STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465119	A. Building B. Wing	01/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Provo Rehabilitation and Nursing	1001 North 500 West Provo, UT 84604

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 observation and interview, the facility did not treat 2 of 54 sample residents with respect and dignity and care for each resident 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, a resident was dressed in a hospital gown because no clean clothes were available, and a request for pain medication went unanswered for a period of time. Resident identifiers: 22 and 47. Findings include: 1. Resident 47 was admitted on [DATE] with diagnoses that included dementia, diabetes mellitus, hypertension, bipolar disorder, cognitive communication deficit, dysphagia and history of traumatic brain injury. Resident 47's medical record was reviewed on 1/23/23. A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated that resident 47 had severe cognitive impairment and could not make decisions regarding her tasks of daily life. On 1/25/23 at 10:00 AM, resident 47 was observed to be seated in a wheelchair wearing only a hospital gown. Resident 47 remained in the hospital gown until 2:00 PM, when the observation ended. On 1/25/23 at 1:27 PM, an interview was conducted with Certified Nursing Assistant (CNA) 13. When asked about resident 47 wearing a hospital gown during the day, CNA 13 stated that resident 47 ran out of clean clothes . they are all in laundry. CNA 13 stated that 47 was wearing the hospital gown just for today. On 1/30/23 at 3:37 PM, an interview was conducted with the facility Director of Nursing (DON). When asked about resident 47, the DON stated that therapy staff must have gotten the resident out of bed and done therapy with her without getting her dressed. The DON stated she was unaware resident 47 did not have any clean clothes. 2. Resident 22 was admitted to the facility on [DATE] with diagnoses that included degenerative disc disease, dementia, schizoaffective disorder, bipolar type, post-traumatic stress disorder, scoliosis, and hypertension. (continued on next page)

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 - Few	PAIN A. On 1/25/23 at 8:45 AM, an observation was made of resident 22. Resident 22 walked down the hallway and stopped at the nurse's station. Licensed Practical Nurse (LPN) 6 was observed to be in the nurses station standing at the medication cart. Resident 22 approached LPN 6 and stated that his knee hurt. LPN 6 did not look up from the medication cart or acknowledge resident 22. LPN 6 then stated, Well, you will just have to wait a minute I'm busy. Resident 22 nodded and went over to a chair across from the nurse's station and sat down. LPN 6 was not observed to administer any pain medication to resident 22 during the medication pass observation. On 1/25/23 at 10:50 AM, resident 22 was approached by a staff member and invited to participate in a facility activity. Resident 22 responded by saying that he could not go to the activity because his knees hurt too much. Resident 22 also stated that he thought he could not have more medications until 3:00 PM, and that was too far away. On 1/25/23 at 11:10 AM, resident 22 was observed to approach LPN 6 at the nurse's station, and ask for a pain pill, stating that his knee is really hurting. Resident 22 was observed to be bending over at the waist and rubbing his right knee while grimacing. LPN 6 stated, Ya, I know I'm sorry. LPN 6 did not make any other comments to the resident, and turned away from the resident while the resident was standing at the nursing station. On 1/25/23 at 11:12 AM, LPN 6 approached resident 22 and handed him a cup of water, and a cup containing a pill. LPN 6 immediately turned around and walked back to her medication cart without observing if resident 22 swallowed the pill. In addition, LPN 6 did not assess resident 22's pain level. On 1/30/23 at 3:37 PM, an interview was conducted with the facility DON. The DON stated that LPN 6 should have communicated to resident 22, for example saying I will prepare those right now or let me check and see if you can get some. LEGS B. On 1/25/23 at 11:13 AM, resident 22 was observed to ask LPN 6 for leg cream. LPN 6 did not respond. On 1/25/23 at 11:13 AM, resident 22 was observed to ask the Wound Nurse (WN) for leg cream. The WN walked past resident 22 without stopping and yelled back down the hallway to resident 22 that she would check with his nurse. Resident 22 was observed to yell back to the WN but we've run out! The WN did not respond to resident 22. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/25/23 at 11:14 AM, LPN 6 was observed to assess resident 22's legs. Resident 22 stated that from the knee down, his legs were weeping serum and possibly infected. Resident 22 stated that his dermatologist had prescribed a lotion of some sort, but he couldn't remember the name of it. LPN 6 stated to resident 22 that if he didn't know the name of the cream, I don't know what lotion to look for, at which time LPN 6 walked away from resident 22. LPN 6 was not observed to review the Medication Administration Record or resident 22's physician orders to determine if resident 22 had an order for medication for his legs. [Note: On 1/26/23, resident 22 saw a dermatologist. The dermatologist indicated that resident 22 had xerotic skin for which he was supposed to be using a specific moisturizing lotion. The dermatologist also prescribed Triamcinolone ointment to be applied to resident 22's legs from the knees down.] [Cross refer to F697]

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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** 44640 Based on interview and record review, it was determined, the facility did not ensure the resident's right to formulate an advanced directive. Specifically, for 1 out of 54 sampled residents, the resident's electronic medical record did not document a code status, the staff stated the resident was a full code and the Physician Orders for Life-Sustaining Treatment (POLST) form documented the resident's wishes as Do not attempt or continue any resuscitation (DNR). Resident identifier: 298. Findings include: Resident 298 was admitted to the facility on [DATE] with diagnoses which included fracture of the femur, history of falling, chronic respiratory failure with hypoxia, dysphagia, need for assistance with personal care, hypertension, muscle weakness, and chronic obstructive pulmonary disease (COPD). On 1/23/23, resident 298's medical record was reviewed. On 1/23/23 at 12:10 PM, an interview was conducted with the resident and his family. The family members stated they filled out paperwork when the resident came into the facility and some of it had to do with his resuscitation wishes. The family stated the resident wished to be DNR. On 1/23/23 at 12:20 PM, an observation was made of resident 298's electronic medical record banner, the code status area had no information entered. On 1/23/23, the Physician Orders did not have a Do Not Resuscitate order documented. On 1/23/23 at 12:45 PM, an interview was conducted with Licensed Practical Nurse (LPN) 3. LPN 3 stated if a resident had no code status entered in the banner section of the medical record, the resident was assumed to be a full code. LPN 3 stated residents were asked on admit what their wishes were and a POLST form was filled out. Resident 298's care plan dated 1/23/23 documented a goal of, the POLST will be honored as written. On 1/24/23 at 11:00 AM, an observation was made of resident 298 in his room with family at his bedside. On 1/25/23 at 11:00 AM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated that if the staff needed it they found the resident's code status in the banner section of the medical record. RN 1 stated if the code status was not there then the nurses were told to run the resident as a full code. RN 1 stated it would be bad if a resident was a DNR and we ran them as a full code. RN 1 stated the POLST form should be filled out on admit and the computer was also updated on admit. On 1/25/23 at 1:10 PM, an observation was made of resident 298 in his room sitting in his wheelchair with his son sitting next to him. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/26/23 at 12:18 PM, an observation was made of the Corporate Resource Nurse (CRN). The CRN brought the POLST form for resident 298 and stated it had been signed by the nurse and that the provider did not need to sign it just the nurse did. The CRN stated they had waited to have the POLST form signed because no family had been in with the resident. [Note:The POLST form that was provided by the CRN was signed by resident 298 and not a family member.] On 1/26/23 at 12:20 PM, an observation was made of the POLST form for resident 298. The form was signed by LPN 5 and the date was written as 1/26/23. The POLST form was not signed by a provider. On 1/26/23 at 12:25 PM, an interview was conducted with LPN 5. LPN 5 stated on admit the POLST form was filled out with the admission packet and sent to the medical record department to be scanned. LPN 5 stated the electronic medical record tells the nursing staff what the resident's preference was, if there was not a preference put into the banner of the electronic record then the resident was ran as a full code. LPN 5 stated she had signed resident 5's POLST form today, 1/26/23. On 1/26/23 at 12:45 PM, an interview was conducted with LPN 7. LPN 7 stated if a resident was run as a full code and their wish was to be a DNR that would be very bad. LPN 7 stated that is why the POLST forms and the entry into the computer were supposed to be done on admit. On 1/26/23 at 1:10 PM, an interview was conducted with RN 3. RN 3 stated she was unsure what happens in an emergency if there was no code information in the banner section of the medical record. RN 3 stated, I guess we call the family to find out what they want us to do. On 1/26/23 at 2:00 PM, an observation was made of resident 298's medical record. The banner of the medical record now revealed resident 298 to be a DNR. The physician orders now revealed a DNR order. The POLST form was signed by the provider and dated 1/26/23. On 1/30/23 at 4:20 PM, an interview was conducted with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) 1. The ADON 1 stated the POLST form was given to the family on admission and until it was signed the resident was considered a full code. The DON stated the POLST form should be completed within a day or 2 of admission. The admitting nurse was expected to complete the POLST form, if it did not get completed the staff on the next shift were to complete it. The DON stated the incomplete POLST form sat in a red folder at the nurses desk. The DON stated it was not acceptable to let the POLST form sit incomplete if the family have been in to see the resident. The DON stated it was not acceptable to run a full code on a resident who wished to be DNR because the POLST form sat in the red folder incomplete.

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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** 44640 Based on observation and interview, the facility did not provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Specifically, the wall behind the head of the bed in rooms 504, 505, 506 and 510 were in disrepair. The base of the intravenous (IV) poles and the front of the night stands in rooms 500, 501, 504, 505, 506, 508, and 510 were covered with layers of dried enteral feeding solution and the night stands had many areas of missing paint on the top, sides and front. Additionally, the wheelchairs throughout the facility were dirty and not cleaned regularly. Resident identifiers: 24, 27, 50, 68, 81, 82, 85, 298, and 349. Findings included: 1. Resident 24 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included heart failure, diabetes mellitus, respiratory failure, dependence on a ventilator, obesity, pain, muscle weakness, and need for assistance with personal care. Resident 50 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included hypertension, gastroesophageal reflux disease, neurogenic bladder, malnutrition, respiratory failure and traumatic brain injury. Resident 68 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included nontraumatic intracerebral hemorrhage, chronic respiratory failure with hypoxia, congestive heart failure, gastroesophageal reflux disease, type 2 diabetes mellitus and functional quadriplegia. Resident 81 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included anemia, obstructive uropathy, seizure disorder, depression and respiratory failure. Resident 82 was admitted to the facility on [DATE] with diagnoses which included chronic respiratory failure with hypoxia, nontraumatic subarachnoid hemorrhage, epilepsy, hypertension and gastroesophageal reflux disease. Resident 85 was admitted to the facility on [DATE] with diagnoses which included hypertension, gastroesophageal reflux disease, neurogenic bladder, cardiovascular accident, quadriplegia, seizure disorder, malnutrition and respiratory failure. Resident 298 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses which included hypertension, neurogenic bladder, multiple sclerosis, depression, respiratory failure, gastroesophageal reflux disease and quadriplegia. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/23/23, 1/24/23, 1/25/23, and 1/26/23 observations were made of the IV poles and night stands of residents 24, 50, 68, 81, 82, 85, and 298 were observed. For all of the residents on all of the days listed, the lower one fourth and the base of the IV poles and the front of the night stands were observed to be coated with multiple layers of dried enteral feeding solution. The night stands were also observed to have areas of missing paint on the top, front and sides. On 1/26/23 at 9:35 AM, an interview was conducted with the Housekeeping Supervisor (HSK). The HSK stated the housekeepers cleaned all the surfaces in the rooms daily, and that the nightstands and IV poles were part of the daily cleaning. The HSK then accompanied this surveyor to the 500 hallway. The HSK was observed to look in resident 24, 50, 68, 81, 82, 85, and 298's rooms. The HSK stated the IV poles should not look like that, but the housekeeper had only been on the floor since 9:00 AM. The HSK was asked if the material that was on the IV poles and night stands could have come from one night of use. The HSK stated it could not have and the that the IV poles and night stands were not being cleaned correctly. 2. On 1/23/23 for residents 24, 68, 82, and 85 the wall behind the head of the bed was observed to be in disrepair with multiple scratches and tears in the wall paper. On 1/26/23 at 9:57 AM, an interview was conducted with the Maintenance Manager (MM). The MM stated maintenance was in charge of whatever required maintenance in the facility and were in charge of giving things new paint if needed. The MM stated any staff member could put in a work order to let them know when something needed to be fixed. The MM stated he was unaware of any rooms that needed his attention in the 500 hallway. The MM then accompanied this surveyor to the 500 hallway. The MM was observed to look in resident 24, 68, 82, and 85's rooms. The MM then stated he was was aware of the walls being damaged, and they were letting the damaged walls and night stands get worse before they were going to fix them. The MM stated they had already put plastic behind the head of the bed in some of the rooms in the 500 hallway that were for residents not on ventilators. The MM stated, We don't want to disturb the residents on ventilators. The MM stated the rooms should be kept up and that it was possible to move the residents to another room to complete the work. The MM stated the work could be done within 4 to 12 hours. 22992 3. On 1/25/23 at 10:46 AM, an observation was made of a wheelchair at the north end of the 500 hallway. A wheelchair was dirty, the brake handles were observed to have an unknown white material on them. The metal frame had a dried brown substance, dust and an unknown white material on it. Additionally, the seat cushion had white and yellow stains. 4. On 1/23/23 at approximately 10:00 AM, an observation was made of resident 27 and his wheelchair, while the resident was in the day room. Resident 27's wheelchair was observed to be soiled, specifically the metal bars that connected the arm rests to the seat. The entirety of the bars were observed to be coated with dried debris and a greasy substance. 5. On 1/23/23 at approximately 10:00 AM, an observation was made of resident 349 and her wheelchair, while the resident was in the day room. Resident 349's wheelchair was observed to be soiled, specifically the black metal areas underneath the seat. The metal areas were observed to be soiled with debris and dust. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/30/23 at 1:18 PM, an observation was made of resident 27's wheelchair, and resident 349's wheelchair. Both wheelchairs were noted to still be soiled in the same manner as on 1/23/23. On 1/30/23 at 8:19 AM, an interview was conducted with Certified Nursing Assistant (CNA) 2. CNA 2 stated the night shift cleaned the wheelchairs and sometimes administration took them out and sprayed them off. CNA 2 stated he did not know the schedule of when the cleaning took place. On 1/30/23 at 8:22 AM, an interview was conducted with CNA 11. CNA 11 stated the CNAs cleaned the wheelchairs when the residents asked them to do it. CNA 11 stated there was no sign off sheet, and that it was charted in the task section of the medical record. On 1/30/23 at 8:25 AM, an interview was conducted with the Certified Nursing Assistant Coordinator (CNAC). The CNAC stated the wheelchairs were wiped down on the resident's shower day by the aides and the concierges also helped with keeping the wheelchairs clean. On 1/30/23 at 2:00 PM, an observation was made of a document titled Concierge Daily Responsibilities. Under the section labeled, Cleaning of Equipment it documented that wheelchairs were to be dusted/wiped down daily to maintain a higher level of cleanliness.

