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	05/28/2021

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 - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22992 Based on interview and observation, the facility did not treat 5 of 51 sample residents with dignity and care for each resident in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. Specifically, a resident's privacy was not protected during a personal phone call or during a transfer. In addition, staff members were observed to enter resident rooms without knocking. Also, a resident was repositioned without being told first. An additional resident was observed wearing a hospital gown instead of other clothing to the dining room as was her preference. Also, a staff member was observed to verbalize her political views in an aggressive manner toward staff and residents. Resident identifiers: 54, 90, 94, 102 and 108. Findings include: 1. On 5/24/21 the following observations were made of resident 108: a. At 12:33 PM, a staff member entered resident 108's room to deliver a meal tray. The staff member did not knock prior to entering the resident's room. b. At 1:10 PM, the Social Services Worker (SSW) entered resident 108's room and seated herself next to resident 108's bed, where resident 108 was in a seated position. The SSW stated that she wanted to discuss resident 108's mental health assessment with a member of an outside mental health agency. The resident consented. The SSW dialed the phone, and then placed the mental health agency staff member on speaker phone. The resident described her mental health struggles and that she was struggling with feelings of worthlessness, etc. The conversation could be heard across the hall in a resident room. The SSW did not close resident 108's door to ensure the resident's privacy. c. At 1:23 PM, while the resident was speaking with the mental health agency staff member and the SSW, a nursing staff member entered the room and obtained resident 108's blood glucose level. The nursing staff member did not ask resident 108's permission to do so, despite resident 108 being on the phone. (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 - Some	d. At 2:22 PM, Certified Nursing Assistant (CNA) 6 entered resident 108's room. CNA 6 stated that she was there to get resident 108 ready to leave for a physician's appointment. CNA 6 did not close the door. At 2:24 PM, a male transportation staff member arrived and stood in the doorway of resident 108's room. CNA 6 positioned resident 108's bed so that resident 108 was in a seated position. CNA 6 then assisted resident 108 out of bed by pulling resident 108's legs around to the side of the bed. Resident 108 was wearing a hospital gown, and as her legs were pulled to the side of the bed, her hospital gown opened, and the area between resident 108's legs was exposed to the male transportation staff member, including an area covered by an incontinence brief. Resident 108 was then assisted to a standing position, during which time CNA 6 moved resident 108's hospital gown out of the way so she could adjust resident 108's incontinence brief. CNA 6 was observed to remove the tape on the left side of resident 108's incontinence tape, and let the tabs fall, exposing resident 108's left hip and upper thigh area. CNA 6 did not change or offer to change resident 108's incontinence brief. Resident 108 was then seated in a wheelchair with her back exposed, and her back resting directly against the wheelchair backrest. CNA 6 did not offer to help resident 108 get dressed. Resident 108 was not wearing a bra, and CNA 6 did not offer to help resident 108 put one on. Resident 108's hair was observed to be plastered to her head in the back, and messy in the front. CNA 6 did not comb or offer to comb resident 108's hair. The transportation staff member then began wheeling resident 108 out of the room, with resident 108 in only a hospital gown. CNA 6 stopped the transportation staff member, and a blanket was placed on resident 108's lap and legs. All observations of resident 108 were made from a resident room across the hall. On 5/24/21 at 2:32 PM, an interview was conducted with CNA 6. CNA 6 stated that she was usually supposed to close the door while providing resident cares. On 5/28/21 at 12:55 PM, two CNAs were observed to enter resident 108's room without knocking. 2. On 5/23/21 at 3:45 PM, an interview was conducted with resident 94. Resident 94 stated that staff were not knocking prior to entering his room. 3. On 5/27/21 the lunch meal was observed in the main dining room. Resident 54 was observed to be seated in his wheelchair with his back to the kitchen door. CNA 1 approached resident 54, and moved resident 54's wheelchair from a reclining position to an upright position without first addressing the resident, or asking the resident's permission to change positions. When resident 54 was repositioned without warning, the resident appeared to be startled and let out a yelp. 4. On 5/26/21, resident 90 was observed to be in a hospital gown as he was laying in bed. The hospital gown was observed to not be covering resident 90's legs and incontinence brief. On 5/28/21 at 1:04 PM, resident 90 was observed to be in a hospital gown as he was laying in bed. The hospital gown was observed to not be covering resident 90's legs and incontinence brief. 30563 5. Resident 102 was admitted to the facility on [DATE] with diagnoses which included cerebral infarction due to thrombosis of right vertebral, hemiplegia, and hypertension. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/26/21 at 9:06 AM, an interview and observation was conducted with resident 102. Resident 102 was observed to be wheeled in her wheelchair from the dining room to her room. Resident 102 was observed to be wearing a hospital gown. Resident 102 stated that she was in the dining room for breakfast and wore a gown. Resident 102 stated that she would like to wear clothing to the dining room. Resident 102 stated she was going to have a shower so the staff did not dress her to go to the dining room. Resident 102's medical record was reviewed 5/25/21 through 5/28/21. An annual Minimum Data Set (MDS) dated [DATE] revealed resident 102 had a BIMS score of 14 which revealed resident was cognitive. The MDS further revealed that resident 102 required 1 person extensive assist with dressing. On 5/27/21 at 5:53 PM, an interview was conducted with CNA 13. CNA 13 stated resident did not have confusion. CNA 13 stated that resident 102 liked to be dressed and did not like to wear hospital gowns. CNA 13 stated resident 102 also liked to pick out her clothing. CNA 13 stated that resident 102 wanted to be dressed for dinner in the dining room. On 5/27/21 at 10:03 AM, an interview was conducted with CNA coordinator. CNA coordinator stated that residents should be dressed before being taken to the dining room. On 5/28/21 at 10:52 AM, an interview was conducted with the Director of Nursing (DON). The DON stated resident 102 was alert and oriented x 2 -3. The DON stated that resident 102 had clothing and her daughter brought her more anytime she needed them. The DON stated that resident 102 liked to wear clothing. The DON stated that he would expect staff to get her dressed before taking her to the dining room. 6. On 5/24/21, an observation was conducted of Registered Nurse (RN) 4. RN 4 was observed at the nurses station in the room behind the nurses station. RN 4 yelled to other staff members All of these Republicans that refuse the get the vaccine, I'm going to laugh when they all die of COVID. RN 4 stated We need to trust the science. RN 4 stated that our country was built on science. RN 4 turned to a staff member and asked How many times does our constitution have science mentioned in it? RN 4 was observed to turn to the Infection Preventionist (IP) and ask how many times science was used on her citizenship test. The IP was observed to ignore RN 4. RN 4 then touched the IP on the shoulder and asked the question again. The IP did not respond. Residents were observed to be in the hallway and within hearing distance from RN 4.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30563 Based on interview and record review it was determined, for 1 of 51 sample residents, that the facility did not determine through the interdisciplinary team that a resident was safe to self-administer medications. Specifically, a resident was not assessed for safety prior to providing the resident a pain relief gel to self administer. Resident identifier: 17. Findings include: Resident 17 was admitted to the facility on [DATE] with diagnoses which included femur fracture, muscle weakness, need for assistance with personal care, difficulty walking, respiratory failure, low back pain, and morbid obesity with alveolar hypoventilation. On 5/26/21 at 11:51 AM, an interview was conducted with resident 17. Resident 17 stated his knees and shoulders needed to have pain relief gel applied twice a day. Resident 17 stated there were not enough staff to apply the gel twice daily to his shoulders and knees. Resident 17 stated that the gel helped but needed to be applied during the busy times of the day in the morning and before bed. Resident 17's medical record was reviewed on 5/28/21. An order dated 11/16/2020 revealed Voltaren Gel 1% apply application transdermally every 6 hours as needed for pain. There was no care plan regarding self administration of medications. On 5/28/21 at 1:33 PM, an interview was conducted with Certified Nursing Assistant (CNA) 8. CNA 8 stated that resident 17 had pain relief gel in his drawer in his room. CNA 8 stated resident 17 applied it to his shoulders and knees. CNA 8 stated that the gel provided pain relief and he seemed to feel better after the gel was applied. CNA 8 stated that resident 17 asked to have her apply it occasionally. On 5/28/21 at 1:45 PM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated Voltaren gel was a medication to be administered by the nurse. RN 1 stated that resident 17 had the gel in his top drawer and was able to apply it himself to his knees but needed assistance applying it to his shoulders. On 5/28/21 at 1:50 PM, a follow up interview was conducted with resident 17. Resident 17 stated that he wanted the nurse to apply the gel to his shoulders and knees. Resident 17 stated that the gel really helps with the pain. Resident 17 stated that the nurses were too busy to apply it in the morning and at night. Resident 17 stated that he sometimes asked CNAs to apply it but they were very busy. Resident 17 stated he tried to apply the gel to his shoulders but was unable to reach all the way behind his shoulder. Resident 17 stated he did not apply it to his knees because he was unable to reach his knees and almost fell forward trying to reach them. On 5/28/21 at 1:57 PM, an interview was conducted with Clinical Resource Nurse (CRN) 2. CRN 2 stated there was not a self assessment for self medication administration for resident 17. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/28/21 at 2:18 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that when a resident wanted cream like Voltaren gel, then a self assessment was supposed to be completed. The DON stated that resident 17 did not have a self assessment and should have an assessment prior to having medications or creams at bedside.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43710 Based on observation, interview and record the review, for 4 of 51 sample residents, it was determined that the facility did not ensure each resident had the right to receive services with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. Specifically, it was observed that residents call lights were out of reach of the residents. Resident identifiers: 22, 32, 101, and 167. Findings include: 1. Resident 32 was admitted on [DATE] with diagnoses which included a history of non traumatic intracranial hemorrhage, hypertension, type two diabetes, dementia, hyperlipidemia, anxiety disorder, neuromuscular dysfunction of bladder, angina pectoris and major depressive disorder. On 5/23/21, at approximately 8:20 PM, it was observed that the call light for resident 32 was out of reach. Resident 32 stated that she felt as though she was having a medical emergency. The call light was observed to be was wrapped around the headboard of resident 32's bed out of reach of the resident. 2. Resident 22 was admitted on [DATE] with diagnoses which included a history of atherosclerotic heart disease, chronic diastolic heart failure, chronic ischemic heart disease, chronic kidney disease, chronic respiratory failure with hypoxia, essential hypertension, Gastro-Esophageal Reflux Disease, hypothyroidism, long term use of insulin, major depressive disorder, morbid obesity, asthma, cardiac pacemaker, type 2 diabetes, and atrial fibrillation. On 5/27/21, at approximately 9:08 AM, it was observed that the call light for resident 22 was out of reach. 3. Resident 101 was admitted on [DATE] with diagnoses which included a history of chronic respiratory failure with hypoxia, hypertension, tracheostomy, spina bifida, multiple sclerosis, functional quadriplegia, Gastro-Esophageal Reflux Disease, chronic pain, major depressive disorder, insomnia, anxiety and muscle weakness. On 5/26/21, at approximately 9:00 AM, it was observed that the call light for Resident 101 was out of reach of the resident. 4. Resident 167 was admitted to the facility on [DATE] with diagnoses which included chronic respiratory failure with hypoxia, anemia, debility, diabetes mellitus and hypertension. On 5/26/21 at approximately 9:00 AM, an observation was made of resident 167. Resident 167 was in her bed, in a reclined position. The call light was observed to be wrapped around the bed rails at the head of resident 167's bed, out of resident 167's reach. On 5/27/21 at approximately 12:00 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that it is the policy of the facility to place the call light near residents when staff leave the room.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30563 Based on observation, interview and record review it was determined, for 4 of 51 sample residents, that the facility did not provide residents with the right to make choices about aspects of his or her life that were significant to the residents. Specifically, residents that had requested female staff members to care for them were not provided female staff members. In addition, residents were not allowed to get out of bed when they desired. Resident identifiers: 82, 99, 101 and 112. Findings include: 1. Resident 82 was admitted to the facility 8/3/17 and readmitted on [DATE] with diagnoses which included chronic respiratory failure, morbid obesity, anxiety, ventilator dependent, and muscle weakness. On 5/24/21 at 5:18 PM, an interview was conducted with resident 82. Resident 82 stated that she had requested female Certified Nurse Aids (CNAs) only for cares. Resident 82 stated she had trust issues with male CNAs. Resident 82 stated that there was usually only a male CNA scheduled for the 500 hall. Resident 82 stated if there were only male CNAs on the 500 hall, then the staff called for help from another hallway. Resident 82 stated she waited for the next shift when there were female CNAs available to change her incontinence brief. Resident 82's medical record was reviewed on 5/24/21 through 5/28/21. A quarterly Minimum Data Set (MDS) dated [DATE] revealed resident 82 had a Brief Interview of Mental Status (BIMS) score of 14 which revealed that resident 82 was cognitively intact. A care plan dated 5/13/2019 and revised by Clinical Resource Nurse (CRN) 1 on 5/12/21 was reviewed. The Focus was Actual behavior problem r/t (related to) refusing care . pericares, and repositioning. [Resident 82] will only allow certain aides to take care of her. She will refuse cares if the ones she doesn't like are working. A goal developed was Will have fewer episodes of by review date. Interventions were developed by a CRN. Interventions included: approach in a calm manner, document behaviors, and resident response to interventions. An intervention developed by CRN 3 on 5/23/21 was to Provide a log for refusal of care. A care plan dated 11/17/20 revealed, Resistive to showers and care by nursing team - education provided but continues to refuse. A goal developed was Will cooperate with cares through next review date. Interventions developed were Allow to make decisions about treatment regime, to provide sense of control and [Resident 82] will tell staff she refuses then tell other staff they never asked her, so always have 2 staff members when doing cares and let nurse know if she refuses. On 5/23/21 at 2:10 PM, an interview was conducted with the Social Service Worker (SSW). The SSW stated that resident 82 stated that she only allowed female CNAs for personal cares. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/24/21 at 10:30 AM, an interview was conducted with CNA 3. CNA 3 stated that resident 82 was only assigned female staff for brief changes and showers per the resident's request. CNA 3 also stated that if you are a new aide or she hasn't seen you before she will refuse all cares. She won't even let you do a brief change. She has only a handful of aides she lets work with her. It's scary because last week she wasn't changed almost all day, but she didn't like the aide that was on that day. The whole hall reeked. On 5/27/21 at 10:03 AM, an interview was conducted with CNA coordinator. The CNA coordinator stated that for residents who only wanted female CNAs, he made sure there were 2 CNAs staffed. The CNA coordinator stated there was a male and female staff for the morning and evening shifts. The CNA coordinator stated that there was one CNA at night. The CNA coordinator stated CNAs should have had radios to ask for assistance when there was one CNA. 2. Resident 99 was admitted to the facility on [DATE] with diagnoses which included multiple sclerosis, hypertension, major depressive disorder, muscle weakness, and post-traumatic stress disorder. A quarterly MDS dated [DATE] revealed that resident 99 had a BIMS score of 15 which revealed resident 99 was cognitively intact. On 5/26/21 at 10:58 AM, an interview was conducted with resident 99. Resident 99 stated that she requested female CNAs to shower her, change her brief, and assist her with toileting. Resident 99 stated that she also requested that CNA 11 not work with her. Resident 99 stated that CNA 11 was small and unable to operate her sit to stand lift. Resident 99 stated she was scheduled to shower three times per week. Resident 99 stated that she was only able to shower twice a week because male CNAs were scheduled for shower aides. Resident 99 further stated she wanted to get up at 6:00 AM but there were not enough staff. Resident 99 stated that staff usually got her up until 8:00 AM. A care plan dated 10/16/20 and updated on 2/9/21 revealed Resistive to care r/t (related to) only female staff. Goal developed was Will participate in care through next review date. Interventions developed were Provide consistency in care to promote comfort with ADLs (Activities of Daily Living). Maintain consistency in timing of ADLs, caregivers and routine, as much as possible. Another intervention developed was provide resident with opportunities for choice during care provision. A progress note 5/19/2021 at 10:46 AM revealed, Resident refused her shower this morning. Resident was approached at 0820 (8:20 AM) that shower was available. Resident stated that it was too late for her. Aids asked resident if she wanted to be dressed for the day and resident stated she was not ready. Aids checked in on resident again an hour later and resident was still eating breakfast and stated that she was not yet ready to be dressed. On 5/27/21 at 12:35 PM, an interview was conducted with CNA 12. CNA 12 stated that resident 99 wanted to get up as early as possible about 6:00 AM. CNA 12 stated that she was usually able to get into resident 99's room about 6:30 AM to get her up. CNA 12 stated that resident 99's shower sometimes took a long time. CNA 12 stated that resident 99 complained when she was not up at 6:00 AM. CNA 12 stated resident 99 became upset if another resident was up before her. On 5/27/21 at 3:49 PM, an interview was conducted with CNA 15. CNA 15 stated that resident 99 requested female CNAs only and did not allow some CNAs to assist her. CNA 15 stated she had reported that to the CNA coordinator. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/27/21 at 9:43 AM, an interview was conducted with CNA coordinator. The CNA coordinator stated that resident 99 wanted female CNAs only and required a 2 person transfer with a sit to stand. The CNA coordinator stated that no one had voiced a complaint about CNA 11 being small and unable to operate lifts. 3. Resident 112 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included multiple sclerosis, hypertension, unspecified dementia without behavioral disturbance and contractures. A Quarterly MDS dated [DATE] revealed that resident 99 had a BIMS score of 10 which indicated mild cognitive impairment. On 5/24/21 at 10:02 AM, an interview was conducted with resident 112. Resident 112 stated he wanted to get up at 4:00 AM every morning but could not get up until 6:00 AM because of staffing. Resident 112 stated he needed 2 CNAs to get him out of bed and ready for the day. Resident 112 stated there were not 2 CNAs until 6:00 AM. Resident 112 stated that he wanted yellow briefs but was provided blue ones. Resident 112 stated that the blue briefs were really tight on my balls. Resident 112 stated that he also asked for a cup of ice at 4:00 AM but usually had to wait until 6:00 AM to get it. Resident 112 further stated he could not have a shower until 6:00 AM because the shower aide starts at 6:00 AM. Resident 99's medical record was reviewed 5/24/21 through 5/28/21. A shower refusal form dated 4/10/21 revealed that resident 112 did not want a shower because he was not assisted out of bed until 7:00 AM. On 5/27/21 at 3:49 PM, an interview was conducted with CNA 15. CNA 15 stated that resident 112 was alert and oriented. CNA 15 stated that resident 112 wanted to be out of bed and showered by 4:30 AM on his shower days. CNA 15 stated that the shower aide was scheduled at 6:00 AM. CNA 15 stated that she assisted resident 112 out of bed as soon as she came on shift. 22992 4. Resident 101 was admitted to the facility on [DATE] with diagnoses that included chronic respiratory failure with hypoxia, hypertension, spina bifida, tracheostomy status, multiple sclerosis, and functional quadriplegia. On 5/26/21 at 9:20 AM, an interview was conducted with resident 101. Resident 101 stated that the day prior he had attended an activity, and then wanted to get out of his chair to rest in bed for a while before staff showered him. Resident 101 stated that staff wouldn't put me back in bed until after my shower. Resident 101 further stated its frustrating because I was in my wheelchair from about 9:00 (AM) until 2:00 PM. Resident 101 stated that they made me stay in my wheelchair until 2:00 PM when it was my time to shower. they didn't even tell me why. Resident 101's medical record was reviewed on 5/23/21. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An admission MDS dated [DATE] revealed resident 101 had a BIMS score of 15 which revealed that resident 101 was cognitively intact. The MDS also revealed that resident 101 was totally dependent on two staff members for transfers between bed and wheelchairs.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43710 Based on observation, interview and record the review, for 3 of 51 sample residents, it was determined that the facility did not ensure that the resident had a right to personal privacy and confidentiality of his or her personal and medical records. Specifically, another resident's name was used in another resident's medical record. Resident identifiers: 38, 108 and 370. Findings include: 1. Resident 38 was admitted on [DATE] with diagnoses which included a history of unspecified dementia with behavioral disturbance, vascular dementia with behavioral disturbance, essential tremor, hyperlipidemia, hypertension, Gastro-esophageal Reflex Disease, major depressive disorder, atrial fibrillation, muscle weakness, obstructive sleep apnea and dysphagia. Resident 38's medical record was reviewed on 5/25/21 A progress note for resident 38 revealed that staff had named another resident in resident 38's note, after the two residents were involved in an altercation. 2. On 5/28/21, a wound note for resident 370 was located in resident 108's medical record. On 5/28/21, the DON confirmed that the wound note for resident 370 was incorrectly scanned into resident 108's medical record.

