STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275026	A. Building B. Wing	12/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ivy at Great Falls	1130 17th Ave S Great Falls, MT 59405

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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 - Immediate jeopardy to resident health or safety Residents Affected - Many	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35356 IMMEDIATE JEOPARDY On [DATE] at 12:28 p.m., the facility administrator was notified that an Immediate Jeopardy existed in the area of F600 - Freedom from Abuse and Neglect. Severity and Scope identified for the Immediate Jeopardy was identified to be at the level of L, and upon removal of immediacy would be lowered to an F. The surveyors exited the facility without a plan to remove the immediacy. The facility submitted a plan alleging the removal of immediacy would be completed by the end of the day on [DATE]. The plan was accepted by the State Survey Agency, and the immediacy verified to have been removed as of [DATE], during an onsite revisit completed on [DATE]. Based on observation, interview, and record review, the facility failed to: a) Provide the necessary care and services required to avoid physical harm and mental anguish resulting in the negligence of care for 6 (#s 15, 16, 17, 18, 19, and 20) of 21 sampled residents; b) Failed to provide sufficient staffing to ensure the necessary provision of care and services for the prevention and treatment of avoidable pressure ulcers resulting in the neglect of care for 1 (#s 15 and 19); c) Failed to provide sufficient staffing to provide the necessary provision of care for residents with indwelling urinary catheters resulting in neglect of care for 1 (#19); d) Failed to provide adequate supervision to ensure a safe smoking environment which resulted in the neglect of care for 4 residents (#s 16, 17, 18, and 20); e) Failed to develop and implement resident care policies and procedures which ensured that the facility provided care and services meet the needs for residents with indwelling urinary catheter care (#15) and prevention and management of avoidable pressure ulcers for (#s 15 and 19); f) Failed to ensure adequate orientation of temporary travel staff; (continued on next page)

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	g) Failed to establish an updated Facility Assessment to identify resident acuity and facility staffing needs; and, failure of the governing body and administration to respond to reported staffing concerns. The cumulative effect of these systemic failures resulted in the development of avoidable pressures ulcers for (#s 15 and 19); development of medical device related PUI and hospitalization for UTI, AKI, and sepsis for (#15); feelings of despair and fear of dying for (#15); and burnt clothing with the potential for more than serious harm for (#s 16, 17, 18, and 20); and the facility failed to ensure a resident was free from abuse of power and potential sexual abuse by a direct care nurse over a period of time and failed to implement interventions, and investigate reports of suspicion of an inappropriate relationship to prevent further abuse by a nurse for (#9), report and investigate potential verbal abuse for (#8), and neglect of a resident and protect his dignity by not providing care and services to meet the needs of a resident for (#46) of 6 sampled residents. Findings include: Avoidable Pressure Ulcers 1. Resident #15 (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an observation and interview on [DATE] at 2:37 p.m., resident #15 was laying in his bed on his right side in a contracted fetal position. His room was dark, and the curtains were closed. The room had a strong odor of urine and a stale smell of unwashed body odor. The resident would only stare at the television and avoided eye-contact when being interviewed. Resident #15's hair was long and un-groomed. It had an appearance of being stringy and oily which was matted down in the back. The white pillowcase which he was laying his head on had a wide yellow halo ring around his head. His face was unshaven, and his gray beard was long and stained brownish down his right chin. He was wearing a soiled hospital gown with a softball sized hard dried red stain on the right sleeve. His bedding around his right shoulder was also soiled with dried spills and food debris. He stated he could move his arm, demonstrating how he could pick up his mug, which contained an orange liquid, and attempt to drink from the cup. When he tipped the mug to attempt to drink from the straight straw the orange liquid spilled out of the hole of the straw and saturated his hospital gown on the right shoulder and sleeve. Resident #15 mumbled an expletive and put the mug back down without getting a drink. His left arm was contracted to his chest and his left hand was swollen with two plus pitting edema, with the fingers of his left hand tucked into his right armpit. He stated he could not move his left hand or fingers, attempting to do so without success and groaned in pain when attempting to move his fingers from under his right armpit. There were dried sticky red stains on the top of his left hand. He was covered with a sheet and was laying on a moist wrinkled draw sheet. His legs were bilaterally contracted up towards his stomach with his left leg laying over his right leg with a soiled pillow between his knees. He was wearing bilateral blue heel protectors' which were soiled. The Velcro and foot beds had white-yellow waxy skin flakes. There were no other pressure relieving modalities in place. His toenails were thick, yellow, and long, with some growing straight out past the toe, and others curled down the pad of the toes. He had thick yellow waxy build-up on the bottom, top, and between his toes bilaterally. He had an uncovered catheter bag with 100 ml of dark orange fluid in the bag, and tubing was cloudy with a thick white cloudy sediment in the tubing. On the floor beneath his catheter bag there was a large puddle of yellowish/brown fluid that was dried around the outer perimeter, and wet at the center. Resident #15 stated he had a cyst removed from his spine, and the surgeon severed his spinal column, paralyzing him. He said he was not able to reposition himself in bed, and relied on staff to provide his care. He said he had two bed sores. When asked about his swollen hand and how his bed sores were healing he stated, No one's going to help, they don't care, I don't care, shit happens. During an interview on [DATE] at 9:45 a.m., staff member S stated she had not worked the side of the hall which resident #15 resided and was not aware of any new skin issues. She stated she had not provided care for resident #15 in weeks due to limited staffing. Staff member S stated there were supposed to be three CNAs for that unit but most days they only had two aides to work the entire unit, and only one aide for others. She stated they were doing the best they could, but it was difficult to provide the necessary care when there was not enough help. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on [DATE] at 9:50 a.m., staff member E stated she was not aware of any new skin concerns for resident #15. She stated she had not been able to provide necessary skin assessments for the residents due to limited staffing. She stated she could not provide the necessary supervision of care provided when she had to work the unit by herself. She said she had to rely on the aides to report any new findings, but if they could not complete their cares, they would not be able to identify and report any new skin issues. She stated she had been telling administration since [DATE], they were in a staffing crisis, and the response she got back from administration and the governing body was there were no staffing concerns. Staff member E stated she was doing the best she could with the limited support from administration. Stating the facility had lost so many staff because they were being over-worked and were afraid for their own licenses due to the level of neglect in the facility. During an observation on [DATE] at 2:00 p.m., staff member Q and F completed a comprehensive head-to-toe skin assessment for resident #15. The following was a summary of the observed findings: - Right Ear: Two new Unstageable PUI. - Glans Penis: Two new full-thickness MDR Mucosal Pressure Ulcers Injuries. - Scrotum: Two new partial thickness MDR Mucosal Pressure Ulcer Injuries. - Perineum: One new Unstageable PUI. - Left Heel: One new deep-tissue PUI. - Right Great Toe: One new deep-tissue PUI. - Right Shoulder: One new Stage I PUI. - Right posterior thigh: Two new Stage I PUIs. During an interview on [DATE] at 2:05 p.m., staff member R stated she had just started working at the facility on Sunday [DATE] and was not provided any orientation from the facility when she started. She stated she was the only nurse working the unit. There were supposed to be three CNAs, but one CNA was called away to work elsewhere in the facility. She said they had not been fully staffed on that unit since she started, and the facility continued to accept new admits and she was having difficulty completing her required tasks. The staff member stated there were many residents on that unit who had skin integrity issues and new wounds and was worried for the residents of the facility were not being adequately cared for due to lack of available staff. She said she had not been able to assess all the residents on that unit for skin issues because she did not have the time, support from unit managers, or adequate staff to complete all her tasks. She stated she had worked in many facilities were staffing was a problem, but that this facility had a major problem. During an interview on [DATE] at 4:00 p.m., staff member Q stated she was responsible for providing wound care for all the residents. She stated due to the lack of staffing, she had been pulled from her duties as wound nurse to work nights on the floor for the last three weeks. She sated she had not been able to complete adequate wound care services or assessments for the residents. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on [DATE] at 12:30 p.m., staff member O stated individuals, such as resident #15, were a high risk for the development of pressure ulcers. He stated if the proper care and interventions were not implemented, residents could develop new and worsening pressure ulcers. He stated it would be important to provide adequate staffing to care for individuals such as resident #15 since their care needs were a higher acuity and required more skilled care. He stated he had been personally worried regarding the lack of staffing at the facility. When staffing is inadequate it was the care of the residents unfortunately, which suffered. 2. Resident #19 During an observation and interview on [DATE] at 1:10 p.m., resident #19 attempted to raise her right hand to show her contracture. She stated it hurt all the time, but stated her bigger concern was the sore on her right foot. During an interview on [DATE] at 3:20 p.m., staff member Q stated she had looked at resident #19's foot last week, and it was a pressure injury from the foot board on her bed. Review of resident #19's electronic health record showed no documentation of staff member Q's wound assessment. During an observation on [DATE] at 9:45 a.m., staff member BB removed the dressing on resident #19's right foot. She stated it had begun as a very large blister. She stated she could not stage it, but the wound nurse would do that. The area was approximately 3 inches long with a 2 inch black center on the bottom of her right foot. During an observation on [DATE] at 3:20 p.m., resident #19's feet were both pressed against the footboard. During an observation and interview on [DATE] at 4:20 p.m., staff member E stated resident #19's pressure injury on the right foot had been identified at some point, but not reported to nursing staff. Staff member E removed the dressing from resident #19's right foot, and stated the pressure injury was Unstageable, because it had necrotic tissue covering the 2 inch black center portion. She stated the footboard should have been removed. For the complete findings for avoidable pressure ulcers see F686. Indwelling Catheter Care During an observation and interview on [DATE] at 2:37 p.m., resident #15 was laying in his bed on his right side in a contracted fetal position watching television. The room had a strong smell of urine. There was an uncovered catheter bag with 100 ml of dark orange fluid in the bag, and tubing was cloudy with a thick white cloudy sediment in the tubing. On the floor beneath his catheter bag there was a large puddle of yellowish/brown fluid that was dried around the outer perimeter, and wet at the center. The resident stated, No one's going to help, they don't care, I don't care, shit happens. During an interview on [DATE] at 3:58 p.m., Staff member R stated there were no treatment orders in resident #15's medical record for catheter care. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of resident #15's Discharge Orders and Admission Assessment, showed the resident admitted to the facility from a long-term acute care hospital on [DATE]. He was discharged with daily Foley care, and to change Foley [every] month. A review of resident #15's Order Summary, dated [DATE] to [DATE], did not show indwelling urinary catheter orders for care were entered until [DATE]. Review of resident #15's TARs from [DATE] to [DATE], did not show orders were initiated for catheter care of resident #15's indwelling urinary catheter. Review of resident #15's EHR showed he was hospitalized from [DATE] to [DATE] for a complicated urinary tract infection, severe sepsis, and acute kidney injury related to long-term use of indwelling urinary catheter. Review of resident #15's Hospitalist Progress Note, dated, [DATE], showed: -Complicated urinary tract infection: With history of chronic indwelling Foley catheter - not exchanged since , d+[DATE]. See severe sepsis below. - Severe Sepsis: present at admit with tachycardia, fever, AKI, suspected source - UTI in setting of chronic Foley . - Acute kidney injury: in setting of chronic Foley use with underlying neurogenic bladder. Most concerned for prerenal disease with hypovolemia vs septic . need to replace Foley with new one now (last changed 1 mo ago). Review of resident #15's Hospital Discharge Orders, dated [DATE], showed, Foley Care Q shift . Diagnosis: E. Coli and Enterococcus UTI. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an observation and interview on [DATE] at 9:00 a.m., staff members S and DD, assisted staff member Q with wound care for resident #15. The resident had a loose bowel movement and was provided peri-care. During the peri-care staff member Q started to clean the resident's scrotum. When the scrotum was repositioned the resident's penis with an indwelling Foley catheter, was tucked under his scrotum. His penis and the tubing were peeled away from the resident's scrotum revealing two quarter-sized bright red macerated blisters on the resident's scrotum. Underneath the shaft of the penis there was a bright red swollen area of macerated tissue. The glans of the resident's penis had two separate medical device related injuries to the mucosal tissue around the insertion site of the catheter. The first mucosal membrane injury was at the 12 o'clock position on top of the glans. The injury was a full-thickness mucosal tissue injury, approximately the size of a dime, with a straight line of eschar tissue down the center of the injury. The catheter tubing was not anchored to prevent pressure relief around the glans. The tubing was pulled tight and adhered to the tissue from where it exited the resident's urethra. The tubing was peeled upwards revealing a second full-thickness mucosal injury at the 6:00 o'clock position of the glans approximately the size of a penny. The resident's urinary meatus under the tubing of the second injury had split open the tissue around the urinary meatus, revealing a one cm deep laceration into the resident's urethra. The tissue around the second MDRPI had a thick glob of grayish-green and red exudate which could not be cleared away with a dry gauze pad. The entry of the resident's urethra was bright red and inflamed, when staff cleaned the tubing the urethra started to actively bleed bright red blood around the tubing. The fluid inside the catheter tubing which was exiting the urethra had a thick white purulent collection of fluid. The genitals and groin had a thick white cheesy substance which staff member Q had difficulty wiping it clean. The tissue underneath was bright red, swollen with areas of maceration and excoriation. There was a strong foul musty odor. During an interview on [DATE] at 9:00 a.m., staff members S and Q stated they were not aware of the injuries around the resident's genitals from the catheter. Staff member S stated she had not worked with resident #15 in weeks, and there had only been one aide to work his side of the unit. She stated there were many days they did not have enough staff to complete the required care. Staff member Q stated she was unaware of the new injury to the resident's genitals. She stated it appeared to have developed due to lack of catheter and peri-care, and improper anchoring of the catheter tubing. Staff member Q said she had not been able to provide skin assessments for the residents since she had to work nights on the floor for the last three weeks due to lack of available staff. During an interview on [DATE] at 9:55 a.m., staff member C stated all indwelling urinary catheters should be immediately assessed for removal when a resident was admitted with one, and they should be assessed and care provided at least every shift with any identified concerns reported to the nurse. She stated there were a number of risks associated with long-term use of indwelling catheters to include infections and trauma, and the necessary care to prevent these types of injuries. She stated they were trying to hire new staff but no one wants to work. During an interview on [DATE] at 2:50 p.m., staff member U stated he was not aware of the injury to resident #15's genitals related to his catheter. Staff member U stated he was trying to manage all the necessary care and services for the residents on that unit, but it was difficult when he was the only CNA working the entire unit. Stating it had been like this for a long time now. He said he kept coming back for the residents. He had been working many hours of overtime every pay period just to try and help the residents. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on [DATE] at 2:05 p.m., staff member R stated she had just started working at the facility on Sunday [DATE]. She had not been provided orientation or supervision. She had been working short-staffed on the unit since Sunday, and was the only nurse working the entire unit. She said she had a new admit Monday and two new admits the following days. She stated she could not keep up with completing the new admission services and continue to provide adequate care for all the residents on the unit. She stated she could now understand why admission orders were not entered for the care of resident #15's catheter. She stated she felt overwhelmed by the responsibilities and did not feel there was adequate oversight support. Review of resident #15's TAR and Orders from [DATE] to [DATE], did not show orders or care were provided for resident #15's Foley catheter until [DATE]. Facility developed avoidable MDR mucosal pressure ulcer injuries to the resident's scrotum and glans penis were identified on [DATE]. Review of resident #15's Care Plan, with initiation date of [DATE], did not address the resident's indwelling urinary catheter. During an interview on [DATE] at 12:30 p.m., staff member O stated residents should be assessed for necessity of an indwelling urinary catheter upon admission. Should the catheter be deemed necessary, catheter care orders should be implemented and followed, and the resident assessed for any potential complications. Should staff be unable to to provide these necessary services, the potential or infection and injury could occur. During an interview on [DATE] at 9:00 a.m., resident #15 stated he had a friend who was in a nursing home and was put at the end of the hall and staff forgot about him. He said his friend died . Resident #15 stated he was worried that would happen to him, and why he did not like being so far down the hallway. He said it took too long for staff to bring his medications and other things that he quit asking. For the complete findings for indwelling urinary catheter care see F690. Smoking Supervision During an observation and interview on [DATE] at 3:30 p.m., resident #16 and #17 were outside in the facility courtyard smoking and were unsupervised by staff. During an interview on [DATE] at 3:45 p.m., staff member E stated the facility had changed their smoking policy to no smoking policy. Previously residents who smoked were assessed for safety, provided aprons, and supervised by a staff member during designated times. She said since the facility became a no smoking facility, residents can go outside to smoke whenever they want, and they have not been supervised. She stated the facility did not have enough staff to supervise the residents every time they go outside to smoke. She said she told administration about her concerns with residents smoking outside unsupervised, but they did not do anything to stop the issue. During an observation and interview on [DATE] at 1:48 p.m., resident #17 and #18 were outside in the facility courtyard smoking and were unsupervised by staff. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on [DATE] at 2:00 p.m., staff member BB stated she was aware of the residents outside smoking and were unsupervised by staff. She stated there were not enough staff to supervise residents when they went outside to smoke. The facility was supposed to be non-smoking. She stated the administration knew about the residents smoking unsupervised and have not intervened. During an interview on [DATE] at 2:05 p.m., staff member AA stated the facility decided to become non-smoking, but residents continued to go outside and smoke anyway. She said there were not enough staff to go out with the residents every time they went out to smoke. She stated there was a staff member who attempted to redirect the resident from smoking unsupervised in the courtyard, and was fired for violating their Resident Rights. Staff member AA stated administration was aware of their concerns, but staff were afraid to do anything else for fear of reprisal. She stated staff including administration walk by the courtyard all day long and they do not intervene. During an interview on [DATE] at 2:15 p.m., staff member F stated they were aware of the residents going outside to smoke unattended. He stated they did not have enough staff to accommodate even the previous scheduled smoking times. He stated he had notified administration of his concerns with residents going outside unsupervised, but nothing was done to correct the issue. During an interview on [DATE] at 3:46 p.m., staff member A stated the facility was non-smoking. He stated when the facility discontinued their smoking policy, they started those residents who smoked on a smoking cessation program. He stated residents should be supervised if they were outside smoking on facility property. Staff member A said it could be very dangerous to leave cognitively impaired residents unsupervised while smoking. Staff member A stated he was not fully aware of the situation with the residents smoking unsupervised by staff. He said he had been working between two facilities and was not always at the building to oversee everything. During an observation and interview on [DATE] at 4:30 p.m., resident #20 was in the outside courtyard smoking unsupervised. The temperature was 39 degrees Farenheit with a cold wind. He was wearing a pair or old cloth gloves with multiple holes. There was a brown/yellow burn with a blackened burn hole in the center of the stain on the inside of the index finger of the left glove. When he removed his hand from the glove, there was a dark yellow stain on the inner aspect of his left index finger. Resident #16 entered the courtyard wearing a thin shall and was barefoot. She had on her elopement wrist alarm. Resident #16 then started to sort through old cigarette butts on the ground. There were no staff around to supervise the residents. During an observation on [DATE] at 5:03 p.m., it was dark outside, and there were no lights on in the courtyard. The temperature outside was 30 degrees Farenheit, and it was starting to snow. Resident #18 was smoking in the courtyard. Resident #16 was also sitting in the courtyard in her bare feet and had a thin shall on over her t-shirt. She was wearing her elopement band. Staff member I walked by the bay of windows that looked out into the courtyard and did not stop to supervise the two residents. Resident #18 and #16 then entered back into the facility. When resident #16 walked through the door, the elopement alarm sounded. It alarmed for five minutes before a staff member responded. Staff member F turned off the alarm, and went outside to check if there was anyone outside because it was too dark to see into the courtyard. During an interview on [DATE] at 5:13 p.m., staff member I stated she did not see anyone outside in the courtyard when she walked by earlier, but could not stop because she was late to pick up her child. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	For complete findings regarding smoking supervision see F689: Accidents and Hazards Staffing The following cumulative areas of neglect occurred due to a repeated systemic pattern of failures to provide sufficient staffing in the following areas of care: - To ensure the necessary provision of care and services to for the prevention and treatment of avoidable pressure ulcers (See F686). - To provide the necessary provision of care for residents with indwelling urinary catheters See F690). - To provide adequate supervision to ensure a safe smoking environment (See F689). For complete findings regarding insufficient staffing (See F725). Development of Facility Assessment A request was submitted on [DATE], [DATE] and [DATE], for a copy of the facility's comprehensive Facility Assessment. Review of an email regarding the requested Facility Assessment, from staff member B on [DATE] at 10:30 a.m., showed, No, I am waiting to hear back from [staff member A] to tell me where they are . A review of the Facility Assessment, received on [DATE] at 11:23 a.m., showed: ABC-Nursing and Rehab Facility Assessment, Continuation of Facility Assessment from [DATE]. The assessment provided was not for the correct facility and it was not for 2021. Development of Policy and Procedures A request for a copy of the facility's Policy and Procedure for Pressure Ulcer Management and indwelling urinary catheter care was requested on [DATE] and again on [DATE]. The requested information was not provided by the end of the survey. A second request was submitted via email to staff member B on [DATE] at 10:38 a.m., with a response showing, Ok now I know what happened. We don't have a policy on it. The stuff I gave you on Thursday was the info that we have for wound and catheters . During an interview on [DATE] at 9:00 a.m., staff member C stated she would look for a couple policy and procedures. She stated they have not transitioned all the policy and procedures yet for this facility, so they may not have them. Lack Administrative and Governing Body Oversight and Response to Reported Staffing Concerns (continued on next page)