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F 0600 Level of Harm - Actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22992 Based on interview, record review, and observation the facility did not ensure that 7 of 54 sample residents were free of neglect. Specifically, residents were not assisted with activities of daily living, had untreated pain, experienced weight loss, experienced falls with injuries, and obtained wounds. The findings for all the residents listed in this deficiency were cited at a harm level. Resident identifiers: 22, 27, 33, 47, 146, 244, and 298. Findings include: HARM ASSISTANCE WITH TOILETING 1. Resident 27 was admitted on [DATE] and readmitted on [DATE] with diagnoses that included dementia, Parkinson's disease, neurocognitive disorder with Lewy Bodies, neuropathy, and insomnia. Resident 27's medical record was reviewed on 1/23/23. Resident 27's quarterly Minimum Data Set (MDS) assessment dated [DATE] was reviewed. The MDS indicated that resident 27 was severely cognitively impaired. The MDS indicated that resident 27 required extensive assistance of two people for bed mobility, transferring, dressing, and toilet use. The MDS indicated that resident 27 required extensive assistance of one person for personal hygiene and bathing. The MDS further indicated that resident 27 was unable to move on and off the toilet without staff assistance. The MDS also indicated that resident 27 was always incontinent of bladder, and frequently incontinent of bowel. And the MDS also indicated that resident 27 was at risk for pressure sores, and currently had Moisture Associated Skin Damage (MASD). On 2/8/22 facility staff developed a care plan for resident 27 indicating that the resident had an ADL (Activities of Daily Living) Self Care Performance Deficit r/t (related to) Immobility secondary to Parkinson's disease, impaired cognition secondary to Dementia with Lewy bodies . The goal listed was to safely perform bed mobility, transfers, eating, dressing, grooming, toilet use and personal hygiene through the review date. Interventions on the care plan included Requires Extensive assistance staff participation to use toilet, Requires Extensive assistance staff participation with transfer, and Requires Extensive Assistance staff participation to reposition and turn in bed. On 11/11/22 facility staff developed a care plan for resident 27 indicating that he had MASD to his sacrum related to incontinence. The care plan goal indicated that resident 27 Will be free from MASD through the review date. Interventions included encourage good nutrition and hydration in order to promote healthier skin, identify potential causative factors and eliminate/resolve, when possible, reposition frequently, treatment as ordered, and wound nurse to follow. Resident 27's medical record indicated that from 1/1/23 through 1/29/23, resident 27 required extensive assistance or was totally dependent on staff for bed mobility 69 of 79 opportunities. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	On 10/20/22 a weekly skin evaluation indicated that resident 27 has reddened Non blanchable area to his LT (left) buttock. Area was cleaned and barrier cream applied. [Note: No documentation could be found to indicate that the wound nurse had observed the wound until 11/11/22, approximately 22 days later.] On 10/29/22 a nurses note documented, Coccyx with open area. Wound care tech came and treated wound. Cleaned wound Anasept applied then dressing. Wound care nurse was notified. [Note: The first wound note was not entered until 11/11/22, approximately 14 days later.] On 11/10/22 a nurses note documented, Pt (patient) continues to area (sic) to buttocks that is no (sic) blanchable. I had informed the MD in the past about this area. We have applied barrier cream and bridged him while in bed. I have informed the wound CNA (Certified Nursing Assistant) about area. On 11/11/22 a nurses note documented, Wound care team assessed sacrum, 2.3 [centimeter (cm)]x (by)3. 1xUTD (unable to determine) open area with redness in surrounding tissue wound bed is 40 slough, 30 granular, 30 macerated. entire area is blanching. On 11/16/22 resident 27 was assessed by a Physician Assistant-Certified (PA-C). The PA-C documented that the resident had MASD on his sacrum that had been present longer than one week. The size of the wound was documented as 2.3 cmx3.1 cm x UTD, with 90 percent granulation and 10 percent slough. The PA-C documented that the Tissue does blanch. The PA-C indicated that with each brief change, staff were to remove resident 27's dressing, cleanse the wound, apply skin prep to periwound, apply Medihoney to wound bed, and cover with Bandage. On 11/17/22, a Skin Ulcer Non-Pressure Weekly assessment was completed for resident 27. The assessment indicated that resident 27 had MASD to his sacrum that was 2.3x3.1xUTD . Patient has new MASD that is open, initial visit with wound provider this week, debrided with a curette to remove slough and macerated edges. Patient has barriers in wound healing of cognitive impairment and incontinence. MD (medical doctor) and family notified. On 11/18/22 a nurses note documented, Wound note MASD to sacrum wound nurse to call family. On 11/23/22, a Skin Ulcer Non-Pressure Weekly assessment was initiated for resident 27 but was left blank. On 11/23/22, resident 27 was assessed by a PA-C. The PA-C documented that resident 27's wound had increased in size and measured 2.5x3.4xUTD. On 11/28/22, a Skin Ulcer Non-Pressure Weekly assessment was completed for resident 27. The assessment indicated that the wound had increased in size and measured 2.5x3.4xUTD. On 12/5/22, resident 27 was assessed by a PA-C. The PA-C documented that Selective debridement due to slough today; 50 [percent] granular tissue with granular buds noted post debridement. Continue with current treatment. Pt is soiled today. On 12/12/22, a Skin Ulcer Non-Pressure Weekly assessment was completed for resident 27. The assessment indicated that the wound was unchanged in size from 11/28/22. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	On 12/14/22, resident 27 was assessed by a PA-C. The PA-C documented that resident 27's wound measured 2.4x3.6xUTD. The periwound was described as Macerated. The PA-C documented that Sizes slightly larger after last week's debridement with increased granular tissue. Continue treatment. On 12/21/22, resident 27 was assessed by a PA-C. The PA-C documented that resident 27's sacrum had increased slough, so selective debridement was completed. On 12/28/22, a Skin Ulcer Non-Pressure Weekly assessment was completed for resident 27. The assessment indicated that resident 27's wound measured 2.1x2.5xUTD. On 1/1/23 a nurses note documented, Resident has ongoing pressure wound to coccyx, difficult for resident to turn on side. Has pressure reducing mattress in place. On 1/4/23, resident 27 was assessed by a PA-C. The PA-C documented that resident 27's wound measured 1x2.1x0.3. On 1/11/23, resident 27 was assessed by a PA-C. The PA-C documented that resident 27's wound measured 1.5x2.3x0.3, which indicated the wound had increased in size. On 1/27/23, a Skin Ulcer Non-Pressure Weekly assessment was completed for resident 27. The assessment indicated that the wound had not changed in size since 1/11/23. No documentation was located to indicate what days and times, if any, resident 27 refused to be repositioned or have his brief changed. On 1/30/23 at 11:30 PM, an observation was made of the Wound Nurse (WN) and CNA 2. The WN and CNA 2 were observed to enter the room of resident 27. Resident 27 was lying in his bed. The WN raised the resident's bed to approximately waist height and both the WN and CNA 2 pulled resident 27 toward the edge of the bed. The WN and CNA 2 then walked out into the hallway to obtain hand sanitizer. No side rails were observed to be pulled up on the bed, as resident 27 was lying on his right side, with his back near the edge of the bed, unattended by staff. The WN and CNA 2 returned to the bedside of resident 27 and donned gloves. The WN pulled back the soiled brief, and blood was observed on the brief. No dressing was observed on the wound. The WN cleaned the wound on resident 27 with dry gauze. Resident 27 said ouch as the wound was cleaned. The wound area had different shades of red, and dark red, neither area blanched when pressed on by the WN. The WN stated, We debrided last week, that's why it hurts. No pain alleviation was offered to resident 27. The WN again left the bedside to go to the hallway to obtain hand sanitizer. CNA 2 was standing at the foot of the bed with his back to the resident. While the WN was in the hallway, the soiled brief was observed to return to the original position and touch the cleaned wound. The WN donned gloves and returned to the bedside and repositioned resident 27 using the draw sheet on the bed. Her gloves were not observed to be changed. The WN applied ointment to a gloved finger then to the wound. The WN and CNA 2 were then called away to the doorway, the soiled brief again returned to its original position and touched the wound. The WN returned to the bedside, pulled the brief away from the wound and a new dressing was applied to the wound. The WN then put the soiled brief back in place over the new dressing on resident 27. At that time, both the WN and CNA 2 were observed to have left the room to obtain hand sanitizer, resident 27 was still observed to be close to the edge of the elevated bed with no side rails in position. Both staff then returned to reposition resident 27. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	On 1/30/23 at 11:30 AM, an interview was conducted with Licensed Practical Nurse (LPN) 8. When asked about resident 27, LPN 8 stated that staff were instructed to help the resident turn and keep him off his bum. LPN 8 stated that resident 27 did not get out of bed or attempt to get out of bed during the nighttime hours. LPN 8 stated that resident 27's sacrum wound was old and that it was caused by staff not repositioning the resident or changing his incontinence briefs timely. LPN 8 stated that in the recent past, there would only be one CNA assigned to the memory care unit, which was not enough to ensure the safety and good care of the residents. ASSISTANCE WITH EATING 2. Resident 244 was admitted to the facility on [DATE] with diagnoses that included but not limited to gastro esophageal reflux disease, muscle weakness, major depressive disorder, anxiety disorder, and insomnia. Resident 244's medical record was reviewed on 1/24/23. An annual Minimum Data Set (MDS) assessment dated [DATE], documented that resident 244 required supervision assistance with one person. In addition, a quarterly MDS assessment dated [DATE] documented that resident 244 had a Brief Interview for Mental Status (BIMS) score of 15. A Plan of Care problem with an effective date of 1/4/17 documented that resident 244 required extensive assist with bed mobility, transfers, . eating, toilet use and personal hygiene. Another care area identified with an effective date of 1/24/17 documented that resident 244 was at nutritional risk as evidence by periods of decreased oral intake. An intervention implemented on 1/1/18, documented that resident 244 would have weekly weights x 30 days and monthly if stable and to promptly identify signs and symptoms of weight loss and dehydration; interventions initiated timely daily. [Note: no weekly weights were done.] Registered Dietician Nutritional Risk Review dated 12/22/22 documented that resident 244 had an 8% (percent) weight loss since 11/2/22. A nurse practitioner/ physician assistant progress note dated 8/25/22 documented that resident 244 had some noted weight loss recently due to food preferences. A nurse practitioner/ physician assistant progress note dated 12/27/22 documented that resident 244's sister expressed concerns on 12/7/22 about resident 244's difficulty eating and stated it took resident 244 a long time to eat the food that he had so far. A new patient encounter progress note dated 1/3/23 documented that resident 244 had reportedly been losing weight. On November 2 he weighed 187 pounds, today he weighs 168 which is a 10% weight loss. He states his appetite has not been very good as he just has not felt well. He remains at risk for significant weight loss and malnutrition. The exact meal percentage consumption for the last 30 days documented that resident 244 had consumed 50 % or less of his meals for 46 out of 72 documented encounters. The snack consumption for the last 30 days documented that resident 244 accepted a snack 3 times out of the 24 instances documented. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	On 1/23/23 at 10:25 AM, resident 244 was observed sitting up in his bed with his eyes closed. A breakfast meal tray was observed on a bedside table in front of resident 244. Most of the food on the breakfast tray appeared to be untouched except, for the cereal. On 1/25/23 at 12:05 PM, resident 244 was observed to have his eyes closed when his lunch tray was dropped off. The lunch tray was observed on a bedside table located to the right of resident 244. Resident 244 eye's continued to appear closed until 12:16 PM. On 1/25/23 at 1:47 PM, resident 244 was observed to have his eyes closed and lunch tray at bedside remained untouched. On 1/26/23 at 10:00 AM, resident 244 was observed to have his eyes closed and had a napkin placed across his chest with a handful of cheerios scattered across the napkin. A breakfast meal tray was observed on a bedside table in front of the resident. The breakfast meal tray had a piece of toast with jelly, a cut up sunny side up egg and a bowel of cheerios. The cheerios were the only item of food that was touched by the resident. On 1/26/23 at 12:10 PM, resident 244 was observed to be sitting up in bed and staring at his food with shaking hands. A lunch tray compromised of meat and rice was observed on a bedside table located in front of resident 244. Resident 244 continued to stare at his food for 17 minutes before he picked up his cup of milk with a shaky hand. Resident 244 was observed to bring the cup of milk to his mouth without spilling but began to cough when he drank the milk. Resident 244 was then observed to spill the remainder of his milk as he tried to put the cup back on his bedside table. A follow up interview was conducted with resident 244. Resident 244 stated he did not like his food, and he did not plan to eat it. Resident 244 stated the only thing he liked was the milk and that he was not hungry. On 1/26/23 at 1:17 PM, resident 244 was observed to have his eyes closed and his lunch tray appeared to be untouched expected for the milk he drank. On 1/30/23 at 12:07 PM, resident 244's sister was observed to feed resident 244 homemade soup. A follow up interview was conducted with resident 244. Resident 244 stated he needed help feeding himself. Resident 244 stated that staff took his meal trays away and had not offered him any meal substitutions when he did not like the food. On 1/26/23 at 11:15 AM, an interview was conducted with Certified Nursing Assistant (CNA) 3. CNA 3 stated the resident 244 was an extensive two person assist and needed to be pulled up in bed for every meal. CNA 3 stated that resident 244 ate in his room and that he was capable of feeding himself. CNA 3 stated that the only help resident 244 required with meals was to have his tray set up for him. CNA 3 stated they were unsure the percentage of his meals that he ate. On 1/25/23 at 12:34 PM, an interview was conducted with the Minimum Data Set Coordinator (MDSC). The MDSC stated that resident 244 was able to feed himself and only required setup assist with his tray. The MDSC stated that resident 244 didn't always eat all his food because he didn't like what he was served. The MDSC stated that resident 244 got a boost with all his meals as a supplement. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	On 1/26/23 at 10:46 AM, an interview was conducted with CNA 2. CNA 2 stated that resident 244 ate about 25% of his breakfast today. CNA 2 stated resident 244 didn't eat very much of his meals. CNA 2 stated that resident 244 was capable of using silverware and was able to feed himself and did not require any help that he was aware of. On 1/26/23 at 12:35 PM, an interview was conducted with the Occupational Therapist (OT). The OT stated they had not worked with resident 244 since October. The OT was asked if resident 244 was able to feed himself with his shaky hands and the OT responded that they were unsure how much help resident 244 needed with meals. The OT stated they evaluated and worked with residents that needed more assistance on ADLs. The OT stated they were not working with resident 244 since he didn't need help with any ADLs that he was aware of. On 1/30/23 at 11:11 AM, an interview was conducted with Licensed Practical Nurse (LPN)1. LPN 1 stated that resident 244 was able to feed himself and was able to reach for his own waters. LPN 1 stated that every once in a while, resident 244 did not each much but stated that he always ate his cereal. On 01/30/23 at 12:21 PM, an interview was conducted with the Certified Nursing Assistant Coordinator (CNAC). The CNAC stated that resident 244 was a set up assistance for meals. The CNAC stated they made sure to sit him up in bed and during brief changes. The CNAC stated she handed resident 244 his chocolate milk with meals and stated that resident 244 did not have problems grabbing thing with his hands. The CNAC stated there were times where he did not eat his food because he did not like what was serve to him. The CNAC stated that resident 244 verbalized when he did not like his meal. The CNAC stated they have asked resident 244 if he needed help with meals but stated that resident 244 has refused the help. The CNAC stated they thought it was weird that resident 244's sister was feeding him lunch today because resident 244 was able to feed himself and did not that much help with meals. On 1/30/23 at 3:56 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that supervision assist meant that a staff member had to help and encourage the resident to eat during meals. The DON stated if the resident's MDS documented him as a supervision assist, she expected staff to be at bedside during mealtimes to help feed him. The DON that when a resident has a 10% weight loss, they were triggered for weight loss and put on weekly weights, as well as reviewed in the weekly Nutrition at Risk meetings. PAIN MANAGEMENT 3. Resident 22 was admitted to the facility on [DATE] with diagnoses that included degenerative disc disease; dementia; schizoaffective disorder, bipolar type; post-traumatic stress disorder; scoliosis; and hypertension. On 1/23/23 resident 22's medical record was reviewed. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	A care plan for resident 22 was developed on 3/9/20 with a focus area of Has acute and chronic pain r/t (related to) Chronic Physical Disability, pain in lower back, hip and knees. Goals included: Will voice a level of comfort of (sic) through the review date, Will verbalize adequate relief of pain or ability to cope with incompletely relieved pain through the review date, and Will not have an interruption in normal activities due to pain through the review date. Interventions included: Able to call for assistance when in pain, reposition self, ask for medication, tell you how much pain is experienced, tell you what increases or alleviates pain; anticipate need for pain relief and respond immediately to any complaint of pain; engage in daily recreation activities for distraction to manage pain; monitor/record/report any signs and symptoms of non-verbal pain; and monitor/report to nurse if resident complains of pain or has requests for pain treatment. On 10/4/22, the Director of Nursing (DON) completed a quarterly Pain Management Review for resident 22. Despite resident 22's care plan indicating that resident 22 was able to describe his pain, the DON documented that resident 22 was unable to be interviewed. The DON also indicated that no observations were made of resident 22 in pain, but in contrast, that resident 22 was receiving oxycodone as needed for pain. On 1/4/23 a quarterly Pain Management Review was completed by facility staff for resident 22. The pain review indicated that resident 22 was interviewed that day. The review also indicated that resident 22 was receiving oxycodone for pain, and that at the time of the interview, resident 22 was experiencing pain at a level of 6 out of 10. The pain review indicated that resident 22 would like to experience no pain. The pain review also indicated that resident 22 had experienced pain in the last 5 days on a daily basis or several times a day. The review specified that the pain was located in resident 22's right knee and was especially bad in the late evening. At that time, resident 22 described the pain as stabbing, and that it affected his sleep. Resident 22 also indicated that physical activity made the pain worse, but rest and repositioning relieved the pain. Staff documented on the pain review that resident 22 could be observed to have difficulty sleeping and/or make facial expressions such as grimacing when he was experiencing pain. The goal was to Encourage the resident to verbalize his needs, and pain level before medication and document effectiveness of medication. The facility Provider Notifications binder at the nurse's station in the 100 hall was reviewed. The binder indicated that on 1/23/23 resident 22 was requesting time of scheduled oxy (oxycodone) to be changed from 1600 (4:00 PM) to 1400 (2:00 PM). The facility Provider Orders binder at the nurses station in the 100 hall was reviewed. The binder indicated that on 1/23/23 an order was written to increase resident 22's oxycodone to every 4 hours as needed. The order was signed by the Nurse Practitioner (NP). On 1/24/23 at approximately 9:30 AM, resident 22 was observed to approach the facility NP at the nurse's station. Resident 22 was observed to tell the NP that he was experiencing an increased amount of pain. The NP responded to resident 22 by stating that she was aware of his request for an increased dosage of his pain medication, and had approved it, so the resident should start to experience pain relief soon. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	On 1/24/23, the facility Nurse Practitioner (NP) entered an encounter note in resident 22's medical record. The encounter note indicated that Patient is seen today with complaint of pain. He states this pain is mostly in his knees, though he has pain to his back as well. He states he has been taking oxycodone every 6 hours but will have to take Tylenol in between because it does not carry through long enough. He states mostly at night it is very bothersome for him and makes for a long rough night. He states that he would like his oxycodone increased to every 4 hours. He also has a scheduled dose at 4:00 in the afternoon, that he would like changed to earlier in the afternoon. The NP documented resident 22's pain level at a 6. The NP documented that resident 22 had a diagnosis of Osteoarthritis involving multiple joints on both sides of body and to Increase Oxycodone to every 4 hours as needed and Change scheduled oxycodone to 1400 (2:00 PM) from 1600 (4:00 PM). On 1/25/23 at 8:45 AM, an observation was made of resident 22. Resident 22 walked down the hallway and stopped at the nurse's station. Licensed Practical Nurse (LPN) 6 was observed to be in the nurses station standing at the medication cart. Resident 22 approached LPN 6 and stated that his knee hurt. LPN 6 did not look up from the medication cart or acknowledge resident 22. LPN 6 then stated, Well, you will just have to wait a minute I'm busy. Resident 22 nodded and went over to a chair across from the nurse's station and sat down. LPN 6 was not observed to administer any pain medication to resident 22 during the medication pass observation. On 1/25/23 at 10:50 AM, resident 22 was approached by a staff member and invited to participate in a facility activity. Resident 22 responded by saying that he could not go to the activity because his knees hurt too much. Resident 22 also stated that he thought he could not have more medications until 3:00 PM, and that was too far away. On 1/25/23 at 11:10 AM, resident 22 was observed to approach LPN 6 at the nurse's station, and ask for a pain pill, stating that his knee is really hurting. Resident 22 was observed to be bending over at the waist and rubbing his right knee while grimacing. LPN 6 stated, Ya, I know I'm sorry. LPN 6 did not make any other comments to the resident, and turned away from the resident while the resident was standing at the nursing station. On 1/25/23 at 11:12 AM, LPN 6 approached resident 22 and handed him a cup of water, and a cup containing a pill. LPN 6 immediately turned around and walked back to her medication cart without observing if resident 22 swallowed the pill. In addition, LPN 6 did not assess resident 22's pain level. On 1/25/23 at 11:35 AM, resident 22's Controlled Drug Record was reviewed. The record did not have any oxycodone listed as having been signed out by LPN 6 that day. Resident 22's Medication Administration Record (MAR) did not indicate any as needed pain medications given on 1/25/22 at 11:12 AM by LPN 6. On 1/25/23 at 12:14 PM, resident 22 was observed to ask LPN 6 if she could put some cream on his knee because it was still hurting. LPN 6 responded by asking if the pain medications had helped, and resident 22 stated Not totally. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	On 1/25/23 at 12:45 PM, an interview was conducted with resident 22. Resident 22 stated that not last night but the night before, indicating the evening of 1/23/23, his pain had increased to a 9 out of 10. Resident 22 stated that at that time facility staff put ice and aspercreme on his knee and had given him some oxycodone. Resident 22 stated that after those interventions he was able to get another 2 hours of sleep. On 1/25/23 at 2:20 PM, an interview was conducted with LPN 6. LPN 2 stated that she had given oxycodone to resident 22 at 11:11 AM and had documented it. When asked about the Provider Notification and Provider Orders binders, LPN 6 stated that one binder was to let the providers know of any concerns, and the other binder was for providers to record their responses. LPN 6 stated that she checked the binder at the beginning of each shift, but that there really isn't a process in place yet. LPN 6 reviewed the binder and confirmed that resident 22 was to have his oxycodone increased as of 1/23/23. A nurses note dated 1/26/23 indicated that resident 22's Oxycodone 5mg increased to q4 (every four hours) prn (as needed) from q6 (every six hours) prn per NP on 1/25/23. New increased dose started today, resident aware of new changes. The entry was made by Assistant Director of Nursing (ADON) 2, not LPN 6 even though LPN 6 was made aware on 1/25/23. Resident 22's January 2023 MAR was reviewed. On 1/25/23, resident 22 did not receive his 4:00 PM scheduled dose of oxycodone. The MAR also indicated that resident 22's increased oxycodone orders did not go into effect until the morning of 1/26/23. On 1/30/23 at 11:02 AM, a follow up interview was conducted with resident 22. Resident 22 was asked about his pain management. Resident 22 produced a notepaper and stated that he had spoken with the NP on 1/23/23, and that the NP agreed to increase his pain medications. Resident 22 stated that it took time for the orders to get processed so he was without the increased dose for a day or longer. Resident 22 also stated that the oxycodone only covered his pain for 4 hours, and before his pain medication dose was increased, he was using lidocaine ointment to help get him through the remaining two hours before he could have more oxycodone. Resident 22 stated that by the end of the 4 hours his pain level was a 4 to 5, but at the end of 6 hours without pain medication his pain level increased to a 6. Resident 22 stated that he had a diagnosis of scoliosis, so it put his hip out, causing pain. Resident 22 stated that the majority of his pain was from his right knee which he injured in a fall. On 1/30/23 at 11:25 AM, an interview was conducted with the NP. The NP stated that she spoke with resident 22 two weeks ago at which time resident 22 talked about the pain with me. The NP stated that on 1/23/23 she had spoken with resident 22 about his pain again, at which time she approved the increase in pain medication. The NP stated that she wrote the order for the increased pain medication in the binder at the nurse's station. The NP stated that whenever she wrote an order in the binder, she always verbally informed the nurse on duty about the new order as well. On 1/30/23 at 11:35 AM, an interview was conducted with the Medical Director (MD). The MD stated that approximately three weeks ago, he and the NP had started a new process of writing down the new orders in a binder at the nurses station. The MD stated that when there was a verbal order given, the MD or NP would tell the nurse on duty, and write it in the binder so there was a record of the verbal order. The MD stated that he expected nurses to put the verbal order into effect ASAP, at most an hour. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	4. Resident 298 was admitted on [DATE] with diagnoses which included femur fracture, history of falling, chronic respiratory failure with hypoxia, cognitive communication deficit, dysphagia, need for assistance with personal care, and chronic obstructive pulmonary disease (COPD). On 1/23/23 at 12:00 PM, an interview was conducted with resident 298's family member (FM). The FM stated the resident was admitted on [DATE] at 8:00 AM and went almost an entire day without his pain being controlled. The FM stated the facility would not give resident 298 any pain medication because they didn't have an order (air quotes used when the FM said this). The FM stated on her arrival she demanded the nurse get resident 298 something for pain and the nurse went straight to the facility supply and got resident 298 a pain medication. The FM stated it did help resident 298 but he wouldn't have gotten anything if she had not come in. On 1/24/23, resident 298's medical record was reviewed. Resident 298 was admitted to the facility in the morning on 1/21/23, the first vital sign check was documented at 9:53 AM. A physician order dated 1/20/23 revealed an order for Tramadol 50 mg give 1 tablet by mouth every 4 hours as needed for moderate to severe pain. A physician order dated 1/21/23 revealed an order for Percocet tablet 5-325 milligrams (mg) give 1 tablet by mouth every 4 hours as needed for pain. The Medication Treatment Record (MAR) for January 2023 revealed, at 1:56 PM resident 298 had pain at a level 5 on a 0-10 pain scale with 0 being no pain and 10 being immense pain. A Non-pharmalogical Intervention (NPI) was documented at 1:56 PM as, speak to/approach in a calm manner. No pain medication was documented as administered to resident 298. No documentation was found in the medical record of Tramadol being administered to resident 298 on 1/21/23. On 1/21/23 at 9:59 PM, the MAR documented resident 298 continued to complain of pain at a level 5 on the 0-10 pain scale and was administered Percocet 5mg. Note: This was 8 hours after resident 298 complained about pain. The pain medication was administered by the oncoming night shift nurse not the admitting day shift nurse. On 1/30/23 at 1:50 PM, an interview was conducted with Licensed Practical Nurse (LPN) 9. LPN 9 stated she was the nurse who admitted resident 298 to the facility on [DATE]. LPN 9 stated the resident, and his family were upset because all she could give him was Tramadol for pain because the provider had already been into the facility to see the residents for the day, so the resident's orders didn't get sent to the pharmacy until the next day. LPN 9 stated she could have gotten the narcotic pain medication out of the house supply with a verbal order from the provider. LPN 9 stated that she probably should have done that sooner and that the family was upset she didn't give the resident anything for his pain except [TRUNCATED]