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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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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** 22992 Based on observation, interview and record the review, for 4 of 51 sample residents, it was determined that the facility did not ensure that residents had a safe, clean, comfortable and homelike environment. Specifically, there were strong urine and fecal odors, torn wall paper in resident rooms, soiled wheelchairs, a broken head board, and arm rests torn on wheelchairs. Resident identifiers: 51, 101, 105 and 112. Findings include: 1. On 5/23/21 at 4:45 PM through 8:00 PM, a strong urine odor was present throughout the 300 hall. A strong urine odor was observed outside of room [ROOM NUMBER]. 2. On 5/24/21 at 10:15 AM, a strong urine and fecal odor was present throughout the 300 hall from the top of the hall by rooms [ROOM NUMBERS] down to the entrance of the 400 hall. 3. On 5/23/21 at 5:07 PM, a staff member opened room [ROOM NUMBER]. There was a strong urine odor that permeated through the hall. There was a strong urine odor outside room [ROOM NUMBER]. 4. On 5/24/21 at 11:00 AM, a strong urine and fecal odor was present throughout the 500 hall. 5. On 5/24/21 at 1:15 PM, an observation was made outside of room [ROOM NUMBER]. There was a strong urine odor that permeated into the 300 hallway. An interview was conducted with Certified Nursing Assistant (CNA) 10. CNA 10 stated that she had COVID-19 and had lost her sense of smell. CNA 10 stated that prior to losing her sense of smell the facility smelled of urine. 6. On 5/26/21 at 9:20 AM, resident 101's room was observed. The wallpaper behind the resident's bed was observed to be torn and shredded in an area approximately 12 to 15 inches in length. The resident's wheelchair was observed to be heavily soiled with debris and crusted spills on the base and arms. Resident 101 stated that he used his wheelchair every day. Resident 101's room had a strong odor of urine. The pole used to hang resident 101's tube feeding formula was observed to be heavily soiled with what appeared to be dried tube feeding formula. On 5/28/21 at 1:17 PM, an additional observation was made of resident 101's room. The room was observed to have a strong urine smell. 7. On 5/26/21 at 9:46 AM, resident 105's room was observed. The headboard of resident 105's bed was observed to be broken and leaning to the resident's right. In addition, the wallpaper behind the resident's bed was observed to be torn and shredded in an area approximately 12 inches by 12 inches in diameter. 8. On 5/27/21 at 12:30 PM, resident 51's wheelchair was observed. The wheelchair armrests were both torn and cracked on the majority of the armrest area. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9. On 5/24/21 at 10:02 AM, an observation was made of resident 112's wheelchair. Resident 112's wheelchair was observed to be soiled with a white substance on the wheels with crumbs and debris on the foot rests and cushion. The arm rests were observed to be torn. On 5/27/21 at 1:04 PM, an observation was made of resident 112. Resident 112 was observed in the dining room. Resident 112's wheelchair was soiled. Resident 112 stated that it was not working and he needed new ball bearings. The arm rests were observed to be torn. On 5/27/21 at 3:11 PM, an interview was conducted with the Director of Therapy (DOT). The DOT stated that he was in charge of wheelchair repair and replacement. The DOT stated that staff were supposed to inform him if a wheelchair was in disrepair so that it could be fixed or replaced. The DOT stated that he was unaware that resident 51's wheelchair armrests were torn, and stated that he would address it. On 5/28/21 at 10:50 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that the night shift CNAs were supposed to clean the wheelchairs.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30563 Based on interview and record review it was determined, for 4 of 51 sample residents, that the facility did not establish a grievance policy to ensure the prompt resolution of all grievances regarding resident rights. In response to a grievance, the facility did not ensure all written grievance decisions included the date the grievance that was received, steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns, nor a statement as to whether the grievance was confirmed or not confirmed. Specifically, a resident complained of staffing, quality of food, desiring female CNAs only and not receiving showers. Other residents complained of missing items. Resident identifiers: 37, 82, 105 and 108. Findings include: 1. On 5/23/21 at 5:28 PM, an interview was conducted with resident 82. Resident 82 stated that she had complained about staffing, food quality, wanting only female Certified Nursing Aides (CNAs) and not receiving showers. Resident 82 stated she had talked to the Administrator and Social Worker about her concerns but there was no follow-up or changes. Resident 82 stated she was not aware on how to file grievances. Resident 82 stated she knew how to contact the Ombudsman to voice a complaint. On 5/23/21 at 7:33 PM, an interview was conducted with the Administrator. The Administrator stated that he talked to residents and tried to solve the grievances without filling out a form. The Administrator stated that usually he was able to resolve the concerns. The Administrator stated that resident 82 was very particular about who cared for her. The Administrator stated that resident 82 typically liked female CNAs. The Administrator stated resident 82 had ongoing issues and he had talked to the resident multiple times. The Administrator stated that he had not filed a grievance for resident 82 because he did not think about filling out an official grievance form. 2. On 5/28/21 at 1:00 PM, an interview was conducted with resident 108. Resident 108 had been observed to be in a hospital gown on 5/24/21, 5/25/21, and 5/28/21. The resident stated that when she was admitted to the facility on [DATE], she had brought with her at least one night gown, but that the facility had washed it and I haven't gotten it back. The resident stated that she had no clothes to wear, and had been wearing hospital gowns during her stay at the facility. 3. On 5/26/21 at 9:46 AM, an interview was conducted with resident 105. Resident 105 stated that she had lost a pair of ear buds in the previous 2 weeks, and had spoken with the DON (Director of Nursing) about it, but had not heard anything back. 4. On 5/23/21 at 4:06 PM, an interview was conducted with resident 37. Resident 37 stated that his thumb was rubbing on the wheelchair, and he had an open sore from it. Resident 37 stated that he had asked for gloves, but they said they don't have anything like that . so I have this bandage here but it doesn't stick to my hand real well. Resident 37 also stated that while he was a resident at the facility, he had an electronic tablet and art pads go missing. Resident 37 stated that he had reported the missing items to the Social Service Worker (SSW) and the CNA Coordinator, but that nothing had been followed up on. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/24/21 at 2:10 PM, an interview was conducted with the SSW. The SSW stated that that a written grievance form from staff or residents was submitted to her. The SSW stated that depending on the grievance she provided it to the department head that it applied to. The SSW stated that any new grievances were discussed with the managers. The SSW stated that department head would follow-up on the grievance. The SSW stated that there had been complaints regarding call lights and staffing. The facility grievance log was reviewed and there were no grievances for residents 37, 82, 105 or 108. 22992

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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** 38031 Based on observation, interview and record review it was determined, for 7 out of 51 residents, that the facility did not ensure that the residents were free from abuse and neglect. Specifically, a resident was not provided catheter care and required treatment at a local hospital for acute sepsis, a resident sustained a fall resulting in a head laceration due to a one person assist when two people were required, a resident with pressure ulcers (PU) located on the bilateral heels did not have the heels floated as ordered and repositioning did not occur for an observed 3 hour time period, and a resident was not provided incontinence care resulting in moisture associated skin damage (MASD) with an open area and a bloody presentation. These examples of neglect were cited at a harm level. Additionally, a resident reported an allegation of verbal and physical abuse from a licensed nurse with medication administration, a resident reported an allegation of physical abuse from a Certified Nurse Assistant (CNA) during incontinence care, and a resident reported an allegation of rough treatment during incontinence care in September 2020 followed by an allegation of verbal abuse with cares by the same nurse in May 2021. Resident identifiers: 1, 17, 84, 101, 105, 108 and 112. Findings include: A. The following examples were cited at harm level for neglect. According to the interpretive guidance neglect was defined as the failure of the facility, it's employees or service providers to provide good and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. 1. Resident 84 was admitted to the facility 1/1/21. He has a history of traumatic subdural hemorrhage, nontraumatic subarachnoid hemorrhage, falls, tracheostomy, neuromuscular dysfunction of the bladder, chronic respiratory failure, quadriplegia, dependence on respirator, insomnia, Parkinson's disease and dementia. Resident 84's medical record was reviewed on 5/23/21. On 5/20/21 at 10:23 PM, a nursing progress note indicated that resident 84's Foley cath (catheter) is patent and draining well at this time. On 5/22/21 at 7:48 PM, a nursing progress note indicated that res (resident) continued with no urine output since cath change to collect UA (urinalysis) and diaphoresis. MD order received at 1850 (6:50 PM) to transport resident to [name of local emergency room]. [Name of local city paramedics] arrived at 1910 (7:10 PM) to transport and left at 1930 (7:30 PM). The nurses note did not indicate the date or time the catheter had been changed. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	On 5/22/21 the emergency room Report for resident 84 indicated that the facility staff note that they went to change the patients Foley catheter today for source control and had not had urine output since. They also note change in trach (tracheostomy) sputum upon suctioning from clear to green. emergency room Physician diagnoses included acute sepsis, pneumonia (ventilator associated), acute UTI (urinary tract infection). The emergency room Report also documented that a urinalysis indicated red colored urine, turbid in nature, nitrites present in abnormal nature, large amount of hemoglobin, proteins present at greater than 3000, Large abnormal [NAME] Blood Cells and bacteria 3 plus. On 5/22/21, a Computerized Tomography scan was performed in the emergency room . The impression from the radiologist included prominently distended bladder. The Foley catheter is malpositioned, the balloon is just inferior to the prostal gland. There is bilateral hydroureter with bilateral hydronephrosis, likely secondary to bladder outlet obstruction. On 5/25/21 at 10:06 AM, a record review showed a late entry progress note for 5/23/21 regarding resident 84. The nursing progress note stated that resident 84 was hospitalized on [DATE]. The note also stated that patient was reported to be tachy (tachycardic) with a HR (heart rate) reaching 145 and a low grade fever. Patient was assessed and on call was notified of the change at 1000 (10:00 AM). Orders were received to do CBC (complete blood count) and CRP (C-Reactive Protein). Due to patient being very dehydrated and all staff efforts being without good outcome, [primary physician]had to be contacted to get a PIV (peripheral intravenous) to draw from as well as have a line in place. [Primary physician] placed PIV at 1715 (5:15 PM) and sample was taken to the lab. No urine output had been seen since midmorning and RN (Registered Nurse) suspected it clogged and was told to change it to get culture. catheter was changed at 1500 (3:00 PM) and no urine was produced. RN notified on call. On call at 1845 (6:45 PM) called and told the night RN to send patient out. [Note: It should be noted that resident 84's physician orders indicated that resident 84 was exclusively hydrated and fed via a feeding tube, therefore it is unclear how resident 84 became dehydrated as indicated in the nurses progress note on 5/23/21.] On 5/23/21 a confidential staff interview was conducted with Staff Member (SM) 2. SM 2 stated that resident 84 should have been rounded on every two hours. SM 2 stated that the facility was so short staffed on multiple occasions that the staff wasn't able to check the fullness of residents' catheter bags. SM 2 stated that he/she frequently saw resident catheter bags filled to capacity, as well as residents' catheter bags not being emptied timely. SM 2 stated that on the day of hospitalization , resident 84's catheter was not flowing and the catheter bag was full. SM 2 stated the resident's physician was notified, and the catheter was changed to get clean urine for a urinalysis. SM 2 stated that the new catheter was not draining, and resident 84 then had a bladder scan with no reading. SM 2 then stated that resident 84's physician requested that resident 84 be sent to the local emergency room . SM 2 stated that he/she felt the resident was septic because no one changed resident 84's catheter bag in a timely manner. 2 . Resident 1 was admitted on [DATE] with diagnoses that included functional quadriplegia, diabetes mellitus, chronic respiratory failure with hypoxia, dysphagia, muscle weakness, , hypertension, difficulty walking, atrial fibrillation, and morbid obesity. Resident 1's medical record was reviewed on 5/23/21. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	Resident 1's quarterly Minimum Data Set (MDS) admission assessment dated [DATE] was reviewed. The MDS indicated that resident 1 required extensive assistance with 2 staff members for bed mobility, and was totally dependent on 2 staff members for transferring. Nurses notes for resident 1 revealed the following: a. On 5/12/21 at 8:00 PM, CNA found RN and alerted her that patient had fallen out of bed during a brief change and was on the floor. CNA states she was changing the resident when she ran out of wipes. She told the resident to go ahead and roll back while she went and got more wipes. The resident then rolled forward rolling off the bed and onto the floor instead of rolling backwards onto her back. CNA returned to the room to find the resident on the floor. Resident head was resting on the stand holding the ventilator and posterior head was actively bleeding . Res (Resident) c/o (complains of) pain all over body and especially her head. Res was assisted back into Bed and Posterior head was clean and area assessed. 1.5 inch laceration and goose bump noted to posterior head . NP (Nurse Practitioner) notified and gave orders to transport Res to [name of local emergency room] . b. On 5/13/21 at 1:20 AM, Resident was transferred back to facility via [name of ambulance company] 3 staples noted to laceration on posterior head. Res Noted to have bruised ribs. Staples to be removed 5/19/21. Resident 1's Medication Administration Record (MAR) indicated that resident 1 received a tramadol for pain on the following dates and times: a. On 5/13/21 at 12:46 PM for pain 10/10 b. On 5/14/21 at 7:57 AM for pain 2/10 c. On 5/14/21 at 7:48 PM for pain 5/10 [Note: Resident 1 did not receive any other tramadol during the month of May 2021 as of 5/26/21.] The MAR also indicated that resident 1 complained of pain 9/10 during the night shift on 5/12/21. Physical therapy notes dated 5/12/21 documented that resident 1 required maximum assistance for bed mobility training. Physical therapy notes dated 5/14/21 documented that resident 1 was still not feeling like herself after falling out of bed; body aches due to fall. Physical therapy notes dated 5/18/21 documented that resident 1 was extremely anxious and did not want to attempt sitting EOB (end of bed) today either; has taken a big step back since her fall a week ago. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	On 5/23/21 at 7:45 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that after the incident on 5/12/21 with resident 1, we took all agency staff off that hall. Now all staff that are up there are our people or are agency who have trained for that hall and know how to reposition those residents. The DON also stated that the CNA left the resident on her side when she left the room and that the CNA should not have left the resident on her side. She should have laid her (the resident) back down on her back and taken all of the supplies in with her. On 5/24/21 at 10:30 AM, an interview was conducted with CNA 3. CNA 3 stated that resident 1 needs two people to change her. She's a total assist. CNA 3 further stated that when he changed resident 1's briefs, he always used two people because the bed is kind've small so I can pull her over to the side to give me enough space, so in case she falls forward she falls into the bed. On 5/24/21 at 10:55 AM, an interview was conducted with resident 1. Resident 1 stated that she was unable to move herself around in bed. When asked about the incident on 5/12/21, resident 1 stated that there were usually two people that changed her brief, but on 5/12/21 it was only one. Resident 1 stated that the lone staff member had rolled the resident to her right side on the edge of the bed and left the room. Resident 1 stated that she had subsequently fallen out of the bed and hit her head on the equipment next to her bed. Resident 1 stated that it was scary. On 5/23/21, a confidential staff interview was conducted with SM 2. SM 2 stated that the facility was poorly staffed. SM 2 stated that all the residents on the 500 hall should be 2 person assistance with brief changes. SM 2 stated that it's dangerous how low the staffing was for the 500 hall. SM 2 stated that there was one agency CNA for the 500 hall one day, and that resident 1 had an accident because there was only one CNA. SM 2 stated that resident 1 was rolled to her side for a brief change. SM 2 stated that the agency CNA left the room to get wipes and resident 1 rolled out of bed. SM 2 stated that when resident 1 rolled out of bed she hit her head and ended up with stitches. SM 2 stated when Agency CNAs worked on the 500 hall there were a lot more accidents. 3. Resident 108 was admitted to the facility on [DATE] with diagnoses that included pneumonia, muscle weakness, difficulty in walking, need for assistance with personal care, cognitive communication deficit, heart failure, dementia, urinary tract infection, hyperlipidemia, hypertension, diabetes, and chronic pain. Resident 108's medical record was reviewed on 5/23/21. On 4/29/21, staff completed an Initial Admission Record for resident 108. The admission record indicated that resident 108 had a blister on left heel, old pressure wound on coccyx. There were no measurements or description of either wound. On 4/30/21, staff completed an Initial Admission Record for resident 108. The admission record indicated that resident 108 had a blister on left heel, old pressure wound on coccyx. There were no measurements or description of either wound. On 4/30/21, staff completed a document entitled Functional Performance Evaluation. The evaluation indicated that resident 108 requiredsubstantial/maximal assistance with sit to lying, lying to sitting on side of bed, sit to stand, and chair/bed to chair transfer. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	On 4/30/21, staff completed a document entitled Braden Scale for Predicting Pressure Sore Risk. The document indicated that resident 108 was slightly limited in her ability to respond to pressure-related discomfort, had skin that was occasionally moist, was chairfast, and was slightly limited in her ability to change and control body position. The document also indicated that resident 108 was at low risk for developing a pressure sore. On 4/30/21 staff developed a care plan for resident 108 that indicated resident had a self care performance deficit related to immobility and weakness. The care plan indicated that resident 108 required Extensive assistance 2 staff participation to reposition and turn in bed. On 5/3/21 staff completed a weekly skin evaluation. Staff indicated that there were no wounds, and no new skin issues. On 5/10/21 staff completed a weekly skin evaluation. Staff indicated that there were no wounds, and no new skin issues. Nurses notes for resident 108 indicated the following note: On 5/12/21 wound team note. team notified 5/11 of sores present on admit. [Resident 108] has MASD under L (left) breast, center to L [NAME] (sic), and BL (bilateral) buttock, scaring (sic) noted on BL buttocks from old wounds. she has a fluid filled blister on her R (right) heel, 4.7x4.5xUTD (unable to determine). PI (pressure injury) unstageable. dark in color. no drainage. no s/s (signs or symptoms) of infection. [NAME] (Decubitis ulcer) noted on the L pad of foot. old and very stable, 0.5x0.7xUTD. education on offloading. On 5/12/21 staff developed a care plan for resident 108 that stated Has pressure ulcer development to R (right) heel r/t (related to) immobility. The care plan also stated that the pressure ulcer was present on admission, was unstageable, and was 4.7 centimeters by 4.5 centimeters in size. On 5/12/21 staff also developed a care plan for resident 108 that stated resident 108 Has actual impairment to skin integrity r/t MASD. [Note: The initial skin integrity care plan for resident 108 developed on 4/30/21 did not indicate that resident 108 had any impairments to her skin integrity.] Resident 108's physician orders were reviewed. On 5/12/21, resident 108 had an order written for Wound care to L pad of foot: [NAME], and Wound care to R heel: PI unstageable. No orders for wound care were written prior to 5/12/21. On 5/18/21 staff completed a weekly skin evaluation. Staff documented that resident 108 had an unstageable pressure ulcer to her R heel that was present on admission. However, no notes could be located in resident 108's medical record to indicate that resident 108 had any skin issues on her R heel prior to 5/11/21. In addition, nurses notes did not indicate that the wound team was notified of any skin issues prior to 5/11/21. On 5/19/21 Wound Assessment Progress Note was completed by a wound specialist. The note indicated that resident 108 had an unstageable pressure ulcer on her right heel that was 4.7x4.5xUTD in size. The note also indicated the that wound was intact, dark discoloration [with] fluid and boggy. The note indicated that resident 108 had a skin issue on her left heel that was resolved. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	On 5/28/21 at 2:00 PM, an interview was conducted with the facility Wound Nurse (WN). The WN stated that resident 108's heel should not be placed directly on the bed or a pillow. The WN stated that resident 108 doesn't have a lot of mobility in her right leg. The WN stated that resident 108 would try to lift her R leg but doesn't succeed. The WN stated that resident 108 was admitted with a blister to her right heel. When asked why there was no documentation about a wound to her R heel prior to 5/11/21 or treatment implemented prior to 5/12/21, the WN stated he did not know. On 5/24/21 at 11:05 AM, an interview was conducted with resident 108. When asked about her stay, resident 108 stated I'm not getting very good care here. Resident 108 stated that she had pain a lot in my back and two sores on my butt. When asked if she could move herself around in her bed, the resident stated she did not attempt to reposition herself in bed because it hurts too much. The resident also stated that she had a sore on her right heel and it hurts like hell. I think it's because I'm just laying in bed. I can wiggle my toes but I can't move my foot off the pillows. It's damn scary to be worried about my foot . On 5/25/21 at 1:23 PM, a follow up interview was conducted with resident 108. Resident 108 stated that staff repositioned her in bed but they don't do it very often. I'll have to call for someone to help. The resident stated that she also had two painful sores on her bottom, that she was admitted with, but my butt feels like its on fire. It needs to be moved. On 5/24/21 a continuous observation was made of resident 108 as follows: a. At 11:35 AM, resident 108 was observed to be in her room in seated her bed, with the head of the bed elevated, and her legs outstretched toward the end of the bed. b. At 12:33 PM, a staff member entered the room to deliver resident 108's lunch tray. c. At 1:10 PM, the Social Services Worker (SSW) entered the room, seated herself in a chair, and spoke with resident 108 for several minutes. d. At 1:23 PM, a staff member entered resident 108's room and obtained a blood sugar sample. e. At 1:41 PM, a staff member entered resident 108's room and administered resident 108's insulin. f. At 2:22 PM, a staff member entered resident 108's room to assist resident 108 out of bed and into her wheelchair. During the duration of the observation from 11:35 AM to 2:22 PM, no staff members were observed to reposition resident 108, nor did resident 108 make any efforts to reposition her buttocks or her legs. On 5/28/21 at 12:55 PM, two staff members were observed to enter resident 108's room. They slid resident 108 up in bed, but did not reposition her right heel. The right heel was observed to be directly laying on a pillow, instead of being floated. 4. Resident 112 was admitted to the facility on [DATE] and 1/1/19 with diagnoses which included multiple sclerosis, benign prostatic hyperplasia with lower urinary tract symptoms, mononeuropathy, and dementia with behavioral disturbance. (continued on next page)

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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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F 0600 Level of Harm - Actual harm Residents Affected - Some	On 5/24/21 at 10:02 AM, an interview was conducted with resident 112. Resident 112 stated that he needed his brief to be changed. Resident 112 was observed to have a foul odor. Resident 112 stated that he wanted to have his brief changed every 2 hours, but not allowed to be changed until every 4 hours. Resident 112 stated that he has not been continent for most of his life. Resident 112 stated that he has a red buttocks and back from sitting in his urine for long periods of time. At 10:30 AM, a therapy staff member wheeled resident to the therapy gym. At 12:40 PM, resident 112 was observed outside the dining room in his wheelchair. Resident 112 stated he had not been changed. At 1:19 PM, an observation was made of resident 112 with CNA 12 and CNA 14 buttocks and backside. Resident 112 was observed to have red areas with small opening that were bleeding. On 5/24/21 at 1:25 PM, an interview was conducted with CNA 10. CNA 10 stated that resident 112 was compliant with brief changes. CNA 10 stated that resident 112 has set times to have his brief changed. CNA 10 stated usually after smoking he was changed. CNA 10 stated that his butt is terrible. CNA 10 stated that she slathers his buttocks with cream. CNA 10 stated that his buttocks is from sitting in a soiled brief for to long and not being changed. CNA 10 stated she thought the bleeding was from hemorrhoids. On 5/24/21 at 1:30 PM, an interview was conducted with CNA 12. CNA 12 stated that she changed resident 112's brief when he got up this morning. CNA 12 stated that therapy did not do brief changes. CNA 12 stated that resident 112 had sores and dead skin on his buttocks. CNA 12 stated that sometime his back side bleeds like it did today. CNA 12 stated that resident 112 should have been changed around his smoke break which was about 10:30 AM. CNA 12 stated that another CNA should have changed his brief before he left for therapy. CNA 12 stated resident 112 did not have a brief change until 1:30 PM. Resident 112's medical record was reviewed 5/24/21 through 5/28/21. A quarterly MDS dated [DATE] revealed resident 112 was frequently incontinent of bowel and bladder. Resident 112 had not been on a toileting program for bowel or bladder. Resident 112 had a BIMS of 11 which revealed mild cognitive impairment. A care plan dated 5/19/15 revealed, Has bowel incontinence r/t MS The goal developed were Will have less than two episodes of incontinence per day through the review date. The interventions developed were Check resident [with] rounds and prn and assist with toileting as needed and Provide pericare after each incontinent episode According to the CNA documentation in the tasks section from 4/29/21 until 5/28/21 resident 112 had 4 continent bowel episodes and 1 continent bladder episode. CNA documentation further revealed that resident 112 was documented as being toileted at 7:40 AM. Resident 112's Bowel and Bladder Evaluation dated 1/28/21 and 4/28/21 resident 112 was an unlikely candidate for bowel and bladder re-training. The evaluation dated 4/28/21 revealed that resident 112 was always incontinent of bowel and bladder which made resident an unlikely candidate for re-training. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	On 5/24/21 at 12:45 PM, an interview was conducted with CNA 10. CNA 10 stated resident 112 was usually changed every 2 hours. CNA 10 stated that resident 112 was able to verbalize to staff when he needed to have a brief changed. CNA 10 stated it can be difficult when staffing is low to change resident 112 because he required 2 person assist with a hoyer lift. On 5/24/21 at 2:00 PM, an interview was conducted with the DON. The DON stated resident 112 was a 2 person assist with brief changes. The DON stated that resident 112 should receive a brief change every 2 hours. On 5/27/21 at 3:43 PM, an interview was conducted with RN 3. RN 3 stated stated that resident 112 was continent but he was hard to transfer so he used briefs. RN 3 stated that resident 112 was alert and Oriented x 4 (person, place, time, and situation). RN 3 stated that resident 112 knew what he wants and where he was. RN 3 stated that resident 112 was able to tell when he had a brief change. RN 3 stated that she was no aware of any skin issues and nothing had been reported to her regarding his buttocks. RN 3 stated resident 112 was not on a bowel and bladder retraining program. On 5/28/21 at 10:52 AM, a follow up interview was conducted with the DON. The DON stated that resident 112 was alert and oriented for the most part and able to tell staff what he wanted and needed. The DON stated that he was compliant with cares as long as it was not during a smoking break. The DON stated that he talked to the Wound Nurse regarding resident 112's buttocks. The DON stated that resident 112 had MASD which was caused by sitting in his urine for to long. B. The following examples were cited at a potential for harm related to abuse allegations: 1. Resident 105 was admitted to the facility on [DATE] with diagnoses which included chronic respiratory failure with hypercapnia, heart failure, major depressive disorder, anxiety disorder, and functional quadriplegia. On 5/26/21 at 9:46 AM, an interview was conducted with resident 105. Resident 105 stated that there was a nurse who was giving me a bad time. When asked to elaborate, resident 105 stated that when RN 7 administered resident 105's heparin, she sometimes doesn't clean my arm with an alcohol wipe before she gives me a heparin shot and she injects it quickly instead of slowly so it makes me bleed all over the pillowcase, my nightgown, and my pillow. Its all soaked with blood. Resident 105 stated that she asked RN 7 why she insisted on doing it that way when resident 105 had asked her to do it differently. Resident 105 stated that RN 7 responded by saying when you go to school to be a nurse, you can tell me how to give a shot. Resident 105 stated that she felt she was being verbally and physically abused. Resident 105 stated that she reported the alleged abuse to the DON the same day, as well as the next day, but nothing happened. Resident 105 stated that the DON told her he would speak to RN 7 about it, but nothing changed and she was still the same. Resident 105 stated that RN 7 had made my life miserable. On 6/8/21 at 4:00 PM, an interview was conducted with RN 7. RN 7 stated that she had had an issue with resident 105. When asked to explain, RN 7 stated that the resident would try and tell me how to giver her shots. I told her don't tell me how to do my job. I went to school to be a nurse. Unless she has a nursing degree, she can't tell me how to do my job. I'm working under my license, not hers. RN 7 then stated that the DON had approached her and stated that resident 105 was alleging that RN 7 was abusive to her. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	On 5/28/21 at 8:26 AM, the DON was informed of the allegations of verbal abuse toward resident 105 by RN 7. The DON stated that he was not aware of the situation, even though both RN 7 and resident 105 stated that he had spoken with them about it, and would investigate and report immediately. A review of the State Agency database revealed that the facility did not investigate or report the incident until 6/8/21, approximately 12 days after the incident was reported to the facility by the state surveyor. 2. Resident 17 was admitted to the facility on [DATE] and readmitted on [DATE] with left femur fracture, muscle weakness, diabetes, major depressive disorder, and major depressive disorder. On 5/26/21 at 11:56 AM, an interview was conducted with resident 17. Resident 17 was asked if he felt staff had been abusive. Resident 17 stated the other night I was messy and CNA 8 cam into his room crying. Resident 17 stated that CNA 8 told him that she did not get any respect and she was burned out. Resident 17 stated that she was very upset. Resident 17 stated that she was rough and rolled him over and changed his brief really fast. Resident 17 stated that she did not fully cover him back up and she did not fully clean him. Resident 17 stated that he reported it to the CNA coordinator. Resident 17's medical record was reviewed 5/26/21 through 5/28/21. A quarterly MDS dated [DATE] revealed that resident 17 had a BIMS score of 14 which revealed he was cognitively intact. On 5/27/21 at 9:55 AM, an interview was conducted with the CNA coordinator. The CNA coordinator stated when a resident reported any concerns or abuse from a resident, then he talked with the staff member. The CNA coordinator stated he then educated the CNAs. The CNA coordinator stated that some of the CNAs were really little so they seam a little rougher but they were not rough. The CNA coordinator stated that CNA 8 was a solid aide and he had to put her on the 300 hall rather than the 500 hall. The CNA coordinator stated that he had not received any reports regarding resident 17 and CNA 8. On 5/28/21 at 1:07 PM, a phone interview was conducted with CNA 8. CNA 8 stated there were issues with staffing. CNA 8 stated a lot of time we were running with low staff. CNA 8 stated there have been times when we have had issues and I've had to run my tail off. CNA 8 stated there had been times that I have been on a hall with 30 residents and my partner goes on break and there are 20 call lights going. CNA 8 stated I have had moments when my stress level has gotten so high that I have just shut down. CNA 8 stated At work try to keep emotions in check but several times she remembered being really stressed. CNA 8 stated that resident 17 had noticed when something with me is off and will ask me what is wrong. CNA 8 stated that resident 17 had to wait for long periods of time to be changed out of a dirty brief because someone was on break. CNA 8 stated that the CNA coordinator call her in and told her not to tell residents when she was short staffed. CNA 8 stated that she had voiced she was burnt out to the CNA coordinator and then she was assigned on the 300 hall instead of the 500 hall where she liked to work. CNA 8 stated that the CNA coordinator did not listen to her concerns. On 5/28/21 at 7:57 AM, an interview was conducted with CRN 2. CRN 2 stated that the DON and Administrator completed the abuse investigations. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	On 5/28/21 at 10:52 AM, an interview was conducted with the DON. The DON stated he did not have an abuse investigation for resident 17. The DON stated that he was not aware that resident 17 had complained about care from a CNA. The DON was told that resident 17 had complained a CNA treated him abusively. A review of the FRI reports through the State Survey agency on 6/7/21 revealed there were no reported abuse investigations. 3. Resident 101 was admitted to the facility on [DATE] with diagnoses which included vascular dementia, essential tremor, hyperlipidemia, hypertension, anxiety disorder, major depressive disorder, chronic pain, chronic respiratory failure, tracheostomy status, functional quadriplegia, insomnia, multiple sclerosis, and spina bifida. On 5/28/21 at 1:17 PM, an interview was conducted with resident 101. When asked if he had ever felt like he was abused at the facility, resident 101 stated that on one occasion, RN 7 entered his room to provide cares, at which time resident 101 told RN 7 can you give me a minute? I'm on the phone with my girlfriend. Resident 101 stated that RN 7 responded by saying I'm here to do your cares now, your girlfriend can call you back. Resident 101 stated that RN 7 has said rude things before this incident, and that they don't treat me with the kind of respect I deserve. My bedroom is my domain. I live here. The nurses don't have the right to speak to anyone that way. Resident 101 stated that both RN 7 and LPN 4 have told him on multiple occasions that this isn't a hotel when resident 101 asked for assistance with something. Resident 101 stated that on those occasions he told the nurses that he realized he wasn't living in a hotel but its still my home. Resident 101 stated that he had reported his concerns to management with regard to how he was being treated, but they don't resolve it. I don't want to get people in trouble, I just want them educated and courteous. On 6/8/21 at 4:00 PM, an interview was conducted with RN 7. RN 7 stated that she has had conversations with resident 101 and his girlfriend regarding their phone calls. RN 7 stated that resident 101's girlfriend would call the facility and tell staff that resident 101 would like a pain pill, but when I get there he (resident 101) says to come back in five minutes. I've explained to her that she (resident 101's girlfriend) can call back in 5 minutes when we are done with his (resident 101's) care. Review of the facility grievance log revealed a grievance form for resident 101 on 9/29/2020 at 12:30 PM. The summary stated, Pt reports the p.m. nurse [RN 7] and CNA [CNA 11] handled him roughly when changing him and would not listen to him instructing them. The form documented that the SSW 1 and the Assistant Director of Nursing (ADON) met with the patient to let the patient voice their grievance, and concluded that if the patient was not turned correctly it caused him pain. The form further documented that the corrective action taken was that the ADON educated RN 7 and CNA 11 on 9/30/2020. On 5/28/21 the DON was informed of the allegations of verbal abuse toward resident 101 by RN 7. The DON stated that he was not aware of the situation, and would inve [TRUNCATED]

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38031 Based on interview and record review it was determined, for 3 out of 51 sampled residents, that the facility did not implement written policies and procedures to investigate allegations of abuse and neglect. Specifically, a resident reported an allegation of verbal and physical abuse from a licensed nurse with medication administration, a second resident reported an allegation of physical abuse from a Certified Nurse Assistant (CNA) during incontinence care, and a third resident reported an allegation of rough treatment during incontinence care in September 2020 followed by an allegation of verbal abuse with cares by the same nurse in May 2021 and all allegations were not investigated for potential incidents of abuse. Resident identifiers: 17, 101, and 105. Findings include: 1. Resident 101 was admitted to the facility on [DATE] with diagnoses which included vascular dementia, essential tremor, hyperlipidemia, hypertension, anxiety disorder, major depressive disorder, chronic pain, chronic respiratory failure, tracheostomy status, functional quadriplegia, insomnia, multiple sclerosis, and spina bifida. On 5/28/21 at 1:17 PM, an interview was conducted with resident 101. When asked if he had ever felt like he was abused at the facility, resident 101 stated that on one occasion, Registered Nurse (RN) 7 entered his room to provide cares, at which time resident 101 told RN 7 can you give me a minute? I'm on the phone with my girlfriend. Resident 101 stated that RN 7 responded by saying I'm here to do your cares now, your girlfriend can call you back. Resident 101 stated that RN 7 had said rude things before this incident, and that they don't treat me with the kind of respect I deserve. My bedroom is my domain. I live here. The nurses don't have the right to speak to anyone that way. Resident 101 stated that both RN 7 and Licensed Practical Nurse (LPN) 4 have told him on multiple occasions that this isn't a hotel when resident 101 asked for assistance with something. Resident 101 stated that on those occasions he told the nurses that he realized he wasn't living in a hotel but its still my home. Resident 101 stated that he had reported his concerns to management with regard to how he was being treated, but they don't resolve it. I don't want to get people in trouble, I just want them educated and courteous. Review of the facility grievance log revealed a grievance form for resident 101 on 9/29/20 at 12:30 PM. The summary stated, Pt (patient) reports the p.m. nurse [RN 7] and CNA (Certified Nurse Assistant) [CNA 11] handled him roughly when changing him and would not listen to him instructing them. The form documented that the Social Service Worker (SSW) 1 and the Assistant Director of Nursing (ADON) met with the patient to let the patient voice their grievance, and concluded that if the patient was not turned correctly it caused him pain. The form further documented that the corrective action taken was that the ADON educated RN 7 and CNA 11 on 9/30/20. On 6/8/21 at 4:00 PM, an interview was conducted with RN 7. RN 7 stated that she has had conversations with resident 101 and his girlfriend regarding their phone calls. RN 7 stated that resident 101's girlfriend would call the facility and tell staff that resident 101 would like a pain pill, but when I get there he (resident 101) says to come back in five minutes. I've explained to her that she (resident 101's girlfriend) can call back in 5 minutes when we are done with his (resident 101's) care. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/28/21, the DON was informed of the allegations of verbal abuse toward resident 101 by RN 7. The DON stated that he was not aware of the situation, and would investigate and report immediately. On 5/28/21 at 12:25 PM, an interview was conducted with the facility Administrator. The Administrator stated that resident 101 did not have an abuse investigation. The Administrator stated that he was not working at the facility in September 2020. On 5/28/21 at 12:56 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that he was never made aware of this incident, and that it should have been reported to him. The DON stated that the SSW should have reported the abuse to the previous Administrator, and then he would have been involved in the investigation because it involved nursing. The DON stated that when an allegation of abuse involved the nursing staff he would interview the resident to get their side of the story. The DON stated that he would have expanded the investigation out to other resident interviews to determine if it was happening with other residents also. The DON stated that the allegation would have been reported to the State Survey Agency (SSA) by either himself or the facility Administrator. The DON stated that for an allegation of abuse an initial entity report was submitted to the SSA in 2 hours and the final investigation within 5 days. The DON stated that he would also inform Adult Protective Services (APS), the police and the resident's family. The DON stated that he would notify the police as soon as it happened so they could do their investigation. The DON stated that any staff that were involved in the investigation were removed from the floor immediately pending the investigation results. The DON stated that both RN 7 and CNA 11 were still employed by the facility and RN 7 still worked with the resident. The DON further stated that RN 7 predominately worked on the floor with resident 101. A review of the State Agency database revealed that the facility did not investigate or report resident 101's abuse allegations until 6/8/21, approximately 12 days after the incident was reported to the facility by the state surveyor. 22992 2. On 5/26/21 at 9:46 AM, an interview was conducted with resident 105. Resident 105 stated that there was a nurse who was giving me a bad time. When asked to elaborate, resident 105 stated that when RN 7 administered resident 105's heparin, she sometimes doesn't clean my arm with an alcohol wipe before she gives me a heparin shot and she injects it quickly instead of slowly so it makes me bleed all over the pillowcase, my nightgown, and my pillow. Its all soaked with blood. Resident 105 stated that she asked RN 7 why she insisted on doing it that way when resident 105 had asked her to do it differently. Resident 105 stated that RN 7 responded by saying when you go to school to be a nurse, you can tell me how to give a shot. Resident 105 stated that she felt she was being verbally and physically abused. Resident 105 stated that she reported the alleged abuse to the DON the same day, as well as the next day, but nothing happened. Resident 105 stated that the DON told her he would speak to RN 7 about it, but nothing changed and she was still the same. Resident 105 stated that RN 7 had made my life miserable. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/8/21 at 4:00 PM, an interview was conducted with RN 7. RN 7 stated that she had had an issue with resident 105. When asked to explain, RN 7 stated that the resident would try and tell me how to giver her shots. I told her don't tell me how to do my job. I went to school to be a nurse. Unless she has a nursing degree, she can't tell me how to do my job. I'm working under my license, not hers. RN 7 then stated that the DON had approached her and stated that resident 105 was alleging that RN 7 was abusive to her. On 5/28/21 at 8:26 AM, the DON was informed of the allegations of verbal abuse toward resident 105 by RN 7. The DON stated that he was not aware of the situation, even though both RN 7 and resident 105 stated that he had spoken with them about it, and would investigate and report immediately. A review of the State Agency database revealed that the facility did not investigate or report the incident until 6/8/21, approximately 12 days after the incident was reported to the facility by the state surveyor. 30563 3. Resident 17 was admitted to the facility on [DATE] and readmitted on [DATE] with left femur fracture, muscle weakness, diabetes, major depressive disorder, and major depressive disorder. On 5/26/21 at 11:56 AM, an interview was conducted with resident 17. Resident 17 was asked if he felt staff had been abusive. Resident 17 stated the other night I was messy and CNA 8 came into his room crying. Resident 17 stated that CNA 8 told him that she did not get any respect and she was burned out. Resident 17 stated that she was very upset. Resident 17 stated that she was rough and rolled him over and changed his brief really fast. Resident 17 stated that she did not fully cover him back up and she did not fully clean him. Resident 17 stated that he reported it to the CNA coordinator. Resident 17's medical record was reviewed 5/26/21 through 5/28/21. A quarterly Minimum Data Set, dated dated dated [DATE] revealed that resident 17 had a Brief Interview for Mental Status score of 14 which revealed he was cognitively intact. On 5/28/21 at 1:07 PM, a phone interview was conducted with CNA 8. CNA 8 stated there were issues with staffing. CNA 8 stated a lot of times they were running with low staff. CNA 8 stated there have been times when we have had issues and I've had to run my tail off. CNA 8 stated there had been times that I have been on a hall with 30 residents and my partner goes on break and there are 20 call lights going. CNA 8 stated I have had moments when my stress level has gotten so high that I have just shut down. CNA 8 stated At work I try to keep emotions in check but several times she remembered being really stressed. CNA 8 stated that resident 17 had noticed when something with me is off and will ask me what is wrong. CNA 8 stated that resident 17 had to wait for long periods of time to be changed out of a dirty brief because someone was on break. CNA 8 stated that the CNA coordinator called her in and told her not to tell residents when she was short staffed. CNA 8 stated that she had voiced she was burnt out to the CNA coordinator and then she was assigned on the 300 hall instead of the 500 hall where she liked to work. CNA 8 stated that the CNA coordinator did not listen to her concerns. On 5/28/21 at 7:57 AM, an interview was conducted with CRN 2. CRN 2 stated that the DON and Administrator completed the abuse investigations. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/27/21 at 9:11 AM, an interview was conducted with the CNA Coordinator (CNAC). The CNAC was asked what the process was if a resident reported a CNA was rough with them. The CNAC stated that he would talk to them, educate them and then just keep an eye on it. The CNAC denied ever having getting a report that a staff member had been rough with a resident. The CNAC stated that he would just do a quick talk with the staff member if I hear someone's being rough, but then if I hear it again, that's when I would document it. When asked at what point the CNAC would report allegations of abuse or staff being rough with residents, the CNAC stated that he would talk to the CNA, and if he heard of it happening more than once then I say this is something we really need to address and do paperwork. The CNAC stated that some of the CNAs were really little so they seem a little rougher but they were not rough. The CNAC stated that CNA 8 was a solid aide and he had to put her on the 300 hall rather than the 500 hall. The CNA coordinator stated that he had not received any reports regarding resident 17 and CNA 8. On 5/28/21 at 8:25 AM, an interview was conducted with the DON. The DON stated that he did not have any reports of abuse for either resident 17 or resident 105. The DON stated that he had not received any reports by the CNA Coordinator about resident 17 being treated roughly by a CNA. The DON stated that resident 105 had asked if a bruise was normal with a heparin shot, and that resident 105 did not report any concerns with with the nurse being mean. The DON stated he was not sure if Registered Nurse (RN) 7 took this the wrong way. The DON stated that he was making rounds with resident 105 weekly, and that was when the resident reported the bruise on the stomach. The DON stated that resident 105 reported that RN 7 had caused the bruise with the heparin injection. The DON stated that resident 105 did not report the conversation with RN 7 or the statement, the next time you go to nursing school you can tell me how to give a shot. The DON stated that resident 105 reported that she had questioned RN 7 about the administration of the medication. The DON stated that had he known about the conversation and the resident's reports of verbal and physical abuse he would have reported it. The DON stated that now that he was informed he would initiate an investigation about potential abuse. The DON stated that he had not received any reports of physical abuse for resident 17. The DON stated that resident 17 was alert and oriented times 3 to 4 (self, place, situation, and time). The DON stated that he had not received any reports of CNA 8 being physically rough during incontinence care. The DON was informed that resident 17 reported that CNA 8 was crying, rolled him roughly during incontinence care, and did not fully clean the resident. The DON was informed that resident 17 reported these allegations to the CNA Coordinator. The DON was informed that the CNA Coordinator stated that if he hears something he goes to the CNA, speaks to the resident, and watches to see if it happens again before he documents and initiates an investigation. The DON did not have any further comment. On 6/8/2021 at 8:39 AM, the State Agency Complaints and Incidents Tracking System was reviewed. No entity reports were identified for the abuse allegations involving resident 17. Review of the facility policy and procedure for Abuse Prevention documented When an incident or allegation of resident abuse or injury of unknown source is identified, the Administrator/Designee will initiate an investigation. The policy further stated that the investigation would consist of : 1. An interview with the person(s) reporting the incident; 2. An interview with the resident(s); 3. Interviews with any witnesses to the incident, including the alleged perpetrator, as appropriate; (continued on next page)

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	465119	A. Building B. Wing	05/28/2021

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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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. A review of the resident's medical record; 5. An interview with staff members (on all shifts) having contact with the resident(s) during the period of the alleged incident; 6. Interviews with other residents to whom the accused employee provides care or services; 7. An interview with staff members (on all shifts) having contact with the accused employee; and 8. A review of all circumstances surrounding the incident. The policy stated if the suspected perpetrator was an employee they would be removed immediately from the care of any residents; and would be suspended during the investigation. The policy then stated that All alleged violations will be reported via phone or in writing within 24 hours to the State Licensing Agency. The policy and procedure was last revised on November 28, 2016.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38031 Based on interview and record review it was determined, for 3 out of 51 sampled residents, that the facility did not ensure that allegations of abuse, neglect, exploitation, or mistreatment were reported immediately, but not later than 2 hours after the allegation was made, if the allegation involved abuse or resulted in serious bodily injury, to the Administrator of the facility, the State Survey Agency (SSA), and adult protective services (APS), and the results of all investigations were reported to the Administrator and the SSA within 5 working days of the incident. Specifically, allegations of abuse were not reported to the SSA or APS. Resident identifiers: 17, 101, and 105. Findings include: 1. Resident 101 was admitted to the facility on [DATE] with diagnoses which included vascular dementia, essential tremor, hyperlipidemia, hypertension, anxiety disorder, major depressive disorder, chronic pain, chronic respiratory failure, tracheostomy status, functional quadriplegia, insomnia, multiple sclerosis, and spina bifida. On 5/28/21 at 1:17 PM, an interview was conducted with resident 101. When asked if he had ever felt like he was abused at the facility, resident 101 stated that on one occasion, RN 7 entered his room to provide cares, at which time resident 101 told RN 7 can you give me a minute? I'm on the phone with my girlfriend. Resident 101 stated that RN 7 responded by saying I'm here to do your cares now, your girlfriend can call you back. Resident 101 stated that RN 7 has said rude things before this incident, and that they don't treat me with the kind of respect I deserve. My bedroom is my domain. I live here.The nurses don't have the right to speak to anyone that way. Resident 101 stated that both RN 7 and LPN 4 have told him on multiple occasions that this isn't a hotel when resident 101 asked for assistance with something. Resident 101 stated that on those occasions he told the nurses that he realized he wasn't living in a hotel but its still my home. Resident 101 stated that he had reported his concerns to management with regard to how he was being treated, but they don't resolve it. I don't want to get people in trouble, I just want them educated and courteous. On 6/8/21 at 4:00 PM, an interview was conducted with RN 7. RN 7 stated that she has had conversations with resident 101 and his girlfriend regarding their phone calls. RN 7 stated that resident 101's girlfriend would call the facility and tell staff that resident 101 would like a pain pill, but when I get there he (resident 101) says to come back in five minutes. I've explained to her that she (resident 101's girlfriend) can call back in 5 minutes when we are done with his (resident 101's) care. On 5/28/21 the DON was informed of the allegations of verbal abuse toward resident 101 by RN 7. The DON stated that he was not aware of the situation, and would investigate and report immediately. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility grievance log revealed a grievance form for resident 1 on 9/29/2020 at 12:30 PM. The summary stated, Pt reports the p.m. nurse [Registered Nurse (RN) 7] and CNA (Certified Nurse Assistant) [CNA 11] handled him roughly when changing him and would not listen to him instructing them. The form documented that the Social Service Worker (SSW) 1 and the Assistant Director of Nursing (ADON) met with the patient to let the patient voice their grievance, and concluded that if the patient was not turned correctly it caused him pain. The form further documented that the corrective action taken was that the ADON educated RN 7 and CNA 11 on 9/30/20. On 5/28/21 at 12:25 PM, an interview was conducted with the facility Administrator. The Administrator stated that resident 101 did not have an abuse investigation. The Administrator stated that he was not working at the facility in September 2020. On 5/28/21 at 12:56 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that he was never made aware of this incident, and that it should have been reported to him. The DON stated that the SSW should have reported the abuse to the previous Administrator, and then he would have been involved in the investigation because it involved nursing. The DON stated that when an allegation of abuse involved the nursing staff he would interview the resident to get their side of the story. The DON stated that he would have expanded the investigation out to other resident interviews to determine if it was happening with other residents also. The DON stated that the allegation would have been reported to SSA by either himself or the facility Administrator. The DON stated that for an allegation of abuse an initial entity report was submitted to the SSA in 2 hours and the final investigation within 5 days. The DON stated that he would also inform APS, the police and the resident's family. The DON stated that he would notify the police as soon as it happened so they could do their investigation. The DON stated that any staff that were involved in the investigation were removed from the floor immediately pending the investigation results. The DON stated that both RN 7 and CNA 11 were still employed by the facility and RN 7 still works with the resident. The DON further stated that RN 7 predominately worked on the floor with resident 101. A review of the State Agency database revealed that the facility did not investigate or report the incident until 6/8/21, approximately 12 days after the incident was reported to the facility by the state surveyor. 22992 2. On 5/26/21 at 9:46 AM, an interview was conducted with resident 105. Resident 105 stated that there was a nurse who was giving me a bad time. When asked to elaborate, resident 105 stated that when RN 7 administered resident 105's heparin, she sometimes doesn't clean my arm with an alcohol wipe before she gives me a heparin shot and she injects it quickly instead of slowly so it makes me bleed all over the pillowcase, my nightgown, and my pillow. Its all soaked with blood. Resident 105 stated that she asked RN 7 why she insisted on doing it that way when resident 105 had asked her to do it differently. Resident 105 stated that RN 7 responded by saying when you go to school to be a nurse, you can tell me how to give a shot. Resident 105 stated that she felt she was being verbally and physically abused. Resident 105 stated that she reported the alleged abuse to the DON the same day, as well as the next day, but nothing happened. Resident 105 stated that the DON told her he would speak to RN 7 about it, but nothing changed and she was still the same. Resident 105 stated that RN 7 had made my life miserable. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/8/21 at 4:00 PM, an interview was conducted with RN 7. RN 7 stated that she had had an issue with resident 105. When asked to explain, RN 7 stated that the resident would try and tell me how to giver her shots. I told her don't tell me how to do my job. I went to school to be a nurse. Unless she has a nursing degree, she can't tell me how to do my job. I'm working under my license, not hers. RN 7 then stated that the DON had approached her and stated that resident 105 was alleging that RN 7 was abusive to her. On 5/28/21 at 8:26 AM, the DON was informed of the allegations of verbal abuse toward resident 105 by RN 7. The DON stated that he was not aware of the situation, even though both RN 7 and resident 105 stated that he had spoken with them about it, and would investigate and report immediately. A review of the State Agency database revealed that the facility did not investigate or report the incident until 6/8/21, approximately 12 days after the incident was reported to the facility by the state surveyor. 30563 3. Resident 17 was admitted to the facility on [DATE] and readmitted on [DATE] with left femur fracture, muscle weakness, diabetes, major depressive disorder, and major depressive disorder. On 5/26/21 at 11:56 AM, an interview was conducted with resident 17. Resident 17 was asked if he felt staff had been abusive. Resident 17 stated the other night I was messy and CNA 8 came into his room crying. Resident 17 stated that CNA 8 told him that she did not get any respect and she was burned out. Resident 17 stated that she was very upset. Resident 17 stated that she was rough and rolled him over and changed his brief really fast. Resident 17 stated that she did not fully cover him back up and she did not fully clean him. Resident 17 stated that he reported it to the CNA coordinator. Resident 17's medical record was reviewed 5/26/21 through 5/28/21. A quarterly Minimum Data Set, dated dated dated [DATE] revealed that resident 17 had a Brief Interview for Mental Status score of 14 which revealed he was cognitively intact. On 5/28/21 at 1:07 PM, a phone interview was conducted with CNA 8. CNA 8 stated there were issues with staffing. CNA 8 stated a lot of time we were running with low staff. CNA 8 stated there have been times when we have had issues and I've had to run my tail off. CNA 8 stated there had been times that I have been on a hall with 30 residents and my partner goes on break and there are 20 call lights going. CNA 8 stated I have had moments when my stress level has gotten so high that I have just shut down. CNA 8 stated At work try to keep emotions in check but several times she remembered being really stressed. CNA 8 stated that resident 17 had noticed when something with me is off and will ask me what is wrong. CNA 8 stated that resident 17 had to wait for long periods of time to be changed out of a dirty brief because someone was on break. CNA 8 stated that the CNA coordinator call her in and told her not to tell residents when she was short staffed. CNA 8 stated that she had voiced she was burnt out to the CNA coordinator and then she was assigned on the 300 hall instead of the 500 hall where she liked to work. CNA 8 stated that the CNA coordinator did not listen to her concerns. On 5/28/21 at 7:57 AM, an interview was conducted with CRN 2. CRN 2 stated that the DON and Administrator completed the abuse investigations. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/27/21 at 9:11 AM, an interview was conducted with the CNA Coordinator (CNAC). The CNAC was asked what the process was if a resident reported a CNA was rough with them. The CNAC stated that he would talk to them, educate them and then just keep an eye on it. The CNAC denied ever having getting a report that a staff member had been rough with a resident. The CNAC stated that he would just do a quick talk with the staff member if I hear someone's being rough, but then if I hear it again, that's when I would document it. When asked at what point the CNAC would report allegations of abuse or staff being rough with residents, the CNAC stated that he would talk to the CNA, and if he heard of it happening more than once then I say this is something we really need to address and do paperwork. The CNAC stated that some of the CNAs were really little so they seam a little rougher but they were not rough. The CNAC stated that CNA 8 was a solid aide and he had to put her on the 300 hall rather than the 500 hall. The CNA coordinator stated that he had not received any reports regarding resident 17 and CNA 8. On 6/8/2021 at 8:39 AM, the State Agency Complaints and Incidents Tracking System was reviewed. No entity reports were identified for the abuse allegations involving resident 17. On 5/28/21 at 8:25 AM, an interview was conducted with the DON. The DON stated that he did not have any reports of abuse for either resident 17 or resident 105. The DON stated that he had not received any reports by the CNA Coordinator about resident 17 being treated roughly by a CNA. The DON stated that resident 105 had asked if a bruise was normal with a heparin shot, and that resident 105 did not report any concerns with with the nurse being mean. The DON stated he was not sure if Registered Nurse (RN) 7 took this the wrong way. The DON stated that he was making rounds with resident 105 weekly, and that was when the resident reported the bruise on the stomach. The DON stated that resident 105 reported that RN 7 had caused the bruise with the heparin injection. The DON stated that resident 105 did not report the conversation with RN 7 or the statement, the next time you go to nursing school you can tell me how to give a shot. The DON stated that resident 105 reported that she had questioned RN 7 about the administration of the medication. The DON stated that had he known about the conversation and the resident's reports of verbal and physical abuse he would have reported it. The DON stated that now that he was informed he would initiate an investigation about potential abuse. The DON stated that he had not received any reports of physical abuse for resident 17. The DON stated that resident 17 was alert and oriented times 3 to 4 (self, place, situation, and time). The DON stated that he had not received any reports of CNA 8 being physically rough during incontinence care. The DON was informed that resident 17 reported that CNA 8 was crying, rolled him roughly during incontinence care, and did not fully clean the resident. The DON was informed that resident 17 reported these allegations to the CNA Coordinator. The DON was informed that the CNA Coordinator stated that if he hears something he goes to the CNA, speaks to the resident, and watches to see if it happens again before he documents and initiates an investigation. The DON did not have any further comment.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30563 Based on observation, interview and record review it was determined, for 4 of 51 sample resident, that the facility did not develop and implement a comprehensive person-centered care plan. The care plan needed to include measurable objectives and timeframe's to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment. Specifically, a care plan was not developed after a resident had a suicide attempt. In addition, care plans were not implemented for resident's in regards to bowel and bladder incontinence, positioning, restorative nursing services. Resident identifiers: 37, 99, 102, and 112. Findings include: 1. Resident 99 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included multiple sclerosis, post-traumatic stress disorder, muscle weakness, anxiety disorder and major depressive disorder. On 5/26/21 at 11:22 AM, an interview was conducted with resident 99. Resident 99 stated that she attempted suicide after an agency CNA (Certified Nursing Assistant) treated her terrible. Resident 99 stated there were not enough staff and she felt like a burden on staff. Resident 99 stated that she tried to cut my throat. Resident 99 stated that she used a knife from home and put a hole in my neck. Resident 99 stated she was suppose to see a counselor after she returned from the hospital. Resident 99 stated that a counselor came into her room and said he was in a hurry and would come back to talk. Resident 99 stated she wanted to talk to a counselor but the counselor had not returned. Resident 99 stated that she had attempted suicide prior to admission. Resident 99's medical record was reviewed 5/26/21 through 5/28/21. The ED (Emergency Department) History and Physical Report dated 3/19/21 at 3:41 PM revealed that resident 99 was .brought in by EMS (Emergency Medical Services), VS (vital signs) normal but pt (patient) unresponsive. Superficial self inflicted abrasion on right arm and chest/neck. The report further revealed, According to caregivers at the facility patient was in her normal state this morning. Her normal state is bedbound only moves right upper extremity and is conversant. Patient had mentioned to some of the workers that she wanted to kill herself. She had a visitor at the facility today. This afternoon patient was found unresponsive with superficial cut marks to her neck. A nursing progress note dated 3/19/21 at 1:00 PM revealed, At 1205 (12:05 PM) Aid reported that she went to check in on resident and noticed that resident had a pocket knife in her left hand and noticed that she had a cut on her lower R (right) forearm and bloody smear just below the front side of her neck. Resident refused to answer specifically why she was upset. She said repeatedly 'I just want to die', 'I want to be with [name removed]', '[name removed] wants me to be with him', 'Put me in the ground next to [name removed]'. Resident was placed on one on one watch with staff. Provider, DON (Director of Nursing) and Administrator alerted to situation. Provider ordered to send resident to [local hospital] ED (Emergency Department) for further psychiatric and medical eval and treatment for suicidal ideation and action. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A nursing progress note dated 3/22/21 at 3:42 PM revealed, MD (Medical Doctor) recommended psych (psychological) evaluation, [local mental health company] notified and coordinating a visit for evaluation. A care plan dated 5/11/21 revealed, Resident has a history of suicide attempts. A goal developed was Resident will have no incidents of self harm. Interventions were Administer medications as ordered. Monitor/document for side effects and effectiveness, encourage to express feelings, Monitor/record/report to MD prn risk for harm to self: suicidal plan, past attempt at suicide, risky actions (stockpiling pills, saying goodbye to family, giving away possessions or writing a note), intentionally harmed or tried to harm self, refusing to eat or drink, refusing med or therapies, sense of hopelessness or helplessness, impaired judgment or safety awareness, provide [local] Mental Health crisis number, resident followed by [local] Mental health. [Note: The suicide attempt was 3/19/21 and the care plan was not created until 5/11/21.] On 5/28/21 at 9:18 AM, a list was provided by the facility Discharge Planner. The list was resident names that the local mental health company was providing services to. Resident 99 was not on the list. The facility Discharge Planner responded that resident 99 was not receiving services but paperwork was being sent today to have resident 99 be on services the following week. 2. Resident 112 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included multiple sclerosis, benign prostatic hyperplasia with lower urinary tract symptoms, mononeuropathy, and dementia with behavioral disturbance. On 5/24/21 at 10:02 AM, an interview was conducted with resident 112. Resident 112 stated that he needed his brief to be changed. Resident 112 was observed to have a foul odor. Resident 112 stated that he wanted to have his brief changed every 2 hours, but was not allowed to be changed until every 4 hours. Resident 112 stated that he had red buttocks and back from sitting in his urine for long periods of time. At 10:30 AM, a therapy staff member wheeled resident to the therapy gym. At 12:40 PM, resident 112 was observed outside the dining room in his wheelchair. Resident 112 stated he had not been changed. At 1:19 PM, an staff provided a brief change for resident 112. On 5/24/21 at 1:25 PM, an interview was conducted with CNA 10. CNA 10 stated that resident 112 was compliant with brief changes. CNA 10 stated that resident 112 had set times to have his brief changed. CNA 10 stated usually after smoking he was changed. CNA 10 stated that resident 112's butt is terrible. CNA 10 stated that she slathers resident 112's buttocks with cream. CNA 10 stated that resident 112's buttocks bleeding was from sitting in a soiled brief for too long and not being changed. CNA 10 stated she thought the bleeding was from hemorrhoids. On 5/24/21 at 1:30 PM, an interview was conducted with CNA 12. CNA 12 stated that she changed resident 112's brief when he got up this morning. CNA 12 stated that resident 112 had sores and dead skin on his buttocks. CNA 12 stated that sometimes resident 112's buttocks bleeds like it did today. CNA 12 stated that resident 112 should have been changed around his smoke break which was about 10:30 AM. CNA 12 stated that another CNA should have changed his brief before he left for therapy. CNA 12 stated resident 112 did not have a brief change until 1:30 PM. Resident 112's medical record was reviewed 5/24/21 through 5/28/21. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A quarterly MDS dated [DATE] revealed resident 112 was frequently incontinent of bowel and bladder. Resident 112 had not been on a toileting program for bowel or bladder. Resident 112 had a BIMS of 11 which revealed mild cognitive impairment. A care plan dated 5/19/15 revealed, Has bowel incontinence r/t MS The goal developed were Will have less than two episodes of incontinence per day through the review date. The interventions developed were Check resident [with] rounds and prn and assist with toileting as needed and Provide pericare after each incontinent episode. On 5/24/21 at 2:00 PM, an interview was conducted with the Director of Nursing (DON). The DON stated resident 112 was a 2 person assist with brief changes. The DON stated that resident 112 should receive a brief change every 2 hours. On 5/28/21 at 10:52 AM, a follow up interview was conducted with the DON. The DON stated that resident 112 was alert and oriented for the most part and able to tell staff what he wanted and needed. The DON stated that the resident was compliant with cares as long as it was not during a smoking break. The DON stated that he talked to the Wound Nurse regarding resident 112's buttocks. The DON stated that resident 112 had Moisture Associated Skin Damage (MASD) which was caused by sitting in his urine for too long. 3. Resident 102 was admitted to the facility on [DATE] with diagnoses which included hemiplegia affecting left non-dominant side, hypertension, anemia, morbid obesity, cerebral infarction due to thrombosis of right vertebral artery and intellectual disabilities. On 5/26/21 at 9:19 AM, an interview was conducted with resident 102. Resident 102 stated she was walking last year before the pandemic. Resident 102 stated she was no longer able to walk outside. Resident 102 stated she was using a walker when she was walked outside. Resident 102 stated that she walked a little in her room but was unable to go very far and usually used a wheelchair. Resident 102's medical record was reviewed on 5/25/21 through 5/28/21. An annual MDS dated [DATE] revealed that resident 102 had limited range of motion to 1 side lower extremity. A care plan dated 5/20/2019 revealed Has hemiplegia/Hemiparesis affecting left non dominate side r/t (related to) stroke. The goal was Will maintain optimal status and quality of life within limitation imposed by hemiplegia/hemiparesis through review date. An intervention developed was Therapy to evaluate and treat as ordered. A care plan dated 5/7/19 and updated on 5/20/2020 revealed ADL self care performance deficit r/t immobility and weakness secondary to CVA with hemiplegia affecting left side, obesity and incontinence. A goal developed was Patient will safely ambulate on level surfaces 400 feet using SBAC with Modified independence with adequate velocity 80% of the time to facilitate increased participation in functional activity. An intervention developed was Nursing rehab: resident to receive restorative nursing services with AROM to LE/UEs using the omnicycle 5 days a week for at least 15 min to maintain strength. An additional intervention dated 5/25/21 revealed Nursing rehab: Resident to receive restorative nursing services with ambulation in the [parallel] bars 5 days a week for at least 15 min to maintain strength. There were no Restorative Weekly Log provided for resident 102. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/28/21 at 10:53 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that he did not know anything about the RNA program. On 5/28/21 at 10:45 AM, an interview was conducted with the MDS coordinator. The MDS coordinator stated that the RNA program has been broken. The MDS coordinator stated that the RNA program had recently be discussed in the Quality Assurance meeting. The MDS coordinator stated the RNA system was changing. The MDS coordinator stated that orders for RNA services were missed getting put into the electronic medical record. The MDS coordinator stated that sometimes there was no RNA program at all. The MDS coordinator stated the documentation portion of the RNA program was broken. The MDS coordinator stated there were times that an RNA was pulled to the floor as a CNA because there were not enough staff. The MDS coordinator stated there were residents that did not get services on certain days because it was during a pandemic. The MDS coordinator stated that she would estimate that the RNA had been pulled to the hall to complete CNA duties about ten times. 22992 4. Resident 37 was admitted to the facility on [DATE] with diagnoses that included spinal stenosis, functional quadriplegia, chronic pain, neuromuscular dysfunction of bladder, and urinary retention. Resident 37's medical record was reviewed on 5/23/21. On 11/26/20, an admission MDS assessment was completed by staff for resident 37. The MDS indicated that resident 37 was always incontinent of both bowel and bladder, and that the resident was not on a toileting program. On 3/29/21, a quarterly MDS assessment was completed by staff for resident 37. The MDS indicated that resident 37 was always incontinent of both bowel and bladder, and that the resident was not on a toileting program. Resident 37's care plan was reviewed. The resident's care plan did not indicate that resident 37 was on a bowel and bladder training program, nor did it address resident 37's needs with regard to his incontinence.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40498 Based on observation, interview and medical record review the facility did not review and revise the Care Plan for 1 out of 49 sample residents. Specifically, a resident with persistent pain had no new interventions since 11/12/19. Resident Identifier: 53. Finding include: 1. Resident 53 was admitted to the facility on [DATE] with diagnoses that included cerebral infarction due to embolism of right anterior cerebral artery, hypertension, hyperlipidemia, homonymous bilateral field deficits-left side, vascular headache, asthma, low back pain, insomnia, history of falling and dementia. On 5/25/21 at approximately 2:36 PM, resident 53 complained of pain in bilateral shoulders. Resident 53 stated he had taken medication for it but it has not provided relief. Resident 53 stated he told the physician that the Lortab did not provide relief. On 5/27/21 at approximately 5:42 PM, an interview was conducted with resident 53. Resident 53 stated that his left shoulder pain was an 8 out of 10 on the pain scale. Resident 53 was observed to hold his left shoulder. Resident 53 stated that he told the nurses that this shoulder hurts so it must be his chest, and it must be a heart attack. Resident 53 was observed to rub his left shoulder. [Note: No additional PRN pain medication was administered per review of the Medication Administration Record.] On 5/27/21 at approximately 6:43 PM, resident 53 was observed grimacing, holding and rubbing both shoulders while standing near the nurses' station. Resident 53 complained of pain in his shoulders and requested his pain medication from Registered Nurse (RN) 2. RN 2 asked resident 53 how he rated his pain. Resident 53 responded that it was an 8 out of 10. RN 2 administered resident 53 his scheduled evening dose of Acetaminophen 1000 milligrams (mg) by mouth with water. On 5/27/21 at approximately 7:40 PM, resident 53 was observed at the nurses' station. Resident 53 stated that he had shoulder pain and no one loves me, no one cares about me. Resident 53's medical record was reviewed 5/27/21. Resident 53 had the following medication orders for pain: a. Acetaminophen 1000 mg by mouth two times a day for pain not to exceed (NTE) 3000 mg in a 24 hour period from all sources. Order Date: 3/2/21 b. Acetaminophen 1000 mg by mouth every 24 hours as needed (PRN) for pain prn NTE 3000 mg in a 24 hour period from all sources. Order Date: 3/2/21 Resident 53's Care Plan included the following related to pain: (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Focus Area: Has acute/chronic pain related to (r/t) low back pain, vascular headaches. Tylenol (Acetaminophen) as ordered. Date Initiated: 7/23/19 Created on: 7/23/19 Goal: Will voice a level of comfort of through the review date. Date Initiated: 7/23/19 Created on: 7/23/19 Interventions: Administer analgesia medication as per orders. Give 1/2 hour before treatments or care. Date Initiated: 11/12/19 Created on: 11/12/19; Anticipate need for pain relief and respond immediately to any complaint of pain. Date Initiated: 11/12/19 Created on: 11/12/19; Monitor/document for side effects of pain medication. Observe for constipation, new onset or increased agitation, restlessness, confusion, hallucinations, dysphoria, nausea, vomiting, dizziness and falls. Report occurrences to the physician. Date Initiated: 11/12/19 Created on: 11/12/19; Monitor/record/report to Nurse any signs/symptoms (s/sx) of non-verbal pain: Changes in breathing (noisy, deep/shallow, labored, fast/slow), Vocalizations (grunting, moans, yelling out, silence), Mood/behavior (changes, more irritable, restless, aggressive, squirmy, constant motion), Eyes (wide open/narrow slits/shut, glazed, tearing, no focus), Face (sad, crying, worried, scared, clenched teeth, grimacing) Body (tense, rigid, rocking, curled up, thrashing). Date Initiated: 11/12/19 Created on: 11/12/19 Pain assessment every shift. Date Initiated: 11/12/19 Created on: 11/12/19 [Note: The Care Plan interventions had not been revised or updated since 11/12/19.]

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22992 Based on interview, record review, and observation, the facility did not ensure that 6 of 51 sample residents who were unable to carry out activities of daily living received the necessary services to maintain good grooming, and personal hygiene. Specifically, residents stated they were not receiving showers according to their preferences due to low staffing, and two residents did not receive assistance with nail care. Resident identifiers: 28, 82, 90, 98, 101, and 112. Findings include: 1. Resident 90 was admitted to the facility on [DATE] wtih diagnoses that included chronic respiratory failure with hypercapnia, need for assistance with personal care, cognitive communication deficit, tracheostomy status, dependence on respirator status, pain, and severe protein calorie malnutrition. On 5/26/21 at approximately 11:00 AM, resident 90 was observed to be laying in bed with his feet exposed. The resident's toenails were observed to extend approximately one-third of an inch past the end of his toes. Resident 90's medical record was reviewed on 5/28/21. Resident 90's care plan indicated that resident 90 required extensive assistance by staff for his personal hygiene and grooming. 2. Resident 101 was admitted to the facility on [DATE] with diagnoses that included chronic respiratory failure with hypoxia, hypertension, spina bifida, tracheostomy status, multiple sclerosis, and functional quadriplegia. On 5/28/21 at 1:17 PM, an interview was conducted with resident 101. Resident 101 stated that he wanted his fingernails and toenails cut, but that he could not cut them by himself. Resident 101 stated that he doesn't like that his fingernails were so long, and stated that his toenails were excessively long. Resident 101's fingernails were observed to be approximately one-quarter inch past the end of his fingers. Resident 101's toenails were observed to extend approximately one-third of an inch past the end of his toes. Resident 101's medical record was reviewed on 5/28/21. Resident 101's care plan indicated that resident 101 required extensive assistance by staff for his personal hygiene and grooming. 3. Resident 28 was admitted to the facility on [DATE] with diagnoses which included history of displaced intertrochanteric fracture of right femur, convulsions, anemia, dysphagia, type 2 diabetes, anxiety, hypertension, depression, dementia and Obstructive Sleep Apnea. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/27/21 at 11:26 AM, an interview was conducted with resident 28. Resident 28 stated that she was incontinent of bowel and bladder, but could feel when she goes and called for assistance from staff. Resident 28 stated that she sometimes had to wait for 2 hours to be changed. Resident 28 stated that happened more frequently at night and on weekends. Resident 28 stated that this was because they were too short of staff. Resident 28 stated that sometimes she did not get a shower. Resident 28 stated that she frequently had staff come into schedule a shower, and then did not come back. Resident 28 stated that staff sometimes tell her I have been so busy, let me come back and they frequently did not come back. Resident 28 stated that she had her husband bring wipes for personal bed baths and had been using those without staff assistance. Reident 28's medical record was reviewed on 5/27/21. Facility provided a document entitled Shower Log that indicated resident 28 had only refused a shower twice in the past 30 days. The shower log, as well as the CNA task section of the electronic medical record indicated that resident 28 had received one shower in the past 30 days. 30563 4. Resident 112 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included multiple sclerosis, hypertension, contractures to both knees, and unspecified dementia. On 5/24/21 at 10:02 AM, an interview was conducted with resident 112. Resident 112 stated that he had scheduled shower days on Tuesday and Saturday. Resident 112 stated that he asked CNAs on Tuesday and Saturday morning if there was a shower aide. Resident 112 stated that usually there was no shower aide so he did not receive showers. Resident 112 was observed to have a coat that was soiled and greasy hair. On 5/26/21 at 10:08 AM, an observation was made of resident 112. Resident 112 was observed to have a black coat that was soiled. Resident 112's hair was greasy and messy. Resident 112 stated he was not receiving showers on Tuesday and Saturday because there were not enough staff. On 5/27/21 at 1:04 PM, resident 112 was observed in the dining room. Resident 112 was wearing a black coat that had white substance dried and resident had holes in her coat. Resident 112's hair was messy and greasy. Resident 112's wheelchair was soiled. Resident 112's medical record was reviewed 5/24/21 through 5/28/21. A quarterly MDS dated [DATE] revealed resident 112 was totally dependent with one person staff assistance for showers. A care plan dated 1/2/19 and revised on 11/25/20 revealed, At risk for an ADLS (Activities of Daily Living) Self Performance Deficit r/t (related to) MS (multiple sclerosis) affecting all extremities, neuropathy, incontinence. A goal developed was, Will safely perform Bed Mobility, Transfers, Dressing, Grooming, Toilet Use and Personal hygiene with assist as needed through the review date. Some interventions developed were Converse with resident while providing care and Explain all procedures/tasks before starting. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Shower observation forms were reviewed for resident 112. Resident 112 had a Skin observation - Shower on 3/2/21, 3/6/21, 3/13/21, 3/20/21, 3/27/21, 4/13/21, 4/20/21, 4/24/21, 4/27/21, 5/4/21, and 5/8/21. There was no documentation of showers on 3/9/21, 3/16/21, 3/23/21, 3/30/21, 4/3/21, 4/6/21, 4/17/21, 5/1/21, 5/11/21, 5/15/21 and 5/18/21. Shower refusal forms were completed on 4/10/21 and 5/22/21 with the shower aide and the nurses signature. On 5/27/21 at 3:47 PM, an interview was conducted with Registered Nurse (RN) 3. RN 3 stated that resident 112 was compliant with cares provided by CNAs. RN 3 stated that resident 112 occasionally refused showers. On 5/27/21 at 6:45 PM, an interview was conducted with the Infection Preventionist (IP). The IP stated that CNAs filled out a form when showers were completed. The IP stated showers were documented in the electronic medical record. The IP stated agency CNAs had a CNA binder for the days of the shower were to be completed. The IP stated that Agency CNAs did not have access to electronic charting so nurses had to document showers in the electronic medical record. 5. Resident 82 was admitted to the facility on [DATE] with diagnoses which included chronic respiratory failure with hypercapnia, morbid obesity, diabetes type 2, muscle weakness and anxiety disorder. On 5/23/21 at 5:18 PM, an interview was conducted with resident 82. Resident 82 stated that she was scheduled for showers on Monday, Wednesday and Friday. Resident 82 stated that she was not receiving showers. Resident 82 stated that CNAs documented that she refused when she was not offered a shower or bed bath. Resident stated that her last shower was on 5/19/21 and was not offered one on 5/21/21. Resident 82's medical record was reviewed 5/23/21 through 5/28/21. A quarterly MDS dated [DATE] revealed that resident 82 was dependent on 1 person physical assist for bathing. A care plan dated 11/17/2020 revealed, Resistive to showers and cares by nursing team - education provided but continues to refuse. A goal developed was Will cooperate with care through next review date. Interventions developed were Allow to make decisions about treatment regime, to provide sense of control, Educate resident/family/caregivers of the possible outcome(s) of not complying with treatment or care, [NAME] will tell staff she refuses then tell other staff they never asked her, so always have 2 staff members when doing cares and let nurse know if she refuses. An intervention developed on 5/23/21 by CRN 3 revealed, Provide a log for refusal of care. A review of resident 82's CNA documentation in the task section revealed over 30 days resident received a shower on 5/5/21. Resident 82 refused showers on 4/26/21, 4/28/21, 5/7/21, 5/14/21 and 5/21/21. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A shower refusal form with the resident's signature was dated 3/22/21. A form titled Concern/Refusal revealed resident refused a shower on 4/12/21. There was no additional information. On 5/24/21 at 2:10 PM, an interview was conducted with the Social Service Worker (SSW). The SSW stated that she talked with the resident a few months ago when she started. The SSW stated that resident 82 was very sensitive to how she was approached by staff. The SSW stated that staffing issues triggered her Big time. The SSW stated that the resident did not like staff to be rotated. On 5/28/21 at 10:52 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that resident 82 refused cares from certain CNAs. The DON stated that each resident had a shower schedule. The DON stated that there was a shower aide that checked off the showers as part of the tasks in the electronic medical record. The DON stated that nurses were to check if showers were completed. The DON stated that there were refusal forms that residents signed and that was how the DON was notified when a resident refused showers. The DON stated that if a resident refused then he would discuss with the resident why refusing. The DON stated that the shower aide was used as a CNA about twice a week. 38031 6. Resident 98 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included end stage renal disease, type 2 diabetes mellitus, congestive heart failure, left below knee amputation, morbid obesity, dorsalgia, major depressive disorder, and insomnia. On 5/26/21 at 10:46 AM, an interview was conducted with resident 98. Resident 98 stated that he frequently had to wait long times for staff to answer call lights. He stated that he had to wait for 7 days to get a shower, and that staff kept putting it off until the next day. He stated that the nursing aide staff was short of people, and he thought that having 4 aides for 100 people was not enough. Review of resident 98's shower logs for the last 30 day look back period from 4/28/21 to 5/27/21 revealed that resident 98 received a shower on 5/13/21, 5/22/21, 5/25/21, and 5/27/21. Review of resident 98's Skin observation - Shower sheet revealed that resident 98 received a shower on 3/12/21, 3/20/21, 3/22/21, 3/31/21, 4/21/21, 4/27/21, 5/6/21, and 5/11/21. According to the shower log and shower sheet resident 98 went 7 days without a shower from 4/28/21 to 5/6/21, and an additional 8 days without a shower from 5/14/21 to 5/21/21. It should be noted that no documentation was found that resident 98 refused any showers. On 5/27/21, an interview was conducted Staff Member (SM) 5. SM 5 stated that it was hard because so many people required extensive assistance. SM 5 stated that they were very staffed this week but that was not typically the case. SM 5 stated that when staffing was short or low they were not able to get showers completed and that was the first task that was skipped. SM 5 stated that the shower aide was often taken off of shower duty and used as a floor aide when staffing was low. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/28/21 at 8:25 AM, an interview was conducted with the DON. The DON stated that each resident had a shower schedule. The DON stated that the nurse would make sure that the resident showers were being completed, and would follow up with the shower aide. The DON stated that if a resident refused a shower the aide would document the refusal on a shower sheet. The DON stated that the shower aides would be pulled off shower duty to staff the floor when they were short staffed and this occurred approximately two times per week.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22992 Based on interview, record review and observation it was determined, for 1 of 51 sample residents, that the facility did not provide care to prevent unavoidable pressure ulcers, nor did they provide timely treatment and services for the resident's pressure ulcer. Specifically, a resident developed an unstageable pressure sore and was not provided interventions to prevent the pressure sore. In addition, after the pressure sore was developed treatment and services were not provided in a timely manner to heal the pressure sore. This resulted in a finding of harm. Resident identifier: 108. Findings include: Resident 108 was admitted to the facility on [DATE] with diagnoses that included pneumonia, muscle weakness, difficulty in walking, need for assistance with personal care, cognitive communication deficit, heart failure, dementia, urinary tract infection, hyperlipidemia, hypertension, diabetes, and chronic pain. Resident 108's medical record was reviewed on 5/23/21. On 4/29/21, staff completed an Initial Admission Record for resident 108. The admission record indicated that resident 108 had a blister on left heel, old pressure wound on coccyx. There were no measurements or description of either wound. On 4/30/21, staff completed an Initial Admission Record for resident 108. The admission record indicated that resident 108 had a blister on left heel, old pressure wound on coccyx. There were no measurements or description of either wound. On 4/30/21, staff completed a document entitled Functional Performance Evaluation. The evaluation indicated that resident 108 required substantial/maximal assistance with sit to lying, lying to sitting on side of bed, sit to stand, and chair/bed to chair transfer. On 4/30/21, staff completed a document entitled Braden Scale for Predicting Pressure Sore Risk. The document indicated that resident 108 was slightly limited in her ability to respond to pressure-related discomfort, had skin that was occasionally moist, was chairfast, and was slightly limited in her ability to change and control body position. The document also indicated that resident 108 was at low risk for developing a pressure sore. On 4/30/21 staff developed a care plan for resident 108 that indicated resident had a self care performance deficit related to immobility and weakness. The care plan indicated that resident 108 required Extensive assistance 2 staff participation to reposition and turn in bed. On 5/3/21 staff completed a weekly skin evaluation. Staff indicated that there were no wounds, and no new skin issues. On 5/10/21 staff completed a weekly skin evaluation. Staff indicated that there were no wounds, and no new skin issues. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Nurses notes for resident 108 indicated the following note: On 5/12/21 wound team note. team notified 5/11 of sores present on admit. [Resident 108] has MASD (moisture associated skin damage) under L (left) breast, center to L [NAME] (sic), and BL (bilateral) buttock, scaring (sic) noted on BL buttocks from old wounds. she has a fluid filled blister on her R (right) heel, 4.7x4.5xUTD (unable to determine). PI (pressure injury) unstageable. dark in color. no drainage. no s/s (signs or symptoms) of infection. [NAME] (Decubitis ulcer) noted on the L pad of foot. old and very stable, 0.5x0.7xUTD. education on offloading. On 5/12/21 staff developed a care plan for resident 108 that stated Has pressure ulcer development to R (right) heel r/t (related to) immobility. The care plan also stated that the pressure ulcer was present on admission, was unstageable, and was 4.7 centimeters by 4.5 centimeters in size. On 5/12/21 staff also developed a care plan for resident 108 that stated resident 108 Has actual impairment to skin integrity r/t MASD. [Note: The initial skin integrity care plan for resident 108 developed on 4/30/21 did not indicate that resident 108 had any impairments to her skin integrity.] Resident 108's physician orders were reviewed. On 5/12/21, resident 108 had an order written for Wound care to L pad of foot: [NAME], and Wound care to R heel: PI unstageable. No orders for wound care were written prior to 5/12/21. On 5/18/21 staff completed a weekly skin evaluation. Staff documented that resident 108 had an unstageable pressure ulcer to her R heel that was present on admission. However, no notes could be located in resident 108's medical record to indicate that resident 108 had any skin issues on her R heel prior to 5/11/21. In addition, nurses notes did not indicate that the wound team was notified of any skin issues prior to 5/11/21. On 5/19/21 Wound Assessment Progress Note was completed by a wound specialist. The note indicated that resident 108 had an unstageable pressure ulcer on her right heel that was 4.7x4.5xUTD in size. The note also indicated the that wound was intact, dark discoloration [with] fluid and boggy. The note indicated that resident 108 had a skin issue on her left heel that was resolved. On 5/28/21 at 2:00 PM, an interview was conducted with the facility Wound Nurse (WN). The WN stated that resident 108's heel should not be placed directly on the bed or a pillow. The WN stated that resident 108 doesn't have a lot of mobility in her right leg. The WN stated that resident 108 would try to lift her R leg but doesn't succeed. The WN stated that resident 108 was admitted with a blister to her right heel. When asked why there was no documentation about a wound to her R heel prior to 5/11/21 or treatment implemented prior to 5/12/21, the WN stated he did not know. On 5/24/21 at 2:32 PM, an interview was conducted with Certified Nursing Assistant (CNA) 6. CNA 6 stated that resident 108 could move her leg a little bit. CNA 6 stated that resident 108's heels were supposed to be floated during the day. CNA 6 stated that she was supposed to do rounds on resident 108 every two to three hours. CNA 6 stated that rounds included repositioning resident 108 because resident 108 required staff assistance to reposition herself in bed. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 5/28/21 at 1:50 PM, an interview was conducted with Registered Nurse (RN) 8. RN 8 stated that he was unsure how resident 108's pressure ulcer started. RN 8 stated that resident 108 could not reposition herself in bed. On 5/24/21 at 11:05 AM, an interview was conducted with resident 108. When asked about her stay, resident 108 stated I'm not getting very good care here. Resident 108 stated that she had pain a lot in my back and two sores on my butt. When asked if she could move herself around in her bed, the resident stated she did not attempt to reposition herself in bed because it hurts too much. The resident also stated that she had a sore on her right heel and it hurts like hell. I think it's because I'm just laying in bed. I can wiggle my toes but I can't move my foot off the pillows. It's damn scary to be worried about my foot . On 5/25/21 at 1:23 PM, a follow up interview was conducted with resident 108. Resident 108 stated that staff repositioned her in bed but they don't do it very often. I'll have to call for someone to help. The resident stated that she also had two painful sores on her bottom, that she was admitted with, but my butt feels like its on fire. It needs to be moved. On 5/24/21 a continuous observation was made of resident 108 as follows: a. At 11:35 AM, resident 108 was observed to be in her room in seated her bed, with the head of the bed elevated, and her legs outstretched toward the end of the bed. b. At 12:33 PM, a staff member entered the room to deliver resident 108's lunch tray. c. At 1:10 PM, the Social Services Worker (SSW) entered the room, seated herself in a chair, and spoke with resident 108 for several minutes. d. At 1:23 PM, a staff member entered resident 108's room and obtained a blood glucose sample. e. At 1:41 PM, a staff member entered resident 108's room and administered resident 108's insulin. f. At 2:22 PM, a staff member entered resident 108's room to assist resident 108 out of bed and into her wheelchair. During the duration of the observation from 11:35 AM to 2:22 PM, no staff members were observed to reposition resident 108, nor did resident 108 make any efforts to reposition her buttocks or her legs. On 5/28/21 at 12:55 PM, two staff members were observed to enter resident 108's room. They slid resident 108 up in bed, but did not reposition her right heel. The right heel was observed to be directly laying on a pillow, instead of being floated. On 5/28/21 at 10:50 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that the facility did not have a policy regarding pressure sore prevention or treatment.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30563 Based on observation, interview and record review it was determined, for 2 of 51 sample residents, that the facility did not ensure that a resident with limited range of motion received appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Specifically, residents did not received physician ordered RNA (Restorative Nursing Services). Resident identifiers: 99 and 102. Findings include: 1. Resident 99 was admitted to the facility on [DATE] with diagnoses which included multiple sclerosis, major depressive disorder, histrionic personality disorder, and muscle weakness. On 5/26/21 at 11:17 AM, an interview was conducted with resident 99. Resident 99 stated she had limited range of motion (ROM) to the right side of her body. Resident 99 stated that when she received a PICC (Peripherally Inserted Central Catheter) line, her insurance changed and therapy was discontinued. Resident 99 stated then therapy was sometimes started again. Resident 99 stated she was previously lifting 5 pound weights but currently unable to lift any weight. Resident 99 stated she was without therapy for about 4-5 months at a time. Resident 99 stated that she was recently started on therapy. Resident 99's medical record was reviewed on 5/24/21 through 5/28/21. A care plan dated 11/19/19 and revised on 5/13/21 reveled ADL (activities of daily living) self care performance deficit r/t (related to) MS, Lupus with R sided weakness. W/C (wheelchair) bound and uses an electric w/c for mobility. The goal was Will safely perform eating, grooming, personal hygiene) with modified independence, through the review date. One of the Goals dated 5/25/21 revealed Nursing Rehab: resident to receive restorative nursing services with PROM (passive range of motion) LE (lower extremities)/UE (upper extremities) with splints to bilat (bilateral) hands 5 days a week for at least 15 minutes to prevent worsening contractures. A physician's order dated 5/25/21 revealed resident to receive restorative nursing services with PROM to LE/UEs 5 days a week for at least 15 min to prevent worsening of contractures. Another physician's order dated 5/25/21 revealed, Resident to receive restorative nursing services with splints to bilat hands 5 days a week for at least 15 min to prevent worsening of contractures No directions specified for order. A review of resident 99's Physical Therapy Discharge Summary dated 3/8/21 revealed Discharge Recommendations: RNA. The form further revealed Restorative Program Established/Trained = Restorative Range of Motion Program, Other restorative program (set up for LE strengthening and rom which closed chain ex.). In addition, Range of Motion Program Established/Trained: work on contracture managemetn (sic) in all 4 extremities. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the Restorative Weekly Log resident 99 was provided. On 4/19/21, 4/20/21 and 4/21/21 there was note NA with no additional information. On 4/22/21 and 4/23/21 resident was provided 15 minutes of upper and lower extremity exercises. RNA services were provided on 4/26/21. There was nothing documented on 4/27/21. On 4/28/21 a note Concerned with [NAME] (sic) pain. On 4/29/21 a note Busy with [name removed]. On 4/30/21 resident 99 was out of facility at family birthday party. On 5/3/21 talk [with] her in the bath not able to get . On 5/4/21 resident was LOA (Leave of Absence) and 5/5/21 there was a line through the day. On 5/6/21 and 5/7/21 resident 99 was provided 15 minutes of exercises. On 5/10/21 and 5/12/21 it was documented Ran out of time. Resident was provided 15 minutes on 5/11/21 and 5/14/21. It was documented that resident was LOA on 5/15/21. On 5/19/21, 5/20/21 and 5/22/21 it was documented resident 99 was provided 15 minutes each day. On Wednesday 5/21/21 there as an R circled with no additional information and on 5/21/21 Friday there was a slash through the date. There were no additional notes. In addition, all notes for all residents provided RNA services were on the same sheet of paper. On 5/28/21 at 2:15 PM, an interview was conducted with the Minimum Data Set (MDS) Coordinator. The MDS coordinator stated she believed that resident 99 was receiving RNA services. 2. Resident 102 was admitted to the facility on [DATE] with diagnoses which included hemiplegia affecting left non-dominant side, hypertension, anemia, morbid obesity, cerebral infarction due to thrombosis of right vertebral artery and intellectual disabilities. On 5/26/21 at 9:19 AM, an interview was conducted with resident 102. Resident 102 stated she was walking last year before the pandemic. Resident 102 stated she was no longer able to walk outside. Resident 102 stated she was using a walker when she was walked outside. Resident 102 stated that she walked a little in her room but was unable to go very far and usually used a wheelchair. Resident 102's medical record was reviewed on 5/25/21 through 5/28/21. An annual MDS dated [DATE] revealed that resident 102 had limited range of motion to 1 side lower extremity. A care plan dated 5/20/19 revealed Has hemiplegia/Hemiparesis affecting left non dominant side r/t (related to) stroke. The goal was Will maintain optimal status and quality of life within limitation imposed by hemiplegia/hemiparesis through review date. An intervention developed was Therapy to evaluate and treat as ordered. A care plan dated 5/7/19 and updated on 5/20/20 revealed ADL (activities of daily living) self care performance deficit r/t immobility and weakness secondary to CVA (cerebrovascular accident) with hemiplegia affecting left side, obesity and incontinence. A goal developed was Patient will safely ambulate on level surfaces 400 feet using SBAC with Modified independence with adequate velocity 80% of the time to facilitate increased participation in functional activity. An intervention developed was Nursing rehab: resident to receive restorative nursing services with AROM to LE/UEs using the omnicycle 5 days a week for at least 15 min to maintain strength. An additional intervention dated 5/25/21 revealed Nursing rehab: Resident to receive restorative nursing services with ambulation in the [parallel] bars 5 days a week for at least 15 min to maintain strength. Resident 102's Physical Therapy Discharge Summary dated 3/15/21 revealed discharge recommendations for Restorative Ambulation Program. There were no Restorative Weekly Log provided for resident 102. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/28/21 at 11:30 AM, an interview was conducted with RNA 1. RNA 1 stated that he was taken from RNA work for CNA work about once a week. RNA 1 stated that most of the time he was able to complete the RNA tasks. RNA 1 stated he had been working with resident 102 for about a month and a half. RNA 1 stated that he completed AROM with her legs using an omnicycle and that the resident was standing and walking with the parallel bars. RNA 1 stated he had not noticed a decline with resident 102. RNA 1 stated she had contractures to her knees because she had a hard time bending them. RNA 1 stated it's was probably more arthritis that affected her ability to bend and caused her pain. RNA 1 stated he saw resident 102 before lunch and was usually changed to a floor CNA after lunch. RNA 1 stated that he documented on a list that had all the resident names for RNA services. On 5/27/21 at approximately 7:00 PM, an interview was conducted with CNA 13. CNA 13 stated that resident 102 was walking with therapy prior to the pandemic. CNA 13 stated that resident 102 was not receiving therapy services. On 5/28/21 at 10:53 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that he did not know anything about the RNA program. On 5/28/21 at 10:45 AM, an interview was conducted with the MDS coordinator. The MDS coordinator stated that the RNA program has been broken. The MDS coordinator stated that the RNA program had recently be discussed in the Quality Assurance meeting. The MDS coordinator stated the RNA system was changing. The MDS coordinator stated that orders for RNA services were missed getting put into the electronic medical record. The MDS coordinator stated that sometimes there was no RNA program at all. The MDS coordinator stated the documentation portion of the RNA program was broken. The MDS coordinator stated there were times that an RNA was pulled to the floor as a CNA because there were not enough staff. The MDS coordinator stated there were residents that did not get services on certain days because it was during a pandemic. The MDS coordinator stated that she would estimate that the RNA had been pulled to the hall to complete CNA duties about ten times.

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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** 22992 Based on observation, interview and record review it was determined, for 3 of 51 sample residents, that the facility did not ensure residents received adequate supervision and assistance devices to prevent accidents. Specifically, one resident was assisted with a brief change with only one staff member instead of two, resulting in the resident falling out of bed and sustaining a head laceration. This incident was found to have occurred at a harm level. In addition, a resident sustained a burn after a staff member placed a wet wash cloth from the microwave on the resident. This incident was found to have occurred at a harm level. Another resident was not assessed to determine if he was safe to smoke independently. Resident identifiers: 1, 37, and 103. Findings include: HARM 1. Resident 1 was admitted on [DATE] with diagnoses that included functional quadriplegia, diabetes mellitus, chronic respiratory failure with hypoxia, dysphagia, muscle weakness, , hypertension, difficulty walking, atrial fibrillation, and morbid obesity. Resident 1's medical record was reviewed on 5/23/21. Resident 1's quarterly Minimum Data Set (MDS) admission assessment dated [DATE] was reviewed. The MDS indicated that resident 1 required extensive assistance with 2 staff members for bed mobility, and was totally dependent on 2 staff members for transferring. Resident 1's care plan dated 2/23/21 was reviewed. The care plan indicated that resident 1 required extensive staff participation to reposition and turn in bed. Nurses notes for resident 1 revealed the following: a. On 5/12/21 at 8:00 PM, CNA found RN (Registered Nurse) and alerted her that patient had fallen out of bed during a brief change and was on the floor. CNA states she was changing the resident when she ran out of wipes. She told the resident to go ahead and roll back while she went and got more wipes. The resident then rolled forward rolling off the bed and onto the floor instead of rolling backwards onto her back. CNA returned to the room to find the resident on the floor. Resident head was resting on the stand holding the ventilator and posterior head was actively bleeding . Res (Resident) c/o (complains of) pain all over body and especially her head. Res was assisted back into Bed and Posterior head was clean and area assessed. 1.5 inch laceration and goose bump noted to posterior head . NP (Nurse Practitioner) notified and gave orders to transport Res to [name of local emergency room] . b. On 5/13/21 at 1:20 AM, Resident was transferred back to facility via [name of ambulance company] 3 staples noted to laceration on posterior head. Res Noted to have bruised ribs. Staples to be removed 5/19/21. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Resident 1's Medication Administration Record (MAR) indicated that resident 1 received a Tramadol for pain on the following dates and times: [Note: Pain scale was 0 to 10 with 0 indicating no pain and 10 indicating excruciating pain.] a. On 5/13/21 at 12:46 PM for pain 10/10 b. On 5/14/21 at 7:57 AM for pain 2/10 c. On 5/14/21 at 7:48 PM for pain 5/10 [Note: Resident 1 did not receive any other Tramadol during the month of May 2021 as of 5/26/21.] The MAR also indicated that resident 1 complained of pain 9/10 during the night shift on 5/12/21. Physical therapy notes dated 5/12/21 documented that resident 1 required maximum assistance for bed mobility training. Physical therapy notes dated 5/14/21 documented that resident 1 was still not feeling like herself after falling out of bed; body aches due to fall. Physical therapy notes dated 5/18/21 documented that resident 1 was extremely anxious and did not want to attempt sitting EOB (end of bed) today either; has taken a big step back since her fall a week ago. On 6/8/21 at 4:00 PM, an interview was conducted with RN 7. RN 7 stated that she was on duty the night that resident 1 fell out of bed. RN 7 stated that there was only one CNA working that night, and it was an agency CNA, who was not familiar with resident 1. RN 7 stated that the CNA working that night had rolled resident 1 on to her side, and then told resident 1 to roll back, but had left the room before making sure that resident 1 was in a safe position. RN 7 stated that she thought resident 1 had somehow rolled forward, resulting in resident 1 hitting her head on the ventilator stand and sustaining an inch-long gash in her head. RN 7 stated that after that incident, resident 1 always insisted on having two people assist her with cares. On 5/23/21, a confidential staff interview was conducted with SM (Staff Member) 2. SM 2 stated that the facility was poorly staffed. SM 2 stated that all the residents on the 500 hall should be 2 person assistance with brief changes. SM 2 stated that it's dangerous how low the staffing was for the 500 hall. SM 2 stated that there was one agency CNA (Certified Nursing Assistant) for the 500 hall one day, and that resident 1 had an accident because there was only one CNA. SM 2 stated that resident 1 was rolled to her side for a brief change. SM 2 stated that the agency CNA left the room to get wipes and resident 1 rolled out of bed. SM 2 stated that when resident 1 rolled out of bed, she hit her head and ended up with staples. SM 2 stated when Agency CNAs worked on the 500 hall there were a lot more accidents. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 5/23/21 at 7:45 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that after the incident on 5/12/21 with resident 1, we took all agency staff off that hall. Now all staff that are up there are our people or are agency who have trained for that hall and know how to reposition those residents. The DON also stated that the CNA left the resident on her side when she left the room and that the CNA should not have left the resident on her side. She should have laid her (the resident) back down on her back and taken all of the supplies in with her. The DON stated that staff can use 1 person to change resident 1. The DON stated that he had not provided education to staff on how to provide 1 person care. On 5/24/21 at 9:16 AM, an interview was conducted with the Administrator. The Administrator stated that he had seen that we were staffing only 1 aide when we should be staffing 2. The Administrator stated that 2 weeks ago, I told them (management) we had to have 2 CNAs up there (500 hall) because of the care. The Administrator stated that after an incident when a resident rolled out of bed a Quality Assurance (QA) plan was created. On 5/24/21 at 10:30 AM, an interview was conducted with CNA 3. CNA 3 stated that resident 1 needs two people to change her. She's a total assist. CNA 3 further stated that when he changed resident 1's briefs, he always used two people because the bed is kind've small so I can pull her over to the side to give me enough space, so in case she falls forward she falls into the bed. On 5/24/21 at 10:55 AM, an interview was conducted with resident 1. Resident 1 stated that she was unable to move herself around in bed. When asked about the incident on 5/12/21, resident 1 stated that there were usually two people that changed her brief, but on 5/12/21 it was only one. Resident 1 stated that the lone staff member had rolled the resident to her right side on the edge of the bed and left the room. Resident 1 stated that she had subsequently fallen out of the bed and hit her head on the equipment next to her bed. Resident 1 stated that it was scary. On 5/26/21 a confidential staff interview was conducted with SM 11. SM 11 stated that all the residents on the 500 hall should be assisted by two staff members with brief changes, transfers etc. SM 11 stated that he/she had worked on the 500 hall alone multiple times. SM 11 stated that if there was not another staff member to assist him/her, then he/she would ask the resident, and if the resident says they are ok with me doing stuff by myself I do it. SM 11 stated that after resident 1's fall on 5/12/21, resident 1 doesn't trust anyone [to work with her] by themselves anymore. 30563 2. Resident 103 was admitted to the facility on [DATE] with diagnoses which included multiple sclerosis, mild cognitive impairment, hyperlipidemia, and edema. Resident 103's medical record was reviewed on 5/24/2021 through 5/28/2021. A nursing progress notes dated 2/11/21 at 2:48 PM by RN 6, revealed, Has burns on the back of her neck. Stated that resident heat up a wet wash rag in the microwave and put it on her neck unsupervised. resident education about hot pack use with supervision was completed and she understood well. abx (antibiotic) ointment for burns was applied. she tol (tolerated) well. MD (Medical Doctor) notified. DON notified. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Resident 103's Treatment Administration Record (TAR) and Medication Administration Record (MAR) for February 2021 were reviewed. There was no documentation of treatment for the burn. Resident 103's orders were reviewed and there were no orders for a burn treatment. On 5/24/21 at 1:15 PM, an interview was conducted with resident 103. Resident 103 stated she asked staff to put a wash rag on her back because she was unable to get a hot pack from the therapy department. Resident 103 stated a CNA warmed up a wet wash cloth and did not check with the nurse. Resident 103 stated that her skin was red. On 5/27/21 at 5:44 PM, an interview was conducted with RN 6. RN 6 stated that the therapy staff members have hot packs for residents. RN 6 stated CNAs should not provide any heated item for residents to put on their bodies. RN 6 stated that she heard from the night shift nurse that resident 103 had sustained a burn on her shoulders. RN 6 stated she was unable to remember who the night shift nurse was. RN 6 stated that she explained to resident 103 to not let CNAs heat up things to place on her body. RN 6 stated that she applied an ointment to the red skin. RN 6 stated resident 103 stated it was painful and felt better after the ointment was applied. RN 6 stated that resident 103 stated she was not aware of how hot the wash cloth was until the washcloth was removed. RN 6 stated that she reported to MD and they said to apply the ointment until healed. RN 6 stated that she notified the DON and did not hear back from the DON. RN 6 stated she educated CNAs not to heat wash cloths and all hot packs were to be applied by therapy staff. On 5/27/21 6:04 PM, an interview was conducted with the DON. The DON stated there were no incident reports or investigation information regarding resident 103's burn. The DON stated he was not aware of the incident. The DON stated that if it was documented that he was notified then he had been notified. The DON stated that he did not complete any systemic changes after the incident. The DON stated that he would have told nurse to notify the MD. The DON stated that he would have educated staff and resident. 40498 POTENTIAL FOR HARM 3. Resident 37 was admitted to the facility on [DATE] with diagnoses which included spinal stenosis, functional quadriplegia, chronic pain, gout and neuromuscular dysfunction of bladder. On 5/27/21 at approximately 9:53 AM, an interview was conducted with the DON. The DON stated that the facility's smoking program was that upon admission, the resident read and signed the facility's Smoking Policy to acknowledge that they understood the facility's smoking rules. The DON stated that the resident was given information on the smoking times and location for the care unit they reside in. The DON stated that the resident was then evaluated by facility staff to determine if the resident was safe to smoke independently or if there was a need for supervision when they were smoking. The facility's Smoking Policy (Revised 3/2008) revealed the following: Policy: It is the policy of this facility to provide to its' residents a smoke free environment. It is also policy to provide those residents who choose to smoke a means in which to do so that does not jeopardize their safety or the safety of other residing in the facility. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Procedure: 1. 2. Upon admission (7-10 days), residents who desire to smoke will be assessed as well as their ability to do so safely. The Interdisciplinary Team will accomplish this using the Smoking Assessment form and a review of the resident's clinical record. At the end of this period it will be determined if the resident will be allowed to smoke with or without protective devices. 3. All resident will be on supervised smoking. 4. The results of the evaluation will be put in the resident's chart. 5. Upon annual review by the IDT (interdisciplinary team), or at any time a significant change of condition occurs, smoking residents will be reassessed as to their ability to smoke safely with or without protective devices and their ability to understand and comply with facility non-smoking policy using the Smoking Assessment form. 7. The frequency of smoking for all residents will be the following times (posted at nurses station) with staff supervision. These times will be no more than twenty (20) minute increments or 2 cigarettes. 8. All smoking materials are to be left at nurses station. [Note: There was no mention in the facility's Smoking Policy about allowing resident to smoke independently if they leave the facility's property or providing smoking materials when a resident wanted to leave the facility's property to smoke.] On 5/27/21, resident 37's medical record was reviewed. Resident 37's Care Plan dated 4/1/21 revealed Potential for injury r/t (related to) Smoking. A goal developed was Will be compliant with smoking protocols and individual smoking plan until next review. Another goal was Will have no injuries related to smoking. Interventions developed were Complete smoking assessment. Explain smoking policy. Maintain smoking materials at nurses' station or other designated area. Monitor to assess compliance with facility smoking policy/individual plan. Observe smoking while in designated area. Report non-compliance or unsafe smoking habits to MD and responsible party. Resident 37's Smoking Agreement that he signed on 4/6/21 revealed .3. I agree to abide by individual restrictions related to smoking safety based on the facilities interdisciplinary team's assessment of my ability to smoke responsibly and safely. [Note: No smoking safety evaluation/assessment was found in resident 37's medical record.] (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 5/27/21 at approximately 12:23 PM, an interview was conducted with Certified Nursing Assistant 1. CNA 1 stated that resident's, who smoked could not have their own lighter and they could only have one cigarette, but she give them whatever they want. CNA 1 further stated that residents, who smoked have to be able to wheel themselves out and light the cigarette themselves. CNA 1 stated if residents wanted to smoke on the facility's property, then they would only go during the scheduled times. On 5/27/21 at approximately 6:00 PM, resident 37 was observed near the nurses' station asking CNA 2 for a cigarette. CNA 2 first replied that he could not have a cigarette and stated that smoking is a privilege here. Resident 37 replied back to CNA 2 that she knew he could go smoke anytime he wanted as long as he went off the facility's property. CNA 2 then provided a cigarette and lighter to resident 37. Resident 37 wheeled himself in his wheel chair down the hall and outside. On 5/27/21 at approximately 6:16 PM, an interview was conducted with CNA 2. CNA 2 stated that the smoking times for residents to smoke had recently changed about 3 weeks ago. CNA 2 stated that the facility used to allow smoking 5 times a day, but they did not have enough staff to supervise residents outside smoking so the facility decreased smoking for residents to only 3 times a day. CNA 2 pointed out a sign posted near the nurses' station, which revealed 3 times a day when residents could smoke (10:30 AM, 2:30 PM & 6:30 PM). CNA 2 then stated that resident, who smoked independently, could smoke whenever they want as long as they went off the facility's property. CNA 2 stated that nursing decided if resident were safe to smoke independently. On 5/27/21 at approximately 6:27 PM, resident 37 was observed wheeling himself in his wheel chair coming back toward the nurses' station. An interview was conducted with resident 37. Resident 37 stated that he had become tired of only being able to smoke during the posted times and only out in the courtyard. Resident 37 stated that a couple months ago that the CNA Coordinator told him that he could smoke whenever he wanted as long as he went off of the facility's property. Resident 37 stated he had enjoyed going to smoke when he wanted to and he liked leaving the facility's property to smoke because it gave him some new scenery rather than just going to the facility's courtyard. Resident 37 stated that he usually smoked 2 to 3 times a day and went off property to smoke. On 5/27/21 at approximately 7:18 PM, an interview was conducted with the DON. The DON stated that the facility's smoking times were recently changed because there were too many staff outside supervising smokers rather inside assisting residents. The DON stated that they allowed residents, who smoked safely independently to leave the facility's property to smoke. The DON stated that residents, who smoked were evaluated to determine if they could smoke safely without supervision. The DON stated that resident 37 should have had an evaluation to assess whether he could smoke safely without supervision.