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Ivy at Great Falls	1130 17th Ave S Great Falls, MT 59405

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on [DATE] at 1:00 p.m., staff member B stated staff member A was not currently at the building and had not been able to be at the building consistently for several weeks because he had been providing full-time administrative oversight at their sister facility. Staff member B said staff member A would drive everyday between the two facilities, and would not usually be in the facility until late afternoon or evening. She said he was expected to put in a full eight hours at the sister facility before he could return to this facility. Staff member B said she was currently acting as the administrator in his absence. She stated she did not have an administrator's license and was not currently working on obtaining an administrator license. She said she was currently working under staff member A's license. Staff member B stated they had termed their previous DON several weeks ago and did not have an ADON to cover the role. She stated the DON was also the Infection Control Nurse, and they did not currently have an Infection Control Nurse. She said Staff member C had flown in from out of state to help. During an interview on [DATE] at 1:20 p.m., staff member C stated she was from the corporate office and had oversight for over nine different facilities throughout the country. She said she had been there for less than one week, and stated they were having difficult time getting staff hired to work the facility because the nursing shortage was an issue throughout the entire country and what where they suppose[d] to do when no one wants to work. She said they had hired a bunch of travel staff paying them 100.00 dollars an hour to work. She stated they tried offering bonuses for staff to pick up extra shifts but the staff were not willing to work. She stated in order to help the staffing issue, they decided to hold all new admissions. Staff member C stated she supposse[d] she was the DON and Infection Control Nurse. She said that she did not want to be there. Staff member C said staff member A was at the facility full-time. She said he drives back from the sister facility after working full-time there and works another eight hours for the facility. She stated she thought it was fine, and did not have any concerns with the arrangement. She said it was only temporary until they were able to hire a new administrator for their sister facility. During an interview on [DATE] at 2:00 p.m., staff member R stated she was hired as a temporary travel staff to help with the staffing needs for the facility. She stated she arrived on Sunday [[DATE]] and had not been fully staffed since she arrived. She stated the unit was full of high acuity residents which take more staff to care for them. She said staff that were scheduled to work the unit were pulled to work other units, which put a burden on the remaining staff to complete their duties. During an interview on [DATE] at 2:10 p.m., staff member S stated there were only two CNAs for the entire unit, which was a challenge since many of the residents needed 2-person assistance with care. They had another aide scheduled to work with them, but that individual had to go help with transportation. She stated this was a common occurrence for a long time now, and they have asked for help from administration, and they were told there was not a staffing issue. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on [DATE] at 2:15 p.m., staff member E stated tearfully that the facility had been understaffed since [DATE]. She said staff were worn out and tired, and some were afraid for their licenses, so they quit. Other staff were working overtime, and becoming exhausted. She stated she was afraid for the safety and health of the residents. She said because of the limited staffing, care and services were not able to be completed because there was not enough staff to do everything. She said most days for the last several months, there has only been one CNA and one nurse to work the 600 Unit. She stated the 600 Unit had high acuity residents with many of those residents being bariatric and needed two person-assist for cares. She states there were often times they either provide unsafe care, or no care at all because there is not enough staff to complete the workload. She stated she had sent emails to staff member A and the corporate office sharing her staffing concerns. She said she was told there was no problem with staffing. She said she had worked greater than 60 hours in some weeks trying to provide the care the residents deserved. Staff member E stated they were so short staffed, but administration kept allowing admissions. During an interview on [DATE] at 2:30 p.m., staff member T stated she did not feel there were enough staff to get the job done. She said they do what they can to keep the residents cleaned, and changed, and provide feeding [TRUNCATED]

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 41952 Based on interview and record review, the facility failed to implement abuse and neglect policies and procedures including: reporting suspicion of abuse to designated staff at the facility; reporting of allegations to proper authorities; protection of residents during and after investigations; prevention of abuse; not providing required abuse training; conducting thorough investigations; and correction of allegations. This deficient practice affected 1 (#9) resident for an ongoing inappropriate relationship; and, verbal abuse for 1 (#8) of 6 sampled residents, and had the potential to affect all residents residing at the facility. Findings Include: Resident #9 During an interview on 12/8/21 at 5:10 p.m., staff member B stated she had called corporate in September for direction on what to do for an investigation of NF7 and resident #9's relationship allegations. Staff member B interviewed both NF7 and resident #9 who both denied a relationship and so nothing further was done. Staff member B stated at no time during the two allegations was NF7 suspended, and she did not know what else was done by corporate or staff member A, regarding reporting and investigation. During an interview on 12/9/21 at 10:22 a.m., staff member M stated he did not have abuse training at the facility, and he generally picked things up as he went along. During an interview on 12/9/21 at 11:20 a.m., staff member DDD stated she had not received abuse training at the facility. She had gotten abuse training from other jobs. She stated she reported concerns or suspicion of resident abuse to nurses on duty, but then her direct supervisor because nothing was done by nursing. Staff member DDD stated staff on the unit were aware of the inappropriate relationship (between NF7 and resident #9) and did not act on it. They actively avoided the area of the resident #9's room when NF7 was there. During an interview on 12/9/21 at 11:30 a.m., staff member EEE stated, she would see NF7 and resident #9 going to his room talking closely and was not sure what was happening or if it was appropriate. Staff member EEE stated she had not had abuse training in the last year. Resident #8 During an interview on 12/9/21 at 11:28 a.m., staff member EEE stated she witnessed resident #8 and the provider, at the nurses station having a heated argument ,and the provider was unprofessional and too close to the resident. They both calmed down and left the area. There was no investigation into the argument or alleged verbal abuse by the facility. Information was requested for the last facility abuse training, including the content and sign in sheet, but this was not provided by the end of the survey. Review of the facility policy, Abuse prevention program showed: (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. Develop and implement policies and procedures to aid our facility in preventing abuse, neglect, or mistreatment of our residents. 4. Require staff training/orientation programs that include such topics as abuse prevention, identification, and reporting of abuse, stress management, and handling of verbally aggressive resident behavior. 8. Protect residents during abuse investigations. The facility abuse policies provided did not contain direction for facility staff on the following areas: - That all staff are mandated reporters for suspicion of abuse - On what the types of abuse there were or how to identify possible abuse - How to report suspicion or allegations of abuse, or who to report allegation to - That staff need to protect the resident when they witness abuse, to prevent further abuse

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 41952 Based on interview and record review the facility staff failed to report suspicion of abuse for an investigation; and, failed to report allegations and the suspicion of abuse to the proper authorities, for 2 (#s 8 and 9) of 6 sampled residents. Findings include: During an interview on 12/7/21 at 3:45 p.m., NF6 stated she normally would get self-reports (of abuse) from the facility in the past but had not seen any reports of abuse from the facility for a long time. During an interview on 12/8/21 at 5:15 p.m., staff member B stated she received direction on investigating the allegations of abuse regarding NF7 and resident #9's inappropriate relationship. She only did the facility interviews, not reporting for abuse events. During an interview on 12/8/21 at 5:40 p.m., staff member A stated corporate interviewed NF7 and did the investigation for the inappropriate relationship between NF7 and resident #9. He was not sure if the abuse situation was reported to the proper authorities as he did not report it himself. Review of the facility reported documents provided, showed: - Management was aware of an inappropriate relationship between NF7 and resident #9, as early as 10/5/21, per a compliance hotline report for inappropriate sexual texts between the resident and staff member. Also, there were several other allegations by multiple staff for this individual's neglect of duties (medication pass, tube feeding, dressing changes, fall neuro checks), HIPAA violations (showing the computer screen and explaining resident medications to resident #9), and an ongoing inappropriate relationship with resident #9 on 10/4/21 night shift. On 11/16/21, pertaining to an incident of staff finding NF7 in bed with resident #9, in a room that was supposed to be unoccupied, there was no documentation of abuse reporting to the proper authorities, including the State Survey Agency, local police, nurse licensing boards, or others. Review of the facility policy, Abuse Investigation and reporting showed: Reporting 1. All alleged violations involving abuse, neglect, exploitation, or mistreatment .will be reported by the facility Administrator, or his/her designee, to the following persons or agencies: a. The State licensing/certification agency .; b. The local/State Ombudsman; c. Adult Protective Services .; d. Law enforcement officials; . (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10. Any allegations of abuse will be filed in the employee's personnel record .

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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. 41952 Based on interview and record review, the facility failed to protect, prevent, report, thoroughly investigate, and correct abuse allegations for 2 (#s 8 and 9) of 51 sampled residents. This deficient practice had the potential to allow for abuse to occur, and continue to occur, without intervention and possible verbal, physical and/or sexual harm. Findings include: 1. During an interview on 12/9/21 at 10:25 a.m., staff member M stated he went to the 600 unit because of reports from staff member DDD to see the room of resident #9 and speak with the nursing staff on duty in October 2021. She witnessed NF7 and resident #9 in bed together. Staff member M stated it seemed like everyone knew about the relationship and were not going to intervene. Staff member M then went to staff member B to report what he witnessed and what staff member DDD had reported, and staff member B told him she already knew. Staff member M and DDD gave written statements to staff member B. During an interview on 12/8/21 at 5:40 p.m., staff member A stated corporate interviewed NF7 and did the investigation for the inappropriate relationship with resident #9. He was not sure if it was reported to the proper authorities as he had not reported it, as required. Review of facility investigations showed: - Management was aware of an inappropriate relationship between NF7 and resident #9 as early as 10/5/21, per a compliance hotline report for inappropriate sexual texts between the resident and the staff member; and, several other allegations of neglect of duties by NF7 for (medication pass, tube feeding, dressing changes, fall neuro checks), HIPAA violations (showing the computer screen and explaining resident medications to resident #9), and having an ongoing inappropriate relationship with resident #9 on 10/4/21 night shift. The facility failed to protect resident #9 during investigation from further potential abuse. The allegations were not fully investigated or interventions implemented by the facility. NF7 was never suspended for an investigation or disciplined for the neglect of her duties, HIPAA violations, and inappropriate relationship. - For the incident on 11/16/21, witness statements of finding NF7 and resident #9 were in the investigation. The staff that witnessed them together and reported it did not stay and protect resident #9 from NF7. No information regarding follow up with resident #9 such as an interview, assessment, monitoring, or care plan were performed. There was no documentation of reporting of the event to the proper authorities, including the State Survey Agency, local police, and the professional licensing board (nursing). 2. During an interview on 12/7/21 at 11:22 a.m., staff member BBB stated she and two CNAs had witnessed an argument between resident #8, and a provider at the nurses station that got out of control. Both were quite shaken up and the resident had to be calmed down by staff as he was visibly shaking. Staff member BBB stated the provider re-approached the resident again, a short time later in the therapy department, and staff member BBB overheard raised voices. But another therapist intervened. Staff member BBB stated the abuse event was not addressed by administration. The resident reported the event to staff member B. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/8/21 at 6:03 p.m., staff member A stated resident #8 had a long history with a psychological diagnosis and firing providers. Staff member A stated he suspended the provider and investigated an argument he had with resident #8 in the therapy room. It was not substantiated as abuse so the provider came back and had no contact with resident #8, per his request. Staff member A was not aware of a prior incident at the nurses station. During an interview on 12/9/21 at 11:28 a.m., staff member EEE stated she witnessed resident #8 and the provider at the nurses station having a heated argument and that the provider was unprofessional. They both calmed down and left the area. Review of resident #8's medical record showed his primary physician is still the one he had an argument with and no longer wanted as his physician. Review of the facility policy, Abuse Investigation and Reporting showed: 1. The individual conducting the investigation will, as a minimum: a. Review the completed documentation forms; b. Review the resident's medical record to determine events leading up to the incident; c. Interview the person(s) reporting the incident; d. Interview any witnesses to the incident; e. Interview the resident (as medically appropriate); f. Interview the residents Attending Physician .; g. Interview staff members (all shifts) who have had contact with the resident during the period of the alleged incident; . i. Interview other residents to whom the accused employee provides care or services; and j. Review all events leading up to the alleged incident. 5. Upon conclusion of the investigation, the investigator will record the results of the investigation on approved documentation forms and provide the completed documentation to the Administrator.