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47432 Based on observation, interview and record review, for 2 of 54 sampled residents, that the facility did not ensure that the residents were free from physical restraints imposed for purposes of convenience, and not required to treat the residents' medical symptoms. Specifically, a resident had bed rails that were not used for mobility, and a resident with a hand mitt was not assessed regularly and evaluated for the continued need of the restraint. Resident identifiers: 82 and 146. Findings include: 1. Resident 146 was admitted to the facility on [DATE] with diagnoses that included osteoarthritis, polyneuropathy, Parkinson's disease and generalized anxiety disorder. Resident 146's medical record was reviewed on 1/23/23. An incident report revealed that on 1/8/23 at 11:30 PM, resident 146 had a fall with injuries. Record review of Resident 146's Minimum Data Set (MDS) Annual assessment dated [DATE] documented that Resident 146 had a Brief Interview for Mental Status (BIMS) score of 3, indicating that Resident 146 had a severe cognitive impairment. The MDS Annual Assessment also documented that Resident 146 required assistance to complete Activities of Daily Living (ADLs). Record review of Resident 146's care plan and medical record revealed shows that Resident 146 had physician orders for her bed to be in the low position, with a mat next to the bed, and 1/2 length bed rails on the left side of the bed for mobility, dated 5/20/17. On 1/13/23, the facility completed a Bed Rail/Transfer Bar Safety Assessment form and a Use of Bedrails form for Resident 146. The box was checked that stated Resident 146 consented to having bed rails placed. Another box was checked that stated that Resident 146 was unable to sign the consent form. Resident 146's physician orders were modified on 1/13/23 and revealed, orders for 1/2 bed rails on both sides of the bed. An incident report dated 01/13/2023 at 11:50 PM stated that, . (Resident 146) was found on the floor in her room on floor mat. Bed was in lowest position. Removed air mattress d/t (due to) every time (resident) . gets close to the edge of the bed she rolls out with the air mattress. A nursing progress note dated 01/14/2023 at 2:56 PM stated, Cont (continue) to monitor for recent fall . bed side rail upper x (times) 2 in place for safety reason . A nursing progress note dated 01/14/2023 at 10:58 PM stated, Fall Monitoring: . Resident is in bed, bed is low, side rails up x2 . (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/25/23 at 10:22 AM, Resident 146 was observed lying in bed. The bed was low to the ground, a fall mat was next to her bed, and 1/2 side rails on both sides of the bed were in the up position. On 1/26/23 at 10:22 AM, The Certified Nursing Assistant Coordinator (CNAC) was interviewed. The CNAC stated that resident 146 had bed rails so that the resident can grab and pull herself up. On 1/26/23 at 11:15 AM, Registered Nurse (RN) 1 was interviewed. RN 1 stated that resident 146 had several falls at the start of January 2023. RN 1 stated that usually the bed rails were used for mobility, but for resident 146 they were used as a safety device. On 1/26/23 at 12:25 PM, the Director of Nursing (DON) was interviewed. The DON stated that the bed rails on resident 146's bed were used for bed mobility during changing. On 1/26/23 at 12:45 PM, a follow up interview was conducted with the DON. The DON stated that resident 146 climbed out of bed all the time, even with the side bed rails up. 44640 2. Resident 82 was admitted to the facility on [DATE] with diagnoses which included chronic respiratory failure with hypoxia, nontraumatic subarachnoid hemorrhage, epilepsy, hydrocephalus, encephalopathy, cognitive communication deficit, hypertension and gastroesophageal reflux disease. Findings include: On 1/23/23 at 12:10 PM, the door to resident 82's room was open, resident 82 was observed to be on droplet and contact precautions. A mitten restraint was observed on resident 82's left hand, resident 82 was lying in bed asleep. On 1/24/23 at 10:09 AM, an observation was made of two respiratory therapists (RTs) in resident 82's room providing cares. Resident 82 was observed to have a mitten restraint on his left hand. The RTs were not observed to remove, adjust or examine the mitten restraint. Resident 82 was not observed to be agitated or combative after the RTs left the room. On 1/24/23 at 2:24 PM, an observation was made of resident 82 lying in bed awake with a mitten restraint on his left hand. Resident 82 was not observed to be restless or moving his left hand. On 1/25/23 at 9:00 AM, an observation was made resident 82 lying in bed asleep. A mitten restraint was observed on resident 82's left hand. On 1/25/23 at 11:45 AM, an observation was made of the Wound Care Team (WCT). The WCT performed wound care on resident 82. A mitten restraint was observed in place on resident 82's left hand at the beginning of the wound care. The mitten restraint was observed to be dirty with brown spots observed on the tip and palm of the mitten. After the wound care was complete, resident 82 was repositioned in bed by the WCT. No removal or repositioning of the mitten on resident 82's left hand was observed. Resident 82 was not combative, no attempt was made by resident 82 to touch his tracheostomy during the wound care or after. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/30/23 at 9:12 AM, an observation was made of resident 82 lying in bed asleep with a mitten restraint on his left hand. On 1/23/23, resident 82's medical record was reviewed. On 8/16/22 an admit Minimum Data Set (MDS) revealed, resident 82 had a restraint that was marked under other in the restraint section and documented as used less than daily. The trunk and limb restraint sections were documented as not used. The MDS classified a restraint as: physical restraints are any manual method or physical or mechanical device, material or equipment attached or adjacent to the residents body that the individual cannot remove easily which restricts freedom of movement or normal access to ones body. On 11/16/22 a quarterly MDS assessment revealed resident 82's restraint assessment had changed to being used daily. Physician orders dated 8/17/22 revealed, resident 82 had hand mittens to prevent pulling on percutaneous endoscopic gastrostomy (PEG) tube and tracheostomy (trach) tube. Check skin on hands for redness and circulation every 2 hours. The November 2022 Treatment Administration Record (TAR) revealed the physician order only required a skin check to be documented once a shift, not every 2 hours. On November 15th (day shift), 18th (night shift), 27th (night shift), 28th (night shift), and the 30th (day shift) there was no documentation that resident 82's skin and hands were checked for redness or circulation. The December 2022 TAR revealed the physician order only required a skin check to be documented once a shift, not every 2 hours. Resident 82's hands were not checked for redness or circulation on the 4th (day shift), 14th (night shift), 20th (day shift) and the 23rd (night shift). The January 2023 TAR revealed the physician order only required a skin check to be documented once a shift, not every 2 hours. Resident 82's hands were not checked for redness or circulation on the 14th (night shift), 20th (day shift) and the 21st (day or night shift). There was no evidence found in the medical record of resident 82 being reevaluated by a provider for the initial and continued need of the mitten restraint. There was no evidence found in resident 82's medical record of the mitten restraint being removed when it was not needed or of resident 82 being assessed by nursing staff to determine the need for continued use of the mitten restraint. A care plan dated 8/14/22 revealed a focus of physical restraint use MITTENS related to (r/t) Injury/Pulling of peg tube and trach. With a goal of the restraint use will be minimized/eliminated by the review date on 11/21/22. Interventions included, evaluate/record continuing risks/benefits of restraint, alternatives to restraint, need for ongoing use, reason for restraint use. Monitor/document/report to medical doctor (MD) as needed (PRN) changes regarding effectiveness of restraint, less restrictive device, if appropriate; any negative or adverse effects noted, including: decline in mood, change in behavior, decrease in adl self performance, decline in cognitive ability or communication, contracture formation, skin breakdown, sign/symptom (s/sx) of delirium, falls/accidents/injuries, agitation, weakness. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/26/23 at 8:30 AM, an interview was conducted with CNA 6. CNA 6 stated he was one of the aides assigned to the 500 hallway. CNA 6 stated there was only one resident who had restraints on the 500 hallway and he had been discharged to the local hospital. CNA 6 stated there was no other resident currently with restraints. CNA 6 stated the CNA was responsible to put the restraint on the resident, it was the nurses responsibility to check the placement and the resident's skin. On 1/26/23 at 8:53 AM, an interview was conducted with Licensed Practical Nurse (LPN) 5. LPN 5 stated she was the nurse assigned to care for the residents in the 500 hallway. LPN 5 stated there were no residents on the 500 hallway that had restraints. LPN 5 stated she was not sure how often they would check the restraints on a resident because she did not have any residents with restraints. On 1/26/23 at 9:00 AM, a continuous observation of resident 82 was initiated. Resident 82 was observed to be lying in bed, the mitten restraint on resident 82's left hand was not checked, released or removed during the three hour observation period, which ended at 12:03 PM. On 1/26/23 at 12:24 PM, an interview was conducted with the Director of Nursing (DON). The DON stated the facility did not have a physician note which stated the justification on why resident 82 had a restraint. The DON stated resident 82 came to the facility with the mitten so they left it on him. The DON stated the medical doctor (MD) signed the order when the resident was admitted . A Physician Progress Note dated 8/18/22 revealed, Patient arrived to the facility already on Seroquel for psychosis and agitation, however since he has been here he has been somnolent without any acute agitation or uncontrolled behaviors. He has admits [mits] on one hand to prevent pulling at his tubes as he has a history of this issue. Given his somnolence and lack of obvious agitation, plan to discontinue Seroquel . On 1/26/23 at 12:30 PM, an interview was conducted with the Director of Respiratory Therapy ([NAME]). The [NAME] stated resident 82 was nonverbal but could say yes or no with blinking. The [NAME] stated resident 82 was pretty good but he had pulled out his trach a couple of times. The [NAME] stated the CNAs put the mitten in place and the RT had put in on a couple of times. The [NAME] stated there was supposed to be documentation on why the restraint was in place, how often it was to be taken off and how the skin looked. The [NAME] stated this charting was done by the nurses and CNAs. On 1/26/23 at 1:00 PM, an interview was conducted with the Assistant Director of Nursing (ADON) 2. The ADON 2 stated, restraints are used on a monitoring system. For example, side rails are in place while a resident is in bed to help with mobility. Fall mats are on the floor while the resident is in bed, for if they fall out. The nurses and aids are expected to monitor the residents who have restraints to keep them safe. On 1/26/23 at 1:30 PM, a telephone interview was conducted with Certified Nurse Assistant (CNA) 8. CNA 8 stated the CNAs would let the nurses know if resident 82 got out of the mitten. CNA 8 stated they would check the resident's skin during the resident's shower. CNA 8 stated, we will do a full skin assessment and then the nurse and RT will put the mitten back in place. CNA 8 stated resident 82 usually had his mitten on. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/26/23 at 1:50 PM, a telephone interview was conducted with CNA 5. CNA 5 stated resident 82 wore the mitten because he pulled on his trach. CNA 5 stated, the RT and the RN would put the mitten on and take it off when it is needed. CNA 5 stated resident 82's hand was usually pretty sweaty and soggy when the mitten was taken off for his shower. CNA 5 stated the CNAs would chart a shower was completed and if there was skin breakdown, but the CNAs did not chart the quality of the skin under the mitten specifically. On 1/30/23 at 9:15 AM, an interview was conducted with LPN 3. LPN 3 stated she was the nurse assigned to care for the residents in the 500 hallway. LPN 3 stated there were no residents with restraints in that hallway. LPN 3 stated if there were a resident with restraints we should check them every 2 hours, document in the progress notes, and leave the restraint off for a while before it was back in place. LPN 3 then stated there was one resident who had mitten restraints that had just returned from the local hospital, but he was the only resident with them. LPN 3 stated that resident was not resident 82. On 1/30/23 at 3:02 PM, an interview was conducted with the ADON 1. The ADON 1 stated the mitten is considered a restraint and it needed to have a physician order, be checked every 2 hours and documented in the TAR. The ADON 1 stated the nurses are expected to check the restraint and remove it for 15- 20 minutes then they can put the restraint back in place. The ADON 1 stated the nurses had just been putting the mitten restraint back in place for resident 82 because he had a history of pulling on his trach tube. The ADON 1 stated the facility did not have a process in place to verify the restraint was checked every 2 hours and that it was only kept on the resident if needed. The ADON 1 stated if the restraint was not checked every 2 hours it could lead to redness of the skin, decrease in circulation, and possible loss in function of resident 82's hand. The facility policy titled, Restraints, Physical that was reviewed on 11/2022 stated under the General Use Section that each resident requiring physical restraints shall have the restraint released for at least ten (10) minutes ever two (2) hours . each resident requiring physical restraints shall be checked by a staff member at least every thirty (30) minutes.

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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** 22992 Based on interview and record review, the facility failed to report an allegation of abuse. Specifically, an injury of unknown origin was identified on a resident with cognitive impairment, and the resident alleged that staff hit him; however, the incident was not reported to the State Survey Agency. Resident identifier: 33. Findings include: Resident 33 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included dementia, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, anxiety disorder, osteoporosis, pseudobulbar affect, major depressive disorder, and hypertension. Resident 33's medical record was reviewed on 1/23/23. Resident 33's Minimum Data Set (MDS) dated [DATE] indicated that resident 33 had severe impairment in both his long term and short-term memory. Nurses' notes for resident 33 revealed the following: a. On 12/31/22 at 9:55 AM, Resident c/o (complains of) left hand pain, aid (sic) reports that he is unable to lift his left hand like he normally does. Resident states when I asked what happened, 'they beat me with this', and he lifted up the bed remote. MD (medical doctor) and family notified. b. On 12/31/22 at 5:18 PM, X-ray result on 12/31 No acute fracture or bony destruction is seen. No osteomyelitis is noted. No other nursing notes indicated follow up, if any, regarding the resident's allegation of abuse, or the injury of unknown origin. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/30/23 at 11:30 AM, an interview was conducted with Licensed Practical Nurse (LPN) 8. LPN 8 stated that on 12/31/22, she arrived at the facility for her shift at 6:00 AM. LPN 8 stated that when she arrived for her shift, she received report from Staff Member (SM) 1, who was a licensed nurse, and Certified Nursing Assistant (CNA) 10. LPN 8 stated that SM 1 reported that overnight there had been some confrontation with resident 33. LPN 8 stated that SM 1 reported that resident 33 wouldn't let staff change his incontinence brief and it took two of them to hold him down. LPN 8 stated that CNA 10 stated we had to hold him down because we needed to change him. LPN 8 stated that resident 33 was bedridden so he can't do much. LPN 8 stated that after receiving report from SM 1, she went to check on resident 33. LPN 8 stated that at that time, resident 33 said the boy CNA and the nurse held me down, and that they had hit his hand with the bed remote. LPN 8 stated that the resident was complaining of pain in his hand, so staff obtained an X-ray of his hand. LPN 8 stated that resident 33 is adamant that he doesn't want [CNA 10] to work with him anymore. LPN 8 stated that after she had spoken with resident 33 on 12/31/22, she called the Assistant Director of Nursing (ADON) 2. LPN 8 stated that ADON 2 told her if you suspect abuse, call [the Administrator] because he's the abuse coordinator. LPN 8 stated that she reported the incident with resident 33 to the Administrator (ADM) the same day because it's abuse. LPN 8 stated that the ADM's response was to obtain an X-ray of resident 33's hand. LPN 8 stated that the ADM did not contact her regarding the incident after that initial conversation. LPN 8 stated that she worked on 1/1/23 and asked SM 1 about the incident with resident 33 again, because the resident was complaining that SM 1 hit him. LPN 8 stated that SM 1's response was well, he hit us with a remote! On 1/30/23 at 1:50 PM, an interview was conducted with resident 33. Resident 33 was asked multiple questions about himself and was only be able to provide yes and no answers. Resident 33 was asked if any staff members had hit him, and he shook his head to indicate yes. Resident 33 was asked if it was a remote that was used to hurt his hand he shook his head yes. Resident 33 was asked if he was afraid of any of the staff, and he shook his head no. Resident 33 was asked which hand had been hit, and the resident lifted his left hand. When asked about the staff members involved in the incident, resident 33 was not able to provide an intelligible reply. On 1/30/23 at 2:15 PM, an interview was conducted with CNA 10. CNA 10 confirmed he had worked with resident 33 on 12/31/22. CNA 10 stated that it was typical for resident 33 to throw the bed remote at staff and refuse a brief change until the last round of the shift. CNA 10 stated that on 12/31/22, resident 33 had hit the CNA in the back of the head with a remote. CNA 10 denied holding the resident down to change the resident's incontinence brief. CNA 10 stated that when he was changing resident 33's brief that shift, resident 33 started getting mad, so the CNA went to inform SM 1 who could help calm the resident down. CNA 10 stated that when he and SM 1 returned, resident 33 was whipping the bed remote around in the air by the cord, and that resident 33 was upset at that time, stating that CNA 10 had hit him. CNA 10 states he was attempting to block resident 33 from hitting him in the head while attempting to put a clean brief back on resident 33. CNA 10 stated that no one from the facility staff, including the ADM had contacted him regarding the alleged incident. On 1/30/23, the facility's abuse investigations were reviewed. The incident involving resident 33 was not included in any of the abuse investigations. On 1/30/23 at 1:51 PM, an interview was conducted with the facility ADM. When asked about the incident involving resident 33, the ADM stated, Let me go back, I don't remember anything like this. let me go talk with [the Director of Nursing] and my team. I don't remember hearing anything like that. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/30/23 at 1:52 PM, an interview was conducted with ADON 2. ADON 2 stated that she did not recall speaking with LPN 8 about the incident with resident 33 but did indicate that if a staff member wanted to make a report about abuse, she directed them to contact the ADM directly. On 1/30/23 at 1:53 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that she reviewed the nurses' notes from the previous 24 hours each morning, and any incidents were discussed in stand up meeting. When asked about the incident involving resident 33 on 12/31/22, and it being reported as an injury of unknown origin, the DON stated, Well we got the X-ray. The doctor says it is normal arthritis. When asked about resident 33's specific complaint that he had been struck by staff, the DON stated, He says that all the time, and he hits other people with the remote. A review of the State Survey Agency database revealed that the incident involving resident 33 had not been reported to the agency as required. The facility's abuse policy and procedure was reviewed. The policy indicated the following: . Reporting/Response 1. All allegations of abuse, neglect, misappropriation of resident property, or exploitation should be reported immediately to the Administrator. 2. Allegations of abuse, neglect, misappropriation of resident property, or exploitation will be reported outside the Facility and to the appropriate State or Federal agencies in the applicable timeframes, as per this policy and applicable regulations.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22992 Based on interview and record review, the facility failed to thoroughly investigate an allegation of abuse. Specifically, an injury of unknown origin was identified on a resident with cognitive impairment, and the resident alleged that staff hit him; however, no investigation was completed. Resident identifier: 33. Findings include: Resident 33 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included dementia, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, anxiety disorder, osteoporosis, pseudobulbar affect, major depressive disorder, and hypertension. Resident 33's medical record was reviewed on 1/23/23. Resident 33's Minimum Data Set (MDS) dated [DATE] indicated that resident 33 had severe impairment in both his long term and short-term memory. Nurses' notes for resident 33 revealed the following: a. On 12/31/22 at 9:55 AM, Resident c/o (complains of) left hand pain, aid (sic) reports that he is unable to lift his left hand like he normally does. Resident states when I asked what happened, 'they beat me with this', and he lifted up the bed remote. MD (medical doctor) and family notified. b. On 12/31/22 at 5:18 PM, X-ray result on 12/31 No acute fracture or bony destruction is seen. No osteomyelitis is noted. No other nursing notes indicated follow up, if any, regarding the resident's allegation of abuse, or the injury of unknown origin. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/30/23 at 11:30 AM, an interview was conducted with Licensed Practical Nurse (LPN) 8. LPN 8 stated that on 12/31/22, she arrived at the facility for her shift at 6:00 AM. LPN 8 stated that when she arrived for her shift, she received report from Staff Member (SM) 1, who was a licensed nurse, and Certified Nursing Assistant (CNA) 10. LPN 8 stated that SM 1 reported that overnight there had been some confrontation with resident 33. LPN 8 stated that SM 1 reported that resident 33 wouldn't let staff change his incontinence brief and it took two of them to hold him down. LPN 8 stated that CNA 10 stated we had to hold him down because we needed to change him. LPN 8 stated that resident 33 was bedridden so he can't do much. LPN 8 stated that after receiving report from SM 1, she went to check on resident 33. LPN 8 stated that at that time, resident 33 said the boy CNA and the nurse held me down, and that they had hit his hand with the bed remote. LPN 8 stated that the resident was complaining of pain in his hand, so staff obtained an X-ray of his hand. LPN 8 stated that resident 33 is adamant that he doesn't want [CNA 10] to work with him anymore. LPN 8 stated that after she had spoken with resident 33 on 12/31/22, she called the Assistant Director of Nursing (ADON) 2. LPN 8 stated that ADON 2 told her if you suspect abuse, call [the Administrator] because he's the abuse coordinator. LPN 8 stated that she reported the incident with resident 33 to the Administrator (ADM) the same day because its abuse. LPN 8 stated that the ADM's response was to obtain an X-ray of resident 33's hand. LPN 8 stated that the ADM did not contact her regarding the incident after that initial conversation. LPN 8 stated that she worked on 1/1/23 and asked SM 1 about the incident with resident 33 again, because the resident was complaining that SM 1 hit him. LPN 8 stated that SM 1's response was well, he hit us with a remote! On 1/30/23 at 1:50 PM, an interview was conducted with resident 33. Resident 33 was asked multiple questions about himself and was only be able to provide yes and no answers. Resident 33 was asked if any staff members had hit him, and he shook his head to indicate yes. Resident 33 was asked if it was a remote that was used to hurt his hand he shook his head yes. Resident 33 was asked if he was afraid of any of the staff, and he shook his head no. Resident 33 was asked which hand had been hit, and the resident lifted his left hand. When asked about the staff members involved in the incident, resident 33 was not able to provide an intelligible reply. On 1/30/23 at 2:15 PM, an interview was conducted with CNA 10. CNA 10 confirmed he had worked with resident 33 on 12/31/22. CNA 10 stated that it was typical for resident 33 to throw the bed remote at staff and refuse a brief change until the last round of the shift. CNA 10 stated that on 12/31/22, resident 33 had hit the CNA in the back of the head with a remote. CNA 10 denied holding the resident down to change the resident's incontinence brief. CNA 10 stated that when he was changing resident 33's brief that shift, resident 33 started getting mad, so the CNA went to inform SM 1 who could help calm the resident down. CNA 10 stated that when he and SM 1 returned, resident 33 was whipping the bed remote around in the air by the cord, and that resident 33 was upset at that time, stating that CNA 10 had hit him. CNA 10 states he was attempting to block resident 33 from hitting him in the head while attempting to put a clean brief back on resident 33. CNA 10 stated that no one from the facility staff, including the ADM had contacted him regarding the alleged incident. On 1/30/23, the facility's abuse investigations were reviewed. The incident involving resident 33 was not included in any of the abuse investigations. On 1/30/23 at 1:51 PM, an interview was conducted with the facility ADM. When asked about the incident involving resident 33, the ADM stated, Let me go back, I don't remember anything like this. let me go talk with [the Director of Nursing] and my team. I don't remember hearing anything like that. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/30/23 at 1:52 PM, an interview was conducted with ADON 2. ADON 2 stated that she did not recall speaking with LPN 8 about the incident with resident 33 but did indicate that if a staff member wanted to make a report about abuse, she directed them to contact the ADM directly. On 1/30/23 at 1:53 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that she reviewed the nurses' notes from the previous 24 hours each morning, and any incidents were discussed in stand up meeting. When asked about the incident involving resident 33 on 12/31/22, and it being reported as an injury of unknown origin, the DON stated, Well we got the X-ray. The doctor says it is normal arthritis. When asked about resident 33's specific complaint that he had been struck by staff, the DON stated, He says that all the time, and he hits other people with the remote. The facility's abuse policy and procedure was reviewed. The policy indicated the following: . Investigation 1. All identified events are reported to the Administrator immediately. 2. After receiving the allegation, and during and after the investigation, the Administrator will ensure that all residents are protected from physical and psychosocial harm . 4. All allegations of abuse, neglect, misappropriation of resident property, and exploitation will be promptly and thoroughly investigated by the Administrator or his/her designee.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 44640 Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive, person-centered care plan for each resident consistent with the resident's rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. Specifically, for 1 out of 54 sampled residents, a resident who required oxygen did not have a care plan developed for oxygen use. Resident identifiers: 298. Findings included: 1. Resident 298 was admitted on [DATE] with diagnoses which included femur fracture, history of falling, chronic respiratory failure with hypoxia, cognitive communication deficit, dysphagia, need for assistance with personal care, and chronic obstructive pulmonary disease (COPD). On 1/23/23 at 12:00 PM, an interview was conducted with a family member (FM) of resident 298. The FM stated resident 298 was admitted to the facility and not placed on wall oxygen, so the portable oxygen tank resident 298 was using ran out. The FM stated resident 298's oxygen levels got very low, and the family were the ones to bring it to the staff's attention. On 1/24/23, resident 298's medical record was reviewed. Resident 298's physician's orders revealed no orders for supplemental oxygen. Resident 298's Treatment Administration Record (TAR) for January 2023 revealed no oxygen treatment instructions. Resident 298's care plan revealed no focus areas, goals or interventions addressing oxygen usage. An Initial Admission Record (IAR) dated 1/21/23 revealed, resident 298 had a pulmonary diagnosis of COPD, shortness or breath, trouble breathing when lying flat, trouble breathing with exertion, and diminished lung sounds. The IAR documented resident 298 was on 3 liters (L) of oxygen (O2) via nasal cannula (NC) on admission. On 1/21/23 at 9:53 AM, resident 298's O2 saturation level via NC was 87% (percent). On 1/22/23 at 5:21 AM, resident 298's O2 saturation level via NC was 87%. On 1/24/23 at 4:26 AM, resident 298's O2 saturation level via NC was 92%. On 1/30/23 at 1:50 PM, a telephone interview was conducted with Licensed Practical Nurse (LPN) 9. LPN 9 stated the administration staff were the ones who entered the care plan into the medical record, after the admission was complete. LPN 9 stated resident 298 was on oxygen on admit. LPN 9 stated she thought it was the Certified Nurses Assistant (CNA's) job to attach the resident's NC to the wall O2. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/30/23 at 2:45 PM, an interview was conducted with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON). The ADON stated it is the nurses responsible to set up the resident's oxygen. The administration will get the care plan set up after the admission is completed. The care plan is there for the nurses to follow and provide the correct care. [Cross refer to F695]

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22992 Based on interview and record review, the facility did not ensure that for 1 of 54 sample residents the resident had a discharge summary that includes, but is not limited to: a recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results; a final summary of the resident's status to include items in paragraph (b)(1) of S483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative; reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter); or a post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. Resident identifier: 93. Findings include: Resident 93 was admitted on [DATE] with diagnoses that included dementia, cognitive communication deficit, and anxiety disorder. Resident 93's medical record was reviewed on 1/25/23. Review of 93's medical record revealed that resident 93 was discharged on [DATE]. However, no documentation could be located to indicate why the resident discharged , or where the resident was discharged to. There was no discharge summary that included a recapitulation of the resident's stay, a final summary of the resident's status, a reconciliation of all pre-discharge medications with the resident's post-discharge medications, or a post-discharge plan of care. On 1/25/22 at 12:52 PM, an interview was conducted with the facility Director of Nursing (DON). The DON confirmed that no discharge summary was in place for resident 93. The DON stated that she was aware that the discharge summaries were not being completed for residents as required, and that facility staff had completed a Quality Assessment and Assurance plan a week or two ago. The DON stated that the discharge summaries would now be the responsibility of the social services worker.

