STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375536	A. Building B. Wing	02/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tuscany Village Nursing Center	2333 Tuscany Blvd Oklahoma City, OK 73120

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(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 - Actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 41318 Based on observations, interviews, and record reviews, the facility failed to ensure residents were treated with dignity for one (#8) of one sampled resident reviewed for dignity. This resulted in the resident feeling miserable, un-digitized and he wanted to die. The administrator identified 126 residents resided in the facility. Findings: Resident (Res) #8 was admitted with diagnosis which included fusion of the spine. The Res's care plan, dated 07/20/21, documented to respect the Res's privacy. The Res's quarterly assessment, dated 01/12/22, documented the Res's cognition was intact. Res #8's ADL report, dated 01/15/22, documented the Res was totally dependent on staff for bed mobility and toilet use. On 01/31/22 at 5:55 a.m., Res #8 was observed from the hall, laying in bed, in only an adult brief. His blanket was observed hanging off the side of the bed. The call light was observed, out of reach, attached to the blanket. He stated he needed to be changed and he has to wait for hours for staff assistance. On 02/01/22 at 7:46 a.m., Res #8 was observed from the hall, laying in bed, in only an adult brief. His blanket was observed hanging off the end of the bed. At 8:32 a.m., Res #8 was observed in the same uncovered position. A meal tray was observed on a bedside table positioned over the Res. The meal was still covered. At 9:00 a.m., Res #8 stated he hadn't eaten breakfast. He stated, I need to be fed, diaper changed, and covered up. I haven't been checked on for 3-4 hours. I'm cold. At 9:02 a.m., NCNA #1 was observed to come in to Res #8's room and retrieve his roommate's breakfast tray. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 - Actual harm Residents Affected - Some	At 9:20 a.m., another Res brought Res #8 a cup of coffee. NCNA #2 came in and moved the bedside table closer to the Res for the Res to drink coffee. NCNA #2 took the resident's breakfast tray and heated it up. At 9:25 a.m., Res #8 was asked how he felt. He stated, Like a piece of shit. Makes me feel like an un-respected piece of shit. No dignity, no pride. When you are stuck to this rubber mat, it's miserable. I have had to lower my standards to lay here in my underwear for everyone to see. Makes me want to give up on life. It doesn't make your day start out right. Then I will yell for help and they tell me to push my call light. Well, I can't reach my call light. At 1:32 p.m., NCNA #1 was asked how staff ensured residents were treated with dignity. She stated, Treat them how you would want to be treated. At 1:34 p.m., the DON was asked how staff ensured residents were treated with dignity. She stated to knock and announce before entering in the room, explain what care they are providing, and provide privacy when providing care. She was asked if a resident was able to be seen from the hallway, wearing only a adult brief, was that treating the resident in a dignified manner. She stated, No.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 41318 Based on observations, interviews, and record reviews, the facility failed to ensure a clean, homelike environment and linens were provided for seven (#5, 8, 9, 11, 14, and #15) of eight sampled residents reviewed for environment. The administrator identified 126 residents resided in the facility. Findings: A facility policy titled, Resident Room Cleaning, revised November 2021, read in part, .PURPOSE: To Provide a clean, attractive, and safe environment for residents .and staff .Remove General Waste .place a clean plastic bag into the empty trash container .Clean and Sanitize Toilets . On 01/31/22, at 5:26 a.m., no trash liner was observed in a trash can in Res #15's room. CNA #1 stated, We don't have anything to work with. At 5:55 a.m., Res #8 was observed laying in bed without a fitted sheet under him. At 6:35 a.m., no trash liner was observed in the trash can in Res #9's room. On 02/01/22 at 7:38 a.m., PT #1 stated she has been frustrated with the facility due to not having housekeeping. She stated they have recently hired new staff. At 7:39 a.m., Res #11 