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35356 IMMEDIATE JEOPARDY On 12/9/21 at 12:28 p.m., the facility administrator was notified that an Immediate Jeopardy existed in the area of F686 - The Prevention of Pressure Ulcers. Severity and Scope identified for the Immediate Jeopardy was identified to be at the level of J, and upon removal of immediacy would be lowered to a G. The surveyors exited the facility without a plan to remove the immediacy. The facility submitted a plan alleging the removal of immediacy would be completed by the end of the day on 12/17/21. The plan was accepted by the State Survey Agency, and the immediacy verified to have been removed as of 12/17/21, during an onsite revisit completed on 12/22/21. Based on observation, interview, and record review, the facility failed to: a) Ensure interventions to prevent avoidable pressure ulcer injuries were implemented for 2 (#s 15 and 19) of 21 sampled residents; b) Failed to prevent, identify, assess, monitor, and treat 12 new avoidable PUIs of which two full-thickness and two partial-thickness injuries of the genital mucosal membrane related to an indwelling catheter related injuries, two Unstageable PUI of the right ear, one Unstageable PUI of the perineum, one deep-tissue injury of the left heel, one deep-tissue injury of the right great toe, and three new Stage I pressure ulcer injuries, one on the right shoulder and two on the right posterior thigh for 1 (#15); and, c) Failed to prevent, identify, and assess an avoidable Unstageable PUI of the right sole for 1 (#19) resident. Findings include: 1. Resident #15 (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an observation and interview on 12/6/21 at 2:37 p.m., resident #15 was laying in his bed on his right side in a contracted fetal position. His room was dark, and the curtains were closed. The room had a strong odor of urine and stale body odor. The resident would only stare at the television and avoided eye-contact when being interviewed. Resident #15's hair was long and ungroomed. It had an appearance of being stringy and oily which was matted down in the back. The white pillowcase which he was laying his head had a wide yellow halo ring around his head. His face was unshaven, and his gray beard was long and stained brownish down his right chin. His left arm was contracted to his chest and his left hand was swollen with two plus pitting edema, with the fingers of his left hand tucked into his right armpit. He stated he could not move his left hand or fingers, attempting to do so without success and groaned in pain when attempting to move his fingers from under his right armpit. There were dried sticky red stains on the top of his left hand. He was covered with a sheet and was laying on a moist wrinkled draw sheet. His legs were bilaterally contracted up towards his stomach with his left leg laying over his right leg with a soiled pillow between his knees. He was wearing bilateral blue heel protectors' which were soiled. The Velcro and foot beds had white-yellow waxy skin flakes. There were no other pressure relieving modalities in place. He had thick yellow waxy build-up on the bottom, top, and between his toes bilaterally. Resident #15 stated he had a cyst removed from his spine, and the surgeon severed his spinal column, paralyzing him. He said he was not able to reposition himself in bed, and relied on staff to provide his care. He said he had two bed sores. When asked about his swollen hand and how his bed sores were healing he stated, No one's going to help, they don't care, I don't care, shit happens. Afterwards he covered his eyes with his right hand and refused to answer any further questions. During an interview on 12/6/21 at 3:58 p.m., staff member R stated she had just started working at the facility on Sunday 12/5/21. She stated she provided wound care Sunday to a pressure ulcer on resident #15's right hip and sacrum. Staff member R said the dressing to the PUI on the resident's right hip had been completely saturated with a foul smelling discharge that had saturated his bottom bedding. She said she asked other staff if the smell was normal, and they assured it was. Staff member R said she was worried about the care of resident #15's PUI on his right hip. During an interview on 12/6/21 at 4:00 p.m., staff member Q stated she was responsible for providing wound care for facility's residents. She said she had, been pulled from wound care duties for the past three weeks to work nights on the floor. Staff member Q stated when she could dedicate her time to wound care duties she would assess, monitor, and treat the resident's wounds three to four times a week. Since working nights, she had not been able to dedicate the same amount of time for wound care. Staff member Q stated resident #15 had been admitted to their facility with a PUI on his sacrum, which was healing, and a deep tissue injury on his right hip, which she was aware had opened. She stated she was not aware of any other PUI for resident #15. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an observation and interview on 12/7/21 at 9:00 a.m., staff members S and DD, assisted staff member Q with wound care for resident #15. The resident had a loose bowel movement which had seeped up and under the dressing covering the resident's sacral PUI. The feces under the dressing was dried around the outer perimeter and moist in the center. Staff member Q removed the dressing from the sacral PUI which was dated 12/5/21 and cleansed the sacral wound of stool. Staff member S then finished providing peri-care for resident #15. When the staff member started to clean the resident's scrotum, the resident's penis with an indwelling Foley catheter, was tucked under his scrotum. His penis and the tubing were peeled away from the resident's scrotum revealing two quarter-sized bright red macerated blisters on the resident's scrotum. Underneath the shaft of the penis was a bright red swollen area of macerated tissue. The glans of the resident's penis had two separate indwelling catheter related injuries to the mucosal tissue around the insertion site of the catheter. The first mucosal membrane injury was at the 12 o'clock position on top of the glans. The injury was a full-thickness mucosal tissue injury, approximately the size of a dime, with a straight line of eschar tissue down the center of the injury. The catheter tubing was not anchored to prevent pressure relief around the glans. The tubing was pulled tight and adhered to the tissue from where it exited the resident's urethra. The tubing was peeled upwards revealing a second full-thickness mucosal injury at the 6:00 o'clock position of the glans approximately the size of a penny. The resident's urinary meatus under the tubing of the second injury had split open the tissue around the urinary meatus, revealing a one cm deep laceration into the resident's urethra. The tissue around the second MDRPI had a thick glob of grayish-green and red exudate which could not be cleared away with a dry gauze pad. The entry of the resident's urethra was bright red and inflamed. When staff cleaned the tubing the urethra started to actively bleed bright red blood around the tubing. Staff member S stated she was not aware of the injuries around the resident's genitals. She stated she had not noticed anything when she provided the resident a bed bath on Thursday. Staff member Q stated she was not aware of the new injuries to the resident's genitals, and stated they appeared to be from the catheter tubing creating a pressure injury. She stated the resident's catheter should have been anchored to prevent it from being pulled tight on the skin of the penis. Staff member Q stated catheter care should be provided at least every shift. Resident #15 stated he was not aware of the new wounds to his genitals. Review of resident #15's Order Summary Report with active physician orders as of 10/12/21, did not include indwelling Foley catheter orders for care of the catheter. (continued on next page)

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Ivy at Great Falls	1130 17th Ave S Great Falls, MT 59405

