STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325033	A. Building B. Wing	10/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rio Rancho Center	4210 Sabana Grande SE Rio Rancho, NM 87124

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34439 Based on observation, record review, and interview, the facility failed to promote care with dignity and respect for 9 (R #41, 61, 70, 71, 89, 91, 92, 122 and 128) of 9 (R #41, 61, 70, 71, 89, 91, 122 and 128) residents reviewed during random observation by: 1. Entering Rooms #123, 128,151 and room [ROOM NUMBER] without first knocking on the door. 2. Resident #71 is a smoker and is not offered assistance to go out and smoke. These deficient practices are likely to result in residents feeling as if their feelings and preferences are unimportant to the facility staff. The findings are: Findings regarding entering rooms without knocking: A. On 09/22/21 at 4:17 pm during observation and interview Certified Nurse Aide (CNA) #12 was observed entering room [ROOM NUMBER] without knocking. When asked if she should knock before entering, she stated. I was just getting his water, its really hectic right now and yeah, I should be knocking before entering. B. On 09/23/21 at 12:37 pm during observation and interview CNA #10 was observed entering room [ROOM NUMBER] without knocking. CNA #10 was also observed talking on her telephone she remained on talking on the telephone on the empty side of the room. When asked if she should have knocked before entering the the room, she stated Yes, normally we should be knocking sometimes we just have to go in. C. On 09/23/21 at 12:48 pm during observation Registered Nurse (RN) #1 was observed entering room [ROOM NUMBER] without knocking. When asked if she should have knocked before entering, she stated. Yeah, I should have knocked. I just know them (residents) so well. I'm sorry. D. On 09/23/21 at 12:50 pm during observation CNA #8 was observed entering room [ROOM NUMBER] without knocking. When asked if she should have knocked before entering, she stated. Normally we do, but I am so busy just getting trays. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	E. On 09/23/21 at 1:12 pm during an interview with the Director of Nursing (DON), when asked if staff should be knocking before entering resident rooms, she stated. They (staff) should knock even if they know the resident. They (staff) should be making some sort of announcement before entering the room of a resident. Findings regarding smoking: F. On 09/22/21 at 2:12 pm during an interview with R #71, she stated. I really would like to go out to smoke, they (staff) never want to put me in my chair to take me out. It has been a while since I have gone out to smoke, no one comes to ask me if I want to go. G. Record review of Smoking Evaluation dated 09/20/21 revealed, Supervised smoking is required. Resident has MS(Multiple Sclerosis- a chronic disease affecting the central nervous system-the brain and the spinal cord) and has difficulty without assistance does not smoke very much. H. On 09/22/21 at 1:22 pm during an interview with the Social Services Director (SSD), she stated. We have 6 different smoking times, those are all supervised times, R #71 is not asked if she wants to go out to smoke but, if she said she wanted to go out to smoke she would have to let someone know, we do not go around asking residents if they want to go out to smoke. All the smokers know the smoking schedule and they all go out to the middle courtyard and someone is there to supervise them. If [name of R #71] wanted to go out to smoke we would have to assist her if we had staff available to help get her out of bed. 45428

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 34439 Based on observation and interviews, the facility failed to provide reasonable accommodations of resident needs and preferences for 1 (R #71) of 1 (R #71) resident reviewed. This deficient practice is likely to result in residents feeling that their preferences are not important. A. On 09/20/21 at 12:16 pm during interview and observation of R #71's room several bags of personal belongings were piled on the bare floor along with a bottle of laundry detergent. The table surfaces are cluttered and dirty, resident room had a foul smell and had dirty laundry stacked high in a laundry basket next to the room door. R #71 stated, My bed isn't clean they never really clean it. My mom and some of my family will not come in to visit because the smell is so bad. B. On 09/28/21 at 1:42 pm during an interview with the Social Services Director (SSD), she stated. She (R#71) does have an excessive amount of belongings so it is hard to keep her room clean. Her family was going to come and pick up a lot of her belongings and they have not come yet to pick it up. We do not have a place to store her excess belongings. C. On 09/28/21 at 1:44 pm during an interview with R #71 she stated, The room is so crowded that they have to put the lift (a mechanical device used to assist in moving a resident between surfaces) on the other side of my bed into my roommates side just to get me out of bed. My room is so crowded and it is dirty and it makes me feel bad. I ask for help and I cannot get anyone to help me clean up my room or wash my dirty laundry.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 34439 Based on interview and record review the facility failed to give the resident council feedback on their concerns for 8 (R #26, 28, 38, 56, 58, 75, 106 and 126) of 8 (R# 26, 28, 38, 56, 58, 75, 106 and 126) residents reviewed in the resident Council Meeting and Resident Council Meeting Minutes. If the facility is not ensuring that the Resident Council grievances are responded to and resolved, then residents are likely to feel that their issues/concerns are not taken seriously. The findings are: FACILITY A. On 09/22/21 at 10:07 am during interview with the Resident Council (RC) which consisted of R # 26, 28, 38, 56, 58, 75, 106 and 126, they stated that the RC has not met monthly. The RC confirmed that they have never received a response from their concerns in writing or verbally from the facility. The RC identified that their primary grievances are related to food preferences not being honored, that meals they receive almost never match the menus, cell phone use by staff while providing care, showers not being offered and having coffee being limited to a single cup per resident which had been pre-poured and served cold. B. On 09/22/21 at 10:15 am during interview with the Resident Council (RC) President (R #106) at the Resident Council meeting, he stated he has brought these issues to the Administrator (ADM) with no response. Findings related to Cell Phone use: C. On 09/22/21 at 1:35 pm during observation Licensed Practical Nurse (LPN) #4 was observed on personal cell phone sitting at the nurses station on the north unit. D. On 09/22/21 at 1:55 pm during observation Certified Nursing Assistant (CNA) #10 was observed on personal cell phone while in the facility hallway on the north unit. E. On 09/27/21 at 2:10 pm during observation CNA #14 was observed on personal cell phone while on the facility hallway on the north unit. F. On 09/28/21 at 5:11 pm during observation LPN #2 was observed on personal cell phone at the nurses station on the south unit while R #33 was sitting with her. Findings related showers not being offered: G. On 09/22/21 at 10:07 am during an interview R #26 stated he had not been offered a shower in two weeks. H. Record review of shower sheets indicated R #26 had not had a shower in two weeks and there was no documentation reflecting a shower had been offered or given in the previous 2 weeks. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	I. On 09/27/21 at 12:13 pm during an interview with the Director of Nursing (DON) she stated residents should be offered showers twice a week and if it (showers) is not documented then they were not offered, she could not provide documentation for any showers for R #26 in the last two weeks. Findings related to food issues: J. On 09/22/21 at 10:07 am during a Resident Council meeting with facility residents they stated they are not offered any alternate choices, if they do not like the food they are served they have no other choices. Residents are not provided with menus and the menus that are posted are where many residents do not have access to. They also stated that very often menus are not followed as posted. K. On 09/27/21 at 2:42 pm during an interview with the Dietary Manager, he stated. We have to follow the menu, there is no other choices in place for the residents. There is not an always available menu. I can only cook extra alternates according to the production sheet (paper that tells the staff how many alternate meals to cook according to preferences). We do not have a system in place to let the residents know what the alternate meal is for the day, we only cook enough alternates for the residents that have stated on their assessments that they prefer a certain meal. We do not have a system in place so residents that do not like what is being served they can ask for something else. We make a main meal and a limited amount of the alternate meals. It is not available to all the residents. We do not send out menus, we have them posted in a couple of places. L. On 09/28/21 at 3:20 pm during an interview with the Corporate Manager, he stated. Upon intake (admission to the facility) we do the preferencing, the Registered Dietician will do an assessment. We give them (residents) whatever options we can give them based off of the two meals offered for that day. They have choices between two meals and that is selected by the system for them depending on the assessment. There is no restaurant style ordering available. If we can accommodate what they are asking for we will try but, we do not have an always available menu available for the residents. They get what what is cooked from the two meals prepared. We do not cook extra food, so if they do not like the meal they are served they may be given the option of the second meal offered depending if there is some still available. M. On 09/28/21 at 3:35 pm during an interview with the Administrator, she stated there had not been a resident council meeting for several months, but residents were given a survey form that they could fill out if they had any issues or they could talk to any of the staff to let them know of the issues. She further stated that food choices, as far as an always available menu there was not that kind of system in that facility. Resident did have concerns and she had spoken with the Dietary Manager and they were going to figure some things out so that residents could have some choices.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41988 Based on record review and interview, the facility failed to provide follow up report within 5 working days from the date of the incidents to the State Survey Agency, for 2 (R's #281 and 282) of 2 (R's #281 and 282) residents reviewed for incidents. If the facility fails to report incidents to the State Agency, then the State Agency will be unable to assure residents a safe and hazard free environment. The findings are: Findings for R #281: A. Record review of R #281's progress notes dated [DATE] revealed, THIS NURSE RESPONDED TO RESIDENT IN THE DINING ROOM NOTED BY CNA [Certified Nursing Assistant] TO HAVE HER HEAD DOWN AND FACE 'BLUE'. THIS NURSE ASSESSED RESIDENT AND NOTED RESIDENT NON RESPONSIVE, EYES OPEN WITH PUPILS DILATED, RESIDENT IMMEDIATELY TRANSPORTED PER GERI CHAIR [a large padded chair designed to help seniors with limited mobility] TO HER ROOM AND HER NOTED CODE STATUS IS FULL CODE, RESIDENT PLACED ON FLOOR WHEN CPR [Cardiopulmonary Resuscitation- an emergency procedure that involves chest compressions] INITIATED AND 911 CONTACTED AND RESPONDED. RESIDENT TRANSFERRED OUT VIA STRETCHER WITH APPARENT RHYTHM (had a heartbeat)TO [Name of local hospital]. B. Record review of R #281's face sheet revealed R #281 was discharged on [DATE] due to Other: _Resident deceased . C. On [DATE] at 3:29 pm during an interview with the Administrator (ADM), she stated, The deposition of what occurred [R #281 incident on [DATE]] stated they [staff] thought it was a heart attack and it [R #281 incident on [DATE]] was not reported [to State Agency (SA)]. ADM confirmed the incident that occurred to R #281 on [DATE] was never reported to the SA and it should have been. Findings for R #282: D. Record review of R #282's progress notes dated [DATE] revealed, Note: Patient was found to be choking in bed while being fed by CNA's and NA's [Nursing Aides]. Patient was not responsive to verbal or physical stimuli, (does not respond to noise or touch) Vitals signs showed an oxygen saturation [O2 sat] of 31% [percent]. (blood oxygen content and oxygen delivery). At the time a bolus [a small round mass of substance, especially of chewed food at the moment of swallowing] of food was seen to be in patients mouth. Bolus taken out with finger and patient placed on a non-breather mask [a device used to assist in the delivery of oxygen] at 15 L [liters]. Patients O2 sat climbed to 65% before EMS [Emergency Medical Services] arrived. Patient breathing, still not responsive to verbal or physical stimuli. E. Record review of R #282's face sheet revealed R #282 was discharged from the facility on [DATE]. F. On [DATE] at 3:31 pm during an interview with the ADM, she stated, I didn't know the nature of the incident as I wasn't here, but we looked everywhere for it [Incident report for R #282 incident on [DATE]]. I can't find a record of it. It [R #282 incident on [DATE]] should have been reported.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39509 Based on record review and interview, the facility failed to conduct a comprehensive assessment for each resident's functional capacity for 3 (R #28, 85, and 105) of 3 (R #28, 85, and 105) residents reviewed by: 1. Not conducting and completing resident assessments for Brief Interview of Mental Status (resident interview that helps identify mental status). 2. Not ensuring resident assessment of pain was completed This deficient practice is likely to result in residents not receiving an appropriate and complete assessments which is likely to result in residents receiving less than optimal care and treatment. The findings are: Resident #105 A. Record review of R #105's face sheet dated 09/27/21 revealed she was admitted to the facility on [DATE] with multiple diagnoses including paraplegia (neurological condition that interrupts the control of body and muscles), Severe Sepsis (overwhelming infection) with septic shock (a most severe form of infection). B. Record review of R #105 Minimum Data Set (MDS) (an comprehensive assessment of a resident required by federal rules) section C (a section of the MDS that evaluates and rates a persons ability to recall and engage memory) dated 05/27/21 revealed that section C was marked as not assessed. C. On 09/22/21 at 11:14 am during interview with MDS Coordinator (MDS #1) she stated that the MDS section C is completed by the facility social workers. She stated that in May and June 2021, there was no social worker in the building and the assessment was not completed. She confirmed the assessment is required and should have been completed. 44363 Resident #28 D. Record review of R #28's face sheet dated 09/20/21 revealed he was admitted to the facility on [DATE] with multiple diagnoses including Chronic Systolic Congestive Heart Failure (heart disease that affects pumping action of the heart muscles), Chronic Obstructive Pulmonary Disease (lung disease that causes obstructed airflow from the lungs) and Parkinson's Disease (a progressive nervous system disorder that affects movement). E. Record review of R #28's MDS Section J (a section of the MDS that evaluates and rates a persons pain) dated 06/17/21 revealed that Section J was marked as not assessed. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	F. On 09/28/21 at 12:19 pm MDS #1 stated occasionally a MDS will be completed remotely. MDS#1 confirmed when a MDS is completed remotely a nurse does not assess the resident. MDS #1 confirmed the assessment is required and should have been completed. Resident #85 G. Record review of R #85's face sheet dated 09/20/21 revealed he was admitted to the facility on [DATE] with multiple diagnoses including Chronic Obstructive Pulmonary Disease and Hypertension (high blood pressure). H. Record review of R #85 MDS Section C dated 07/19/21 revealed that section C was marked as not assessed. I. On 09/28/21 at 12:20 pm MDS #1 stated social workers are usually responsible for section C of the MDS. MDS #1 was unable to determine reason why R #85 was not assessed. MDS #1 confirmed the assessment is required and should have been completed.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44363 Based on record review and interview, the facility failed to ensure that the Minimum Data Set (MDS) Assessments were accurate for 2 (R #69 and 228) of 2 (R #69 and 228) residents reviewed by: 1. Not accurately reflecting R #69's feeding tube (a tube that has been surgically placed and is used to provide nutrition to people who cannot obtain nutrition by mouth, are unable to swallow safely, or need nutritional supplementation). 2. Not accurately reflecting R #228's current mental status and mood. These deficient practices are likely to result in residents not receiving the appropriate care and treatment they need. The findings are: Resident #69 A. On 09/21/21 at 10:19 am R #69 was observed to have a feeding tube. B. Record review of R #69's face sheet dated 09/21/21 revealed he was admitted to the facility on [DATE] with multiple diagnoses including Personal History of Traumatic Brain Injury (a head injury causing damage to the brain) and Dysphasia (difficulty swallowing food or liquid). C. Record review of R #69 Progress notes revealed a skin check was performed on 03/19/21 and the following new skin condition was identified: G-tube (type of feeding tube) to abdomen. D. Record review of R #69's Minimum Data Set (MDS) (an comprehensive assessment of a resident required by federal rules). Section K (a section of the MDS that evaluates and rates a persons swallowing and nutritional status) dated 07/23/21 revealed that Section K was marked as not having a feeding tube. E. On 09/28/21 at 12:19 pm MDS (Minimum Data Set Coordinator) #1 stated Section K is typically completed by the Registered Dietician. MDS #1 confirmed R #69 does have a feeding tube and confirmed MDS dated [DATE] Section K was inaccurate and should have been documented to include R #69 feeding tube. 39509 Resident #228 F. Record review of R #228 face sheet dated 01/04/21 revealed she was admitted on [DATE] with the diagnoses that include: Chronic Respiratory Failure with Hypoxia (low blood oxygen level), Other Disorders of Psychological Development. (diagnoses of either physical or mental impairment or both). G. Record review of MDS Section C (a section of the MDS that evaluates and rates memory and mental status) dated 07/21/21 revealed no review was conducted and was noted as not assessed. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	H. Record review of MDS Section D (a section of the MDS that evaluates and rates mood and related behaviors) dated 07/21/21 revealed no review was conducted and was noted as not assessed. I. On 09/29/21 at 12:19 pm during interview with MDS #1 stated that the MDS evaluations for sections C and D are typically performed by the Social Services Director. MDS #1 stated that during several months there was no Social Services Director. MDS #1 stated that the sections were not completed and were noted as not assessed so the MDS could be completed and submitted on time.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44363 Based on observation, record review, and interview the facility failed to develop baseline care plans for 1 (R #85) of 1 (R #85) residents reviewed. This deficient practice is likely to result in residents not having care plans developed and available for staff review. Without care plans, staff cannot consistently provide needed care and cannot be aware of resident's needs and concerns. The findings are: A. On 09/20/21 at 9:25 am during observation and interview R #85 was observed to have a Foley catheter (a tube that is placed into the bladder to drain urine). R #85 voiced being unhappy with the change in his health causing him to have a Foley catheter and an ostomy (a hole made by surgery to allow stool or urine to leave your body through your belly). B. Record review of Admission Record for R #85 revealed admitted [DATE]. C. Record review of Physician orders for R #85 revealed order for Illiostomy (an ostomy placed in the ileum (lowest part of the small intestine)) Care every shift dated 04/12/21 and an order to Perform Foley Catheter Care every shift dated 04/12/21. D. Record review of Care Plan dated 09/20/21 revealed no Baseline Care Plan to address Foley catheter or Illiostomy on admitted [DATE]. E. On 09/28/21 at 12:07 pm during interview Minimum Data Set Coordinator (MDS) #2 confirmed R #85 was admitted to the facility with both the Foley catheter and the Illiostomy. MDS #2 confirmed R #85 did not have a Baseline Care Plan for a Foley catheter and did not have a Baseline Care plan for the Illiostomy. MDS #2 confirmed a Care Plan should have been initiated by nursing to address Foley catheter and Illiostomy for R #85 on admitted [DATE].

