident #23's care plan, dated 10/19/22, showed, Eating: I require a 1:1 feeding . I want to be waken about 7. I don't like to be late to breakfast. [sic] 40068 7. During an observation on 1/31/23 at 10:42 a.m., resident #254's hair appeared very greasy, and he had what appeared to be a significant amount of dandruff around his shirt collar. During an interview on 2/1/23 at 10:47 a.m., resident #254 stated staff never asked him if he wanted to be showered. He stated the last time he had a shower was two weeks ago. He stated he would ask for one this week, however he was leaving the facility in a couple days. During an interview on 2/1/23 at 10:49 a.m., staff member N stated the 300 wing did not have a bath aide. She stated staff try and give baths to the residents when they can, and all nurses and CNAs are supposed to share the bathing task. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of resident #254's Bathing Preference Questionnaire, not dated, showed, Question: We offer routine bathing two times per week - Does this meet or exceed your expectations? (answer)Yes . (question) What type of bathing experience do you prefer? (answer) Showers . Review of resident #254's care plan showed, I will be offered bathing up to 2 times per week. Date initiated 2/1/23 . Goal I will be asked to bathe at least two times per week date initiated 2/1/23. If I refuse to shower, re-approach as needed. Date initiated 2/1/23. Offer bathing as ordered. Date initiated 2/1/23. Offer bed baths if I am unwilling to bathe 2/1/23. Review of resident #254's bathing documentation showed, the resident was admitted on [DATE]. From 1/19/23 - 1/31/22 the resident had one bed bath completed on 1/31/22. No refusals were documented.

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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. 44770 Based on interview and record review, the facility failed to change a wound vacuum dressing on a diabetic ulcer, for 1 (#54), of 1 sampled resident, causing the resident increased skin breakdown above her original wound. Findings include: During an interview on 2/2/23 at 8:51 a.m., resident #54 stated having the wound vac treatment helped her wound to heal. Resident #54 stated, The nurses had some confusion in the beginning and didn't know when or how to change it (vac treatment). It went for a while not getting changed, but the wound clinic got it straightened out. Review of a physician order for resident #54, dated 10/18/22, showed: 1. Remove old dressing. 2. Cleanse with NS. 3. Protect the peri-ulcer area with Cavilon. 4. Use versitel/black foam as the primary dressing. 5. Use VacOpsite as the secondary dressing. 6. This order to be carried out 2 times per week . Please send patient with wound vac supplies so we can reapply it, please reapply wound vac when patient returns, set at 125mmHg. Review of resident #54's Wound Clinic Note, dated 11/22/22, showed, [Resident] is being seen today for her reports of new area of breakdown above ulceration. Staff at [Facility] report they have not been changing wound vac as they do not know how often to change it . Review of a Facility Reported Incident, reported to the State Survey Agency, dated 11/25/22, showed, Interviews with nursing staff revealed [Resident #54] had complained of pain to her wound for a few days. Her medication was administered as scheduled per physician orders. Resident was seen at her wound care appointment on Tuesday 11/15/22. She had her wound vac changed at the appointment. The orders revealed the wound vac was to be changed 2 times a week on Thursday and Sunday. The wound vac did not get changed on Thursday 11/17/22. Record review did reveal the wound vac was changed on Sunday 11/20/22. The investigation was substantiated. Education was given to the nurses to follow physician orders on wound care. During an interview on 2/2/23 at 11:03 a.m., staff member C stated there was no additional investigation or documentation for resident #54's wound vacuum incident. The wound care nurse was not available for interview during the survey.

