STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465086	A. Building B. Wing	09/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Health Services	5865 South Wasatch Drive Ogden, UT 84403

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 - 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** 22992 Based on interview and observation, the facility did not treat each resident with respect and dignity and care for 8 of 30 sample residents in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. Specifically, residents voiced concerns with call light response times, and long call light response times were observed. Resident identifiers: 2, 4, 9, 15, 22, 28, 32, and 42. Findings include: 1. On 8/31/21 at 10:00 AM, an interview was conducted with six residents from the resident council. Residents were asked about call light response times, and had the following concerns: a. Resident 9 stated that he waited at least 10 minutes for his call light to be answered. b. Resident 15 stated that she did not wait for staff to answer her call lights because it took too long. Resident 15 stated I just yell. c. Resident 28 stated that she usually waited for approximately an hour for staff to respond to her call light. Resident 28 further stated that she has brought up the issue in resident council, but that call light response times were still an hour sometimes. 2. On 8/30/21 at 8:53 AM, an interview was conducted with resident 22. When asked about call light response times, resident 22 stated I don't even bother to use call lights because of the long wait times. Resident 22 stated that there was one occasion when he waited approximately one hour for his call light to be answered. 3. On 8/29/21 at 11:00 AM, an interview was conducted with resident 42. Resident 42 stated that he would push his call light for help, and still they don't come . I have to go out and find someone to help me. Resident 42 stated that 90 percent of the time, call lights took about 45 minutes or more to be answered. Resident 42 further stated that when staff did answer his call light, they would say things like, What do you want? in a rude tone. Resident 42 stated that he has been left on the toilet for 45 to 60 minutes before staff returned, and its not comfortable. During the interview, a staff member entered the resident's room without knocking. 33215 (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	4. On 8/29/21 at 10:53 AM, an interview was conducted with resident 4. Resident 4 stated the call light response time was an issue. Resident 4 stated she did a lot for herself because staff did not respond timely. 5. On 8/29/21 at 1:16 PM, an interview was conducted with resident 2. Resident 2 stated the staff did not respond to her call light timely and she had wet herself. Resident 2 stated that she could not help it. 6. On 8/29/21 at 11:49 AM, an interview was conducted with resident 32. Resident 32 stated that the night shift did not answer call lights. Resident 32 stated that he had his call light on that day to request a pain pill, and I don't know how long I sat there before they came. 7. On 8/29/21 at 8:26 AM, the call light for resident room [ROOM NUMBER] was activated. At 8:43 AM, staff were observed to respond to the call light. The call light was activated for 17 minutes. 8. On 8/29/21 at 2:15 PM, the call light for resident room [ROOM NUMBER] was activated. At 2:36 PM, staff were observed to respond to the call light. The call light was activated for 21 minutes. 9. On 8/30/21 at 11:52 AM, the call light for resident room [ROOM NUMBER] was activated. At 12:23 PM, staff were observed to respond to the call light. The call light was activated for 31 minutes. 10. On 8/30/21 at 12:45 PM, the call light for resident room [ROOM NUMBER] was activated. At 12:57 PM, staff were observed to respond to the call light. The call light was activated for 12 minutes.

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33215 Based on interview and record review it was determined, for 5 of 30 sample residents, that the facility did not provide written notice, including the reason for the change, before the resident's room or roommate in the facility was changed. Specifically, residents did not receive written notice prior to a roommate change, and other residents did not receive written notice prior to a room change. Resident identifiers: 1, 2, 9, 14, and 22. Findings include: 1. Resident 2 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included schizoaffective disorder, type 2 diabetes mellitus without complications, rheumatoid arthritis, muscle wasting and atrophy, and insomnia. On 8/29/21 at 1:29 PM, an interview was conducted with resident 2. Resident 2 stated she did not like her roommate and her roommate bothered her. Resident 2 stated she had told staff but the staff told her to ignore her roommate. Resident 2 further stated the staff told her they would not move her roommate. Residents 2's medical record was reviewed on 8/30/21. Written notification informing resident 2 of the roommate change and the reason for the change was unable to be located in the medical record. 2. Resident 14 was admitted to the facility on [DATE] with diagnoses which included but not limited to dementia without behavioral disturbance, Alzheimer's disease late onset, major depressive disorder, and history of falling. Resident 14's medical record was reviewed on 8/30/21. On 7/21/21 at 5:34 PM, a General progress note documented [Resident 14] has a new room and new roommate. I tried to introduce the 2 of them but they said they already know each other. Family notified. On 7/21/21 at 5:35 PM, a General progress note documented Notified clients and her daughter about room change. Client was excited to meet her new roommate, and is agreeable to the room change. Admin (Administrator) and nursing and social work notified. Resident 14's census report was reviewed and documented that resident 14 was moved to resident 2's room on 7/23/21. Written notification informing resident 14 of the room change and the reason for the change was unable to be located in the medical record. (continued on next page)

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/1/21 at 11:00 AM, an interview was conducted with the Administrator. The Administrator stated a progress note would be completed by himself or the Resident Advocate Trainee prior to a resident room change or roommate change. The Administrator stated the resident family would be notified by telephone. The Administrator stated the facility was not providing written notices to residents prior to a room change or a roommate change. 43212 3. Resident 1 was admitted to the facility on [DATE] with diagnoses which included but not limited to type 2 diabetes, schizophrenia, hypertension, and polymyalgia. On 8/29/21 at 9:09 AM, an interview was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 stated resident 1 had been moved to a room closer to the nursing cart and where the CNAs could observe resident 1 more closely due to inappropriate behaviors. On 8/29/21 at approximately 10:00 AM, an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated resident 1 was moved closer to where staff could keep a closer eye on him. Resident 1's medical record was reviewed on 9/1/21. On 8/10/21 at 1:46 PM, a general progress note documented Resident is moving to room [ROOM NUMBER]B today, all his belongings and T.V. is moved with resident. Resident is oriented to his room-mate as well room. Resident has adjusted to RM (room) 111B this shift. Written notification informing resident 1 and his representative of the room change and the reason for the change was unable to be located in the medical record. 4. Resident 9 was admitted to the facility on [DATE] with diagnoses which included but not limited to schizoaffective disorder, dementia, anxiety disorder, chronic obstructive pulmonary disease, and type 2 diabetes. Resident 9's medical record was reviewed on 9/1/21. Written notification informing resident 9 of the roommate change and the reason for the change was unable to be located in the medical record. On 8/31/21 at 11:56 AM, an interview was conducted with the Administrator and the Business Manager. The Administrator stated when a resident was moved to a different room in the facility either he or the Resident Advocate would show the resident what rooms were available and the resident would choose which room they wanted. The Administrator stated staff would help the resident move and the resident's family members and the new roommate would be notified. The Administrator stated families were notified by a telephone call. The Administrator stated information about room changes were kept in the resident's progress notes. 22992 (continued on next page)

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Resident 22 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease, benign prostatic hyperplasia, intervertebral disc degeneration, aortic valve stenosis, and major depressive disorder. Resident 22's medical record was reviewed on 8/29/21. Resident 22's progress notes indicated that on 7/29/21, resident 22 was moved to a different room. Written notification informing resident 22 and/or his representative of the room change was unable to be located in the medical record. On 8/30/21 at 8:53 AM an interview was conducted with resident 22. Resident 22 stated that he had requested a roommate or room change because he was not getting along with his previous roommate. Resident 22 stated that he had since changed rooms, but did not receive written notice that this was going to occur.

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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. 22992 Based on interview and record review, the facility did not ensure that residents maintained their right to organize and participate in resident groups in the facility. Specifically, resident council was not conducted at regular intervals. Resident identifiers: 13 and 28. Findings include: 1. On 8/31/21 at 10:00 AM, an interview was conducted with six residents from the resident council. Multiple residents stated that they had not had resident council meetings regularly for several months, and that they missed having the council meetings. Resident 28 stated that there was a long time that the facility was not conducting resident council meetings. Resident 28 further stated that the facility activities director usually conducted the meetings, but that the facility did not currently have an activities director. Resident 13 stated that there was nothing to do at the facility, including participate in resident council meetings. 2. Resident council meeting notes were reviewed. Review of the notes revealed that resident council was conducted on 11/5/20, 4/22/21, 5/27/2, 6/25/21, and 7/23/21. Review of the notes also revealed that during time when clients were not having group activities, Resident Advocate staff conducted individual 'resident council interviews' to document residents (sic) issues, and reviewed with council president. The resident council notes revealed that multiple individual interviews were done during November 2020, but not after that. Review of the notes also revealed that in-person resident council meetings resumed in April 2021. 3. On 8/31/21 at 1:12 PM, an interview was conducted with the facility Administrator (ADM). The ADM confirmed that no group or individual resident council meetings were conducted between November 2020 and April 2021. The ADM stated that the facility did not conduct resident council meetings for a few months because he misunderstood the requirements for visitation and group activities during the COVID-19 pandemic.

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to manage his or her financial affairs. 33215 Based on interview and record review it was determined, for 2 of 30 sampled residents, that the facility did not provide the residents the right to manage his or her financial affairs. Specifically, residents who had authorized the facility to manage any personal funds did not have ready and reasonable access to those funds. Resident identifiers: 4 and 28. Findings include: On 8/29/21 at 10:49 AM, an interview was conducted with Resident 4. Resident 4 stated she could only get money from her personal funds account on Mondays, Wednesdays, and Fridays. Resident 4 stated if she needed money on a Tuesday she would have to wait until Wednesday. On 8/31/21 at 10:00 AM, an interview was conducted with six residents from the resident council. The residents were asked about banking hours and resident funds. Resident 28 stated that there were specific banking hours and you could not access your money unless it was within those timeframes. Resident 28 stated that banking hours were only for part of the day on Mondays, Wednesdays, and Fridays. Resident 28 stated that she had attempted to withdraw money from her account, but they told me I had to wait until banking hours to access her money. All of the residents stated that they did not have access to their money on the weekends. On 8/30/21 at 2:53 PM, a Resident Banking Access sign was observed to be posted in the 300 hall. The sign documented that resident banking access was at 3:00 PM, in the ice cream bistro on Monday, Wednesday, and Friday. All other days, residents could obtain petty cash from the charge nurse. On 8/31/21 at 11:57 AM, an interview was conducted with Registered Nurse (RN) 4. RN 4 stated she was the charge nurse for the day. RN 4 stated the medication carts did not ever have money in them for resident access. RN 4 stated it had been years since the medication carts had a money box. RN 4 stated if it was off hours for banking the resident could ask the front office but on the weekends there was no way to access resident money. On 8/31/21 at 12:19 PM, an interview was conducted with the Business Manager. The Business Manager stated the routine banking hours for residents were Monday, Wednesday, and Friday between 3:30 PM or 4:00 PM. The Business Manager stated she was not strict on the banking hour times. The Business Manager stated she would usually have a money box that was locked and available in the nursing medication carts. The Business Manager stated if a resident requested money on the weekends the money box would be available in the nursing medication carts. On 8/31/21 at 12:38 PM, an interview was conducted with RN 3. RN 3 stated the medication carts in the past had a money box in them but it had been a couple months or longer since the medication carts had a money box. RN 3 stated resident banking hours were Mondays, Tuesdays, and Fridays. RN 3 stated if a resident requested money outside of the banking hours the resident would have to request from the Administrator or the Business Manager. RN 3 stated if a resident requested money on the weekend the resident would have to wait because she did not have access to the money.

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. 22992 Based on interview, the facility did not ensure that residents had their individual financial records available through quarterly statements and upon request. Resident identifier: 42. Findings include: 1. On 8/31/21 at 10:00 AM, an interview was conducted with six residents from the resident council. The residents were asked about resident funds. All of the residents stated that they were not receiving quarterly statements regarding their financial records. 2. On 8/29/21 at 11:00 AM, an interview was conducted with resident 42. Resident 42 stated that he had never received a quarterly statement regarding his financial records. 3. On 8/31/21 at 12:19 PM, an interview was conducted with the Business Manager and the Administrator. The Administrator stated he thought the residents were receiving quarterly statements regarding personal funds. The Business Manager stated she could not remember when the last statements were issued and to which residents she had issued the statements to. The Business Manager stated the statements were not completed electronically or quarterly.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22992 Based on interview and record review, the facility did not ensure that 2 of 30 sample residents had the right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Resident identifiers: 5 and 32. Findings include: 1. Resident 5 was admitted to the facility on [DATE] with diagnoses that included diabetes mellitus, coronary artery disease, hyperlipidemia, hemiplegia, and cerebral infarction. Resident 5's medical record was reviewed on 8/29/21. No documentation could be located to indicate that resident 5 had a Physicians Order of Life Sustaining Treatment (POLST). On 8/31/21 at 4:27 PM, an interview was conducted with Registered Nurse (RN) 4. RN 4 confirmed that resident 5 did not have a POLST in his medical record. On 9/1/21 at 2:10 PM, an interview was conducted with resident 5. Resident 5 stated that if his heart stopped beating, he did not want to be resuscitated. Resident 5 stated that he had filled out his advance directives at the hospital already. 2. Resident 32 was readmitted to the facility on [DATE] with diagnoses that included paranoid schizophrenia, major depressive disorder, cognitive communication deficit, and diabetes mellitus. Resident 32's medical record was reviewed on 8/29/21. No documentation could be located to indicate that resident 32 had a POLST. On 9/1/21 at 1:00 PM an interview was conducted with resident 32. Resident 32 stated that if his heart stopped beating, he did not want to be resuscitated, stating just let me die. On 9/1/21, an interview was conducted with the facility Director of Nursing (DON). The DON confirmed that resident 5 and 32 did not have a POLST in their medical record. The DON stated that if a POLST was not in the medical record, and the resident stopped breathing, the facility would initiate resuscitation efforts.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44639 Based on observations and interviews, it was determined the facility did not provide residents with a safe, clean, comfortable, and homelike environment. Specifically, wheelchairs were observed to be dirty and soiled, walls had holes with drywall exposed, baseboard trim was peeling from walls in resident rooms, on multiple occasions halls were observed to have extended periods of urine and feces smells, and blinds in residents' rooms were broken and unable to be retracted. Resident identifier: 5. Findings include: 1. On 8/29/21 at 9:23 AM, in room [ROOM NUMBER], the baseboard trim lining the bottom of the resident's wall was observed to be peeling away from the dry wall. 2. On 8/29/21 at 9:25 AM, in room [ROOM NUMBER], a hole in the drywall was observed in the resident's bathroom. 3. On 8/29/21 at 9:37 AM, in room [ROOM NUMBER], the baseboard trim on a wall near bathroom was observed to be peeling from the wall. 4. On 8/29/21 at 9:42 AM, in room [ROOM NUMBER], a metal privacy curtain hanger was observed to be hanging off the ceiling with the sharp metal edge exposed. The privacy curtain was observed to be on the ground. On observation, Certified Nursing Assistant (CNA) 1 then stated, I did not know that was like that. On 8/29/21 at 10:32 AM, room [ROOM NUMBER] was observed to have the door closed with yellow and black Caution tape placed over the door. 5. On 8/29/21 at 10:40 AM, in room [ROOM NUMBER], the window blinds were observed to have several broken slats and the blinds were unable to be retracted or opened. 6. On 8/29/21 at 10:42 AM, in room [ROOM NUMBER], the window blinds were observed to have several broken slats and the blinds were unable to be retracted or opened. 7. On 8/30/21 at 10:32 AM, a strong urine smell was observed when entering the 100 hall, memory care unit. This was still present at 11:24 AM. 8. On 8/30/21 at 11:20 AM, the outdoor area adjacent to the 100 hall was observed. A pile of large, used fence posts with peeling paint were observed to be laying along the fence in the resident outdoor area. 9. On 8/29/21 at 1:06 PM, in the resident communal/dining area of the 100 hall, a box filled with trash was observed to be left on the resident counter space next to a bowl filled with bananas. 10. On 8/31/21 at 8:27 AM, when entering the 100 hall, memory care unit, a strong urine smell was observed. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11. On 9/1/21 at 8:00 AM, two large, 55 Gallon, gray plastic trash bins were observed to be stored within the resident bathroom that adjoined rooms [ROOM NUMBERS]; one bin was labeled Laundry and the other was labeled Trash. 12. On 9/1/21 at 8:02 AM, an unused bed in room [ROOM NUMBER] was observed to have no linens and the mattress was observed to be torn in multiple areas. At this time, the blinds in room [ROOM NUMBER] were also observed to have several broken slats and were unable to be opened or retracted. 13. On 9/1/21 at 8:01 AM, the switch for overhead lighting within room [ROOM NUMBER] was observed to not turn on any lighting within the room. 14. On 9/1/21 at 8:03 AM, in room [ROOM NUMBER], the baseboard trim lining the wall was observed peeling away from the wall with dry wall in that area cracked and exposing insulation. 15. On 9/1/21 at 8:05 AM, within the communal dining area of the 100 hall, a curtain hanger above the window was observed to be broken and was hanging off of the wall. 16. On 8/29/21 during the lunch meal, resident 5's electric wheelchair was observed. The wheelchair was observed to be soiled with dried spills and debris on the foot and side areas. 17. On 8/29/21 at 9:07 AM, room [ROOM NUMBER] had what appeared to be feces on the floor. 18. On 8/29/21 at 9:35 AM , in room [ROOM NUMBER], paint patches were observed on the walls and paint was peeling and worn off of the chair guards along the wall. 19. On 8/29/21 at 9:36 AM, in room [ROOM NUMBER], window blinds were bent and broken. 20. On 8/29/21 at 9:54 AM, in room [ROOM NUMBER], a strong smell of feces was observed when entering the room. 21. On 8/31/21 at 12:38 PM, a strong smell of urine was observed when entering the 100 hallway, memory unit. 22. On 8/31/21 at 3:18 PM, a strong smell of urine was observed when entering the 100 hallway, memory unit. On 8/30/21 at 1:44 PM, CNA 2 stated they noticed maintenance would take about one week to fix major maintenance issues. CNA 2 stated the maintenance worker was somewhat responsive. CNA 2 also stated when there was a maintenance issue that needed to be addressed staff would communicate that to the maintenance person by writing it within the maintenance book located at the nurses' station. On 8/30/21 at 2:20 PM, the maintenance log was examined. There were no issues from the 100 hall listed on the maintenance log. The Maintenance Log Book read, 8/12; Fan in S1 (sic) not working,, 8/22; Sprinkler by shed broken,, 8/22; sink in room [ROOM NUMBER] is pulling away from wall, and, 8/25; [name of resident] needs her air conditioner fixed; Date Completed 8/27/21. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/1/21 at 8:10 AM, Licensed Practical Nurse (LPN) 1 reported maintenance could be a little slow at addressing issues. LPN 1 reported when someone tried to find the maintenance person they never can because the maintenance person came late in the day. LPN 1 stated, There are definitely a lot of things that need repairs.