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39509 Based on observation, record review, and interview the facility failed to develop and implement a comprehensive person-centered care plan for 1 (R #105) of 1 (R #105) residents. Failure to develop and implement a resident centered care plan is likely to result in staff's failure to understand and implement the needs and treatments of residents resulting in decline in abilities and a failure to thrive. The findings are: Resident #105 A. Record review of R #105 face sheet dated 09/27/21 revealed she was admitted to the facility on [DATE] with multiple diagnoses including Paraplegia (neurological condition resulting in loss of muscle and body functions). B. Record review of R #105 physician orders revealed she has orders to monitor and manage a Foley Catheter (a medical device which a tube is inserted into the bladder allowing urine to freely drain into an attached bag) and a Colostomy (a medical device placed to divert the movement of product from the large intestine into an attached bag). C. Record review of R #105 care plan revealed no plan in place on care plans for the monitoring and management of either the Foley Catheter or the Colostomy. D. On 09/21/21 at 5:11 pm during interview with Minimum Data Set Coordinator (MDS#1) she reviewed R #105's care plan and confirmed there was no plan in place to care for and manage her Foley Catheter or Colostomy. MDS #1 confirmed the presence and care for both should be included in her care plan.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44363 Based on observation, record review, and interview, the facility failed to revise the care plan for 4 (R #46,105, 114, and 279) of 5 (R #46, 71, 105, 114, and 279) residents reviewed. If the facility is not updating the care plan to reflect the resident's current care areas and treatment, then the facility may not be providing the appropriate care and treatment to meet the residents' needs. The findings are: Findings related to R #46: A. On 09/20/21 at 4:15 pm R #46 was observed to be receiving oxygen. B. Record review of Physician orders for R #46 revealed order dated 06/02/21 for Oxygen at 1.5 L/min (liters per minute) via Nasal Cannula (tubing place in the nostrils that is used to deliver supplemental oxygen) continuously for shortness of breath. C. Record review of care plan dated 09/27/21 revealed no care plan for oxygen. D. On 09/29/21 at 1:25 pm during interview with Director of Nursing (DON) she confirmed R #46 did not have a care plan for oxygen use. DON confirmed R #46 care plan should have been updated when the physician ordered oxygen for R #46. 41988 Findings for R #114: E. Record review of R #114's care plan dated 08/26/21 did not contain O2 (oxygen) use for R #114. F. On 09/20/21 at 12:41 pm during an interview and observation of R #114, R #114 was observed wearing O2. R #114 confirmed he wears O2 daily. G. On 09/20/21 at 12:46 pm during an interview with Certified Nursing Assistant (CNA) #6, she confirmed R #114 was wearing O2. H. On 09/21/21 at 4:49 pm during an interview with the Director of Nursing (DON), she stated, It [R #114 O2 use] should be care planned. Findings for R #279: I. Record review of R #279's physician orders dated 09/15/21 revealed, Colostomy care (care on how to change, empty or clean the the pouch system used to collect human waste). J. Record review of R #279's care plan dated 09/20/21 did not contain Colostomy care or use for R #279. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	K. On 09/21/21 at 4:53 pm during an interview with the DON, she stated, I don't see it [Colostomy care for R #279 in care plan] and it [R #279 Colostomy care] should have been added [to R #279's care plan]. DON confirmed Colostomy was not care planned for R #279 and should have been. 39509 Resident #105 L. Record review of R#105's face sheet revealed she was admitted on [DATE] with multiple diagnoses including, Paraplegia (paralysis that occurs to the lower half of the body). M. Record review of R#105's physician orders dated 09/27/21 revealed orders that included care of a Foley Catheter (a medical tube that is inserted into the bladder and allows the drainage of urine into a plastic bag.) N. Record review of R#105's care plan dated 09/21/21 revealed there was no care plan for the care maintenance of a Foley catheter. O. On 09/21/21 at 5:11 pm during interview with the Minimum Data Set (MDS) Coordinator (MDS#1) she reviewed R#105's care plan and confirmed there was no care plan for the care of a Foley Catheter. She stated that this should have been included in R#105's care plan.