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F 0676 Level of Harm - Actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46232 Based on interview and record review it was determined, for 1 of 54 sampled residents, that the facility did not provide the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living (ADLs). Specifically, a resident did not receive help with feeding assistance and cueing. The deficient practice identified was found to have occurred at a harm level. Resident Identifier: 244. Findings include: Resident 244 was admitted to the facility on [DATE] with diagnoses that included but not limited to gastro esophageal reflux disease, muscle weakness, major depressive disorder, anxiety disorder, and insomnia. Resident 244's medical record was reviewed on 1/24/23. An annual Minimum Data Set (MDS) assessment dated [DATE], documented that resident 244 required supervision assistance with one person. In addition, a quarterly MDS assessment dated [DATE] documented that resident 244 had a Brief Interview for Mental Status (BIMS) score of 15. A Plan of Care problem with an effective date of 1/4/17 documented that resident 244 required extensive assist with bed mobility, transfers, . eating, toilet use and personal hygiene. Another care area identified with an effective date of 1/24/17 documented that resident 244 was at nutritional risk as evidence by periods of decreased oral intake. An intervention implemented on 1/1/18, documented that resident 244 would have weekly weights x 30 days and monthly if stable and to promptly identify signs and symptoms of weight loss and dehydration; interventions initiated timely daily. [Note: no weekly weights were done.] Registered Dietician Nutritional Risk Review dated 12/22/22 documented that resident 244 had an 8% (percent) weight loss since 11/2/22. A nurse practitioner/ physician assistant progress note dated 8/25/22 documented that resident 244 had some noted weight loss recently due to food preferences. A nurse practitioner/ physician assistant progress note dated 12/27/22 documented that resident 244's sister expressed concerns on 12/7/22 about resident 244's difficulty eating and stated it took resident 244 a long time to eat the food that he had so far. A new patient encounter progress note dated 1/3/23 documented that resident 244 had reportedly been losing weight. On November 2 he weighed 187 pounds, today he weighs 168 which is a 10% weight loss. He states his appetite has not been very good as he just has not felt well. He remains at risk for significant weight loss and malnutrition. The exact meal percentage consumption for the last 30 days documented that resident 244 had consumed 50 % or less of his meals for 46 out of 72 documented encounters. (continued on next page)

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F 0676 Level of Harm - Actual harm Residents Affected - Few	The snack consumption for the last 30 days documented that resident 244 accepted a snack 3 times out of the 24 instances documented. On 1/23/23 at 10:25 AM, resident 244 was observed sitting up in his bed with his eyes closed. A breakfast meal tray was observed on a bedside table in front of resident 244. Most of the food on the breakfast tray appeared to be untouched except, for the cereal. On 1/25/23 at 12:05 PM, resident 244 was observed to have his eyes closed when his lunch tray was dropped off. The lunch tray was observed on a bedside table located to the right of resident 244. Resident 244 eye's continued to appear closed until 12:16 PM. On 1/25/23 at 1:47 PM, resident 244 was observed to have his eyes closed and lunch tray at bedside remained untouched. On 1/26/23 at 10:00 AM, resident 244 was observed to have his eyes closed and had a napkin placed across his chest with a handful of cheerios scattered across the napkin. A breakfast meal tray was observed on a bedside table in front of the resident. The breakfast meal tray had a piece of toast with jelly, a cut up sunny side up egg and a bowel of cheerios. The cheerios were the only item of food that was touched by the resident. On 1/26/23 at 12:10 PM, resident 244 was observed to be sitting up in bed and staring at his food with shaking hands. A lunch tray compromised of meat and rice was observed on a bedside table located in front of resident 244. Resident 244 continued to stare at his food for 17 minutes before he picked up his cup of milk with a shaky hand. Resident 244 was observed to bring the cup of milk to his mouth without spilling but began to cough when he drank the milk. Resident 244 was then observed to spill the remainder of his milk as he tried to put the cup back on his bedside table. A follow up interview was conducted with resident 244. Resident 244 stated he did not like his food, and he did not plan to eat it. Resident 244 stated the only thing he liked was the milk and that he was not hungry. On 1/26/23 at 1:17 PM, resident 244 was observed to have his eyes closed and his lunch tray appeared to be untouched expected for the milk he drank. On 1/30/23 at 12:07 PM, resident 244's sister was observed to feed resident 244 homemade soup. A follow up interview was conducted with resident 244. Resident 244 stated he needed help feeding himself. Resident 244 stated that staff took his meal trays away and had not offered him any meal substitutions when he did not like the food. On 1/26/23 at 11:15 AM, an interview was conducted with Certified Nursing Assistant (CNA) 3. CNA 3 stated the resident 244 was an extensive two person assist and needed to be pulled up in bed for every meal. CNA 3 stated that resident 244 ate in his room and that he was capable of feeding himself. CNA 3 stated that the only help resident 244 required with meals was to have his tray set up for him. CNA 3 stated they were unsure the percentage of his meals that he ate. On 1/25/23 at 12:34 PM, an interview was conducted with the Minimum Data Set Coordinator (MDSC). The MDSC stated that resident 244 was able to feed himself and only required setup assist with his tray. The MDSC stated that resident 244 didn't always eat all his food because he didn't like what he was served. The MDSC stated that resident 244 got a boost with all his meals as a supplement. (continued on next page)

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F 0676 Level of Harm - Actual harm Residents Affected - Few	On 1/26/23 at 10:46 AM, an interview was conducted with CNA 2. CNA 2 stated that resident 244 ate about 25% of his breakfast today. CNA 2 stated resident 244 didn't eat very much of his meals. CNA 2 stated that resident 244 was capable of using silverware and was able to feed himself and did not require any help that he was aware of. On 1/26/23 at 12:35 PM, an interview was conducted with the Occupational Therapist (OT). The OT stated they had not worked with resident 244 since October. The OT was asked if resident 244 was able to feed himself with his shaky hands and the OT responded that they were unsure how much help resident 244 needed with meals. The OT stated they evaluated and worked with residents that needed more assistance on ADLs. The OT stated they were not working with resident 244 since he didn't need help with any ADLs that he was aware of. On 1/30/23 at 11:11 AM, an interview was conducted with Licensed Practical Nurse (LPN)1. LPN 1 stated that resident 244 was able to feed himself and was able to reach for his own waters. LPN 1 stated that every once in a while, resident 244 did not each much but stated that he always ate his cereal. On 01/30/23 at 12:21 PM, an interview was conducted with the Certified Nursing Assistant Coordinator (CNAC). The CNAC stated that resident 244 was a set up assistance for meals. The CNAC stated they made sure to sit him up in bed and during brief changes. The CNAC stated she handed resident 244 his chocolate milk with meals and stated that resident 244 did not have problems grabbing thing with his hands. The CNAC stated there were times where he did not eat his food because he did not like what was serve to him. The CNAC stated that resident 244 verbalized when he did not like his meal. The CNAC stated they have asked resident 244 if he needed help with meals but stated that resident 244 has refused the help. The CNAC stated they thought it was weird that resident 244's sister was feeding him lunch today because resident 244 was able to feed himself and did not that much help with meals. On 1/30/23 at 3:56 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that supervision assist meant that a staff member had to help and encourage the resident to eat during meals. The DON stated if the resident's MDS documented him as a supervision assist, she expected staff to be at bedside during mealtimes to help feed him. The DON that when a resident has a 10% weight loss, they were triggered for weight loss and put on weekly weights, as well as reviewed in the weekly Nutrition at Risk meetings. [Cross refer to F692]

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F 0677 Level of Harm - Actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22992 Based on interview, observation and record review, the facility did not ensure that 4 of 54 sample residents who were unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Specifically, residents were not assisted with toileting or bathing as needed. This resulted in a finding of harm for one resident. Resident identifiers: 27, 60, 295 and 349. Findings include: HARM 1. Resident 27 was admitted on [DATE] and readmitted on [DATE] with diagnoses that included dementia, Parkinson's disease, neurocognitive disorder with Lewy Bodies, neuropathy, and insomnia. Resident 27's medical record was reviewed on 1/23/23. Resident 27's quarterly Minimum Data Set (MDS) assessment dated [DATE] was reviewed. The MDS indicated that resident 27 was severely cognitively impaired. The MDS indicated that resident 27 required extensive assistance of two people for bed mobility, transferring, dressing, and toilet use. The MDS indicated that resident 27 required extensive assistance of one person for personal hygiene and bathing. The MDS further indicated that resident 27 was unable to move on and off the toilet without staff assistance. The MDS also indicated that resident 27 was always incontinent of bladder, and frequently incontinent of bowel. And the MDS also indicated that resident 27 was at risk for pressure sores, and currently had Moisture Associated Skin Damage (MASD). On 2/8/22 facility staff developed a care plan for resident 27 indicating that the resident had an ADL (Activities of Daily Living) Self Care Performance Deficit r/t (related to) Immobility secondary to Parkinson's disease, impaired cognition secondary to Dementia with Lewy bodies . The goal listed was to safely perform bed mobility, transfers, eating, dressing, grooming, toilet use and personal hygiene through the review date. Interventions on the care plan included Requires Extensive assistance staff participation to use toilet, Requires Extensive assistance staff participation with transfer, and Requires Extensive Assistance staff participation to reposition and turn in bed. On 11/11/22 facility staff developed a care plan for resident 27 indicating that he had MASD to his sacrum related to incontinence. The care plan goal indicated that resident 27 Will be free from MASD through the review date. Interventions included encourage good nutrition and hydration in order to promote healthier skin, identify potential causative factors and eliminate/resolve, when possible, reposition frequently, treatment as ordered, and wound nurse to follow. Resident 27's medical record indicated that from 1/1/23 through 1/29/23, resident 27 required extensive assistance or was totally dependent on staff for bed mobility 69 of 79 opportunities. (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Few	On 10/20/22 a weekly skin evaluation indicated that resident 27 has reddened Non blanchable area to his LT (left) buttock. Area was cleaned and barrier cream applied. [Note: No documentation could be found to indicate that the wound nurse had observed the wound until 11/11/22, approximately 22 days later.] On 10/29/22 a nurses note documented, Coccyx with open area. Wound care tech came and treated wound. Cleaned wound Anasept applied then dressing. Wound care nurse was notified. [Note: The first wound note was not entered until 11/11/22, approximately 14 days later.] On 11/10/22 a nurses note documented, Pt (patient) continues to area (sic) to buttocks that is no (sic) blanchable. I had informed the MD in the past about this area. We have applied barrier cream and bridged him while in bed. I have informed the wound CNA (Certified Nursing Assistant) about area. On 11/11/22 a nurses note documented, Wound care team assessed sacrum, 2.3 [centimeter (cm)]x (by)3. 1xUTD (unable to determine) open area with redness in surrounding tissue wound bed is 40 slough, 30 granular, 30 macerated. entire area is blanching. On 11/16/22 resident 27 was assessed by a Physician Assistant-Certified (PA-C). The PA-C documented that the resident had MASD on his sacrum that had been present longer than one week. The size of the wound was documented as 2.3 cmx3.1 cm x UTD, with 90 percent granulation and 10 percent slough. The PA-C documented that the Tissue does blanch. The PA-C indicated that with each brief change, staff were to remove resident 27's dressing, cleanse the wound, apply skin prep to periwound, apply Medihoney to wound bed, and cover with Bandage. On 11/17/22, a Skin Ulcer Non-Pressure Weekly assessment was completed for resident 27. The assessment indicated that resident 27 had MASD to his sacrum that was 2.3x3.1xUTD . Patient has new MASD that is open, initial visit with wound provider this week, debrided with a curette to remove slough and macerated edges. Patient has barriers in wound healing of cognitive impairment and incontinence. MD (medical doctor) and family notified. On 11/18/22 a nurses note documented, Wound note MASD to sacrum wound nurse to call family. On 11/23/22, a Skin Ulcer Non-Pressure Weekly assessment was initiated for resident 27 but was left blank. On 11/23/22, resident 27 was assessed by a PA-C. The PA-C documented that resident 27's wound had increased in size and measured 2.5x3.4xUTD. On 11/28/22, a Skin Ulcer Non-Pressure Weekly assessment was completed for resident 27. The assessment indicated that the wound had increased in size and measured 2.5x3.4xUTD. On 12/5/22, resident 27 was assessed by a PA-C. The PA-C documented that Selective debridement due to slough today; 50 [percent] granular tissue with granular buds noted post debridement. Continue with current treatment. Pt is soiled today. On 12/12/22, a Skin Ulcer Non-Pressure Weekly assessment was completed for resident 27. The assessment indicated that the wound was unchanged in size from 11/28/22. (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Few	On 12/14/22, resident 27 was assessed by a PA-C. The PA-C documented that resident 27's wound measured 2.4x3.6xUTD. The periwound was described as Macerated. The PA-C documented that Sizes slightly larger after last week's debridement with increased granular tissue. Continue treatment. On 12/21/22, resident 27 was assessed by a PA-C. The PA-C documented that resident 27's sacrum had increased slough, so selective debridement was completed. On 12/28/22, a Skin Ulcer Non-Pressure Weekly assessment was completed for resident 27. The assessment indicated that resident 27's wound measured 2.1x2.5xUTD. On 1/1/23 a nurses note documented, Resident has ongoing pressure wound to coccyx, difficult for resident to turn on side. Has pressure reducing mattress in place. On 1/4/23, resident 27 was assessed by a PA-C. The PA-C documented that resident 27's wound measured 1x2.1x0.3. On 1/11/23, resident 27 was assessed by a PA-C. The PA-C documented that resident 27's wound measured 1.5x2.3x0.3, which indicated the wound had increased in size. On 1/27/23, a Skin Ulcer Non-Pressure Weekly assessment was completed for resident 27. The assessment indicated that the wound had not changed in size since 1/11/23. No documentation was located to indicate what days and times, if any, resident 27 refused to be repositioned or have his brief changed. On 1/30/23 at 11:30 PM, an observation was made of the Wound Nurse (WN) and CNA 2. The WN and CNA 2 were observed to enter the room of resident 27. Resident 27 was lying in his bed. The WN raised the resident's bed to approximately waist height and both the WN and CNA 2 pulled resident 27 toward the edge of the bed. The WN and CNA 2 then walked out into the hallway to obtain hand sanitizer. No side rails were observed to be pulled up on the bed, as resident 27 was lying on his right side, with his back near the edge of the bed, unattended by staff. The WN and CNA 2 returned to the bedside of resident 27 and donned gloves. The WN pulled back the soiled brief, and blood was observed on the brief. No dressing was observed on the wound. The WN cleaned the wound on resident 27 with dry gauze. Resident 27 said ouch as the wound was cleaned. The wound area had different shades of red, and dark red, neither area blanched when pressed on by the WN. The WN stated, We debrided last week, that's why it hurts. No pain alleviation was offered to resident 27. The WN again left the bedside to go to the hallway to obtain hand sanitizer. CNA 2 was standing at the foot of the bed with his back to the resident. While the WN was in the hallway, the soiled brief was observed to return to the original position and touch the cleaned wound. The WN donned gloves and returned to the bedside and repositioned resident 27 using the draw sheet on the bed. Her gloves were not observed to be changed. The WN applied ointment to a gloved finger then to the wound. The WN and CNA 2 were then called away to the doorway, the soiled brief again returned to its original position and touched the wound. The WN returned to the bedside, pulled the brief away from the wound and a new dressing was applied to the wound. The WN then put the soiled brief back in place over the new dressing on resident 27. At that time, both the WN and CNA 2 were observed to have left the room to obtain hand sanitizer, resident 27 was still observed to be close to the edge of the elevated bed with no side rails in position. Both staff then returned to reposition resident 27. (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Few	On 1/30/23 at 11:30 AM, an interview was conducted with Licensed Practical Nurse (LPN) 8. When asked about resident 27, LPN 8 stated that staff were instructed to help the resident turn and keep him off his bum. LPN 8 stated that resident 27 did not get out of bed or attempt to get out of bed during the nighttime hours. LPN 8 stated that resident 27's sacrum wound was old and that it was caused by staff not repositioning the resident or changing his incontinence briefs timely. LPN 8 stated that in the recent past, there would only be one CNA assigned to the memory care unit, which was not enough to ensure the safety and good care of the residents. POTENTIAL FOR HARM 2. Resident 60 was admitted to the facility on [DATE] with diagnoses that included dementia, cognitive communication deficit, diabetes mellitus, anxiety disorder, right hand contracture and muscle weakness. Resident 60's medical record was reviewed on 1/23/23. Resident 60's annual MDS assessment dated [DATE] was reviewed. The MDS indicated that resident 60 was severely cognitively impaired. The MDS indicated that resident 60 required extensive assistance with one staff member for bed mobility, dressing, eating, toilet use, personal hygiene, and bathing. The MDS also indicated that resident 60 required extensive assistance with two staff members for transfers. The MDS indicated that resident 60 did not ambulate independently and required the use of a wheelchair. The MDS further indicated that resident 60 was unable to move on and off the toilet without staff assistance. The MDS also indicated that resident 60 was always incontinent of bladder, and frequently incontinent of bowel. The MDS also indicated that resident 60 was at risk for pressure sores, and currently had MASD. On 12/6/20 facility staff developed a care plan for resident 60 indicating that the resident had an ADL Self Care Performance Deficit r/t Immobility secondary to dementia . The goal listed was to safely perform bed mobility, transfers, eating, dressing, grooming toilet use and personal hygiene through the review date. Interventions on the care plan included Requires Extensive assistance 1-2 staff participation to . use toilet, Requires Extensive assistance 1-2 staff participation with transfers, and Requires Extensive Assistance 1-2 staff participation to reposition and turn in bed. On 1/6/21 facility staff developed a care plan for resident 60 indicating that resident 60 had bowel and bladder incontinence. Interventions included the use of disposable briefs for resident 60, and that the briefs should be changed with rounds, cares and as needed. On 1/25/23 the following observations were made of resident 60: a. At 10:02 AM, the resident was seated in her wheelchair by the main nurse's station in the 100 hall. b. At 11:10 AM, staff wheeled resident 60 into the day room. c. At 12:23 PM, staff wheeled resident 60 from the day room directly to the dining room. d. At 1:42 PM, staff wheeled resident 60 from the dining room directly to the day room. (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Few	On 2/9/18 facility staff developed a care plan for resident 349 indicating that the resident had an ADL Self Care Performance Deficit r/t functional mobility, strength and reduced balance, dementia . The goal listed was to maintain current level of function in bed mobility, transfers, eating, dressing, grooming toilet use and personal hygiene through the review date. Interventions on the care plan included requires assistance (one person extensive) to . use toilet, Requries (sic) (one person extensive staff participation with transfers, and Requires extensive assistance staff participation to reposition and turn in bed. On 6/30/21 facility staff developed a care plan for resident 349 indicating that resident 349 had bowel and bladder incontinence. Interventions included the use of disposable briefs for resident 349, and that the briefs should be changed with rounds, cares and as needed. On 1/25/23 the following observations were made of resident 349: a. At 10:02 AM, the resident was seated in her wheelchair in the day room. b. At approximately 12:30 PM, staff wheeled resident 349 from the day room directly to the dining room. d. At 1:44 PM, staff wheeled resident 349 from the dining room directly to the day room. e. At 1:51 PM, the observation ended. At no time during the continuous observation was resident 349's incontinence brief changed, nor was resident 349 repositioned. On 1/25/23 at 1:51 PM, an interview was conducted with CNA 14. CNA 14 stated that she was paired with CNA 15 that day. CNA 14 stated that they showered resident 349 at approximately 6:25 AM that morning, but that they had not changed resident 60's incontinence brief after that. On 1/25/23 at 1:54 PM, an interview was conducted with CNA 13. CNA 13 stated that she and CNA 16 had changed resident 349's incontinence brief that morning before breakfast. CNA 13 confirmed that she had not changed resident 349's incontinence brief since that time. CNA 13 stated that she was about to do rounds again with CNA 16, and they would change resident 349's incontinence brief. On 1/25/23 at 1:57 PM, an interview was conducted with CNA 15. CNA 15 stated that resident 349 required extensive assistance of staff to change her incontinence brief. CNA 15 stated that the typical schedule was to change the residents' incontinence briefs when she arrived for her shift at 6:00 AM, then at 9:00 AM, before lunch, after lunch, and at 2:00 PM before she left her shift. CNA 15 stated that she and CNA 14 had changed resident 349's incontinence brief when they first arrived for their shift at 6:00 AM, but had not changed it since then. CNA 15 stated that CNAs assigned on the 100 hall did not have assigned residents, we just help each other and we communicate. On 1/25/23 at 2:19 PM, an interview was conducted with CNA 16. CNA 16 confirmed that he did not change resident 349's incontinence brief after the initial brief change that morning. (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Few	On 1/30/23 at 3:37 PM, an interview was conducted with the facility Director of Nursing (DON). The DON stated that facility CNAs were provided a sheet to document if a resident received a brief change, and how often they should be checked. The DON stated that facility staff should be checking residents' incontinence briefs every couple of hours. When asked how the facility management was ensuring that briefs were being changed timely, the DON stated that facility staff were asking the [CNAs] if they have done their brief changes. On 1/30/23 at 3:17 PM, an interview was conducted with the facility Administrator (ADM). The ADM was asked what interventions had been put into place since November 2022 when the facility was cited for F677 after multiple residents were identified as not having their incontinence briefs changed in a timely manner. The ADM stated that they the CNA Coordinator was reviewing the electronic health record documentation to ensure the staff were documenting brief changes. When asked if there was a specific auditing process in place, the ADM stated there was not. When asked if observations were being made by facility management to ensure brief changes were occurring versus being documented, the ADM stated that intervention had not been put into place. 44640 4. Resident 295 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included sepsis, urinary tract infection, extended spectrum beta lactamase resistance, quadriplegia, hypertension, gastroparesis, malnutrition, ileostomy status and cachexia. On 1/23/23 at 10:00 AM, an interview was conducted with resident 295. Resident 295 stated he wished he could have a more thorough bed bath when he got one. Resident 295 stated he didn't get one very often, maybe once a week. Resident 295 stated a bed bath more often might be nice. An observation was made of resident 295. Resident 295's hair was oily, combed back, and large amounts of dandruff were observed in resident's 295's hair. On 1/24/23, resident 295's medical record was reviewed. Review of resident 295's bathing task for the last 30 days revealed resident 295 was not available on 12/28/22 (resident was in the local hospital), resident refused on 1/4/23, and resident refused on 1/23/23. All other dates were marked with not applicable (N/A) which meant per the certified nurses aides (CNA's) this task was not performed. On 3/12/22 a baseline care plan documented that resident 295 was at risk for alterations in Activities of Daily Living (ADLs) due to weakness, decline in function and mobility, bowel obstruction, status post-surgery and quadriplegia. An intervention documented resident required staff participation with bathing. An MDS dated [DATE] revealed resident 295 was totally dependent on staff with the bathing task and required substantial/maximal assistance with showering/bathing. Review of resident 295's bathing task revealed the residents bathing preference was day (AM), evening (PM) with as needed (PRN) night (NOC). Resident 295 had a shower schedule of Mondays, Wednesdays, and Fridays. (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Few	Resident 295's shower/bathing history for the month of October 2022 revealed: a. 10/5/22 Sponge bath b. 10/7/22 Resident refusal c. 10/12/22 Sponge bath d. 10/19/22 Sponge bath e. 10/26/22 Resident refusal No resident refusal forms were provided by the facility for the 10/7/22 or 10/26/22. Resident 295 went 13 days from when a bath refusal was documented on 10/26/22 to when another bath was offered on 11/8/22. Resident 295's shower/bathing history for the month of November 2022 revealed: a. 11/8/22 Resident refusal b. 11/16/22 Resident refusal c. 11/23/23 Sponge bath d. 11/30/22 Resident refusal No resident refusal forms were provided by the facility for the month of November. Resident 295 went 14 days from when a bath refusal was documented on 11/30/22 to when a bath was documented on 12/14/22. Resident 295's shower/bathing history for the month of December 2022 revealed: a. 12/14/22 Sponge bath b. 12/21/22 Resident refusal c. 12/28/22 Resident unavailable (resident hospitalized) No resident refusal forms were provided by the facility for the month of December. Resident 295's shower/bathing history for the month of January 2023, up until the survey date, revealed: a. 1/4/23 Resident refusal b. 1/23/23 Resident refusal (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Few	A resident refusal form for 1/23/23 was not provided by the facility. On 1/26/23 at 12:40 PM, an interview was conducted with CNA 2. CNA 2 stated resident 295 was always good with cares and taking his bath, he was cooperative. CNA 2 stated he thought resident 295 was scheduled 2 or 3 times a week for a bath. CNA 2 stated resident 295 usually wouldn't ask for things so they had to anticipate his needs. On 1/30/23 at 1:10 PM, an interview was conducted with the CNA Coordinator (CNAC). The CNAC stated the CNAs were assigned to an area when they come on shift, and some CNAs did showers and some did resident care. The CNAC stated that the CNAs had a shift sheet which gave them information on the residents, and it included if residents were an every 2 or 4 hour turn, when their bath was and other needed information. The CNAC stated that the facility had a concierge service that did not do resident care but helped with getting waters, cleaning equipment and other things so the CNAs had more time with the residents. The CNAC stated that CNAs were expected to complete the tasks, including baths, that they were assigned for their shift and if they were unable to do this they were supposed to pass this information on to the oncoming shift. On 1/30/23 at 3:27 PM, an interview was conducted with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) 1. The DON stated the CNAs were supposed to shower the residents on their scheduled shower days, unless the resident refused then the CNA was supposed to offer another day. The CNAs were supposed to have the residents sign a refusal form every time they refused a shower. The ADON 1 stated the residents' shower days were in the care plan so the CNAs and the nurses knew when they were and treatments could be coordinated if needed. [Cross refer to F867]