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F 0690 Level of Harm - 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** 43710 Based on observation, interview and record the review, for 6 of 51 sample residents, it was determined that the facility did not ensure that 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, the facility failed to ensure proper care for a resident with a urinary catheter which resulted in the resident being hospitalized . This finding was cited at a harm level. In addition, a resident was not toileted timely, resulting in the resident having skin breakdown. This finding was also cited at a harm level. In addition, residents were not placed on a bowel and bladder training program despite requests and staff assessment of appropriateness Resident identifiers: 37, 82, 84, 99, 102, and 112. Findings include: HARM 1. Resident 84 was admitted to the facility 1/1/21. He has a history of traumatic subdural hemorrhage, nontraumatic subarachnoid hemorrhage, falls, tracheostomy, neuromuscular dysfunction of the bladder, chronic respiratory failure, quadriplegia, dependence on respirator, insomnia, Parkinson's disease and dementia. Resident 84's medical record was reviewed on 5/23/21. On 5/20/21 at 10:23 PM, a nursing progress note indicated that resident 84's Foley cath (catheter) is patent and draining well at this time. On 5/22/21 at 7:48 PM, a nursing progress note indicated that res (resident) continued with no urine output since cath change to collect UA (urinalysis) and diaphoresis. MD order received at 1850 (6:50 PM) to transport resident to [name of local emergency room]. [Name of local city paramedics] arrived at 1910 (7:10 PM) to transport and left at 1930 (7:30 PM). The nurses note did not indicate the date or time the catheter had been changed. On 5/22/21 the emergency room Report for resident 84 indicated that the facility staff note that they went to change the patients foley catheter today for source control and had not had urine output since. They also note change in trach (tracheostomy) sputum upon suctioning from clear to green. emergency room Physician diagnoses included acute sepsis, pneumonia (ventilator associated), acute UTI (urinary tract infection). The emergency room Report also documented that a urinalysis indicated red colored urine, turbid in nature, nitrites present in abnormal nature, large amount of hemoglobin, proteins present at greater than 3000, Large abnormal [NAME] Blood Cells and bacteria 3 plus. On 5/22/21, a Computerized Tomography scan was performed in the emergency room . The impression from the radiologist included prominently distended bladder. The foley catheter is malpositioned, the balloon is just inferior to the prostal gland. There is bilateral hydroureter with bilateral hydronephrosis, likely secondary to bladder outlet obstruction. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	On 5/25/21 at 10:06 AM, a record review showed a late entry progress note for 5/23/21 regarding resident 84. The nursing progress note stated that resident 84 was hospitalized on [DATE]. The note also stated that patient was reported to be tachy (tachycardic) with a HR (heart rate) reaching 145 and a low grade fever. Patient was assessed and on call was notified of the change at 1000 (10:00 AM). Orders were received to do CBC (complete blood count) and CRP (C-Reactive Protein). Due to patient being very dehydrated and all staff efforts being without good outcome, [primary physician]had to be contacted to get a PIV (peripheral intravenous) to draw from as well as have a line in place. [Primary physician] placed PIV at 1715 (5:15 PM) and sample was taken to the lab. No urine output had been seen since midmorning and RN (Registered Nurse) suspected it clogged and was told to change it to get culture. catheter was changed at 1500 (3:00 PM) and no urine was produced. RN notified on call. On call at 1845 (6:45 PM) called and told the night RN to send patient out. [Note: It should be noted that resident 84's physician orders indicated that resident 84 was exclusively hydrated and fed via a feeding tube, therefore it is unclear how resident 84 became dehydrated as indicated in the nurses progress note on 5/23/21.] On 5/23/21 a confidential staff interview was conducted with Staff Member (SM) 2. SM 2 stated that resident 84 should have been rounded on every two hours. SM 2 stated that the facility was so short staffed on multiple occasions that the staff wasn't able to check the fullness of residents' catheter bags. SM 2 stated that he/she frequently saw resident catheter bags filled to capacity, as well as residents' catheter bags not being emptied timely. SM 2 stated that on the day of hospitalization , resident 84's catheter was not flowing and the catheter bag was full. SM 2 stated the resident's physician was notified, and the catheter was changed to get clean urine for a urinalysis. SM 2 stated that the new catheter was not draining, and resident 84 then had a bladder scan with no reading. SM 2 then stated that resident 84's physician requested that resident 84 be sent to the local emergency room . SM 2 stated that he/she felt the resident was septic because no one changed resident 84's catheter bag in a timely manner. 30563 2. Resident 112 was admitted to the facility on [DATE] and 1/1/19 with diagnoses which included multiple sclerosis, benign prostatic hyperplasia with lower urinary tract symptoms, mononeuropathy, and dementia with behavioral disturbance. On 5/24/21 at 10:02 AM, an interview was conducted with resident 112. Resident 112 stated that he needed his brief to be changed. Resident 112 was observed to have a foul odor. Resident 112 stated that he wanted to have his brief changed every 2 hours, but was not allowed to be changed until 4 hours had passed. Resident 112 stated that he had not been continent for most of his life. Resident 112 stated that he had a red buttocks and back from sitting in his urine for long periods of time. At 10:30 AM, a therapy staff member wheeled resident to the therapy gym. At 12:40 PM, resident 112 was observed outside the dining room in his wheelchair. Resident 112 stated he still had not been changed. At 1:19 PM, an observation was made of resident 112's buttocks and backside, with CNA 12 and CNA 14 buttocks present. Resident 112 was observed to have red areas with a small opening that were bleeding. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	On 5/24/21 at 1:25 PM, an interview was conducted with CNA 10. CNA 10 stated that resident 112 was compliant with brief changes. CNA 10 stated that resident 112 had set times to have his brief changed. CNA 10 stated usually after smoking the resident was changed. CNA 10 stated that resident 112's butt is terrible. CNA 10 stated that she slathered the resident's buttocks with cream. CNA 10 stated that the resident's red buttocks were from sitting in a soiled brief for too long and not being changed. CNA 10 stated she also thought the bleeding was from hemorrhoids. On 5/24/21 at 1:30 PM, an interview was conducted with CNA 12. CNA 12 stated that she changed resident 112's brief when he got up this morning. CNA 12 stated that therapy did not do brief changes. CNA 12 stated that resident 112 had sores and dead skin on his buttocks. CNA 12 stated that sometime resident 112's back side bleeds like it did today. CNA 12 stated that resident 112 should have been changed around his smoke break which was about 10:30 AM. CNA 12 stated that another CNA should have changed his brief before the resident left for therapy. CNA 12 stated resident 112 did not have a brief change until 1:30 PM. Resident 112's medical record was reviewed 5/24/21 through 5/28/21. A quarterly MDS dated [DATE] revealed resident 112 was frequently incontinent of bowel and bladder. Resident 112 had not been on a toileting program for bowel or bladder. Resident 112 had a BIMS of 11 which revealed mild cognitive impairment. A care plan dated 5/19/15 revealed, Has bowel incontinence r/t MS (multiple sclerosis) The goal developed was Will have less than two episodes of incontinence per day through the review date. The interventions developed were Check resident [with] rounds and prn (as needed) and assist with toileting as needed and Provide pericare after each incontinent episode. According to the CNA documentation in the tasks section from 4/29/21 until 5/28/21 resident 112 had 4 continent bowel episodes and 1 continent bladder episode. CNA documentation further revealed that resident 112 was documented as being toileted at 7:40 AM. Resident 112's Bowel and Bladder Evaluation dated 1/28/21 and 4/28/21 resident 112 was an unlikely candidate for bowel and bladder re-training. The evaluation dated 4/28/21 revealed that resident 112 was always incontinent of bowel and bladder which made resident an unlikely candidate for re-training. On 5/24/21 at 12:45 PM, an interview was conducted with CNA 10. CNA 10 stated resident 112 was usually changed every 2 hours. CNA 10 stated that resident 112 was able to verbalize to staff when he needed to have a brief changed. CNA 10 stated it can be difficult when staffing is low to change resident 112 because he required 2 person assist with a hoyer lift. On 5/24/21 at 2:00 PM, an interview was conducted with the Director of Nursing (DON). The DON stated resident 112 was a 2 person assist with brief changes. The DON stated that resident 112 should receive a brief change every 2 hours. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	On 5/27/21 at 3:43 PM, an interview was conducted with Registered Nurse (RN) 3. RN 3 stated stated that resident 112 was continent but he was hard to transfer so he used briefs. RN 3 stated that resident 112 was alert and Oriented x 4 (person, place, time, and situation). RN 3 stated that resident 112 knew what he wanted and where he was. RN 3 stated that resident 112 was able to tell when he had a brief change. RN 3 stated that she was not aware of any skin issues and nothing had been reported to her regarding the resident's buttocks. RN 3 stated resident 112 was not on a bowel and bladder retraining program. On 5/28/21 at 10:52 AM, a follow up interview was conducted with the DON. The DON stated that resident 112 was alert and oriented for the most part and able to tell staff what he wanted and needed. The DON stated that the resident was compliant with cares as long as it was not during a smoking break. The DON stated that he talked to the Wound Nurse regarding resident 112's buttocks. The DON stated that resident 112 had Moisture Associated Skin Damage (MASD) which was caused by sitting in his urine for too long. POTENTIAL FOR HARM 3. Resident 82 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included chronic respiratory failure with hypercapnia, morbid obesity, diabetes, lymphedema, and anxiety disorder. On 5/23/21 at 5:18 PM, an interview was conducted with resident 82. Resident 82 stated that one night she needed to have her brief changed but the 500 hall was short staffed. Resident 82 stated that she had wait all night to be changed. Resident 82 stated earlier today I was changed between 4:00 PM and 4:30 PM. Resident 82 stated prior to that she was changed earlier in the morning. Resident 82 stated she was soaked when she was changed between 4:00 and 4:30 PM. Resident 82 stated that she did not feel safe with Agency staff changing her brief. Resident 82 stated that Agency staff were not trained on how to change her brief safely. Resident 82's medical record was reviewed 5/23/21 through 5/28/21. A quarterly MDS dated [DATE] revealed that resident 82 had a BIMS of 15 which indicated resident was cognitive. The MDS further revealed that resident 82 required 1 person extensive assistance with toilet use and personal hygiene. Resident 82 was not on a trial toileting program and was always incontinent of bowel and bladder. The MDS revealed that resident 82 was at risk for developing pressure ulcers. A care plan initiated on 7/18/18 revealed ADL Self Care Performance Deficit r/t (related to) respiratory failure with obesity hypoventilation syndrome with trach/vent and pulmonary htn (hypertension) . lymphedema. The goal revised on 11/22/2020 by the DON revealed Will improve current level of function in Bed Mobility, Transfers, Eating, Dressing, Grooming, Toilet Use and Personal Hygiene through the review date. One intervention developed was TOILET USE: Requires one to two person extensive assist to use toilet. [Note: There was no information that resident 82 refused ADL care.] Another care plan dated 7/18/18 and revised on 4/27/20 revealed Has bowel incontinence. The goal was Will remain free from skin breakdown due to incontinence and brief use through the review date. Some of the interventions developed were Ensure there is an unobstructed path to the bathroom. INCONTINENT: Check as required for incontinence. Wash, rinse and dry perineum. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Change clothing PRN after incontinence episodes Another care plan dated 5/19/19 and updated on 5/12/21 by Corporate Resource Nurse (CRN) 1 revealed Actual behavior problem r/t refusing care and vitals to be taken IE pericares, and repositioning [resident 82] will only allow certain aides to take care of her. She will refuse cares if the ones she doesn't like are working. The goal developed was Will have fewer episodes of by review date. Interventions developed were Document behaviors, and resident response to interventions. An intervention dated 5/23/21 by CRN 3 revealed, Provide a log for refusal of care. A review of resident 82's Bowel and Bladder Evaluation forms revealed on 4/27/21 and 1/27/21 she was an unlikely candidate for retraining. According to CNA documentation in the tasks section of resident 82's medical record. Resident was not changed on 4/27/21,4/30/21, 5/8/21, 5/18/21 and 5/21/21 . Resident 82 was changed once during a 24 hour period on 4/25/21, 4/26/21, 5/3/21, 5/4/21, 5/5/21, 5/7/21, 5/11/21, 5/12/21, 5/15/21, 5/19/21, 5/20/21 and 5/22/21. Resident 82 was documented as being changed twice on 5/23/21 which resident 82 confirmed during her interview. There was a binder at the nurses station for resident 82's refusals. According to the form there was a date, concern/refusal, and able to redirect columns on the form. There was nothing documented on 4/27/21, 5/8/21, 5/18/21, or 5/21/21. There was a note on 4/30/21 which revealed resident 82 . refused to be changed or showered by me. Another note revealed, [Resident 82] refused to be changed/showered [and] told us if we turn her light off she was just going to turn it back on. [Resident 82] said I could not change her because of my attitude [and] 'aura.' There was no documentation regarding which staff members talked with resident 82. A form dated 5/16/21 revealed that resident 82 refused to be changed by staff on floor and was requesting a staff member that was not on the scheduled floor and refused four times. The CNA that signed the form was a male CNA and CNA 7 a female CNA. According to the staffing schedule on 5/16/21 provided by the facility DON the male CNA was not listed to be working that day. There was no signature from the resident on the form. According to the Tasks section of the electronic medical record for resident 82 toilet use was completed twice in a 24 hour period on 5/16/21. Resident 82's progress notes revealed the following entries: a. On 2/21/21 at 10:56 AM, . Res incont of BM (bowel movement), frequently refuses to be changed unless specific staff members are available, Briefs are changed when res allows. Redirection and education attempted without success. b. On 3/14/21 at 10:26 PM, Resident refused to be changed by CNA on PM Shift. CNA offered multiple times and resident continued to refuse. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	c. On 3/15/21 at 4:48 AM, Resident refused to be changed by CNA on NOC (night) Shift. CNA offered multiple times and resident continued to refuse. Residents room smells strongly of urine. Will continue to educate resident on importance of frequent brief changes to prevent UTI (urinary tract infection and skin breakdown. d. On 4/30/21 at 12:14 AM, Resident refused to be changed by female agency aid at 2300. Resident called asking to have brief change and RN informed resident that girl agency aid on 400 hall could come up and change her, resident refused and stated she would wait for am aid. e. On 4/30/21 at 3:08 PM, Patient refused to be changed from 10 pm on 4/29 because she didn't like the aide from an agency. Patient continued to refused care because she did not like the aide was on the floor. Both aides were female and the nurse offered to assist in changing her and told [resident 82] that it wasn't healthy to be sitting in BM for that amount of time. Patient refused and cried and talked about things not relevant to the aides changing her that she was mad about. (an old boss from [AGE] years ago, ect) RN listened and tried to offer her assistance and come to a resolve but patient was not able to be redirected. Patient refused to be changed and sat in her BM until 1500 (3:00 PM) on 4/30. DON notified. Administrator also came and met with [resident 82] and heard her voiced concerns. Patient still refused cares all day. On 5/24/21 at 10:30 AM, an interview was conducted with CNA 3. CNA 3 stated that resident 82 was only assigned female staff for brief changes and showers per the resident's request. CNA 3 also stated that if you are a new aide or she hasn't seen you before she will refuse all cares. She won't even let you do a brief change. She has only a handful of aides she lets work with her. It's scary because last week she wasn't changed almost all day, but she didn't like the aide that was on that day. The whole hall reeked. On 5/23/21 at 7:33 PM, an interview was conducted with the Administrator. The Administrator stated that resident 82 was particular about who cares for her. The Administrator stated that typically she likes female aides. The Administrator stated that resident 82 wanted to be cared for by specific aides. The Administrator stated that he had talked with resident 82 a lot. The Administrator stated that he was unable to resolve resident 82's concerns. The Administrator stated that he did not file a grievance for resident 82 because he tried to address issues directly. 4. Resident 99 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included multiple Sclerosis, hypertension, major depressive disorder, muscle weakness, and neuromuscular dysfunction of bladder. On 5/26/21 at 10:49 AM, an interview was conducted with resident 99. Resident 99 stated that she had to hold her bowel movements because there were not enough staff. Resident 99 stated that she held her bowel movements during the night shift because there was only one CNA on the 200 hall. Resident 99 stated that CNA 11 was really small and did not know how to operate the sit to stand lift. Resident 99 stated that she did not feel safe with CNA 11 using the sit to stand lift. Resident 99 stated that she skipped meals and did not drink because there were not enough staff to get her up to the bathroom. Resident 99 stated that she was changed at 10:00 PM and then waited till the dayshift CNAs came at 6:00 AM to be changed and put on the toilet. Resident 99 stated that last night she waited for 4 hours to get to the bathroom for a bowel movement. Resident 99 stated that she wanted to use the toilet instead of going in her brief. Resident 99 stated that if she did not have a bowel movement when she was put on the toilet staff will say to her Well, you didn't have to even go. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Resident 99's medical record was reviewed 5/25/21 through 5/28/21. A quarterly MDS dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 which revealed resident was cognitively intact. The MDS revealed that resident 99 did not have a trial toileting program for bowel or bladder. Resident 99 was frequently incontinent of urine. Resident 99 was frequently incontinent of bowel. A care plan dated 12/12/19 revealed Bowel/Bladder: [Resident 99] has requent (sic) bowel/bladder incontinence. The goals developed were Risk for septicemia will be minimized/prevented via prompt recognition and treatment of symptoms of UTI through the review date and Will remain free from skin breakdown due to incontinence and brief use through the review date. Interventions included Check as required for incontinence. Wash, rinse and dry perineum. Change clothing PRN after incontinence episodes and Monitor/document for s/sx UTI: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse,increased temp, Urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. [Note: There was no information regarding a retraining program or assisting resident 99 to the toilet.] Another care plan dated 12/19/21 created by CRN 1 and updated on 5/10/21 revealed resident 99 has Multiple Sclerosis and is w/c (wheelchair) dependent. The goal developed was Will maintain optimal status and quality of life within limitations imposed by Disease process through review date, as evidenced by: An intervention developed was Bowel/bladder program to improve or maintain continence PRN (as needed). Resident 99 had a Bowel and Bladder Evaluation completed on 3/24/21 that revealed she was a possible candidate for bowel and bladder retraining. An assessment completed on 2/4/21 revealed that resident 99 was Continent or Good Candidate for retraining. According to the CNA documentation in the tasks section, toilet use did not occur during the night shift on 4/29/21, 4/30/21, 5/1/21, 5/2/21, 5/6/215/9/21, 5/14/21, 5/15/21, 5/17/21, 5/22/21, 5/23/21, and 5/24/21. On 5/27/21 at 1:53 PM, an interview was conducted with CNA 12. CNA 12 stated that multiple residents on the 200 hall had complained to her about CNA 11. CNA 12 stated that she told the CNA coordinator that resident 99 did not want CNA 11 to care for her. CNA 12 stated that residents refused to use the restroom because they did not feel safe during transfers with CNA 11. CNA 12 stated that CNA 11 worked as the only CNA on night shift for the 200 hall. CNA 12 stated that the CNA Coordinator told her that other halls have complained about CNA 11, so we have to make due. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	On 5/27/21 at 3:49 PM, an interview was conducted with CNA 15. CNA 15 stated there were no residents on a bowel and bladder retraining program. CNA 15 stated resident 99 was incontinent with urine but continent with bowel movements. CNA 15 stated that resident 99 knew when she had urinated. CNA 15 stated resident 99 used 1 person with a sit to stand for transfers to the bathroom. CNA 15 stated that resident 99 complained of other CNAs on the hall that were unable to transfer her because the CNA was not big enough to use the lifts. CNA 15 stated that she usually toileted resident 99 before she left at night so that the resident did not have to get up with CNA 11 during the night. CNA 15 stated she told the CNA coordinator that resident 99 was not comfortable with CNA 11 transferring her. CNA 15 stated that she told the CNA coordinator and Administrator that resident 99 wanted a female CNA only and would not let some CNAs help her. CNA 15 stated that she had been told by residents and other staff that CNA 11 had a hard time using lifts. CNA 15 stated that she stayed late a few times to toilet resident 99 before leaving for the night. 5. Resident 102 was admitted to the facility on [DATE] with diagnoses which included hemiplegia, hypertension, anemia and cerebral infarction due to thrombosis of right vertebral artery. On 5/26/21 at 9:11 AM, an interview was conducted with resident 102. Resident 102 stated she would like to use the toilet verses using a brief. Resident 102 stated staff would take her to the restroom, if they answered her call light. Resident 102 stated it took staff up to an hour to answer her call light. Resident 102 stated that she has had accidents in her pants waiting for staff to answer her call light. Resident 102 stated that if she was able to use the bathroom without help she would get herself to the bathroom so she did not have to use a brief. Resident 102 stated it made her feel like she can't do nothing. Resident 102's medical record was reviewed 5/25/21 through 5/28/21. A annual MDS dated [DATE] revealed that resident 102 had not had a trial of a toileting program for bowel or bladder. The MDS revealed that resident 102 was always incontinent of bladder and frequently incontinent of bowel. Resident 102 had a BIMS of 14 which revealed resident was cognitively intact. A care plan dated 5/20/19 revealed, Has bowel/bladder incontinence. One of the goals developed was Will decrease frequency of urinary incontinence through review date. Interventions included, Offer assistance with toileting with rounds, cares and prn and BRIEF USE: uses disposable briefs. Check/Change with rounds, cares and prn. Another care plan dated 5/7/19 and updated on 5/20/20 revealed ADL Self Care Performance Deficit r/t Immobility and weakness secondary to CVA with hemiplegia affecting left side, Obesity & Incontinence. A goal developed was Will improve current level of function in Bed Mobility, Transfers, Eating, Dressing, Grooming, Toilet Use and Personal Hygiene; ADL Score through the review date. An intervention developed was TOILET USE: requires Extensive assistance to: wash hands, adjust clothing, clean self, transfer onto toilet, transfer off toilet, to use toilet. A Bowel and Bladder Evaluation dated 10/26/20 revealed that resident 102 was a possible candidate for a bowel and bladder re-training. A Bowel and Bladder Evaluation dated 4/12/21 revealed that resident 102 was an Unlikely Candidate for a re-training program. The form revealed that it was unknown how long resident had been incontinent, always incontinent of bowel and bladder, and was indifferent with behavior/attitude. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	According to CNA documentation in the tasks section in the last 30 days resident 102 was continent of bowel 4 times and did not have any continent episodes of bladder. On 5/28/21 at 1:29 PM, an interview was conducted with CNA 8. CNA 8 stated that resident 102 really wanted to be continent. CNA 8 stated that a majority of the time she is incontinent. CNA 8 stated that resident 102 was a 2 person pivot transfer. CNA 8 stated resident 102 was not able to transfer herself to use the bathroom. CNA 8 stated that she did not assist resident 102 to the bathroom and had her use her brief. On 5/27/21 at 5:53 PM, an interview was conducted with CNA 13. CNA 13 stated resident 102 did not have any confusion. CNA 13 stated that resident 102 used the toilet for bowel movements. CNA 13 stated resident 102 was able to use the call light and tell staff when she needed to use the bathroom. CNA 13 stated that she assisted resident 102 to the bathroom every 4 hours. CNA 13 stated resident 102 was not on a re-training program for bowel and bladder. On 5/27/21 at 2:41 PM, an interview was conducted with the DON. The DON stated the facility had a new bowel and bladder program. The DON stated that new admissions were monitored for 3 days to determine a bowel and bladder routine. The DON stated if a resident was continent, then the routine would be written on the CNA report sheet. The DON stated that if a resident was more incontinent then maybe they would be put on a re-training program. The DON stated the facility tried to have enough staff to take residents to the bathroom every 1 to 2 hours. On 5/28/21 at 10:52 AM, an interview was conducted with the DON. The DON stated that no residents were on a bowel and bladder re-training program. The DON stated that incontinence care protocol was to change residents every 2 hours. The DON stated that some residents who were continent were able to wait to use the bathroom every 4 hours. The DON stated if a resident was ambulatory then they were taken to the toilet every 2 hours. The DON stated if they were not ambulatory and incontinent then the resident was changed and cleaned every 2 hours. The DON did not know which residents were on a re-training program. 22992 6. Resident 37 was admitted to the facility on [DATE] with diagnoses that included spinal stenosis, functional quadriplegia, chronic pain, neuromuscular dysfunction of bladder, and urinary retention. Resident 37's medical record was reviewed on 5/23/21. On 11/26/20, an admission MDS assessment was completed by staff for resident 37. The MDS indicated that resident 37 was always incontinent of both bowel and bladder, and that the resident was not on a toileting program. A bowel and bladder evaluation dated 11/22/20 was filled out upon resident 37's admission. The evaluation indicated that the resident was incontinent of bowel, but showed willingness to do a training program. The evaluation indicated that resident 37 was a good candidate for bowel and bladder training. The evaluation did not indicate that resident 37 was incontinent of bladder, as indicated by resident 37's MDS. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	On 3/29/21, a quarterly MDS assessment was completed by staff for resident 37. The MDS indicated that resident 37 was always incontinent of both bowel and bladder, and that the resident was not on a toileting program. Resident 37's care plan was reviewed. The resident's care plan did not indicate that resident 37 was on a bowel and bladder training program, nor did it address resident 37's needs with regard to his bowel and bladder incontinence. On 5/23/21 at 4:06 PM, an interview was conducted with resident 37. Resident 37 stated that he had been asking staff to be on a bowel and bladder training program, and that he had spoken with Restorative Nurse Aid (RNA) 1 about it, but had not been started on a program yet. On 5/28/21 at 11:30 AM, an interview was conducted with RNA 1. RNA 1 stated that the facility had not initiated a bowel and bladder training program for resident 37, but that resident 37 has been wanting to do it. On 5/28/21 at 10:50 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that the facility did not currently have any residents on a bowel and bladder training program. The DON stated the the facility did not have a policy about bowel and bladder training.