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During the continued observation and interview on 12/7/21 at 9:00 a.m., staff members S and DD, continued to assist staff member Q with wound care for resident #15. The resident was then assisted onto his left side to provide wound care to the right ischial wound. The bedding under the resident was covered with stool, and a thick foul smelling gray-green purulent discharge saturated the bedding under the resident's right hip. The dressing to the right ischial pressure injury was completely saturated with the same drainage. Several inches below the dressing was second area where the resident had been laying on his catheter tubing. The area was oval approximately the size of a golf ball, that was bright red, and did not blanche when pressed with a finger. Staff member Q stated it appeared to be a new area which she would Stage at I. Staff member Q then removed the dressing from the PUI on the right ischium. The surrounding tissue under the dressing had a deep red non-blanchable area approximately the size of a softball with a silver dollar sized hole in the center. The hole was deep and cavernous and was pulled up and away from any underlying connective tissue. The cavernous opening was approximately the size of a baseball. Deep inside the cavernous wound were gauze packing strips which were thickly saturated with the same yellow-gray-green purulent drainage. Staff member Q then attempted to remove the packing gauze with her thumb and forefinger. She penetrated the opening with her fingers pushing the tissue surrounding the edge of the opening down and into the cavernous area. Unable to reach the strips of gauze with her fingers, she then used tweezers, with which she pulled out two separate long lengths of heavily saturated gauze strips. Staff member Q stated resident #15 had been admitted into the facility with the PUI on his right ischium. She said the injury was a SDTI, which had not been open when he readmitted to the facility on [DATE]. It had since opened the other day, and they were able to remove a large mucous plug from the opening. Staff member Q said the wound was tunneling. Staff member Q stated she was not aware of any other pressure ulcer injuries for resident #15. She stated she would be doing a full head-to-toe skin assessment of the resident that day to ensure there were no new PUIs. She said when the resident admitted back to the facility in October 2021, she had completed his skin assessment at that time and the only two injuries were the sacral and ischial PUI. Resident #15 stated he was not aware of the current status of his ischial. When asked if he was willing to move to his left side to help off-load the pressure on his right hip, the resident agreed. Staff were able to place pillows behind his back and legs. During an interview on 12/7/21 at 9:45 a.m., staff member S stated she had not worked the side of the hall which resident #15 resided. She stated she had not provided care for resident #15 in weeks, with the exception of a bed bath on Thursday [12/1/21]. She stated she had not noticed any changes to the resident's skin at that time. During an interview on 12/7/21 at 9:50 a.m., staff member E stated the resident had received a bed bath on Thursday [12/1/21] and she was not informed of any new skin concerns for resident #15. She stated it was the expectation that the CNAs would report any skin changes immediately. She would then go and assess those findings further. During an interview on 12/7/21 at 9:55 a.m., staff member C stated it was the expectation that skin assessments were completed once a week. She stated those assessments were triggered in the TAR to remind the nurses to complete the weekly skin assessments. Any wound orders were to be put into the TAR as well, and wound dressing to be completed as ordered. For residents with an indwelling Foley catheter, the skin around the catheter insertion site should be assessed and peri-care completed at least every shift. Staff member C stated she had only been at the facility for a couple days and was not aware of resident #15 care concerns. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an observation and interview on 12/7/21 at 2:00 p.m., staff member Q and F completed a comprehensive head-to-toe skin assessment for resident #15. The following was a summary of the observed findings: - #1 and #2 - Right Ear: Two new Unstageable PUI. The first [#1] was approximately 1.5 x 1.0 cm oval covered with white-gray slough. The second area [#2] was 0.8 x 0.4 cm oval covered with white-gray slough. Staff member Q stated the two areas were new and Staged as Unstageable PUIs. - #3 and #4 - Glans Penis: Two new MDR Mucosal Pressure Ulcers Injuries. The first [#3] MPUI was a full-thickness injury which was approximately 1.5 x 1 cm round, with a line of eschar down the middle on the posterior side of the glans penis. The second MPUI [#4] was a full-thickness injury approximately 1.0 x 1.0 cm deep lacerated area open into the anterior aspect of the urethra. The area was covered with 50 percent gray-green slough at the ventral end of the laceration. The internal tissue of the urethra surrounding the catheter tubing were bright-red, swollen, and bleeding a moderate amount of bright red blood. Staff member Q stated she was not aware of the two new injuries to the glans penis and stated they were caused by the catheter tubing not being properly anchored to offload the pressure of the tubing off the penis. Staff member Q stated the Staging of mucosal tissue was different because of the type of tissue involved. - #5 and #6 - Scrotum: Two new MDR Mucosal Pressure Ulcer Injuries. The first MPUI [#5]was a partial thickness deep red, non-blanchable, area approximately 0.5 cm x 0.5 cm with the appearance of a blister, skin remained intact. The second MPUI [#6] was a partial-thickness blistered area approximately 2.2 cm x 2. 0 cm. - #7 - Perineum: One new Unstageable PUI [#7]. The injury was approximately 0.4 cm x 0.2 cm round with eschar covering 50 percent in the center. Staff member Q stated the areas would be Staged as Unstageable due to the eschar covering the injury. - #8 - Left Heel: One new deep-tissue PUI [#8]. The injury was approximately 11.0 cm x 14.5 cm round. It was deep purple in color and the skin was intact. The center had intact skin with a creamy white-yellow center approximately 5 cm x 4 cm. The underlying tissue was spongey when pressed. Staff member Q stated the area was new and was not there upon admission. She stated the injury was a DTI which would indicate damage to the underlying tissues but would be unable to determine the extent until the injury opened. - #9 - Right Great Toe: One new deep-tissue PUI [#9]. The injury was approximately 4.0 x 3.5 cm non-blanchable reddened area with a 0.3 cm x 0.3 cm center with intact, deep purple in color. Staff member Q stated the area was new and Staged as a DTI, meaning there would be additional damage to the underlying tissues, but would not be able to tell the extent until the area opened. - #10 - Right Shoulder: One new PUI [#10]. The injury was approximately 1.3 cm x 1.5 cm round non-blanchable reddened area with intact skin. Staff member Q stated the area was new and a Stage I. - #11 and #12 - Right posterior thigh: Two new PUIs. The first areas [#11] was approximately 1.5 cm x 1.5 cm round intact reddened non-blanchable area. The second injury [#12] was approximately 0.6 cm x 0.6 cm round intact reddened non-blanchable area. Both had the appearance of laying on plastic tubing. Staff member Q stated the two areas were new and a Stage I. She stated they may have formed from laying on the catheter tubing for an extended period of time. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 12/8/21 at 6:00 p.m., staff member A stated he had asked staff member P to meet on 12/8/21 between 2:00 and 3:00 p.m., to discuss her findings from her assessment of resident #15 on 12/7/21. This appointment did not happen but arranged for an appointment with staff member O on 12/9/21. During an interview on 12/9/21 at 12:30 p.m., staff member O stated individuals, such as resident #15, were a high risk for the development of pressure ulcers. It would be important to attempt regular position changes and pressure relieving measures, as well as regular skin assessments to prevent the development of new pressure ulcer injuries. Staff member O stated the facility had a full-time nurse who provided wound care for the residents. He stated himself or staff member P should be notified of any new pressure ulcers in order to provide orders for the care of the wounds. He stated PUI which produce large amounts of drainage can worsen if the drainage was left to [NAME] in the wound. He stated regular catheter care should be provided for residents with indwelling Foley catheters to prevent the development of device related pressure injuries. He stated he was aware of two pressure injuries for resident #15, one on his sacrum and one on his hip. He stated he was not aware of the 12 new pressure ulcers. He stated staff member P assessed resident #15 on 12/7/21 and felt the pressure ulcers on his sacrum and ischium were improving. He stated new orders were placed for a wound clinic evaluation for resident #15. During an interview on 12/9/21 at 12:45 p.m., staff member Q stated she had not assessed resident #15's wounds or completed skin assessments for the resident in over three weeks. She stated she was not able to complete those duties because she had been working the floor. Review of resident #15's Discharge Orders from the discharging facility, dated 9/10/21, showed, Discharge Patient As directed. Comments: Patient DC to the [Facility] 9/10 . Patient will need continued wound care with BID dressing change with dakins wet to dry. VAC can be re-applied as needed. Patient will need follow up with Ortho for MRI results, wound care, and plastic surgery . A review of the resident's medical record and admitting orders did not show a referral was made for Ortho for wound care and plastic surgery. Review of resident #15's Hospital Progress Note, dated 10/5/21, showed, Sacral decubitus ulcer: present at admit; associated with pressure/immobility with his underlying partial quadriplegia. Wound care RN consulting. Concerned incontinence may hinder healing of his sacral decub, especially after discharge from hospital long-term. [follow-up] on add[itional] wound care rec[ords]. [every 2 hours] turns. Will need close monitoring of skin with outpatient wound care clinic follow-up after discharge. Resident #15 was discharged from the hospital back to the facility on [DATE]. No orders were placed for a referral to the wound care clinic until 12/8/21. Review of resident #15's Care Plan, with an initiation date of 10/13/21, showed: - Focus: I was readmitted from a hospital stay, with 2 new SDTI on my right ischuim. I am also returning with stage IV pressure ulcer to my sacrum, present from my original admission. I am at risk for non healing pressure ulcer related to pain, paraplegia, weakness COPD, and spinal fusion. One SDTI has resolved. - Goals: I want my pressure ulcer to be free from infection and show improvement over the next review. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Interventions: Dietician to review nutritional interventions for healing Date Initiated: 10/13/202. I do not like to turn off of my left side Date Initiated: 12/07/2021. Q weekly pressure ulcers assessment. Date Initiated: 10/13/2021. Report any signs or symptoms of infection eg foul odor, increased drainage, wound increased in size. Date Initiated: 10/13/2021. See TAR for current dressing orders. Date Initiated: 10/13/2021. [sic] Review of resident #15's TAR, dated October 2021, showed wound orders to Coccyx [sacrum]: Cleanse with wound cleanser and pat dry, Calazime to wound edge, apply silver powder to wound base, apply alginate, and secure with foam dressing. every morning and at bedtime for Wound Care. Review of the October TAR showed the treatments were not completed on October 1st, 12th, 13th, 25th, and 26th; and were only completed one time on October 2nd, 3rd, 14th, 15th, 19th, 21st, 22nd, 30th, and 31st. - Review of resident #15's TAR, dated October 2021, did not show orders related to the newly identified ischial Pressure Ulcer on resident #15's Ischium that was identified on re-admission on 10/12/21. Review of resident #15's Skin Integrity Report, dated 10/12/21 showed: - Right Ischium (outer) present at admission on 10/12/21 intact, deep-purple 4.0 cm x 2.0 cm pressure ulcer. - On 10/19/21 showed, intact, deep-purple 3.5 cm x 2.0 cm. - On 10/21/21 showed, resolved. Review of resident #15's Skin Integrity Report, dated 10/12/21, showed: - Right Ischium (inner), intact, deep-purple SDTI, assessed on 10/12/21, 10/19/21, and 10/26/21. - On 11/2/21 the SDTI on right Ischium opened to show, slough on edges and 90% necrotic eschar at 3.4 cm x 4.0 cm. Assessed on 11/9/21, 11/16/21, and 11/23/21, and on 11/30/21, the right Ischium wound showed, 75% slough, 25% granulation at 3.5 cm x 3.6 cm. There were no further assessments of the right Ischium PUI from 11/23/21 to 12/7/21 (14-days). Review of resident #15's TAR, dated November 2021, showed: - Right ischium: Cleanse area with wound cleaner and pat dry. Apply layer of calazime to wound edges, then pack with 1/4 inch packing gauze soaked in di-daksol and secure with border Gauze. DO NOT USE FOAM. everyday shift for skin intergrity -D/C Date- 12/06/2021 [at] 1958. Review of the TAR showed the treatments were not completed on 11/12/12, 11/13/21, 11/14/21 and 11/27/21. - Right ischium: Cleanse area with wound cleaner and pat dry. Skin prep around wound and allow to dry completely, apply a thin layer of santyl ointment and cover with a foam dressing. everyday shift for skin intergrity -D/C Date-11/11/2021 [at] 1441. [sic] A review of the TAR showed the treatments were not completed on 11/3/21, 11/5/21 and 11/9/21. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Coccyx [Sacrum]: Cleanse with wound cleanser and pat dry, Calazime to wound edge, apply silver powder to wound base, apply alginate, and secure with foam dressing. every morning and at bedtime for Wound Care. [sic] A review of the TAR showed the treatments were not completed on, November 3rd, 5th, 9th, 14th, and 27th; and only completed one time on November 8th, 12th, 13th, 15th, 16th, 17th, 18th, 19th, 20th, 21st, 22nd, and 26th. Review of resident #15's TAR, dated December 2021, showed: - Coccyx [Sacrum]: Cleanse with wound cleanser and pat dry, Calazime to wound edge, apply silver powder to wound base, apply alginate, and secure with foam dressing. every morning and at bedtime for Wound Care [sic]. A review of the TAR showed the treatments were only completed one time on 12/1/21 and 12/5/21. -Right ischium: Cleanse area with wound cleaner and pat dry. Apply layer of calazime to wound edges, then pack with 1/4 inch packing gauze soaked in di-dak-sol and secure with border Gauze. DO NOT USE FOAM. everyday shift for skin intergrity -D/C Date - 12/06/2021 [at] 1958. [sic] Review of resident #15's Order Summary Report, dated 9/10/21 to 12/7/21, showed: - Barrier Cream or Equivalent to affected area every Shift and PRN Notify MD of any abnormalities PRN as needed for Prophylaxis for 60 Days. - BLE: Apply moisturizing lotion to areas r/t dry skin. Report any changes to provider/Wound Nurse. every day and night shift for Skin integrity. [sic] - Monitor all scratches to extremities and torso for changes and report to wound nurse if open. every day and night shift for skin integrity. Skin prep (or equivalent) to bilateral heels q shift and PRN for 2 weeks Notify MD of any abnormalities PRN every shift for Preventative Care for 14 Days. [sic] A request for a copy of the facility's Policy and Procedure for Pressure Ulcer Management was requested on 12/8/21 and again on 12/9/21. The requested information was not provided by 12/10/21 at 6:00 p.m. 33796 2. Resident #19 During an observation and interview on 12/7/21 at 1:10 p.m., resident #19 attempted to raise her right hand to show her contracture. She stated it hurt all the time, but stated her bigger concern was the sore on her right foot. During an interview on 12/7/21 at 3:20 p.m., staff member Q stated she had looked at resident #19's foot last week, and it was a pressure injury from the foot board on her bed. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of resident #19's electronic health record showed no documentation of staff member Q's wound assessment. During an observation on 12/8/21 at 9:45 a.m., staff member BB removed the dressing on resident #19's right foot. She stated it had begun as a very large blister. She stated she could not stage it, but the wound nurse would do that. The area was approximately 3 inches long with a 2 inch black center on the bottom of her right foot. During an observation on 12/8/21 at 3:20 p.m., resident #19's feet were both pressed against the footboard. During an observation and interview on 12/8/21 at 4:20 p.m., staff member E stated resident #19's pressure injury on the right foot had been identified at some point, but not reported to nursing staff. Staff member E removed the dressing from resident #19's right foot, and stated the pressure injury was Unstageable, because it had necrotic tissue covering the 2 inch black center portion. She stated the footboard should have been removed. Review of resident #19's Physician Orders, dated 10/22/21, showed to cover the bottom of resident #19's right foot with an ABD Pad and secured it with Kerlix. Review of resident #19's Nursing Progress Note, dated 10/23/21, showed Notify wound nurse if blister opens. Review of resident #19's electronic health record did not include documentation notifying the wound nurse of the blister opening. Review of resident #19's Nursing Progress Note, dated 10/24/21, showed the blood blister remained intact to the bottom of the right foot. Review of resident #19's Nursing Progress Note, dated 10/28/21, showed the physician had rounded on 10/27/21, and wrote orders for a boot related to the right heel blister. The type of boot was not specified. During an observation on 12/8/21 at 4:30 p.m., resident #19 did not have a boot on the right foot, and no boot was found in the room. Review of resident #19's Nursing Progress Note, dated 10/28/21, as a 'late entry', showed large open blister to the right foot with minimal brown drainage. Review of resident #19's Skin Evaluation, dated 10/21/21, showed no current skin issues. Review of resident #19's SBAR Communication Form, dated 10/22/21, showed the resident had a 6.0 cm x 6. 0 cm blood blister. The resident is not aware of how it happened. Review of resident #19's electronic health record did not include a pressure injury assessment for 10/22/21. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of resident #19's Skin Only Evaluation Form, dated 10/28/21, showed an open blister to the right foot arch and showed, Treatment in place. Review of resident #19's Skin Only Evaluation Form, dated 11/04/21, showed, Dressing to foot intact, did not remove. Dressing change to be done in the evening. Review of resident #19's Skin Only Evaluation Form, dated 11/11/21, showed, Continues with wound to bottom of right foot. Dressings changed at night by night shift. Writer did not remove dressing. Review of resident #19's Skin Only Evaluation Form, dated 11/18/21, showed the dressing to the right foot arch remained intact. Review of resident #19's Skin Only Evaluation Form, dated 11/25/21, showed the right foot dressing remained intact. Review of resident #19's Skin Only Evaluation Form, dated 12/09/21, showed No new skin abnormalities. Review of resident #19's Care Plan, not dated, showed the resident had a blood blister to the bottom of her right foot. The interventions included avoid pressure to the blister, and do not use foot board. During an interview on 12/9/21 at 12:20 p.m., staff member MM stated it was not possible for one CNA to provide adequate care for the 22 residents on the 200 hall.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 35356 IMMEDIATE JEOPARDY On 12/9/21 at 12:28 p.m., the facility administrator was notified that an Immediate Jeopardy existed in the area of F689- Free of Accidents and Hazards. Severity and Scope identified for the Immediate Jeopardy was identified to be at the level of K, and upon removal of immediacy will be lowered to an E. The surveyors exited the facility without a plan to remove the immediacy. The facility submitted a plan alleging the removal of immediacy would be completed by the end of the day on 12/17/21. The plan was accepted by the State Survey Agency, and the immediacy verified to have been removed as of 12/17/21, during an onsite revisit completed on 12/22/21. Based on observation, interview, and record review, the facility failed to provide a safe and secure environment with sufficient supervision to prevent smoking related injury for 4 (#s 16, 17, 18, and 20) of 21 sampled residents, which resulted in cigarette burns on the resident's gloves for 1 (#20) resident, and created potential for harm related to temperatures below freezing and an unsafe environment for 1(#16). Findings include: Review of facility's Policy and Procedure, dated 12/6/21, showed, Non Smoking building at this time. Review of the facility policy and procedure titled, Smoking, showed: - 2. Each resident will be evaluated on admission to determine if he or she is a smoker or non-smoker. If a smoker, the evaluation will include: .e. All smokers will be supervised during smoking without exception . - 10. The staff shall consult with the Attending Physician and the Director of Nursing to determine if safety restrictions need to be placed on a resident's smoking privileges based on the Safe Smoking Evaluation . - 15. All smoking materials will be kept in a lock box at the adjacent nurses' station. Residents who smoke will turn in all smoking materials and paraphernalia to staff in charge when leaving the smoking area. No resident may have or keep any smoking materials or paraphernalia, including cigarettes, tobacco, lighters, matches, etc. in their possession outside the designated smoking areas . - 21. Staff members and volunteer workers are not permitted to purchase and/or provide any smoking articles for residents. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an observation and interview on 12/7/21 at 3:30 p.m., resident #17 was outside in her wheelchair in the facility's courtyard smoking a cigarette. There were no staff outside to supervise. Staff were walking past the window which looks out into the courtyard, but did not stop to assist resident #17. Resident #17 stated she had her own cigarettes and lighters that she kept in her purse in her room. She said staff did not come out with her while she smoked. There were ashes on her pants. Resident #16 then entered the courtyard and sat down next to resident #17. Resident #16 was wearing an elopement alarm on her wrist, and she did not have on a smoking apron. Resident #16 stated she would come outside and bum a cigarette from whoever was outside. Resident #17 then handed resident #16 a light, half smoked cigarette, which resident #16 finished smoking. Resident #16 then tossed the lit cigarette into an open garbage receptacle in the courtyard. The receptacle had copious amounts of dried leaves and loose paper debris, and multiple cigarette butts in the bottom of the receptacle. Resident #16 then went back inside. Resident #17 stayed outside and lit another cigarette. Staff did not stop to intervene or supervise. The courtyard was littered with cigarette butts covering the ground around the smoking area and in the landscaping under the windows. A review of resident #17's EHR did not show a Safe Smoking Evaluation was completed. A review of the facility's Smoking Cessation list, showed resident #17 was listed for a nicotine patch. A review of resident #16's Smoking- Safety Screen, dated 5/21/21, showed the resident had cognitive loss, and supervised smoking per company policy with smoke apron during authorized times. During an interview on 12/7/21 at 3:45 p.m., staff member E stated the facility had changed their smoking policy to a no smoking policy. Previously, residents who smoked were assessed for safety, provided aprons, and supervised by a staff member during designated times. She stated all smoking supplies were to be kept in a lock box at the nurses' station. She said since the facility became a no smoking facility, residents can go outside to smoke whenever they want, and they have not been supervised. She stated the facility did not have enough staff to supervise the residents every time they go outside to smoke. She said she told administration about her concerns with resident smoking unsupervised, but they did not respond. During an observation and interview on 12/8/21 at 1:48 p.m., resident #17 was outside in the facility's courtyard, sitting in her wheelchair smoking a cigarette. She had a small purse on her seat which was open and had a box of Marlboro Reds and a lighter. She stated the staff do not come out with her when she smokes. At that time, resident #18 entered the courtyard in her wheelchair and light a cigarette. Resident #18 stated she had her own smoking supplies and would come outside to smoke when she wanted. She stated she was not supervised when she was outside. The garbage receptacle had not been emptied and still had dry leaf and paper debris, as well as smoked cigarettes. The ground was still littered with cigarette butts. Several staff members walked by the bay of windows looking out into the courtyard while resident #s 17 and 18 were outside smoking and did not stop to supervise them. Review of resident #18's Smoking Safety Evaluation, dated 12/1/21, showed, Supervision will be required for all Residents during designated smoking times. During an interview on 12/8/21 at 2:00 p.m., staff member BB stated she was aware of the residents outside smoking unsupervised. She stated there were not enough staff to supervise residents when they went outside to smoke. The facility was supposed to be non-smoking. She stated she did not store any of the residents' smoking supplies at the nurses' station. (continued on next page)

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	275026	A. Building B. Wing	12/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ivy at Great Falls	1130 17th Ave S Great Falls, MT 59405

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 12/8/21 at 2:05 p.m., staff member AA stated they used to have aprons and the smoking supplies were kept in a box at the nursing stations. When COVID began, the facility decided to become non-smoking, so staff quit going outside to supervise the residents. She stated they had discussed opening the smoking back up but did not have the staff to do so. She stated the staff have notified administration of their concerns but were afraid to do anything else for fear of reprisal. She stated staff walk by the courtyard all day long and they do not intervene. During an interview on 12/8/21 at 2:15 p.m., staff member F stated they were aware of the residents going outside to smoke unattended. He stated they did not have enough staff to accommodate the scheduled smoking times. During an interview on 12/8/21 at 3:46 p.m., staff member A stated the facility was non-smoking. He stated when the facility discontinued their smoking policy, they started those residents who smoked on a smoking cessation program. He stated a safe smoking assessment should be completed on all residents at the time of their admission and repeated if they smoke. He stated there were smoking disposal receptacles in the courtyard which were safe to extinguish a cigarette. He stated he was not aware of the amount of cigarette butts on the ground or in the open garbage can. He stated residents should be supervised if they were outside smoking on facility property. Staff member A said it could be very dangerous to leave cognitively impaired residents unsupervised while smoking. During an observation and interview on 12/8/21 at 4:30 p.m., resident #20 was in the outside courtyard, sitting in his wheelchair. The temperature was 39 degrees Farenheit with a cold wind. Resident #20 was smoking a cigarette. He was wearing a pair or old cloth gloves with multiple holes. He was holding the lit cigarette in his left gloved hand and the cigarette was close to the material of the glove. The resident removed his gloves to show a large brown/yellow burn on the inside of the index finger of the left glove. When he removed his hand from the glove, there was a dark yellow stain on the inner aspect of his left index finger. Resident #20 stated he did not recall burning his gloves and did not think he had burned his hand. There were ashes on his lap. Resident #16 entered the courtyard wearing a thin shall and was barefoot. She had on her elopement wrist alarm. She sat down and asked resident #20 for a cigarette. Resident #20 did not respond. Resident #16 then started to sort through old cigarette butts on the ground. There were no staff around to supervise the residents. Review of Resident #20's Smoking - Safety Screen, dated 7/13/21, showed, safe to smoke with supervision. During an observation on 12/8/21 at 5:03 p.m., it was dark outside, and dark in the courtyard. There were no lights on in the courtyard. It was 30 degrees Farenheit outside and starting to snow. Resident #18 was smoking in the courtyard. Resident #16 was also sitting in the courtyard in her bare feet and had a thin shall on over her t-shirt. She was wearing her elopement guard. Staff member I walked by the bay of windows that looked out into the courtyard and did not stop to supervise the two residents. Resident #18 and #16 then entered back into the facility. When resident #16 walked through the door, the elopement alarm sounded. It alarmed for five minutes before a staff member responded. Staff member F turned off the alarm and went outside to check if there was anyone outside because it was too dark to see into the courtyard. During an interview on 12/8/21 at 5:13 p.m., staff member I stated she did not see anyone outside in the courtyard when she walked by earlier. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 12/8/21 at 5:18 p.m., staff member A stated staff member I was to be watching for residents when they go outside to smoke. He stated the elopement alarm was re-activated on the door which leads into the courtyard. Staff member A stated he was not aware that resident #16 was outside again in her bare feet without staff supervision. He stated he was surprised she made it outside without the alarm activating. Staff member A then called staff member N to inquire about the elopement alarm. Staff member N stated he re-activated the elopement alarm on the courtyard door while resident #16 was still outside.