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46232 Based on interview and record review it was determined that the facility did not ensure, for 1 of 54 sample residents, that all residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents choices. Specifically, one resident developed a penile wound and did not promptly receive appropriate wound care follow up and no investigation was done on the cause of the wound. The deficient practice identified was found to have occurred at a harm level. Resident Identifier: 244. Findings include: Resident 244 was admitted to the facility on [DATE] with diagnoses that included but not limited to gastro esophageal reflux disease, muscle weakness, major depressive disorder, anxiety disorder, and insomnia. Resident 244's medical record was reviewed on 1/24/23. A Plan of Care problem with an effective date of 1/4/17 documented that resident 244 required extensive assist for bed mobility, transfers, eating, toilet use and personal hygiene. An intervention implemented on 1/4/17, documented that resident 244 required skin inspections such as observing for redness, open areas, scratches, cuts and bruises. Another intervention implemented on 1/23/23 documented that resident 244 had actual impairment to his skin integrity related to trauma to penis. An intervention implemented on 1/23/23 documented resident 244 needed to be encouraged to have good nutrition and hydration in order to promote healthier skin. A physician order with a start date of 11/6/22 documented as followed, Wound care to top of penis, betadine and open to air every shift for trauma to penis. A nursing progress note dated 10/13/22 documented, Resident 244's sores around his penis are getting much worse. On the dorsal side it now looks like a hematoma has formed and he is complaining of extreme pain with brief changes . Needs to be followed up with wound care. [Note: Resident 244 was seen by wound care 13 days later on 10/26/22.] A physician progress note dated 12/1/22 documented that on 10/13/22 resident 244 had a dark red lesion to the lateral right aspect of his glans penis. There was no open lesion or drainage noted. The physician documented that lesions/sore appeared to be from friction and positioning. Wound care provider progress notes documented: a. Resident 244 was first seen by the wound care provider on 10/26/22 and identified resident wound was caused by trauma and stated the resident's penis had dark discoloration. b. Wound notes on 11/9/22, 11/16/22, 11/23/22, 11/30/22, and 12/7/22 stated that the wound was stable and the discoloration was lightening up. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	c. Wound note on 12/19/22 stated, Wound is getting smaller and there seems to be some hemosiderin staining without any open area. Continue current treatment plan. d. Wound notes for 12/28/22, 1/2/23, and 1/11/23 documented that the wound was stable and had improved as well as had decreased in size. Skin Ulcer non pressure weekly assessments revealed: a. On 11/6/22 it was documented that the onset of the penile wound was on 10/26/22. It stated that there was a dark discoloration to the trauma site at the top of the penis and that the wound was stable and there were no signs of infection. b. On 11/18/22 resident 244's penile wound was described as epithelial tissue that was dark red/purple and lightening up. c. On 12/12/22 it was documented that, wound continues to improve in discoloration continue iodine and open to air. Patient has barriers in wound healing of limited mobility, incontinence and wearing briefs due to incontinence. Weekly Skin evaluations dated 9/26/22, 10/10/22 and 10/31/22 revealed that resident 244's scrotal area was excoriated. No documentation could be located to indicate an investigation was completed regarding how resident 244 obtained the penile wound. On 1/30/23 at 8:55 AM, a wound observation was done on resident 244 while he got his brief changed. Resident was observed to be thin, no lines on the skin were noted from the brief being too tight. Resident 244's penis was noted to be in the center of peri area, pointing downward and the scrotal sac laid flat against the perineum. Resident 244's penis did not appear to have enough length to have been pinched in between either thigh. Certified Nursing Assistant (CNA) 4 was observed to hold the penis in his left hand and pulled the skin back, away from the head of the penis with his right hand. A ruby red area was noted on the resident's right side of the head of the penis; around the penis rim, the area had a center spot with spindles that came from the center area in every direction. The area was uniform in color. No drainage was noted and no open area noted to the penis. The same red discoloration was noted on the base of the scrotum in three different areas, one larger and two smaller areas. This was seen when resident 244 was rolled onto his left side and the buttocks area was viewed. The resident was rolled back to his back and the scrotum was lifted up; no other reddened areas were noted on the scrotum. Paste was applied to resident 244's buttocks and a brief was put under the resident. On 1/25/23 at 10:45 AM, an interview was conducted with CNA 7. CNA 7 stated that resident obtained his penile wound because he slid down in bed and sat on his penis. CNA 7 stated resident 244 has had this wound since November. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 1/25/23 at 10:48 AM, an interview was conducted with the Wound Physician Assistant (WPA). The WPA stated that resident 244 obtained his penis wound because the resident sat on it. The WPA stated when he first saw the penile wound, there was discoloration on it but stated that the color of it had improved. The WPA stated it was never an open wound but they applied betadine to protect his skin. The WPA stated resident 244's wound was stable enough that the nurses were applying betadine. On 1/30/23 at 8:55 AM, an interview was conducted with CNA 4 while he completed a brief change on resident 244. CNA 4 stated resident 244's penile wound happened because of the way resident 244 bent his legs that caused his penis to be pinched. CNA 4 was told it was a bruise and stated that resident 244's penis was black when he first saw it. CNA 4 stated he was unsure how long the penis was left in any certain position for it to have turned black. CNA 4 stated it was a significantly worse bruise when they discovered it back in December and stated the bruise was heading in the right direction since it had improved. CNA 4 stated they were told to keep a close eye on resident 244's penis and was told to notify the nurse if there were any concerns. CNA 4 stated they came in every 2 hours and repositioned resident 244. CNA 4 stated when a new brief was put on resident 4, they pulled the scrotum and the penis up in the center of the peri area and then put the brief in place. CNA 4 stated this was how the scrotum and penis were protected from being pinched. On 1/30/23 at 10:53 AM, an interview was conducted with the Wound Nurse (WN). The WN stated that resident 244's penile wound was due to a catheter he had while he was hospitalized . The WN stated that was what the wound care provider said at the initial evaluation of 244's penile wound on 10/26/22. The WN stated resident 244's wound had gotten smaller and the discoloration had lightened up. The WN stated the current wound care orders were to apply iodine to resident 244 penis. The WN stated the iodine helped lighten the bruising and it created a barrier that helped protect the skin. On 1/30/23 at 11:02 AM, an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated resident 244 has had the penile wound for several for months. LPN 1 stated that it looked really bad when it was first discovered. LPN 1 stated that initially the resident's penis wound was tomato red in color. LPN 1 stated that resident 244 complained of a lot of pain when his wound was first discovered but stated he no longer complained of pain. LPN 1 stated the wound care nurse did the wound care on Mondays, Wednesdays and Fridays. LPN 1 stated the wound care orders were to apply betadine to resident 244's penis. On 1/30/23 at 12:26 PM, an interview was conducted with the Certified Nursing Aid Coordinator (CNAC). The CNAC stated that resident 244's skin appeared to be really thin and they were careful during brief changes to avoid any skin issues. The CNAC stated that resident 244 sometimes got a sore underneath his penis because of how sensitive and delicate his skin was. The CNAC stated she was not aware that resident 244 had a sore on his penis. The CNAC stated that when a new skin issue was discovered on any resident, their protocol was to notify the resident's nurse and wound nurse right away. The CNAC stated that resident 244 was able to reposition himself if he was uncomfortable but stated facility staff repositioned him every two hours. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 1/30/23 at 4:13 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that resident 244's penile wound happened because the resident's penis was long and the resident sat on it. The DON stated that staff had to constantly go back and pull resident 244's penis out from underneath him. The DON stated wound care should have evaluated resident 244 sooner than 10/26/22. The DON stated that staff knew the protocol for getting the wound care nurse involved. The DON stated that if any staff noticed a wound, they notified the wound care nurse that same day. The DON stated she was unsure why there was a 13-day delay for wound care to see resident 244 and that no investigation was done on his penile wound. [Cross refer to F692]

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F 0689 Level of Harm - 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** 47432 Based on observation, interview and record review, for 3 of 54 sampled residents, that the facility did not ensure that the residents' environment remained as free of accident hazards as is possible. Specifically, one resident with a history of falls was left unattended and subsequently fell out of bed, receiving an eye laceration. The deficient practice for this resident was cited at a harm level. In addition, one resident with a history of falls was observed to not have interventions in place, and one resident was left unattended at the side of his bed. Resident identifiers: 27, 41 and 146. Findings include: HARM 1 . Resident 146 was admitted to the facility on [DATE] with diagnoses that included osteoarthritis, polyneuropathy, Parkinson's disease and generalized anxiety disorder. Resident 146's medical record was reviewed on 1/23/23. On 1/6/23 a Fall Committee note indicated that resident 146 had experienced 3 falls where she was found on the floor mat next to her bed. No injuries occurred . already in a low bed and a floor mat has been added. She has dementia and is not aware of her own safety. Will continue to try and keep her from having an injury but she will climb out of bed. An incident report dated 1/8/23 at 11:30 PM stated that, Pt (Patient) found lying face flat on the floor at 2330 (11:30 PM) yelling for help. When turned over to back pt (patient) had blood all over face two gashes found above and under right eye Gashes were heavily bleeding. Bruising on rt (right) eye and chin. Wound treated. Neuro status at baseline, awake and responsive with pupils dilating wnr (within normal range). Family contacted without success. Provider [Medical Director] notified and acknowledged. Pt to be sent to hospital for stitches and CT [computerized tomography] scan. On 1/11/23 a Fall Committee note indicated that resident 146 was found with two gashes . above and below right eye. Bruising noted on right eye and chin. Resident had rotator cuff injury to left arm with sling in place . Right eye laceration was treated and closed with glue. On 1/30/23 at 10:09 AM, Licensed Practical Nurse (LPN) 1 was interviewed. LPN1 stated that the day of Resident 146's fall on 1/8/23, resident 146 had received an x-ray. LPN 1 stated after the x-ray tech finished working with Resident 146, the x-ray tech left Resident 146's bed in the high position and did not replace the floor mat, which was moved so the x-ray could be taken. On 1/30/23 at 12:07 PM, LPN 2 was interviewed. LPN 2 stated she was the staff member that found resident 146 after the fall on 1/8/23. LPN 2 stated that the bed was in the high position, that the bed mat was not in place when the fall on this date occurred, and that the bed rails were not in place when this fall occurred. LPN 2 stated that the x-ray tech left the bed in the high position and did not replace the floor mat. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	An incident report dated 1/13/23 at 11:50 PM stated that, . was found on the floor in her room on floor mat. Bed was in lowest position. Removed air mattress d/t (due to) every time . gets close to the edge of the bed she rolls out with the air mattress. Record review of Resident 146's Minimum Data Set (MDS) Annual assessment dated [DATE] documented that resident 146 has a Brief Interview for Mental Status (BIMS) score of 3, indicating that resident 146 has a severe cognitive impairment. This MDS Annual Assessment also documented that resident 146 requires assistance to complete Activities of Daily Living (ADLs). On 01/25/2023 at 10:22 AM, Resident 146 was observed laying in her bed. The bed was placed low to the ground and there was a fall mat next to her bed. POTENTIAL FOR HARM 2 . Resident 41 was admitted to the facility on [DATE] with diagnoses that included Huntington's disease, insomnia, and dementia. Resident 41's medical record was reviewed on 1/23/23. An incident report dated 12/29/2022 at 6:55 AM stated, CNAs (certified nursing assistants) were doing their rounds around 0430 (4:30 AM) and walked into Res (resident) room and found her on the floor. Her head was on the opposite side of the headboard laying on her blanket. Her legs were under her bed and she had a small skin tear and bruise on her right upper front hip area. She was awake and responding but was having a hard time breathing. She was put back on her bed. Resident unable to give Description. Her vitals were taken and we started neuro checks. Her BP (blood pressure) was 134/100, P (pulse) 89, O2 (oxygen) 77, RR (respiratory rate) 20. She seemed to have some trouble breathing so I started her on 2L (liters) of oxygen and tested her or [sic] covid. Her O2 (oxygen) went up to 88 and her covid test came back positive. Her pupils were reactive and she has some weakness on her left arm compared to her right arm. She was reacting to her name and was Ox3. Neuro checks are being done according to the times on sheet. A tiger text was sent to provider [Medical Director] and DON (Director of Nursing). An incident report dated 1/20/23 at 4:05 PM stated, The CNA reported that resident was trying to fight with brief change and trying to hit/kick him and then fell out of bed and hit her head on the floor. The bleeding from corner of R (right) eye laceration. The nursing staff helped her back in bed, assessed, the bleed from corner of R (right) eye laceration. The laceration site seen by wound nurse and ADON (Assistant Director of Nursing) , new order to send her out to ER (emergency room). Resident has sent to ER. The care plan, orders, and Minimum Data Set (MDS) Assessments for resident 41 were reviewed. Resident 41 had orders for a fall mat to be next to her bed and for her bed to be in the low position since 9/15/22. Resident 41's Quarterly MDS dated [DATE] documented that Resident 41 has Brief Interview for Mental Status (BIMS) score of 99, indicating that the resident was unable to complete the interview. The MDS also documented that Resident 41 required assistance to complete Activities of Daily Living (ADLs). On 1/25/23 at 10:24 AM, Resident 41's room was observed. There was no fall mat next to her bed, and the bed was not in a low position. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 1/25/23 at 1:44 PM, CNA 1 was interviewed. CNA1 stated that Resident 41 fell down sometimes, so there should be cushioning on the floor next to Resident 41's bed and the bed should be in a low position. 44640 3. On 1/30/23 at 11:30 PM, an observation was made of the Wound Nurse (WN) and CNA 2. The WN and CNA 2 were observed to enter the room of resident 27. Resident 27 was lying in his bed, the WN raised the resident's bed to approximately waist height and both the WN and CNA 2 pulled resident 27 toward the edge of the bed. The WN and CNA 2 then walked out into the hallway to obtain hand sanitizer. No side rails were observed to be pulled up on the bed. The WN and CNA 2 returned to the bedside of resident 27, gloves were donned. The WN pulled back the soiled brief, blood was observed on the brief. No dressing was observed on the wound. The WN cleaned the wound on resident 27 with dry gauze. Resident 27 said ouch as the wound was cleaned. The wound area had different shades or red, and dark red, neither area blanched when pressed on by the WN. The WN stated, We debrided last week, that's why it hurts. No pain alleviation offered to resident 27. The WN again left the bedside to go to the hallway to obtain hand sanitizer. CNA 2 was standing at the foot of the bed with his back to the resident. While the WN was in the hallway, the soiled brief was observed to return to the original position and touch the cleaned wound. The WN donned gloves and returned to the bedside and repositioned resident 27 using the draw sheet on the bed. Gloves were not observed to be changed. The WN applied ointment to a gloved finger then to the wound. The WN and CNA 2 were then called away to the doorway, the soiled brief again returned to its original position and touched the wound. The WN returned to the bedside, pulled the brief away from the wound and a new dressing was applied to the wound. The WN then put the soiled brief back in place over the new dressing on resident 27. At that time, both the WN and CNA 2 were observed to have left the room to obtain hand sanitizer, resident 27 was still observed to be close to the edge of the elevated bed with no side rails in position. Both staff then returned to reposition resident 27.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44640 Based on interview and record review it was determined, for 1 out of 54 sampled residents, the facility did not ensure residents who were incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. Specifically, a resident did not receive catheter care in coordination with good nursing care and as outlined in the residents care plan and went to the hospital for treatment. Resident identifiers: 295. Findings included: Resident 295 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included sepsis, urinary tract infection, extended spectrum beta lactamase resistance, quadriplegia, hypertension, gastroparesis, malnutrition, ileostomy status and cachexia. On 1/24/23, resident 295's medical record was reviewed. On 1/23/23 at 10:00 AM, an interview was conducted with resident 295. Resident 295 stated he had a catheter and an ileostomy. Resident 295 stated facility staff hardly ever provided him with catheter care, he would try to do it the best he could with wipes. Resident 295's hands were observed to be very stiff, all four fingers on both hands were straight out and his thumbs were folded into the palms. It was observed that resident 295 had difficulty when trying to grab the container of wipes with both hands. Resident 295's latest quarterly Minimum Data Set (MDS) assessment was performed on 12/20/22. Resident 295's MDS revealed the following: a. Resident 295 was dependent for toileting and the helper performed all the physical effort. b. Resident 295 required one person assistance for catheter care. c. Resident 295 required substantial/maximal assistance for rolling left and right, moving for sitting to lying or lying to sitting, and transferring, including toilet transferring. d. Resident 295 was always incontinent of urine and bowel. Resident 295's care plan revealed the following: a. Has indwelling catheter, provide catheter care every shift and as needed. b. Monitor/document for pain/discomfort due to catheter. Physician order dated 3/12/22 revealed, Indwelling catheter care as needed. The Treatment Administration Record (TAR) for November 2022 revealed, catheter care was completed one time on 11/9/22. No other dates in November were documented. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The TAR for December 2022 revealed, catheter care was not completed. The TAR for January 2023 revealed, catheter care was not completed. A Daily Skilled Note dated 1/23/23 revealed, Foley care provided during shift. A hospital history and physical (H&P) dated 12/28/22 revealed, resident 295 was admitted to the hospital for sepsis secondary to a urinary tract infection (UTI). The H&P revealed that resident 295 stated, that Foley care at the care center he had been managing himself. Resident 295's discharge instructions from a the local hospital on 1/1/23 revealed the reason for the stay was treatment for sepsis secondary to a UTI. On 1/26/23 at 12:40 PM, an interview was conducted with Certified Nursing Assistant (CNA) 2. CNA 2 stated catheter care should be done with every set of cares and brief change. CNA 2 stated the CNAs were supposed to let the nurses know if anything is wrong with the catheter. On 1/30/23 at 1:15 PM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated the nurse should be doing catheter care once a shift and it was supposed to be documented in the TAR when it was done. On 1/26/23 at 1:50 PM, an interview was conducted with CNA 5. CNA 5 stated when catheter care was completed the CNA should clean the area with a warm wash cloth and use alcohol to disinfect the catheter tubing and empty the catheter bag. On 1/30/23 at 3:27 PM, an interview was conducted with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) 1. The DON stated the CNAs and nurses were supposed to do catheter care every shift. The DON stated staff were supposed to document it in the medical record. The ADON 1 stated the nurses were supposed to check the catheter for sediment and make sure it was functioning correctly. The DON stated it was ultimately the nurses responsibility to make sure the catheter was taken care of appropriately.