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Mountain View Health Services	5865 South Wasatch Drive Ogden, UT 84403

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 43212 Based on record review and interview, it was determined that the facility did not ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately, but not later than 24 hours if the event that caused the allegation do not involve abuse and do not result in serious bodily injury to the State Survey Agency. Specifically, an entity report of an abuse allegation was not submitted to the State Survey Agency until approximately 73 hours after the incident occurred. Resident identifiers: 1 and 17. Findings include: Resident 1 was admitted to the facility on [DATE] with diagnoses that included, but not limited to, schizophrenia, type 2 diabetes, hypertension and idiopathic epilepsy and epileptic syndromes with seizures. Resident 17 was originally admitted to the facility on [DATE] with medical diagnoses that included, but not limited to, Alzheimer's disease with dementia, hyperlipidemia, hypertension, major depressive disorder and history of Coronavirus disease 2019 (COVID-19). On 8/29/21 at 8:50 AM, an observation was made of resident 1 and resident 17 in an open bathroom on the 100 hallway (memory care unit). Resident 17 was observed to have her back to the wall by the sink and resident 1 was standing directly in front of her. Resident 1 was observed to turn his head toward the surveyor, and then took a step backwards. Resident 17 was observed to walk around resident 1 and leave the room. Resident 17 was observed to be fully clothed. Resident 1 was observed to turn around and face the doorway, while still standing by the sink. Resident 1 was observed to have his penis exposed and turned on the water and began splashing his penis with water. On 8/29/21 at 9:09 AM, an interview was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 was informed about the observation made by the surveyor that morning. On 8/29/21 at approximately 10:00 AM an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated that he had been notified by CNA 1 about the incident between resident 1 and resident 17. LPN 1 stated he had not observed that behavior from resident 1 before. On 9/1/21 at 1:17 PM, an interview was conducted with LPN 1. LPN 1 stated that CNA 1 told him that a surveyor had reported to her that resident 1 was with resident 17 and resident 1 was doing up his pants, or his pants were coming down. LPN 1 stated he asked CNA 1 where both residents were and instructed CNA 1 to check on resident 17. LPN 1 stated he then went and reported the incident to the administrator. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/31/21 at approximately 3:50 PM, an interview was conducted with the facility administrator (ADM). The ADM stated he was told by LPN 1 about the incident between resident 1 and resident 17 on 8/29/21. The ADM stated he was told that resident 1 was observed in the bathroom with his pants down and his penis exposed. The ADM stated he was unaware that resident 1 and resident 17 were in the bathroom together with resident 1 in close proximity to resident 17 while exposed. On 9/1/21 at 1:13 PM, an interview was conducted with the facility ADM. The ADM stated he sent a fax to the State Survey Agency at 10:34 AM that day regarding resident 1 and resident 17. The ADM stated he had also notified the ombudsman, resident 1's mental health provider and adult protective services (APS). The ADM stated he did not call the police. The ADM stated that after the interview conducted on the previous day he realized it was more than just [resident 1] seen getting up from the toilet with his pants down so he filed a report.

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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** 22992 Based on interview and record review, the facility did not develop a baseline care plan for 1 of 30 sample residents within 48 hours of the resident's admission. Resident identifier: 98. Findings include: Resident 98 was admitted to the facility on [DATE] with diagnoses that included sepsis, viral pneumonia, chronic obstructive pulmonary disease, acute respiratory failure, congestive heart failure, protein-calorie malnutrition, and dementia. Resident 98's medical record was reviewed on 8/29/21. No baseline or comprehensive care plan could be located for resident 98 in his medical record. Resident progress notes dated 8/18/21 indicated that resident 98 was admitted to the facility on hospice services. On 9/1/21 at 9:30 AM, an interview was conducted with the facility Director of Nursing (DON). The DON stated that resident 98's hospice nurses should have developed a care plan for resident 98 and placed it in his medical record. The DON confirmed that resident 98 did not have a baseline or comprehensive care plan in his medical record.