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44363 Based on observation, record review, and interview, the facility failed to meet professional standards for 5 (R #'s 46, 69, 94, 113 and 114) of 5 (R #'s 46, 69, 94, 113 and 114) residents by: 1. Not doing weekly skin checks for R #46 and R #69 in accordance with the physician's order. 2. Not labeling, dating, and changing O2 (oxygen) tubing in accordance with standards of practice and care plan for R #94 and R #114. 3. Not providing anticoagulation medication (blood thinner) monitoring in an acceptable time frame for R #113. 4. Providing oxygen (O2) to R #114 without physician orders. If the facility is not performing weekly skin checks, providing non ordered treatments to residents, not performing anticoagulation medication monitoring, and not changing and labeling O2 tubing as ordered, then residents are likely to not receive the therapeutic benefits and care they need. The findings are: Weekly Skin Check Findings for R #46: A. Record review of face sheet revealed R #46 admitted [DATE] with multiple diagnosis including Chronic Diastolic Congestive Heart Failure (heart disease that affects pumping action of the heart muscles) and Cellulitis (bacterial infection of the skin). B. Record review of R #46 Physician Orders revealed order dated 06/04/21 for Weekly Skin Check by Licensed Nurse on night shift every Friday. C. Record review of R #46 Observation History (list of skin checks) revealed R #46 did not receive a weekly skin check as follows: 1. 06/04/21 2. 07/02/21 3. 07/16/21 4. 07/23/21 5. 07/30/21 6. 09/10/21 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	D. During interview on 09/29/21 at 1:26 PM Director of Nursing (DON) confirmed she is familiar with R #46 and confirmed R #46 is currently being followed by the wound nurse for actual skin breakdown. DON confirmed R #46 had several missing skin checks. DON confirmed the expectation is for residents to have skin checks weekly by licensed nurse as ordered. Weekly Skin Check Findings for R #69: E. Record review of R #69 revealed admitted [DATE] with multiple diagnosis including Personal History of Traumatic Brain Injury (A head injury causing damage to the brain) and Hemiplegia (paralysis of one side of the body) and Hemiparesis (weakness or the inability to move on one side of the body) following Cerebral Infarction (also known as a stroke, refers to damage to tissues in the brain due to a loss of oxygen to the area). F. Record review of R #69 Physician orders revealed order dated 04/08/21 for Weekly skin check by licensed nurse on day shift every Friday. G. Record review of R #69 Observation History (list of skin checks) revealed R #69 did not receive a weekly skin checks from 03/26/21 to 06/04/21. H. On 09/28/21 at 2:57 pm during interview DON confirmed R #69 did not receive weekly skin checks between 03/06/21 and 06/04/21. DON confirmed the expectation is for residents to have skin checks weekly by licensed nurse as ordered. DON confirmed if weekly skin checks are not completed then changes in skin condition might be missed and wounds and sores would go unnoticed and untreated. 41988 Findings for R #94: I. Record review of R #94's physician orders dated 09/16/21 revealed, Oxygen at 2L (liters)/min (minute) Nasal Cannula (a device used to deliver supplemental oxygen or increased airflow). J. On 09/21/21 at 10:03 am during an interview and observation with R #94, R #94 was observed wearing O2. R #94's O2 tubing is not dated or initialed. K. On 09/21/21 at 10:09 am during an interview with Certified Nursing Assistant (CNA) #4, she stated, It [R #94's O2 tubing] looks new, but it [R #94's O2 tubing] should be labeled and dated and it's not. L. On 09/21/21 at 4:49 pm during an interview with the Director of Nursing (DON), she stated, It [R #94's O2 tubing] should have been labeled when it was changed. M. Record review of R #94's physician orders dated 09/16/21 revealed,Oxygen tubing change weekly, Label each component with date and initials, every day shift, every Sun (Sunday) Label each component with date and initial. Findings for R #113: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	N. Record review of R #113's physician orders dated 05/20/21 revealed, Xarelto Tablet (blood thinner to treat and prevent blood clots) 10 MG (milligrams), Give 1 tablet by mouth one time a day for dvt (deep vein thrombosis- a blood clot in the in a deep vein, usually in the legs) prevention. O. Record review of R #113's physician orders dated 09/26/21 revealed, Anticoagulant Medication Monitoring: Monitor for discolored urine, black tarry stools, sudden severe headache, N&V [nausea and vomiting], diarrhea, muscle joint pain, lethargy (lack of energy and enthusiasm periods of weakness), bruising, sudden changes in mental status and, SOB [shortness of breath], nose bleeds-document 'Y' if monitored and none of the above observed. 'N' if monitored and any of the above was observed, select chart code 'other/see nurses notes' and progress note findings. P. On 10/04/21 at 9:17 am during an interview with the DON, she stated, He [R #113] went a while without the order [for anticoagulant medication monitoring]. It [anticoagulant medication monitoring order] should have been in their physician orders. DON confirmed the order to monitor anticoagulant medication use for R #113 should have been input with the initial medication order and not several months later. Findings for R #114: Q. Record review of R #114's physician orders revealed no physician order for O2 use. R. On 09/20/21 at 12:41 pm during an interview and observation, R #114 is observed wearing O2 tubing that was not dated or initialed. R #114 stated, I just started wearing it [O2] recently in here [facility]. S. On 09/20/21 at 12:46 pm during an interview with CNA #6, she stated, He [R #114] wears it [O2] off and on. It [R #114's O2 tubing] should be labeled. CNA #6 confirmed R #114 was wearing O2. T. On 09/21/21 at 4:49 pm during an interview with the DON, she stated, It [R #114 O2 use] should be ordered. DON confirmed R #114 should have physician orders for O2 use.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44363 Based on record review and interview, the facility failed to provide ADL (activities of daily living) assistance for baths/showers for 6 (R #'s 28, 46, 71, 113, 117, and 279) of 6 (R #'s 28, 46, 71, 113, 117, and 279) residents reviewed for ADL care. This deficient practice is likely to affect the dignity and health of the residents. The findings are: Findings for Resident #28 A. On 09/20/21 at 2:33 pm during interview R #28 stated, I don't always get my scheduled showers. I didn't get my shower on Saturday (09/18/21) so I wont get one till Wednesday. If they (staff) miss my shower they (staff) won't give me one in between my scheduled days. B. On 09/22/21 at 5:21 pm during interview Licensed Practical Nurse (LPN) #6 stated she was informed on report (passing of duties from outgoing nurse to on coming nurse) that there was only 3 Certified Nurse Assistants(CNA's) to cover the south halls during the morning shift on (09/22/21). LPN #6 stated she is not sure how everything could get done on the morning shift with only 3 CNA's and staff was not able to provide showers during the morning shift. LPN #6 reviewed R #28 bath/shower documentation and confirmed R #28 had only one shower documented for the month of September which was today (09/22/21). C. Record review of R #28 medical record revealed R #28 was offered and/or received a shower on 09/22/21. No other bath/showers were documented for R #28 for the month of September 2021. D. On 09/27/21 at 12:13 pm during interview with Director of Nursing (DON) she stated the expectation is for residents to be offered a shower twice a week and for bathing to be documented in the resident's electronic medical record in the assigned CNA documentation section and on the weekly bath/shower sheets. DON confirmed R #28 did not have any documented showers in his electronic medical record for the month of September 2021 to show R #28 was offered or received bath/showers. Findings for Resident #46 E. On 09/20/21 at 4:15 pm during interview with R #46 she stated, I would like to take more showers. We get one maybe once a week. If I ask for one they will not give me one if it's not scheduled. Sometimes I don't get one when it is scheduled because they say there is not enough staff to give me a shower. F. Record review of R #46 medical record revealed R #46 was offered and/or received showers on 09/06/21, 09/19/21, and 09/27/21. G. On 09/27/21 at 12:13 pm during interview with DON she confirmed R #46 should be offered a shower a minimum of twice weekly. DON confirmed R #46 was not offered or received bath/showers twice weekly as expected. 45428 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Findings for Resident #71 H. On 09/20/21 at 12:26 during an interview with R #71, she stated. Nursing staff has no time for me and I do not always get my showers as wanted or needed. I would like to have showers done regularly and they (staff) tell me that they do not have time or they are short staffed. I. On 09/23/21 at 1:26 pm during an interview with Certified Nursing Assistant(CNA) #10 she stated, it is difficult to assist R #71 due to lack of staff. J. Record review of shower sheet for the month of September 2021 revealed R #71 had only been offered showers on 09/16/21 and 09/22/21. 41988 Findings for R #113: K. Record review of R #113's care plan dated 05/24/21 revealed, Focus- Resident/Patient is at risk for decreased ability to perform ADL(s) related to: Limited mobility. Interventions- Provide resident/patient with extensive assist for bathing. L. Record review of R #113's Documentation Survey Report dated September 2021 revealed R #113 had not been offered a bath/shower for the entire month. M. Record review of R #113's bath/shower logs located at the nurses station revealed no bath/shower logs present for R #113. N. On 09/20/21 at 3:58 pm during an interview with R #113, he stated, I usually get bed baths and I didn't get one for at least two weeks. I shouldn't have to baby sit these people that are only giving me one [bed bath] a week. I was angry and filled out a grievance for it. O. On 09/23/21 at 9:27 am during an interview with CNA #10, when asked where residents showers and baths are documented if they are provided a bath or a shower or refused a bath or a shower. She stated, It's [resident baths/showers] documented in the shower book and ADL's [in the electronic health record (EHR)]. P. On 09/23/21 at 9:35 am during an interview with CNA #4, she stated, We have scheduled shower days, but sometimes we don't get to them. They [resident baths/showers] should be documented in the shower logs and [Name of EHR]. If it's [R #113's baths/showers] not there [in EHR or shower log], then it didn't happen. He [R #113] never refuses and he [R #113] likes his baths. Q. On 09/23/21 at 1:04 pm during an interview with Licensed Practical Nurse (LPN) #4, she stated, There's nothing in here [shower logs for R #113]. I don't have anything in there [shower logs] for him [R #113]. It [R #113 offered baths/showers] has not been charted in here [EHR] either. LPN #4 confirmed there is no documentation that shows R #113 was offered a bath/shower. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R. On 09/27/21 at 12:13 pm during an interview with the DON, she stated, They [residents] should be offered [a bath or shower] twice a week. They [staff] should be documenting it [bath/shower] in [Name of EHR] and on the shower sheets. I have no additional documentation that proves it [baths/showers] was getting done. Findings for R #117: S. Record review of R #117's care plan dated 05/29/21 revealed, Focus-Resident/Patient requires assistance/is dependent for ADL care in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, toileting related to: generalized weakness. Interventions- Provide resident/patient with total assist of 1 for bathing. T. Record review of R #117's Documentation Survey Report dated September 2021 revealed R #117 refused one bath/shower on 09/01/21, but R #113 had not been offered any other bath/shower for the rest of the month. U. On 09/21/21 at 9:35 am during an interview with R #117, she stated, I feel grungy and I smell myself. I need at least one shower a week and I'm not getting that. V. On 09/23/21 at 9:35 am during an interview with CNA #4, she stated, She [R #117] never refuses and she likes her showers. W. On 09/23/21 at 9:46 am during an interview with CNA #6, she confirmed residents will miss showers due to there not being enough staff available. X. On 09/23/21 at 1:05 pm during an interview with LPN #4, she stated, I see nothing charted for her [R #117] either. Y. On 09/27/21 at 12:13 pm during an interview with the DON, she stated, She's [R #117] going to have to get bed baths only because she's very compromised. (very frail, sick) DON confirmed R #117 was not offered baths/showers as expected. Findings for R #279: Z. Record review of R #279's face sheet revealed R #279 was admitted into the facility on [DATE]. AA. Record review of R #279's care plan dated 09/21/21 revealed, Focus-Resident/Patient is at risk for decreased ability to perform ADL(s) in bathing, personal hygiene, dressing, bed mobility, transfer, locomotion, toileting related to: nausea/vomiting. pain, recent acute illness with recent surgery. Interventions- Provide resident/patient with extensive assist of 1 for bed mobility. transfers, toileting care, colostomy care, (care on how to change, empty or clean the the pouch system used to collect human waste) mobility, personal hygiene, and bathing. BB. Record review of R #279's Documentation Survey Report dated September 2021 revealed R #279 had not been offered any bath/shower for the month. CC. On 09/21/21 at 12:07 pm during an interview with R #279, she stated, I haven't taken take a shower. I don't like laying here 4-5 days without being cleaned. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	DD. On 09/27/21 at 12:13 pm during an interview with the DON, she stated, If she's [R #279] not in the book and I can't find it [documentation of baths/showers being offered], then I can't say it [baths/shower] happened.

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39509 On [DATE], R #281 was found unresponsive in the dining room. Resident was transferred from the dining room to the resident's room before CPR was initiated. R #281 later died . On [DATE], R #283 was found unresponsive in his room following the lunch meal service. Before CPR was initiated, Nurse went to the Nurse's station to look up resident's code status and call 911. CPR was not immediately initiated until full code status was confirmed in the electronic medical record. R #283 was not able to be revived and pronounced deceased . On [DATE] and [DATE] Nursing staff (licensed nurses and certified aides) were interviewed and found to be unaware of resident's advance directives (a resident's code status which describes their wish to either accept or reject emergency intervention such as Cardiopulmonary Resuscitation). Nursing staff stated they must have access to resident's electronic health record (EHR) (a medical resident found on an electronic device such as a computer) to access and identify resident's code status. Nursing Staff stated that EHR's can be found at the computers located at the two facility nurses stations (an area in which staff maintain resident records and computers) or at the front desk. Nursing staff stated that in the event of a resident found non-responsive (unconscious and unable to respond) they would go to the nearest nurses station, review the resident's EHR then return to the residents location with that information to be provided to others on scene or begin treatment according to resident wishes. Nursing staff further stated that if they were to find a non-responsive resident they would begin CPR until the resident's code status was confirmed. Nursing Staff further stated that if they started CPR for a resident found unresponsive they would stop CPR if the resident's codes status was found to be DNR (Do Not Resuscitate: a person's request to not receive emergency intervention). This is process is reported as being the facility policy. This resulted in an Immediate Jeopardy (IJ) at a scope and severity of K (a pattern of jeopardy to resident health and safety) being identified on [DATE] at 1:47 pm. A Plan of Removal was received and rejected on [DATE] at 11:15 am. A Plan of Removal was received and rejected on [DATE] at 12:18 pm. A Plan of Removal was received and accepted on [DATE] at 12:56 pm. Based on this Plan of Removal, the interventions included: 1. An audit of all residents was completed on [DATE] to verify that resident code status orders are congruent (equivalent and the same) with the MOST (Medical Orders for Scope of Treatment) form (a standardized form signed by each resident indicating their wishes to be followed in the event of a medical emergency such as a heart attack). This was completed by the Center Nurse Executive (CNE). Corrective action was taken as necessary to ensure accuracy of resident code status. 2. A printed list of each resident's code status will be carried by each licensed nurse and Certified Medication Aide (CMA) beginning [DATE]. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	3. Licensed nursing staff will be educated on Code Status Orders and Cardiac and/or Respiratory Arrest policies and procedures, as well as maintaining an updated printed document which identifies each resident's code status. The document will be carried on their person at all times while on duty beginning [DATE] or before their next scheduled shift. 4. All facility staff will be educated on procedures related to finding a resident unresponsive. 5. A random audit will be completed 5 times per week for 4 weeks then monthly for 2 months to verify that licensed nurses and CMA's have the printed list of current code status on their person. Based on the Plan of Removal, the Scope and Severity was reduced from the Level of K to H (actual harm). Based on record review and interview, the facility failed to ensure that personnel would be able to provide basic life support to residents requiring emergency care without delay for those residents that have been identified as wanting intervention, and not initiate basic life support for residents' whose wish is to not have intervention. This deficient practice is likely to result in residents who desire emergency intervention to have treatment delayed which is likely to result in death; or residents who do not desire emergency intervention to have unwanted emergency interventions started, resulting in resident receiving severe injuries and unwanted results (Broken bones, punctured lungs, undesired revival). The findings are: Findings for R #281: A. Record review of the complaint allegation received by the State Agency identified While unattended during meal she [R #281] choked and was found dead. Report states she was not a DNR but no one attempted any life saving measures. B. Record review of R #281's progress notes dated [DATE] revealed, This nurse responded to resident in the dining room noted by CNA (Certified nursing assistant) to have her head down and face 'blue'. This nurse assessed resident and noted resident non responsive, eyes open with pupils dilated, resident immediately transported per geri chair [a large padded chair designed to help seniors with limited mobility] to her room and her noted code status is full code, resident placed on floor when CPR [cardiopulmonary resuscitation- an emergency procedure that involves chest compressions] initiated and 911 contacted and responded. Resident transferred out via stretcher with apparent rhythm (had a heartbeat) to [name of local hospital]. C. On [DATE] at 11:11 am during interview with Licensed Practical Nurse (LPN) #1 regarding R #281, she stated A CNA came to the desk and she informed me there was a patient she wanted me to see that wasn't eating, her [R #281] face was blue and her pupils were small. She was taken to her room. LPN #1 described that R #281 was leaning over the table when found and was wheeled in the geri-chair back to her room while being unresponsive. LPN #1 reported that she requested another nurse to call code blue. LPN #1 confirmed she responded to the unresponsive resident in the dining hall and did not begin CPR until the resident was brought to her room due to privacy issues. LPN #1 stated that it was easier to move the resident to her room, than to clear all the residents from the dining room to start CPR. LPN #1 confirmed that she did not immediately know R #281's code status until she was informed by another nurse. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Findings for R #283 D. Record review of R #283's progress notes dated [DATE] revealed, The CNA stated that around 12:00 p. m. the residents food tray was placed in his room, and then between 12:15 p.m. and 12:20 p.m. the resident was observed unresponsive when the residents meal tray was being picked up from his room. The attending nurse was immediately notified, and CPR was initiated as the resident has a Full Code Status. In addition to CPR the AED [Automated External Defibrillator- portable electronic device used to help those experiencing sudden cardiac arrest] defibrillator was also implemented, Crash Cart was brought to the room, suctioning of mouth was started to suction out food particles observed in the mouth and throat. Paramedics (911) were called and dispatched and they arrived at around 12:40 p.m. RN (Registered Nurse) contacted Emergency Contact #1 at 12:45 p.m. to inform him of the residents change In condition. Paramedic arrived and they implemented CPR and other measures but were unsuccessful in their attempt to stabilize the resident, and he passed on. I was called into the room by paramedic prior to them leaving to show me a medium size piece of meat that was laying next to the resident. At 12:50 p.m. RN informed the on-call clinical supervisor again to inform him of the residents passing away, he stated he will contact [Name of local medical investigator]. RN contacted [Name of Emergency Contact #1] to inform him of the residents passed away . RN did the pronunciation and time of death was 1:16 p.m. E. Record review of R #283's face sheet with a print date of [DATE] revealed R #283 was a Full Code. F. On [DATE] at 10:56 am during an interview, the Director of Nursing (DON) stated The CNA found him [R #283] when she went to collect a tray. She [CNA] called the two nurses. Everybody [residents] had metal utensils except for the fork. The piece [of food in R #283's mouth] we found wasn't that tough and we were able to pull it out and I gave that to [Name of local medical investigator]. G. On [DATE] at 11:10 am during an interview with LPN #5, she stated, I didn't go into the room [R #283's room]. I prepared paperwork for him [R #283] and called 911. As soon as we knew there was something going on [R #283 unresponsive], I went to the desk [nursing station] and looked at his [R #283] code status and called 911. It just seems like everyone [staff] went automatically [to R #283's room] when we knew [R #283's code status]. As far as I know, CPR didn't begin [on R #283] until everyone was notified [of R #283's code status]. LPN #5 confirmed she had to go the nurses station to find out R #283's code status and relay that information to the staff in R #283's room before CPR could begin. Findings related to code status: H. Record review of resident census dated [DATE] revealed a census of 107 residents I. Record review of Advance Directive Order Listing Report provided on [DATE] by facility Infection Preventionist revealed that 60 residents requested they be considered as full code (a person's request to receive full emergency intervention should they become unresponsive) should they require emergency intervention. The remaining 47 residents requested they be considered as Do Not Resuscitate and directing that no emergency interventions be provided should they become unresponsive. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	J. On [DATE] at 2:42 pm during interview with the DON she stated that all licensed nursing staff (Registered Nurses and Licensed Practical Nurses) have completed a hands on CPR class in compliance with the American Heart Association in which all were trained in the standard procedure to respond to a resident who is found to be unresponsive. K. On [DATE] at 3:21 pm during interview with LPN #4, she stated that if a resident were found unresponsive she would assess the resident, place the resident in a position and begin doing CPR, she would call somebody to go and look at the medical record [to confirm their code status] before I go and do something, but of course you want to save someone's life. I would start CPR. I have 30 residents, some I've had for more of a long time but for the newer ones I'd have to look (their code status in the medical records) . My people in the front (unit front hallway) I'd automatically assume they are a full code except for the hospice . It's a judgment call. LPN #4 confirmed she would ask staff to clear a room and check a residents code status before beginning CPR. LPN #4 also confirmed she would consider moving an unresponsive resident if possible. L. On [DATE] at 4:11 pm during an interview with LPN #3, she stated, I would approach them [resident] and ask if it would be ok to help them. I would call for help. I would move them [choking resident] to a safer place and I would make sure it was Ok to administer CPR and I would ask someone to check [resident code status]. If I knew they were a full code, I'd start CPR. M. On [DATE] at 9:23 am during interview with Certified Medication Aide (CMA) #3, when asked what she would do if she found a resident unresponsive, she stated I would report it to the nurse. I would have to check the resident's code status. Yeah, of course it would take time. I would try to get them to their room or somewhere with no other residents around [before starting CPR]. N. On [DATE] at 9:30 am during interview with CMA #4, she confirmed that she is CPR certified but that she does not know residents code statuses. CMA #4 confirmed that if she found a resident unresponsive, she would try to arouse them and if not she would get the nurse. Regarding code statuses, CMA #4 stated It's on the computer. It would cause a little delay cause I would have to check the computer or call out for some else to check [code status] if we [staff] weren't by a computer. O. On [DATE] at 9:57 am during interview with Physical Therapist (PT) #1, he confirmed that he is CPR certified however he only knows the code statuses of the residents he works with. If he found a resident unresponsive, he stated that he would call the nurse. P. On [DATE] at 10:01 pm during interview with RN #2 he stated, As an RN, I would try to find out what's going on .I would call the doctor and do CPR and call 911 regardless of their code status. I would get them on a hard surface as quickly as possible. Usually we don't know off the bat (what their code status is) but it's on the screen [at the Nurse's Station computer] and usually we keep a list of code statuses, but I don't see it here right now. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Q. On [DATE] at 11:11 am during interview with LPN #1 she stated We should know everyone's code status, but unfortunately, we would have to send someone to check the code status [of an unresponsive resident]. This happened with a patient a long time ago [referring to R #281] .I'd do everything I could to take care of it (resident's needs) and send someone for help to check their code status. I don't know their (residents) code status. I would start (CPR) immediately, I would start CPR even if I didn't know their code status. LPN #1 stated that it would be reasonable to take up to one minute to locate a resident's code status in the medical record however anything longer than a minute would be considered wasting time to start CPR. R. On [DATE] at 3:08 pm during interview with Regional Nurse Leader (RNL), she stated that Staff should start CPR until the resident's code status can be confirmed. If the resident is DNR, we stop CPR. That is the facility policy. By the time we get the crash cart we know the code status. It's [a resident's code status] on the MAR and TAR [Treatment Administration Record], and iPads for aides on [name of electronic health record]. The nurses station is centrally located. We should keep a printed copy of code statuses. 41988