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F 0692 Level of Harm - Actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22992 Based on interview, observation and record review, the facility did not ensure that 3 of 54 sample residents maintained acceptable parameters of nutritional status. Specifically, residents with weight loss did not receive timely and appropriate interventions. This will be cited at a harm level for all three residents. Resident identifiers: 33, 47, and 244. Findings include: HARM 1. Resident 33 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included dementia, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, anxiety disorder, osteoporosis, pseudobulbar affect, major depressive disorder, and hypertension. Resident 33's medical record was reviewed on 1/23/23. Resident 33's weights were recorded as follows: a. 7/5/22 - 179.2 pounds (lbs) b. 1/3/23 - 169.4 lbs The weight loss above is a 5.5 percent weight loss in six months. No other weights were recorded for resident 33 between 7/5/22 and 1/3/23. In addition, no weights were recorded after 1/3/23 as of 1/23/23. Review of resident 33's nursing progress notes indicated that no notes had been entered regarding resident 33's weight loss. A Nutrition/Hydration Risk Evaluation dated 1/16/23 indicated that resident 33's weight status was Stable within 3 Months. No indication was made as to how the staff member made this determination. The Evaluation indicated that the resident was at Medium Risk. The Evaluation did not indicate any interventions for resident 33 to maintain or improve his nutritional status. Review of resident 33's assessments indicated that no other nutrition assessments had been completed for resident 33. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Some	On 1/30/23 at 3:38 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that she was part of the Nutrition at Risk (NAR) committee. The DON stated that each week the facility Registered Dietitian (RD) provided the NAR committee members with a list of residents who had experienced weight loss. The DON stated that after a resident experienced weight loss, they were typically reweighed weekly, and evaluated in the weekly NAR meeting until their weight stabilized. The DON stated that residents' weights usually have to be stable for several weeks before the residents would be removed from the list of residents who required weekly weights. The DON confirmed that resident 33 had not been re-weighed or re-evaluated by the NAR committee after experiencing a 10 pound weight loss. The DON did not provide an explanation as to why the resident had not been weighed weekly after the identified weight loss occurred. 2. Resident 47 was admitted on [DATE] with diagnoses that included dementia, diabetes mellitus, hypertension, bipolar disorder, cognitive communication deficit, dysphagia and history of traumatic brain injury. Resident 47's medical record was reviewed on 1/23/23. Resident 47's weights were recorded as follows: a. 6/7/22 - 188 lbs b. 7/5/22 - 186 lbs c. 8/2/22 - 178 lbs d. 8/9/22 - 176 lbs e. 9/6/22 - 174 lbs f. 10/4/22 - 173 lbs g. 11/1/22 - 174 lbs h. 12/6/22 - 169 lbs i. 1/3/22 - 163 lbs No weights were recorded after 1/3/23 for resident 47 as of 1/23/23. The weight loss above is a 12.4 percent weight loss in six months. On 12/6/22, the facility NAR committee recommended to increase resident 47's supplement to 60 milliliters twice daily. On 1/5/22, the facility NAR committee recommended to increase resident 47's supplement to 120 milliliters twice daily. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Some	On 1/30/23 at 3:38 PM, an interview was conducted with the facility DON. The DON confirmed that resident 47 had not been re-weighed or re-evaluated by the NAR committee weekly after experiencing a 6 pound weight loss between 12/6/22 and 1/3/22. The DON also confirmed that the NAR committee had not re-evaluated resident 47 after 1/3/23. The DON did not provide an explanation as to why the resident had not been weighed weekly after the identified weight loss had occurred. 46232 3. Resident 244 was admitted to the facility on [DATE] with diagnoses that included gastroesophageal reflux disease, muscle weakness, major depressive disorder, anxiety disorder, and insomnia. Resident 244's medical record was reviewed on 1/24/23. An annual Minimum Data Set (MDS) assessment dated [DATE], documented that resident 244 required supervision assistance by one person to eat his meals. In addition, a quarterly MDS assessment dated [DATE] documented that resident 244 had a Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment. Resident 244's care plan was reviewed. The focus area of the care plan that related to Activities of Daily Living (ADLs) for resident 244 dated 1/4/17 documented that resident 244 required extensive assistance for eating. The focus area of the care plan that related to nutrition dated 1/24/17 documented that resident 244 was at nutritional risk as evidenced by periods of decreased oral intake. An intervention implemented on 1/1/18 documented that resident 244 would have weekly weights for 30 days and monthly if stable and to promptly identify signs and symptoms of weight loss and dehydration. The last update to the nutritional risk focus area was on 12/22/22 that indicated the resident will be offered food and fluids and encouraged to eat. The update also indicated that weight loss was expected, but did not indicate the reason. On 7/5/22, staff documented that resident 244 weighed 185 lbs. On 8/2/22, staff documented that resident 244 weighed 179.4 lbs. A nurse practitioner/ physician assistant progress note dated 8/25/22 documented that resident 244 had some noted weight loss recently due to food preferences. No weights were documented for resident 244 between 8/2/22 and 11/2/22. On 11/2/22, staff documented that resident 244 weighed 187 lbs. On 12/6/22, staff documented that resident 244 weighed 173.2 lbs. On 12/6/22, a physician note indicated that a follow up visit was requested due to reported weight loss. Resident has not been eating well. He does report some depression but not as bad as it was before. He does not want to get up out of bed to participate in meals in the dining room as discussed as an option. He is willing to do mirtzapine if any more wt (weight) loss. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Some	A Nutrition Interdisciplinary Team Update for resident 244 dated 12/7/22 was reviewed. The Update indicated that resident 244 had lost 7.4 percent of his body weight in one month, and that he was only eating an average of 40 percent of his meals. The Update also indicated that a family member was notified of wt (weight) change via phone call, she is concerned about the loss and would like him to receive additional supplement drinks if possible. She would also like to to (sic) ensure that he is getting the feeding assistance that he needs d/t (due to) his tremors and would like staff to encourage him to come to the dining room for meals. NAR team recommends switch supplement. No indication was made on the Update that resident 244 would received increased assistance with dining, or would be encouraged to eat in the dining room. [Note: This is the only NAR meeting note for resident 244 between 7/1/22 and 1/24/23.] On 12/7/22 a physician note indicated that the physician was visiting with resident 244 and his sister. She is at residents bedside helping him with lunch. She expressed that he has significant difficulty with eating and is taken (sic) a long time to eat the food that he has so far. On 12/13/22, staff documented that resident 244 weighed 172 lbs. A Registered Dietitian Nutritional Risk Review dated 12/22/22 documented that resident 244 had experienced an 8 percent weight loss since 11/2/22, but that a fortified diet and supplements were being given. No other interventions were listed. A nurse practitioner/ physician assistant progress note dated 12/27/22 documented that resident 244 sister expressed concerns on 12/7/22 about resident 244's difficulty eating and stated it took resident 244 a long time to eat the food that he had so far. A new patient encounter progress note dated 1/3/23 documented that resident 244 had reportedly been losing weight. November 2 he weighed 187 pounds, today he weighs 168 which is a 10% weight loss. He states his appetite has not been very good as he just has not felt well. He remains at risk for significant weight loss and malnutrition. On 1/4/22, staff documented that resident 244 weighed 168 lbs. The exact meal percentage consumption for the last 30 days from 12/28/22 through 1/25/23 documented that resident 244 had consumed 50 % or less of his meals for 46 out of 72 documented times. The snack consumption for the last 30 days from 12/2822 through 1/25/23 documented that resident 244 accepted a snack 3 times out of the 24 instances documented. On 1/23/23 at 10:25 AM, Resident 244 was observed sitting up in his bed with his eyes closed. A breakfast meal tray was observed on a bedside table in front of resident 244. Most of the food on the breakfast tray appeared to be untouched except for the cereal. On 1/25/23 at 12:05 PM, Resident 244 was observed to have his eyes closed when his lunch tray was dropped off. The lunch tray was observed on a bedside table located to the right of resident 244. Resident 244 eye's continued to appear closed until 12:16 PM when the observation ended. On 1/25/23 at 1:47 PM, Resident 244 was observed to have his eyes closed and the lunch tray at his bedside appeared untouched. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Some	On 1/26/23 at 10:00 AM, Resident 244 was observed to have his eyes closed and had napkin placed across his chest with a handful of cheerios scattered across the napkin. A breakfast meal tray was observed on a bedside table in front of the resident. The breakfast meal tray had a piece of toast with jelly, a cut up sunny side up egg and a bowel of cheerios. The cheerios were the only item of food that appeared to have been eaten by the resident. On 1/26/23 at 12:10 PM, Resident 244 was observed to be sitting up in bed and staring at his food with shaking hands. A lunch tray comprised of meat and rice was observed on a bedside table located in front of resident 244. Resident 244 was observed to stare at his food for 17 minutes before he picked up his cup of milk with a shaky hand. Resident 244 was observed to bring the cup of milk to his mouth without spilling but began to cough when he drank the milk. Resident 244 was then observed to spill the remainder of his milk as he tried to put the cup back on his bedside table. A follow up interview was conducted with resident 244. Resident 244 stated he did not like his food and he did not plan to eat it. Resident 244 stated the only thing he liked was the milk and that he was not hungry. On 1/26/23 at 1:17 PM, Resident 244 was observed to have his eyes closed and his lunch tray appeared to be untouched expected for the milk he drank. On 1/30/23 at 12:07 PM, Resident 244's sister was observed to feed resident 244 homemade soup. A follow up interview was conducted with resident 244. Resident 244 stated he needed help feeding himself. Resident 244 stated that staff took his meal trays away and had not offered him any meal substitutions when he did not like the food. On 1/26/23 at 11:15 AM, an interview was conducted with Certified Nursing Assistant (CNA) 3. CNA 3 stated the resident 244 was an extensive two person assist and needed to be pulled up in bed for every meal. CNA3 stated that resident 244 ate in his room and that he was capable of feeding himself. CNA 3 stated that the only help resident 244 required with meals was to have his tray set up for him. CNA3 stated they were unsure the percentage of meals that resident 244 ate. On 1/25/23 at 12:34 PM, an interview was conducted with the Minimum Data Set Coordinator (MDSC). The MDSC stated that resident 244 was able to feed himself and only required setup assist with his tray. The MDSC stated that resident 244 didn't always eat all his food because he didn't like what he was served. The MDSC stated that resident 244 got a supplement with his meals. On 1/26/23 at 10:46 AM, an interview was conducted with CNA 2. CNA 2 stated that resident 244 ate about 25% of his breakfast that day. CNA 2 stated resident 244 didn't usually eat very much of his meals. CNA 2 stated that resident 244 was capable of using silverware and was able to feed himself and did not require any help that the CNA was aware of. On 1/26/23 at 12:35 PM, an interview was conducted with the Occupational Therapist (OT). The OT stated they had not worked with resident 244 since October 2022. The OT was asked if resident 244 was able to feed himself with his shaky hands and the OT responded that they were unsure how much help resident 244 needed with meals. The OT stated they evaluated and worked with residents that needed more assistance on activities of daily living (ADLs). The OT stated they were not working with resident 244 since he didn't need help with any ADLs that he was aware of. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Some	On 1/30/23 at 11:11 AM, an interview was conducted with Licensed Practical Nurse (LPN)1. LPN 1 stated that resident 244 was able to feed himself and was able to reach for his own waters. LPN 1 stated that every once in a while, resident 244 did not eat much but stated that he always ate his cereal. On 01/30/23 at 12:21 PM, an interview was conducted with the Certified Nursing Assistant Coordinator (CNAC). The CNAC stated that resident 244 needed set up assistance for meals. The CNAC stated they made sure to sit him up in bed to eat. The CNAC stated she handed resident 244 his chocolate milk with meals and stated that resident 244 did not have problems grabbing things with his hands. The CNAC stated there were times where resident 244 did not eat his food because he did not like what was served to him. The CNAC stated that resident 244 verbalized when he did not like his meal. The CNAC stated they have asked resident 244 if he needed help with meals but stated that resident 244 had refused the help. The CNAC stated they thought it was weird that resident 244's sister was feeding him lunch today because resident 244 was able to feed himself and did not need that much help with meals. On 1/30/23 at 3:56 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that supervision assist meant that a staff member had to help and encourage the resident to eat during meals. The DON stated if the resident's MDS documented him as a supervision assist, she expected staff to be at bedside during meal times to help feed him. The DON that when a resident has a 10% weight loss, they were triggered for weight loss and put on weekly weights, as well as reviewed in the weekly NAR meetings.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46232 Based on observation, interview, and record review, it was determined that for 1 of 54 sampled residents, the facility did not ensure that a resident who was supplemented with enteral means received the appropriate treatment and care of the feeding tube such as providing needed personal, skin, oral and nasal care as well as examining and cleaning the insertion site in order to identify, lessen or resolve possible skin irritation and local infection. Specifically, multiple observations were made of a resident with a dirty nasal gastric feeding tube over multiple days. Resident identifier: 39. Findings include: Resident 39 was admitted to the facility on [DATE] with diagnoses that included but not limited to cerebral infarction, dysphagia, cognitive communication deficit and need for personal assistance with personal care. Resident 39's medical record was reviewed on 1/24/23. A care plan with a revision date of 1/5/23 identified a focus area of nutritional risk factors due to resident 39's need of enteral feeding related to inadequate oral intake. A goal identified was resident 39 will not have skin irritation or infection at feeding tube site. An enteral feed order with a start date of 1/2/23 stated, every shift assess nose/facial area for signs and symptoms of irritation related to taping of nasal gastric tube. No documentation was located for feeding tube cares. On 1/23/23 at 10:31 AM, an observation was made of resident 39's feeding tube. Resident 39's feeding tube was soiled right below the nose with what appeared to be clumps stuck to the tube. On 1/25/23 at 1:39 PM, an observation was made of resident 39's feeding tube while resident was in bed. Resident 39's feeding tube continued to appear dirty and untouched from the prior observation. On 1/26/23 at 9:47 AM, on observation was made of resident 39's feeding tube while the resident was in his wheelchair. Resident 39's feeding tube continued to have crusty clumps right below the resident's nose. On 1/30/23 at 11:07 AM, an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated that resident 39 had the feeding tube for supplementation. LPN 1 stated that speech therapy was working with resident 39 to wean him off of the feeding tube when the resident returned back to base line. LPN 1 stated it was protocol to check the feeding tube and nose every shift. LPN 1 stated they looked for bruising or any skin irritation and stated if the feeding tube looked dirty during the check, they cleaned it. LPN 1 stated they were not aware of resident 39's dirty feeding tube. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/30/23 at 12:46, an interview was conducted with Registered nurse (RN) 2. RN 2 stated that when a resident had a feeding tube, they had a lot of things to monitor to avoid any complications. RN 2 stated one of the things monitored was the feeding tube insertion site for any skin irritation or infection every shift. RN 2 stated that if a feeding tube looked dirty at that time, the nurses cleaned it. On 1/30/23 at 4:13 PM, an interview was conducted with the Director of Nursing (DON). The DON stated she expected the nurses to clean the feeding tube if it appeared soiled or dirty during their shift.

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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** 44640 Based on observation, interview, and record review it was determined, that the facility did not ensure that a resident who needed respiratory care was provided such care, consistent with professional standards of practice. Specifically, for 1 out of 54 sampled residents, a resident who required oxygen was not provided supplemental oxygen on admission and did not have a physicians order for oxygen and supplemental oxygen. Resident identifiers: 298. Findings included: Resident 298 was admitted on [DATE] with diagnoses which included femur fracture, history of falling, chronic respiratory failure with hypoxia, cognitive communication deficit, dysphasia, need for assistance with personal care, and chronic obstructive pulmonary disease (COPD). On 1/23/23 at 12:00 PM, an interview was conducted with a family member (FM) of resident 298. The FM stated resident 298 was admitted to the facility and not placed on wall oxygen so the portable oxygen tank resident 298 was using ran out. The FM stated resident 298's oxygen levels got very low, and the family had to make the staff aware of the situation. On 1/23/23 at 12:15 PM, an observation was made of resident 298 lying in bed wearing a nasal cannula (NC) connected to the wall supply of oxygen. On 1/25/23 at 1:10 PM, an observation was made of resident 298 sitting in his wheelchair with his NC lying on his bedside table in front of him. Resident 298 stated he just finished eating. Observation was made as resident 298 placed the NC back in his nares. On 1/24/23, resident 298's medical record was reviewed. Resident 298's physician's orders revealed no orders for supplemental oxygen. Resident 298's Treatment Administration Record (TAR) revealed no oxygen treatment instructions. Resident 298's care plan revealed no areas, goals or interventions focused on oxygen usage. An Initial Admission Record (IAR) dated 1/21/23 revealed, resident 298 had a pulmonary diagnosis of COPD, shortness or breath, trouble breathing when lying flat, trouble breathing with exertion, and diminished lung sounds. The IAR documented resident 298 was on 3 liters (L) of oxygen (O2) via nasal cannula (NC) on admission. On 1/21/23 at 9:53 AM, resident 298's O2 saturation level via NC was 87% (percent). On 1/22/23 at 5:21 AM, resident 298's O2 saturation level via NC was 87%. On 1/24/23 at 4:26 AM, resident 298's O2 saturation level via NC was 92%. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/26/23 at 12:30 PM, and interview as conducted with the Director of Respiratory Therapy ([NAME]). The [NAME] stated if a resident was admitted who did not need active airway support they were admitted to the rehabilitation side of the unit and nursing took care of their respiratory needs. The [NAME] stated nursing should have placed resident 298 on wall oxygen on admission if he came in on a portable oxygen tank. On 1/30/23 at 1:30 PM, an interview was conducted with Certified Nursing Assistant (CNA) 8. CNA 8 stated she was there when resident 298 was admitted to the unit. CNA 8 stated the resident did come with an oxygen tank and that she didn't put the resident on wall oxygen. CNA 8 stated the nurses were the ones that set up the oxygen. On 1/20/23 at 1:50 PM, a telephone interview was conducted with Licensed Practical Nurse (LPN) 9. LPN 9 stated she was the nurse who admitted resident 298. LPN 9 stated the resident was brought to the facility by family members and wore a NC attached to a portable O2 tank. LPN 9 stated she had asked the CNA to get the O2 supplies the resident may need. LPN 9 stated resident 298 was never switched over from the portable O2 tank to the wall O2 and he ran out of supplemental oxygen. LPN 9 stated resident 298's O2 saturation level dropped to 55 percent and that was very low. LPN 9 stated when resident 298 was placed on the wall O2 his O2 saturations increased rapidly, and he was able to relax more. LPN 9 stated it was a mistake and that she thought it was the CNA's responsibility to ensure the resident's oxygen was set up correctly. On 1/30/23 at 3:15 PM, an interview was conducted with the Assistant Director of Nursing (ADON) 1. ADON 1 stated it was the expectation of the facility that the nurses would make sure a resident was set up appropriately on oxygen if they required it. The ADON 1 stated the CNAs were there to assist the nurses but that was a nursing responsibility. [Cross refer to F656]