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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** 43710 Based on observation, interview and record the review, for 1 of 51 sample residents, it was determined that the facility did not ensure that the resident who needed respiratory care, including tracheostomy care and tracheal suctioning, was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences. Specifically, the facility failed to repair or provide a Continuous Positive Airway Pressure (CPAP) to the resident. Resident identifier: 28. Findings include: Resident 28 was admitted to the facility on [DATE] with diagnoses which included a history of displaced intertrochanteric fracture of right femur, convulsions, anemia, dysphagia, type 2 diabetes, anxiety, hypertension, depression, dementia and Obstructive Sleep Apnea (OSA). On 5/24/21 at 1:34 PM, resident 28's family member was interviewed. Resident 28's family member stated that resident 28 had been having problems with her CPAP machine. Resident 28's family member stated that he started complaining to administration 4 months ago regarding resident 28's CPAP machine not functioning. Resident 28's family member stated that she originally had issues with her mask, which they could not get replaced by administration. Resident 28's family member stated that since then, the CPAP machine was having mechanical problems, which included drying out the humidifying liquid which made resident 28 remove the CPAP mask due to discomfort. Resident 28's family member stated that because she could not get good sleep, she slept all day and had no energy for therapies. Resident 28's family member stated that he thought resident 28 was getting weaker due to this. On 5/27/21 at 11:31 AM, an interview with resident 28 was conducted. Resident 28 stated that it had been 4 months trying to get her CPAP fixed. Resident 28 stated that she was using a nasal cannula for supplemental oxygen during sleeping. Resident 28 stated that her CPAP hydration fluid was broken and it became dry and unusable. Resident 28 stated that she needed a new machine, and had a sleep study a year ago. Resident 28 stated that she did not sleep at night which caused her to sleep during the day. Resident 28 also stated that she had no energy. Resident 28 stated that she felt that she was not having much success with her therapies, and was unable to walk as much. Resident 28's medical record was reviewed on 5/24/21. Resident 28's medical record revealed care conference note dated 3/23/21. The notes revealed that resident 28 needed a new mask for her CPAP. There were no further notes regarding resident 28's CPAP machine. An order dated 5/24/21 revealed CPAP to be ordered through [local company] medical settings: pressure of 14cm (centimeters) of water pressure, with O2 (oxygen) to keep SPO2 (saturations) above 90%. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/24/21 at 1:40 PM, an interview was conducted with Certified Nursing Assistant (CNA) 10. CNA 10 stated she had not worked with resident 28 much. CNA 10 stated that she was not aware that resident 28's CPAP was not functioning. CNA 10 stated that resident 28's saturations were sometimes in the 80s and she checked to make sure resident 28 had her oxygen on. On 5/24/21 at 1:45 PM, an interview was conducted with Registered Nurse (RN) 4. RN 4 stated that a company was supposed to bring resident 28 a new CPAP machine. RN 4 stated she did not know why resident 28 did not have a new CPAP machine. RN 4 stated that she thought maybe resident 28 ordered the CPAP. RN 4 stated that resident 28's family member would know more about the situation with the CPAP than her. On 5/24/21 at 1:50 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that resident 28's CPAP was not working but she refused to use it. The DON stated that there was a request for a new sleep study and there should have been an order for the sleep study. On 5/27/21 at approximately 3:00 PM, an interview with the Director of Nursing (DON) was conducted in which the DON stated that he was working on getting a new CPAP machine for Resident 28.

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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** 43710 Based on observation, interview and record the review, for 3 of 51 sample residents, it was determined that the facility did not ensure that pain management was provided to residents who required such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Specifically, a resident experienced uncontrolled pain from a hip fracture for at least six hours prior to being sent to the hospital. This resulted in a finding of harm. In addition, the nursing staff did not provide oral or topical pain medication to residents who were complaining of pain. Resident identifiers: 17, 53 and 110. Findings include: HARM 1. Resident 110 was admitted on [DATE] with diagnoses which included a history of dementia with behavioral disturbance, displaced interochanteric fracture of right femur, convulsions, anemia, cognitive communication deficit, dysphagia, type 2 diabetes, anxiety disorder, primary hypertension and major depression disorder. Resident 110's medical record was reviewed 5/23/21 through 5/28/21. Nurses notes for resident 110 revealed the following entries: a. On 3/2/21 at 11:33 AM, a large bruise was located on the resident's right thigh. The nurse did not indicate if the resident was in pain. b. On 3/2/21 at 4:24 PM, Symptoms or signs noted of Condition change: Pain (uncontrolled). RLE (right lower extremity) rotated laterally. The note indicated that the physician had been notified at 4:00 PM. The note did not indicate how long resident %% had been in pain, onset of pain, level of pain, or interventions for pain management. On 3/2/21 at 6:51 PM, R (right) leg is turned laterally and pt (patient) cries out upon attempt to rotate medially. Large R bruise noted on inner R thigh than L (left) leg. NP (Nurse Practitioner) assessed pt (patient) and ordered R hip x-ray. Pt denies pain, except upon palpation of site. [Note: No progress notes had been entered prior to this to indicate when the pain first started, or how it progressed.] c. On 3/2/21 at 10:15 PM, the NP entered a note that After detailed skin check and nursing assessment of shortened and internally rotated R LE with new bruising to upper groin/leg area. Pt was sitting in w/c (wheelchair) yesterday, but unable to get out of bed today d/t (due to) pain. Also c/o (complains of) pain with any slight movement to RLE and pain to R hip with palpation. Xray ordered. Follow up note: Findings of Comminuted acute intertrochanteric fracture of the right hip with comminuted components and pt sent to ER . for further management and orthopedic consult. d. On 3/2/21 at 10:28 PM, a radiology note indicated that the resident had Comminuted acute intertrochanteric fracture of the right hip with comminuted components. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	e. On 3/2/21 at 10:35 PM, the facility contacted the resident's husband and stated that the physician was recommending the resident be sent out to the hospital. f. On 3/6/21 at 3:18 AM, Resident readmitted on [DATE] S/P (status post) r hip cephalomedullary nail. Resident 110's March 2021 Medication Administration Record (MAR) revealed that resident 110 had an order to Monitor level of pain every shift. On 3/2/21, facility staff documented that resident 110 did not have any pain for either shift, despite calling the physician for uncontrolled pain at 4:24 PM. The MAR also indicated that from the time the first nurses note was entered at 4:24 PM until the resident was sent out to the hospital at approximately 10:35 PM, no pain medication was administered to the resident, a timeframe of at least 6 hours. An abuse investigation report dated 3/2/21 revealed that Resident reports attempting to transfer self to wheelchair on 3/2/21 and then suffering increased pain leading to being sent to [local] emergency room . Review of an incident report revealed that resident 110 told staff she was transferring from her chair when the injury happened. However, according to a 12/10/20 Admission, Minimum Data Set (MDS) Assessment, resident 110 could not state what the date, month or year was. She was assessed as having long term and short term memory problems, as well as severely impaired cognitive skills for daily decision making. In addition the incident report did not indicate what time the resident allegedly fell . On 5/27/21 at 4:29 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that the information about the resident attempting to transfer to the wheelchair was obtained through an interview with the husband. The DON could not provide an explanation as to why resident 110 was in pain from a fractured hip with no pain medication for at least 6 hours. On 5/27/21 at 5:36 PM, an interview was conducted with resident 110's husband. Resident 110's husband stated that resident 110 had a seizure with a fall in February and she was complaining of pain in her lower legs. Resident 110's husband stated that resident 110 was sent to the hospital and her lower legs were X-rayed and there were no fractures. Resident 110's husband stated that a couple weeks later, the facility called him and stated that resident 110 had pain in her right hip with some bruising. Resident 110's husband stated that the facility then sent her to the hospital a second time and she had a fractured hip which required surgery. Resident 110's husband stated he did not witness a fall and was not told about a fall. Resident 110's family member stated that he had not witnessed or been told by facility staff that resident 110 had transferred herself to her wheel chair, sustaining an injury to her hip. 30563 POTENTIAL FOR HARM 2. Resident 17 was admitted to the facility on [DATE] with diagnoses which included femur fracture, muscle weakness, need for assistance with personal care, difficulty walking, respiratory failure, low back pain, and morbid obesity with alveolar hypoventilation. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	On 5/26/21 at 11:51 AM, an interview was conducted with resident 17. Resident 17 stated his knees and shoulders needed to have Voltaren gel twice a day. Resident 17 stated there were not enough staff to apply the gel twice daily to his shoulders and knees. Resident 17 stated that the gel helped but needed to be applied during the busy times of the day in the morning and before bed. Resident 17's medical record was reviewed on 5/28/21. An order dated 11/16/20 revealed Voltaren Gel 1% apply application transdermally every 6 hours as needed for pain. A quarterly MDS dated [DATE] revealed that resident 17 had scheduled pain medications, as needed medications, and non-medication interventions for pain. A pain assessment was completed and revealed resident had almost constant pain. Resident 17's pain made it had for him to sleep at night and limited his day to day activities. A care plan dated 10/9/20 and updated on 3/25/21 revealed Has acute/ chronic pain r/t (related to) surgical repair of LLE (left lower extremity) fx (fracture), muscle spasms, neuropathy Duloxetine as ordered.Tylenol as ordered, lidocaine gel 0.5% as ordered, Diclofenac as ordered, Pramipexole as ordered oxycodone 5/325mg (milligrams) as ordered, Voltaren gel 1% as ordered. The goals were Will not have an interruption in normal activities due to pain through the review date. Will voice a level of comfort through the review date. Will verbalize adequate relief of pain or ability to cope with incompletely relieved pain through the review date. The interventions developed were Administer analgesia medication as per orders. Give 1/2 hour before treatments or care. Anticipate need for pain relief and respond immediately to any complaint of pain. Report occurrences to the physician. Monitor/record pain characteristics: . Pain assessment every shift. According to the Medication Administration Record for May 2021 resident 17 had Voltaren Gel Applied on the following days with the following pain score [Pain scores were 0 to 10 with 0 indicated no pain and 10 indicated excruciating pain]: a. 5/1/21, 6 and the gel was effective. b. 5/12/21, 8 and the gel was effective c. 5/16/21, 6 and the gel was effective. d. 5/19/21, 3 and the get was effective. e. 5/22/21, 7 and the gel was effective. f. 5/26/21, 10 and the gel was effective. On 5/28/21 at 1:33 PM, an interview was conducted with Certified Nursing Assistant (CNA) 8. CNA 8 stated that resident 17 had Voltaren gel in his drawer in his room. CNA 8 stated he applied it to his shoulders and knees. CNA 8 stated that the gel provided pain relief and he seemed to feel better after the gel was applied. CNA 8 stated that resident 17 asked to have her apply it occasionally. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	On 5/28/21 at 1:45 PM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated Voltaren gel was a medication to be administered by the nurse. RN 1 stated that resident 17 had the gel in his top drawer and was able to apply it himself to his knees but needed assistance applying it to his shoulders. On 5/28/21 at 1:50 PM, a follow up interview was conducted with resident 17. Resident 17 stated that he wanted a nurse to apply the gel to his shoulders and knees. Resident 17 stated that the gel really helps with the pain. Resident 17 stated that the nurses were too busy to apply it in the morning and at night. Resident 17 stated that he sometimes asked CNAs to apply it but they were very busy. Resident 17 stated he tried to apply the gel to his shoulders but was unable to reach all the way behind his shoulder. Resident 17 stated he did not apply it to his knees because he was unable to reach his knees and almost fell forward trying to reach them. 40498 3. Resident 53 was admitted to the facility on [DATE] with diagnoses that included cerebral infarction due to embolism of right anterior cerebral artery, hypertension, hyperlipidemia, homonymous bilateral field deficits-left side, vascular headache, asthma, low back pain, insomnia, history of falling and dementia. On 5/25/21 at approximately 2:36 PM, resident 53 complained of pain in both shoulders. Resident 53 stated he had taken medication for it but it did not provide relief. Resident 53 stated he told the physician that the Lortab did not provide relief. On 5/25/21 at approximately 2:45 PM, resident 53 reported pain in his chest area. Resident 53 stated, I think I'm having a heart attack. Registered Nurse (RN) 3 stated that resident 53 always had complaints of pain. The Assistant Director of Nursing (ADON) approached and obtained resident 53's vital signs and they were within normal limits. The ADON stated that resident 53 had a diagnosis of gastroesophageal reflux (GERD). Resident 53's medical record was reviewed 5/27/21. Resident 53 had the following medication orders for pain: a. Acetaminophen 1000 mg (milligrams) by mouth two times a day for pain not to exceed (NTE) 3000 mg in a 24 hour period from all sources. Order Date 3/2/21 b. Acetaminophen 1000 mg by mouth every 24 hours as needed (PRN) for pain prn NTE 3000 mg in a 24 hour period from all sources. Order Date 3/2/21 c. Pantoprazole Tablet Delayed Release 40 mg by mouth one time a day for GERD. Order Date 12/18/20 Resident 53 was having his pain assessed twice-a-day, morning and evening, using a pain scale of 0 - 10, where a score of 0 was no pain, and a score of 10 was the worst possible pain. Review of resident 53's April 2021 and May 2021 Medication Administration Records (MARs) revealed the following pain score monitoring while receiving Acetaminophen 1000 mg by mouth twice a day [morning and evening]: April 2021 (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Actual harm Residents Affected - Few	a. 4/4/21 morning pain score was 3, evening pain score was 1. b. 4/5/21 morning pain score was 4, evening pain score was 1. c. 4/6/21 morning pain score was 2, evening pain score was 1. d. 4/8/21 morning pain score was 8, evening pain score was 0. [Note: An additional PRN pain medication (Acetaminophen 1000 mg) by mouth was administered at 12:21 PM and charted as Effective.] e. 4/9/21 morning pain score was 2, evening pain score was 2. f. 4/10/21 morning pain score was 2, evening pain score was 0. g. 4/11/21 morning pain score was 0, evening pain score was 6. h. 4/12/21 morning pain score was 4, evening pain score was 1. i. 4/13/21 morning pain score was 1, evening pain score was 1. j. 4/14/21 morning pain score was 4, evening pain score was 1. k. 4/15/21 morning pain score was 0, evening pain score was 5. l. 4/17/21 morning pain score was 0, evening pain score was 1. m. 4/18/21 morning pain score was 2, evening pain score was 2. n. 4/19, 21 morning pain score was 2, evening pain score was 1. o. 4/20/21 morning pain score was 2, evening pain score was 0. p. 4/22/21 morning pain score was 0, evening pain score was 4. q. 4/24/21 morning pain score was 2, evening pain score was 0. r. 4/26/21 morning pain score was 3, evening pain score was 1. s. 4/27/21 morning pain score was 1, evening pain score was 1. t. 4/28/21 morning pain score was 1, evening pain score was 1. u. 4/29/21 morning pain score was 0, evening pain score was 1. [Note: No additional PRN pain medication was administered except for the dose on 4/8/21.] May 2021 (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	a. 5/2/21 morning pain score was 3, evening pain score was 0. b. 5/3/21 morning pain score was 3, evening pain score was 3. c. 5/5/21 morning pain score was 0, evening pain score was 10. d. 5/9/21 morning pain score was 5, evening pain score was 5. e. 5/10/21 morning pain score was 4, evening pain score was 0. f. 5/11/21 morning pain score was 4, evening pain score was 0. g. 5/12/21 morning pain score was 4, evening pain score was 4. h. 5/17/21 morning pain score was 4, evening pain score was 2. i. 5/24/21 morning pain score was 2, evening pain score was 1. j. 5/26/21 morning pain score was 2, evening pain score was 0. [Note: No additional PRN pain medication was administered.] On 5/27/21 at approximately 5:42 PM, an interview was conducted with resident 53. Resident 53 stated that his left shoulder pain was an 8 out of 10 on the pain scale. Resident 53 was observed to hold his left shoulder. Resident 53 stated that he told the nurses that this shoulder hurt so it must be his chest, so it must be having a heart attack. Resident 53 was observed to rub his left shoulder. [Note: No additional PRN pain medication was administered until 6:43 PM.] On 5/27/21 at approximately 5:50 PM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated she did not know why resident 53 did not receive any additional PRN pain medication after reporting a pain score of 10 out of 10 on 5/5/21. RN 1 stated that if a resident had reported a pain score of 10 to her, that she would have checked to see if the resident had a PRN pain medication ordered and then would administer it and notify the resident's provider. On 5/27/21 at approximately 6:43 PM, resident 53 was observed grimacing, holding and rubbing both shoulders while standing near the nurses' station. Resident 53 complained of pain in his shoulders and requested his pain medication from RN 2. RN 2 asked resident 53 how he rated his pain. Resident 53 responded that it was an 8 out of 10. RN 2 administered resident 53 his scheduled evening dose of Acetaminophen 1000 milligrams (mg) by mouth with water. On 5/27/21 at approximately 6:50 PM, an interview was conducted with RN 2. RN 2 stated she did not know why resident 53 did not receive any additional PRN pain medication after reporting a pain score of 10 on 5/5/21. RN 2 stated if a resident had reported a pain score of 10 that she would have checked to see if the resident had a PRN pain medication ordered and would have administered it. On 5/27/21 at approximately 7:29 PM, an interview was conducted with the DON. The DON stated that he did not know why resident 53 did not receive any additional PRN pain medication after reporting a pain score of 10 on 5/5/21. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	On 5/27/21 at approximately 7:40 PM, resident 53 was observed at the nurses' station. Resident 53 stated that he had shoulder pain and no one loves me, no one cares about me. 38031 On 5/28/21 at 8:25 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that the process for evaluating a resident's pain was by done by the nurse every shift with a pain assessment utilizing a pain scale and with each pain medication administration. The DON stated that if the pain was reported at a higher level the nurse would assess the resident and report it to the physician. The DON stated that for a report of a pain level of a 10/10 (on a scale of 1 to 10, with 10 being the highest), he would expect the nurse to administer a PRN (as needed) pain medication, and then follow up with the physician. The DON stated that if the physician was informed he would expect that the resident would get something additional for the pain, like with a fracture. The DON stated that this would also be dependent on what was the cause of the pain. What is the reason behind this? If it is something big, yes. If its a one time thing, maybe not. With a fracture they get an x-ray and see what is causing the pain and treat the pain. The DON stated that resident 17 had not reported any pain in the arm and knees. The DON stated that resident 17 had Voltaren gel that helped if applied every night. If they are consistent with it, it would really help. The DON stated that resident 53 reported chest pain. The DON stated that resident 53 was not alert and oriented. The DON stated that resident 53 had left the facility before to seek treatment for chest pain and then returned to the facility. The DON then stated that resident 53 was alert and oriented enough to come back to the facility. The DON stated that he was not aware that resident 53 was reporting pain at a level of 8/10 last evening. The DON stated the facility did not have a policy and procedure for pain management.