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44363 Based on observation, record review, and interview the facility failed to provide quality of care for injuries and medication use by not: 1. Assessing for injuries for R #'s 41 and 46. 2. Identifying injuries for R #'s 41 and 46 3. Providing timely notification to a physician for R #'s 41 and 46. 4. Providing important medications for R #282. The deficient practice is likely to result in residents pain not being addressed, discomfort, and a diminished quality of life. The findings are: Findings For R #41: A. Record review of R #41 Progress note dated 09/22/21 stated that a skin check was completed and no new injuries were noted. B. On 09/221/21 at 2:00 pm during observation R #41 was observed to have bruising to her upper left arm on the under side and three bruises to the top of her left wrist. R #41 expressed some discomfort. C. On 09/22/21 at 2:05 pm during interview Licensed Practical Nurse (LPN) #1 stated, I did do the skin assessment on her (R #41) this morning and do not recall her having bruising when I checked her. LPN #1 then went to check R #41 and confirmed R #41 had bruising to her left upper arm on the under side and three bruises on the top of her wrist. LPN #1 stated the bruising under her (R #41) arm appears old. LPN #1 stated bruising should be documented in the residents medical record, the physician should be notified and the residents responsible party should be notified. LPN #1 confirmed R #41 at that time did not have bruises documented and the physician and responsible party were not notified. Findings For R #46: D. Record review for R #46 revealed a bath and skin report dated 09/19/21 with documented redness rash, peeling blisters, open areas, and bruises. Bath and skin report dated 09/19/21 section to be signed by the nurse was blank. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	E. On 09/22/21 at 4:00 pm during interview LPN #6 confirmed she is familiar with R #46 and is aware of an area on her (R #46) sacrum (low back) that had open area that is currently being monitored and has scabs on her (R #46) left shin that LPN #6 stated come and go. LPN #6 confirmed she was not aware of R #46 having any bruising or redness rash. LPN #6 stated she did not work on 09/19/21 and was not made aware of anything new being reported. LPN #6 stated the expectation is for the Certified Nurse Assistant (CNA) to report skin conditions to the nurse. The nurse would then determine if it is new or something the nurse is already aware of and monitoring or providing treatment. If it is, determine the condition is new then the nurse should assess the resident and notify the provider. LPN #6 confirmed there is no documentation by a nurse in R #46 medical record to show that R #46 was assessed by a nurse and there is no documentation that the provider was notified. F. On 09/29/21 at 1:26 pm during interview with the Director of Nursing (DON), she confirmed she is familiar with R #46 and is aware of R #46 having an open area to her sacrum and areas to her left shin that have been described as peeling or blisters. DON confirmed she is not aware of R #46 having redness rash or bruising. DON stated the expectation is for the CNA to notify the nurse of any skin condition found while providing care. DON stated the form requires a nurse to sign off on the form to acknowledge he/she was informed by the CNA. DON verified the bath and skin report dated 09/19/21 was not signed by a nurse. DON stated skin conditions should be assessed by a nurse and should have a documented action taken which should include notifying the DON and physician for directions for further action. DON confirmed she was not aware of R #46 bruising and redness and rash and she confirmed R #46 was not assessed by a nurse on 09/19/21 to address bruising and redness rash and physician was not informed. 41988 Findings For R #282: G. Record review of R #282's face sheet revealed R #282 was admitted into the facility on [DATE] and discharged on [DATE]. H. Record review of R #282's progress notes (as written in the electronic health record) dated 05/11/21 revealed, Note: RN [Registered Nurse] spoke with resident's sister (POA- Power Of Attorney) to notify her that the resident is needing refills on Anti-viral medications Prezcobix 800-150 mg [milligram] tablet and Tivicay (medication used to treat Human Immunodeficiency Virus) 50 mg tablet. She stated she will contact the pharmacy to try to obtain medications. RN provided phone numbers of pharmacy used to contact. I. Record review of R #282's Medication Administration Record (MAR) for May 2021 revealed R #282 was administered Prezcobix 800-150 mg and Tivicay 50 mg, on 05/11/21 and 05/12/21 only. J. On 09/28/21 at 9:41 am during an interview with R #282's POA, she confirmed R #282 went several days without his HIV (Human Immunodeficiency Virus- interferes with the body's ability to fight infections) medications once R #282 returned to the facility. K. On 09/30/21 at 2:48 pm during an interview with the Director of Nursing (DON), she stated, It is our [facility] responsibility to make sure he [R #282] and all facility residents have their current physicians ordered medications. DON further confirmed R #282 went several days without his HIV medication and should not have.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39509 Based on record review, observation, and interview, the facility failed to ensure that residents receive the necessary treatment and services to promote healing of pressure ulcers (skin damage which results from unrelieved pressure on the body) for 2 (R #42 and #113) of 2 (R #42 and #113) residents reviewed, by not identifying and beginning treatment of pressure ulcers immediately, and performing weekly skin assessments for a resident susceptible to pressure ulcers. This deficient practice is likely to result in residents' pressure ulcers not healing and/or getting worse. The findings are: Resident #42 A. Record review of R #42's face sheet revealed she was admitted to the facility on [DATE] with multiple diagnoses including Dementia (a disease of the brain that results in a decline in memory), Cerebral Infarction (a open blood vessel located in the brain causing internal bleeding and pressure), Malignant Neoplasm (a cancer) of the Female Breast. B. Record review of R #42's daily care notes revealed the following: 09/17/21 A skin check was performed. No skin injury/wounds were noted. 09/22/21 Has a small open skin area to the left side of her buttock, tender to touch. 09/26/21 Wound dressing changed to left buttock/sacral area, wound has increased in size since noted by this nurse on 09/23/21, Tx (treatment) per order. C. Record review of R #42's physician orders dated 09/27/21 revealed an order to begin wound care to a sacral (buttock) area. D. Record review of R #42's Treatment Administration Record dated 09/28/21 revealed that no wound care had been documented on or before 09/28/21. E. On 09/29/21 at 1:30 pm during interview with Registered Nurse (RN) #2, he stated that he was the nurse assigned to monitor wound care for the facility. He stated that he was aware of R #42's sacral wound. He stated that he had observed the wound and stated that it was small in size, was skin deep with minimal fluid accumulation. RN #2 reviewed the daily care notes and confirmed that the notes were correct and that R #42's wound had been identified on 09/22/21 and that treatment should have commenced (start) immediately. He also stated the providing physician should have been notified of the new wound immediately. He stated that initial treatment of any wound can commence without a physician's order and can include placing a cream over the wound or placing a bandage over the wound. He confirmed there was no indication this had occurred prior to 09/26/21. 41988 Findings for R #113: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	F. Record review of R #113's care plan dated 05/24/21 revealed, Focus- Resident is at risk for skin breakdown: d/t (due to) hx (history) of vascular ulcers to right foot and left heel. Interventions Observe skin condition daily with ADL (Activities of Daily Living) care and report abnormalities, and Weekly skin check by license nurse. G. Record review of R #113's skin assessment page with a print date of 09/28/21 revealed R #113 received skin assessments on 08/14/21, 08/21/21, and 09/18/21. H. On 09/28/21 at 10:30 am during an interview with the Nurse Practitioner (NP), she stated, Their [facility] staffing is terrible and the person that does wound care is often pulled to the [nursing] floor. They [nursing] should be doing a weekly skin assessment. They [nursing] should be doing a weekly skin assessment at the bare minimum. I. On 09/28/21 at 2:48 pm during an interview with the Director of Nursing (DON), she stated, He [R #113] should have regular skin checks. DON confirmed R #113 did receive weekly skin assessments between 08/21/21 and 09/18/21, and should have been been receiving weekly skin assessments.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39509 Based on observation, record review, and interview the facility failed to properly assess the potential for accidents for 4 (R #24, 55, 85, and 89) of 4 (R #24, 55, 85, and 89) residents reviewed for smoking. If the facility fails to properly assess and supervise residents who smoke, then accidents or serious injury is likely to occur. The findings are: A. On 09/21/21 during observation of the facility, it was noted that there was an open air courtyard. At the entrance to this courtyard was a sign which indicated smoking times beginning at 7:00 am with the last time being 9:00 pm. Each time had a designated department that was to assist and monitor residents while smoking. Observation of the courtyard there were cigarette butts (the filtered unsmoked end of the cigarette) laying on the ground and ashtrays on several table in the courtyard. B. Record review of facility policy and procedure for smoking dated 06/01/96 and revised 11/04/19 revealed: The admitting nurse will perform a smoking evaluation on each patient who chooses to smoke A patient's smoking status-independent, supervised, or not permitted to smoke . Smoking supplies (including but not limited to tobacco, matches, lighters, lighter fluid etc) will be labeled with the patient's name, room number and bed number, maintained by staff and stored in a suitable cabinet kept at the nursing station. Patients will not be allowed to maintain their own lighter, lighter fluid, or matches. C. Record review of Smoking Assessments revealed: R #24 smoking assessment dated [DATE], R#24 requires supervision while smoking R #55 smoking assessment dated [DATE], R#55 requires supervision while smoking R #89 smoking assessment dated [DATE], R#89 requires supervision while smoking D. Smoking Observations 1. On 09/21/21 at 9:12 am R #89 was observed as she entered the smoking area. She reached to the ground, picked up a cigarette butt and moved towards a resident sitting at a table smoking. R #89 asked the resident for and was provided a lighter to light her cigarette butt. She lit her cigarette butt and sat down to smoke. There was no staff present in the smoking area at the time. 2. On 09/21/21 at 12:01 pm R #24 was observed sitting in the smoking area smoking a cigarette with no staff present. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. On 09/22/21 at 10:05 am multiple residents including R #55 and R #89 were observed entering the smoking area. Staff arrived and from a box he drew cigarettes and gave them to the residents present and lit cigarettes for all residents. At 10:06 am he left the area leaving the box on a table next to R #55. at 10:08 am the staff returned to the area with a snack. He leaned against a rail and consumed his snack as residents smoked. At 10:11 am staff again left the area and returned at 11:12 am. At 11:13 am staff again left the smoking area taking the supply box with him. R #55 continued to smoke her cigarette after staff left. She reached into an ashtray, picked up a cigarette butt and then lit and continued to smoke the cigarette. At 11:15 am staff returned with a bottle of water for R #55 as she continued to smoke. He gave her the water and exits the area. At 11:16 am R #55 finished smoking and exits the area. 4. On 09/22/21 at 5:26 pm R #24 was observed in his wheelchair as he propelled himself past the nursing station. He was observed to remove a pack of cigarettes and a lighter from his pocket. He removed a cigarette, exited the building to the outside smoking area where he lit his cigarette, went to a table and sat and smoked his cigarette. 5. On 09/23/21 at 9:46 am R #24 is observed sitting in the smoking area smoking a cigarette there is no staff in the area. 6. On 09/23/21 at 1:19 pm Certified Nurses Aide (CNA) accompanied R #89 into the smoking area where he provided a cigarette and light to R #89. CNA then stepped back to a corner area where he sat and used his cell phone-he was not observed to lift his head up from his phone to observe residents during this time. At 1:24 pm R #89 had finished smoking his cigarette and left the area. CNA continued to use his cell phone until 1:26 pm when he exited the area. 7. 09/27/21 12:13 PM R #89 was sitting in the smoking area she is observed to ask another resident for a cigarette. The resident provided her a cigarette and a lighter. She lit the cigarette and sat down to smoke. There was no staff present and no one monitoring the area. 8. 09/27/21 4:06 pm Multiple residents including R's # 55 and 89 were in the smoking area smoking. A CNA is sitting by a window using his cell phone. At 4:08 pm CNA left the smoking area as residents including R #55 and 89 are still smoking. At 4:11 pm the smoking residents finished smoking and left the area. E. On 09/28/21 02:40 PM during interview with the Director of Nursing (DON) and Administrator (ADM) they stated that all smokers, no matter how they are assessed are expected to smoke during assigned times. They stated that residents no matter how they are assessed are asked to turn in all smoking materials. They stated that smokers are not suppose to have lighters on their person or in their rooms. They stated that when residents are in the smoking area, they should be closely monitored and that staff should not be distracted by cell phones while monitoring smokers. 44363 Resident #85 F. On 09/20/21 at 1:13 pm during interview R #85 stated he has always smoked cigarette and confirmed he smokes cigarettes at this facility. (continued on next page)