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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** 44639 Based on observations, interviews and record reviews, it was determined the facility did not develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs as identified in the comprehensive assessment. Specifically, for 6 of 30 sample residents, residents did not have updated fall care plans or implementations of fall interventions, a resident did not have a care plan and interventions initiated for contractures, residents with activities care plans did not have interventions implemented, and a resident with unplanned weight loss did not have care plan interventions reviewed. Resident identifiers: 17, 24, 25, 27, 28, and 44. Findings included: 1. Residents 17 and 27 had activities care plan with interventions not in place. a. Resident 17 was originally admitted to the facility on [DATE] with medical diagnoses that included, but not limited to, Alzheimer's disease with dementia, hyperlipidemia, hypertension, major depressive disorder and history of Coronavirus disease 2019 (COVID-19). On 8/29/21 at 1:45 PM, resident 17 was observed wandering in the 100 hall, entering residents rooms, and trying to open the doors at the front and back of the 100 hall. Resident 17's record review was completed on 9/01/21. The following documentation was noted: i. A care plan was noted with the focus of Resident is at potential risk for changes to mood, behavior, and psychosocial well being related to recent COVID-19 restrictions as dictated by the CDC [Centers for Disease Control and Prevention]. These restrictions make changes to visitation from resident's friends and family . Interventions/ Tasks: Offer supportive and in room activities that are of interest to resident. ii. Within resident 17's paper chart was a care plan titled, Socially Inappropriate Behavioral Care Plan with an intervention Encourage increased socialization and participation in activities as a therapeutic use of distraction. iii. Within resident 17's paper chart was a care plan titled, Altered Thought Process; Recreational Therapy had a Problem noted as, I have STM [Short Term Memory] and LTM [Long Term Memory] loss, I have difficulties with recall skills and orientation. I am easily distracted and have a short attention pan. I wander. Approaches were noted as, Involve me activities of appropriate cognitive level that might hold my attention, such as: music, manicure, special events, current events, exercise, cookouts, socials, outings, active games, crafts, reminisce, trivia, flower arranging. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/30/21 at 1:25 PM, Certified Nursing Assistant (CNA) 2 stated the facility was not doing any in room activities at this time. CNA 2 also reported activities that are held included bingo, which was held on Wednesdays. CNA 2 reported, Since covid started [the facility] hasn't been doing anything. CNA 2 also reported the residents do not appear to have enough activities in the memory care unit, and the residents, seem to get bored. On 08/31/21 at 3:30 PM, the Administrator was interviewed. The administrator expressed the staff are encouraged to do activities with the residents in the memory care unit, and the facility has had trouble following the posted activities schedule because they do not have the staff to hold activities. On 9/1/21 at 11:07 AM, CNA 4 reported residents on the memory care unit wander a lot and staff try to keep residents busy, but that can be tough because the memory care unit does not have a lot of planned activities. On 9/1/21 at 9:15 AM, Licensed Practical Nurse (LPN) 1 reported, There are not a lot of activities in the memory care unit. LPN 1 also stated the memory care unit does keep a movie playing at most times, and in the past, the unit did provide female residents with a nail painting activity. LPN 1 stated, It has been a while since we have done that. b. Resident 27 was admitted to the facility on [DATE] with diagnoses which included, but not limited to, dementia, type 2 diabetes, chronic viral hepatitis C, hypertension, major depressive disorder, and osteoarthritis. On 8/30/21 at 9:01 AM an observation was made of resident 27 laying on his bed. An interview was conducted. Resident 27 stated there were no activities when asked if he participated in facility activities. Resident 27's medical record was reviewed on 8/30/21. i. Resident 27's care plan revealed a focus of Resident is at potential risk for changes to mood, behavior, and psychosocial well-being related to recent COVID-19 restrictions as dictated by the [Centers for Disease Control and Prevention] CDC. These restrictions make changes to visitation from resident's friends and family. Interventions/tasks documented Offer supportive and in room activities that are of interest to resident. ii. An activity assessment initiated on 3/21/19 revealed resident 27's activity preferences were 1:1, independent and small group activities. Activities of interest a were documented as being music, TV, Movies, social activities and cookouts. The activities assessment was reviewed on 7/1/19, 12/30/19, and 5/19/20. iii. Resident 27's MDS documents were reviewed. On 3/30/21 the MDS documents keeping up with the news, doing things with groups of people, doing favorite activities, and going outside to get fresh air when the weather is good were very important. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/30/21 at 2:53 PM, an observation was made of a Weekend Activity Book in the kitchen area. Inside the book were instructions for activities that could be held. The top of the first page was titled March Saturday Activities. Activities that were listed included an ice cream activity with instructions for staff to take the resident to the ice cream room to eat ice cream. A daily chronicle and word packet were included with instructions to pass it out to residents. Other activities that were listed were give out a deck of cards or a board game. A list of residents was included in the book with instructions to mark the residents that participated in the activities. There were no markings by any of the resident's names in the book. On 8/31/21 at 3:19 PM, an interview with Certified Nursing Assistant (CNA) 3. CNA 3 stated the facility had not had an activities director for about 2 months. CNA 3 stated bingo was offered in the facility in the main part of the facility if residents wanted to go. CNA 3 stated a staff member would take the residents from the memory unit if they wanted to go. CNA 3 stated only 2 residents wanted to participate in bingo. CNA stated bingo was held on Tuesday afternoons. CNA 3 stated some days the residents colored and it helps them relax. CNA 3 stated when the virus hit activities were stopped completely. CNA 3 stated the facility resident advocate (RA) was in the facility 2-3 times per week and would visit with residents on a 1:1 basis. 2. Several residents (residents 25 and 44) had care plans without post-fall reviews or implementation of interventions per care plan documentation. a. Resident 25 was originally admitted to the facility on [DATE] with medical diagnoses that included, but not limited to, Alzheimer's disease, major depressive disorder, hyperlipidemia, history of urinary tract infection, and history of COVID-19. On 08/29/21 at 10:18 AM, resident 25 was observed seated on a sofa in the communal dining area. While wearing regular tube socks, resident 25 was then observed to attempt walking independently toward her wheelchair, through shuffling of her feet. CNA 1 was then observed to notice resident 25 attempting to walk independently toward her wheelchair located at the back of the sofa, and CNA 1 assisted resident 25 several more steps toward her wheelchair. Without locking the wheels of the wheelchair, CNA 1 helped to transfer resident 25 into her wheelchair. With CNA 1 standing to the left of the wheelchair, the wheelchair began to slightly roll backward as resident 25 went to sit and CNA 1 was able to stop the wheelchair from rolling away, enough that resident 25 was was able to transfer into the wheelchair without falling. A review of resident 25's medical record was completed on 09/01/21. The following documentation regarding falls was noted: i. Per resident 25's August 2021 Minimum Data Set (MDS) assessment, resident 25 was coded as having had two or more falls since the previous assessment. ii. A Health Status Note following a fall on 3/3/2021 read, Note Text: Resident was left sitting in [wheelchair] next to [the] bed. The CNA went to go assist her roommate and [resident 25] tried to transfer herself into her bed. [Resident 25's] bed was higher than the [wheelchair], and she slid down onto the floor onto her buttocks. The fall was witnessed by the CNA whom was assisting her roommate. She was assisted into bed. [Moves all extremities] without pain. No injuries noted. MD [Medical Doctor] notified of fall at 1335, family at 1345 and administrator at 1350. Vital signs taken . (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	iii. A Health Status Note following a fall on 4/16/2021 read, Note Text: CNA's reported [resident 25] fell this morning and hit her head. Saw [resident 25] during my shift, awake and alert, no signs of being in pain, took med, will continue to monitor. iii. A Health Status Note following a fall on 6/17/21 read, Note Text: Resident was on the couch in the dining room/TV area and slid off couch, unsure if she hit her head and no head injury noted, no bruises or open wounds, Neuro checks started/implemented. Neuros WNL [within normal limits], .Resident was assisted off the floor and able to stand and answer to yes/no questions. MD [name] notified. Will continue to monitor. Awaiting for UA [urine analysis] results from lab as UA was collected last night. iv. A Health Status Note following a fall on 7/23/21 read, Note Text: at 19:38 this evening, resident found on floor in dining room by wheelchair, possible fall, alert, nonverbal but cooperative, no injuries noted, vitals taken by CNA . MD notified and family notified will continue to monitor. v. Within resident 25's medical record, post-fall completed neuro reports were unable to be found. On 09/01/21 at 2:13 PM, the Director of Nursing (DON) stated completed neuro reports are kept after completion, and the facility staff will have them sent via email. On 09/01/21 at 2:00 PM, an email with completed neuro reports from resident 25's falls was received. Neuro reports dated 4/16/21 through 4/17/21 were provided. No other neuro reports were sent via email. The missing post fall neuro reports were from falls occurring on 6/17/21 and 7/23/21. [Note: Per interviews with facility staff, the fall policy specifies, if a fall is witnessed and the resident does not hit their head neuro checks are not initiated]. vi. Resident 25's care plans titled, Actual Fall Care Plan initiated on 12/16/20 was reviewed. Per care plan new intervention and review of Actual Fall Care Plan was completed on 12/16/20 and 3/3/21. Interventions per care plan included, Follow facility fall protocol for post fall interventions, and, Lock w/c [wheelchair]. [Note: Fall documentation was present from falls on 3/3/21, 4/16/21, 6/17/21, and 7/23/21. No care plan updates noted on 4/16/21, 6/17/21 or 7/23/21 per Actual Fall Care Plan within resident 25's medical record.] b. Resident 44 was originally admitted to the facility on [DATE] with medical diagnoses that included, but not limited to, paranoid schizophrenia, major depressive disorder, hypertension, heart failure, chronic obstructive pulmonary disease, gastro-esophageal reflux disease, diverticulosis, hypoxemia, urinary incontinence, morbid obesity, type 2 diabetes mellitus, pulmonary edema, asthma, adenoviral pneumonia, acute and chronic respiratory failure, obstructive sleep apnea, chronic kidney disease, anemia in chronic kidney disease, history of urinary tract infection, osteoarthritis, chronic pain and history of COVID-19. On 8/29/21 at 11:18 AM, resident 44 was observed ambulating, with a shuffle gait, wearing regular tube socks, while wearing a skirt with a length that cause the skirt to wrap underneath the front of resident 44's feet. A CNA was observed to attempt raising the skirt, which did subsequently wrap around the front of resident 44's feet again. A review of resident 44's medical record was completed on 09/01/21. The following documentation regarding falls was noted: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	i. A Health Status Note from 6/29/2021 read, Note Text: Resident had a fall in the memory hall dining room at 10:45a.m. no injuries noted. Resident stated she got up from the chair and slipped on the floor because it was just mopped and bumped her [left] side of her head on the dining table . Neuro checks implemented . Informed MD [Medical Doctor] and family. Will continue to monitor. ii. A General Note from 7/15/2021 read, Note Text: [Resident] was found siting on the floor facing the toilet with one sock on and one sock off ppt [patient] is c/o [complaining of] bottom hurting and states that she hit her head MD notified Will (sic) pass on to next shift to call the family . WCTM [Will continue to monitor]. iii. A Health Status Note from 7/23/2021 read, Note Text: [Resident 44] was a little sore walking today but no sign of difficulty walking around . fell yesterday was not reported to nurse, unable to assess for pain but no verbal complaints of pain given to nurse. iv. A General Note from 8/30/21 read, Note Text: Resident was found on her bum after slipping out of w/c. Her socks on her left foot was found half on. No apparent injury, abrasions, contusions. Unwitnessed fall, neuros started. MD notified and family notified. v. Within resident 44's medical record, post-fall completed neuro reports were unable to be found. On 09/01/21 at 2:13 PM, the Director of Nursing (DON) stated completed neuro check reports are kept after completion, and the facility staff will have them sent via email. On 09/01/21 at 2:00 PM, an email with completed neuro reports from resident 44's falls was received. Neuro reports dated from 6/29/21 through 07/02/21 were provided. No other neuro reports were sent via email. The missing post fall neuro reports were from falls occurring on 7/15/21, 7/23/21 and 8/30/21. [Note: Per interviews with facility staff, the fall policy specifies, neuro checks would be initiated if a fall is unwitnessed or the resident hits their head]. v. Incident/Accident Reports from falls on 6/29/21, 7/15/21, and 8/30/21 were provided. Per Incident/Accident Report from 8/30/21, Additional comments and/or steps taken to prevent recurrence: Ensure socks/footwear is (sic) on properly. vi. Within resident 44's electronic medical record was a Care Plan with the focus of, The resident is Low risk for falls r/t unsteadiness fall 2/2018, and an intervention/task written as, Ensure that the resident is wearing appropriate footwear when ambulating or mobilizing in w/c. The most recent time this care plan was revised was on 05/10/2018. vii. Within resident 44's paper chart was a document entitled Actual Fall Care Plan. Per the Actual Fall Care Plan, adjustments and review of the fall related care plan interventions was completed on 12/25/20, 7/15/21 and 7/22/21. Per the Actual Fall Care Plan, an intervention included, Follow facility fall protocol for post fall interventions. [Note: Review of resident 44's fall care plan was not evident post fall on 6/29/21 or 8/30/21.] Following resident 44's fall on 8/30/21 staff working in the Memory Care Unit were interviewed on 08/31/21. The following information was gathered: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	i. On 08/31/21 at 10:32 AM, CNA 6 reported being unaware resident 44 had fallen yesterday. CNA 6 stated when a resident has a fall the CNA's will be provided the information during report at the beginning of their shift. This helps the CNA's to know which residents they have to complete neuro check reports on. CNA 6 reported she was not provided a neuro check report for resident 44 and had not been checking her vitals per the facility's fall protocol. ii. On 08/31/21 at 11:03 AM, RN 3 reported not being informed of resident 44's fall during report at the beginning of her shift. RN 3 reported she had just found out resident 44 had a fall because of an alert on resident 44's electronic medical record that indicated RN 3 needed to complete a post-fall note during her shift. RN 3 stated the neuro check report should have been started following resident 44's fall on 8/30/21, but RN 3 was unsure where the neuro check report would be kept or if the neuro check report had been initiated post-fall. RN 3 also stated following this fall an intervention to prevent further falls would include, to ensure resident 44 was wearing proper footwear. RN 3 stated, [Resident 44] should not be wearing just socks. On 08/30/21 at 1:49 PM, CNA 2 was interviewed regarding the facility's fall protocol. CNA 2 stated following identification of a fall the CNA would call the nurse or radio for help, take the resident's vitals, help the resident to get up, and then the nurse would contact the family and the doctor. Following a fall, the CNA staff are to complete a neuro check report for a certain time frame if the resident hit their head during the fall or if the fall was unwitnessed. Once the neuro check report was completed it was provided to the nurse, and CNA 2 was unsure what happened to the information after it was provided to the nurse. On 09/01/21 at 10:20 AM, the DON reported when a fall is unwitnessed the fall would be treated by gathering vitals, assessing the resident, and then contacting the doctor and family. The DON reported if the fall is unwitnessed, staff can not know if the resident hit their head, so the CNA's do the vitals and neuros as specified on the neuro check reports. When asked about updating care plans post-falls, the DON stated she had tried to train all the nurses on how to update the care plans. The DON stated, I try to put the monkey on their back. The DON stated it can be hard for her to follow-up on all falls to ensure the care plans were updated, but the DON reported trying to audit the resident care plans once having received the incident/accident reports. The DON stated when reviewing the care plans she looked to see what interventions were in place and how the fall interventions could be adjusted. On 09/01/21 at 01:20 PM, the DON was interviewed regarding footwear of the residents. When asked what would constitute appropriate footwear, as specified in resident 44's care plan, the DON stated proper footwear was shoes or non-skid slippers. The DON also stated, We do not have any non-skid slippers in stock, and then elaborated, hopefully this gets us some. 3. A resident (resident 28) was identified to have contractures, per documentation within resident 28's medical record, but did not have a care plan or interventions in place for treatment or prevention of worsening contractures. a. Resident 28 was originally admitted to the facility on [DATE], with medical diagnoses that included, but not limited to, Alzheimer's disease with dementia, restlessness and agitation, dizziness and giddiness, repeated falls, diarrhea, polyneuropathy, hyperlipidemia, hypothyroidism, chronic leukemia, history of urinary tract infection, pleural effusion, depressive episodes and chronic respiratory failure with hypoxia. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/30/21 at 08:19 AM, resident 28 was observed at breakfast attempting to hold a cup with her left hand. After three attempts at grasping the cup, resident 28 was able to grasp the cup in order to bring it to her mouth. At this time, resident 28's right hand was closed and kept close to her body. On 08/30/21 at 11:38 AM, there were no splints or assistive devices to prevent contractures present at resident 28's bedside. On 09/01/21 at 12:00 PM, resident 28 was observed at lunch. After attempting to use a fork to eat the meal, resident 28 was unable to grasp the fork with her left hand, and resident 28 ended up putting the fork back down on the table. Using her left hand, resident 28 was then observed to grasp the meat patty from her plate and was able to bring it to her mouth. A review of resident 28's medical record was completed on 09/01/21. The following documentation regarding contractures was present: i. A Weekly Note from 5/13/21 stated, Resident . Uses w/c [wheelchair] for mobility, has contractures in both hands. ii. A Weekly Note from 7/15/21 stated, Rt. [Right] hand fully closed d/t [due to] contractures and Lt. [left] hand is partially contracted. iii. A Weekly Note from 7/22/21 stated, Resident has hand contractures and right hand completely closed. iv. A Weekly Note from 8/5/21 stated, Resident has contractures to both hands and Right (sic) hand contracture is completely closed. v. A Weekly Note from 8/26/21 stated, Contractures to both hands and left hand [resident] is still able to use and right hand is completely closed (sic). vi. Resident 28's MDS assessment history was reviewed regarding functional status and Functional Limitation in Range of Motion. MDS records from 12/28/20, 3/30/21, and 6/30/21 indicated, Upper Extremity (shoulder, elbow, wrist, hand) . Impairment on one side. [Note: per nursing documentation resident with contractures to both hands]. vii. Occupational Therapy (OT) documentation from therapy services was present from 12/10/19 to 3/8/20. OT documentation indicated resident 28 was seen for Contracture; right hand. viii. On 08/30/21 at 12:08 PM, resident 28's care plan was reviewed. Within resident 28's electronic care plan, no care plan related to contractures was noted. On 08/30/21 at 11:30 AM, CNA 2 reported being unaware if resident 28 had any contractures, and CNA 2 reported staff are not doing anything to prevent or treat any contractures resident 28 is suffering from. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/01/21 at 9:20 AM, LPN 1 reported being aware of resident 28's contractures. LPN 1 stated, in the past, LPN 1 had tried to place a rolled cloth into resident 28's right hand, which is fully contracted, but he was unable to open the right hand. LPN 1 also stated there are no consistent interventions in place to help prevent further contracture to resident 28's left or right hand. LPN 1 stated, resident 28 can currently use her left hand for some activities like eating. On 09/01/21 at 9:33 AM, the DON stated at this time there are no interventions in place to prevent further contracture to resident 28's left hand. On 09/01/21 at 11:59 AM, CNA 4 stated in the past CNA 4 had observed LPN 1 trying to place a towel in resident 28's right hand, but LPN 1 was not able to get the towel inside of resident 28's right hand. CNA 4 stated, at this time, the CNA staff are not doing anything to prevent further contractures to resident 28's left or right hand. 45470 4. Resident 24 was admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included COVID-19, schizophrenia, anxiety disorder, conversion disorder, chronic kidney disease, and cognitive communication deficit. Resident 24's medical record was reviewed on 8/29/21. Resident 24's care plan was reviewed. Review of the care plan indicated that it was not developed until 1/15/21, approximately 3 weeks after resident 24 was admitted . The care plan indicated that the facility was to monitor resident 24's weights every week. Review of resident 24's graphed weight records revealed the following weights: a. 1/3/21 - 157.1 lbs. b. 2/7/21 - 155.8 c. 3/7/21 - 157.6 d. 4/4/21 - 150.8 e. 5/2/21 - 150.4 f. 6/6/21 - 148.2 g. 7/4/21 - 146.2 On 7/3/21, the RD documented that resident 24's weight was overall trending downward, although no acute significant loss. Resident weight upon initiation of TF (tube feeding) Jan (January) 2021 161.6 [lbs], currently 144 [lbs], [decrease] 10.9 [percent] [in] 7 months. RD to cont (continue) to watch [and] f/u (follow up)PRN (as needed). The RD recommended that resident 24's tube feeding rate be increased to 75 ml an hour for 24 hours. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of weekly weights provided by the DM revealed the following weights: a. 7/11/21 - 146.0 b. 7/18/21 - 143.8 c. 7/25/21 - 143.0 d. 8/1/21 - 142.8 e. 8/8/21 - 142.0 f. 8/15/21 - 141.8 g. 8/22/21 - 139.8 Review of resident 24's physician orders revealed that despite weight loss from 7/4/21 through 8/22/21, the resident's tube feeding was not changed until 8/30/21. On 8/30/21, resident 24's tube feeding rate was increased to 85 ml an hour for 24 hours. It should be noted that between 7/4/21 and 8/22/21, resident 24 had lost approximately 6.4 lbs. On 8/29/21, the RD documented that resident 24's weight was dropping, and that the trend downward not desired. The RD also documented that resident 24 had lost 2.2 percent of his body weight in one month. The RD recommended that resident 24's tube feeding rate be increased to 85 ml an hour for 24 hours. Resident 24's care plan revealed that despite resident 24's weight loss and multiple changes in tube feeding rate, the care plan was not updated after 4/15/21.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 22992 Based on interview and record review, the facility did not ensure that resident care plnas were developed within 7 days after completion of the comprehensive assessment for 2 of 30 sample residents. Resident identifiers: 1 and 24. Findings include: 1. Resident 24 was admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included COVID-19, schizophrenia, anxiety disorder, conversion disorder, chronic kidney disease, and cognitive communication deficit. Resident 24's medical record was reviewed on 8/29/21. On 12/31/20, the facility completed an annual Minimum Data Set (MDS) for resident 24. The MDS indicated that a care plan for activities should have been developed. Review of resident 24's medical record indicated that neither an assessment of resident 24's activity needs, nor an activities care plan had been developed. 43212 2. Resident 1 was admitted to the facility on [DATE] with diagnoses that included, but not limited to, schizophrenia, type 2 diabetes, hypertension and idiopathic epilepsy and epileptic syndromes with seizures. Resident 1's medical record was reviewed on 8/30/21. On 8/19/21 a quarterly Minimum Data Set (MDS) was completed for resident 1. The MDS documented that wandering behaviors were not exhibited, that resident 1 rejected evaluation or care necessary to achieve goals for health and well-being on 1-3 days, that resident did not exhibit any behavioral symptoms including behaviors that impacted other residents. The MDS documented that resident 1 had symptoms of hallucinations and delusions. The MDS also documented that resident 1 did not have scheduled pain medications, but did receive as needed (PRN) pain medication. Non-medications interventions were documented as being received. Resident 1's care plan was documented as being initiated on 8/3/21. Resident 1's care plan, documented that resident 1 had behavior problems related to schizophrenia. Interventions/tasks included to prevent behaviors were Caregivers to provided opportunity for positive interaction, attention. Stop and talk with him/her as passing by .If reasonable discuss the resident's behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable to the resident .Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situation. Document behavior and potential causes. There was no care plan development addressing pain, or inappropriate behaviors with other residents. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 1's medication administration record (MAR) was reviewed. The July MAR documented resident 1 received pain medication on 7/28/21 and on 8/3/21. Resident 1's progress notes included documentation on 8/14/21 Licensed Practical Nurse (LPN) 1 documented Resident has been frequently touching staff and other residents without consent, On 8/25/21 that the Director of Nursing (DON) documented Spoke with [name of local mental health provider] about residents being sexually inappropriate. States she will see him today.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22992 Based on interview, observation and record review, the facility did not provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community for 14 of 30 sample residents. Resident identifiers: 5, 13, 15, 17, 22, 24, 25, 27, 28, 32, 35, 36, 42, and 43. Findings include: 1. On 8/29/21 at 8:15 AM, an observation was made of the activities calendar posted at the facility. The calendar listed the following activities: a. On 8/29/21 - Daily Chronicle, TV time, Bible quote of the week b. On 8/30/21 - Doorway exercise, Daily Chronicle, Overhead positivity, One on one visits, and Banking c. On 8/31/21 - Doorway exercise, Doorway Bingo, Travel Bug, Leisure Cart, Sensory one on ones. During the duration of the survey from 8/29/21 through 9/1/21, no activities were observed to be occurring at the facility. 2. On 8/31/21 at 10:00 AM, an interview was conducted with six residents from the resident council. The resident council members all stated that the facility did not have an Activities Director. Multiple residents stated that they had not had resident council meetings regularly for several months, and that they missed having the council meetings. Resident 13 stated that there was nothing to do at the facility, including participate in resident council meetings, so she read, watched television and slept . Resident 42 stated that the only activity at the facility was bingo once a week, so he just entertained himself by watching television. Resident 15 stated there were no activities so I just read. When asked about the activity calendar posted in the hallway, all of the residents stated that the activities listed on the calendar were not being done. Resident 28 stated that the lack of activities at the facility had been brought up by residents multiple times in resident council, but that there were still no activities occurring. Resident 28 further stated that the facility had been trying to use the resident advocate to also lead the activities but that the resident advocate was too busy to do activities. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The resident council notes from the previous several months were reviewed and revealed the following: [Note: Resident council was conducted on 11/5/20, 4/22/21, 5/27/21, 6/25/21, and 7/23/21. An interview with the Administrator (ADM) on 8/31/21 at 1:12 PM, confirmed that no resident council meetings occurred between November 2020 and April 2021.] a. On 4/22/21, the notes indicated that the activities occurring in the facility were church services every other week. b. On 5/27/21, the notes indicated that residents were requesting the facility hire a recreational therapist. The residents requested bingo, van rides, outdoor cookouts, movie nights, balloon game in the hall, and yahtzee. c. On 6/25/21, the notes indicated that the residents wanted to sing, play dominoes, and socialize more. The notes also indicated that church services were happening every other week. d. On 7/23/21, the notes indicated that the residents were again requesting van rides, outside walks, and a book club. The notes also indicated that there was a music group coming on 8/10/21. 3. On 8/29/21 at 1:30 PM, an interview was conducted with residents 43 and 35, who resided in the same room. Resident 35 stated that there used to be more activities. Resident 35 stated that the facility used to employ an activities person but they don't anymore. Resident 35 stated that he would like it if there were more activities. Resident 43 stated that the only activity currently happening at the facility was bingo. 4. Resident 24 was admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included COVID-19, schizophrenia, anxiety disorder, conversion disorder, chronic kidney disease, and cognitive communication deficit. Resident 24 was observed multiple times throughout the survey from 8/29/21 through 9/1/21. At no time was resident 24 observed to be out of his bed in his room. Resident 24's medical record was reviewed on 8/29/21. On 12/31/20, the facility completed an annual Minimum Data Set (MDS) for resident 24. The MDS indicated that a care plan for activities should have been developed. Review of resident 24's medical record indicated that neither an assessment of resident 24's activity needs, nor an activities care plan had been developed. Review of resident 24's physician orders revealed that the resident was receiving a tube feeding that was running at 85 ml an hour for 24 hours a day. The physician orders also revealed that the resident had been on a 24 hour continuous tube feeding since his readmission to the facility on [DATE]. On 9/1/21 at 8:42 AM, an interview was conducted with the facility Registered Dietitian (RD). The RD was asked if she had considered changing the resident's tube feeding, so that it was not running 24 hours a day, allowing the resident to leave his room and potentially attend activities. The RD stated that she had not considered that option, and that some residents preferred to stay in their room. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 9/1/21 at 9:30 AM, an interview was conducted with the facility Director of Nursing (DON). The DON confirmed that resident 24 was confined to his room, and stated that she wanted to get resident 24 more socialized and out of bed and less isolated. The DON stated that she had been in communication with the Speech Therapist, in an attempt to have a percutaneous endoscopic gastrostomy (PEG) tube placed. The DON stated that the PEG tube placement would allow resident 24 to potentially leave his room and attend activities. The DON stated that she had spoken with the Business Office Manager (BOM) and Administrator (ADM) about the PEG tube placement to see if it could be completed, because they were in charge of making resident appointments, but had not heard back 5. Resident 5 was admitted to the facility on [DATE] with diagnoses that included diabetes mellitus, coronary artery disease, hyperlipidemia, hemiplegia, transient ischemic attack, and arthritis. On 8/29/21 at 12:30 PM, an interview was conducted with resident 5. Resident 5 stated, there's no activities here. I spend 90 percent of my time in bed. There is only bingo. Resident 5's medical record was reviewed on 8/29/21. Resident 5's MDS Admission assessment dated [DATE], revealed that resident 5 should have an activities care plan developed. Review of resident 5's medical record revealed that no activities care plan had been developed for resident 5. 6. On 8/30/21 at 8:53 AM an interview was conducted with resident 22. When asked about the activities program at the facility, resident 22 stated, if you don't play bingo, its pretty damn boring. Resident 22 stated that he mostly smoked cigarettes to keep himself entertained. Resident 22 also stated that there was not an activities director at the facility. 7. On 8/29/21 at 11:49 AM, an interview was conducted with resident 32. Resident 32 stated that there were no activities being held at the facility except bingo. Resident 32 stated, I just sleep and smoke. There's nothing else to do. 8. On 8/29/21 at 11:00 AM, an interview was conducted with resident 42. Resident 42 stated that there was not an activities director at the facility. Resident 42 stated that there used to be one, but ever since she left, its just boring . It would be nice to do other things. 43212 9. Resident 27 was admitted to the facility on [DATE] with diagnoses which included dementia, type 2 diabetes, chronic viral hepatitis C, hypertension, major depressive disorder, and osteoarthritis. On 8/30/21 at 9:01 AM, an interview was conducted with resident 27. Resident 27 stated there are no activities when asked if he participated in facility activities. An observation was made of resident 27's room. Resident 27 did not have any activity supplies in his room and he was observed to be laying on his bed. On 8/31/21 resident 27's medical record was reviewed. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 3/21/19 an activities assessment was completed for resident 27. Resident 27's activity assessment revealed that resident 27 was interested in music, watching TV, watching movies, social gatherings, and cookouts. Resident 27's activity preferences revealed resident 27 preferred activities in small groups, independently and 1:1. Resident 27's leisure interests were documented as reading newspapers, doing things with groups of people, and getting fresh air. The activities assessment was updated on 7/1/19, 12/20/19, and 5/19/2020. An annual MDS dated [DATE] revealed that resident 27 felt that keeping up with the news, doing things with groups of people, doing favorite activities, and going outside when the weather was good were very important. Resident 27's care plan revealed Offer supportive and in room activities that are of interest to resident dated 2/5/21, and Provide activities in the SNU (Special Needs Unit) or supervised while outside of the SNU was dated 8/3/2021. 10. Resident 36 was admitted to the facility on [DATE] with diagnoses that included, but not limited to, schizoaffective disorder, dementia, anxiety disorder, type 2 diabetes, and chronic obstructive pulmonary disease. On 8/29/21 at 2:15 PM, resident 36 stated what activities when asked if he participates in facility activities. During the survey observations was made of resident 36 in his room. Resident 36 was watching television and did not have any activity materials in his room. On 8/31/21 resident 36's medical record was reviewed. An MDS admission assessment dated [DATE] revealed that resident 36 felt that having books, newspapers, and magazines were very important. Other activities documented as very important were listening to music he liked, doing things with groups of people, doing favorite activities, going outside to get fresh air when the weather was good, and participating in religious services or practices. On 5/21/21 an activities assessment was completed for resident 36. Resident 36's activity assessment revealed that leisure interests included having reading materials, books and newspapers, listening to music, doing things with groups of people, doing favorite activities, getting fresh air on a good day, playing bingo, special events, sporting events and participating in religious activities were very important. Activity preferences were documented as being one on one, independent and in small groups. 44639 11. Resident 17 was admitted to the facility on [DATE] with medical diagnoses that included Alzheimer's disease with dementia, hyperlipidemia, hypertension, major depressive disorder and history of Coronavirus disease 2019 (COVID-19). On 8/29/21 at 1:45 PM, resident 17 was observed wandering within the memory care unit hallway. Resident 17 was observed to enter another residents' room, and was then observed to attempt opening the exit door located at the front end of the memory care unit hallway. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 8/29/21 at 9:57 AM, resident 17 was observed to be at the exit door located at the far end of the memory care unit hallway. After attempting to open the door, resident 17 began to wander toward the other end of the memory care unit hallway. On 8/30/21 at 1:23 PM, resident 17 was observed to enter another residents' room. Resident 17 walked into the room, stood in the center of the room for several seconds and then exited the other residents' room. On 8/30/21 at 1:33 PM, resident 17 was observed to enter a different residents' room. Resident 17 stood near a resident's wardrobe closet and then turned and left the resident's room several seconds later. On 9/1/21 a review of resident 17's medical record was completed. A care plan with a focus that stated, Resident is at potential risk for changes to mood, behavior, and psychosocial well being related to recent COVID-19 restrictions as dictated by the CDC (Centers for Disease Control and Prevention). These restrictions make changes to visitation from resident's friends and family, and an intervention was noted as, Offer supportive and in room activities that are of interest to resident. A care plan entitled, Socially Inappropriate Behavioral Care Plan was reviewed. The care plan problem stated, Potential impaired social interaction manifested by verbally abusive, physically abusive, making disruptive sounds, inappropriate sexual behavior, wandering, taking others possesions (sic). An intervention noted was, Encourage increased socialization and participation in activities as a therapeutic use of distraction. A care plan entitled, Altered Thought Process; Recreational Therapy was reviewed. The care plan problem/need was written as, I have STM [short term memory] and LTM[long term memory] loss, I have difficulties with recall skills and orientation. I am easily distracted and have a short attention span. I wander. An intervention was listed as, Involve me in activities of appropriate cognitive level that might hold my attention such as: Music, manicure, special events, current events, exercise, cookouts, socials, outings, active games, crafts, reminisce, trivia, flower arranging. 12. Resident 25 was admitted to the facility on [DATE] with medical diagnoses that included Alzheimer's disease, major depressive disorder, hyperlipidemia, history of urinary tract infection, and history of COVID-19. On 08/29/21 at 9:32 AM, resident 25 was observed seated at a sofa in the communal dining room, with no other residents and with no activity or engagement item near her. Resident sat at the sofa until 10:11 AM, without engagement, and resident spent this time itching her red, inflamed eye. At 10:17 AM, resident 25 then attempted to walk unassisted to her wheelchair located behind the sofa. On 08/29/21 at 1:17 PM, resident 25 was observed to be falling asleep while seated in front the the television in the communal dining area. A review of resident 25's medical record was completed on 09/01/21. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A care plan with a focus that stated, Resident is at potential risk for changes to mood, behavior, and psychosocial well being related to recent COVID-19 restrictions as dictated by the CDC. These restrictions make changes to visitation from resident's friends and family. An intervention was noted as, Offer supportive and in room activities that are of interest to resident. A care plan entitled, Altered Thought Process: Recreation Therapy and the problem/Need was listed as, Alteration in thought Process (sic). I have a severe thought process impairment. I have difficulties with recall skills and orientation. I am easily distracted and have a short attention span. An intervention listed was, Invite me to activities of appropriate cognitive level such as: Music activities, crafts, active games, current events, outings, exercise, movies, reminisce, special events, trivia, socials, reading, cooking. An assessment entitled, Therapeutic Recreation Assessment 2. The assessment stated, Leisure: [Resident 25] likes to attend special events, current events, pet visits, socials, crafts, music, reminiscing, active games, tv and movies. She says having reading material, pet visits and keeping up on the news are somewhat important to her. Listening to music, group activities, getting fresh air on a good day and doing her favorite activities are very important to her. Within the Analysis of Needs and Interests it was listed, Activity Pursuit Areas Impressions: [Resident 25] identified activities of interest. She likes group activities. On 8/30/21 at 2:53 PM, an observation was made of a Weekend Activity Book in the kitchen area of the SNU. Inside the book were instructions for activities that could be held. The top of the first page was titled March Saturday Activities. Activities that were listed included an ice cream activity with instructions for staff to take the resident to the ice cream room to eat ice cream. A daily chronicle and word packet were included with instructions to pass it out to residents. Other activities that were listed were give out a deck of cards or a board game. A list of residents was included in the book with instructions to mark the residents that participated in the activities. There were no markings by any of the resident's names in the book. On 8/31/21 at 3:19 PM, Certified Nursing Assistant (CNA) 3 was interviewed. CNA 3 stated the facility had not had an activities director for about 2 months. CNA 3 stated bingo was offered in the main part of the facility if residents wanted to go. CNA 3 stated a staff member took the residents from the SNU if they wanted to go. CNA 3 stated only 2 residents wanted to participate in bingo. CNA 3 stated bingo was held on Tuesday afternoons. CNA 3 stated some days the residents colored and it helps them relax. CNA 3 stated when the virus hit activities were stopped completely. CNA 3 stated the facility resident advocate (RA) was in the facility 2-3 times per week and would visit with residents on a 1:1 basis. On 8/30/21 at 1:25 PM, CNA 2 was interviewed. CNA 2 stated the facility was not doing any in-room activities at this time. CNA 2 stated activities that were held included bingo, which was held on Wednesdays. CNA 2 stated Since COVID started [the facility] hasn't been doing anything. CNA 2 also reported the residents do not appear to have enough activities in the memory care unit, and the residents, seem to get bored. On 8/30/21 at 2:09 PM, a resident within the memory care unit was observed at their bedroom doorway. When the resident was asked, How are you? their response was, I am bored. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 9/1/21 at 11:07 AM, CNA 4 was interviewed. CNA 4 stated residents on the memory care unit wandered a lot, and the CNA's tried to keep residents busy, but that was tough because the memory care unit did not have a lot of planned activities. On 9/1/21 at 9:15 AM, Licensed Practical Nurse (LPN) 1 was interviewed. LPN 1 stated There are not a lot of activities in the memory care unit. LPN 1 stated the memory care unit did keep a movie playing at most times, and in the past, the unit did provide female residents with a nail painting activity. LPN 1 stated, It has been a while since we have done that. On 8/31/21, the BOM provided the consultant notes from the facility Certified Therapeutic Recreation Specialist (CTRS) for the previous 10 months. The consultant notes indicated that the CTRS had not provided oversight from 11/30/20 until 5/25/21. The notes further revealed that the CTRS did not provide oversight in June 2021. On 9/1/21 at 3:38 PM, the Therapeutic Recreation Therapist (TRT) was interviewed. The TRT stated that she came to the building twice a month for a couple of hours each time, and she was last in the building on 7/29/21. The TRT stated that she has been trying to keep up with the activity logs, but had not been able to. The TRT stated that she did not document what activities were happening, and which residents were attending. The TRT stated she attempted as many one on one visits as she could when she came in every other week, but she also had to complete paperwork for the residents such as assessments and care plans during that time. The TRT stated it had been approximately 2 years since she had worked at the facility full time. On 9/1/21 at 3:48 PM, the Resident Advocate (RA) was interviewed. The RA stated that he would visit the facility twice a week, for a total of about 15 hours. The RA stated that he played bingo with the residents every Friday, and assisted residents with ordering things online. The RA stated that he would attempt to meet with everyone one on one, but its hard to do it weekly. The RA stated the facility had been attempting to hire a new TRT because the residents need and want more activities than I can offer them on my own. The RA stated that every time he conducted an activity, he would mark the names of the participants on a census sheet, and those sheets were kept in a filing cabinet, not as an individual log in each resident's medical record. On 8/31/21 at 3:30 PM, the ADM was interviewed. The ADM stated that the facility was having one type of religious meetings twice a month and they plan to start having family home meetings once a week. The ADM stated individual visits for residents who were part of the another religion were being provided once a month, and once a month a minister met with residents in the facility's sunroom. The Administrator reported the facility was trying to hold regular concerts and there have been 2 held within the last month. When the ADM was asked what regular activities were held to engage the residents in the memory care unit, the ADM stated that staff were encouraged to do activities as they could. The Administrator also stated the facility was not following the posted activity schedule because they did not have staff to run the activities. The ADM confirmed that the CTRS did not provide oversight from 11/30/20 to 5/25/21.