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F 0689 Level of Harm - Actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44770 Based on interview and record review, the facility failed to prevent falls with significant injuries requiring residents to go to the emergency department, for 3 (#s 47, 229, and 279), of 5 sampled residents; and, #47 had a significant skin tear; #279 had multiple falls and injury to her head; #229 broke open a knee incision and had surgery to clean and repair the incision, and resident #47 was transferring himself to the bathroom independently, due to a lack of staff assistance at the time of the fall. The facility also failed to prevent a fall with fracture to a resident's patella, for 1 (#55), and failed to protect a resident from significant burns, for 1 (#24), of 8 sampled residents. Findings include: 1. Review of a facility reported incident, dated 1/22/23, showed, [Resident #47] had an unwitnessed fall in the main dining room which caused a significant skin tear to his left hand. Due to the significant skin tear, resident was sent to the ER for evaluation and treatment . Review of resident #47's MDS, dated [DATE], with an ARD of 1/4/23, section V0200, showed, resident #47's fall care area was triggered. Review of resident #47's comprehensive care plan showed the resident had a fall on 1/22/23, and fall interventions were added to the care plan. The care plan did not include fall interventions, prior to the fall, on 1/22/23. During an interview on 2/1/23 at 3:03 p.m., staff member I was looking at resident #47's comprehensive care plan. There were only two areas of concern listed on the comprehensive care plan. Staff member I stated, I don't know what happened here. There should be way more stuff on this care plan. His initial assessment looks like it wasn't completed, so neither was the care plan. Staff member I stated, there was a care plan from a previous admission that included falls as a concern, but the new admission care plan did not have falls included until the fall on 1/22/23. 2. During an interview on 1/31/23 at 9:02 a.m., resident #229 stated he fell in his bathroom, and he broke open the surgical incision, which was from his total knee surgery. He stated he got out of bed around 4:00 a. m., to go to the bathroom, and forgot his walker. He made it to the bathroom, but when he got up from the toilet, he fell on to his knee with the incision, and it broke open. He stated he was able to get to his recliner, but then he thought he must have passed out because he woke up with the CNA and the nurse there, and he was covered in blood. He stated he was sent to the hospital, and the wound (opened incision) had to have another surgery to clean it out, a wound vacuum was placed, and then it had to be sutured closed again. During an interview on 2/1/23 at 1:54 p.m., resident #229 stated, There has been four times I have pissed my pants waiting for them to come help. Resident #229 stated, the night he fell in the bathroom and reopened his surgical incision, he couldn't wait any longer, so he went to the bathroom on his own. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	3. Review of resident #279's EMR, showed the resident was admitted to the facility on [DATE]. Resident #279 had a risk for falls, and the facility was advised by NF3 the resident required close supervision to keep her from falling. Resident #279 fell five times (7/7/22, 7/9/22, 7/12/22, 7/17/22, and 7/22/22) between her admission on 7/6/22 and her discharge to home from the facility on 8/10/22. Resident #279 was sent to the emergency department for two of the falls, for injuries to her head, and a hematoma on her hip. During an interview on 2/1/23 at 12:14 p.m., NF3 stated, She (resident #279) was not being closely monitored. I told them up front that you have to watch her all the time. They did not have enough staff to really watch her the way they needed to. We brought her home. They did finally manage to move her to a room next to the nurse's station and that helped some. She fell more at the facility than she did at home. She also hurt herself more there than at home. They (the facility) did not have the staffing to keep a close enough eye on her. I think she fell seven times there and went to the hospital twice! During an interview on 2/1/23 at 12:18 p.m., NF4 stated, They knew she (resident #279) was confused. She had several falls there, and we have all these bills from her having to go to the ER. They also didn't get all the staples out of her head. After she was home, she kept complaining of pain, and when EMS came to my house, they found two more staples. I can guarantee you no one in my family will ever go there again. She hasn't fallen once since she has been home. After several weeks, they moved her closer to the desk after she fell so many times. I know they were having horrible staffing problems. Review of resident #279's comprehensive care plan, dated 7/6/22, showed resident #279 was at risk for falls, and the resident required frequent rounding. During an interview on 2/2/23 at 8:39 a.m., staff member E stated, Management is who follows up on the falls. We can make suggestions, but management is usually who changes the care plans. We are the ones that fill out the fall report, and we can put suggestions on there, but then management does their thing and makes the changes. During an interview on 2/2/23 at 8:53 a.m., staff member Q stated, We don't have time to look at care plans, you have to understand the staffing around here. Hopefully, we get changes in care information from report, but some nurses are good at giving report, and others are not. I usually just ask the resident how they transfer or what kinds of things we do for them. Like I said, I don't know most of the residents on this hall, so it is easier to just ask them. If a resident has a fall, PCC will put up an alert task for extra charting for three days. The alert does not tell you if there is anything to be done differently to prevent falls. It just means we have more to chart. 