was observed laying in bed with no fitted sheet on his bed. He stated the staff took the sheet this morning and hadn't brought one back. At 7:40 a.m., resident #5 was asked if staff kept her room clean. She stated, No. The trash can near her bed was observed full of trash without a trash liner. At 7:46 a.m., Res #8 was observed laying in bed without a fitted sheet under him. At 7:55 a.m., Res #9 was asked if staff cleaned her room. She stated sometimes it doesn't get cleaned for days. She stated when housekeeping doesn't come around, she wished the staff would give her a roll of plastic bags for her trash can so she could change it herself. Resident #14 was asked if staff kept her room clean. She stated the last time her room had been cleaned was a week ago. The shared bathroom for resident #5 and #14 was observed to have a bag of trash on the floor with trash thrown on top of the bag. The trash can next to the toilet was full. The toilet was observed to have a brown colored ring around the inside of the bowl. The biohazard box with a red trash liner had soiled linens in it. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 8:35 a.m., the linen closet on hall 600 was observed to have two pillows, one blanket, four hospital gowns, 12 pillow cases and two top sheets. At 9:00 a.m., Res #8 was observed in the same position without a fitted sheet under him. At 10:01 a.m., Res #15's room was observed. Her bed was not made and no sheets were observed on her bed. She was asked how often her bed was made. She stated, Usually, they don't make my bed. I have been sleeping on this plastic mat for about a week. That's no fun. She stated, Usually, when I ask them to make my bed, they say there isn't any laundry. Res #15's room was observed to have a dried yellow stain on the floor in front of the bed with a discolored pepper packet by the stain, scattered food crumbs under and in front of the bed, and brown stains on the privacy curtains. Two trash cans were observed without trash liners and a strong urine odor was present in the Res's room. NCNA #2 brought linens to the Res's room and stated she was not going to make the bed until housekeeping sprayed the bed. At 10:31 a.m. Res #8 was observed laying in bed without a fitted sheet under him. At 12:30 p.m., the DON stated linens would be changed on bath days and as needed. At 1:26 p.m., Res #8 stated he asked for sheets and to be changed 30 minutes ago. Res stated this had not been completed. On 02/02/22 at 9:22 a.m., resident #5's trash can near her bed still had no liner in it and the trash was full. The bathroom for resident #5 and #14 continued to have a bag of trash on the floor with trash thrown on top of the bag. The trash can next to the toilet continued to be full. The toilet was observed to still have a brown colored ring around the inside of the bowl. The biohazard box with a red trash liner still had soiled linens in it. At 9:50 a.m., the AD was observed with a housekeeping cart on hall 600. He was asked how frequently resident rooms were cleaned. He stated, Every day. He was asked how staff ensured a clean, comfortable, homelike environment. He stated that was the reason they did ambassador rounds, so they could see what needed done and do it. The AD was shown resident #5's trash can with no liner. He was shown the bathroom for resident #5 and #14 with the full trash can, the dirty toilet bowl, the bag of trash on the floor, trash on top of the bag of trash and the biohazard trash box full of soiled linens. He was asked if the room/bathroom had been cleaned recently. He stated, Oh no, they've just left it. On 02/07/22 at 2:43 p.m., the DON was asked how staff ensured there was enough linens available to meet the needs of the residents. She stated the staff would go to the laundry room at the beginning of their shift. She was asked if there had been a shortage on linens. She stated they just bought new linen and have hired laundry aides and housekeepers. 35749