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the activities program is directed by a qualified professional. 22992 Based on record review and interview, the facility did not have an activities program that was directed by a qualified professional who is a qualified therapeutic recreation specialist. Specifically, the facility did not employ a Certified Therapeutic Recreation Specialist. Findings include: On 8/31/21, the facility Business Office Manager (BOM) provided the consultant notes from the facility Certified Therapeutic Recreation Specialist (CTRS) for the previous 10 months. The consultant notes indicated that the CTRS had not provided oversight from 11/30/20 until 5/25/21. The notes also indicated that the CTRS did not provide oversight in June 2021. On 8/31/21, an interview was conducted with the facility Administrator (ADM). The ADM confirmed that the CTRS did not provide oversight from 11/30/20 to 5/25/21.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44639 Based on observations, interviews, and record reviews, it was determined the facility did not ensure residents received treatment and care in accordance with professional standards of practice. Specifically, for 2 of 30 sample residents, the facility did not ensure standards of care were met regarding treatment and care of a resident's edema or treatment and care of a resident's facial rash. Resident identifiers: 44 and 99. Findings include: 1. Resident 44 was originally admitted to the facility on [DATE] with medical diagnoses that included, but not limited to, paranoid schizophrenia, major depressive disorder, hypertension, heart failure, chronic obstructive pulmonary disease, gastro-esophageal reflux disease, diverticulosis, hypoxemia, urinary incontinence, morbid obesity, type 2 diabetes mellitus, pulmonary edema, asthma, adenoviral pneumonia, acute and chronic respiratory failure, obstructive sleep apnea, chronic kidney disease, anemia in chronic kidney disease, history of urinary tract infection, osteoarthritis, chronic pain and history of Coronavirus disease 2019 (COVID-19). On 8/29/21 at 2:47 PM, resident 44 was observed to have a facial rash with red, peeling, flaky skin. When asked if the rash was itchy or painful, resident 44 responded, Yes. On 8/30/21 at 12:03 PM, resident 44 was observed to still have a red facial rash which was flaky and peeling. When resident 44 was asked if the rash was painful, resident 44 responded, Yes. On 8/31/21 at 10:30 AM, resident 44 was observed to still have a facial rash with red, flaky skin. When asked if the rash hurt, resident 44 responded, Yes. On 9/1/21 at 11:09 AM, resident 44 was observed to continue having a red, peeling facial rash present. On 8/30/21 at 12:55 PM, Certified Nursing Assistant (CNA) 2 reported resident 44's facial rash was the same rash that resident 44 had on her breast area. CNA 2 reported the CNAs were not providing any treatment to the facial rash, but the nurse may be providing her a cream. CNA 2 reported when working last week resident 44 did not have the facial rash, and CNA 2 reported, That is new. On 8/30/21 at 2:35 PM, CNA 3 reported if a resident has a skin issue the CNAs would have documented this on the skin check sheets which the CNAs completed when providing a resident a shower. CNA 3 stated these skin check sheets were placed in a binder for the nurses to review, and CNA 3 was unsure what the nurses did with the skin check sheets once they had reviewed them. On 8/30/21 at 3:34 PM, Registered Nurse (RN) 2 reported the best way nurses learned about skin issues was through reviewing the shower skin check sheets for information or learning about the skin issue during report. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/31/21 at 10:39 AM, RN 3 stated resident 44's facial rash, is off and on. When asked what treatment the nurses had been providing for resident 44's facial rash RN 3 reported, I do not know, and stated, I guess I should give her something. RN 3 stated when resident 44 was provided with a treatment or lotion for the facial rash it would be documented on the Medication Administration Record (MAR). On 9/1/21 at 8:11 AM, Licensed Practical Nurse (LPN) 1 reported the triamcinolone medication lotion would be the best choice to apply to resident 44's facial rash. LPN 1 reported when resident 44 was provided with the triamcinolone lotion it cleared up the facial rash. LPN 1 reported, if a nurse was to provide resident 44 with the triamcinolone lotion the nurse would document this within the MAR. On 9/1/21 at 10:21 AM, the Director of Nursing (DON) reported resident 44 did get the facial rash, every once in a while. The DON reported resident 44 will have triamcinolone lotion applied to the facial rash. The DON reported the hydrocortisone cream could be used in addition to the triamcinolone lotion. The DON reported the facial rash had begun, .within the last couple days. About last Monday, which would have been around 8/23/21. The DON reported if a nurse did apply lotion to resident 44's facial rash it would be coded within the resident's MAR. When the DON was asked about whether hydrocortisone or triamcinolone lotion should be used she reported, the triamcinolone works best and reported, the nurses need to be a little more educated about what to provide. On 9/9/21, a review of resident 44's medical record was completed. The following documentation regarding resident 44's facial rash was present: a. Skin check sheets: i. Skin check sheet from 8/2/21 with no skin issues noted. ii. Skin check sheet from 8/6/21 stated, Redness on face and right arm. iii. Skin check sheet from 8/11/21 stated, Sore redness under breasts. iv. Skin check sheet from 8/25/21 stated, Redness under stomach and breast. v. Skin check sheet from 8/30/21 stated, Red under breast. b. A Weekly Note from 8/7/21 stated, Also has facial rash/redness and dermatitis cream is used PRN (as needed). c. A Weekly Note from 8/21/21 stated, Redness rash on face and Triamcilone (sic) cream applied PRN. d. On 8/31/21, following conversation with RN 3 about resident 44's facial rash, RN 3 documented 8/31/2021 10:48, Orders - Administration Note Note Text: Hydrocortisone Lotion 1 % Apply to face topically as needed for skin; Given for facial rash. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	e. On 08/31/21 at 10:53 AM, resident 44's MAR was reviewed for August 2021. An order was noted for, Triamcinolone Acetonide Cream 0.1 %. Apply to rash on face topically every 12 hours as needed for facial rash Apply BID (twice daily) prn. No documentation was present that resident 44 was provided with the Triamcinolone Acetonide Cream in August 2021. 22992 2. Resident 99 was admitted to the facility on [DATE] with diagnoses that included localized swelling, mass and lump, lower limb, bilateral; paranoid schizophrenia; and lymphedema. On 8/29/21 at 8:38 AM, resident 99 was observed. Resident 99 had large edematous legs. No wraps were present. This observation was made throughout the day on 8/30/21, 8/31/21, and 9/1/21. Resident 99's medical record was reviewed on 8/29/21. Resident 99's discharge orders from the hospital dated 8/5/21 revealed that resident 99 was to have leg wraps placed for management of his lymphedema. Resident 99's care plan dated 8/17/21 documented that resident 99 had edema in both lower extremities due to lymphedema. The interventions included to apply compression as ordered and encourage resident to elevate legs while in room. Resident 99's initial nursing evaluation dated 8/6/21 revealed that resident 99 had edema to his bilateral lower extremities. Resident 99's Preadmission Screening and Resident Review (PASRR) dated 8/5/21. The PASRR evaluator indicated that on 6/10/21, resident 99's doctor reported significant swelling in [resident 99's] lower extremities. The evaluator also documented that resident 99 was experiencing a lot of leg pain and fatigue with ambulation, and that the resident could not apply compression stockings independently. Progress notes for resident 99 revealed the following: a. On 8/6/21, staff indicated that resident 99 has lymphydema (sic) wraps to his legs bilaterally upon arrival to the facility from the hospital. b. On 8/6/21, staff indicated that resident 99 had 4 plus edema to bilateral legs, his left leg is larger than his right leg. c. On 8/8/21, staff indicated that ted hose were applied to resident 99's legs for lymphedema. No progress notes were located in resident 99's chart after 8/9/21. Review of resident 99's physician orders revealed that resident 99 did not have an order for compression wraps to be applied. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/1/21 at 9:30 AM, an interview was conducted with the facility Director of Nursing (DON) . The DON stated that she was the nurse who had admitted resident 99 to the facility, and was not aware that there was a discharge order from the hospital for resident 99 to have wraps applied to his legs for lymphedema management.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22992 Based on interview, record review and observation, the facility did not ensure that 1 of 30 sample residents received proper treatment and care to maintain mobility and good foot health. Specifically, a resident had an open wound on his foot that was not being treated by facility staff or a physician. Resident identifier: 33. Findings include: Resident 33 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included schizoaffective disorder, COVID-19, benign prostatic hyperplasia, vascular dementia, and diabetes mellitus. Resident 33's medical record was reviewed on 8/29/21. Resident 33's care plan dated 11/1/18 was reviewed. The care plan indicated that resident 33 was at risk for developing pressure ulcers. The interventions included to monitor, document and report any changes in skin status. A note from a wound healing company for resident 33 dated 5/13/21 was reviewed. The note indicated that resident 33 had a diabetic ulcer on the plantar surface of his left foot. The note also indicated that This wound looks significantly better today. There is a small area of eschar that is residual on the bottom of his foot. We will have the facility apply lotion to his foot every day. We will evaluate this foot 1 more week and if everything is still okay, we will discharge the patient . On 7/21/21 a podiatrist note indicated that resident 33 had been seen by the podiatrist. The podiatrist documented that resident 33 had a callus on his left plantar foot that was debrided. Resident 33's progress notes indicated the following: a. On 8/13/21, facility staff documented that the resident has been repeatedly asking for tums for heartburn and Tylenol for pain on wound right (sic) foot. put name on pediatrist (sic) appointment. Right (sic) foot does look like it is causing pain. b. On 8/27/21, facility staff documented that resident 33 has an ulcer on bottom of left foot, name written in appointment book. [Note: There were no progress notes for resident 33 between 8/13/21 and 8/27/21. In addition, the facility staff did not document that they had notified the facility physician to obtain orders, treatments and/or referrals. No physician notes regarding the wound in August 2021 could be located.] Resident 33's physician orders were reviewed. No orders could be located to indicate that resident 33 had any orders for dressing or treatment of the wound on the resident's left foot since he had complained of pain on 8/13/21. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A list placed at the nurses station entitled Residents to be seen by the podiatrist was reviewed. Facility staff documented that resident 33 had a foot callus on his left foot on 7/3/21. The resident was also listed later on the list after 7/20/21, although no date was documented. On 8/30/21 at 9:21 AM, an observation was made of resident 33. Resident 33 was observed to be laying in his bed with his shoes on. Resident 33 stated that he had a sore on his left foot, but that there were no dressings on it. On 8/30/21 at 3:10 PM, an observation was made of the resident's left foot with the Director of Nursing (DON). The DON removed resident 33's left shoe and sock. Resident 33's left foot had an open wound on the upper plantar area. The DON observed the wound on the left foot and stated it appeared to be an open plantar wart. The DON also stated that because the wound was open, it should have a dressing on it because its starting to crack, and is bleeding. The DON stated that she did not know why a dressing had not been placed on the wound prior to this. The DON stated that the resident would be placed on the podiatrist list. The DON also stated that Registered Nurse (RN) 4 was the wound nurse, and would know more about the wound. On 8/31/21 at 4:27 PM, an interview was conducted with RN 4. RN 4 stated that resident 33 had been being seen by a wound specialist, for a reoccurring callus, but had been discharged from their services. RN 4 stated she was unaware that resident 33 had an open wound on his left foot, and that she had last seen the resident's feet approximately one month prior. RN 4 stated that the wound specialist would be coming to the facility on [DATE], and she would put resident 33 on the list of residents to be seen. On 9/1/21, a follow up interview was conducted with the DON. The DON stated that the podiatrist came to the facility every two months, so if a resident was placed on the podiatrist list to be seen for an issue, it could be up to two months before the resident was seen. The DON stated she would contact the physician about resident 33's foot wound, so the appropriate referrals could be made. The DON stated that on 8/30/21 she placed a padded pink dressing on the resident's foot, but had not contacted the physician, or received orders for a dressing or treatment. The DON stated we need to get in and fix it. When asked why the resident's foot was not treated for approximately two weeks even though he was complaining of pain, and facility staff were aware of the wound, the DON stated it should have been taken care of. It can't go that long.