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Rio Rancho Center	4210 Sabana Grande SE Rio Rancho, NM 87124

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	G. On 09/22/21 at 1:43 pm during interview RN (Registered Nurse) #1 confirmed she is aware of R #85 smoking cigarettes. RN #1 stated, he (R #85) likes to smoke and will be outside all day. RN #1 stated, He (R #85) was smoking in his room Saturday. RN #1 stated she provided education to R #85 regarding smoking policy and explained to him that he could not smoke in the building. RN #1 confirmed residents should not be keeping cigarettes and lighters in their rooms. H. Record review of medical record for R #85 revealed the following: 1. 09/04/21 at 3:21 pm progress note stated, Staff found cigarettes and lighter in R #85's room. 2. 09/18/2021 at 7:41 am progress note stated R #85 room smelled like smoke earlier this morning but resident denied smoking in the room. Resident was reminded that smoking is not allowed in the rooms that he must go outside during the designated smoking times and resident expresses understanding. 3. 09/18/2021 at 10:42 am progress notes stated, Housekeeper brought this nurse resident's (R #85) garbage can inside which were two cigarettes that had been smoked and an empty pack of cigarettes. Floor supervisor and Director of Nursing (DON) made aware. 4. 09/20/21 smoking assessment was completed for R #85. I. On 09/28/21 at 2:45 pm during interview with DON confirmed R #85 should have had a smoking assessment done when they found the cigarettes and lighter in his room on 09/04/21.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 44363 Based on observation, record review, and interview, the facility failed to provide appropriate indwelling catheter (tube inserted either through the urethra (duct by which urine exits the body from the bladder) care for 1 (R #85) of 1 (R #85) reviewed for indwelling catheters and UTI's (Urinary Tract Infections). These deficient practices fail to provide resident dignity and is likely to result in resident developing a urinary tract infection. The findings are: A. On 09/20/21 at 9:05 am during observation and interview R #85 was observed in the activity room, in his wheel chair. R #85 catheter drainage bag was not covered for dignity and was not below the bladder. R #85 stated that he does not like having a catheter because he is able to urinate on his own. R #85 stated he has had an infection related to his catheter. B. On 09/20/21 at 9:25 am during interview Certified Nurse Assistant (CNA) #9 and Licensed Practical Nurse (LPN) #1 confirmed drainage bag is not covered for dignity and stated usually the residents has a cover over their catheter drainage bag. LPN #1 also verified catheter drainage bag should be kept below the bladder and was not. C. On 09/20/21 at 12:22 pm R #85 was observed in his room in his bed. Catheter drainage bag was observed on hand rail on bed and was not below R #85 bladder. Catheter drainage bag continued to be without a dignity cover. D. On 09/23/21 at 1:39 pm R #85 was observed in activity room in his wheel chair. R #85 catheter drainage bag and tubing were observed on the floor. At 1:57 pm therapy staff observed walking residents back to their rooms on north hall, no staff stopped to address drainage bag on floor. At 2:19 pm Occupational Therapist (OT) #1 and CNA #1 verified R #85 catheter drainage bag and tubing were both on the floor and shouldn't be. OT #1 and CNA #1 assisted with ensuring R #85 catheter drainage bag and tubing were off the floor. OT #1 looked for a place to but catheter drainage bag on wheelchair and stated usually there is a place on the back of the wheel chair to hang the bag but there is not on R #85 chair. E. Record review of Physician orders for R #85 revealed an order dated 04/12/21 for the use and reason for the Foley catheter to bedside, straight drainage for the diagnosis/history of need because of Complicated sacral/perineal wounds. F. Record Review of Physician order revealed antibiotic orders for UTI's as follows: 1. 06/21/21 Cephalexin (medication used to treat infections) Capsule 500 MG (miligram) Give 1 capsule by mouth four times a day for 10 days for UTI. 2. 09/10/21 Cephalexin Capsule 500 MG Give 1 capsule by mouth four times a day for 5 days for UTI. G. On 09/28/21 at 2:57 pm during interview with Director of Nursing (DON) she confirmed the expectation is for catheter drainage bags to be covered for dignity. DON confirmed catheter drainage bags should be kept below the bladder and tubing should not be on the floor.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41988 Based on observation, record review, and interview, the facility failed to ensure the enteral tube feeding [a device utilized to provide liquid nutrition and medications, via a tube into the stomach or intestine] nutritional supplement bottle for 1 (R #94) of 1 (R #94) residents reviewed, was managed according to current acceptable standards of practice to ensure safety of the resident. This deficient practice is likely to cause significant health problems, resulting from residents being exposed to previously used or expired supplies. The findings are: A. Record review of R #94's Medication Administration Record (MAR) dated [DATE] revealed the following: 1. Enteral Feed (intake of food via the gastrointestinal tract) Order every shift Glucerna: 1.5 CAL (specialized nutrition with fiber providing complete nutrition), Administer Continuous via Pump_ 50 ML (milliliters) per hour for a total of 1200 ml/1800 kcal (kilocalories- a unit of energy)/24 hours.-Start Date- [DATE]. 2. Enteral Feed: Check for residual Daily. If 500 ML or over, hold feeding for one hour and recheck. If residual is 250 ML or over (upon recheck) hold feeding, notify physician and document amount in ml. every shift-Start Date- [DATE]. B. On [DATE] at 10:01 am during an observation, R #94 is observed actively receiving enteral feeding and nutritional supplement bottle had no date, labeling, or initialing noted as to when the feeding was started. C. On [DATE] at 10:16 am during an interview with Registered Nurse (RN) #4, he stated, It [R #94's nutritional supplement bottle] should be dated and initialed. I'm going to have to put a new one [nutritional supplement bottle] and replace it. D. On [DATE] at 4:47 pm during an interview with the Director of Nursing (DON), she stated, It [R #94's nutritional supplement bottle] should have been labeled and dated.