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 41318 Based on observations, interviews, and record reviews, the facility failed to ensure residents were free from neglect for one (#8) of four sampled resident reviewed for dignity. This resulted in the resident feeling miserable, un-dignified and he wanted to die. The administrator identified 126 residents resided in the facility. Findings: A facility policy titled, Neglect, revised 06/23/17, read in part, .Each resident has the right to be free from neglect .The facility must prohibit and prevent .neglect .Neglect: Failure of the facility .to provide .services to a resident that are necessary to avoid .mental anguish, or emotional distress . 35749 Resident (Res) #8 was admitted with diagnosis which included fusion of the spine. The Res's care plan, dated 07/20/21, documented to respect the Res's privacy. The Res's quarterly assessment, dated 01/12/22, documented the Res's cognition was intact. The Res's ADL report, dated 01/15/22, documented the Res was totally dependent on staff for bed mobility and toilet use. On 01/31/22 at 5:55 a.m., Res #8 was observed from the hall, laying in bed, in only an adult brief. His blanket was observed hanging off the side of the bed. The call light was observed, out of reach, attached to the blanket. He stated he needed to be changed and he has to wait for hours for staff assistance. On 02/01/22 at 7:46 a.m., Res #8 was observed from the hall, laying in bed, in only an adult brief. His blanket was observed hanging off the end of the bed. At 8:32 a.m., Res #8 was observed in the same uncovered position. A meal tray was observed on a bedside table positioned over the Res. The meal was still covered. At 9:00 a.m., Res #8 stated he hadn't eaten breakfast. He stated, I need to be fed, diaper changed, and covered up. I haven't been checked on for 3-4 hours. I'm cold. At 9:02 a.m., NCNA #1 was observed to come in to Res #8's room and retrieve his roommate's breakfast tray. She did not attempt to assist resident #8. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	At 9:20 a.m., another Res brought Res #8 a cup of coffee. NCNA #2 came in and moved the bedside table closer for the resident to drink coffee. NCNA #2 took the resident's breakfast tray and heated it up. At 9:25 a.m., Res #8 was asked how he felt. He stated, Like a piece of shit. Makes me feel like an un-respected piece of shit. No dignity, no pride. When you are stuck to this rubber mat, it's miserable. I have had to lower my standards to lay here in my underwear for everyone to see. Makes me want to give up on life. It doesn't make your day start out right. Then I will yell for help and they tell me to push my call light. Well, I can't reach my call light. At 1:32 p.m., NCNA #1 was asked how staff ensured residents were treated with dignity. She stated, Treat them how you would want to be treated. At 1:34 p.m., the DON was asked how staff ensured residents were treated with dignity. She stated to knock and announce before entering in the room, explain what care they are providing, and provide privacy when providing care. She was asked if a resident was able to be seen from the hallway, wearing only a adult brief, was that treating the resident in a dignified manner. She stated, No.

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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 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. 41318 Based on observations, interviews, and record reviews, the facility failed to ensure ADLs were provided timely for four (#5, 7, 8 and #9) of seven sampled residents reviewed for ADLs. The administrator identified 126 residents resided in the facility. Findings: 1. Resident (Res) #7 was admitted with diagnosis which included muscle weakness. Res's five day assessment, dated 01/11/22, documented the Res's cognition was intact, and required total staff assistance with hygiene. It documented Res was frequently incontinent of bowel movements. The Res's care plan, dated 01/13/22, documented the Res required total staff assistance for toileting. On 01/31/22 at 6:13 a.m., Res #7 was observed laying in bed. He notified CNA #1 he needed to be changed. CNA #1 stated she had to go answer the call lights that had been going off. At 7:21 a.m., CNA #1 was asked if there was enough staff to meet the needs of the residents without them having to wait long periods of time. She stated, No. At 7:26 a.m., Res #7 was observed laying in bed with a brown ring on the sheets under him. He stated he hadn't been changed. At 7:30 a.m., CNA #3 and #8 were observed to provide incontinent care to Res #7. The Res's depend was observed full of partially dried feces. The CNAs were observed to scrub feces off of the Res's left thigh and pubic area. On 02/01/22 at 1:20 p.m., Res #7 was asked how he felt, yesterday morning, having to wait over an hour for