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F 0688 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44639 Based on observations, interviews and record review it was determined the facility did not ensure a resident with limited range of motion received appropriate treatment and services to increase their range of motion and to prevent further decrease in range of motion. Specifically, a resident with documentation of a contracture to the right and left hand was not provided with treatment and services to increase their range of motion or to prevent further decrease in range of motion. This finding resulted in a harm deficiency. Resident identifier: 28. Findings include: Resident 28 was originally admitted to the facility on [DATE], with medical diagnoses that included, but not limited to, Alzheimer's disease with dementia, restlessness and agitation, dizziness and giddiness, repeated falls, diarrhea, polyneuropathy, hyperlipidemia, hypothyroidism, chronic leukemia, history of urinary tract infection, pleural effusion, depressive episodes and chronic respiratory failure with hypoxia. On 8/30/21 at 8:19 AM, resident 28 was observed at breakfast attempting to hold a cup with her left hand. After three attempts at grasping the cup resident 28 was able to grasp the cup in order to bring it to her mouth. At this time resident 28's right hand was closed and kept close to her body. On 8/30/21 at 11:39 AM, resident 28 was again observed to be able to grab a cup of water independently with the left hand. On 8/30/21 at 11:30 AM, Certified Nursing Assistant (CNA) 2 reported resident 28 was independent with eating meals, but resident 28 needed help in other areas like zipping things or completing tasks that needed fine motor skills. CNA 2 reported she was unaware if resident 28 had any contracture issues to the right or left hands. CNA 2 also reported staff did not use any splints or interventions for preventing contractures with resident 28's hands. On 8/30/21 at 11:38 AM, resident 28's room was examined. No splints or range of motion devices were noted. On 9/1/21 at 12:00 PM, resident 28 was observed at lunch to be unable to grasp a fork with the left hand. Resident 28 placed the fork back onto the table and then using her left hand, resident 28 grasped the meat patty and brought the food to her mouth. On 9/1/21 at 9:20 AM, Licensed Practical Nurse (LPN) 1 stated resident 28 had a contracture to both the left and right hands. LPN 1 stated since starting employment at the facility in January 2021, LPN 1 had noticed resident 28 was suffering from a contracture to the left hand. LPN 1 also stated the contracture to resident 28's right hand had gotten worse and resident 28 was not able to use the right hand at all now. LPN 1 stated in the past he tried to place a rolled up towel within resident 28's right hand, but resident 28's right hand would not open. LPN 1 stated there were no consistent interventions in place to help prevent worsening contracture to resident 28's right or left hands. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	On 9/1/21 at 11:59 AM, CNA 4 stated they had seen LPN 1 try to place a towel in resident 28's right hand in the past. CNA 4 stated the CNA staff were not doing anything with resident 28's hands to prevent further contracture to the left or right hand. On 9/1/21 a review of resident 28's medical record was completed. The following observations were made within resident 28's medical record: a. A Weekly Note from 5/13/21 stated, Resident . Uses w/c [wheelchair] for mobility, has contractures in both hands. b. A Weekly Note from 7/15/21 stated, Rt. [Right] hand fully closed d/t [due to] contractures and Lt. [left] hand is partially contracted. c. A Weekly Note from 7/22/21 stated, Resident has hand contractures and right hand completely closed. d. A Weekly Note from 8/5/21 stated, Resident has contractures to both hands and Right (sic) hand contracture is completely closed. e. A Weekly Note from 8/26/21 stated, Contractures to both hands and left hand [resident] is still able to use and right hand is completely closed (sic). f. Resident 28's Minimum Data Set (MDS) assessment history was reviewed regarding functional status and Functional Limitation in Range of Motion. MDS records from 6/30/21 indicate, Upper Extremity (shoulder, elbow, wrist, hand) . Impairment on one side. [Note: per nursing documentation resident with contracture to both hands]. g. Occupational Therapy (OT) documentation from therapy services present from 12/10/19 to 3/8/20. OT documentation indicates resident was seen for Contracture; right hand. h. On 08/30/21 at 12:08 PM, resident 28's care plan was reviewed. Within resident 28's electronic care plan, no care plan related to contractures was noted. On 9/1/21 at 9:33 AM, the Director of Nursing (DON) reported having noticed resident 28's left hand contracture seemed worse the other day. The DON reported because of working as a floor nurse the DON was not always able to observe how all the residents were doing, unless they were on the DON's workload that day. The DON reported there were no interventions being done with resident 28's left or right hands to prevent the contractures from getting worse. The DON also stated being unaware if resident 28 had received any OT services for the hand contractures at this time. On 9/1/21 at 12:47 PM, an OT therapist for the facility was interviewed. The OT therapist stated resident 28 had not received therapy services in, quite a while. The OT therapist reported around the 1st of August 2021, the OT department had received a referral to look into resident 28's contractures. The OT therapist reported resident 28 had not been added to the therapy case load following receipt of the referral around 8/1/21 because one of the OT therapists was on vacation.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 44639 Based on observations, interviews, and record review it was determined the facility did not ensure that the residents' environment remained free of accident hazards as possible, or that each resident received adequate supervision and assistance devices to prevent accidents. Specifically, for 2 of 30 sampled residents, interventions regarding fall prevention were observed to not be followed; these included, proper footwear was not provided or utilized with a resident, and wheels on a resident's wheelchair were not locked with transfers. Resident identifiers: 25 and 44. Findings include: 1. Resident 25 was originally admitted to the facility on [DATE] with medical diagnoses that included, but not limited to, Alzheimer's disease, major depressive disorder, hyperlipidemia, history of urinary tract infection, and history of Coronavirus disease 2019 (COVID-19). On 8/29/21 at 10:18 AM, resident 25 was observed to be seated on a sofa in the 100 hall, communal dining area. At this time, resident 25's wheelchair was left behind the sofa. While wearing regular tube socks resident 25 was observed to stand from the sofa, walk by shuffling her feet and head toward her wheelchair. Certified Nursing Assistant (CNA) 1 was then seen to assist the resident to take several more steps toward resident 25's wheelchair. With the wheelchair wheels unlocked, and CNA 1 standing on the left side of the wheelchair, CNA 1 assisted resident 25 to sit in the wheelchair. As resident 25 began to sit, the wheelchair rolled slightly backward and CNA 1 was able to stop the wheelchair from rolling backward too far, and the resident sat in the wheelchair without falling. On 9/1/21 at 8:01 AM, when attempting to turn on the light within resident 25's room, it was observed the overhead lighting in the resident's room was not working when utilizing the light switch near the door to the room entrance. On 8/30/21 at 1:49 PM, CNA 2 was interviewed regarding residents with fall prevention interventions. CNA 2 stated being unaware of any interventions in place with resident 25 for prevention of falls. CNA 2 stated residents who had recent falls were discussed in report, and that was when CNA 2 learned about fall prevention interventions. Resident 25's medical record review was completed on 9/1/21. The following documentation regarding past falls and interventions were noted: a. Incident/Accident Report from 3/3/21 read, Res (Resident] was sitting in her w/c (wheelchair) went to the bed (sic), w/c was not lock (sic), bed was higher than w/c. CNA went to help roommate and [resident 25] transferred herself and slid down to the floor. [Resident 25] did not hit her head per CNA .Additional comments and/or steps taken to prevent recurrence: Lock w/c [wheelchair]. [Note: Observation made of resident having been transferred to her wheelchair with wheels unlocked.] b. Incident/ Accident Report from 6/17/21 read, Resident was sitting on couch and slid on to floor (sic). Unsure if she hit her head, however will implement neuros .Additional comments and/or steps taken to prevent recurrence: Frequent room checks. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. Incident/Accident Report from 7/23/21 read, FOF [Found on floor] in dining room, alert, non [NAME] [non-cooperative], regular confusion (sic) .Additional comments and/or steps taken to prevent recurrence: ensure socks on. d. Actual Fall Care Plan from resident 25's hard chart read, Interventions: .Keep environment clear of obstructions, floors dry, well lit, etc . Toilet q [every] 2 hours PRN [as needed] .Lock w/c [wheelchair]. [Note: Observations were made of wheelchair unlocked during a transfer and overhead lighting within resident 25's room was not functioning.] 2. Resident 44 was originally admitted to the facility on [DATE] with medical diagnoses that included, but not limited to, paranoid schizophrenia, major depressive disorder, hypertension, heart failure, chronic obstructive pulmonary disease, gastro-esophageal reflux disease, diverticulosis, hypoxemia, urinary incontinence, morbid obesity, type 2 diabetes mellitus, pulmonary edema, asthma, adenoviral pneumonia, acute and chronic respiratory failure, obstructive sleep apnea, chronic kidney disease, anemia in chronic kidney disease, history of urinary tract infection, osteoarthritis, chronic pain and history of COVID-19. On 8/29/21 at 11:18 AM, resident 44 was observed to be walking from a bedroom to the dining room, using a four-wheel walker, wearing regular tube socks and wearing a skirt which hung over resident 44's socks in the front. As resident 44 was walking a CNA came by and raised resident 44's skirt which then fell down below the front of her tube socks again. On 8/31/21 at 9:00 AM resident 44's medical record was reviewed. A General Note from 8/30/2021 read, Note Text: Resident was found on her bum after slipping out of w/c. Her socks on her left foot was found half on. No apparent injury, abrasions, contusions. Unwitnessed fall, neuros started. MD notified and family notified. On 8/31/21 at 10:32 AM, CNA 6 reported resident 44 had not had any recent falls. During a follow-up interview on 8/31/21 at 11:16 AM, CNA 6 reported she was never told during report about resident 44's fall the previous day. CNA 6 reported no neurological checks had been initiated or were being completed by the CNAs. On 8/31/21 at 11:03 AM, Registered Nurse (RN) 3 reported during morning report she was not informed resident 44 had fallen the previous day. RN 3 was able to find out resident 44 had a fall on 8/30/21 because of an order to complete alert charting during the shift. On 8/31/21 at 12:32 PM, resident 44 was observed in the dining room wearing regular tube socks, no non-skid material on the bottom and no shoes were being worn. A review of resident 44's medical record was completed on 9/1/21. The following documentation regarding falls was noted: a. An Incident/Accident Report from a fall on 6/29/21 read, Resident got up from chair in dining room and slipped on floor it was just mopped (sic) and she bumped left (sic) side of her head on dining table . Additional comments and/or steps taken to prevent recurrence: Ensure residents are out of a room that is being mopped until floor is dry. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. An Incident/Accident Report from a fall on 7/15/21 read, Pt [Patient] was found sitting on floor facing toilet one sock on one sock off (sic) . Pt. was on the way to bathroom did not use walker (sic) . Additional comments and/or steps taken to prevent recurrence: bed in low position, walker by bedside, toilet regularly. c. An 'Incident/Accident Report from a fall on 8/30/21 read, Resident slipped out of w/c [wheelchair] onto bottom. Right side of socks were on half way and cause for slipping (sic) .Additional comments and/or steps taken to prevent recurrence: Ensure socks/footwear is on properly. On 8/31/21 at 11:07 AM, RN 3 reported an intervention put in place for resident 44 to prevent further falls was to ensure resident 44 was wearing proper footwear. RN 2 stated proper footwear would include, that the resident should, not be wearing just socks. On 9/1/21 at 1:20 PM, the Director of Nursing (DON) stated proper footwear would include, shoes or non skid slipper socks. When asked why residents were wearing regular socks, the DON reported, We do not have any non-skid slippers in stock. On 8/29/21 at 9:23 AM, CNA 1 was asked about staffing of the 100 hall. CNA 1 reported the facility had one CNA not come in for her shift, so another CNA was rotating all units today. CNA 1 reported feeling rushed and reported difficulty with monitoring a lot of people who wandered. On 9/1/21 at 11:07 AM CNA 4 stated resident 44 wanted to walk a lot so the CNA staff tried to keep resident 44 busy, but that could be tough because the memory care unit did not have a lot of planned activities.