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39509 On 09/29/21 during observation of wound care for R #23, R #23 was grimacing and expressing pain during movement and wound care. Interview with staff confirmed that R #23 receives wound care daily and is repositioned every 2 hours, each time expressing pain during repositioning and wound care. Record review for R #23 revealed order for resident to receive pain medication 30 minutes prior to wound care and movement, however this was not being administered to R #23 as intended despite staff awareness of R #23's pain. In addition, record review and interview also revealed that R #42 was expressing an increase in agitation due to pain of a pressure wound, however was not provided pain medication despite an order for as needed pain medication being available to R #42. These deficient practices resulted in an Immediate Jeopardy (IJ) at a scope and severity of K [pattern of jeopardy to resident health and safety] being identified on 09/29/21 at 6:25 pm. A Plan of Removal was approved and verified on 09/30/21 at 1:55 pm. Based on the Plan of Removal, the interventions included: 1. A comprehensive pain assessments of R's #23 and 42 were conducted by a licensed nurse, results were communicated to the attending physician and new orders received. Both residents were medicated per attending physician orders. 2. The identified Certified Nursing Aide (CNA) and nurse were educated by the Center Nurse Executive (CNE) regarding pain management. 3. Current residents received comprehensive pain assessments on 09/29/21 to assess resident pain with wound care or any residual pain associated with wound care. Any assessed pain that was identified as not addressed will be reviewed with residents attending physician and/or designee for any needed order changes and/or medical treatment plan. Orders and/or changes to treatment plans will be implemented upon receipt from attending physician. 4. Licensed nurses will be educated by the Nurse Practice Educator/Infection Preventionist (NPE/IP) on pain management, including but not limited to offering pain medication as ordered prior to wound care, ceasing wound care for residents with associated pain until pain can be controlled, assessing for pain, implementation of interventions and pain re-evaluation beginning 09/29/21 or before their next scheduled shift. 5. CNA or designee reviewed pain monitoring orders for current residents on 09/29/21 to ensure pain is monitored and documented every shift with corrective action taken as necessary. 6. The Interdisciplinary Team (IDT) will review identified concerns related to pain or ineffective pain management interventions are in place. 7. A random sample audit of residents that receive wound care will be completed 5 times a week to evaluate effective pain management by the CNE with corrective action taken as necessary. Based on the Plan of Removal, the Scope and Severity was reduced from the level K to a level H. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Based on observation, record review, and interview, the facility failed to ensure that pain management was provided for 2 (R #23 and 42) of 4 (R #23, 42, 113, and 122) residents reviewed for wound care. This deficient practice likely resulted in R #23 and #42 experiencing unrelieved pain. The findings are: Findings related to R #23 A. Record review of the Physician Orders for R #23 revealed that he was admitted to the facility on [DATE]. B. Record review of R #23's Physician Order dated 07/19/21 revealed that resident is to be given 600 mg (milligrams) Ibuprofen (a Non-narcotic pain relieving medication) 30 minutes before body movement and dressing change. C. Record review of the Medication Administration Record (MAR) dated September 2021 revealed R #23 had received this medication twice in the past month on 09/20/21 and 09/27/21. D. On 09/29/21 at 2:30 pm during observation and interview, CNA #10, Licensed Practical Nurse (LPN) #3 and LPN #4 were observed as they provided wound care to several wounds at different locations on R #23's body. All three staff members worked to move R #23 from his right side to his left side so they could complete dressing changes of each wound. They then changed R #23's brief and replaced his bedding. R #23 was observed to grunt and grimace (a facial expression of pain) and speak up saying watch it as he was moved. R #23 is unable to engage in a conversation does use facial expressions and some words to express pain/emotion. During interview all three staff stated that R #23 frequently complained of pain, that he often yelled out anytime he was moved from side to side. E On 09/29/21 at 2:30 pm during interview with LPNs #3 & 4 both stated that R #23 is provided dressing changes daily as ordered and occasionally as needed. F. On 09/29/21 at 2:30 pm during interview with CNA #10, she stated that R #23 is moved and repositioned from side to side at least every two hours or more often if needed. CNA #10 confirmed that R #23 frequently expressed pain during repositioning. G. On 09/29/21 at 2:30 pm during interview with LPNs #3 and 4, both stated R #23 is very contracted (a condition in which muscles are constantly tense) and cannot extend his arms and legs without pain. H. On 09/29/22 at 3:22 pm during interview LPN #3 confirmed that R #23's physician's order included an order to medicate R #23 with 600 mg Ibuprofen, 30 minutes before dressing changes and body movements. LPN #3 confirmed that R #23 was not provided pain medication prior to wound care despite demonstrating pain during movement and wound care. I. On 09/29/21 at 4:10 pm during interview with LPN #4, she stated that she thought R #23 was always in pain. Findings related to R #42 (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	J. Record review of R #42's Physician Order dated 04/19/19 revealed an order for the administration of Acetaminophen Extended Release (a non-narcotic pain relieving medication intended to release it's properties over an extended period of time) tablet 650 mg give one tablet by mouth every 6 hours as needed for pain. K. Record review of daily progress note dated 09/28/21 at 1:22 pm revealed resident struck and hit left side torso (Upper body/Chest) of CNA during incontinence care (care provided to change brief and/or clean the lower body of feces and urine). Resident with residual agitation (pain or discomfort as the result of care provided) associated with wound care provision. Progress note did not identify any interventions to relieve R #42's pain. L. Record review of progress note dated 09/29/21 at 3:14 pm resident has been moved to room [ROOM NUMBER] A associated with poor roommate compatibility. Resident has exhibited increased verbal behaviors possible due to wound discomfort to left sacral area (tail bone). Progress note did not identify any interventions to relieve R #42's pain. M. Record review of R #42's MAR revealed R #42's last administered dose of Acetaminophen Extended Release was administered on 09/13/21 and that she has no other pain relieving medication administered for her. N. On 09/29/21 at 4:54 pm interview with nurse she stated R #42 has been in pain since yesterday-09/28/21- after wound care was provided by nurse practitioner. Nurse confirmed that no pain medication had been administered to R #42 since 09/13/21, despite staff awareness that R #42 was exhibiting pain related to her wound.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. 44363 Based on interview and record review, the facility failed to ensure resident specific physician orders and ongoing communication and collaboration (different persons/groups working together) with the dialysis (clinical purification of blood as substitute for normal kidney functioning) facility regarding dialysis care and services for 2 (R #10 and 51) of 2 (R #10 and 51) residents reviewed for dialysis. If the facility is unaware of the status, condition, or complications that arise during dialysis treatment, then residents are likely to not receive the appropriate monitoring and care they need. The findings are: Findings for R #10 A. Record review of R #10 Nursing Documentation Note dated 05/29/21 revealed that daily documentation of R #10's care was to be completed daily and include all nursing services and assessments provided to R #10 including Dialysis. None of the nursing documentation notes included any reference to Dialysis. B. Record review of R #10 Physician Orders revealed no order for R #10 to receive Dialysis. C. Record review of R #10 Medical Record revealed no documentation addressing the status or condition before and after Dialysis treatments. D. On 09/28/21 at 2:50 pm during interview with Director of Nursing (DON) she confirmed R #10 was being transported by the facility to a dialysis clinic three times per week, on Tuesdays, Thursdays, and Saturdays. DON confirmed there was not a physician order in R #10 medical record for Dialysis and confirmed R #10 should have had an order for Dialysis. DON confirmed that nursing staff should document the resident's condition, vital signs and any other relevant information prior to being transported to Dialysis. Nurses should then document the resident's condition and any other relevant information upon return from dialysis. DON was unable to provide any such documentation for R#10. 41988 Findings for R #51: E. Record review of R #51's physician orders dated 06/29/20 revealed, Dialysis center phone number is: _____Dialysis days: _____ Time for Pick up: _____ Transport to: _____Nephrologists' (a physician who specializes in the treatment of kidney disease) name: _____Phone Number: _____. R #51's dialysis order was not completed or resident specific. F. Record review of R #51's facility Dialysis Communication Record revealed forms for the following dates, 07/02/21, 07/19/21, 07/23/21, 07/30/21, 08/13/21, 08/27/21, and 08/30/21. Each form provided is incomplete and sections required by the facility to complete pre and post dialysis is blank. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	G. On 09/28/21 at 3:01 pm during an interview with the Director of Nursing (DON), she confirmed R #51's physician orders for dialysis were not complete or specific for R #51 dialysis use and should have been. DON also stated, I would expect us [facility] to fill it [Dialysis Communication Forms] out. DON also confirmed R #51's Dialysis Communication Forms were not filled out by the facility and should have been.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 39509 Based on record review and interview the facility failed to ensure that they had sufficient staff to meet the needs of all 107 residents identified by the facility census provided by the Administrator (ADM) on 09/20/21. Residents were not provided showers per their personal preferences. This deficient practice is likely to result in residents being uncomfortable and feeling dirty and unclean. The findings are: Resident Council Concerns A. On 09/22/21 at 10:07 am during interview with the Resident Council (RC) which consisted of R # 26, 28, 38, 56, 58, 75, 106 and 126, they identified that their primary grievances are related to food preferences not being honored, cell phone use by staff, and showers not being offered. R#26 B. Record review of R#26 shower sheets (documents that indicate when showers are offered and completed to resident) dated September 2021 indicated there was not any shower information entered during a two week period of September 4-18. On 09/22/21 at 10:07 am R #26 stated he had not been offered a shower during the two weeks prior to 09/22/21. R#71 C. On 09/27/21 at 11:45 am record review of R#71 shower sheet revealed she had been offered showers on 09/16/21 and 09/22/21 for during the month of September. D. On 09/20/21 at 12:26 during an interview with R #71 she stated, nursing staff has no time for her(R #71) and are inconsistent with assisting R #71 with activities of daily living, R #71 stated she would like to have showers done regularly. E. On 09/23/21 at 1:26 pm during an interview with certified nursing assistant(CNA) #10 she stated, it is difficult to assist R #71 due to lack of staff. R#117 F. On 09/21/21 at 9:35 am during an interview with R #117, she stated, I feel grungy and I smell myself. I need at least one shower a week and I'm not getting that. G. On 09/23/21 at 9:35 am during an interview with CNA #4, she stated, She [R #117] never refuses and she likes her showers. H. On 09/23/21 at 9:46 am during an interview with CNA #6, she confirmed residents will miss showers due to there not being enough staff available. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Staff interviews regarding staffing to assist with showers I. On 09/22/21 at 5:21 pm during interview Licensed Practical Nurse (LPN) #6 stated there were only 3 CNA's to cover the south halls during the morning shift. LPN #6 stated she is not sure how everything could get done on the morning shift with 3 CNA's. LPN #6 stated staff was not able to provide showers during the morning shift because there were only 3 CNA's. J. On 09/23/21 at 9:35 am during an interview with CNA #4, she stated, We have scheduled shower days, but sometimes we don't get to them.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 34439 Based on record review and interview, the facility failed to maintain the posted daily nurse staffing data (schedule) for a minimum of 18 months. This deficient practice is likely to result in all 107 residents residing in the facility to not have access to accurate staffing information. A. Record review of facility daily nurse staffing data revealed that the facility was able to provide staff posting for the month of September 2021 and no other months for the year of 2021. B. On 09/29/21 at 1:33 pm during interview with Office Manager (OM) she stated that she did not have and could not reproduce the past 18 months of posted daily nurse staffing data. She stated that she did not keep the daily postings, that she normally threw them away. She also stated she was able to reproduce the data from her computer for only the past 30 days. C. On 09/29/21 at 1:33 pm during interview with the Director of Nursing (DON), she stated that the daily posting's should be maintained for 18 months and that they should not be thrown away daily as indicated by the OM.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 44363 Based on record review and interview, the facility failed to complete monthly pharmacy reviews of resident medication orders for 4 (R#19, 28, 96, and 228) of 6 (R# 19, 28, 69, 96, 113, and 228) residents. This deficient practice is likely to result in residents receiving medications contrary to their needs or optimal (best possible) benefits. The findings are: Resident #28 A. Record review of Progress Notes for R #28 revealed a Drug Regimen Review Documentation (DRR) note was entered by the Pharmacist/Pharmacy consult on 06/28/21. Note stated that a medication regimen review was performed and to see report for comments/recommendation(s). B. Record review of R #28 medical record failed to show report from pharmacist with comments/recommendations. C. On 09/23/21 at 11:28 am during interview with Director of Nursing (DON) she confirmed there are missing reports for Medication Regimen Review from the pharmacist. DON was unable to provide information on report and comments/recommendations made for R #28 by pharmacist on 06/28/21 and was unable to show if or how recommendations were addressed. 39509 Residents #19, 96, 228 E. Record review of R #19 monthly pharmacy review revealed there was no pharmacy review documented for the months of November 2020, March 2021, and July 2021. G. Record review of R #96 monthly pharmacy review revealed there was no pharmacy review documented for the months of November 2020, January 2021, March 2021, June 202,1 and July 2021 H. Record review of R #228 monthly pharmacy review revealed there was no pharmacy review documented for the months of November 2020, January 2021, March 2021, June 202,1 and July 2021 I. 10/04/21 09:17 AM during interview with DON, she confirmed that there were several months of pharmacy review documents that were missing and others that were available but not complete.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 34439 Based on record review, observation, and interview the facility failed to: 1. Ensure medications were labeled appropriately for 1 (R#61) resident 1. Ensure medications that were expired were not stored with current medications 2 Ensure that all boxes in the medication storage room were stored off the bare floor 3. Ensure that loose pills in the medication carts are removed. 4. Ensure medications are not left unattended at the nurses station These deficient practices are likely to result in resident injury, through dosing with expired medications, dosing with medications that have been improperly stored and dosing with wrong medications related to medications not being properly labeled. The findings are: A. On 09/2021 at 4:30 pm during observation of the North front even number rooms medication cart a Novolog Flex Pen (insulin pen) belonging to R #61 was observed to have been opened on 08/16/21 and expired on 09/13/21. B. On 09/20/21 at 4:34 pm during an interview with LPN (Licensed Practical Nurse) #3, confirmed Novolog Flex Pen belonging to R #61 was opened on 08/16/21 and had expired on 09/13/21 and it should have been discard and not used beyond the expiration date. C. On 09/28/21 at 2:49 pm during observation of central supply room the following was observed: one large box of gloves, one large box of plastic translucent cups and two boxes of Ambu bags(self inflating bag used to provide ventilation to a person not breathing normally), dust on shelving and floor, debris (empty packaging, wrappers, used gloves) on shelving and floor, one open pack of medication cups on the floor, two bottles of Gericare Iron supplement (a liquid dietary supplement to iron, a key mineral that's often lacking in diets) that had expired on 11/2019, five boxes of pure and gentle enema saline laxative (used to treat constipation) that had expired on 01/2020, seven boxes of pure and gentle enema saline laxative that had expired on 12/2020. D. On 09/28/21 at 2:53 PM during an interview with Infection Preventionist (IP) he confirmed that the iron supplement and the enema saline laxative were expired. E. On 09/20/21 at 3:50 pm during observation of the south back medication cart the following was observed: three lose pills , one unidentified small round blue pill, one unidentified oblong yellow pill, one unidentified oblong white pill were in the second drawer of the cart. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	F. On 09/20/21 at 3:52 pm during an interview with Registered Nurse (RN) #3, he stated, those pills should not be in there and he proceeded to discard them in the sharps(container used to safely dispose of needles and other sharp objects) container attached to the medication cart. G. On 09/20/21 at 3:59 pm during observation of the south front medication cart the following was observed: one half of an unidentified small white oblong pill was observed in the second drawer of the cart. Record review of narcotic book kept on the medication cart revealed liquid morphine (medication used to control pain) for R #39 was documented as containing 14.25 milliliter (ml) of morphine and was observed to contain 12 ml. H. On 09/20/21 at 4:04 pm during an interview with LPN #2 she stated that pills should not be in the drawer and discarded the pill in the sharps container attached to the medication cart. LPN #2 stated she normally would discard medications in the medication room. I. On 09/20/21 at 5:28 pm Director of Nursing (DON) confirmed that the liquid morphine was recorded as 14. 25 ml and the bottle revealed 12 ml. She stated, I will be looking in to this (missing Morphine). J. On 09/20/21 at 4:42 pm during observation and interview with LPN#5 of the north front odd number room medication cart a cup containing nine unlabeled, undated pills was observed in the top drawer of the cart. LPN #5 stated those medications are not labeled or dated but they belong to R #129, R #129 refused to take her medications this morning and I did not discard them. K. On 09/28/21 at 2:40 pm during observation of the north medication room the following was observed: debris (empty packaging, wrappers, used gloves) were observed on the floor and on the counter tops., L. On 09/22/21 at 4:00 pm during random observation of north nurses station the following was observed: a medication card (packaging used to hold medications) containing 22 Klorocon 8 meq (potassium chloride) tablet for R #63, a medication card containing 30 tablets of Carvedilo(beta blocker used for high blood pressure) 3.12 mg for R #128 and a medication card containing 15 tablets of Digoxin (used for blood pressure support)125 mcg (micrograms) for R #129. Medications were observed sitting on the counter unattended. M. On 09/22/21 at 4:40 pm during and interview with Certified Medication Aide (CMA)#2, he stated, that medications should never be left unattended and unlocked. During observation R #49, R #61, R #75 and R #126 were observed on and around north nurses station where medications were left unattended. N. On 09/22/21 at 4:53 pm during an interview with DON, she stated. It is not acceptable to have any medication left out (unattended) like that. 45428