assistance from staff. He stated, That's not the first time that has happened. When stuff happens over and over again, you get used to it. 2. Res #8 was admitted with diagnosis which included fusion of the spine. The Res's care plan, dated 07/20/21, documented to respect the Res's privacy. The Res's quarterly assessment, dated 01/12/22, documented the Res's cognition was intact. Res #8's ADL report, dated 01/15/22, documented the Res was totally dependent on staff for bed mobility and toilet use. On 01/31/22 at 5:55 a.m., Res #8 was observed laying supine in bed. He stated he needed to be changed and he has to wait hours for staff assistance. (continued on next page)

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/01/22 at 7:46 a.m., Res #8 was observed from the hall, laying in bed, in only an adult brief. His blanket was observed hanging off the end of the bed. There was no fitted sheet observed on the Res's bed. At 8:32 a.m., Res #8 was observed in the same, uncovered position. A meal tray was observed on a bedside table positioned over the Res. The meal was still covered. At 9:00 a.m., Res #8 stated he hadn't eaten breakfast. He stated, I need to be fed, diaper changed, and covered up. I haven't been checked on for 3-4 hours. I'm cold. At 9:02 a.m., NCNA #1 was observed to come in to Res #8's room and retrieved his roommate's breakfast tray. She did not attempt to assist Res #8. At 10:32 a.m., Res #8 was observed to have a blanket placed on him and his call light with in reach. At 1:26 p.m., Res #8 was asked if he had been changed. He stated, No, I asked about 30 minutes ago for a bed sheet and to be changed. 3. Res # 9 was admitted with diagnosis which included diabetes mellitus. The Res's quarterly assessment, dated 01/14/22, documented the Res's cognition was intact, required total staff assistance with toileting, and was always incontinent of bowel and bladder. On 01/31/22 at 6:35 a.m., Res #9 was observed laying in bed with a brown ring on the bed pad, lift sheet, and fitted sheet. CNA #1 and the DON was observed to provide incontinent care to the resident. At 7:21 a.m., CNA #1 was asked what a brown ring on the sheets under residents indicated. She stated, It means they're soiled. On 02/01/22 at 7:55 a.m., Res #9 was asked if she received incontinent care timely. She stated, Sometimes. It depends on who worked that night. She was asked if she had been checked on yesterday (01/31/22). She stated, No. 4. Resident #5 had diagnoses which included bipolar disorder and acute transverse myelitis. A resident assessment, dated 11/01/21, documented the resident's cognition was intact and she required total assistance for bathing. A care plan, dated 11/15/21, read in part, .Self Care Deficit .Bathe per schedule and as needed . A January ADL flowsheet documented the resident had last been bathed on 01/24/22. On 02/01/22 at 7:40 a.m., resident #5 was asked if she was receiving timely ADL care. She stated, No, I haven't had a shower in over a week. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/07/22 at 2:45 p.m., the DON was asked when incontinent care was to be completed. She stated every two hours and as needed. She was asked when showers were to be completed. She stated as scheduled and as needed. 35749

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - 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** 35749 Based on record review and interviews, the facility failed to ensure pressure ulcers did not develop and weekly skin assessments were conducted for two (#1 and #2) of three sampled residents reviewed for pressure ulcers. This resulted in resident #2 developing an unstageable pressure ulcer. The DON identified 18 residents had wounds. Findings: 1. Resident #2 was admitted on [DATE] with diagnoses which included Alzheimer's disease and cerebral infarct. A nurse's note, dated 12/22/21 at 11:12 p.m., read in part, .Resident admitted to facility .skin CDI [clean, dry, intact] without redness or open areas noted . An admission resident assessment, dated 12/26/21, documented the resident required extensive assistance for transfers and bed mobility and had no un-healed pressure ulcers. A care plan, dated 12/29/21, read in part, .Skin Breakdown: At risk for/actual .Measures will be taken to prevent skin breakdown .Assist resident to turn and reposition frequently .Inspect skin complete body head to toe every week and document results . There