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45470 Based on interview and record review, the facility did not ensure that 1 of 30 sample residents maintained acceptable parameters of nutritional status. Specifically, a resident who was exclusively tube fed lost weight without timely interventions to prevent further weight loss. The findings were cited at a harm level. Resident identifier: 24. Findings include: Resident 24 was admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included COVID-19, schizophrenia, anxiety disorder, conversion disorder, chronic kidney disease, and cognitive communication deficit. Resident 24's medical record was reviewed on 8/29/21. Resident 24's Nutritional Assessment was reviewed. The Nutritional Assessment indicated that the facility Dietary Manager (DM) completed the assessment on 12/28/20, which was 4 days after resident 24 was readmitted . The Assessment further indicated that the facility Registered Dietitian (RD) did not review the Assessment until 1/15/21, approximately 3 weeks after resident 24 was readmitted . The Assessment indicated that resident 24 weighed 161.6 pounds (lbs). The Assessment indicated that resident 24 was receiving an enteral tube feeding of Replete with Fiber for 65 milliliters (ml) an hour for 24 hours a day. The Assessment also indicated that resident 24 had experienced a recent significant weight change. The Assessment indicated that resident 24 was not eating any food by mouth, and was exclusively tube fed due to a swallowing difficulty. The Assessment indicated that resident 24's estimated calorie needs to be between 1470 and 1838 calories a day. The Assessment indicated that resident 24's tube feeding formula would provide 1560 calories a day. Resident 24's care plan was reviewed. Review of the care plan indicated that it was not developed until 1/15/21, approximately 3 weeks after resident 24 was admitted . The care plan indicated that the facility was to monitor resident 24's weights every week. Review of resident 24's graphed weight records revealed the following weights: a. 1/3/21 - 157.1 lbs. b. 2/7/21 - 155.8 c. 3/7/21 - 157.6 d. 4/4/21 - 150.8 e. 5/2/21 - 150.4 f. 6/6/21 - 148.2 g. 7/4/21 - 146.2 (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 8/31/21 at 1:30 PM, an interview was conducted with the DM. The DM stated that weights were taken and recorded on a graph the first Sunday of every month. Review of resident 24's physician orders revealed that despite weight loss from January 2021 through July 2021, the resident's tube feeding was not changed until 7/5/21. On 7/5/21, resident 24's tube feeding rate was increased to 75 ml an hour for 24 hours. It should be noted that between 1/3/21 and 7/4/21, resident 24 had lost approximately 11 lbs. On 7/3/21, the RD documented that resident 24's weight was overall trending downward, although no acute significant loss. Resident weight upon initiation of TF (tube feeding) Jan (January) 2021 161.6 [lbs], currently 144 [lbs], [decrease] 10.9 [percent] [in] 7 months. RD to cont (continue) to watch [and] f/u (follow up)PRN (as needed). The RD recommended that resident 24's tube feeding rate be increased to 75 ml an hour for 24 hours. Review of weekly weights provided by the DM revealed the following weights: a. 7/11/21 - 146.0 b. 7/18/21 - 143.8 c. 7/25/21 - 143.0 d. 8/1/21 - 142.8 e. 8/8/21 - 142.0 f. 8/15/21 - 141.8 g. 8/22/21 - 139.8 Review of resident 24's physician orders revealed that despite weight loss from 7/4/21 through 8/22/21, the resident's tube feeding was not changed until 8/30/21. On 8/30/21, resident 24's tube feeding rate was increased to 85 ml an hour for 24 hours. It should be noted that between 7/4/21 and 8/22/21, resident 24 had lost approximately 6.4 lbs. On 8/29/21, the RD documented that resident 24's weight was dropping, and that the trend downward not desired. The RD also documented that resident 24 had lost 2.2 percent of his body weight in one month. The RD recommended that resident 24's tube feeding rate be increased to 85 ml an hour for 24 hours. Resident 24's care plan revealed that despite resident 24's weight loss and multiple changes in tube feeding rate, the care plan was not updated after 4/15/21. Review of resident 24's August 2021 Medication Administration Record (MAR) revealed that facility staff were to administer the tube feeding formula twice a day. The MAR indicated that facility staff did not document that resident 24 received his evening enteral feedings on the following dates: 8/4/21, 8/12/21, 8/15/21, 8/18/21, and 8/24/21. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 8/31/21 at 1:00 PM, an interview was conducted with the DM. The DM stated that she was aware of resident 24's weight loss, and that the RD had recently increased the rate of resident 24's tube feeding. The DM stated that she did not know why resident 24 was losing weight. The DM further stated that she was not involved in making decisions about tube feeding recommendations. On 9/1/21 at 8:42 AM, an interview was conducted with the facility RD. The RD stated that she participated in the skin and weight meetings, and that she was in weekly communication with the DM. The RD stated that she was responsible for evaluating the residents receiving tube feedings to determine if their needs were being met. The RD stated that resident 24 had experienced a general change of condition. The RD stated that she thought that resident 24 was receiving some of his calories by mouth, and that there were other things happening. The RD stated that she had recently increased the tube feeding rate for resident 24, and that she was thinking about changing the formula to a 1.1 or 1.2 calorie formula. The RD stated that she was going to wait to change the resident's formula to correct his weight loss until after the survey was over so that she didn't shake things up for facility staff. On 9/1/21 at 9:30 AM, an interview was conducted with the facility Director of Nursing (DON). The DON confirmed that resident 24 was not receiving any food by mouth. When asked about resident 24's tube feeding, the DON stated we are aware that he is losing weight. My assumption would be that the RD may not be coming in because of COVID.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33215 Based on observation, interview, and record review it was determined, for 1 of 30 sample residents, that the facility did not ensure that a resident who needs respiratory care is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents goals and preferences. Specifically, a resident that did not require oxygen therapy was provided an oxygen concentrator without a physician's order for oxygen therapy. Resident identifier: 4. Findings include: On 8/29/21 at 12:32 PM, an interview was conducted with resident 4. Resident 4 stated she wore oxygen and recently had to turn up the oxygen due to shortness of breath. Resident 4 was observed to have an oxygen concentrator in her room and the nasal cannula tubing was observed not to be dated. Resident 4 was admitted to the facility on [DATE] with diagnoses which included but not limited to major depressive disorder, post-traumatic stress disorder, generalized anxiety, chronic migraine, conversion disorder with seizures or convulsions, personal history of traumatic brain injury, and bradycardia. Resident 4's medical record was observed on 9/1/21. A Care Plan Focus initiated on 8/2/21, documented The resident has oxygen therapy. A Goal initiated on 8/2/21, documented The resident will have no s/sx (signs or symptoms) of poor oxygen absorption through the review date. An Intervention initiated on 8/2/21, documented Monitor for s/sx of respiratory distress and report to MD (Medical Director) PRN (as needed): Respirations, Pulse oximetry, Increased heart rate (Tachycardia), Restlessness, Diaphoresis, Headaches, Lethargy, Confusion, Atelectasis, Hemoptysis, Cough, Pleuritic pain, Accessory muscle usage, Skin color. The Oxygen Summary was reviewed from February 2021 to current. Resident 4's oxygen saturation was documented on room air and averaged 94.1 percent. Resident 4's oxygen saturation was not documented below 90 percent. The Order Summary Report was reviewed. A physician's order for oxygen therapy was unable to be located. On 9/1/21 at 12:47 PM, an interview was conducted with resident 4. Resident 4 stated the staff did not fill the humidifier bottle on her oxygen. The humidifier bottle attached to the oxygen concentrator was observed to be empty. The oxygen concentrator was observed to be set between 3 to 3.5 liters of oxygen. Resident 4 stated she would adjust the oxygen level on her own if she was feeling shortness of breath. Resident 4 stated the staff have never changed the oxygen tubing. On 9/1/21 at 12:52 PM, an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated the oxygen tubing should be changed weekly. LPN 1 stated the oxygen concentrator humidifier bottles were filled by the Certified Nursing Assistants (CNAs). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/1/21 at 12:57 PM, an interview was conducted with CNA 5. CNA 5 stated she filled the oxygen concentrator humidifier bottles for the residents. CNA 5 stated she would glance at the humidifier bottle when she was in the resident room and fill the bottle if necessary. On 9/1/21 at 1:00 PM, an interview was conducted with the Director of Nursing (DON). The DON stated if a resident had oxygen therapy there should be a physician's order. The DON stated the oxygen tubing should be changed every 2 to 3 weeks on Sundays. The DON stated if the oxygen tubing was changed the nursing staff would document the change on the Treatment Administration Record. The DON stated she was told to have a physician's order for the oxygen concentrator humidifier bottles. The DON was informed that resident 4 had an oxygen concentrator in her room without a physician's order. The DON asked why does the resident have oxygen. The DON was informed resident 4 was observed wearing the oxygen. The DON asked why was the resident wearing the oxygen. The DON stated the oxygen concentrator might belong to resident 4's roommate. On 9/1/21 at 1:06 PM, an observation of resident 4's room was conducted. An oxygen concentrator was observed at the foot end of resident 4's bed and an additional oxygen concentrator was observed at the foot end of the roommates bed.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. 33215 Based on observation and interview, it was determined that the facility did not have the nurse staffing information posted. The facility must post the following information on a daily basis: Facility name, the current date, the resident census, and the total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: Registered nurses, Licensed practical nurses, and Certified nurse aides. The facility must post the nurse staffing data on a daily basis at the beginning of each shift. Specifically, the nurse staffing data was not posted on a daily basis and the daily resident census was not accurate. Findings include: On 8/29/21 at 8:21 AM, an interview was conducted with Registered Nurse (RN) 3. RN 3 stated she was not sure what the resident census was for the day but information could be located on the nurse staffing post located by the medication storage room. On 8/29/21 at 8:21 AM, the nurse staffing post was observed. The nurse staffing post was dated 8/26/21, and the current census was documented as 47. On 8/30/21 at 8:00 AM, the nurse staffing post was observed. The nurse staffing post was dated 8/26/21, and the current census was documented as 47. On 8/31/21 at 8:00 AM, the nurse staffing post was observed. The nurse staffing post was dated 8/26/21, and the current census was documented as 47. On 9/1/21 at 7:23 AM, the nurse staffing post was observed. The nurse staffing post was dated 8/26/21, and the current census was documented as 47. On 9/1/21 at 9:29 AM, an interview was conducted with the Director of Nursing (DON). The DON stated the nurse staffing post was being completed by the Administrator and the Business Manager. The DON stated that recently she given the assignment of the nurse staffing post and she would have one of the Certified Nursing Assistants complete the posting. The DON further stated the night nurse that was in the facility after 11:00 PM, would complete the nurse staffing post every night. The DON stated that she relied on the night nurse to post the nurse staffing post every night.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33215 Based on interview and record review it was determined, for 2 of 30 sample residents, that the irregularities noted by the pharmacist during the drug regimen review were not reported to the attending physician and the facility's Medical Director (MD). Specifically, irregularities were not documented on a separate written report that includes the resident name and the irregularity the pharmacist identified. In addition, the attending physician did not document in the resident's medical record that the identified irregularities had been reviewed and what action, if any, had been taken to address the irregularities. Resident identifiers: 7 and 41. Findings include: 1. Resident 7 was admitted to the facility on [DATE] with diagnoses which included but not limited to type 2 diabetes mellitus without complications, mood disorder, essential hypertension, atherosclerotic heart disease, and chronic kidney disease. Resident 7's medical record was reviewed on 8/30/21. The Consultant Pharmacist's Medication Regimen Review dated 4/2/21, documented This resident takes medications that requires periodic monitoring of an A1c (glycated hemoglobin), CBC (complete blood count) and CMP (comprehensive metabolic panel) every six months. A review of the chart shows that these labs have not been drawn since September of 2020. This was discussed with the medical director and the following has been approved: 1. Draw A1c, CBC and CMP on the next convenient lab date, then every six months thereafter. [Note: The Consultant Pharmacist's Medication Regimen Review included recommendations for other residents that resided at the facility.] A separate written report documenting the pharmacist recommendation was unable to be located in the medical record. In addition, no documentation was located that the attending physician documented in resident 7's medical record that the identified recommendations had been reviewed. 2. Resident 41 was admitted to the facility on [DATE] with diagnoses which included but not limited to Wernicke's encephalopathy, psychosis, alcohol use, chronic pain, and encephalopathy. Resident 41's medical record was reviewed on 8/30/21. The Consultant Pharmacist's Medication Regimen Review dated 6/3/21, documented This resident has an order for Seroquel, Depakote and Duloxetine for psychosis and encephalopathy. These medications do not carry a labeled indication for this diagnosis. This was discussed with the medical director, and it was confirmed there is sufficient evidence that symptoms of depression, agitation and mood instability are common behavioral symptoms of psychosis and encephalopathy, and that these medications are effective in treating these symptoms. Prior attempts with other agents have resulted poorly in managing the patients behaviors. As a result the medical director feels that the benefits of treatment with these medications for this diagnosis currently outweigh any potential risks at this time. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[Note: The Consultant Pharmacist's Medication Regimen Review included recommendations for other residents that resided at the facility.] A separate written report documenting the pharmacist recommendation was unable to be located in the medical record. In addition, no documentation was located that the attending physician documented in resident 41's medical record that the identified recommendations had been reviewed. On 9/1/21 at 9:29 AM, an interview was conducted with the Director of Nursing (DON). The DON stated the Consultant Pharmacist's Medication Regimen Review reports were sent to the Administrator and Business Manager. The DON stated she had asked the Administrator and Business Manager to forward a copy of the reports to her so she could write the necessary physician's orders and include the reports in the book so things were not missed. The DON stated that individualized resident forms were completed and signed by the MD. The DON stated If the pharmacist recommended labs she would go ahead and do the labs. The DON stated the reports were a process that needed to be fixed.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22992 Based on interview and record review, the facility did not ensure that 1 of 30 sample residents was free of significant medication errors. Specifically, a resident was not administered pain and anxiety medication as prescribed to assist in comfort during the dying process. Resident identifier: 98. Findings include: Resident 98 was admitted to the facility on [DATE] with diagnoses that included sepsis, viral pneumonia, chronic obstructive pulmonary disease, acute respiratory failure, congestive heart failure, protein-calorie malnutrition, and dementia. Resident 98's medical record was reviewed on 8/29/21 and again on 8/31/21. Resident 98's physician orders were reviewed. Resident 98 had the following medications prescribed: A. On 8/22/21, Lorazepam 2 milligrams per milliliter (mg/ml) 0.5 ml by mouth every 8 hours for anxiety and restlessness. [Note: Lorazepam is an anti-anxiety medication.] Resident 98's August 2021 Medication Administration Record (MAR) was reviewed. a. On 8/24/21, the resident was not administered Lorazepam at 12:00 AM. Review of the narcotic record revealed that the Lorazepam was not administered at 12:00 AM. b. On 8/27/21, the resident was not administered Lorazepam at 12:00 AM. Review of the narcotic record revealed that the Lorazepam was not administered at 12:00 AM as scheduled. c. On 8/28/21, the resident was not administered Lorazepam at 12:00 AM or 8:00 AM. Review of the narcotic record revealed that the Lorazepam was not administered at 12:00 AM. d. On 8/29/21, the resident was not administered Lorazepam at 12:00 AM. Review of the narcotic record revealed that the Lorazepam was not administered at 12:00 AM or 8:00 AM. e. On 8/31/21, the resident was not administered Lorazepam at 12:00 AM. Review of the narcotic record revealed that the Lorazepam was not administered at 12:00 AM as scheduled. B. On 8/22/21, Dilaudid 1 mg/ml 0.5 ml by mouth every 4 hours for pain of shortness of breath. [Note: Dilaudid is a narcotic pain medication.] Resident 98's August 2021 MAR was reviewed. a. On 8/23/21, the Dilaudid was not administered at 12:00 AM, 4:00 AM, 8:00 AM, 12:00 PM, or 8:00 PM. Review of the narcotic record revealed that the Dilaudid was not administered at noon, 4:00 PM, or 8:00 PM. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. On 8/24/21, the Dilaudid was not administered at 12:00 AM or 4:00 AM. Review of the narcotic record revealed that the Dilaudid was not administered at 12:00 AM, 4:00 AM, 12:00 PM or 8:00 PM. c. On 8/25/21, the Dilaudid was not administered at 12:00 AM or 4:00 AM. The narcotic sheets did not indicate that Dilaudid was administered on this date. d. On 8/26/21, the Dilaudid was not administered at 12:00 AM or 4:00 AM. The narcotic sheets did not indicate that Dilaudid was administered on this date. e. On 8/27/21, the Dilaudid was not administered at 12:00 AM, 4:00 AM or 12:00 PM. The narcotic sheets did not indicate that Dilaudid was administered on this date. f. On 8/28/21, the Dilaudid was not administered at 12:00 AM, 4:00 AM, or 8:00 AM. The narcotic sheets did not indicate that Dilaudid was administered on this date. g. On 8/29/21, the Dilaudid was not administered at 12:00 AM, 4:00 AM, or 8:00 AM. The narcotic sheets did not indicate that Dilaudid was administered on this date. h. On 8/30/21, the Dilaudid was not administered at 12:00 AM or 4:00 AM. The narcotic sheets did not indicate that Dilaudid was administered on this date. i. On 8/31/21, the Dilaudid was not administered at 12:00 AM or 4:00 AM. Review of the narcotic record revealed that the Dilaudid was not administered at 12:00 AM or 4:00 AM. On 8/31/21 at 4:20 PM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated that she had held resident 98's Lorazepam and Dilaudid on 8/28/21 at 8:00 AM because the daughter did not want the nurse to administer the medications at that time. RN 1 stated she did not know why the other documentation was missing for the Lorazepam and Dilaudid doses, and had no way of knowing if the medications were administered. On 9/1/21 at 9:30 AM, an interview was conducted with the Director of Nursing (DON). The DON stated she did not know why resident 98 was not administered his Lorazepam and Dilaudid as prescribed by the physician.