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 41988 Based on observation, record review, and interview, the facility failed to ensure the nutritional needs and preferences were met for all 107 residents listed on the facility census provided by the Administrator (ADM) on 09/20/21 by: 1. Not following meal tickets or the menu for R #'s 113, #114, and #117. 2. Not ensuring menus were posted in areas that were visible by all 107 residents. 3. Not ensuring residents were given food choices and that resident food preferences were honored. 4. Not providing an alternative meal to residents that request an alternate meal. If the facility is not following meal tickets, posting menus, honoring resident's meal choices/preferences, and not providing an alternative meal, then residents are likely to have experience weight loss, frustration, and depression. The findings are: Not Following Meal Tickets: Findings for R #113: A. Record review of R #113's physician orders dated 05/20/21 revealed, Consistent Carbohydrate diet (a diet in which carbohydrate intake is either limited or set at a particular value), Regular Texture. B. Record review of R #113's meal tickets revealed, Consistent Carbohydrate, Double Meat or egg and veg (vegetables) only. Do not double bread, casserole. Large Portions, Extra Protein. C. On 09/20/21 at 3:55 pm during an interview with R #113, he stated, They don't offer a diabetic diet [consistent carbohydrate]. R #113 also confirmed he is rarely given double portions as stated on his meal ticket. D. On 09/22/21 at 6:03 pm during an interview with R #113, he stated, It looks like I got everything except double portion. She [Certified Nursing Assistant (CNA) #13] just said they don't have extra [food for double portions]. It's an ongoing issue. E. On 09/22/21 at 6:07 pm during an interview with CNA #13, she stated,They had to go get some more [food for R #113] from the kitchen. CNA #13 confirmed R #113 was not served double portions. F. On 09/27/21 at 3:13 pm during an interview with the Dietary Manager (DM), he stated, It [R #113 not receiving double portions] has to do with my crew not paying attention to [meal] tickets. DM confirmed R #113 should have been served double portions. Findings for R #114: (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	G. Record review of R #114's meal ticket dated 09/20/21 revealed the following meal served; Garden Harvest Soup, Saltines, Egg Salad Sandwich on Wheat, Lettuce and Tomato Half Slices, Watermelon, 2% (percent) Milk, Pickled Beets, and Assorted Beverage. H. On 09/20/21 at 12:35 pm during an observation of R #114, R #114 is observed being served lunch. R #114's lunch consists of a bowl of soup, ice cream, and one bread stick with one scoop of egg salad on plate. I. On 09/20/21 at 12:48 pm during an interview with CNA #6, she stated, It [R #114's meal] just looks like a scoop of egg salad and bread stick. J. On 09/27/21 at 3:02 pm during an interview with the DM, he stated, I came up short on my bread order. The cook that I had that day was getting ready to send out lunch and she said she didn't have enough bread. I was in a situation where I only have enough to give all residents and that was bread sticks. It was the choice I was forced to make. Findings for R #117: K. Record review of R #117's meal ticket dated 09/22/21 revealed the following meal served; Tossed Salad w/ (with) Signature Dressing, Ice Cream Variety, Saltines, Potato Salad, Assorted Beverage, Black Beans, Veggie Cheeseburger on Roll, and Ketchup. L. On 09/22/21 at 12:12 pm during an interview and observation, R #117 is served lunch which consists of a tossed salad with cucumbers and mushrooms, one scoop of potato salad, and chocolate ice cream. R #117 stated, They [dietary staff] never get these [meals] right. They [CNA's] can come and get this [tray]. They [dietary staff] didn't even send salad dressing. I want beans, rice, and vegetables I can eat. M. On 09/22/21 at 12:19 pm during an interview with CNA #6, she confirmed R #117 was not served everything listed on the ticket. CNA #6 stated, I'll just take the tray and put it back. CNA #6 also confirmed R #117 will not be brought an alternative lunch. N. On 09/27/21 at 2:42 pm during an interview with the DM, he stated, She [R #117] doesn't like salad. She [R #117] doesn't care for the veggie cheeseburger all of the time. They [CNA's] come to me and say X,Y, and Z didn't get salad dressing. I'm rebuilding a staff that was broken when I got here. Not ensuring menus were posted and Food Choices/ Preferences: O. On 09/23/21 at 9:34 am during a random observation of posted menus revealed, one was located in the activity room, and the other one was located by the facility dinning room (not currently being used is being remodeled). The posted menus only revealed the breakfast menu for the day no other meals were posted. P. On 09/23/21 at 9:55 am during an interview with Certified Nursing Assistant (CNA) #4, she stated, We just serve the food we are given and residents will always ask us why things are missing, so we tell them we can go check. I'm not sure who takes the orders or if everyone is served the same thing. CNA #4 confirmed she does not take residents orders before each meal. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Q. On 09/23/21 at 12:19 pm during an interview with CNA #6, she confirmed she does not take resident orders before each meal. R. On 09/23/21 at 1:12 pm during an interview with the Activities Director (AD), she stated, they [dietary staff] are the ones that change those [posted menus]. AD confirmed both posted menus still only revealed the breakfast menu. S. On 09/27/21 at 2:48 pm during an interview with the Dietary Manager (DM), he stated, As far as I understand, what comes on their [resident meal] tickets is based on their [resident] preferences. There are no [meal] choices. It would be the CNA's [that take resident meal orders] I'm not sure how it is, there isn't a daily [meal] choice. DM also stated he was not sure if residents had menus in their rooms and understood that some residents could not leave their rooms, so those residents would most likely not know what the daily meals served would be. T. On 09/28/21 at 3:17 pm during an interview with the Administrator (ADM), she stated, It [resident meals] is generated by the system and it is put into the system by their [resident] likes and dislikes. It's [resident meals] not a daily selection. That's something that we can look at like giving them [residents] menus in their [residents] rooms. We have a company that is contracted for food service and they are they ones that put out the meals. The facility will assist the food service department if they need to purchase any items that they may need, but the facility does not make any of the food selections. The residents can talk about it in the resident council meetings. U. On 09/28/21 at 3:44 pm during an interview with the Regional Dietary Manager (RDM), he stated, Upon entrance, we do preferencing, we have a meal tracker to keep track of their [resident] meals. This system toggles between all dynamics. It starts with texture modification and then therapeutic modifications. It strictly goes off of preferences. Say they hate meat loaf and like fish, it'll go to fish for the main. They have a choice on the two meals measured off of preference and diet modification. There's not that restaurant style menu available. They have a choice on what's on the menu based off of preferences, and based on what feedback they give when the assessment is done upon admission. We don't technically post an always available on the meal ticket with this system. The preferences are pre-chosen, the system will automatically choose between the first and the second item offered. We do it upon intake and menu changes. If something comes up in resident council or when we change menus. We have spring/summer and fall/winter menu. It is a planned menu and that is how we serve and how we order food. Not everything is available all the time, so we cannot offer an always available menu. Not providing an alternative meal: V. On 09/22/21 at 10:07 am during a resident council meeting with facility residents they stated they are not offered any alternate choices if they do not like the food they are served they have no other choices. Residents are not provided with menus and the menus that are posted are where many residents do not have access to. They also stated that very often menus are not followed as posted. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	W. On 09/27/21 at 2:42 pm during an interview with the Dietary Manager, he stated. We have to follow the menu, there is no other choices in place for the residents. There is not an always available menu. I can only cook extra alternates according to the production sheet (paper that tells the staff how many alternate meals to cook according to preferences). We do not have a system in place to let the residents know what the alternate meal is for the day, we only cook enough alternates for the residents that have stated on their assessments that they prefer a certain meal. We do not have a system in so residents that do not like what is being served they can ask for something else. We make a main meal and a limited amount of the alternate meal. It is now available to all the residents. We do not send out menus, we have them posted in a couple of places. X. On 09/28/21 at 3:20 pm during an interview with the Corporate Manager, he stated. Upon intake (admission to the facility) we do the preferencing, the Registered Dietician will do an assessment. We give them (residents) whatever options we can give them based off of the two meals offered for that day. They have choices between two meals and that is selected by the system for them depending on the assessment. There is no restaurant style ordering available. If we can accommodate what they are asking for we will try but, we do not have an always available menu available to the residents. They get what what is cooked from the two meals prepared. We do not cook extra food, so if they do not like the meal they are served they may be given the option of the second meal offered depending if there is some [food] still available. 34439

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41988 Based on observation, interview, and record review, the facility failed to serve food to residents that was appetizing and at the correct temperature by not serving food within an acceptable timeframe during meal service for 1 (R #113) of 1 (R #113) residents reviewed during meal service. This deficient practice is likely to cause residents to refuse to eat, causing weight loss, and other health complications. The findings are: Findings for R #113: A. Record review of R #113's face sheet revealed R #113 was admitted into the facility on [DATE] and currently resident in room [ROOM NUMBER]-A (North Unit Short Hall). B. On 09/22/21 at 5:07 pm during a dinning observation, an announcement was made that the North Unit food carts are ready to be served by the Certified Nursing Assistant's (CNA's). C. On 09/22/21 at 5:19 pm during a dinning observation, CNA's brought food carts to North Unit nursing station to begin dinner service. D. On 09/22/21 at 5:52 pm, during a dinning observation, CNA's begin serving the North Unit Short Hall. E. On 09/22/21 at 6:02 pm during a dinning observation, CNA #13 is observed brining R #113 his dinner tray in room [ROOM NUMBER]-A. F. On 09/22/21 at 6:03 pm during an interview with CNA #13, she stated, It usually takes 30 minutes [to serve residents trays], but a resident needed to be changed and now I'm behind [delivering trays]. The others [CNA's] have to assist [residents with meals], so they [CNA's] will assist [residents with meals] after they deliver [all of the] trays. G. On 09/22/21 at 6:04 pm during an interview with R #113, he stated, The food is kind of warm, this is an ongoing issue. H. On 09/27/21 at 3:21 pm during an interview with the Dietary Manager (DM), he stated, I was told that on north hallway, they [CNA's] will roll the cart all the way to the back hall and then go get another cart to bring to the front hall. I spoke to the Administrator (ADM) about that. That [R #113 waiting almost 1 hour to be served dinner] should not be happening. I. On 09/28/21 at 3:17 pm during an interview with the ADM, she stated, Once it [resident trays]comes out of the kitchen, nursing takes the cart into the unit. A delay until 6 pm is too long of a delay [for residents to not receive their food]. 34439