was no documentation of a skin assessment from 12/22/21 to 01/01/22. A nurse's note, dated 01/01/22 at 6:32 a.m., read in part, .Wound noted to sacrum - Unstageable - 3.5CM x 3.5CM x UT - adherent slough noted to peri bed - moderate serous sanquinous [sic] drainage noted - MD contacted - received new order . A physician's order, dated 01/01/22, read in part, .CLEANSE SACRUM WITH NS AND/OR WIPES; PAT DRY; APPLY MEDIHONEY TO PERIBED; APPLY BORDER DRESSING Q MWF AND PRN Dx : Pressure ulcer of sacral region, unstageable . A wound report, dated 01/12/22, documented the wound was 2.5 CM x 1.4 CM x 0.2 CM. On 02/07/22 at 10:48 a.m., the wound care nurse was asked if resident #2 had pressure ulcers on admit. She stated, No. She was asked what type of assistance the resident required. She stated moderate to maximum assistance with turning and repositioning. She was asked if the resident developed a pressure ulcer. She stated, Yes. She was asked if there were any skin assessments from 12/22/21 to 01/01/22. She stated no. The WC nurse was asked if the pressure ulcer was unavoidable. She stated, Yes and no. 41318 2. Resident (Res) #1 was admitted with diagnoses which included muscle weakness, and kidney transplant status. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	A nurse's note, dated 05/05/21, read in part, .Wounds to buttocks, scrotum . Res's care plan, dated 05/07/21, read in part, .Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate . The Res's admission assessment, dated 05/09/21, documented the Res's cognition was moderately impaired, required extensive staff assistance with bed mobility, transfers, toilet use, and hygiene. A nurse's note, dated 05/11/21, read in part, .Resident scrotum noted w/open areas . A nurse's note, dated 05/15/21, read in part, .open wound to sacrum note . A nurse's note dated 05/16/21, read in part, .wound to sacrum . On 02/07/22 at 2:45 p.m., the DON was asked who was responsible for assessing the resident's wounds. She stated the wound care nurse would assess wounds weekly. She was asked what was assessed. She stated odor, characteristics, and measurements. She was shown the nurses' notes and was asked if wounds were assessed. She stated, Should be. At 4:20 p.m., the DON stated she was not able to locate the wound assessments.

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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. 35749 Based on observations, interviews, and record reviews, the facility failed to ensure adequate staff to meet the needs of the residents for four (#5, 7, 8, and #9) of four residents reviewed for staffing. The administrator identified 126 residents resided in the facility. Findings: 1. Resident (Res) #7 was admitted with diagnosis which included muscle weakness. The Res's five day assessment, dated 01/11/22, documented the Res's cognition was intact, and required total staff assistance with hygiene. It documented Res was frequently incontinent of bowel movements. The Res's care plan, dated 01/13/22, documented the Res required total staff assistance for toileting. On 01/31/22 at 6:13 a.m., Res #7 was observed laying in bed. He notified CNA #1 he needed to be changed. CNA #1 stated she had to go answer the call lights that had been going off. At 7:21 a.m., CNA #1 was asked if there was enough staff to meet the needs of the residents without them having to wait long periods of time. She stated, No. At 7:26 a.m., Res #7 was observed laying in bed with a brown ring on the sheets under him. He stated he hadn't been changed. At 7:30 a.m., CNA #3 and #8 were observed to provide incontinent care to Res #7. The Res's adult brief was observed full of partially dried feces. The CNAs were observed to scrub feces off of the Res's left thigh and pubic area. On 02/01/22 at 1:20 p.m., Res #7 was asked how he felt, yesterday morning, having to wait over an hour for assistance from staff. He stated, That's not the first time that has happened. When stuff happens over and over again, you get used to it. 2. Res #8 was admitted with diagnosis which included fusion of the spine. The Res's quarterly assessment, dated 01/12/22, documented the Res's cognition was intact. The Res's ADL report, dated 01/15/22, documented the Res was totally dependent on staff for bed mobility and toilet use. On 01/31/22 at 5:55 a.m., Res #8 was observed laying in bed. He stated he needed to be changed and he had to wait hours for staff assistance. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375536	A. Building B. Wing	02/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tuscany Village Nursing Center	2333 Tuscany Blvd Oklahoma City, OK 73120