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 35356 IMMEDIATE JEOPARDY On 12/9/21 at 12:28 p.m., the facility administrator was notified that an Immediate Jeopardy existed in the area of F690 - Catheter Care. Severity and Scope identified for the Immediate Jeopardy was identified to be at the level of J, and upon removal of immediacy would be lowered to a G. The surveyors exited the facility without a plan to remove the immediacy. The facility submitted a plan alleging the removal of immediacy would be completed by the end of the day on 12/17/21. The plan was accepted by the State Survey Agency, and the immediacy verified to have been removed as of 12/17/21, during an onsite revisit completed on 12/22/21. Based on observation, interview, and record review, the facility failed to ensure and assessment for removal of a urinary indwelling catheter was completed after admission, and failed to ensure appropriate treatment an services were provided to prevent urinary injury for 1 (#15) of 21 sampled residents. The extent of this deficient practice resulted in a indewlling catheter related pressure injury of the glans penis and hospitalization for the development of an MDRO UTI, acute kidney injury, and sepsis for 1 (#15) resident. Findings include: During an observation and interview on 12/6/21 at 2:37 p.m., resident #15 was laying in his bed on his right side in a contracted fetal position. There was a strong urine odor in the room. There was an uncovered catheter bag with 100 ml of dark orange fluid in the bag, and tubing was cloudy with a thick white cloudy sediment in the tubing. On the floor beneath his catheter bag there was a large puddle of yellowish/brown fluid that was dried around the outer perimeter, and wet at the center. The resident stated, No one's going to help, they don't care, I don't care, shit happens. Afterwards he covered his eyes with his right hand and refused to answer any further questions. During an interview on 12/6/21 at 3:58 p.m., staff member R stated she had just started working at the facility on Sunday 12/5/21. She stated there were no treatment orders in resident #15's medical record for catheter care. (continued on next page)

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an observation and interview on 12/7/21 at 9:00 a.m., staff members S and DD, assisted staff member Q with wound care for resident #15. The resident had a loose bowel movement and was provided peri-care. During the peri-care the staff member Q started to clean the resident's scrotum. When the scrotum was repositioned the resident's penis with an indwelling Foley catheter, was tucked under his scrotum. His penis and the tubing were peeled away from the resident's scrotum revealing two quarter-sized bright red macerated blisters on the resident's scrotum. The base of the resident's base had a bright red swollen area of macerated tissue. The glans of the resident's penis had two separate medical device related injuries to the mucosal tissue around the insertion site of the catheter. The first mucosal membrane injury was at the 12 o'clock position on top of the glans. The injury was a full-thickness mucosal tissue injury, approximately the size of a dime, with a straight line of eschar tissue down the center of the injury. The catheter tubing was not anchored to prevent pressure relief around the glans. The tubing was pulled tight and adhered to the tissue from where it exited the resident's urethra. The tubing was peeled upwards revealing a second full-thickness mucosal injury at the 6:00 o'clock position of the glans approximately the size of a penny. The resident's urinary meatus under the tubing of the second injury had split open the tissue around the urinary meatus, revealing a one cm deep laceration into the resident's urethra. The tissue around the second MDRPI had a thick glob of grayish-green and red exudate which could not be cleared away with a dry gauze pad. The entry of the resident's urethra was bright red and inflamed, when staff cleaned the tubing the urethra started to actively bleed bright red blood around the tubing. The fluid inside the catheter tubing which was exiting the urethra had a thick white purulent collection of fluid. The genitals and groin had a thick white cheesy substance which staff member Q had difficulty wiping off. The tissue underneath was bright red, swollen with areas of maceration and excoriation. There was a strong smell of stale body odor. During an interview on 12/7/21 at 9:00 a.m., staff members S and Q stated they were not aware of the injuries around the resident's genitals related to his catheter. Staff member S stated she had not noticed anything when she provided the resident a bed bath on Thursday. She said she did not usually work the hallway which the resident resided, so she did not regularly perform catheter care. She stated the catheter care should be completed at least every shift and any abnormal findings reported to the nurse. Staff member Q stated she was not aware of the new injuries to the resident's genitals, and stated they appeared to be from the catheter tubing creating a pressure injury. She said the resident was admitted to the facility with an indwelling catheter related to neurogenic bladder due to paraplegia in early September 2021. She stated he was also readmitted back to the facility with the indwelling urinary catheter on 10/12/21. She said the resident's catheter should have been anchored to prevent it from being pulled tight on the skin of the penis. Staff member Q stated catheter care should be provided at least every shift. Resident #15 stated he was not aware of the new wounds to his genitals. During an interview and observation on 12/7/21 at 9:00 a.m., resident #15 stated he was not aware of the new catheter related wounds to his genitals. He then placed his hand over his eyes and turned his head away. During an interview on 12/7/21 at 9:55 a.m., staff member C stated all indwelling urinary catheters should be immediately assessed for removal when a resident was admitted with an indwelling urinary catheter. She stated indwelling catheters should be assessed and care provided at least every shift, and concerns identified reported to the nurse. She stated there were a number of risks associated with long-term use of indwelling catheters to include infections and trauma. (continued on next page)

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 12/7/21 at 2:50 p.m., staff member U stated he believed he had provided catheter care for resident #15. He could not remember any concerns with surrounding tissue or with the drainage of the catheter bag. Review of resident #15's Order Summary Report with active physician orders as of 10/12/21, did not include indwelling Foley catheter orders for care of the medical device. During an observation and interview on 12/7/21 at 2:00 p.m., resident #15's catheter bag was attached to the bed frame and was uncovered. There was 150 ML of dark-orange fluid in the collection bag. The catheter tubing was not anchored to prevent pressure injury from the device. Staff member F stated it was the expectation for the CNAs to perform catheter care and peri-care every shift. They should empty the urinary collection bag every shift, or as needed. They were to report any abnormal findings to the nurse, and the nurse should assess the situation immediately. During an interview on 12/8/21 at 6:00 p.m., staff member A stated he had asked staff member P to meet on 12/8/21 between 2:00 and 3:00 p.m., to discuss her findings from her assessment of resident #15 on 12/7/21. This appointment did not happen but arranged for an appointment with staff member O on 12/9/21. During an interview on 12/9/21 at 12:30 p.m., staff member O stated residents should be assessed for necessity of an indwelling urinary catheter upon admission. Should the catheter be deemed necessary, the rationale would be documented. He stated catheter care orders should be implemented and followed and the resident assessed for any potential complications such as infection. He stated resident #15 had a neurogenic bladder secondary to his paraplegia and multiple pressure ulcer injuries which would require the use of an indwelling catheter. He stated if the catheter tubing was not properly anchored it could cause trauma of the underlying tissues. Improper care of the catheter could cause increased risk for an infection, but most residents with long-term catheterization were colonized and may not necessary develop an active infection. He stated if a resident were to need long-term urinary catheterization, usually greater than three months, an evaluation for a suprapubic catheter would be recommended. Staff member O stated in resident #15's case, a suprapubic catheter may be a better option. Review of resident #15's Discharge Orders from the discharging facility, dated 9/10/21, showed, Discharge Patient As directed. Comments: Patient DC to the [Facility] 9/10 . He will need daily Foley care. With change of Foley q month . [sic] A review of resident #15's Physician Order Summary, dated 9/10/21 to 12/8/21, did not show indwelling urinary catheter orders for care were entered until 12/8/21. Review of resident #15's TARs from 9/1/21 to 10/31/21, did not show orders were initiated for catheter care of resident #15's indwelling urinary catheter. Review of the resident's EHR showed he was hospitalized from 10/5/21 to 10/12/21 for a complicated urinary tract infection, severe sepsis, and acute kidney injury related to long-term use of indwelling urinary catheter. Review of resident #15's Hospitalist Progress Note, dated, 10/7/21, showed: -Complicated urinary tract infection: With history of chronic indwelling Foley catheter - not exchanged since 9/7. See severe sepsis below. (continued on next page)

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Severe Sepsis: present at admit with tachycardia, fever, AKI, suspected source - UTI in setting of chronic Foley (although has complicated recent ID hx including endocarditis with septic emboli to spine as well as covid infection). bid and urine cx's sent from ED and pending. Foley exchanged 10/6. Cont abx - will adjust based on results of ex ID and sens. (cont vanco til determine sens of enterococcus) wean IVFs as po intake improves. strict i/o [sic]. - Acute kidney injury: in setting of chronic Foley use with underlying neurogenic bladder. Most concerned for prerenal disease with hypovolemia vs septic ATN. renal fx improved to 0.6 with IVFs. Plan: cont IVF. Avoid use of nephrotoxic meds; need to replace Foley with new one now (last changed 1 mo ago). [sic] Review of resident #15's Hospital Discharge Orders, dated 10/11/21, showed, Foley Care Q shift . Diagnosis: E. Coli and Enterococcus UTI. Review of resident #15's TAR and Orders from 10/11/21 to 12/7/21, did not show orders or care were provided for resident #15's Foley catheter until 12/8/21. Facility developed avoidable MDR mucosal pressure ulcer injuries to the resident's scrotum and glans penis were identified on 12/7/21. Review of resident #15's Care Plan, with an initiation date of 9/10/21, did not address the resident's indwelling urinary catheter. A request was submitted for the facility's policy and procedure for indwelling urinary catheter care on 12/8/21 and again on 12/9/21, no documents were provided by the end of the survey.

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 33796 Based on observations, interview, and record review, the facility failed to identify and prevent a severe weight loss of 7.6 percent in one month for 1 (#6) of 2 sampled residents. Findings include: During an interview on 12/6/21 at 2:45 p.m., resident #6 stated the last time he had been weighed he was down to 113 pounds. He stated the food at the facility was really bad, and it was always cold. Resident #6 also said he had back pain most days. He said the cold food and pain did not help his appetite. During an observation on 12/8/21 at 9:20 a.m., a physician ordered juice supplement was not observed on resident #6's breakfast tray. Review of resident #6's physician order, dated 4/28/21, showed House Supplement juice at bkft and dinner to promote weight gain. Review of resident #6's breakfast meal ticket did not include the juice supplement. It showed 'Choice of Juice. ' Review of resident #6's physician order, dated 6/16/21, showed 'House Supplement.' No frequency was included in the order. During an observation and interview on 12/9/21 at 9:50 a.m., resident #6 was weighed by staff. He weighed 113.2 pounds. He stated he was concerned about his low weight, and was going to make an effort to eat more. He stated he did not receive house supplements. Review of resident #6's weight log showed he weighed 122.6 pounds on 12/1/21. During an interview on 12/9/21 at 9:55 a.m., staff member L stated he had not known resident #6 was having pain and food concerns. He also thought the resident appeared confused today. Resident #6's intake record was reviewed, and staff member L stated the resident had been eating 36 percent of his meals the last 5 days. Review of resident #6's dietary note, dated 12/9/21, showed the resident was agreeable to snacks, and liked cereal, and would 'request as he wants.' Review of resident #6's care plan showed it had not been updated with the cause of weight loss, personal preferences, and interventions, as written in the facility Nutritional Assessment Policy statement.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 33796 Based on observation, interview, and record review, the facility failed to identify and effectively manage daily back pain for 1 (#6) of 3 sampled residents. Findings include: During an interview and observation on 12/6/21 at 2:45 p.m., resident #6 stated his back pain was very bad. He received a daily Tramadol, but it was not enough. He stated, I have not seen a doctor since I got here. I go to my kid's house to take a bath, which helps with the pain. My heating pad helps too. He winced in pain with movement sitting on his bed. He stated it hurts the worst after he assisted his wife with her meals. The bending forward really hurts. The food here is really bad, and it is cold all the time. The last time I was weighed, I was down to 113 pounds. Resident #6 stated all his clothes disappeared, and now he does his laundry at his kid's house. Review of resident #6's Physician Orders, dated 3/1/21, showed an order for, Tramadol, 50 mg by mouth as needed for pain related to a compression fracture of the vertebra. bid [sic] Review of resident #6's 11/2021 MAR showed he received Tramadol once a day for 23 days. Fifteen of those days his pain was documented at an eight, nine, or 10. The HOURS column on resident #6's MAR showed PRN, but did not include the bid. During an interview on 12/8/21 at 3:30 p.m., staff member E stated resident #6 would have to ask for the second Tramadol. She stated she did not know when he could ask for the second Tramadol, since the order did not include any parameters. During an observation and interview on 12/8/21 at 8:45 a.m., resident #6 was sitting in a recliner in his wife's room. He winced in pain as he sat up. He stated he was not aware he could ask for a second Tramadol. That would probably help. Review of resident #6's Physician Note and Order, dated 2/26/21, showed the provider wrote, Pt with a lot of pain, but does not ask for pain med. Will schedule Tylenol and Naproxen for pain. Review of the physician order, dated 2/26/21, showed, acetaminophen 1000 mg po TID, and Naproxen 500 mg as needed. Review of resident #6's current Physician orders and MAR did not include the scheduled acetaminophen. Resident #6 had never requested the Naproxen. Review of resident #6's July 2021 MAR showed the resident was refusing the scheduled acetaminophen because he was going to receive steroid shots in his back and wanted to see if the shots would help. The acetaminophen was discontinued on 7/15/21. Review of resident #6's Quarterly MDS, with an ARD of 8/6/21, showed his pain assessment was not conducted because he was 'rarely or never understood.' During a phone interview on 12/8/21 at 2:04 p.m., NF3 stated she was very concerned about resident #6's pain, and it was difficult for her to watch him be in pain. She stated he did not have the personality or cognition to advocate for himself. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/9/21 at 9:50 a.m., staff member YY stated resident #6's pain was not managed well. She was not aware assisting his wife with meals was causing greater pain, or that he would prefer a bath. During an interview on 12/9/21 at 1:10 p.m., staff member I stated care conferences were only held annually and as requested. She stated she was not aware of resident #6's pain. She stated she would schedule a care conference for resident #6.