33796 4. Review of resident #24's Facility Reported Incident, sent to the State Survey Agency, dated 8/13/22, showed the resident was given a hot cup of coffee during the lunch meal, and it spilled onto his lap. The liquid burn resulted in blisters to both of his inner thighs. The on-call physician was notified. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	Review of resident #24's facility investigation, not dated, showed Initially the burns were not painful, just slight discomfort noted. However, they became painful as the days passed, and on 8/20/22 the resident went to the ER. (for the burns) The intervention initiated was for the resident to have hot liquids with a lid. The staff were unable to determine where the coffee came from. The nurse who delivered the coffee to the resident said it came from the unit coffee pot. The CNA working the floor stated the coffee in the pot was cold, and the nurse must have put the coffee in the microwave. The nurse stated she did not put the coffee in the microwave. During an interview on 2/1/23 at 1:47 p.m., staff member B stated she had not been aware of the seriousness of the resident's burns, and did not know why education was not provided to staff regarding serving hot liquids. During an interview on 2/1/23 at 1:55 p.m., resident #24 stated the thing that bothered him about the burns was going out for a weekly treatment to the wound clinic. The burns have not healed. He stated the coffee cup fell off of his bedside table onto his lap. Review of resident #24's EMR showed he had continued to require wound care for the inner thigh burns for the last five months. 5. Review of resident #55's Facility Reported Incident, sent to the State Survey Agency, dated 5/31/22, showed the resident had a fall while transferring out of bed using a transfer pole. The fall resulted in a fractured patella. Review of the facility Fall Scene Investigation Report, dated 5/24/22, showed the root cause of the fall with the transfer pole was the bed was too high. The investigation did not show follow-up on why the bed was too high, and interventions to prevent further falls. A safety pole transfer evaluation was requested for resident #55, on 2/1/23 and 2/2/23. The facility did not provide the evaluation. During an interview on 2/1/23 at 1:14 p.m., resident #55 stated he did not remember the fall, but still used the transfer pole.

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F 0725 Level of Harm - Actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47003 Based on observation, interview, and record review, the facility failed to provide an adequate number of staff to provide timely responses to requests for care for 14 (#s 3, 15, 20, 21, 26, 27, 29, 36, 37, 56, 229, 230, 235, and 429) of 15 sampled residents, which included several residents dependent on nursing staff for care. This failure caused a decrease in bathing for resident #21, resident #229 and #26 to have episodes of incontinence, resident #230 to have a decrease in bathing and to receive her pain medications late, resident #235 to have a decrease in bathing and had the potential to negatively affect care for all residents of the facility. It was identified some residents were waiting over an hour to receive assistance from staff. Findings include: During an interview on 1/31/23 at 9:05 a.m., resident #29 stated he was irritated and had filed a complaint for the previous evening when a CNA had taken him to the bathroom, and then they did not want anything to do with him for the rest of the shift. Resident #29 stated when he did use his call light no one came to answer it. During an observation and interview, on 1/31/23 at 9:22 a.m., resident #37 was in her room, sitting upright in a chair, wearing a clothing protector. The resident was waiting for her breakfast. The resident stated she had been waiting quite a while for her breakfast to arrive, and the facility did not seem to have enough caregivers to get things done in a timely fashion. Her breakfast was delivered at 9:35 a.m. During an interview on 1/31/23 at 1:51 p.m., resident #36 stated many residents were complaining about very long call light times, of greater than 30 minutes, before being answered; or, or calls being answered and then not having staff return to provide care, requiring another call. The previous night she had her call light go unanswered for over 30 minutes, and when she went out into the hallway to see if a nurse was available, she noticed several other residents in her hall had their call lights on as well, including a resident that was quite dependent on nursing staff for help. During an interview on 2/1/23 at 1:25 p.m., staff member W stated many of the residents complained about how long it took the staff to answer call lights. She said there were frequently instances when the nursing staff were caring for a fully dependent resident requiring one or two staff for assistance that took a significant amount of time; and as such, were unable to leave to answer other resident calls. She stated the facility recently had several resident care staff quit very quickly after their first shift, due to an inability to deal with the overwhelming amount of resident care, and work required during the shift. During an interview on 2/1/23 at 2:46 p.m., staff member M stated there were not enough staff to adequately provide care, and sometimes basic tasks such as turning bedbound residents or various assessments were often not completed timely or held due to staff not having enough time to accomplish all the work required. She stated, when staff complained to management about feeling there was not enough staff to be able to properly care for residents, or when there was a sick call (employee out ill), the facility would tell them to just figure it out. When a supervisor sat down at the nursing station, where the interview could be heard, staff member M stated she did not want to say anymore, and stated, I don't get in trouble. (continued on next page)