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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. 33215 Based on observation and interview it was determined that the facility did not ensure that all drugs and biologicals were labeled in accordance with currently accepted professional principles and included the expiration date when applicable. In addition, drugs and biologicals must be stored in locked compartments and permit only authorized personnel to have access to the keys. Specifically, medications and multi-dose vials of insulin and Tubersol were opened, expired, and available for use. An unidentified medication cup with an unidentified substance was not labeled in the medication cart. In addition, the treatment cart was observed on two separate occasions unlocked and unattended. Findings include: 1. On 8/29/21 at 8:14 AM, an initial tour was conducted of the facility. The treatment cart located in the central area of the facility next to the medication storage room was observed to be unlocked. The two nurses on shift were passing morning resident medications and the other staff present were assisting residents. The treatment cart was observed to be unattended by staff. At 9:08 AM, a staff member locked the treatment cart. On 8/31/21 at 10:18 AM, the treatment cart was inspected and contained the following items: a. The top drawer contained: bandage scissors, paper scissors, 13 non-safety scalpels, pocidone-iodine swabsticks, lubricating jelly, alcohol prep pads, safety hypodermic needles, toenail clippers, woven gauze sponges, and skin barrier film non sting wipes. b. The second drawer from the top contained: skin closure strips reinforced, abdominal pads sterile, suture removal kit, powder free synthetic gloves, antifungal powder, moisturizing body lotion, wound dressing ointment, stomahesive protective powder, clotrimazole, hydrocortizone cream 1% tube, 2 terbinafine hydrochloride cream 1%, hydro gel, venelex ointment, A&D ointment, 3 jars of silver sulfadiazone cream, hydrocortisone cream 2.5%, Medihoney, Medihoney 80% gel, Silver sulfadiazine 1% cream, and Santyl 250 unit/gram ointment. [Note: The Santyl 250 unit/gram ointment was labeled with a resident name, available for use in the treatment cart, and had an expiration date of 6/20.] c. The third and fourth drawer from the top contained: bandages. d. The fifth drawer from the top contained: a bottle of hydrogen peroxide, Eucerin creams, dermal wound cleaner, nystatin cream, hydrocortisone creams, diclofenca sodium gel 1%, Nyamyc nystatin topical powder, triamcinolone cream, Prep H (hemorrhoid cream), muscle rub, triple antibiotic, bengay, and powder. On 9/1/21 at 8:39 AM, the treatment cart located in the central area of the facility next to the medication storage room was observed to be unlocked. The treatment cart was observed to be unattended by staff. At 9:30 AM, the treatment cart was observed to still be unlocked. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. On 8/31/21 at 7:14 AM, the medication administration task was being conducted. Registered Nurse (RN) 3 was observed preparing medications for a resident. An unidentified medication cup with an unidentified substance and a spoon was observed in the top drawer of the medication cart. The medication cup was not labeled. On 8/31/21 at 7:46 AM, an interview was conducted with RN 3. RN 3 stated she had prepared the medications for a resident and the staff took the resident to the shower room. RN 3 stated the cup was not labeled with resident information. RN 3 stated if more than one resident medication cup was in the drawer she would label the cup with the resident name. RN 3 stated she did not like to prepare resident medications without administering them. 3. On 8/31/21 at 10:08 AM, RN 3's medication cart was inspected and the following items were expired and available for use: [Note: Multi-dose vials of insulin should be discarded within 28 days after opened or accessed.] a. A multi-dose vial of Novolog insulin had an open date of 7/27/21, and an expiration date of 8/25/21. [Note: The Novolog insulin should have been discarded on 8/23/21.] b. A multi-dose vial of Novolog insulin had an open date of 8/1/21. [Note: The Novolog insulin should have been discarded on 8/28/21.] c. A multi-dose vial of Novolog insulin had an open date of 7/27/21, and an expiration date of 8/25/21. [Note: The Novolog insulin should have been discarded on 8/23/21.] d. A Humalog Kwikpen was not labeled with an open date or an expiration date. e. A Lantus pen was not labeled with an open date or an expiration date. On 8/31/21 at 10:16 AM, an interview was conducted with RN 3. RN 3 stated multi-dose vials of insulin should be disposed of 28 days after opening. 4. On 8/31/21 at 10:48 AM, the medication fridge within the storage room was inspected and the following items were expired and available for use: a. A multi-dose vial of Tubersol had an open date of 11/5/2020. [Note: Multi-dose vials of Tubersol should be discarded within 30 days after opening.] b. A bottle of Magic mouth wash suspension had an expiration date of 6/21/21. On 8/31/21 at 11:00 AM, an interview was conducted with RN 4. RN 4 stated there was not a system for pulling expired medications from the medication carts. RN 4 stated she would write open dates on items and would pay attention to the dates. On 8/31/21 at 11:15 AM, an interview was conducted with RN 3. RN 3 stated she was usually good at keeping the treatment cart locked but she could get distracted. RN 3 stated it was especially important to keep the treatment cart locked on the memory care unit because they had residents that liked to get into the cart. RN 3 stated she tried to keep the treatment cart locked. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/1/21 at 9:29 AM, an interview was conducted with the Director of Nursing (DON). The DON stated medications should be labeled and there was a sheet on the medication fridge indicating when medications were expired. The DON stated the night shift nurses should be doing medication fridge and medication cart checks for expired medications. The DON stated there should be no excuses because she had been going over the expired medications since July. The DON stated she went by the Tubersol expiration date on the vial and she was not aware the Tubersol had to be discarded 30 days after opening. The DON stated the medication carts, treatment carts, and medication storage room should be locked at all times. The DON stated she had told the staff on numerous occasions to make sure those items are always locked. The DON stated she needed to meet with the staff and charge nurses and provide additional education.

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22992 Based on interview and record review, the facility did not provide or obtain radiology and other diagnostic services to meet the needs of 1 of 30 sample residents. Specifically, a resident did not have timely imaging completed of his cervical and lumbar areas, nor of his gallbladder/liver area as prescribed by physicians. Resident identifier: 22. Findings include: Resident 22 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease, benign prostatic hyperplasia, intervertebral disc degeneration, aortic valve stenosis, and major depressive disorder. On 8/30/21 at 8:53 AM, an interview was conducted with resident 22. Resident 22 stated that he was supposed to have a Magnetic Resonance Imaging (MRI) scan completed on his back, but that the facility had not followed through and scheduled it. The resident also stated that the MRI was supposed to help his back specialist determine if the resident required surgery on his back. Resident 22 stated that he had been experiencing abdominal pain and had been seeing a gastroenterologist, who recommended he have certain procedures such as a colonoscopy, endoscopy, etc. to determine the cause of the pain. The resident stated that the Administrator (ADM) and Business Office Manager (BOM) keep telling me I can't go to those appointments and that the ADM controls the appointments. Resident 22 stated that the ADM had accused him of setting up his own appointments, but it was the nurses that did it. Resident 22's medical record was reviewed on 8/29/21. Resident 22's progress notes indicated the following: a. On 4/1/21, Pain level at 4 at lumbar area from degenerative disc. b. On 4/27/21, Resident informed about making his own appointment's (sic) and if he does then he is responsible for transportation . c. On 5/6/21, a Nurse Practitioner (NP) documented that resident 22 had chronic low back pain - continue current regimen of tramadol, cyclobenzaprine, and gabapentin . d. On 5/24/21, He complains of back pain level 8, he takes tramadol for the pain. e. On 6/16/21, the resident was seen in the local emergency room (ER) for abdominal pain. The resident had a diagnosis of a compression fracture of Lumbar (L) 4 vertebra, and compression deformities at L1, L2, and L3. The resident was to have a follow up at a Spine Clinic, and a follow up with a gastroenterologist. f. On 6/17/21, resident 22 saw a gastroenterologist for abdominal pain. The gastroenterologist recommended a Hepatobiliary Imminodiacetic Acid (HIDA) scan be completed. (continued on next page)

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	g. On 6/23/21, the Spine clinic appointment was made for resident 22, and was scheduled for 7/15/21. h. On 6/23/21, the facility Medical Director documented that the resident had a compression fracture, and would continue receiving Morphine as needed for the pain. i. On 7/15/21, Resident went to spine clinic. Physician ordered cervical and lumbar MRIs. Follow up after imaging. j. On 7/19/21, the Medical Director documented that the resident says he still has intermittent abdominal pain. He saw GI (gastroenterologist) and is supposed to be scheduled for a HIDA scan. He saw the spine specialist who has ordered MRIs of cervical and lumbar spine . k. On 8/5/21, the resident complains of back pain and abdominal pain daily. l. On 8/16/21, the Medical Director documented that the resident had not yet had a HIDA scan, and that management is arranging his follow up appts (appointments) as ordered by GI doctor. m. On 8/31/21, staff documented that the resident had a HIDA scan performed that day. [Note: This was approximately 2.5 months after the gastroenterologist recommended it be completed.] No documentation could be located to indicate that resident 22 had an MRI of his neck and back completed as recommended in July 2021 by the spine clinic. On 9/1/21 at 9:30 AM, an interview was conducted with the facility Director of Nursing (DON). The DON stated she was unaware if resident 22's MRI had been scheduled because the ADM and BOM scheduled those appointments, so they could make sure the insurance would cover the procedures. On 9/1/21 at 1:25 PM, the BOM was asked to provide documentation that resident 22 had the MRI scheduled or completed. The BOM was unable to provide documentation of this.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 44639 Based on observations and interviews, it was determined the facility did not store, prepare, distribute and serve food in accordance with professional standards for food service safety. Specifically, prepared food items were stored within the kitchen's walk-in fridge for longer than the facilities 7-day policy, expired dairy products were stored within the kitchen's walk-in refrigerator, an item was stored open to air within the kitchen's walk-in freezer, and mighty shakes with packaging that was labeled Store Frozen were stored in the facility's unit refrigerator without a date when the items left the facility's freezer. Findings include: 1. On [DATE] at 8:39 AM, during an initial tour of the kitchen, the facility's walk-in refrigerator was examined. a. Buttermilk stored in the walk-in fridge was observed to have separated, and the packaging was labeled with a best by date of [DATE]. b. Heavy whipping cream that was stored in the walk-in fridge was labeled with an open date of [DATE], and a best by date of [DATE]. c. Prepared tuna salad was stored in a container and covered with plastic wrap with prepared date of [DATE]. [Note: 11 days have passed from [DATE] until observation date on [DATE].] On [DATE] at 8:42 AM, the kitchen cook was interviewed. The kitchen cook reported all the kitchen employees shared responsibility in cleaning the fridge. It is the kitchen's policy that prepared items should get thrown away after 7 days. Also, any expired items should be thrown away when the fridge was cleaned. 2. On [DATE] at 7:30 AM, during a follow-up visit to the kitchen, the walk-in freezer was observed. Within the freezer was a box of orange juice concentrate stored on the floor of the freezer. Also, a package of hashbrowns was observed stored open to air. 3. On [DATE] at 10:57 AM, the memory care unit refrigerator was examined. Within the unit refrigerator, 26 Mighty Shakes were stored. The packaging read Store Frozen. The Mighty Shakes were not labeled with a date they left storage in the freezer and were placed in the unit fridge. [Note: Recommendations for storage and use of Mighty Shakes published by the manufacturer read, Once opened, shelf life is 14 days, when kept refrigerated.] On [DATE] at 1:28 PM, the Dietary Manager (DM) was interviewed. The DM reported she was unaware of what the stock of Mighty Shakes was within the unit fridge. The DM reported the kitchen staff did not date the Mighty Shakes when they were taken from the freezer and placed in the unit fridge.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45470 Based on interview, and record review, the facility did not ensure that medical records were complete and accurate for 6 of 30 sample residents. Specifically, documentation was not complete in residents' Medication Administration Records, and resident documents were located in the wrong resident's medical record. Resident identifiers: 4, 7, 14, 24, 41, and 98. Findings include: 1. Resident 24 was admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included COVID-19, schizophrenia, anxiety disorder, conversion disorder, chronic kidney disease, and cognitive communication deficit. Resident 24's medical record was reviewed on 8/29/21. Review of resident 24's physician orders revealed that as of 7/5/21 resident 24 was to receive a tube feeding, Replete with fiber 75 milliliters an hour for 24 hours. Review of resident 24's August 2021 Medication Administration Record (MAR) revealed that facility staff were to hang a tube feeding formula twice a day. The MAR indicated that facility staff did not document that resident 24 received his evening enteral feedings on the following dates: 8/4/21, 8/12/21, 8/15/21, 8/18/21, and 8/24/21. 2. Resident 14 was admitted on [DATE] with diagnoses that included dementia and major depressive disorder. Resident 14's medical record was reviewed on 8/31/21. A document entitled Skin/Hydration/Weight Meeting for resident 42 was located in resident 14's medical record. On 8/31/21 at 1:00 PM, an interview was conducted with Registered Nurse (RN) 4. RN 4 confirmed that resident 42's Skin/Hydration/Weight notes were incorrectly placed in resident 14's medical record. 3. Resident 41 was admitted on [DATE] and readmitted on [DATE] with diagnoses that included Wernicke's encephalopathy, psychosis, alcohol-induced persisting dementia, and chronic pain. Resident 41's medical record was reviewed on 8/31/21. Resident 41's July and August 2021 MAR was reviewed. The following treatments and medications were not documented as having been administered: a. ANTIANXIETY MEDICATION -MONITOR FOR DROWSINESS, SLURRED SPEECH, DIZZINESS, NAUSEA, AGGRESSIVE/IMPULSIVE BEHAVIOR. This was not documented on 7/3/21, 7/8/21, 7/10/21, 7/11/21, 8/9/21, 8/20/21, 8/22/21, 8/24/21, or 8/26/21. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Health Services	5865 South Wasatch Drive Ogden, UT 84403