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35356 IMMEDIATE JEOPARDY On [DATE] at 12:28 p.m., the facility administrator was notified that an Immediate Jeopardy existed in the area of F725 - Sufficient Staffing. Severity and Scope identified for the Immediate Jeopardy was identified to be at the level of I, and upon removal of immediacy would be lowered to an F. The surveyors exited the facility without a plan to remove the immediacy. The facility submitted a plan alleging the removal of immediacy would be completed by the end of the day on [DATE]. The plan was accepted by the State Survey Agency, and the immediacy verified to have been removed as of [DATE], during an onsite revisit completed on [DATE]. Based on observation, interview, and record review, the facility failed to: a) Ensure adequate numbers of staff were available to provide resident care which resulted in the development of avoidable Unstageable and DTI pressure ulcer injuries for 2 (#s 15 and 19); b) Failed to provide a safe and secure environment with sufficient supervision to prevent smoking related injury for 4 (#s 16, 17, 18, and 20), which resulted in cigarette burns on resident's gloves for 1 (#20), and increased risk of injury and safety for these residents; c) Failed to ensure appropriate care was provided for 1 (#15) resident with an indwelling urinary catheter which resulted in an indwelling catheter related trauma of the genetalia and hospitalization for an MDRO UTI, sepsis, and acute kidney injury and psychosocial harm for fear he would die for 1 (#15); and, the facility failed to provide weekly/biweekly showers/bathing, answer call lights in a timely manner, perform ordered dressing changes, and meet resident ADL care needs, related to insufficient nursing staffing and/or lack of hot water, which was upsetting to the residents, and caused 1 (#5) resident to soil himself and feel degraded due to the lack of timely care. This deficient practice for the lack of or untimely ADL care affected 25 (#s 1, 3, 4, 5, 8, 13, 14, 24, 29, 30, 33, 34, 35, 36, 37, 38, 39, 40, 42, 44, 45, 46, 47, 48, 49) of 49 sampled residents. The cumulative effect of these findings had the potential to affect all residents residing at the facility due to the systemic failures identified during the survey. Findings include: 1. Avoidable Pressure Ulcers Resident #15 (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an observation and interview on [DATE] at 2:37 p.m., resident #15 was laying in his bed on his right side in a contracted fetal position. The room smelled of urine and body odor. The resident would only stare at the television and avoided eye-contact when being interviewed. Resident #15's hair was long and un-groomed. It had an appearance of being stringy and oily which was matted down in the back. The white pillowcase which he was laying his head had a wide yellow halo ring around his head. His face was unshaven, and his gray beard was long and stained brownish down his right chin. He was wearing a soiled hospital gown with a softball sized hard dried red stain on the right sleeve. His bedding around his right shoulder was also soiled with dried spills and food debris. He stated he could move his arm, demonstrating how he could pick up his mug, which contained an orange liquid, and attempt to drink from the cup. When he tipped the mug to attempt to drink from the straight straw the orange liquid spilled out of the hole of the straw and saturated his hospital gown on the right shoulder and sleeve. Resident #15 mumbled an expletive and put the mug back down without getting a drink. His left arm was contracted to his chest and his left hand was swollen with two plus pitting edema, with the fingers of his left hand tucked into his right armpit. He stated he could not move his left hand or fingers, attempting to do so without success and groaned in pain when attempting to move his fingers from under his right armpit. There were dried sticky red stains on the top of his left hand. He was covered with a sheet and was laying on a moist wrinkled draw sheet. His legs were bilaterally contracted up towards his stomach with his left leg laying over his right leg with a soiled pillow between his knees. He was wearing bilateral blue heel protectors' which were soiled. The Velcro and foot beds had white-yellow waxy skin flakes. There were no other pressure relieving modalities in place. His toenails were thick, yellow, and long, with some growing straight out past the toe, and others curled down the pad of the toes. He had thick yellow waxy build-up on the bottom, top, and between his toes bilaterally. He had an uncovered catheter bag with 100 ml of dark orange fluid in the bag, and tubing was cloudy with a thick white cloudy sediment in the tubing. On the floor beneath his catheter bag there was a large puddle of yellowish/brown fluid that was dried around the outer perimeter, and wet at the center. Resident #15 stated he had a cyst removed from his spine, and the surgeon severed his spinal column, paralyzing him. He said he was not able to reposition himself in bed and relied on staff to provide his care. He said he had two bed sores. When asked about his swollen hand and how his bed sores were healing he stated, No one's going to help, they don't care, I don't care, shit happens. Afterwards he covered his eyes with his right hand and refused to answer any further questions. During an interview on [DATE] at 9:45 a.m., staff member S stated she had not provided care for resident #15 in weeks due to lack of staff. Staff member S stated there were supposed to be three CNAs for that unit but most days they only had two aides to work the entire unit, and only one aide for others. She stated they were doing the best they could, but it was difficult to provide the necessary care when there was not enough help. During an interview on [DATE] at 9:50 a.m., staff member E stated she had not been able to provide necessary skin assessments for the residents due to limited staffing. She stated could not provide the necessary supervision of care provided when she herself had to work the unit by herself. She said she had to rely on the aides to report any new findings, but if they could not complete their cares, they would not be able to identify and report any new skin issues. She stated she had been telling administration since [DATE], they were in a staffing crisis, and the response she got back from administration and the governing body was there was no staffing concerns. Staff member E stated she was doing the best she could with the limited support from administration. Stating the facility had lost so many staff because they were being over-worked and were afraid for their own licenses due to the level of neglect in the facility. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an observation on [DATE] at 2:00 p.m., staff member Q and F completed a comprehensive head-to-toe skin assessment for resident #15. The following was a summary of the observed findings: - Right Ear: Two new Unstageable PUI. - Glans Penis: Two new full-thickness MDR Mucosal Pressure Ulcers Injuries. - Scrotum: Two new partial thickness MDR Mucosal Pressure Ulcer Injuries. - Perineum: One new Unstageable PUI. - Left Heel: One new deep-tissue PUI. - Right First Metatarsophalangeal Joint: One new deep-tissue PUI. - Right Shoulder: One new Stage I PUI. - Right posterior thigh: Two new Stage I PUIs. During an interview on [DATE] at 2:05 p.m., staff member R stated she had just started working at the facility on Sunday [DATE] and was not provided any orientation from the facility when she started. She stated she was the only nurse working the unit. There were supposed to be three CNAs, but one CNA was called away to work elsewhere in the facility. She said she had not been fully staffed on that unit since she started and the facility continued to accept new admits and she was having difficulty completing her required tasks. The staff member stated there were many residents on that unit who had skin integrity issues and new wounds and was worried for the residents of the facility were not being adequately cared for due to lack of available staff. She said she had not been able to assess all the residents on that unit for skin issues because she did not have the time, support from unit managers, or adequate staff to complete all her tasks. She stated she had worked in many facilities where staffing was a problem, but that this facility had a major problem. During an interview on [DATE] at 4:00 p.m., staff member Q stated she was responsible for providing wound care for all the residents. She stated due to the lack of staffing, she had been pulled from her duties as wound nurse to work nights on the floor for the last three weeks. She sated she had not been able to complete adequate wound care services or assessments for the residents. During an interview on [DATE] at 12:30 p.m., staff member O stated if the proper care and interventions were not implemented, residents could develop new and worsening pressure ulcers. He stated it would be important to provide adequate staffing to care for individuals such as resident #15 since there care needs were a higher acuity and required more skilled care. He stated he had been personally worried regarding the lack of staffing at the facility. When staffing is inadequate it was the care of the residents unfortunately, which suffered. During an interview on [DATE] at 9:00 a.m., resident #15 stated he had a friend who was in a nursing home and was put at the end of the hall and staff forgot about him. He said his friend died . Resident #15 stated he was worried that would happen to him, and why he did not like being so far down the hallway. He said it took too long for staff to bring his medications and other things that he quit asking. He stated he enjoyed all the staff that helped him, he felt they were just too busy. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Resident #19 During an observation and interview on [DATE] at 1:10 p.m., resident #19 stated her concern was the sore on her right foot. During an interview on [DATE] at 3:20 p.m., staff member Q stated she had looked at resident #19's foot last week, and it was a pressure injury from the foot board on the resident's bed. Review of resident #19's electronic health record showed no documentation of staff member Q's wound assessment. During an observation on [DATE] at 3:20 p.m., both resident #19's feet were pressed against the footboard of her bed. During an observation and interview on [DATE] at 4:20 p.m., staff member E stated the footboard should have been removed. During an interview on [DATE] at 10:36 a.m., staff member A stated he was the only CNA working the 200 hall for day shift. He stated the second CNA did not show up for work. During an interview on [DATE] at 3:30 p.m., staff member NN stated he was the only CNA working the 200 hall for the evening shift, because the second CNA had been pulled to another hall. He stated he had to provide care for 25 residents, and three needed assistance with their meals. For the complete findings for avoidable pressure ulcers see F686. 2. Indwelling Catheter Care During an observation and interview on [DATE] at 2:37 p.m., resident #15 was laying in his bed on his right side in a contracted fetal position. The room had a strong smell of urine. There was an uncovered catheter bag with 100 ml of dark orange fluid in the bag, and tubing was cloudy with a thick white cloudy sediment in the tubing. On the floor beneath his catheter bag there was a large puddle of yellowish/brown fluid that was dried around the outer perimeter, and wet at the center. The resident stated, No one's going to help, they don't care, I don't care, shit happens. Afterwards he covered his eyes with his right hand and refused to answer any further questions. Review of resident #15's Discharge Orders and Admission Assessment, showed the resident admitted to the facility from a long-term acute care hospital on [DATE]. He was discharged with daily Foley care, and to change Foley [every] month. A review of resident #15's Order Summary, dated [DATE] to [DATE], did not show indwelling urinary catheter orders for care were entered until [DATE]. Review of resident #15's TARs from [DATE] to [DATE], did not show orders were initiated for catheter care of resident #15's indwelling urinary catheter. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an observation and interview on [DATE] at 9:00 a.m., staff members S and DD, assisted staff member Q with wound care for resident #15. The resident's penis with an indwelling Foley catheter, was tucked under his scrotum. His penis and the tubing were peeled away from the resident's scrotum revealing two quarter-sized bright red macerated blisters on the resident's scrotum. The glans of the resident's penis had two separate injuries to the mucosal tissue around the insertion site of the catheter. The catheter tubing was not anchored to prevent pressure relief around the glans. The tubing was pulled tight and adhered to the tissue from where it exited the resident's urethra. The entry of the resident's urethra was bright red and inflamed, when staff cleaned the tubing the urethra started to actively bleed bright red blood around the tubing. The fluid inside the catheter tubing which was exiting the urethra had a thick white purulent collection of fluid. The genitals and groin had a thick white cheesy substance which staff member Q had difficulty wiping it clean. During an interview on [DATE] at 9:00 a.m., staff members S and Q stated they were not aware of the injuries around the resident's genitals from the catheter. Staff member S stated she had not worked with resident #15 in weeks, and there had only been one aide to work his side of the unit. She stated there were many days they did not have enough staff to complete the required cares. Staff member Q stated she was unaware of the new injury to the resident's genitals. She stated it appeared to have developed due to lack of catheter and peri-care, and improper anchoring of the catheter tubing. Staff member Q said she had not been able to provide skin assessments for the residents since she had to work nights on the floor, for the last three weeks due to lack of available staff. During an interview on [DATE] at 9:55 a.m., staff member C stated they were trying to hire new staff but no one wants to work. During an interview on [DATE] at 2:50 p.m., staff member U stated he was not aware of the injury to resident #15's genitals related to his catheter. Staff member U stated he was trying to manage all the necessary care and services for the residents on that unit but it was difficult when he was the only CNA working the entire unit. Stating it had been like this for a long time now. He had been working many hours of overtime every pay period just to try and help the residents. During an interview on [DATE] at 2:05 p.m., staff member R stated she had just started working at the facility on Sunday, [DATE]. She had not been provided orientation or supervision for the facility. She stated she had been working short-staffed on the unit since Sunday. She said she had a new admit Monday and two new admits the following days. She stated she could not keep up with completing the new admission services and continue to provide adequate care for all the residents on the unit. She stated she could now understand why admission orders were not entered. She stated she felt overwhelmed by the responsibilities and did not feel there was adequate oversight support. During an interview on [DATE] at 2:50 p.m., staff member U stated he was trying to manage all the necessary care and services for the residents on that unit, but it was difficult when he was the only CNA working the entire unit. Staff member U stated it had been like this for a long time now. Staff member U had been working many hours of overtime every pay period just to try and help the residents. Review of resident #15's Hospital Discharge Orders, dated [DATE], showed, Foley Care Q shift . Diagnosis: E. Coli and Enterococcus UTI. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of resident #15's TAR and Physician Orders from [DATE] to [DATE], did not show orders or care were provided for resident #15's Foley catheter until [DATE]. Facility developed avoidable MDR mucosal pressure ulcer injuries to the resident's scrotum and glans penis were identified on [DATE]. Review of resident #15's Care Plan, with an initiation date of [DATE], did not address the resident's indwelling urinary catheter. During an interview on [DATE] at 12:30 p.m., staff member O stated residents should be assessed for necessity of an indwelling urinary catheter upon admission. For the complete findings for indwelling urinary catheter care see F690. 3. Smoking Supervision During an observation and interview on [DATE] at 3:30 p.m., resident #17 and #16 were outside in the facility courtyard smoking unsupervised by staff. During an interview on [DATE] at 3:45 p.m., staff member E stated the facility had changed their smoking policy to a no smoking policy. Previously residents who smoked were assessed for safety, provided aprons, and supervised by a staff member during designated times. She said since the facility became a no smoking facility, residents can go outside to smoke whenever they want, and they have not been supervised. She stated the facility did not have enough staff to supervise the residents every time they go outside to smoke. She said she told administration about her concerns but they did not do anything. During an observation and interview on [DATE] at 1:48 p.m., resident #17 and #18 were outside in the facility courtyard smoking, and unsupervised by any staff. During an interview on [DATE] at 2:00 p.m., staff member BB stated she was aware of the residents outside smoking unsupervised. She stated there was not enough staff to supervise residents when they went outside to smoke. The facility was supposed to be non-smoking. She stated the administration knew about the residents smoking unsupervised and have not intervened. During an interview on [DATE] at 2:05 p.m., staff member AA stated the facility decided to become non-smoking, but residents continued to go outside and smoke anyway. She said there were not enough staff to go out with the residents every time they went out to smoke. She stated staff, including administration, walk by the courtyard all day long and they do not intervene. During an interview on [DATE] at 2:15 p.m., staff member F stated they were aware of the residents going outside to smoke unattended. He stated they did not have enough staff to accommodate even the previous scheduled smoking times. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on [DATE] at 3:46 p.m., staff member A stated the facility was non-smoking. He stated when the facility discontinued their smoking policy, they started those residents who smoked on a smoking cessation program. He stated residents should be supervised if they were outside smoking on facility property. Staff member A said it could be very dangerous to leave cognitively impaired residents unsupervised while smoking. Staff member A stated he was not fully aware of the situation with the residents smoking unsupervised by staff. He said he had been working between two facilities and was not always at the building to oversee everything. During an observation and interview on [DATE] at 4:30 p.m., resident #20 was in the outside courtyard smoking unsupervised. The temperature was 39 degrees Farenheit with a cold wind. He was wearing a pair or old cloth gloves with multiple holes. There was a brown/yellow burn with a blackened burn hole in the center of the stain on the inside of the index finger of the left glove. When he removed his hand from the glove, there was a dark yellow stain on the inner aspect of his left index finger. Resident #16 entered the courtyard wearing a thin shall and was barefoot. She had on her elopement wrist alarm. Resident #16 then started to sort through old cigarette butts on the ground. There were no staff around to supervise the residents. During an observation on [DATE] at 5:03 p.m., it was dark outside, and there were no lights on in the courtyard. The temperature outside was 30 degrees Farenheit, and it was starting to snow. Resident #18 was smoking in the courtyard. Resident #16 was also sitting in the courtyard with bare feet and the resident had a thin shall on over her t-shirt. She was wearing her elopement guard. Staff member I walked by the bay of windows that looked out into the courtyard and did not stop to supervise the two residents. Resident #18 and #16 then entered back into the facility. When resident #16 walked through the door, the elopement alarm sounded. It alarmed for five minutes before a staff member responded. Staff member F turned off the alarm, and went outside to check if there was anyone outside because it was too dark to see into the courtyard. During an interview on [DATE] at 5:13 p.m., staff member I stated she did not see anyone outside in the courtyard when she walked by earlier. For complete findings regarding smoking supervision see F689: Accidents and Hazards 4. Facility Assessment A request was submitted on [DATE], [DATE] and [DATE], for a copy of the facility's comprehensive Facility Assessment. Review of an email regarding the requested Facility Assessment, from staff member B on [DATE] at 10:30 a.m., after the survey, showed, No, I am waiting to hear back from [staff member A] to tell me where they are . A review of the Facility Assessment, received on [DATE] at 11:23 a.m., showed: ABC-Nursing and Rehab Facility Assessment, Continuation of Facility Assessment from [DATE]. The assessment provided was not for the correct facility and it was not current. 5. Lack of Administrative and Governing Body Oversight and Response (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on [DATE] at 2:15 p.m., staff member E stated tearfully that the facility had been understaffed since [DATE]. She said staff were worn out and tired, and some were afraid for their licenses, so they quit. Other staff are working overtime and becoming exhausted. She stated she was afraid for the safety and health of the residents. She said because of the limited staffing, care and services were not able to be completed because there was not enough staff to do everything. She said most days, for the last several months, there has only been one CNA and one nurse to work the 600 Unit. She stated the 600 Unit had high acuity residents with many of those residents being bariatric and needed two person-assist for cares. She stated there were often times they either provided unsafe care, or no care at all because there is not enough staff to complete the workload. She stated she had sent emails to staff member A, and the corporate office, sharing her staffing concerns. She said she was told there was no problem with staffing. She said she had worked greater than 60 hours in some weeks trying to provide the care the residents deserved. Staff member E stated they were so short staffed, but administration kept allowing admissions. During an interview on [DATE] at 2:35 p.m., staff member U stated there was not enough staff to provide care for the residents at the facility. He stated CNAs were constantly being pulled to other units, leaving the 600 Unit short. The 600 Unit has a high acuity and many lifts and two-person lifts. He stated he has often been the only CNA working the entire 600 unit. He stated he has worked approximately 120 hours in two weeks for the last three pay periods. During an interview on [DATE] at 3:58 p.m., staff member Q stated she was the facility's only wound care nurse. She stated she had not been able to keep up with her wound care duties as well as she would like over the last three weeks because she had been working the floor on night shift. During an interview on [DATE] at 4:00 p.m., staff member A stated he had just arrived to the facility from traveling 2.5 hours from their sister facility. He said although he was not able to be at the facility he was always available via phone or email anytime of the day. He said staff member B was an Administrative Assistant, and not the Assistant Administrator. Although she qualified to apply for the license, she was not currently working on obtaining it. He stated he was aware of the staffing issue at the facility, and was repeatedly told by the governing body they were fine. He said he finally told the governing body that he was putting in his resignation if they did not allow for additional staff support. He said they then allowed for him to bring in some temporary travel staff. He said they may have held admissions on a day-by-day basis, but were still actively accepting new residents. He stated the governing body wanted them to accept bariatric residents and by doing so it puts an additional burden on staffing needs because the acuity is so high. During an interview on [DATE] at 8:30 a.m., staff member X was off-duty, but had stopped by the facility to see if he was needed. He stated he just had two days off for the first time after working 18-days straight. He stated he kept coming back for the residents. He was worried they may not get the care they need. Staff member X stated staffing was a big problem for the facility, but administration kept telling them staffing was fine. During an interview on [DATE] at 12:32 p.m., staff members Y and Z stated they were still accepting new admissions. They stated they would hold admissions day to day depending on the staffing levels. She stated their governing body was aware of the issues. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on [DATE] at 3:50 p.m., staff member A stated they were having difficulty getting staff hired and to work the floor. They have been short staffed for weeks. He stated he wanted to bring on travel nurses sooner, but their corporate office would not let them hire travel nurses. He said there are many days when his managers had to work the units due to staffing shortages. He said it was not a good idea to have staff continually work overtime, it created burn-out, and increased risk for errors. During an interview on [DATE] at 8:47 a.m., staff members A, Y and Z stated they wanted to deny admission for a high acuity resident, but their corporate office told them to take admit the resident. They felt they were not adequately staffed to care for that individual, but they were told to do it anyway. During an interview on [DATE] at 7:45 a.m., staff members D and CC stated they were incredibly worried for the safety of the facility's residents due to insufficient staffing. They stated they have been made to admit bariatric patients with high skill acuity without enough staffing to provide the necessary services. There were bariatric residents on the 600 Unit who were only to be admitted for a 30-day stay, but due to not enough staff, those residents have not been assisted to get out of bed and down to therapy. Because of that, those residents were now paying out of pocket for their services, and they were not improving. They stated they have asked corporate to stop admissions, but they have not. They continue to take high acuity admissions without the adequate staff to support their care needs. They felt that something had to be done before something very serious happens. During an interview on [DATE] at 12:30 p.m., staff member O stated he was worried for the staffing at the facility. He stated they were losing providers at the facility because they did not want to jeopardize their licenses due to the inadequate staffing. He stated corporate told them to take on bariatric patients, which take two to three staff to transfer and get up, but they don't have enough staff to care for them. He stated he told corporate that he wanted to approve all admissions, then his email became overwhelming, so he was not able to keep approving the admissions. He stated other nursing facilities in town had closed entire wings due to staffing issues, if they could, why not them. He stated he was worried for the safety and well-being of the residents at the facility due to insufficient staffing. During an observation, interview, and record review on [DATE] at 7:30 p.m., the facility Daily Staffing Report was last posted on [DATE]. During an observation on [DATE] at 4:00 p.m., the Daily Staffing Reports had been updated to [DATE]. During an interview staff member A stated he was not aware the Daily Staffing Report had not been posted since [DATE], thought that might be due to the previous scheduler quitting, and hiring new schedulers. A request for the actual hours worked schedule was made on [DATE], [DATE], and