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	275020	A. Building B. Wing	02/02/2023

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F 0725 Level of Harm - Actual harm Residents Affected - Some	During an interview on 2/2/23 at 8:54 a.m., staff member A stated the facility expectation was a call light should not go unanswered for more than 15 minutes. Staff member A stated the amount of staff was determined by a corporate matrix, and it appeared the facility staffing was within the parameters of the matrix. Staff member A stated the facility was aware of the long call light wait times, but felt like the issue was staff not using their time wisely and needing more education. Staff member C stated there were several residents who required two staff members to assist with cares, and it was not reasonable for staff to leave to answer call lights, while assisting those residents. Staff member C stated everyone in the facility would answer call lights, even the maintenance employees, but they could not provide anything beyond answering the call light if the resident required nursing care. Review of the facility's form CMS-672, dated 1/31/23, showed: - 67 residents required assistance of one or two staff for dressing; and, 22 residents were fully dependent; - 74 residents required assistance of one or two staff for toilet use; and, 15 residents were fully dependent; and, - 69 residents in were in a chair most/all the time; and nine residents were bedfast Review of sampled facility call light wait times, for seven 24-hour time periods, from 1/6/23 to 1/30/23, showed: - Resident #229 - six wait times greater than 15 minutes, with the longest wait time of 49 minutes; - Resident #230 - 28 wait times greater than 15 minutes, with a longest wait of 70 minutes; - Resident #235 - six wait times greater than 15 minutes, with a longest wait of 78 minutes; - Resident #20 - 16 wait times greater than 15 minutes, with a longest wait of 85 minutes; - Resident #56 - seven wait times greater than 15 minutes, with a longest wait of 52 minutes; - Resident #429 - 12 wait times greater than 15 minutes, with a longest wait of 88 minutes; - Resident #29 - 14 wait times greater than 15 minutes, with a longest wait of 38 minutes; - Resident #3 - nine wait times greater than 15 minutes, with a longest wait of 69 minutes; and, - Resident #27- two wait times greater than 15 minutes, with a longest wait time of 44 minutes. Of the 23 longest wait times identified through the sampled days from 1/6/23 to 1/30/23, 20 (87%) occurred between 6:00 a.m. and 6:30 p.m., which were the day shift hours for the facility. 33796 (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Some	Review of a Facility Reported Incident, sent to the State Survey Agency, dated 11/6/22, showed resident #26 stated she felt like she was choking on a piece of ham, and turned her call light on. The light was not answered for 40 minutes. Five residents were interviewed as part of the facility investigation, and two residents said the call lights had a long wait time to be answered. During an interview on 1/31/23 at 11:50 a.m., resident #26 stated staffing and call lights were still a concern. She stated six call lights were on the night before with no staff to answer them. This could not be verified through staff interviews or review of the schedule. Resident #26 also stated some staff nurses would not answer call lights. During an interview on 2/1/23 at 11:10 a.m., resident #15 stated she wrote a grievance regarding staff coming to her room when the call light was on, the light would be turned off, and the staff would not return. She stated she could not walk, and she was dependent on staff for her toileting needs. She stated the long call light times have caused her to be incontinent of bowel and bladder. 44770 During an interview on 1/31/23 at 9:24 a.m., resident #21 stated he would like to have more showers, but the facility did not have enough staff to get the showers done. Review of resident #21's comprehensive care plan, dated 4/5/18, showed resident #21 preferred three showers per week. Review of resident #21's bath record, from 1/1/23 to 1/31/23, showed resident #21 received eight showers out of 27 opportunities, and there were no refusals documented. During an interview on 2/1/23 at 1:54 p.m., resident #229 stated, There has been four times I pissed my pants waiting for them to help. NF5 said resident #229 has never had a problem with incontinence. She stated he just can't wait that long all the time. She stated he waited for a long time when he used his call light; and sometimes, they came in and told him there were other people ahead of him, and turned the call light off. During an interview on 2/1/23 at 9:26 a.m., resident #230 stated, I was having to wait too long to go to the bathroom, so I had to become self-sufficient in here (the facility). Some days I feel neglected here. Last night, they only