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 41988 Based on record review and interview, the facility failed to provide food that accommodates resident preferences for 1 (R #'s 41) of 1 (R #'s 41) resident's observed for food preferences. This deficient practice is likely to result in weight loss due to the resident not eating and/or an allergic reaction to the food being served to the resident. The findings are: Findings for R #41: A. Record review of physician orders dated 07/13/21 revealed, Regular/Liberalized (less restrictive diet with more choices) diet, Regular Texture texture No salt packet on tray. B. Record review of R #41's meal tickets revealed, Lacto-Ovo Vegetarian (a person who eats vegetables, eggs, and dairy products but who does not eat meat), No Salt Packet on Tray, Does Not Want Any Meat. C. On 09/23/21 at 12:46 pm during an interview and observation, R #41 is observed being served a veggie burger, corn, carrots, and beans. R #41 stated, This is the only veggie meal I get. All I get is a veggie burger. We don't get a choice but I'd like a choice. R #41 confirmed she is a vegetarian and does not get a choice as to what vegetarian meals are served to her. D. On 09/27/21 at 3:36 pm during an interview with the Dietary Manager (DM), he stated, If it [meal ticket] says lacto-ovo vegetarian diet we put out grilled cheese, veggie burger, salad, cottage cheese, and fruit. It's difficult to make 100 or so [non-vegetarian] items and then those sparse items [vegetarian items]. I try to put in a variety and not always give them a veggie burger. DM confirmed he only offers a few select vegetarian items and unless it is specified on a meal ticket, he will decide what to serve residents on a vegetarian diet and does not get input from the Registered Dietician as to what to serve to those residents on a Lacto-Ovo vegetarian diet.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41988 Based on observation and interview, the facility failed to store and serve food under sanitary conditions by not: 1. Ensuring the kitchen refrigerator floor was clean and free from beef liquid. 2. Ensuring food items in the refrigerator, freezer, and dry storage were properly labeled, dated, and stored appropriately. 3. Ensuring foods stored in the refrigerator and dry storage were not expired. 4. Ensuring the food in the unit nourishment refrigerators was labeled and dated. 5. Ensuring used trays were not stored in the nourishment room. These deficient practices are likely to cause foodborne illnesses in the 107 residents residing in the facility if food is not being stored properly and safe food handling practices are not adhered to. The findings are: A. On [DATE] at 8:15 am during the initial tour of facility kitchen the following was observed: 1. 1-Large puddle of brown liquid by the refrigerator door entrance and under one of the refrigerator storage racks. 2. 1- quart (qt) plastic container of rice was not labeled or dated and stored in the refrigerator. 3. 1- plastic bag with 7 patties was not labeled or dated and stored in the refrigerator. 4. 1 -12 qt container of shredded cheese was not labeled or dated and stored in the refrigerator. 5. 1- large metal container labeled ,d+[DATE]-B. Beans and was stored in the refrigerator. 6. 1- large metal container with raw chicken was left open to air, not labeled or dated, and stored in the refrigerator. 7. 1- metal container with an unknown red liquid dated [DATE] was not labeled and stored in the refrigerator. 8. 1- large plastic container of pineapple slices dated ,d+[DATE] was not labeled and stored in the refrigerator. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	9. 2- large plastic bags of crinkle cut fries was not labeled or dated and stored in the freezer. 10. 1- plastic bag of pancakes was not labeled or dated and stored in the freezer. 11. 1- large plastic bag of cubed meat was not labeled or dated and stored in the freezer. 12. 1- large bag of frozen broccoli, carrots, and cauliflower was not labeled, dated, left open to air, and stored in the freezer. 13. 1- large plastic bag of breaded patties was not labeled or dated and stored in the freezer. 14. 3- Plastic trays-1 tray with 5 covered bowls of cereal, 1 tray with 13 covered bowls of cereal, and 1 tray with 12 covered bowls of cereal, all trays are covered with cereal spilt from bowls and was stored in the dry storage. 15. 3- plastic trays with approximately 33- 4 oz (ounce) cups of maple syrup was not not labeled or dated and stored in the dry storage. 16. 1- large plastic container of cereal resembling Cheerios was not labeled and stored in the dry storage. 17. 1- large plastic container of cereal resembling Rice Krispies was not labeled and stored in the dry storage. 18. 1- large plastic container of cereal resembling Raisin Bran was not labeled and stored in the dry storage. 19. 13- packages of small tortillas dated [DATE] was not labeled and stored on the bread rack. 20. 3- loaves of Pastian's Bakery Raisin Bread was not dated and stored on the bread rack. 21. 9- loaves Pastian's Marble Rye was not dated, 2 loaves had mold present, and all stored on the bread rack. 22. 1- plastic wrapped 9 ct (count) hoagie rolls was not labeled or dated, stale, and stored on the bread rack. 23. 5- Pastian's Bakery 24 oz Italian Bread Sticks was not dated and stored on the bread rack. 24. 7- 6 ct Pastian's Bakery 6 Italian subs was not labeled or dated and stored on the bread rack. 25. 1- package of tortillas dated [DATE] was left open to air and stored on the bread rack. 26. 1- package corn tortillas was not dated, labeled, left open to air and stored on the bread rack. 27. 12- plastic pitchers of pink liquid was not labeled or dated and stored in the smaller refrigerator by the main refrigerator. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	28. 1- large plastic container of a substance resembling jelly was not not labeled or dated, and stored in the smaller refrigerator by the main refrigerator. 29. 1- large metal container with approximately 30- half cut meat and cheese sandwiches dated ,d+[DATE] was not labeled and stored in the smaller refrigerator by the main refrigerator. 30. 1- large plastic tray with ,d+[DATE] oz thick milk, 4- 8 oz almond milk, and 4- 8 oz soy milk was not dated and stored in the refrigerator by the food serving line. 31. 1- large bin labeled Panko [DATE] was left open to air and stored in the main kitchen area. B. On [DATE] at 8:39 am during an interview with Cook (CK) #1, she confirmed all findings and stated all food and drink items should be labeled, dated, stored appropriately, and not expired. When shown the beef liquid on the refrigerator floor, CK #1 stated, When I came in this morning, a beef tray tipped over and I cleaned it up the best I could before breakfast, but I still need to clean up the rest. CK #1 confirmed beef liquid should not be on refrigerator floor. C. On [DATE] at 12:13 pm during an observation of the North Unit Nourishment Room (freezer and refrigerator included) the following was identified: 1. ,d+[DATE] ct box of Hotpockets Italian Style Meatballs and Mozzarella was not labeled or dated and stored in the freezer. 2. 1- plastic bag of 5- Ben and [NAME] ice cream pints was not labeled or dated and stored in the freezer. 3. 1- large Dominoes pizza box was not labeled or dated and stored in the refrigerator. 4. 1- small [NAME] John's box dated [DATE] was not labeled and stored in the refrigerator. 5. 5 -various sized plastic containers of unidentified food was not labeled or dated and stored in the refrigerator. 6. 2- 11 oz bags of eatz Ranch Tortilla chips were not labeled or dated, 1-left open to air, and both bags stored on counter in the nourishment room. 7. 1-used and dirty food tray was stored on a cart under the microwave in the nourishment room. D. On [DATE] at 12:24 pm during an interview with Infection Preventionist (IP), he confirmed all findings and stated, I will have that fridge cleaned. E. On [DATE] at 12:49 pm during an observation of the South Unit Nourishment Room (freezer and refrigerator included) the following was identified: 1. 1- 28 oz Power Aide Mountain Berry Blast was opened, not labeled or dated, and stored in the freezer. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. 1- Styrofoam cup labeled orange jello ,d+[DATE] was opened, did not contain a name on it, and was stored in the freezer. 3. 1- Marketside Italian Hero Sub half with best by date of [DATE] was not labeled and stored in the refrigerator. 4. 3-old and black bananas was not labeled or dated, and stored in the refrigerator. 5. 1-tray with covered plate and cup of milk was not labeled or dated, did not have a meal ticket present, and was stored in the refrigerator. 6. 1- tray with box from Wingstop was not labeled or dated and stored in the refrigerator. F. On [DATE] at 12:57 pm during an interview with Registered Nurse (RN) #1, she confirmed findings and stated, Everything in there [nourishment refrigerator] should be labeled and dated. I just found out that dietary is supposed to be checking the nourishment refrigerators and doing the logs. We [nursing] have been doing it because they [dietary] have not. G. On [DATE] at 1:19 pm during an interview with the Dietary Manager (DM), he stated Certified Nursing Assistants (CNA's) are responsible for the nourishment refrigerators and not dietary staff.

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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. 34439 Based on interview and record review, the facility failed to ensure a resident received rehab therapy (intended to restore the body to their highest degree of performance) services within a reasonable timeframe after the doctor ordered it for 1 (R #71) of 1 (R #71) resident reviewed for rehab services. This deficient practice is likely to result in a decrease in residents functional mobility. The findings are: A. On 09/20/21 at 3:36 pm during an interview with R #71, she stated, I have not been in therapy and no one has seen me about it. I would like to go to therapy. B. Record review of Physical Therapy Evaluation dated 08/23/21 revealed R #71 has on order for Physical Therapy 3 x (times)/week for 30 days from 08/23/21-09/21/21 C. Record review of Physical Therapy Treatment encounter note dated 08/23/21 revealed R #71 has only had one Physical Therapy session. D. Record review of Physicians orders dated 08/25/21 revealed Physical Therapy 3 x (times) a week for 30 days of skilled Physical Therapy services for general ROM (Range of Motion) safe transfer and bed mobility, proper positioning, manual therapy (exercise), pain MX (management) orthotic MX (a medical device used to control pain or used to assist in walking or standing) pt (patient)/caregiver education E. On 09/21/21 at 3:52 pm during an interview with DOT(Director of Therapy) he stated, Physical therapy had not been done for R #71 because there has not been authorization of payment. F. On 09/22/21 at 12:57 pm during an interview with BOM(Business Office Manager) he stated that the only reason R #71 was not receiving physical therapy was that he had not received authorization from R #71's insurance provider authorizing physical therapy treatment. He later confirmed that authorization was not required for R #71 to receive physical therapy. 45428

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 44363 Based on observation, interview, and record review, the facility failed to maintain proper Infection Prevention measures by not: 1. Ensuring staff wear masks while in the facility as required. 2. Ensuring staff wear masks appropriately. 3. Ensuring staff wear Personal Protective Equipment (PPE) in Admission/Observation Unit (AOU) with residents on precautions for COVID-19 (a highly contagious viral disease). Failure to follow Infection Control requirements is likely to cause the spread of infection and illness to all 107 residents listed on the census as provided by the Administrator (ADM) on 09/20/21. The findings are: A. On 09/22/21 at 4:51 pm during observation and interview Certified Nurse Assistant (CNA) #5 was observed on south units wearing a mask that was not sealed under the chin. During interview, CNA #5 confirmed mask was open and not sealed under his chin. CNA #5 confirmed mask should be sealed all the way around the mask, including under the chin. CNA #5 did not make changes or ensure mask was sealed after confirming the mask should be sealed under his chin. B. On 09/22/21 at 5:17 pm during observation and interview CNA # 7 was observed not wearing a mask while walking down the south front hall to the nurse station. CNA #7 confirmed the expectation is for her to wear a mask at all times. C. On 09/27/21 during observation and interview with Dietary Manager (DM) he was observed wearing a N95 (mask used to protect from exposure to particles or contaminants in the air) mask. DM was observed to have facial hair that inhibited the mask from sealing. DM confirmed that he enters resident rooms on AOU to ask newly admitted residents about dietary preferences. DM stated he has not been informed that N95 mask must seal and that facial hair inhibits proper seal of N95 mask. D. On 09/28/21 at 2:14 pm during observation and interview Licensed Practical Nurse (LPN) #2 was observed at nurse station on south hall without a mask on. LPN #2 noticed surveyor then covered her mouth and nose with her hand. LPN #2 then placed surgical mask on and confirmed the expectation is for her to wear a mask while she is in the facility. E. On 09/28/21 at 5:50 pm during observation and interview CNA # 8 was observed working on north hall AOU and entering resident's rooms without wearing a PPE gown. CNA #8 confirmed she did not wear a gown while entering residents rooms. When asked if all rooms on AOU required gowns, CNA #8 replied yes. F. On 09/23/21 at 9:15 am during interview with Infection Preventionist (IP) regarding PPE requirements he confirmed the following: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1. All staff entering the facility are required to wear a mask that covers the mouth and nose and are only permitted to take off their mask in the break room where they are six feet apart. 2. All staff entering residents rooms on AOU are required to wear a N95 mask, eye protection, gown, and gloves. 3. If wearing a N95 mask it must seal and cannot be inhibited by facial hair. All staff have been in-serviced and taught that they are to follow these guidelines. When they are observed not following facility protocols they are in-serviced immediately. 34439 G. On 09/23/21 at 6:50 am during random observation LPN #1, CNA #11 and Registered Nurse (RN) #1 were observed sitting and conversing at the south side nurses station without a mask. LPN #1, CNA #11 and RN #1 all confirmed they were not wearing a mask and should have been wearing a mask. H. On 09/23/21 at 2:18 pm during and interview with CNA#2, CNA #2 confirmed that he had been told by IP that a N95 mask must be sealed to the face not inhibited by facial hair, CNA #2 stated that since then the facility has not spoken to him about his facial hair he thought it was ok. I. On 09/27/21 at 4:15 pm during an interview with IP stated that a few of the staff refuse to shave facial hair to allow the N95 mask to properly seal to the face upon request. IP confirmed this is (facial hair) makes the N95 mask ineffective. J. On 9/28/21 at 5:11 pm during observation LPN #2 was observed sitting at the nurses station on the south hall without a mask on next to R #33, LPN #2 did not place surgical mask on until she confirmed the expectation is for her to wear a mask while she is working.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44363 Based on record review and interview, the facility failed to ensure staff implemented a program of antibiotic stewardship (a set of commitments and actions designed to optimize the treatment of infections while reducing the adverse events associated with antibiotic use) for 1 (R #85) of 1 (R #85) reviewed for antibiotic use. This deficient practice is likely to result in the use of unnecessary antibiotics or inappropriate use of antibiotics with the risk of side effects and contributing to medicine resistant bacteria. The findings are: A. Record review of current facility Infection Prevention and Control Program Description/Policy revealed, #7 Antibiotic Stewardship Program which includes antibiotic use protocols and a system for monitoring antibiotic use. B. Record review of Progress note for R #85 dated 06/20/21 revealed R #85 was sent to the emergency room (ER) for evaluation due to complaints of uncontrollable pain and spasms to the lower abdomen. C. Record review of Progress noted for R #85 dated 06/21/21 revealed R #85 came back from the hospital and had his Foley (tube inserted into the bladder to drain urine) changed and was diagnosed UTI (Urinary Tract Infection). D. Record review of Physician Orders for R #85 revealed order dated 06/20/21 for Cephalexin (antibiotic/medication used to treat UTI's) Capsule 500 mg (milligrams) Give 1 capsule by mouth four times a day for UTI until 06/30/21. E. Record review of the facility Monthly Report of Resident Infections for June 2021 revealed, no Urinary Tract Infections documented. F. On 09/23/21 at 9:15 am, during an interview with Infection Preventionist (IP) he confirmed R #85 was sent out to theER on [DATE] for lower abdomen pain. IP confirmed R #85 was ordered an antibiotic on 06/20/21 for a UTI. IP stated R #85 returned from the hospital with an antibiotic order and was being administered the antibiotic, the facility did not request lab specimen results and did not do an antibiotic review. IP confirmed R #85 UTI should have been documented on Monthly Report of Resident Infections for June 2021 for tracking and trending.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44363 Based on record review and interview, the facility failed to ensure that 1 (R # 46) of 5 (R # 28, 41, 46, 47, and 85) residents reviewed for pneumococcal (bacterial infection) vaccines were offered the pneumococcal vaccines. This deficient practice is likely to result in residents being at risk of exposure to pneumonia (infection of the air sacs in the lungs)/pneumococcal infections. The findings are: A. Record review of Policy and Procedure for Pneumococcal Vaccine dated 11/15/20 revealed, Centers will provide the opportunity to receive the pnuemococcal vaccine to all patients. B. Record review of R #46 Admission Record revealed admitted [DATE]. C. Record review of R #46's Immunization record dated 09/22/21 revealed no documentation indicating pneumococcal vaccine was offered or administered to R #46. D. Record review of R #46's Pneumococcal Vaccine Informed Consent dated 09/27/20 revealed R #46 gave permission for the facility to administer pneumococcal vaccination. E. On 09/27/21 at 3:23 pm Infection Preventionist (IP) confirmed #46 was not offered or administered the pnuemococcal vaccine and did sign the consent to receive the pneumococcal vaccine for the current year.

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F 0885 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Report COVID19 data to residents and families. 44363 Based on record review and interview, the facility failed to properly notify residents and/or their representatives of an occurrence of COVID 19 (an infectious viral disease that is easily spread amongst people) infection by 5 pm of the following day the diagnosis became known. This deficient practice affects all 107 residents of the facility. Failure to notify residents and/or family is likely to result in residents and family being unaware of what is going on in the facility. The findings are: A. Record review of facility staff on-going Covid -19 Infection Report revealed one staff member tested positive for COVID 19 infection on 08/20/21. B. On 09/28/21 at 2:40 pm during interview with Administrator she confirmed she is responsible for informing residents and/or their representatives of any occurrence of COVID 19 infection. Administrator confirmed the last COVID 19 infection was a staff member on 08/20/21. Administrator does not have documentation or confirmation that all residents and/or their representatives were informed of the COVID 19 infection on 08/20/21. All residents are informed in person at the facility and all Power of Attorney's (POA)'s/family members are informed with a telephone call that day or the next business day.