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. 33796 Based on observation, interview, and record review, the facility failed to provide palatable food and the cooks were not following provided recipes; failed to provide hot food; failed to follow the facility menu; and the dietary department failed to provide foods specified on the residents meal tickets for 9 (#s 6, 19, 22, 24, 25, 26, 27, 28, 30, 32, and 43) of 25 sampled residents. These deficient practices had the potential to affect the residents' quality of life and nutritional status. Findings include: 1. Palatable food During a dinner observation on 12/6/21 at 5:15 p.m., the Turkey Noodle Casserole consisted of small cubes of white and red 'turkey' in a light sauce. Staff member UU stated the last time he had made the 'casserole' it did not turn out well. The noodles in the casserole on 12/6/21 were overcooked, and in a separate steam table, and the casserole dish was not baked. Review of the facility recipe for the Turkey Noodle Casserole showed it should be made with 15 pounds of mushrooms, and also parsley and bay leaf, then baked in the oven with bread crumbs and parmesan cheese on top. The recipe was not available for staff member UU to follow because the recipe was on staff member K's computer, and not printed for the staff to utilize while cooking. During an interview on 12/7/21 at 8:05 a.m., resident #26 said she could not chew the turkey last night (12/6/21) and had to spit it out. She said her meat was supposed to be ground, because she had no teeth. She said the food was terrible at the facility. During an observation and interview on 12/7/21 at 9:45 a.m., staff member TT was cooking beef cubes in the steamer, in their plastic container. He stated he had a pan underneath the cubes to contain the liquid. Staff member TT did not have a recipe for the Beef Tips that was being cooked. He had cooked macaroni to serve with the beef Tips, although review of the menu showed it called for buttered noodles not macaroni. Review of the facility recipe for the Beef Tips showed the beef should be browned in olive oil, with garlic, mushrooms, tomato sauce, and red wine. These ingredients were not used for the beef tips. Staff member TT used ground beef for the altered textures. The production sheet showed the cubed beef should be processed to a ground texture and moistened with sauce. The ground beef was in chunks and not moistened. Staff member TT stated he needed to mash the ground beef. During an interview on 12/7/21 at 10:40 a.m., staff member K stated the facility recipes were on-line in her computer. She stated her printer did not work, and printing the recipes used too much paper. She stated the menu was a 4-week cycle, and the cooks should know how to cook the entrees. Staff member K stated she had not received formal training as a dietary manager but was working on the certification for dietary manager. During an interview on 12/7/21 at 1:10 p.m., staff member L stated he was not aware the cooks were not using the provided recipes (which were approved for use). (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/6/21 at 4:45 p.m., staff member UU stated he would substitute cake when the pies ran out. - Bananas were not in stock throughout the survey. During an interview on 12/9/21 at 11:15 a.m., staff member K stated Sysco (food vendor) was out of bananas. She stated she did not have written documentation for why there was a lack of bananas. - Saltine crackers for the evening soups. During an interview on 12/6/21 at 4:40 p.m., staff member WW stated the facility had been without crackers for a while. Staff member K then stated there were saltine crackers in the store room, but dietary staff had not known they were there. Because of this, crackers were not available for the meal. - Carrots for the lunch meal on 12/7/21 During an interview on 12/7/21 at 9:45 a.m., staff member TT stated he had steamed one bag of shredded carrots intended for salads, and he would substitute salads for the rest of the residents. - Penne for the lunch menu on 12/8/21 During an interview on 12/8/21 at 10:05 a.m., staff member TT stated he would substitute noodles for the baked penne. - Broccoli Cheddar soup for dinner on 12/8/21 During an interview on 12/8/21 at 3:30 p.m., staff member FFF stated he was preparing a frozen vegetable soup instead of the broccoli cheddar soup. The broccoli cheddar soup had not been ordered in preparation for the meal. 4. Missing food items on resident meal tickets During a breakfast observation in the Horseshoe dining room on 12/7/21 at 8:20 a.m., resident #s 24, 25, 27, and 28 did not receive hot or cold cereal, as specified on their meal tickets. During an interview on 12/7/21 at 9:00 a.m., staff member K did not know why the four residents did not receive cereal. Staff member VV stated he had thought he gave everyone cereal. During an observation of breakfast on 12/7/21 at 8:45 a.m., resident #22 did not receive his prune juice. During an observation of breakfast on 12/7/21 at 8:47 a.m., resident #30 did not receive a banana, as specified on her meal ticket. During an observation of lunch on 12/7/21 at 12:40 p.m., resident #22 did not receive extra gravy, as specified on his meal ticket. (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview of breakfast on 12/8/21 at 8:40 a.m., resident #43 did not receive yogurt or cereal, as specified on her meal ticket. The resident stated she never gets what she wants. During an observation of breakfast on 12/8/21 at 9:10 a.m., resident #6 did not receive a banana as specified on his meal ticket. During an observation of breakfast on 12/8/21 at 8:50 a.m., resident #19 did not receive a hard boiled egg, as specified on her meal ticket. During an interview on 12/9/21 at 10:50 a.m., staff member K was asked how she monitored for meal ticket accuracy. She stated the dietary staff at the end of the tramline were responsible for ensuring the trays were accurate, but they (tramline staff) were both new. During an interview on 12/9/21 at 12:00, staff member WW stated he was a new dietary aide at the facility, and had not had any training. He stated he did not need it because he had been a dietary aide at another facility for three years.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 33796 Based on observation, interview, and record review, the facility failed to maintain a clean, sanitary, and functioning kitchen; failed to repair kitchen equipment used for appropriate and efficient resident meal preparation; and, an employee failed to safely thaw hamburger on one identified night. These deficient practices had the potential to adversely affect all residents consuming food from the kitchen. Findings include: During observations of the facility kitchen on 12/6/21 from 1:30 p.m. to 2:30 p.m., the following areas of the kitchen were not clean or equipment functioning properly: - The gas cook top was covered in burnt cheese and other food spills. - The two gas ovens were covered in rust on the inside of each side of the oven. Staff member TT stated he did not know how the rust occurred, but the ovens did not work. - The scoop and whisk metal drawer edges had food spills on them. - The plastic silverware caddy had food at the bottom of the spoon slot, and a spoon with dried food on it, which had not been cleaned thoroughly. - The meat slicer was covered, had been partially cleaned, but still had food crumbs on the bottom plate. - The handles of the oven which was working were sticky, gritty, and unclean. Staff member TT stated the sinks were missing a pump for the dish detergent, so a bag of detergent was next to the sinks, and was put in by hand. - The long shelf above the three compartment sink was dirty and held multiple broken items, plastic containers, and a variety of sanitation supplies. - The floor under the sinks three compartment sink was dirty with a variety of food/garbage debris. - Underneath the three compartment sink was a half of a plastic container, tied to a pipe, with gauze. The container had dried pieces of rotten food in it. Staff member TT stated a tube was connected to the plastic container (under the sink) so water could drain into a nearby floor drain. He stated the pipe had a leak. - The sink drains did not plug or drain properly and dish towels were stuffed in the drains to plug them. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- A sanitizing bucket, filled 1/3 full of water with a sponge in it, did not contain sanitizer per the test strip completed on 12/7/21. The bucket of water remained in place, per the following observations completed on 12/8/21 and 12/9/21, and the bucket remained on the same counter the entire time. - Review of a written dietary staff interview, by the facility management, showed a staff member forgot to get hamburger out to thaw, so the employee came back to the kitchen at 10:00 p.m., and placed the hamburger under running water, leaving the water running on the meat, until he returned at 3:45 a.m. During an interview on 12/9/21 at 11:10 a.m., staff member L stated thawing meat under running water for five hours was not a safe practice for thawing meat. - A large stockpot full of dirty water was sitting on the floor next to the sink. Staff member TT stated a cook had burned food in the pot and it had been soaking. - The steamer had a top and a bottom, and staff member TT stated the top steamer could not be lit and it wasn't working. - The area next to the steamer had contained a large 'soup boiler' that had been removed. This area was a metal square, and the receptacle for the steamers drain water. The area contained dirty water and macaroni throughout the survey which was not cleaned up. - The dishwashing room smelled sour and of old food. Staff member M stated the smell of the dishwashing room was probably stagnant and dirty water in a drain. - The sprayer hose to rinse the dishes only had cold water. - The back wall and light switch in the dish room was splattered with food spills. Review of the requested dietary cleaning schedule showed a schedule dated November 29 through December 5 (2021). Five out of 20 items on the schedule were initialed as cleaned. A December monthly cleaning schedule had 4 of 17 items initialed as cleaned. During an interview on 12/9/21 at 11:25 p.m., staff member K was asked if the department had any cleaning schedule for beginning/rest of November, and she stated she would have to find it. The November cleaning schedule was not provided.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. 44769 Based on observation, interview, and record review the facility failed to provide rehabilitative services as ordered by the physician for 1 (#21) of 1 sampled resident. This resulted in the resident not attaining his highest practicable level of physical well-being. Findings Include: During an observation and interview on 12/9/2021 at 8:31 a.m., resident #21 was lying in his bed dressed in a gown and stated They have only got me out of bed three times since I came here, twice to go to therapy, and once to go to the bathroom. During an interview on 12/9/2021 at 10:54 a.m., staff member D stated resident #21 had received only two therapy sessions when he first got to the facility and had not had any since. Staff member D stated it was because the facility did not have enough staff working to get the resident up and bring him to therapy. The resident's insurance only paid for therapy the first thirty days of his stay. Staff member D stated she told nursing staff and NF4, that the resident needed to be in the therapy gym every day. During an interview on 12/9/2021 at 11:14 a.m., resident #21 stated, My sole purpose for coming to this facility, was to get rehabilitation and now my insurance ran out, it only paid for the first 30 days. Review of resident #21's Skilled Nursing Facility Admission Orders, dated 11/02/21 SNF Rehabilitation Potential - Good Rehabilitation Potential. Review of resident #21's physicians orders from the EHR, with a start date of 11/4/2021 and an end date of 12/4/2021, showed; Skilled Physical therapy 4-6 times per week for 30 days for (modality): high complexity eval, there ex, there act, gait training, manual tx, group therapy, and neuro re-ed. 41952 During an interview on 12/7/21 at 11:35 a.m., staff member BBB stated there were residents who were supposed to be up out of bed and ready for therapy to work with, but there was not enough staff on the units, so the residents stayed in bed. If therapy did occur it would take two staff (1 OT/1 PT) and the whole therapy session was just be getting the resident up out of bed and not actually providing therapy exercises to help residents get better.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 35356 Based on observation and interview, the facility administrator and designated administrative staff, failed to provide the necessary oversight and management of the day-to-day operations of a large skilled nursing facility to ensure policies and procedures were implemented and operationalized for the following areas of deficient practice: a. Resident nursing care and services b. Abuse and neglect policies/procedures used for resident protection c. Dietary - safe, sanitary, and functional kitchen for nutritional services d. Housekeeping services e. Maintenance and facilities upkeep f. Therapy services for residents with physician ordered therapies g. Ensure an adequate amount of staff was onsite for resident care and services and sufficient related to the resident acuity h. Failed to provide sufficient oversight to identify and correct deficient practices, to ensure the highest practicable well-being for the residents. The cumulative effect of these deficient practices had the potential to affect all residents who resided at the facility. Findings include: Administrational Oversight During an interview on 12/6/21 at 1:00 p.m., staff member B stated staff member A had not been able to be at the building consistently for several weeks. She said he was expected to put in a full eight hours at the sister facility before he could return to this facility, which was later in the day. Staff member B said she was currently acting as the administrator in his absence. She stated she did not have an administrator's license and was not currently working on obtaining an administrator license. She said she was currently working under staff member A's license. During an interview on 12/6/21 at 4:00 p.m., staff member A stated although he was not able to be at the facility he was always available via phone or email anytime of the day. He said staff member B was an Administrative Assistant, and not the Assistant Administrator. Although she qualified to apply for the license, she was not currently working on obtaining it. He stated he was aware of the staffing issue at the facility, and was repeatedly told by the governing body they were fine. He said they may have held admissions on a day-by-day basis, but were still actively accepting new residents. He stated the governing body wanted them to accept bariatric residents and by doing so it put an additional burden on staffing needs because the acuity of these residents was so high. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Abuse Identification/Investigation/Reporting During an interview on 12/8/21 at 5:00 p.m., staff member B stated she had awareness of the relationship and abuse investigation between NF7 and resident #9, to include: knowing details of the relationship between the resident/employee, staff member NF7 being in bed with the resident, the DONs participation in the events, and NF7's departure from facility employment. Staff member B stated she was unaware if the facility had an intimacy policy or assessment. Staff member B stated she did a lot of research because corporate did not know the local laws, and she could not find anything in the federal regulations regarding a relationship between a staff member and a resident. During an interview on 12/8/21 at 5:35 p.m., staff member A stated he was not aware of a relationship between NF7 and resident #9 in September 2021. He was brought into it later after a compliance line report was filed. Staff member A stated he and staff member C came in and investigated, and NF7 and resident #9, denied everything, so the investigation was inconclusive. He stated corporate had the investigation, and he did not have copies or know the findings of it. Staff member A stated any relationship, other than a professional relationship between staff and resident, was against the code of conduct, and the boundaries of the employee's professional license. Staff member A stated there was no policy for relationships because staff cannot have relationships with residents. Staff member A stated corporate interviewed NF7 and did the investigation. He was not sure if the events were reported to the proper authorities, although staff member A was a mandatory reporter for the facility, and provided oversight for the abuse/neglect program. Review of NF4's employee file showed a Performance Improvement Plan for several areas, one of which was, On 10/13/21 the Administrator along with corporate staff discussed the need for action/discipline regarding the need to manage inappropriate relationship between nursing staff (NF7 ????) and resident (#9???). [sic] Review of the information provided by the facility for the investigation of NF7 and resident #9 showed the facility management was aware of an inappropriate relationship between NF7 and resident #9 as early as 10/5/21. Also with several other allegations made by multiple staff regarding the neglect of duties for NF7, such as (medication pass, tube feeding, dressing changes, fall neuro checks), HIPAA violations (showing the computer screen and explaining resident medications to resident #9), and more on 10/4/21 night shift. The allegations were not fully investigated and managed to the extent necessary to show the facility took the necessary action for the resident(s) safety. Documents failed to show NF7 was either suspended or removed from direct resident care for the investigation to protect the resident, and was not disciplined/educated for the neglect of her duties or alleged HIPAA violations. For the 11/16/21 incident where the NF7 and resident #9 were found in the same bed, the investigation only showed a few witness statements confirming NF7 and resident #9 were involved in the investigation. No information regarding any follow up with resident #9 was included in the documentation or resident #9's EHR, such as a resident interview, resident physical or psychosocial assessment, monitoring of ongoing occurrences of abuse, or that a care plan was implemented for risk factors related to the resident and his behavior. No documentation was provided for confirmation of the mandatory reporting of the allegation of abuse to the proper authorities, including the State Survey Agency, local police, professional licensing boards or others. (continued on next page)