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/01/22 at 7:46 a.m., Res #8 was observed from the hall, laying in bed, in only an adult brief. His blanket was observed hanging off the end of the bed. There was no fitted sheet observed on the Res's bed. At 8:32 a.m., Res #8 was observed in the same, uncovered position. A meal tray was observed on a bedside table positioned over the Res. The meal was still covered. At 9:00 a.m., Res #8 stated he hadn't eaten breakfast. He stated, I need to be fed, diaper changed, and covered up. I haven't been checked on for 3-4 hours. I'm cold. At 9:02 a.m., NCNA #1 was observed to come in to Res #8's room and retrieved his roommate's breakfast tray. She did not attempt to assist Res #8. At 10:32 a.m., Res #8 was observed to have a blanket placed on him and his call light with in reach. At 1:26 p.m., Res #8 was asked if he had been changed. He stated, No, I asked about 30 minutes ago for a bed sheet and to be changed. 3. Res #9 was admitted with diagnosis which included diabetes mellitus. The Res's quarterly assessment, dated 01/14/22, documented the Res's cognition was intact, required total staff assistance with toileting, and was always incontinent of bowel and bladder. On 01/31/22 at 6:35 a.m., Res #9 was observed laying in bed with a brown ring on the bed pad, lift sheet, and fitted sheet. CNA #1 and the DON was observed to provide incontinent care to the resident. At 7:21 a.m., CNA #1 was asked what a brown ring on the sheets under residents indicated. She stated, It means they're soiled. On 02/01/22 at 7:55 a.m., Res #9 was asked if she received incontinent care timely. She stated, Sometimes. It depends on who worked that night. She was asked if she had been checked on yesterday (01/31/22). She stated, No. 4. Resident #5 had diagnoses which included bipolar disorder and acute transverse myelitis. A resident assessment, dated 11/01/21, documented the resident's cognition was intact and she required total assistance for bathing. A care plan, dated 11/15/21, read in part, .Self Care Deficit .Bathe per schedule and as needed . A January ADL flowsheet documented the resident had last been bathed on 01/24/22. On 02/01/22 at 7:40 a.m., resident #5 was asked if she was receiving timely ADL care. She stated, No, I haven't had a shower in over a week. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/07/22 at 2:45 p.m., the DON was asked when incontinent care was to be completed. She stated every two hours and as needed. She was asked when are showers to be completed. She stated as scheduled and as needed. The DON was asked how the facility ensured adequate staff to meet the needs of the residents. She stated by acuity of the halls. 41318

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35749 Based on observation, record review and staff interviews, the facility failed to ensure medications were available for one (#10) of three sampled residents reviewed for medications. The DON identified 126 residents resided in the facility. Findings: A facility policy titled, Physician Orders, dated 02/12/20, read in part, .nurse will receive and transcribe the physician's orders .nursing will provide residents with medications and treatments . Resident #10 admitted on [DATE] with diagnoses which included COVID-19 and rheumatoid arthritis. Physician's orders, dated 01/29/22, documented the following: Lisinopril 5mg daily, Buproprion 150mg daily, Rosuvastatin 40mg daily, Pregabalin 100mg every 12 hours, Famotidine 20mg twice daily, Carvedilol 3.125mg twice daily, Cetirizine 10mg daily, Aspercreme 4% topical patch daily, [NAME] Thyroid 60mg daily, [NAME] Thyroid 15mg daily, Duloxetine 60mg daily, Vitamin D3 daily, Enoxaparin 40mg subcutaneous syringe daily, and Fluticasone nasal spray daily. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The January 2022 TARs documented enoxaparin and fluticasone had not been administered until 01/30/22. The January 2022 MARs documented the carvedilol and famotidine had not been administered until 01/30/22. The lisinopril, buproprion, rosuvastatin, pregabalin, ceterizine, [NAME] thyroids, vitamin D3 and duloxetine had not been administered at all as of 01/31/22 at 9:53 a.m. On 01/31/22 at 7:36 a.m., resident #10 was asked if she received her medications as ordered. She stated, No, they didn't get ordered til the third day of being here. On 02/01/22 at 11:45 a.m., CMA #3 was asked when resident #10 admitted to the facility. She stated, 01/28/22. She was asked when medications were received for new admissions. She stated stat orders took four hours. She was asked if the resident's ordered medications were available. All the ordered medications, except pregabalin, were observed in the medication cart. When asked about the pregabalin, she stated, I don't have it. I ordered it today. At 11:50 a.m., LPN #4 was asked the procedure for acquiring medications/treatments for new admissions. She stated they usually received medications the same day unless the admit was late in the day, then they would receive them the next morning. She was asked if the resident admitted on [DATE], should the medications/treatments have been started by 01/29/22. She stated, Yes. 41318

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. 41318 Based on record review and interview, the facility failed to ensure physician ordered lab was obtained for one (#1) of one sampled resident reviewed for labs. The administrator identified 126 residents resided in the facility. Findings: Resident (Res) #1 was admitted with diagnosis which included kidney transplant status. The Res's admission assessment, dated 05/09/21, documented the Res's cognition was moderately impaired. A nurse's note, dated 05/11/21, read in part, .NEW STANDING ORDERS, CHECK TACROLIMUS LEVEL DAILY . A nurse's note, dated 05/12/21, read in part, .Pt continues on daily tacrolimus lab draw . A physician's order, dated 05/13/21, documented to obtain Tacrolimus blood every 24 hours. On 02/07/22 at 4:20 p.m., the DON was asked for lab reports. She stated was not able to locate the lab report from 05/15/21.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 35749 Based on record review and resident and staff interviews, the facility failed to ensure resident preferences for meals were provided for three (#5, 8, and #14) of six sampled residents reviewed for food preferences. The DON identified 123 residents received services from the dining room. Findings: On 02/01/22 at 7:15 a.m., Resident #14 was asked if she received her meals as she requested/ordered. She stated they don't take her order. At 7:40 a.m., Resident #5 was asked if she received her meals as requested/ordered. She stated, No, they don't take my menu order at all. On 02/02/22 at 9:13 a.m., Resident #8 was asked how he was doing this morning. He stated, Not too good. He stated when he received breakfast it was nasty and cold. He stated, I've asked every day for bacon and toast. He was asked if they took his menu order. He stated, No. At 9:47 a.m., Resident #5's breakfast tray and meal ticket was observed on a hall cart. There were no food options/choices circled. At 10:00 a.m., the DM was asked who was responsible for getting meal tickets filled out. She stated it was nursings'. She was asked what the meal ticket indicated if there were no food preferences circled. She stated they would get the basic menu and that they did not get to choose any preferences. The DM stated Residents #5, 8 and #14's meal tickets on 02/02/22 had no circled food preferences. 41318

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 35749 Based on observation and interviews, the facility failed to ensure meals were offered and were served timely to two (#8 and #14) of six sampled residents reviewed for meal services. The DON identified 123 residents received services from the kitchen. Findings: 1. Res #8 was admitted with diagnosis which included fusion of the spine. Res's quarterly assessment, dated 01/12/22, documented the Res's cognition was intact. Res's care plan, revised 01/14/22, documented staff were to provide necessary assistance with food and fluids. On 01/31/22 at 6:05 a.m., a sign posted on a cabinet on hall 600 documented breakfast was served from 7:30 a.m., to 9:00 a.m. On 02/01/22 at 8:32 a.m., Res #8 was observed laying in bed. He was not observed to be in a ready to eat position. A meal tray was observed on a bedside table positioned over the Res. The meal was still covered. At 9:00 a.m., Res #8 stated he hadn't eaten breakfast. He stated he needed assistance to eat. At 9:02 a.m., NCNA #1 was observed to come in to Res #8's room and