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. Antianxiety target behavior #2: [STATEMENTS OF IMPENDING DOOM]. This was not documented on 7/3/21, 7/8/21, 7/10/21, 7/11/21, 8/9/21, 8/20/21, 8/22/21, 8/24/21, or 8/26/21. c. Antianxiety target behavior: [REPETITIVE ANXIOUS QUESTIONS/CONCERNS]. This was not documented on 7/3/21, 7/8/21, 7/10/21, 7/11/21, 8/9/21, 8/20/21, 8/22/21, 8/24/21, or 8/26/21. d. ANTIDEPRESSANT MEDICATION - MONITOR FOR INCREASED SEDATION/DROWSINESS, DRY MOUTH, BLURRED VISION, URINARY RETENTION, TACHYCARDIA, MUSCLE TREMOR, AGITATION, HEADACHE, SKIN RASH, PHOTOSENSITIVITY OF SKIN, EXCESS WEIGHT GAIN. This was not documented on 7/3/21, 7/8/21, 7/10/21, 7/11/21, 8/9/21, 8/20/21, 8/22/21, 8/24/21, or 8/26/21. e. Antidepressant target behavior: Irritibility (sic). This was not documented on 7/3/21, 7/8/21, 7/10/21, 7/11/21, 8/9/21, 8/20/21, 8/22/21, 8/24/21, or 8/26/21. f. ANTIPSYCHOTIC MEDICATION -MONITOR FOR DRY MOUTH, CONSTIPATION, BLURRED VISION, DISORIENTATION/CONFUSION, DIFFICULTY URINATING, HYPOTENSION, DARK URINE, YELLOW SKIN, N/V, LETHARGY, DROOLING, EPS SYMPTOMS (TREMORS, DISTURBED GAIT, INCREASED AGITATION, RESTLESSNESS, INVOLUNTARY MOVEMENT OF MOUTH OR TONGUE). This was not documented on 7/3/21, 7/8/21, 7/10/21, 7/11/21, 8/9/21, 8/20/21, 8/22/21, 8/24/21, or 8/26/21. g. Antipsychotic target behavior #2: [PARANOIA-people out to get him]. This was not documented on 7/3/21, 7/8/21, 7/10/21, 7/11/21, 8/9/21, 8/20/21, 8/22/21, 8/24/21, or 8/26/21. h. Antipsychotic target behavior: [DISTRESSING DELUSIONS]. This was not documented on 7/3/21, 7/8/21, 7/10/21, 7/11/21, 8/9/21, 8/20/21, 8/22/21, 8/24/21, or 8/26/21. i. Monitor for serotonin syndrome: monitor for agitation or restlessness, confusion, rapid heart rate and high blood pressure, dilated pupils, loss of muscle coordination or twitching muscles, heavy sweating, diarrhea, headache, shivering or goose bumps. every day and night shift. This was not documented on 7/3/21, 7/8/21, 7/10/21, 7/11/21, 8/9/21, 8/20/21, 8/22/21, 8/24/21, or 8/26/21. j. MOOD STABILIZER MEDICATION - MONITOR FOR DRY MOUTH, CONSTIPATION, BLURRED VISION, DISORIENTATION/CONFUSION, DIFFICULTY URINATING, HYPOTENSION, DARK URINE, YELLOW SKIN, N/V (nausea/vomiting), LETHARGY, DROOLING, EPS (extrapyramidal syndrome) SYMPTOMS (TREMORS, DISTURBED GAIT, INCREASED AGITATION, RESTLESSNESS, INVOLUNTARY MOVEMENT OF MOUTH OR TONGUE). This was not documented on 7/3/21, 7/8/21, 7/10/21, 7/11/21, 8/9/21, 8/20/21, 8/22/21, 8/24/21, or 8/26/21. k. Mood Stabilizer target behavior: Mood swings. This was not documented on 7/3/21, 7/8/21, 7/10/21, 7/11/21, 8/9/21, 8/20/21, 8/22/21, 8/24/21, or 8/26/21. l. Lorazepam 0.5 milligrams (mg) twice daily was not documented as being administered on 7/2/21, 7/9/21, 7/14/21, 7/16/21, 8/2/21, 8/6/21, 8/9/21, 8/13/21, 8/16/21, 8/23/21 or 8/27/21 in the morning. It was also not documented as being administered on 8/20/21 in the evening. m. Oxycodone 5 mg twice daily was not documented as being administered on 7/2/21, 7/9/21, 7/14/21, 7/16/21, 8/2/21, 8/6/21, 8/9/21, 8/13/21, 8/16/21, 8/23/21 or 8/27/21 in the morning. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	n. Cyclobenzaprine 10 mg three times daily was not documented as being administered on 8/20/21 in the evening. 33215 4. Resident 4 was admitted to the facility on [DATE] with diagnoses which included but not limited to major depressive disorder, post-traumatic stress disorder, generalized anxiety, chronic migraine, conversion disorder with seizures or convulsions, personal history of traumatic brain injury, and bradycardia. Resident 4's medical record was observed on 9/1/21. A. An APPOINTMENT REFERRAL FORM for resident 4 was located within the paper medical record. Additional paper work belonging to a discharged resident and a Life Safety Code Documentation Checklist for Skilled Nursing Facilities was attached to resident 4's appointment referral form. B. The August 2021 MAR was reviewed. The following medications were not documented as having been administered at bedtime on 8/4, 8/12, 8/15, 8/18, 8/24, and 8/30. a. Abilify 5 mg daily (QD) related to (r/t) depressive disorder with psychotic symptoms. b. Lamotrigine 150 mg QD r/t conversion disorder with seizures or convulsions. c. Methocarbarnol 500 mg QD for muscle relaxant. d. Topiramate 25 mg QD r/t conversion disorder with seizures or convulsions. e. Trazodone 150 mg 2 tablets QD for insomnia r/t major depressive disorder with psychotic symptoms. f. Clonazepam 1 mg two times a day (BID) r/t generalized anxiety disorder. g. Keppra 500 mg BID r/t conversion disorder with seizures or convulsions. h. Hydroxyzine 50 mg four times a day (QID) r/t generalized anxiety disorder. In addition, Gabapentin 400 mg three times a day for neuropathic pain and Hydroxyzine 50 mg QID r/t generalized anxiety disorder were not documented in the PM on 8/4, 8/15, and 8/30. 5. Resident 7 was admitted to the facility on [DATE] with diagnoses which included but not limited to type 2 diabetes mellitus without complications, mood disorder, essential hypertension, atherosclerotic heart disease, and chronic kidney disease. Resident 7's medical record was reviewed on 8/30/21. The August 2021 MAR was reviewed. The following medications and treatments were not documented as having been administered at bedtime on 8/4, 8/12, 8/18, 8/24, 8/30, and 8/31. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	f. On 8/30/21, the resident was not administered Lorazepam at 12:00 AM. However, the narcotic record revealed that a dose was given at 12:00 AM. B. On 8/22/21, Dilaudid 1 mg/ml 0.5 ml by mouth every 4 hours for pain of shortness of breath. Resident 98's August 2021 MAR was reviewed. a. On 8/23/21, the Dilaudid was not administered at 12:00 AM, 4:00 AM, 8:00 AM, 12:00 PM, or 8:00 PM. Review of the narcotic record revealed that the Dilaudid was not administered at noon, 4:00 PM, or 8:00 PM. b. On 8/24/21, the Dilaudid was not administered at 12:00 AM or 4:00 AM. Review of the narcotic record revealed that the Dilaudid was not administered at 12:00 AM, 4:00 AM, 12:00 PM or 8:00 PM. c. On 8/25/21, the Dilaudid was not administered at 12:00 AM or 4:00 AM. The narcotic sheets did not indicate that Dilaudid was administered on this date. d. On 8/26/21, the Dilaudid was not administered at 12:00 AM or 4:00 AM. The narcotic sheets did not indicate that Dilaudid was administered on this date. e. On 8/27/21, the Dilaudid was not administered at 12:00 AM, 4:00 AM or 12:00 PM. The narcotic sheets did not indicate that Dilaudid was administered on this date. f. On 8/28/21, the Dilaudid was not administered at 12:00 AM, 4:00 AM, or 8:00 AM. The narcotic sheets did not indicate that Dilaudid was administered on this date. g. On 8/29/21, the Dilaudid was not administered at 12:00 AM, 4:00 AM, or 8:00 AM. The narcotic sheets did not indicate that Dilaudid was administered on this date. h. On 8/30/21, the Dilaudid was not administered at 12:00 AM or 4:00 AM. The narcotic sheets did not indicate that Dilaudid was administered on this date.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22992 Based on interview and record review, it was determined for 1 of 30 sample residents that the facility did not ensure that the hospice services met professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. Specifically, a resident who was admitted to the facility on hospice, did not have cares coordinated between hospice and the facility, and information was not conveyed between providers. Resident identifier: 98. Findings include: Resident 98 was admitted to the facility on [DATE] with diagnoses that included sepsis, viral pneumonia, chronic obstructive pulmonary disease, acute respiratory failure, congestive heart failure, protein-calorie malnutrition, and dementia. Resident 98's medical record was reviewed on 8/29/21. Resident progress notes dated 8/18/21 indicated that resident 98 was admitted to the facility on hospice services. No baseline or comprehensive care plan could be located for resident 98 in his medical record. No hospice notes from the hospice provider could be located in the resident's medical record. On 9/1/21 at 1:00 PM, an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated that when a hospice provider saw a resident in the facility, the providers would typically write up a note and place it in the resident's medical record. LPN 1 stated that sometimes the hospice providers would tell us verbally when they leave so we know what's happening with the resident. On 9/1/21 at 9:30 AM, an interview was conducted with the facility Director of Nursing (DON). The DON stated that resident 98's hospice nurses should have developed a care plan for resident 98 and placed it in his medical record. The DON confirmed that resident 98 did not have a baseline or comprehensive care plan in his medical record. The DON also confirmed that no notes from the hospice providers were in the resident's medical record. The DON stated that hospice providers were supposed to document their visits and then place them in the resident's medical record. The DON stated that she had brought the lack of communication between the facility and the hospice providers to the attention of the facility Administrator (ADM) on previous occasions.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 22992 Based on interview and record review, the facility did not ensure that the Quality Assessment and Assurance (QAA) committee developed and implemented appropriate plans of correction to correct identified quality deficiencies. Specifically, the facility was found to be in non-compliance at a harm level with F688 and F692, as well as at substandard quality of care in F679. In addition, several deficiencies were cited during the 2019 recertification survey, and again during the 2021 survey. Resident identifiers: 5, 13, 15, 17, 22, 24, 25, 27, 28, 32, 35, 36, 42, and 43 Findings include: 1. Based on interview, observation and record review, the facility did not provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community for 14 of 30 sample residents. Resident identifiers: 5, 13, 15, 17, 22, 24, 25, 27, 28, 32, 35, 36, 42, and 43. [Cross refer to F679] 2. Based on interview and record review, the facility did not ensure that 1 of 30 sample residents maintained acceptable parameters of nutritional status. Specifically, a resident who was exclusively tube fed lost weight without timely interventions to prevent further weight loss. The findings were cited at a harm level. Resident identifier: 24. [Cross refer to F692] 3. Based on observations, interviews and record review it was determined the facility did not ensure a resident with limited range of motion received appropriate treatment and services to increase their range of motion and to prevent further decrease in range of motion. Specifically, a resident with documentation of a contracture to the right and left hand was not provided with treatment and services to increase their range of motion or to prevent further decrease in range of motion. This finding resulted in a harm deficiency. Resident identifier: 28. 4. During the an abbreviated complaint survey completed on 6/9/21, the facility was cited for non-compliance with regulations F550, F679, and F880. These were cited again during the current recertification survey. 5. During a recertification survey with an end date of 6/24/19, the facility was cited for non-compliance with regulations F578, F584, F609, F656, F684, F687, F689, F760, F756, F761, F842, F867, and F880. These same tags were cited on the survey completed on 9/1/21. This demonstrated the inability to maintain compliance.

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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** 33215 Based on observation and interview it was determined the facility did not maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Specifically, staff were observed without eye protection when the county positivity rate was greater than 5%. A nurse was observed to recap and place a used insulin syringe in her scrub top pocket, oxygen nasal canulas were observed on the floor, and staff used their bare hands to handle resident food. Resident identifiers: 28, 33 and 44. Findings include: 1. On 8/29/21 at 8:00 AM, the survey team entered the facility. A housekeeping staff member was observed without eye protection. Registered Nurse (RN) 3 assisted the survey team with Coronavirus Disease 2019 (Covid19) screening and RN 3 was observed without eye protection. On 8/4/21 to 8/17/21, the county positivity rate was documented at 12.4%. On 8/11/21 to 8/24/21, the county positivity rate was documented at 13.5%. On 8/18/21 to 8/31/21, the county positivity rate was documented at 12.9%. On 8/29/21 at approximately 8:14 AM, a tour of the facility was conducted. The Kitchen Cook, Dietary Manager, Certified Nursing Assistant (CNA) 5, and CNA 7 were observed without eye protection and in resident areas of the facility. CNA 5 was observed assembling face shields at the nurses station. On 8/29/21 at 8:25 AM, a CNA entered the main dining room, and a resident stated, What's with the shield?! On 8/29/21 at approximately 9:00 AM, the Business Office Manager (BOM) was observed without eye protection and in resident areas of the facility. The BOM had her eyeglasses on, which are not approved by the Centers for Disease Control (CDC) as appropriate eye protection. https://www.cdc.gov/niosh/topics/eye/eye-infectious.html On 8/30/21 at 2:15 PM, an interview was conducted with the Director of Nursing (DON). The DON stated staff were required to wear a surgical mask and depending on the county positivity rate the staff were required to wear an N95 mask. The DON stated eye protection was dependent on the county positivity rate also. The DON stated staff were required to wear eye protection approximately 2 or 3 weeks ago and should be wearing eye protection currently. The DON stated the Charge Nurse should monitor staff Personal protective equipment (PPE) when she was not in the facility. The DON stated RN 3 was the Charge Nurse on 8/29/21. The DON stated she was not surprised that no one was wearing eye protection when the survey team entered the facility. The DON stated every week she would go over the PPE required to wear and had numerous staff in-services. The DON stated when she was at the facility things went well. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/30/21 at 1:18 PM, 2:05 PM, and again at 3:06 PM, the DON was observed without eye protection and in resident areas of the facility. On 8/30/21 at 3:10 PM, the DON an observation was made of resident 33's left foot with the DON. The DON entered the room, and observed the wound on the resident's foot without wearing eye protection. On 8/31/21 at 8:07 AM, an interview was conducted with RN 3. RN 3 stated eye protection was considered universal PPE and should wrap around to cover the eyes. RN 3 stated she was the Charge Nurse on 8/29/21, when the survey team entered the facility. RN 3 stated the staff were not wearing eye protection on 8/29/21. RN 3 stated it was early in the morning and the staff were trying to get their eye protection on. 2. On 8/31/21 at 7:23 AM, RN 3 was observed to prepare and administer Lantus Solution 45 units subcutaneously to resident 33. RN 3 was observed to recap the used insulin syringe and place the used insulin syringe in the pocket of her scrub top. On 8/31/21 at 7:56 AM, RN 3 was observed to remove the used insulin syringe from the pocket of her scrub top and dispose of the used insulin syringe in the sharps container on the medication cart. On 8/31/21 at 11:14 AM, an interview was conducted with RN 3. RN 3 stated she would place a used syringe in the sharps container located on the side of the medication cart. RN 3 stated she usually did not put a used syringe in her scrub pocket. On 9/1/21 at 9:29 AM, an interview was conducted with the DON. The DON stated nursing staff should follow the cap and uncap policy for syringes and use the sharps container immediately after the use of a syringe. The DON stated there was no reason that a nurse should ever recap a used syringe and put the used syringe in their pocket. 44639 3. Resident 28 was originally admitted to the facility on [DATE] with medical diagnoses that included but not limited to, Alzheimer's disease with dementia, restlessness and agitation, dizziness and giddiness, repeated falls, diarrhea, polyneuropathy, hyperlipidemia, hypothyroidism, chronic leukemia, history of urinary tract infection, pleural effusion, depressive episodes, and chronic respiratory failure with hypoxia. A physician's order dated 5/1/19, documented PRN (as needed) O2 (oxygen) to keep saturation >90% two times a day. On 8/29/21 at 10:57 AM, resident 28 was observed in bed with the oxygen concentrator running and the nasal canula (nc) was on the ground near the foot of the bed. On 9/1/21 at 8:02 AM, resident 28's nasal canula was observed on the floor near the foot of the bed. (continued on next page)

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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 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 33215 Based on interview it was determined that the facility did not ensure that the designated Infection Preventionist (IP) who was responsible for the facility's infection prevention and control program had completed specialized training in infection prevention and control. Specifically, the Director of Nursing (DON) who was the designated IP had not completed the specialized training in infection prevention and control. Findings include: On 8/30/21 at approximately 2:15 PM, an interview was conducted with the DON. The DON stated she was the designated IP and had completed specialized training. On 9/1/21 at 2:00 PM, the DON provided the IP specialized training she had completed to the survey team. The training consisted of an inservice titled Addendum to Antibiotic Stewardship Program policy and procedures update, the Antibiotic Stewardship Policy, a flyer titled Viruses or Bacteria What's got you sick?, and a flyer titled Be Antibiotics Aware flyer. The DON stated that she was trained to be an IP by the facility Administrator on 8/6/19, and was provided the flyer described above. The DON stated that she had not completed any specialized training, such as the Centers for Disease Control (CDC) training.