gave me chicken. When I asked for some salad, they told me the kitchen was closed. One nurse brought me the wrong inhalers because there is another resident with the same initials as me. I cry at least one time a day over something going on here. I had to wait 45 minutes for my pain medication last night. I don't get showers on a consistent schedule. They said we would get showers twice a week. I refused showers a couple of times, but that was because I was in too much pain, and they had not given me my pain medication on time. They did not come back and offer another shower after the medication kicked in. There just isn't enough staff here to take care of all of us. Review of resident #230's late medication audit, dated from 1/1/23 through 1/31/23, showed resident #230's oxycodone was over one hour late 24 times and over 30 minutes late 36 times. Review of resident #230's bath record, dated from 1/12/23 through 1/31/23, showed the resident received two showers, and refused two showers, out of five opportunities. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Some	During an observation and interview, on 1/31/23 at 9:40 a.m., resident #235 stated, I have only had one shower, and I am supposed to get one two times a week. Resident #235 said she was admitted to the facility on [DATE]. Resident #235 stated, I feel hot and sweaty, and I get sinus headaches when I don't get a shower often enough. They don't even give us a bed bath. I asked once, and they told me they were too busy. I get told there are 'two or three people ahead of you,' when I use my call light. Resident #235's hair appeared unkempt and had a hair clip that was falling out. Review of resident #235's bathing record, dated from 1/10/23 through 1/31/23, showed the resident received two showers out of seven opportunities. During an interview on 2/2/23 at 8:53 a.m., staff member Q stated, We don't have time to look at care plans. You have to understand the staffing around here. I had to take over this cart (medication) in the hall that I don't know hardly anyone, and there is over twenty people here that I have to give meds to. Most nurses won't even do this job anymore because it is just too hard since there isn't enough staff. Hopefully, we get changes in care information from report, but some nurses are good at giving report, and others are not. Sometimes we don't even have time for any report. I usually just ask the resident how they transfer or what kinds of things we do for them. Review of the Resident Council Minutes, dated 8/8/22, showed the residents stated they were turning their call lights on, and not getting a timely response. They also stated they felt bad when reporting grievances related to the concerns. Review of the Resident Council Minutes, dated 9/8/22, showed Less and less showers are being given. Review of the Resident Council Minutes, dated 10/3/22, showed Copper [NAME] - only 1 CNA, need more help. Review of the Resident Council Minutes, dated 11/10/22, showed the call lights were getting turned off, and then staff left. This is still happening. Review of the Resident Council Minutes, dated 1/12/23, showed Call lights are getting turned off by CNA's, leave and don't return. Residents are having to wait too long for their call lights. During an interview on 2/1/23 at 3:50 p.m., staff member A stated it was the responsibility of each department to address resident council concerns, but she may need to provide the oversight in the future.

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 41652 Based on observation, interview, and record review, the facility failed to ensure a resident was free from significant medication errors for 1 (#432) of 1 sampled resident, which resulted in a resident experiencing a seizure related to the cumulative effect of the wrong dose for three days. Findings include: 1. Review of an incident reported to the State Survey Agency, dated 7/17/22, showed resident #432 was administered an incorrect dosage of aripiprazole, an antipsychotic medication, on 7/14/22, 7/15/22, and 7/16/22, and experienced seizure-like activity on 7/17/22. Review of the investigative file associated with resident #432s medication incident, provided by the facility on 1/31/23, showed the following events: - resident #432's discharge orders from acute care, dated 7/13/22, showed an order for aripiprazole 5 mg tablet, Take 1 tablet by mouth every day 7 days, then take 2 tab(s) by mouth daily thereafter, - resident #432's physician orders, dated 7/13/22, and entered into the EMR by staff member F on 7/13/22 at 4:09 p.m., showed aripiprazole, Give 5 mg by mouth one time a day related to OTHER SYMPTOMS AND SIGNS INVOLVING COGNITIVE FUNCTIONS AND AWARENESS (R41.89) for 7 Days AND Give 10mg by mouth one time a day related to .(R41.89), - resident #432's MAR, dated July of 2022, showed the resident received a total of 15 mg of aripiprazole on 7/14/22, 7/15/22, and 7/16/22, and - resident #432's nursing progress note, dated 7/17/22, showed the resident had a seizure on 7/17/22 and the aripiprazole order was entered incorrectly resulting in a larger dose being administered, the aripiprazole was discontinued, and the resident's anti-seizure medication was restarted. Review of resident #432's nursing progress note, dated 7/17/22, showed the resident had been tapered off Keppra (an anti-seizure medication) recently, and the provider was unable to determine if the seizure was an adverse reaction to the high dose of aripiprazole or the recent tapering of Keppra. During an interview on 2/1/23 at 4:38 p.m., staff member B stated the incident was investigated by the previous DON who was no longer employed by the facility. Staff member B stated the entry error by staff member F resulted in a larger dose of aripiprazole being given to resident #432. Staff member B stated admission orders were supposed to be double checked by a second licensed nurse, and there was no documentation showing the double check had occurred. Staff member B stated she had left a message with the consultant pharmacist, but had not heard anything back regarding why the entry error was not identified during the medication regimen review which was done shortly after admission. 44770