retrieved his roommate's breakfast tray. She did not attempt to assist Res #8. At 9:20 a.m., NCNA #2 was observed to go into Res #8's room, retrieve his breakfast tray, and heated it up in a microwave across from Res's room. At 9:25 a.m., Res #8 was observed to eat three bites of eggs, and stated the toast and sausage were hard. He stated, I told her to send back the breakfast tray because it was cold and terrible. I told her to bring me cereal. Here it is two and half hours late. 2. On 02/01/22 at 9:06 a.m., resident #14's call light was activated. NCNA #1 entered the resident's room. The resident stated she did not get breakfast. The NCNA left the room and came back immediately with a breakfast tray. On 02/02/22 at 9:52 a.m., Resident #14 told CNA #7 that she did not receive breakfast again. She stated she had been getting treated bad since she had COVID and she was sick of it. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 10:00 a.m., the DM was asked how staff ensured every resident received a meal tray. She stated when she separated the meal tickets, she knew who they were. She was asked if resident #14 had received a breakfast tray. She stated they were cooking it now. 41318

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35749 Based on observation, record review and interviews, the facility failed to ensure proper PPE was utilized, handwashing was conducted, and soiled adult briefs and wipes were not placed on the floor to prevent the spread of COVID-19 and other infectious diseases for two (#12 and #14) of five sampled residents reviewed for infection control. The administrator identified 126 residents resided in the facility and six residents had COVID-19. Findings: A facility policy titles, Hand Hygiene, dated August 2018, read in part, .Hand hygiene is the most important component for preventing the spread of infection . 1. Resident #14 had diagnosis which included COVID-19. On 01/31/22 at 6:05 a.m., Resident #14's door was observed to have a sign that documented Droplet Precautions. There was a three drawer plastic dresser outside the room. No PPE was observed in the drawers. On 02/01/22 at 9:06 a.m., resident 14's call light sounded. NCNA #16 was observed to enter the room. She turned off the call light. The resident stated she had not received breakfast. The NCNA left the room, took a meal tray from a food cart in the hallway, and delivered the tray to the resident. She was observed unwrapping the tray then left the room. She did not wash or sanitize her hands. At 9:45 a.m., NCNA # 16 was observed entering the residents room and removed her breakfast tray and placed it on a three tiered cart in the hall. She was then observed to enter room [ROOM NUMBER], donned gloves, picked up dirty linens and clothing from the floor, placed them back on the floor, removed her gloves and left the room. She did not wash or sanitize her hands. At 9:50 a.m., CMA #2 was observed looking in the three drawer chest outside room [ROOM NUMBER]. She shook her head and stated, This mask looks used. She stated the PPE should be restocked daily. She was observed to tell another staff member to go have the IC nurse restock the PPE. On 02/07/22 at 2:45 p.m., the DON was asked what PPE was to be worn when staff went into COVID-19 positive residents' rooms. She stated they were to wear a faceshield, N95 mask, gloves and gowns. She was asked how often the PPE dressers were stocked with PPE. She stated they should be stocked between shifts and as needed. 41318 2. Res #12 admitted with diagnosis which included Alzheimer's disease. The Res's quarterly assessment, dated 10/30/21, documented Res's cognition was severely impaired, required extensive staff assistance with toilet use and personal hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/01/22 at 9:52 a.m., CNA #6 was observed assisting Res #12 with changing her adult depends. CNA #6 removed the wet adult brief and tossed it on the floor. CNA #6 wiped the Res with wipes and tossed the wipes on the floor by the wet adult brief. After assisting Res with dressing, CNA #6 picked up the wet depend, and wipes, and tossed them on the floor, behind the door to the Res's room. At 10:57 a.m., the wet depend and wipes were still observed on the floor behind Res #12's door. On 02/07/22 at 2:45 p.m., the DON was asked what staff were to do with a wet adult briefs and soiled wipes. She stated they were to put them in a trash bag.