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22992 Based on interview, observation and record review, the facility did not ensure that pain management was provided to 2 of out 54 residents. Specifically, residents complained of pain but were not provided with pain relief medication in a timely manner. These findings resulted in harm for both residents. Resident identifiers: 22 and 298. Findings include: HARM 1. Resident 22 was admitted to the facility on [DATE] with diagnoses that included degenerative disc disease; dementia; schizoaffective disorder, bipolar type; post-traumatic stress disorder; scoliosis; and hypertension. On 1/23/23 resident 22's medical record was reviewed. A care plan for resident 22 was developed on 3/9/20 with a focus area of Has acute and chronic pain r/t (related to) Chronic Physical Disability, pain in lower back, hip and knees. Goals included: Will voice a level of comfort of (sic) through the review date, Will verbalize adequate relief of pain or ability to cope with incompletely relieved pain through the review date, and Will not have an interruption in normal activities due to pain through the review date. Interventions included: Able to call for assistance when in pain, reposition self, ask for medication, tell you how much pain is experienced, tell you what increases or alleviates pain; anticipate need for pain relief and respond immediately to any complaint of pain; engage in daily recreation activities for distraction to manage pain; monitor/record/report any signs and symptoms of non-verbal pain; and monitor/report to nurse if resident complains of pain or has requests for pain treatment. On 10/4/22, the Director of Nursing (DON) completed a quarterly Pain Management Review for resident 22. Despite resident 22's care plan indicating that resident 22 was able to describe his pain, the DON documented that resident 22 was unable to be interviewed. The DON also indicated that no observations were made of resident 22 in pain, but in contrast, that resident 22 was receiving oxycodone as needed for pain. On 1/4/23 a quarterly Pain Management Review was completed by facility staff for resident 22. The pain review indicated that resident 22 was interviewed that day. The review also indicated that resident 22 was receiving oxycodone for pain, and that at the time of the interview, resident 22 was experiencing pain at a level of 6 out of 10. The pain review indicated that resident 22 would like to experience no pain. The pain review also indicated that resident 22 had experienced pain in the last 5 days on a daily basis or several times a day. The review specified that the pain was located in resident 22's right knee and was especially bad in the late evening. At that time, resident 22 described the pain as stabbing, and that it affected his sleep. Resident 22 also indicated that physical activity made the pain worse, but rest and repositioning relieved the pain. Staff documented on the pain review that resident 22 could be observed to have difficulty sleeping and/or make facial expressions such as grimacing when he was experiencing pain. The goal was to Encourage the resident to verbalize his needs, and pain level before medication and document effectiveness of medication. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	The facility Provider Notifications binder at the nurse's station in the 100 hall was reviewed. The binder indicated that on 1/23/23 resident 22 was requesting time of scheduled oxy (oxycodone) to be changed from 1600 (4:00 PM) to 1400 (2:00 PM). The facility Provider Orders binder at the nurses station in the 100 hall was reviewed. The binder indicated that on 1/23/23 an order was written to increase resident 22's oxycodone to every 4 hours as needed. The order was signed by the Nurse Practitioner (NP). On 1/24/23 at approximately 9:30 AM, resident 22 was observed to approach the facility NP at the nurse's station. Resident 22 was observed to tell the NP that he was experiencing an increased amount of pain. The NP responded to resident 22 by stating that she was aware of his request for an increased dosage of his pain medication, and had approved it, so the resident should start to experience pain relief soon. On 1/24/23, the facility Nurse Practitioner (NP) entered an encounter note in resident 22's medical record. The encounter note indicated that Patient is seen today with complaint of pain. He states this pain is mostly in his knees, though he has pain to his back as well. He states he has been taking oxycodone every 6 hours but will have to take Tylenol in between because it does not carry through long enough. He states mostly at night it is very bothersome for him and makes for a long rough night. He states that he would like his oxycodone increased to every 4 hours. He also has a scheduled dose at 4:00 in the afternoon, that he would like changed to earlier in the afternoon. The NP documented resident 22's pain level at a 6. The NP documented that resident 22 had a diagnosis of Osteoarthritis involving multiple joints on both sides of body and to Increase Oxycodone to every 4 hours as needed and Change scheduled oxycodone to 1400 (2:00 PM) from 1600 (4:00 PM). On 1/25/23 at 8:45 AM, an observation was made of resident 22. Resident 22 walked down the hallway and stopped at the nurse's station. Licensed Practical Nurse (LPN) 6 was observed to be in the nurses station standing at the medication cart. Resident 22 approached LPN 6 and stated that his knee hurt. LPN 6 did not look up from the medication cart or acknowledge resident 22. LPN 6 then stated, Well, you will just have to wait a minute I'm busy. Resident 22 nodded and went over to a chair across from the nurse's station and sat down. LPN 6 was not observed to administer any pain medication to resident 22 during the medication pass observation. On 1/25/23 at 10:50 AM, resident 22 was approached by a staff member and invited to participate in a facility activity. Resident 22 responded by saying that he could not go to the activity because his knees hurt too much. Resident 22 also stated that he thought he could not have more medications until 3:00 PM, and that was too far away. On 1/25/23 at 11:10 AM, resident 22 was observed to approach LPN 6 at the nurse's station, and ask for a pain pill, stating that his knee is really hurting. Resident 22 was observed to be bending over at the waist and rubbing his right knee while grimacing. LPN 6 stated, Ya, I know I'm sorry. LPN 6 did not make any other comments to the resident, and turned away from the resident while the resident was standing at the nursing station. On 1/25/23 at 11:12 AM, LPN 6 approached resident 22 and handed him a cup of water, and a cup containing a pill. LPN 6 immediately turned around and walked back to her medication cart without observing if resident 22 swallowed the pill. In addition, LPN 6 did not assess resident 22's pain level. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	On 1/25/23 at 11:35 AM, resident 22's Controlled Drug Record was reviewed. The record did not have any oxycodone listed as having been signed out by LPN 6 that day. Resident 22's Medication Administration Record (MAR) did not indicate any as needed pain medications given on 1/25/22 at 11:12 AM by LPN 6. On 1/25/23 at 12:14 PM, resident 22 was observed to ask LPN 6 if she could put some cream on his knee because it was still hurting. LPN 6 responded by asking if the pain medications had helped, and resident 22 stated Not totally. On 1/25/23 at 12:45 PM, an interview was conducted with resident 22. Resident 22 stated that not last night but the night before, indicating the evening of 1/23/23, his pain had increased to a 9 out of 10. Resident 22 stated that at that time facility staff put ice and aspercreme on his knee and had given him some oxycodone. Resident 22 stated that after those interventions he was able to get another 2 hours of sleep. On 1/25/23 at 2:20 PM, an interview was conducted with LPN 6. LPN 2 stated that she had given oxycodone to resident 22 at 11:11 AM and had documented it. When asked about the Provider Notification and Provider Orders binders, LPN 6 stated that one binder was to let the providers know of any concerns, and the other binder was for providers to record their responses. LPN 6 stated that she checked the binder at the beginning of each shift, but that there really isn't a process in place yet. LPN 6 reviewed the binder and confirmed that resident 22 was to have his oxycodone increased as of 1/23/23. A nurses note dated 1/26/23 indicated that resident 22's Oxycodone 5mg increased to q4 (every four hours) prn (as needed) from q6 (every six hours) prn per NP on 1/25/23. New increased dose started today, resident aware of new changes. The entry was made by Assistant Director of Nursing (ADON) 2, not LPN 6 even though LPN 6 was made aware on 1/25/23. Resident 22's January 2023 MAR was reviewed. On 1/25/23, resident 22 did not receive his 4:00 PM scheduled dose of oxycodone. The MAR also indicated that resident 22's increased oxycodone orders did not go into effect until the morning of 1/26/23. On 1/30/23 at 11:02 AM, a follow up interview was conducted with resident 22. Resident 22 was asked about his pain management. Resident 22 produced a notepaper and stated that he had spoken with the NP on 1/23/23, and that the NP agreed to increase his pain medications. Resident 22 stated that it took time for the orders to get processed so he was without the increased dose for a day or longer. Resident 22 also stated that the oxycodone only covered his pain for 4 hours, and before his pain medication dose was increased, he was using lidocaine ointment to help get him through the remaining two hours before he could have more oxycodone. Resident 22 stated that by the end of the 4 hours his pain level was a 4 to 5, but at the end of 6 hours without pain medication his pain level increased to a 6. Resident 22 stated that he had a diagnosis of scoliosis, so it put his hip out, causing pain. Resident 22 stated that the majority of his pain was from his right knee which he injured in a fall. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	On 1/30/23 at 11:25 AM, an interview was conducted with the NP. The NP stated that she spoke with resident 22 two weeks ago at which time resident 22 talked about the pain with me. The NP stated that on 1/23/23 she had spoken with resident 22 about his pain again, at which time she approved the increase in pain medication. The NP stated that she wrote the order for the increased pain medication in the binder at the nurse's station. The NP stated that whenever she wrote an order in the binder, she always verbally informed the nurse on duty about the new order as well. On 1/30/23 at 11:35 AM, an interview was conducted with the Medical Director (MD). The MD stated that approximately three weeks ago, he and the NP had started a new process of writing down the new orders in a binder at the nurses station. The MD stated that when there was a verbal order given, the MD or NP would tell the nurse on duty, and write it in the binder so there was a record of the verbal order. The MD stated that he expected nurses to put the verbal order into effect ASAP, at most an hour. 44640 2. Resident 298 was admitted on [DATE] with diagnoses which included femur fracture, history of falling, chronic respiratory failure with hypoxia, cognitive communication deficit, dysphagia, need for assistance with personal care, and chronic obstructive pulmonary disease (COPD). On 1/23/23 at 12:00 PM, an interview was conducted with resident 298's family member (FM). The FM stated the resident was admitted on [DATE] at 8:00 AM and went almost an entire day without his pain being controlled. The FM stated the facility would not give resident 298 any pain medication because they didn't have an order (air quotes used when the FM said this). The FM stated on her arrival she demanded the nurse get resident 298 something for pain and the nurse went straight to the facility supply and got resident 298 a pain medication. The FM stated it did help resident 298 but he wouldn't have gotten anything if she had not come in. On 1/24/23, resident 298's medical record was reviewed. Resident 298 was admitted to the facility in the morning on 1/21/23, the first vital sign check was documented at 9:53 AM. A physician order dated 1/20/23 revealed an order for Tramadol 50 mg give 1 tablet by mouth every 4 hours as needed for moderate to severe pain. A physician order dated 1/21/23 revealed an order for Percocet tablet 5-325 milligrams (mg) give 1 tablet by mouth every 4 hours as needed for pain. The Medication Treatment Record (MAR) for January 2023 revealed, at 1:56 PM resident 298 had pain at a level 5 on a 0-10 pain scale with 0 being no pain and 10 being immense pain. A Non-pharmalogical Intervention (NPI) was documented at 1:56 PM as, speak to/approach in a calm manner. No pain medication was documented as administered to resident 298. No documentation was found in the medical record of Tramadol being administered to resident 298 on 1/21/23. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	On 1/21/23 at 9:59 PM, the MAR documented resident 298 continued to complain of pain at a level 5 on the 0-10 pain scale and was administered Percocet 5mg. Note: This was 8 hours after resident 298 complained about pain. The pain medication was administered by the oncoming night shift nurse not the admitting day shift nurse. On 1/30/23 at 1:50 PM, an interview was conducted with Licensed Practical Nurse (LPN) 9. LPN 9 stated she was the nurse who admitted resident 298 to the facility on [DATE]. LPN 9 stated the resident, and his family were upset because all she could give him was Tramadol for pain because the provider had already been into the facility to see the residents for the day, so the resident's orders didn't get sent to the pharmacy until the next day. LPN 9 stated she could have gotten the narcotic pain medication out of the house supply with a verbal order from the provider. LPN 9 stated that she probably should have done that sooner and that the family was upset she didn't give the resident anything for his pain except Tramadol. LPN 9 stated the resident had been restless and upset, but he then settled down after his oxygen was put on and his pain medication was given. Note: There is no documented administration of Tramadol to resident 298 in the January MAR. The first dose was documented as given at 10:37 AM on 1/22/23 by LPN 9. On 1/30/23 at 3:02 PM, an interview was conducted with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) 1. The ADON 1 stated the admitting nurse should get the resident settled in the room, assess their needs, if the resident is in pain the nurse should check the orders and provide the pain medication that is ordered. The ADON 1 stated the facility does have a supply of medications, including narcotic pain medication, in a locked machine. If the resident is in need of a pain medication the nurses can get one from the machine while they wait for the resident's medications to arrive from the pharmacy. The ADON 1 stated a resident should not sit in pain while staff wait for a medication to come from the pharmacy if it is available in the facility.

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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** 22992 Based on interview and record review, the facility did not ensure that the irregularities identified by the facility pharmacist were reviewed by the facility physician. Resident identifiers: 69 and 78. Findings include: 1. Resident 78 was admitted to the facility on [DATE] with diagnoses that included dementia, chronic kidney disease, anxiety, major depressive disorder and dysphagia. Resident 78's medical record was reviewed on 1/23/23. The monthly consultant pharmacist reviews for resident 78 were reviewed and revealed the following: a. August 2022 - Nursing- Progress notes indicate that trazodone was to be discontinued in August. (see 8/24/22 notes) Recommendation: Follow up with physician to confirm whether trazodone should now be stopped or continued. b. September 2022 - No irregularities c. October 2022 - Unable to be located d. November 2022 - Unable to be located e. December 2022 - Unable to be located. As of 1/23/23, resident 78 had an active physician order for Trazadone. 2. Resident 69 was admitted to the facility on [DATE] with diagnoses that included epilepsy, history of traumatic brain injury, hypotension, and major depressive disorder. Resident 69's medical record was reviewed on 1/23/23. The monthly consultant pharmacist reviews for resident 69 were reviewed and revealed the following: a. December 2022 - [Resident 69] is taking phenobarbital 200 mg (milligrams) at night for seizures. I did not find a recent phenobarbital level . Recommendations: Check phenobarbital level with the next routine lab draw. On 1/26/23 at 8:55 AM, additional information was requested from the Director of Nursing (DON) regarding the above listed residents, and whether the facility physician had seen the pharmacist recommendations. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/26/23 at 10:30 AM, the DON was unable to provide any documentation regarding resident 78 and the trazadone order. The DON stated that she had just emailed the medical director regarding resident 69, and the medical director wrote an order for the resident's phenobarbital to be checked every year. The DON stated she could not find documentation to indicate that the physician had responded to the pharmacist recommendations.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47431 Based on interview and record review, it was determined, for 1 of 54 sampled residents, the facility failed to keep a resident's drug regimen free from unnecessary drugs. Specifically, a resident was prescribed an antibiotic medication for excessive duration without adequate indications for use. Resident identifier: 20. Findings include: Resident 20 was admitted to facility on 2/15/13 and readmitted on [DATE] with diagnoses that included end stage renal disease, atrial fibrillation, cardiac pacemaker, and hydronephrosis. Resident 20's medical record was reviewed on 1/24/23. Resident 20's care plan focus initiated on 10/5/17 documented, (resident) is on Prophylactic Antibiotic Therapy (Amoxicillin) r/t [related to] chronic UTI's [urinary tract infections]. A physician's order documented, Amoxicillin Tablet 500 MG [milligrams] with directions Give 500 mg by mouth at bedtime for prophylactic to start 3/11/2021 and to end Indefinite. The Medication Administration Record (MAR) for November and December 2022 and January 2023 indicated amoxicillin tablet 500 mg was administered daily to resident 20. The Minimal Data Set (MDS) dated [DATE] through 12/16/22 revealed resident 20 received antibiotics on a routine basis. During an interview on 1/26/23 at 12:05 PM with the Assistant Director of Nursing (ADON) 1, who is also the Infection Preventionist. ADON 1 stated that resident 20 was on a prophylactic antibiotic due to the resident scratching their skin causing redness and for vaginal bacteria. The ADON also stated this had not been, flagged to the resident's physician because of the antibiotic being used as a prophylactic.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44640 Based on observation, interview and record review it was determined, for 1 of 54 sampled residents, that the facility did not ensure that medication error rates were not 5 percent or greater. Observations of 30 medication opportunities, on 1/25/23, revealed 2 medication errors which resulted in a 6.67% medication error rate. Specifically, one resident received an incorrect dose of Vitamin D3 and the same resident received a dose of Active Protein without the amount being specified in the order. Resident identifiers: 53. Findings included: Resident 53 was admitted to the facility on [DATE] with diagnoses which included nontraumatic intracerebral hemorrhage in brain stem, hemiplegia and hemiparesis, hypertension, muscle spasm, pain, gastro-esophageal reflux disease, need for assistance with personal care, and dysphagia. On 1/25/23 at 8:05 AM, an observation was made of Registered Nurse (RN) 1 during morning medication administration. RN 1 was observed to administer resident 53 Cholecalciferol 125 micrograms (mcg) tablet. RN 1 was then observed to administer 60 milliliters (ml) of Active Protein to resident 53. Resident 53 was observed to be lying in bed with the head of the bed elevated. Resident 53's Medication Administration Record (MAR) for January 2023 was reviewed and revealed the following physician orders: a. Cholecalciferol (Vitamin D3) tablet 1000 international unit (IU), give one tablet by mouth one time a day for supplement. The medication had an administration hour listed at 7:00 AM. [Note: 1000 IU is 25 mcg.] b. Active Protein supplement, give two times a day for supplement. The medication had an administration hour listed at 7:00 AM and 8:00 PM. On 1/25/23 at 8:20 AM, an interview was conducted with RN 1. RN 1 stated the usual dose of protein was 60 mls but there probably should have been an amount written in the order. On 1/30/23 at 3:30 PM, an interview was conducted with the Director of Nursing (DON). The DON stated the expectation of the facility is that the nurse will administer medication as they are ordered and call the provider if they have a question about an order or medication.

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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. 22992 Based on interview and observation, the facility did not ensure that drugs and biologicals were stored in accordance with currently accepted professional principles. Findings include: 1. On 1/25/23 at 12:04 PM, an observation was made of Licensed Practical Nurse (LPN) 6. LPN 6 was observed to leave the nurses station in the 100 hallway and walk to the day room. LPN 6 was observed to leave the medication cart unlocked until 12:07 PM when she returned. There were 2 residents observed to be seated by the nurses station. It should be noted that the 100 hallway was primarily used for residents who had diagnoses of dementia. 44640 2. On 1/25/23 at 7:30 AM, an observation was made of LPN 7. LPN 7 left a medication administration card which held Pantoprazole on top of the medication cart and went down the 200 hallway into a resident room. Other residents were observed in the hallway near the medication cart. On 1/25/23 at 7:38 AM, an interview was conducted with LPN 7. LPN 7 stated she always leaves medications on top of the medication cart when she needs to have them reordered by pharmacy, they are discontinued or she had a question about them. LPN 7 stated she would then take the medication cards with her to the nursing desk to put them in the proper place. On 1/30/23 at 3:20 PM, an interview was conducted with the Director of Nursing (DON). The DON stated the nurses should not leave medications on top of the medication cart; all medications should be locked up when the nurse is not directly by the cart.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22992 Based on interview and record review, the facility did not provide laboratory services to meet the needs of 1 of 54 sample residents. Resident identifier: 33. Findings include: Resident 33 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included dementia, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, anxiety disorder, osteoporosis, pseudobulbar affect, major depressive disorder, and hypertension. Resident 33's medical record was reviewed on 1/23/23. On 1/15/23, the facility physician ordered that resident 33 have the following labs drawn: Valproic acid, Complete Blood Count, Comprehensive Metabolic Panel, and Lipid Panel. No record of the lab results could be located in resident 33's medical record. On 1/30/23 at 8:15 AM, an interview was conducted with the facility Director of Nursing (DON). The DON confirmed that resident 33's lab had not been completed as ordered. The DON stated that the resident refused to have the labs drawn. When asked about documentation regarding the refusal, the DON stated that she was not sure if the resident refused to have these specific labs drawn, but that he always refuses, so she had assumed he refused this lab draw as well.

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F 0835 Level of Harm - Actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 22992 Based on interview, record review, and observation, the facility failed to be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Specifically, residents experienced neglect, did not receive assistance with activities of daily living, experienced pain without timely intervention, developed wounds, experienced falls with injuries, and experienced weight loss without timely intervention. This resulted in seven deficiencies cited at a harm level. In addition, multiple deficiencies that were cited on the previous recertification survey and complaint surveys were re-cited on the current survey. Resident identifiers: 22, 27, 33, 41, 47, 60, 146, 244, 295, 298, and 349. Findings include: 1. Based on interview, record review, and observation the facility did not ensure that 7 of 54 sample residents were free of neglect. Specifically, residents were not assisted with activities of daily living, had untreated pain, experienced weight loss, and experienced falls with injuries. The findings for all the residents listed in this deficiency were cited at a harm level. Resident identifiers: 22, 27, 33, 47, 146, 244, and 298. [Cross refer to F600] 2. Based on interview and record review it was determined, for 1 of 54 sampled residents, that the facility did not provide the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living (ADLs). Specifically, a resident did not receive help with feeding assistance and cueing. The deficient practice identified was found to have occurred at a harm level. Resident Identifier: 244. [Cross refer to F676] 3. Based on interview, observation and record review, the facility did not ensure that 4 of 54 sample residents who were unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Specifically, residents were not assisted with toileting or bathing as needed. This resulted in a finding of harm for one resident. Resident identifiers: 27, 60, 295 and 349. [Cross refer to F677] 4. Based on interview and record review it was determined that the facility did not ensure, for 1 of 54 sample residents, that all residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents choices. Specifically, one resident developed a penile wound and did not promptly receive appropriate wound care follow up and no investigation was done on the cause of the wound. The deficient practice identified was found to have occurred at a harm level. Resident Identifier: 244. [Cross refer to F684] (continued on next page)

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F 0835 Level of Harm - Actual harm Residents Affected - Some	5. Based on observation, interview and record review, for 3 of 54 sampled residents, that the facility did not ensure that the residents' environment remained as free of accident hazards as is possible. Specifically, one resident with a history of falls was left unattended and subsequently fell out of bed, receiving an eye laceration. The deficient practice for this resident was cited at a harm level. In addition, one resident with a history of falls was observed to not have interventions in place, and one resident was left unattended at the side of his bed. Resident identifiers: 27, 41 and 146. [Cross refer to F689] 6. Based on interview, observation and record review, the facility did not ensure that 3 of 54 sample residents maintained acceptable parameters of nutritional status. Specifically, residents with weight loss did not receive timely and appropriate interventions. This will be cited at a harm level for all three residents. Resident identifiers: 33, 47, and 244. [Cross refer to F692] 7. Based on interview, observation and record review, the facility did not ensure that pain management was provided to 2 of out 54 residents. Specifically, residents complained of pain but were not provided with pain relief medication in a timely manner. These findings resulted in harm for both residents. Resident identifiers: 22 and 298. [Cross refer to F697] 8. On 5/28/21 an annual recertification survey was conducted. Among the deficiencies cited included F550, F584, F600 (at a harm level), F609, F656, F677, F689 (at a harm level), F690 (at a harm level), F695, F697 (at a harm level), F756, and F835. The deficiencies listed were cited again during the current recertification survey. 9. On 6/1/22 a complaint survey was conducted. F880 was cited at that time. F880 was also cited again during the current recertification survey. 10. On 11/3/22 a complaint survey was conducted F550, F677, and F689 were cited. These deficiencies were cited again during the current recertification survey. On 1/30/23 at 3:37 PM, an interview was conducted with the facility Director of Nursing (DON). The DON was asked about the Quality Assurance program, and specifically what had been implemented with regard to brief changes for example. The DON stated that facility CNAs were provided a sheet to document if a resident received a brief change, and how often they should be checked. The DON stated that facility staff should be checking residents' incontinence briefs every couple of hours. When asked how the facility management was ensuring that briefs were being changed timely, the DON stated that facility staff were asking the [CNAs] if they have done their brief changes. On 1/30/23 at 3:17 PM, an interview was conducted with the facility Administrator (ADM). The ADM was asked about the Quality Assurance program, and specifically what had been implemented with regard to brief changes for example. The AM was asked what interventions had been put into place since November 2022 when the facility was cited for F677 after multiple residents were identified as not having their incontinence briefs changed in a timely manner. The ADM stated that they the CNA Coordinator was reviewing the electronic health record documentation to ensure the staff were documenting brief changes. When asked if there was a specific auditing process in place, the ADM stated there was not. When asked if observations were being made by facility management to ensure brief changes were occurring versus being documented, the ADM stated that intervention had not been put into place.