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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. 33796 Based on observation, interview, and record review, the facility failed to provide food with the correct and safe diet texture, as ordered by the physician, placing the resident at risk for choking and inadequate intake, for 1 (#33), of 8 sampled residents. Findings include: Review of resident #33's physician diet order, dated 4/26/22, showed Level 2 mechanical soft solids, minced meats with gravy. During an observation of lunch, on 1/31/23 at 12:50 p.m., resident #33 received a whole rice krispee bar, which she could not eat. She was observed to have no teeth. Review of the menu spreadsheet for the lunch meal showed residents on a Dysphagia level 2 diet texture should receive a pureed or slurried peanut butter cookie instead of the rice krispee bar. During an observation on 1/31/23 at 5:29 p.m., resident #33 received regular green beans, with no modification to the beans, as the side dish. The menu spreadsheet showed the Dysphagia level 2 diet should have received a soft and chopped or mashed vegetable. During an observation of breakfast on 2/1/23 at 8:30 a.m., resident #33 received an English muffin sandwich with a whole slice of ham. She was unable to eat the sandwich, and had it torn apart with her fingers on the table and the plate. She was attempting to gum the pieces of the sandwich. Review of the facility menu spreadsheet, for the breakfast meal, on 2/1/23, showed residents on a Dysphagia level 2 diet should receive a pureed breakfast sandwich. During an observation and interview of lunch on 2/1/23 at 12:32 p.m., resident #33 received turkey that was served in one inch chunks. She was attempting to eat the turkey and could not. She tried to cut the turkey with a knife while she held the turkey piece in her hand. She stated she could not cut the turkey. Staff member Y was requested to come to the table to look at resident #33's turkey. She stated the family had signed a waiver to allow the resident to eat a regular textured diet. She did not know why the physician diet order did not reflect the regular texture. The facility was not able to provide a waiver for #33's upgrade in texture for her meals.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 44770 Based on observation, interview, and record review, the facility failed to maintain proper infection control practices regarding nursing staff failing to wear masks while caring for 1 (#5) of 1 sampled resident; and failed to wear masks in care areas of the facility. The facility was in COVID-19 outbreak status during the survey with three active resident cases of COVID-19. This deficient practice had the potential to spread infection throughout the facility. Findings include: During an interview on 1/31/23, at 7:45 a.m., staff member A stated there were three positive COVID-19 residents in the facility at the time of state survey entrance. Review of a facility reported incident, dated 12/2/2022 at 6:00 p.m., showed: Incident Description- [Resident #5] complains of mistreatment to him and other residents because 2 nurses do not wear their masks when they work the night shift, and he was given COVID 19 because of it. HE is fearful of dying and angry at the facility for allowing this to happen. The 2 nurses were suspended pending the investigation The provider was notified and the investigation begun. The resident is his own representative. FINDINGS- submitted on 12/07/2022: [Resident #5] had complaint of two night shift nurses not wearing their masks when they work which is causing him to fear for his life. The two nightshift nurses accused were suspended and an investigation was immediately initiated. Upon investigation it was found that these two nurses were in fact at times not wearing their masks as per facility protocol. Therefore both nurses were educated on the importance of wearing their masks and given teachable moments. [Resident #5] is his own responsible party and aware of the investigations outcome. Provider made aware as well. [sic] During an observation on 2/2/23 at 8:39 a.m., staff member E was standing at the medication cart at the nurses' station. Staff member E was observed wearing her mask on her chin. The mask was not covering her mouth or her nose. Staff member E pulled her mask up over her nose and mouth when she saw the survey team member in the hall. During an interview 1/31/23 at 2:12 p.m., resident #5 stated he reported two staff members for not wearing masks. Resident #5 stated he had reported the same two staff members twice for not wearing masks. 47752 During an observation, and interview, on 2/1/23 at 9:00 a.m., staff member E was sitting at the nurses station with two other staff members with her mask down. Staff member E stated the policy allows them to have our masks down if no one was around. Staff member E stated her mask should have been up with the other staff members present. During an observation on 2/1/23 at 1:52 p.m., at 2:06 p.m., and 4:17 p.m., staff member E had her mask down at the nurses station with other staff present.