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	275026	A. Building B. Wing	12/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ivy at Great Falls	1130 17th Ave S Great Falls, MT 59405

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 12/8/21 at 5:40 p.m., staff member A stated again stated corporate interviewed NF7 and did the investigation for the inappropriate relationship between NF7 and resident #9. He was not sure if the abuse situation was reported to the proper authorities as he .did not report it, per the mandatory Centers for Medicare and Medicaid (CMS) Federal regulatory requirements. Review of the Appendix PP, State Operations Manual, F609 - Abuse Reporting, shows: If an alleged violation has been identified and reported to the administrator/designee, the facility must immediately report it and provide protection for the identified resident(s) prior to conducting the investigation of the alleged violation. Staffing During an interview on 12/7/21 at 3:50 p.m., staff member A stated they were having difficulty getting staff hired and to work the floor (for resident care). The facility has been short staffed for weeks. He said there were many days when his managers had to work the units (providing resident care services) due to staffing shortages. He said it was not a good idea to have staff continually work overtime. Staffing and Admissions During an interview on 12/8/21 at 8:47 a.m., staff members A, Y and Z stated they wanted to deny admission for a high acuity resident, but their corporate office told them to admit the resident. They felt they were not adequately staffed to care for that individual, but they were told to do it anyway. Although the facility had inadequate staff to provide care and services, related to resident acuity, admissions continued, and allowed by the Administrator of the facility who was aware of the staffing/care concerns. Resident Smoking - Accidents/Hazards During an interview on 12/8/21 at 3:46 p.m., staff member A stated the facility was non-smoking. He stated when the facility discontinued their smoking policy, they started those residents who smoked on a smoking cessation program. He stated residents should be supervised if they were outside smoking on facility property. Staff member A said it could be very dangerous to leave cognitively impaired residents unsupervised while smoking. Staff member A stated he was not fully aware of the situation with the residents smoking unsupervised by staff. Facility Assessment A request was submitted on 12/7/21, 12/8/21 and 12/9/21, for a copy of the facility's comprehensive Facility Assessment. Review of an email regarding the requested Facility Assessment, from staff member B on 12/13/21 at 10:30 a.m. (after the survey ended), showed, No, I am waiting to hear back from [staff member A] to tell me where they are . referring to the assessment. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the Facility Assessment, received after the survey on 12/13/21 at 11:23 a.m., showed: ABC-Nursing and Rehab Facility Assessment, Continuation of Facility Assessment from April 2019. The assessment provided was not for the correct facility and it was not for 2021. Administration had failed to complete/provide the required Facility Assessment. The following cumulative areas of deficient practice occurred due to a repeated systemic pattern of failures; and, due to the failure of administration to provide sufficient staffing to meet the resident care and acuity, in the following areas: - To ensure the necessary provision of care and services for the prevention and treatment of avoidable pressure ulcers (See F686). - To provide the necessary provision of care for residents with indwelling urinary catheters (See F690). - To provide sufficient staffing (See F725). - To provide supervision of cognitively impaired residents when smoking on facility property (See F689). - To develop facility specific policy and procedures for resident care for indwelling urinary catheters, pressure ulcers prevention and management, smoking, and abuse prohibition (See F600). - To develop a comprehensive annually reviewed and updated Facility Assessment (See F600). - To prevent, investigate, and report allegations of abuse and neglect (See F600, F607, F609, and F610). - To maintain dietary services, and ensure meals were provided in a safe, sanitary, and functional kitchen, and to meet nutritional needs of the residents (See F692, F800, and F812). - To ensure housekeeping services were completed as needed to maintain a clean and sanitary environment (See F921). - To ensure facility (structural) upkeep to maintain a safe and sanitary environment (F921).

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. 35356 Based on observation, interview, and record review, the governing body failed to ensure the facility had a licensed administrator with the knowledge and skillset necessary to provide oversight to a large skilled nursing facility. The administrator failed to manage the difficulties occurring with day-to-day operations, and the governing body failed to provide sufficient oversight for the new facility administrator after hire, to identify and correct concerns related leadership, and when deficient practices were occurring for an extended period of time, although various concerns were brought forth to the governing body. During the survey, surveyors found the facility was diverse with both staff and resident acuity and care complexities. Although members of the governing body had been onsite at the facility in recent months, the members of the body failed to act effectively on concerns occurring at the facility level. The administrator, who was appointed by the governing body, and the governing body itself, failed to provide the necessary oversight to ensure policies and procedures were implemented and operationalized for: a. Resident nursing care and service b. Abuse and neglect policies/procedures, and processes used for resident protection c. Dietary services - safe, sanitary, and functional kitchen for nutritional services d. Housekeeping services e. Maintenance and facilities upkeep f. Therapy services for residents with physician ordered therapies g. Ensure adequate amount of staff was onsite for resident care and services and related to the resident acuity h. Failed to provide sufficient oversight to ensure departmental manager accountability, as quality deficient practices within this Form CMS-2567 are related to the lack of departmental oversight, evaluation, monitoring, and accountability for the assigned departmental manager. (continued on next page)

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 12/6/21 at 1:00 p.m., staff member B stated staff member A was not currently at the building and had not been able to be at the building consistently for several weeks because he had been providing full-time administrative oversight at a sister facility. Staff member B stated the corporate office (governing body) was aware that staff member A was splitting his time between the two sister facilities. Staff member B said she was currently acting as the administrator in his absence, but did not have an administrator's license, or working to obtain one. Staff member B said she was working under staff member A's license. Staff member B stated the facility had termed their previous DON several weeks ago and did not have an ADON to cover the role (for nursing department oversight). She said Staff member C (a member of the governing body) had flown in from out of state to help. During an interview on 12/6/21 at 1:20 p.m., staff member C stated she was from the corporate office (governing body) and had oversight for over nine different facilities throughout the country. She said she had been at the facility less than one week, and stated they were having a difficult time getting staff hired to work at the facility because the nursing shortage was an issue, and what where they suppose[d] to do when no one wants to work. Staff member C felt staff member A's absence from the facility (to work at sister facility) was fine, and did not have any concerns with the arrangement. She said it was only temporary until they were able to hire a new administrator for their sister facility. During an interview on 12/6/21 at 4:00 p.m., staff member A stated he stated he was aware of the staffing issue at the facility, and was repeatedly told by the governing body they were fine. He said he finally told the governing body that he was putting in his resignation if they did not allow for additional staff support. He said they then allowed for him to bring in some temporary travel staff. He said they may have held admissions on a day-by-day basis, but were still actively accepting new residents. He stated the governing body wanted them to accept bariatric residents and by doing so it puts an additional burden on staffing needs because the acuity is so high. During an interview on 12/7/21 at 12:32 p.m., staff members Y and Z stated they were still accepting new admissions. They stated they have not completely held admissions. Staff member Y stated, although it was in her contract that she did not need to, she did work the floor, when staffing was low. She stated their governing body was aware of the issues. During an interview on 12/8/21 at 8:47 a.m., staff members A, Y, and Z stated they wanted to deny admission for a high acuity resident, but their corporate office told them to admit the resident. They felt they were not adequately staffed to care for that individual, but they were told to admit the resident by staff members RR and SS. During an interview on 12/9/21 at 7:45 a.m., staff members D and CC stated they have asked corporate to stop admissions, but they have not. They continue to take high acuity admissions without the adequate staff to support their care needs. They stated they felt that something had to be done before something very serious happened. During an interview on 12/9/21 at 12:30 p.m., staff member O stated he told corporate that he wanted to approve all admissions, then his email became overwhelming, so he was not able to keep approving the admissions. He stated other nursing facilities in town had closed entire wings due to staffing issues, if they could, why not them. He stated he was worried for safety and well-being of the residents at the facility due to insufficient staffing. (continued on next page)

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The following cumulative areas occurred due to a repeated systemic pattern of failures for the governing body to provide or support the need for sufficient staffing in the following areas of care: - To ensure the necessary provision of care and services to for the prevention and treatment of avoidable pressure ulcers (See F686). - To provide the necessary provision of care for residents with indwelling urinary catheters See F690). For complete findings regarding insufficient staffing (See F725). Development of Policy and Procedures A request for a copy of the facility's Policy and Procedure for Pressure Ulcer Management and indwelling urinary catheter care was requested on 12/8/21 and again on 12/9/21. The requested information was not provided by the end of the survey. A second request was submitted via email to staff member B on 12/11/21 at 10:38 a.m., with a response showing, Ok now I know what happened. We don't have a policy on it. The stuff I gave you on Thursday was the info that we have for wound and catheters . During an interview on 12/7/21 at 9:00 a.m., staff member C stated she would look for a couple policy and procedures. She stated they have not transitioned all the policy and procedures yet for this facility, so they may not have them. Development of Facility Assessment A request was submitted on 12/7/21, 12/8/21 and 12/9/21, for a copy of the facility's comprehensive Facility Assessment. Review of an email regarding the requested Facility Assessment, from staff member B on 12/13/21 at 10:30 a.m., showed, No, I am waiting to hear back from [staff member A] to tell me where they are . A review of the Facility Assessment, received on 12/13/21 at 11:23 a.m., after the survey ended, showed: ABC-Nursing and Rehab Facility Assessment, Continuation of Facility Assessment from April 2019. The assessment provided was not for the correct facility and it was not for 2021. The facility failed to provide a completed assessment.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 40068 Based on observation and interview, the facility failed to maintain a comfortable and sanitary environment for the residents. This deficient practice had the potential to adversely affect the well-being and safety of the majority of residents in the facility, and specifically for resident #s 32, 50, and 51. Findings include: During an observation on 12/6/21 at 1:30 p.m. the kitchen ceiling was missing ceiling tiles above the sinks used to wash larger pots and pans. The area under the ceiling tiles was a yellowish color. During an observation on 12/6/21 at 1:56 p.m., the area under the dishwasher in the kitchen was slimy and brown. It smelled pungent, and the air felt humid. During an observation on 12/6/21 at 2:38 p.m., the ceiling above the secured unit door had large chunks of plaster coming off and was laying on the ledge just below the ceiling. The area under the plaster was a dark brown color and appeared that it once was moist from water or moisture coming from above the ceiling. During an observation on 12/7/21 at 8:20 a.m., the dining room floor of the secured unit was streaked with a brown color and had brown spills on the floor (fall hazard), and it was sticky and the spills were dry, showing it had not been cleaned for an extended period. During an interview on 12/7/21 at 8:22 a.m., staff member AAA stated housekeeping usually came in daily to the secured unit to clean. She stated that the person who came in to clean the floors with the big mop machine usually did the floor daily. Staff member AAA stated he never cleaned the dining room area and never moved any furniture to clean. She stated the dining room floor should be mopped because it seemed to always be dirty. During an observation on 12/8/21 at 9:52 a.m., resident #s 50 and 51's room smelled of urine. There was a large, partially dried yellowish puddle on the floor. The entire floor appeared to have a hazy film. The main dining area of the secured unit had brown puddles on the floor, two were dried, and one was wet (fall hazard) showing it had not been cleaned recently. During an interview on 12/7/21 at 8:30 a.m., staff member ZZ stated, We clean the secured unit every day. If there were small spills on the floor that were wet I would clean them up because it is a hazard to residents. Otherwise, the floor machine will mop the floors in the secured unit. The mop machine goes into the secured unit daily. During an observation on 12/8/21 at 9:49 a.m., the end of the 100 and 200 wings had a musty smell and there was food on the floor, and the floor felt sticky. During an observation on 12/8/21 at 3:03 p.m., a pile of dead insects were found, in the corner, on the floor, on top of a piece of material, right before entering the 600 hall. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/6/21 at 1:40 p.m., staff member TT stated the ceiling tiles always fall in the kitchen. Staff member TT stated this had been happening for a few months now. Staff member TT stated maintenance was notified, but nothing was done. Staff member TT stated that staff member UU had one fall on him previously. During an interview on 12/6/21 at 1:54 p.m., staff member UU stated the ceiling tiles did fall periodically in the kitchen. Staff member UU stated he thought it was because it was so humid in the kitchen, that the ceiling tiles came loose and would fall. Staff member UU stated when the tiles fall, a bunch of chalky dust falls also, so the clean dishes need to be rewashed. During an interview on 12/6/21 at 2:45 p.m., staff member AAA stated the secured unit often smelled musty and damp. She stated when it rained the secured unit ceiling leaked, and that is why there was yellow rings all over the ceiling. She stated there was a big leak right above the secured unit entrance door. Staff member AAA stated the facility needed a new roof. Staff member AAA stated the facility tried to fix the areas they thought were leaking, however it still smelled humid, and she did not think the issue was actually resolved. During an interview on 12/7/21 at 2:12 p.m., resident #32 stated, The facility is falling apart. The roof needs to be fixed because it leaks. I guess it is expensive, they keep patching areas but its not working. During an interview on 12/7/21 at 11:06 a.m., staff member N stated the facility was having issues with the ceiling tiles falling in the kitchen. He stated that the roof of the facility was very old and leaked. It caused moisture to seep into the ceiling and loosened the ceiling tiles which caused them to fall. Staff member N stated the facility is slowly replacing the roof but it is very expensive, so it is getting done in sections over time. In order to see if the facility has mold, we would have to hire a company to come in to test for it. Staff member N stated the area under the dishwasher might be old food residue. This happened a while back, I didn't know it was like that now though. I would have to go look to see but there used to be fly larva growing under there [name of pest company] told us to use bleach down there. The swamp cooler is the only means for ventilation in the kitchen area. We don't put any water in it but it blows air. Our big air mover broke, the portable one, so I probably need a new one. During an interview on 12/9/21 at 9:40 a.m., staff member M stated there was currently six housekeepers employed. There were three to four of them who worked from 7:00 a.m. until 3:30 p.m. Staff member M stated the secured unit is cleaned every day. The mop machine is the only thing that fully mops the floor of the facility. Staff member M stated if there were spots that the housekeepers saw on the floor, they were expected to clean them up. Staff member M stated if there were bugs in the facility, housekeeping would clean them up and notify him. 41952 During an observation on 12/7/21 at 11:11 a.m., a staff member was observed pushing a floor cleaning machine through the 300/400 halls. There was a smell of a cleaner but the machine did not have water or cleaner coming out to scrub the floors. The machine left dry brown streaks from the machine brushes through the hallways.