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F 0867 Level of Harm - 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, record review, and observation, the facility failed to develop and implement appropriate plans of action to correct identified quality deficiencies; and regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. Specifically, residents experienced neglect, did not receive assistance with activities of daily living, experienced pain without timely intervention, developed wounds, experienced falls with injuries, and experienced weight loss without timely intervention. This resulted in seven deficiencies cited at a harm level. In addition, multiple deficiencies that were cited on the previous recertification survey and complaint surveys were re-cited on the current survey. Resident identifiers: 22, 27, 33, 41, 47, 60, 146, 244, 295, 298, and 349. Findings include: 1. Based on interview, record review, and observation the facility did not ensure that 7 of 54 sample residents were free of neglect. Specifically, residents were not assisted with activities of daily living, had untreated pain, experienced weight loss, and experienced falls with injuries. The findings for all the residents listed in this deficiency were cited at a harm level. Resident identifiers: 22, 27, 33, 47, 146, 244, and 298. [Cross refer to F600] 2. Based on interview and record review it was determined, for 1 of 54 sampled residents, that the facility did not provide the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living (ADLs). Specifically, a resident did not receive help with feeding assistance and cueing. The deficient practice identified was found to have occurred at a harm level. Resident Identifier: 244. [Cross refer to F676] 3. Based on interview, observation and record review, the facility did not ensure that 4 of 54 sample residents who were unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Specifically, residents were not assisted with toileting or bathing as needed. This resulted in a finding of harm for one resident. Resident identifiers: 27, 60, 295 and 349. [Cross refer to F677] 4. Based on interview and record review it was determined that the facility did not ensure, for 1 of 54 sample residents, that all residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents choices. Specifically, one resident developed a penile wound and did not promptly receive appropriate wound care follow up and no investigation was done on the cause of the wound. The deficient practice identified was found to have occurred at a harm level. Resident Identifier: 244. [Cross refer to F684] (continued on next page)

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F 0867 Level of Harm - Actual harm Residents Affected - Some	5. Based on observation, interview and record review, for 3 of 54 sampled residents, that the facility did not ensure that the residents' environment remained as free of accident hazards as is possible. Specifically, one resident with a history of falls was left unattended and subsequently fell out of bed, receiving an eye laceration. The deficient practice for this resident was cited at a harm level. In addition, one resident with a history of falls was observed to not have interventions in place, and one resident was left unattended at the side of his bed. Resident identifiers: 27, 41 and 146. [Cross refer to F689] 6. Based on interview, observation and record review, the facility did not ensure that 3 of 54 sample residents maintained acceptable parameters of nutritional status. Specifically, residents with weight loss did not receive timely and appropriate interventions. This will be cited at a harm level for all three residents. Resident identifiers: 33, 47, and 244. [Cross refer to F692] 7. Based on interview, observation and record review, the facility did not ensure that pain management was provided to 2 of out 54 residents. Specifically, residents complained of pain but were not provided with pain relief medication in a timely manner. These findings resulted in harm for both residents. Resident identifiers: 22 and 298. [Cross refer to F697] 8. On 5/28/21 an annual recertification survey was conducted. Among the deficiencies cited included F550, F584, F600 (at a harm level), F609, F656, F677, F689 (at a harm level), F690 (at a harm level), F695, F697 (at a harm level), F756, and F835. The deficiencies listed were cited again during the current recertification survey. 9. On 6/1/22 a complaint survey was conducted. F880 was cited at that time. F880 was also cited again during the current recertification survey. 10. On 11/3/22 a complaint survey was conducted F550, F677, and F689 were cited. These deficiencies were cited again during the current recertification survey. On 1/30/23 at 3:37 PM, an interview was conducted with the facility Director of Nursing (DON). The DON was asked about the Quality Assurance program, and specifically what had been implemented with regard to brief changes for example. The DON stated that facility CNAs were provided a sheet to document if a resident received a brief change, and how often they should be checked. The DON stated that facility staff should be checking residents' incontinence briefs every couple of hours. When asked how the facility management was ensuring that briefs were being changed timely, the DON stated that facility staff were asking the [CNAs] if they have done their brief changes. On 1/30/23 at 3:17 PM, an interview was conducted with the facility Administrator (ADM). The ADM was asked about the Quality Assurance program, and specifically what had been implemented with regard to brief changes for example. The AM was asked what interventions had been put into place since November 2022 when the facility was cited for F677 after multiple residents were identified as not having their incontinence briefs changed in a timely manner. The ADM stated that they the CNA Coordinator was reviewing the electronic health record documentation to ensure the staff were documenting brief changes. When asked if there was a specific auditing process in place, the ADM stated there was not. When asked if observations were being made by facility management to ensure brief changes were occurring versus being documented, the ADM stated that intervention had not been put into place.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22992 Based on observation, interview, and record review, it was determined, the facility did not maintain an infection prevention and control program that was designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Specifically, observations were made of staff and outside providers not wearing personal protective equipment (PPE) correctly, the appropriate PPE not being worn in contact and droplet isolation rooms, observations of cross contamination during medication pass and wound care, soiled staff telecommunication equipment being used without being cleaned, and equipment not being cleaned in between resident use. Resident identifiers: 21, 27, 50, 82, 244 and 295, Findings include: PPE 1. On 1/25/23 at approximately 10:00 AM, Licensed Practical Nurse (LPN) 6 was observed to answer a phone call at the nurse's station in the 100 hall. LPN 6 was observed to remove her mask while she was speaking on the phone. 2. On 1/25/23 at 11:21 AM, an observation was made of Occupational Therapist (OT) 2. OT 2 was walking past the nurses station in the 100 hallway, where several residents were seated. OT 2 was observed to pull down his mask, cough with his mouth uncovered and open, and then put his mask back on. 3. On 1/25/23 at 1:38 PM, Certified Nursing Assistant (CNA) 14 was observed to be seated at the nurses station in the 100 hallway. CNA 14 was observed to remove her mask as she was typing on the computer. At 1:39 PM, CNA 14 was observed to leave the nurses station, place her mask on her face, and assist a resident. 4. On 1/25/23 at 1:51 PM, an observation was made of OT 2. OT 2 was seated in the day room speaking with a resident. OT 2 was observed to have his mask pulled down so that it did not cover his nose or mouth as he spoke with the resident. 5. On 1/30/23 at 12:33 PM, CNA 14 was observed to not have a mask on as she walked from the nurse's station down the 100 hall, past the day room. PPE - ISOLATION 6. On 1/23/23 at 12:00 PM, an observation was made of the 500 hallway. rooms [ROOM NUMBERS] had droplet/contact precaution signs on the doors, both doors were open. Isolation bins observed outside the doors, gowns and gloves were located in the bins. No masks were located in the bins. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	7. On 1/24/23 at 9:45 AM, an observation was made of an Outside Transport Agency (OTA). A staff member stood outside room [ROOM NUMBER] and donned a gown and gloves then entered room [ROOM NUMBER]. No eye protection was donned. The staff was not observed to instruct the OTA on what PPE should be donned prior to entering room [ROOM NUMBER]. The OTA entered room [ROOM NUMBER] with a surgical mask and gloves, no other PPE in place. At 9:53 AM resident 50 was brought out of room [ROOM NUMBER] into the hallway on a stretcher, no PPE observed on resident 50. Resident 50 was then escorted by the OTA through the facility and past other residents to the transport vehicle. On 1/24/23 at 9:55 AM, an interview was conducted with LPN 4. LPN 4 stated resident 50 was getting his percutaneous endoscopic gastrostomy (PEG) tube replaced. LPN 4 stated that resident 50 was on droplet precautions for Extended Spectrum Beta-Lactamase (ESBL) in his sputum. LPN 4 stated a gown, gloves, eye protection and N-95 should be worn when doing cares with resident 50. 8. On 1/25/23 at 10:51 AM, an observation was made of the Respiratory Therapist (RT). RT was observed to enter resident 82 and resident 50's rooms with no gown or eye protection in place. The precaution sign on the doors revealed staff should don a gown, mask, gloves and eye protection when entering the room. On 1/25/23 at 11:23 AM, an observation was made of the RT. RT was observed to again enter resident 50's room with no gown or eye protection in place. 9. On 1/25/23 at 11:54 AM, an observation was made of the Wound Physician Assistant (WPA) and the Wound Nurse (WN). The WPA wore regular reading glasses into resident 82's room and the WN had eye protection on top of her head when in the room. No masks were changed on exit of the room, no eye protection was cleaned or changed. 10. On 1/25/23 at 1:49 PM, an observation was made of CNA 12. CNA 12 was observed to bag out the soiled linens and trash in room [ROOM NUMBER]. CNA 12 did not wear gloves, a gown or eye protection. On 1/25/23 at 1:53 PM, an interview was conducted with CNA 12. CNA 12 stated the staff were supposed to wear gown, gloves, masks and goggles anytime they entered resident 50's room, room [ROOM NUMBER], to prevent the chance of spreading infection. On 1/23/23 at 10:07 AM, an interview was conducted with the Assistant Director of Nursing (ADON) 1. The ADON 1 stated when a resident is on droplet precautions the staff should wear an KN95 mask, gloves, gown and goggles. The ADON stated resident 82 was on droplet precautions for an infection in his sputum. PPE - WOUNDS 11. On 1/23/23 at 9:38 AM, an observation was made of rooms [ROOM NUMBERS]. Both rooms had a modified contact precautions sign on the doors. room [ROOM NUMBER]'s door was open. On 1/23/23 at 9:44 AM, an interview was conducted with the Certified Nursing Assistant Coordinator (CNAC). The CNAC stated resident 295 had wounds that were infected, and the staff should wear gowns and gloves when they provided cares. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	12. On 1/23/23 at 9:50 AM, an observation was made of room [ROOM NUMBER]. A modified contact precautions sign was observed on the closed door. The sign revealed, staff should clean hands, wear a gown, gloves, use equipment dedicated for that resident and to place soiled supplies in isolation bins. No isolation trash bins were observed in or outside of room. An isolation cart was observed outside the room with gowns, gloves and red and yellow bags. At 9:55 AM, an observation was made of a staff member who exited the room, used hand hygiene (HH), walked down the hallway then returned to the room. The staff member did not don a gown prior to entering room [ROOM NUMBER]. An observation was made while the door was open to room [ROOM NUMBER], another staff member was in the room and leaned against the bed and provided cares to the resident. This staff member did not have a gown, gloves or eye protection in place. At 10:00 AM, an observation was made as both staff exited room [ROOM NUMBER]. HH was used by both staff members. An immediate interview was conducted with the WN and CNA 6. The WN stated she had just performed wound care for resident 295 with the assistance of CNA 6. The WN stated resident 295 had wounds on his heels, ischium, shoulders and that he had a lot of other wounds. The WN stated resident 295 did not have any infections and had just finished his antibiotics so he did not need to have the contact precautions followed anymore. The WN stated contact precautions for resident 295 were to wear a gown and gloves while doing cares. The WN stated the wearing of PPE is a case-by-case basis, but staff use only standard precautions for resident 295, the contact precaution sign is there but we don't need to follow it. The WN and CNA 6 both stated they were regular staff in the facility. On 1/23/23 at 10:02 AM, an interview was conducted with Registered Nurse (RN) 3. RN 3 stated she was the nurse over the care of resident 295 for the day and stated he had an ESBL infection in his wounds. RN 3 stated contact precautions needed to be followed, especially for dressing changes. RN 3 stated he was currently on precautions, and they should be followed until he was taken off of them and the signage was removed. On 1/23/23 at 10:07 AM, an interview was conducted with the ADON 1. The ADON 1 stated resident 295 had ESBL and Carbapenem-resistant A. baumannii (CRAB) in his wounds and in his urine. The ADON 1 stated the WN changed the resident's dressings as ordered and that full PPE should be worn by the WN and all staff that provided cares to the resident. The ADON 1 stated resident 295 was still being treated for the infections and should still be on precautions. On 1/25/23 at 8:00 AM, an interview was conducted with LPN 5. LPN 5 stated resident 295 was on isolation for an infection in his wounds and all PPE should be worn when cares were being done and his wound dressings were being changed. 13. On 1/25/23 at 8:03 AM, an observation was made of the WN and an unidentified CNA. The WN and CNA entered resident 295's room with a surgical mask in place, no additional PPE was donned, the door was closed behind them. This surveyor knocked and opened the door and found both staff standing next to resident 295's bed. Both the WN and the CNA stood close enough to touch the bed with their clothing. When the door was opened both stated, We are doing wound care. The WN and CNA now had gloves on along with the surgical masks. The unidentified CNA wore eye protection and the WN wore eye protection on top of her head. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 1/30/23 at 8:40 AM, an interview was conducted with the WPA. The WPA stated resident 295 had infection in his wounds. The WPA stated the staff had been wearing PPE to change his wound dressings. The WPA stated it was important to wear the PPE to decrease the chance of spreading the infection to others. The WPA stated we try to be really careful to not spread the infection to other residents so PPE should be worn every time we go into the resident's room. On 1/30/23 at 2:38 PM, a follow up interview was conducted with the ADON 1. The ADON 1, who is also the Infection Preventionist, stated that modified contact precautions mean the staff should wear a mask, a gown, gloves and goggles. The ADON 1 stated the staff should be wearing PPE when they enter resident 295's room to do cares or dressing changes because he has infection in his wounds and urine. The ADON 1 stated those who are doing dressing changes should especially wear all of the PPE, gown, gloves, mask and eye protection to ensure nothing is spread to anyone else. CROSS CONTAMINATION 14. On 1/30/23 at 11:30 PM, an observation was made of the WN and CNA 2. The WN and CNA 2 were observed to enter the room of resident 27. Resident 27 was lying in his bed, the WN raised the resident's bed to approximately waist height and both the WN and CNA 2 pulled resident 27 toward the edge of the bed. The WN and CNA 2 then walked out into the hallway to obtain hand sanitizer. The WN and CNA 2 returned to the bedside of resident 27, gloves were donned. The WN pulled back the soiled brief, blood was observed on the brief. No dressing was observed on the wound. The WN cleaned the wound on resident 27 with dry gauze. The WN again left the bedside to go to the hallway to obtain hand sanitizer. CNA 2 was standing at the foot of the bed with his back to the resident. While the WN was in the hallway, the soiled brief was observed to return to the original position and touch the cleaned wound. The WN donned gloves and returned to the bedside and repositioned resident 27 using the draw sheet on the bed. Gloves were not observed to be changed. The WN applied ointment to a gloved finger then to the wound. The WN and CNA 2 were then called away to the doorway, the soiled brief again returned to its original position and touched the wound. The WN returned to the bedside, pulled the brief away from the wound and a new dressing was applied to the wound. The WN then put the soiled brief back in place over the new dressing on resident 27. 15. On 1/25/23 at 1:35 PM, LPN 6 was observed to be carrying a water mug out of a resident's room. As LPN 6 approached the nurse's station in the 100 hallway, she bent down to talk to a resident, where she placed the mug on the facility floor. After speaking with the resident, LPN 6 picked the mug up off of the floor, and then placed the contaminated mug on the medication cart. After a few minutes, LPN 6 was observed to pick up the contaminated mug, fill it with ice and water, and then return it to a resident's room. EQUIPMENT 16. On 1/24/23 at 10:25 AM, an observation was made of the Hoyer lift being brought out of room [ROOM NUMBER], a contact isolation room, and left in the hallway. No cleaning observed. 17. On 1/24/23 at 10:27 AM, an observation was made of the Hoyer lift being taken into room [ROOM NUMBER], Hoyer lift then taken into room [ROOM NUMBER], no cleaning observed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	18. On 1/26/23 at 12:30 PM, an observation was made of CNA 3. CNA 3 brought the Hoyer lift out of room [ROOM NUMBER] and left it in the hallway, CNA 3 returned to room [ROOM NUMBER]. Dust, dirt, particles of a dark substance and areas of dried liquid observed on the base of the Hoyer lift. On 1/30/23 at 12:45 PM, an interview was conducted with the CNAC. The CNAC stated the CNAs and the concierge service clean the wheelchairs and the equipment. The Hoyer should be cleaned after each resident use and the wheelchairs are cleaned once a week. TELECOMMUNICATION EQUIPMENT 19. On 1/30/23 at 8:55 AM, an observation was made of CNA 4. CNA 4 was observed to perform a brief change on resident 244. CNA 4 was observed to pull the soiled brief away from resident 244's peri area. CNA 4 then examined resident 244's penis and scrotal sac for evaluation of a wound. While leaning over the resident, CNA 4's earpiece fell into the soiled brief. CNA 4 was observed to pick up the earpiece and place it back into his right ear. No cleaning of the equipment was observed. Additionally, during the brief change, CNA 4 was observed to move his glasses from his face to the top of his head and rub his scrub pants with soiled gloves. MEDICATION PASS 20. On 1/25/23 at 8:50 AM, an observation was made of LPN 6. LPN 6 was observed to have gloves on from previously administering insulin to another resident. LPN 6 was observed to obtain a medicine cup from the medication cart, the inside of the cup was touched. LPN 6 then removed the gloves, no HH was used. LPN 6 was observed to push the medications through the back of the pill pack into the medicine cup. The pills would touch LPN 6's fingers as they were pushed through and went into the cup. LPN 6 was then observed to obtain the insulin pen for resident 21. LPN did not clean the end of the insulin pen prior to attaching the needle. LPN 6 then took the medication and a water cup over to resident 21 who sat in a chair outside the nurse's station. LPN 6 sat the medication and water cups on the floor in between resident 21 and another resident. LPN 6 administered the insulin to resident 21. LPN 6 then picked up the medicine and water cups by pinching the inside both cups and sat them on the nursing desk counter. LPN 6 touched the nursing desk gate and then picked up the cups again using the pinching method and placed them on the medication cart. LPN 6 then opened a drawer at the nurse's desk, obtained the blood pressure (B/P) machine, returned to the medication cart opened it, obtained Miralax for resident 21 and added it to the water cup. LPN 6 then took the blood pressure machine, water and medicine cup out to resident 21. LPN 6 carried the water and medicine cup using the pinching method with the gloved hands inside of both cups. LPN then placed both cups on the ground next to resident 21 and took resident 21's blood pressure. LPN 6 then gave the water and medicine cup to resident 21 who took all of the medication and drank all of the Miralax. On 1/30/23 at 3:20 PM, an interview was conducted with the Director of Nursing (DON). The DON stated the nurses should use hand hygiene (HH) prior to getting any medications for the residents. The DON stated the nurses are supposed to pull the meds one at a time and not touch the pills with their hands. The DON stated the nurses should not be sticking their fingers inside the cups the give to the residents to drink or eat from. The DON stated it is never ok to place medications or anything you are going to give to a resident on the floor. 44640

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47431 Based on interview and record review, it was determined, for 1 or 54 sampled residents, the facility failed to keep an antibiotic stewardship program that included antibiotics use protocols and a system to monitor all antibiotic use for all residents. Specifically, a resident had an order for an antibiotic (ABX) for over five years. Resident identifier: 20. Findings include: Resident 20 was admitted to facility on 2/15/13 and readmitted on [DATE] with diagnoses that included end stage renal disease, atrial fibrillation, cardiac pacemaker, and hydronephrosis. During a record review for resident 20, it was noted that the resident had a physician's order for Amoxicillin Tablet 500 MG [milligrams] give 500 mg by mouth at bedtime for prophylactic to start 3/11/2021 and to end Indefinite. During an interview on 1/26/23 at 12:05 PM with the Antibiotic Steward who is also the Assistant Director of Nursing (ADON) 1, she stated resident 20 was on an antibiotic for prophylactic purposes. The ADON 1 stated since the antibiotic was for a prophylactic purpose, she did not include resident 20 to the Antibiotic Stewardship Program. The ADON 1 also stated she had not referred the resident to the physician for a change in the medication. The ADON 1 was unable to provide requested documentation regarding the rationale for resident 20 to be on any antibiotic. Record review of the of the Minimal Data Set (MDS) dated [DATE] through 12/16/22 revealed resident 20 received antibiotics on a routine basis. Record review of facility provided Resident Matrix dated 1/23/23, failed to indicate resident 20 being on an antibiotic. Record review of the Clinical Progress Notes from June 2022 through January 2023 did not mention any indications of use for an antibiotic. Including a Physician's visit on 1/8/23 which failed to indicate the use and rational for Amoxicillin Tablet 500 MG, give 500 mg by mouth at bedtime for prophylactic, 500MG, ACTIVE, 3/11/2021.