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F 0725 Level of Harm - Actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38031 Based on observation, interview and record review it was determined, for 17 of 51 sampled residents, that the facility did not have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Specifically, a resident was not provided catheter care and required treatment at a local hospital for acute sepsis, a resident sustained a fall resulting in a head laceration due to a one person assist when two people were required, a resident with pressure ulcers (PU) was not repositioned for an observed 3 hour time period, a resident was not provided incontinence care resulting in moisture associated skin damage (MASD) with an open area and a bloody presentation. These findings were cited at a harm level for 4 resudents. In addition, a resident reported attempting to hold their bowel movements at night due to safety concerns with a one person assistance with incontinence care, and a resident reported being left unattended on a commode for 90 minutes. Additionally, multiple residents reported delayed incontinence care and being left for extended periods of time in soiled and wet briefs which resulted in skin irritation, typical call light response times of two hours, and residents reported needing assistance with eating and none was provided. Furthermore, multiple staff members reported staffing shortages that resulted in unsafe conditions for residents and the inability to complete the necessary cares, medication administration, and services for residents. Resident identifiers: 1, 8, 37, 56, 59, 61, 84, 85, 88, 94, 96, 98, 99, 101, 105, 108, 112. Findings include: A. The following examples were cited at a HARM level related to insufficient nursing staff: 1. Resident 84 was admitted to the facility 1/1/21. He has a history of traumatic subdural hemorrhage, nontraumatic subarachnoid hemorrhage, falls, tracheostomy, neuromuscular dysfunction of the bladder, chronic respiratory failure, quadriplegia, dependence on respirator, insomnia, Parkinson's disease and dementia. Resident 84's medical record was reviewed on 5/23/21. On 5/20/21 at 10:23 PM, a nursing progress note indicated that resident 84's Foley cath (catheter) is patent and draining well at this time. On 5/22/21 at 7:48 PM, a nursing progress note indicated that res (resident) continued with no urine output since cath change to collect UA (urinalysis) and diaphoresis. MD order received at 1850 (6:50 PM) to transport resident to [name of local emergency room]. [Name of local city paramedics] arrived at 1910 (7:10 PM) to transport and left at 1930 (7:30 PM). The nurses note did not indicate the date or time the catheter had been changed. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Some	On 5/22/21 the emergency room Report for resident 84 indicated that the facility staff note that they went to change the patients Foley catheter today for source control and had not had urine output since. They also note change in trach (tracheostomy) sputum upon suctioning from clear to green. emergency room Physician diagnoses included acute sepsis, pneumonia (ventilator associated), acute UTI (urinary tract infection). The emergency room Report also documented that a urinalysis indicated red colored urine, turbid in nature, nitrites present in abnormal nature, large amount of hemoglobin, proteins present at greater than 3000, Large abnormal [NAME] Blood Cells and bacteria 3 plus. On 5/22/21, a Computerized Tomography scan was performed in the emergency room . The impression from the radiologist included prominently distended bladder. The Foley catheter is malpositioned, the balloon is just inferior to the prostal gland. There is bilateral hydroureter with bilateral hydronephrosis, likely secondary to bladder outlet obstruction. On 5/25/21 at 10:06 AM, a record review showed a late entry progress note for 5/23/21 regarding resident 84. The nursing progress note stated that resident 84 was hospitalized on [DATE]. The note also stated that patient was reported to be tachy (tachycardic) with a HR (heart rate) reaching 145 and a low grade fever. Patient was assessed and on call was notified of the change at 1000 (10:00 AM). Orders were received to do CBC (complete blood count) and CRP (C-Reactive Protein). Due to patient being very dehydrated and all staff efforts being without good outcome, [primary physician]had to be contacted to get a PIV (peripheral intravenous) to draw from as well as have a line in place. [Primary physician] placed PIV at 1715 (5:15 PM) and sample was taken to the lab. No urine output had been seen since midmorning and RN (Registered Nurse) suspected it clogged and was told to change it to get culture. catheter was changed at 1500 (3:00 PM) and no urine was produced. RN notified on call. On call at 1845 (6:45 PM) called and told the night RN to send patient out. [Note: It should be noted that resident 84's physician orders indicated that resident 84 was exclusively hydrated and fed via a feeding tube, therefore it is unclear how resident 84 became dehydrated as indicated in the nurses progress note on 5/23/21.] On 5/23/21 a confidential staff interview was conducted with Staff Member (SM) 2. SM 2 stated that resident 84 should have been rounded on every two hours. SM 2 stated that the facility was so short staffed on multiple occasions that the staff wasn't able to check the fullness of residents' catheter bags. SM 2 stated that he/she frequently saw resident catheter bags filled to capacity, as well as residents' catheter bags not being emptied timely. SM 2 stated that on the day of hospitalization , resident 84's catheter was not flowing and the catheter bag was full. SM 2 stated the resident's physician was notified, and the catheter was changed to get clean urine for a urinalysis. SM 2 stated that the new catheter was not draining, and resident 84 then had a bladder scan with no reading. SM 2 then stated that resident 84's physician requested that resident 84 be sent to the local emergency room . SM 2 stated that he/she felt the resident was septic because no one changed resident 84's catheter bag in a timely manner. 2 . Resident 1 was admitted on [DATE] with diagnoses that included functional quadriplegia, diabetes mellitus, chronic respiratory failure with hypoxia, dysphagia, muscle weakness, , hypertension, difficulty walking, atrial fibrillation, and morbid obesity. Resident 1's medical record was reviewed on 5/23/21. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Some	Resident 1's quarterly Minimum Data Set (MDS) admission assessment dated [DATE] was reviewed. The MDS indicated that resident 1 required extensive assistance with 2 staff members for bed mobility, and was totally dependent on 2 staff members for transferring. Nurses notes for resident 1 revealed the following: a. On 5/12/21 at 8:00 PM, CNA found RN and alerted her that patient had fallen out of bed during a brief change and was on the floor. CNA states she was changing the resident when she ran out of wipes. She told the resident to go ahead and roll back while she went and got more wipes. The resident then rolled forward rolling off the bed and onto the floor instead of rolling backwards onto her back. CNA returned to the room to find the resident on the floor. Resident head was resting on the stand holding the ventilator and posterior head was actively bleeding . Res (Resident) c/o (complains of) pain all over body and especially her head. Res was assisted back into Bed and Posterior head was clean and area assessed. 1.5 inch laceration and goose bump noted to posterior head . NP (Nurse Practitioner) notified and gave orders to transport Res to [name of local emergency room] . b. On 5/13/21 at 1:20 AM, Resident was transferred back to facility via [name of ambulance company] 3 staples noted to laceration on posterior head. Res Noted to have bruised ribs. Staples to be removed 5/19/21. Resident 1's Medication Administration Record (MAR) indicated that resident 1 received a tramadol for pain on the following dates and times: a. On 5/13/21 at 12:46 PM for pain 10/10 b. On 5/14/21 at 7:57 AM for pain 2/10 c. On 5/14/21 at 7:48 PM for pain 5/10 [Note: Resident 1 did not receive any other tramadol during the month of May 2021 as of 5/26/21.] The MAR also indicated that resident 1 complained of pain 9/10 during the night shift on 5/12/21. Physical therapy notes dated 5/12/21 documented that resident 1 required maximum assistance for bed mobility training. Physical therapy notes dated 5/14/21 documented that resident 1 was still not feeling like herself after falling out of bed; body aches due to fall. Physical therapy notes dated 5/18/21 documented that resident 1 was extremely anxious and did not want to attempt sitting EOB (end of bed) today either; has taken a big step back since her fall a week ago. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Some	On 5/23/21 at 7:45 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that after the incident on 5/12/21 with resident 1, we took all agency staff off that hall. Now all staff that are up there are our people or are agency who have trained for that hall and know how to reposition those residents. The DON also stated that the CNA left the resident on her side when she left the room and that the CNA should not have left the resident on her side. She should have laid her (the resident) back down on her back and taken all of the supplies in with her. On 5/24/21 at 10:30 AM, an interview was conducted with CNA 3. CNA 3 stated that resident 1 needs two people to change her. She's a total assist. CNA 3 further stated that when he changed resident 1's briefs, he always used two people because the bed is kind've small so I can pull her over to the side to give me enough space, so in case she falls forward she falls into the bed. On 5/24/21 at 10:55 AM, an interview was conducted with resident 1. Resident 1 stated that she was unable to move herself around in bed. When asked about the incident on 5/12/21, resident 1 stated that there were usually two people that changed her brief, but on 5/12/21 it was only one. Resident 1 stated that the lone staff member had rolled the resident to her right side on the edge of the bed and left the room. Resident 1 stated that she had subsequently fallen out of the bed and hit her head on the equipment next to her bed. Resident 1 stated that it was scary. On 5/23/21, a confidential staff interview was conducted with SM 2. SM 2 stated that the facility was poorly staffed. SM 2 stated that all the residents on the 500 hall should be 2 person assistance with brief changes. SM 2 stated that it's dangerous how low the staffing was for the 500 hall. SM 2 stated that there was one agency CNA for the 500 hall one day, and that resident 1 had an accident because there was only one CNA. SM 2 stated that resident 1 was rolled to her side for a brief change. SM 2 stated that the agency CNA left the room to get wipes and resident 1 rolled out of bed. SM 2 stated that when resident 1 rolled out of bed she hit her head and ended up with stitches. SM 2 stated when Agency CNAs worked on the 500 hall there were a lot more accidents. 3. Resident 108 was admitted to the facility on [DATE] with diagnoses that included pneumonia, muscle weakness, difficulty in walking, need for assistance with personal care, cognitive communication deficit, heart failure, dementia, urinary tract infection, hyperlipidemia, hypertension, diabetes, and chronic pain. Resident 108's medical record was reviewed on 5/23/21. On 4/29/21, staff completed an Initial Admission Record for resident 108. The admission record indicated that resident 108 had a blister on left heel, old pressure wound on coccyx. There were no measurements or description of either wound. On 4/30/21, staff completed an Initial Admission Record for resident 108. The admission record indicated that resident 108 had a blister on left heel, old pressure wound on coccyx. There were no measurements or description of either wound. On 4/30/21, staff completed a document entitled Functional Performance Evaluation. The evaluation indicated that resident 108 requiredsubstantial/maximal assistance with sit to lying, lying to sitting on side of bed, sit to stand, and chair/bed to chair transfer. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Some	On 4/30/21, staff completed a document entitled Braden Scale for Predicting Pressure Sore Risk. The document indicated that resident 108 was slightly limited in her ability to respond to pressure-related discomfort, had skin that was occasionally moist, was chairfast, and was slightly limited in her ability to change and control body position. The document also indicated that resident 108 was at low risk for developing a pressure sore. On 4/30/21 staff developed a care plan for resident 108 that indicated resident had a self care performance deficit related to immobility and weakness. The care plan indicated that resident 108 required Extensive assistance 2 staff participation to reposition and turn in bed. On 5/3/21 staff completed a weekly skin evaluation. Staff indicated that there were no wounds, and no new skin issues. On 5/10/21 staff completed a weekly skin evaluation. Staff indicated that there were no wounds, and no new skin issues. Nurses notes for resident 108 indicated the following note: On 5/12/21 wound team note. team notified 5/11 of sores present on admit. [Resident 108] has MASD under L (left) breast, center to L [NAME] (sic), and BL (bilateral) buttock, scaring (sic) noted on BL buttocks from old wounds. she has a fluid filled blister on her R (right) heel, 4.7x4.5xUTD (unable to determine). PI (pressure injury) unstageable. dark in color. no drainage. no s/s (signs or symptoms) of infection. [NAME] (Decubitis ulcer) noted on the L pad of foot. old and very stable, 0.5x0.7xUTD. education on offloading. On 5/12/21 staff developed a care plan for resident 108 that stated Has pressure ulcer development to R (right) heel r/t (related to) immobility. The care plan also stated that the pressure ulcer was present on admission, was unstageable, and was 4.7 centimeters by 4.5 centimeters in size. On 5/12/21 staff also developed a care plan for resident 108 that stated resident 108 Has actual impairment to skin integrity r/t MASD. [Note: The initial skin integrity care plan for resident 108 developed on 4/30/21 did not indicate that resident 108 had any impairments to her skin integrity.] Resident 108's physician orders were reviewed. On 5/12/21, resident 108 had an order written for Wound care to L pad of foot: [NAME], and Wound care to R heel: PI unstageable. No orders for wound care were written prior to 5/12/21. On 5/18/21 staff completed a weekly skin evaluation. Staff documented that resident 108 had an unstageable pressure ulcer to her R heel that was present on admission. However, no notes could be located in resident 108's medical record to indicate that resident 108 had any skin issues on her R heel prior to 5/11/21. In addition, nurses notes did not indicate that the wound team was notified of any skin issues prior to 5/11/21. On 5/19/21 Wound Assessment Progress Note was completed by a wound specialist. The note indicated that resident 108 had an unstageable pressure ulcer on her right heel that was 4.7x4.5xUTD in size. The note also indicated the that wound was intact, dark discoloration [with] fluid and boggy. The note indicated that resident 108 had a skin issue on her left heel that was resolved. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Some	On 5/28/21 at 2:00 PM, an interview was conducted with the facility Wound Nurse (WN). The WN stated that resident 108's heel should not be placed directly on the bed or a pillow. The WN stated that resident 108 doesn't have a lot of mobility in her right leg. The WN stated that resident 108 would try to lift her R leg but doesn't succeed. The WN stated that resident 108 was admitted with a blister to her right heel. When asked why there was no documentation about a wound to her R heel prior to 5/11/21 or treatment implemented prior to 5/12/21, the WN stated he did not know. On 5/24/21 at 11:05 AM, an interview was conducted with resident 108. When asked about her stay, resident 108 stated I'm not getting very good care here. Resident 108 stated that she had pain a lot in my back and two sores on my butt. When asked if she could move herself around in her bed, the resident stated she did not attempt to reposition herself in bed because it hurts too much. The resident also stated that she had a sore on her right heel and it hurts like hell. I think it's because I'm just laying in bed. I can wiggle my toes but I can't move my foot off the pillows. It's damn scary to be worried about my foot . On 5/25/21 at 1:23 PM, a follow up interview was conducted with resident 108. Resident 108 stated that staff repositioned her in bed but they don't do it very often. I'll have to call for someone to help. The resident stated that she also had two painful sores on her bottom, that she was admitted with, but my butt feels like its on fire. It needs to be moved. On 5/24/21 a continuous observation was made of resident 108 as follows: a. At 11:35 AM, resident 108 was observed to be in her room in seated her bed, with the head of the bed elevated, and her legs outstretched toward the end of the bed. b. At 12:33 PM, a staff member entered the room to deliver resident 108's lunch tray. c. At 1:10 PM, the Social Services Worker (SSW) entered the room, seated herself in a chair, and spoke with resident 108 for several minutes. d. At 1:23 PM, a staff member entered resident 108's room and obtained a blood sugar sample. e. At 1:41 PM, a staff member entered resident 108's room and administered resident 108's insulin. f. At 2:22 PM, a staff member entered resident 108's room to assist resident 108 out of bed and into her wheelchair. During the duration of the observation from 11:35 AM to 2:22 PM, no staff members were observed to reposition resident 108, nor did resident 108 make any efforts to reposition her buttocks or her legs. On 5/28/21 at 12:55 PM, two staff members were observed to enter resident 108's room. They slid resident 108 up in bed, but did not reposition her right heel. The right heel was observed to be directly laying on a pillow, instead of being floated. 4. Resident 112 was admitted to the facility on [DATE] and 1/1/19 with diagnoses which included multiple sclerosis, benign prostatic hyperplasia with lower urinary tract symptoms, mononeuropathy, and dementia with behavioral disturbance. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Some	On 5/24/21 at 10:02 AM, an interview was conducted with resident 112. Resident 112 stated that he needed his brief to be changed. Resident 112 was observed to have a foul odor. Resident 112 stated that he wanted to have his brief changed every 2 hours, but not allowed to be changed until every 4 hours. Resident 112 stated that he has not been continent for most of his life. Resident 112 stated that he has a red buttocks and back from sitting in his urine for long periods of time. At 10:30 AM, a therapy staff member wheeled resident to the therapy gym. At 12:40 PM, resident 112 was observed outside the dining room in his wheelchair. Resident 112 stated he had not been changed. At 1:19 PM, an observation was made of resident 112 with CNA 12 and CNA 14 buttocks and backside. Resident 112 was observed to have red areas with small opening that were bleeding. On 5/24/21 at 1:25 PM, an interview was conducted with CNA 10. CNA 10 stated that resident 112 was compliant with brief changes. CNA 10 stated that resident 112 has set times to have his brief changed. CNA 10 stated usually after smoking he was changed. CNA 10 stated that his butt is terrible. CNA 10 stated that she slathers his buttocks with cream. CNA 10 stated that his buttocks is from sitting in a soiled brief for to long and not being changed. CNA 10 stated she thought the bleeding was from hemorrhoids. On 5/24/21 at 1:30 PM, an interview was conducted with CNA 12. CNA 12 stated that she changed resident 112's brief when he got up this morning. CNA 12 stated that therapy did not do brief changes. CNA 12 stated that resident 112 had sores and dead skin on his buttocks. CNA 12 stated that sometime his back side bleeds like it did today. CNA 12 stated that resident 112 should have been changed around his smoke break which was about 10:30 AM. CNA 12 stated that another CNA should have changed his brief before he left for therapy. CNA 12 stated resident 112 did not have a brief change until 1:30 PM. Resident 112's medical record was reviewed 5/24/21 through 5/28/21. A quarterly MDS dated [DATE] revealed resident 112 was frequently incontinent of bowel and bladder. Resident 112 had not been on a toileting program for bowel or bladder. Resident 112 had a BIMS of 11 which revealed mild cognitive impairment. A care plan dated 5/19/15 revealed, Has bowel incontinence r/t MS The goal developed were Will have less than two episodes of incontinence per day through the review date. The interventions developed were Check resident [with] rounds and prn and assist with toileting as needed and Provide pericare after each incontinent episode According to the CNA documentation in the tasks section from 4/29/21 until 5/28/21 resident 112 had 4 continent bowel episodes and 1 continent bladder episode. CNA documentation further revealed that resident 112 was documented as being toileted at 7:40 AM. Resident 112's Bowel and Bladder Evaluation dated 1/28/21 and 4/28/21 resident 112 was an unlikely candidate for bowel and bladder re-training. The evaluation dated 4/28/21 revealed that resident 112 was always incontinent of bowel and bladder which made resident an unlikely candidate for re-training. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Some	On 5/24/21 at 12:45 PM, an interview was conducted with CNA 10. CNA 10 stated resident 112 was usually changed every 2 hours. CNA 10 stated that resident 112 was able to verbalize to staff when he needed to have a brief changed. CNA 10 stated it can be difficult when staffing is low to change resident 112 because he required 2 person assist with a hoyer lift. On 5/24/21 at 2:00 PM, an interview was conducted with the DON. The DON stated resident 112 was a 2 person assist with brief changes. The DON stated that resident 112 should receive a brief change every 2 hours. On 5/27/21 at 3:43 PM, an interview was conducted with RN 3. RN 3 stated stated that resident 112 was continent but he was hard to transfer so he used briefs. RN 3 stated that resident 112 was alert and Oriented x 4 (person, place, time, and situation). RN 3 stated that resident 112 knew what he wants and where he was. RN 3 stated that resident 112 was able to tell when he had a brief change. RN 3 stated that she was no aware of any skin issues and nothing had been reported to her regarding his buttocks. RN 3 stated resident 112 was not on a bowel and bladder retraining program. On 5/28/21 at 10:52 AM, a follow up interview was conducted with the DON. The DON stated that resident 112 was alert and oriented for the most part and able to tell staff what he wanted and needed. The DON stated that he was compliant with cares as long as it was not during a smoking break. The DON stated that he talked to the Wound Nurse regarding resident 112's buttocks. The DON stated that resident 112 had MASD which was caused by sitting in his urine for to long. 5. Resident 99 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included multiple sclerosis, post-traumatic stress disorder, muscle weakness, anxiety disorder and major depressive disorder. On 5/26/21 at 11:22 AM, an interview was conducted with resident 99. Resident 99 stated that she attempted suicide after an agency Certified Nursing Assistant (CNA) treated her terrible. Resident 99 stated there were not enough staff and she felt like a burden on staff. Resident 99 stated that she tried to cut my throat. Resident 99 stated that she used a knife and put a hole in my neck. Resident 99 stated she was supposed to see a counselor after she returned from the hospital. Resident 99 stated that a counselor came into her room and said he was in a hurry and would come back to talk. Resident 99 stated she wanted to talk to a counselor but the counselor had not returned. Resident 99 stated that she had attempted suicide prior to admission as well. Resident 99's medical record was reviewed 5/26/21 through 5/28/21. A care plan dated 5/11/21 revealed, Resident has a history of suicide attempts. A goal developed was Resident will have no incidents of self harm. Interventions were Administer medications as ordered. Monitor/document for side effects and effectiveness, encourage to express feelings, Monitor/record/report to MD prn (as needed) risk for harm to self: suicidal plan, past attempt at suicide, risky actions (stockpiling pills, saying goodbye to family, giving away possessions or writing a note), intentionally harmed or tried to harm self, refusing to eat or drink, refusing med (medications) or therapies, sense of hopelessness or helplessness, impaired judgment or safety awareness, provide [local] Mental Health crisis number, resident followed by [local] Mental health. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Some	The Emergency Department History and Physical Report dated 3/19/21 at 3:41 PM revealed that resident 99 was .brought in by EMS (Emergency Medical Services), VS (vital signs) normal but pt (patient) unresponsive. Superficial self inflicted abrasion on right arm and chest/neck. The report further revealed, According to caregivers at the facility patient was in her normal state this morning. Her normal state is bedbound only moves right upper extremity and is conversant. Patient had mentioned to some of the workers that she wanted to kill herself. She had a visitor at the facility today. This afternoon patient was found unresponsive with superficial cut marks to her neck. Resident 99's progress notes revealed the entries: a. On 3/19/21 at 1:00 PM, At 1205 (12:05 PM) Aid reported that she went to check in on resident and noticed that resident had a pocket knife in her left hand and noticed that she had a cut on her lower R (right) forearm and bloody smear just below the front side of her neck. She immediately called out to the nurse who was outside the door and while nurse was with the resident she alerted another nurse for help. Upon arriving in residents room, writer noted that the first nurse was holding on to left hand to prevent resident from cutting herself and talking calmly to her. Resident was not combative and was not attempting to attack the staff. She appeared withdrawn, somewhat lethargic but was still coherent to answer appropriately. Staff was able to talk resident into letting the pocket knife go. Resident refused to answer specifically why she was upset. She said repeatedly 'I just want to die', 'I want to be with [name removed]', '[name removed] wants me to be with him', 'Put me in the ground next to [name removed]'. Resident was placed on one on one watch with staff. Provider, DON (Director of Nursing) and Administrator alerted to situation. Provider ordered to send resident to [local hospital] ED (Emergency Department) for further psychiatric and medical eval (evaluation) and treatment for suicidal ideation and action. Family notified of concerns. One of the daughters mentioned that resident has had suicidal ideation and attempts in the past at home and the reason why she was placed in a care center. Resident picked up by [local non-emergent ambulance company] [at] 1250 (12:50 PM) and transported to hospital via stretcher. b. On 3/22/21 at 3:42 PM, MD (Medical Doctor) recommended psych (psychological) evaluation, [local mental health company] notified and coordinating a visit for evaluation. c. On 3/26/21 at 9:43 AM, Late Entry: SW (Social Worker) spoke to [resident 99] about her SI (suicidal ideation) hospitalization and how she was feeling. [Resident 99] stated that she felt better and explained her attempt and what brought her to the ED. SW asked if she had met with the therapist and APRN (Advanced Practice Registered Nurse) that week and she said yes. SW asked if she had any SI ideation that week since returning and she said no. [Resident 99] spoke candidly with SW about her attempts.SW feels she is stable at this time. SW talk to nursing about possible plastic utensils. An Investigation regarding resident 99 suicide attempt was provided to the State Survey Agency. The undated form revealed that on 3/19/21 resident 99 had a suicide attempt. The follow up information revealed, .Resident requested a psychiatric visit to evaluate her mental state. [Local mental Health Company] Mental Health was coordinated to perform visit. Provider did write a new medication order to assist with her psychosocial well-being. House provider was updated on recommendation and order from psychiatric provider to which it was agreed to follow those recommendations. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Some	On 5/28/21 at 9:18 AM, a list was provided by the facility Discharge Planner. The list was resident names that the local mental health company was providing services to. Resident 99 was not on the list. The facility Discharge Planner responded that resident 99 was not receiving services but paperwork was being sent today to have resident 99 be on services the following week. On 5/27/21 at 12:45 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that there was no incident report for resident 99's suicide attempt. On 5/27/21 at 12:26 PM, an interview was conducted with CNA 12. CNA 12 stated that she was not working when resident 99 tried to hurt herself. CNA 12 stated that she worked the following day. CNA 12 stated that resident 99 told her that an agency CNA had told her she was a burden, like her husband always did. CNA 12 stated that resident 99 told her she had a knife or something sharp she pressed into her neck. CNA 12 stated that resident 99 told her that a nurse came in and found her. CNA 12 stated that resident 99 told CNA 12 that she was in the wrong head space. CNA 12 stated that resident 99's routine in the morning was usually an hour long and agency CNAs have been upset her routine was so long and told her she was a burden. On 5/27/21 at 2:00 PM, an interview was conducted with SSW 1. SSW 1 stated she started at the facility February 2021. SSW 1 stated resident 99 had a suicide attempt. SSW 1 stated she spoke with resident 99 after her suicide attempt. SSW 1 stated that resident 99 stated that she grabbed her knife from home after an agency CNA that was working with her was not very kind with her. SSW 1 stated that resident 99 told her she tried to stab herself with the knife. SSW 1 stated resident 99 was sent to hospital and was there for a bit and then came back. SSW 1 stated that when resident 99 returned to the facility a mental health company was contacted to work with resident 99. SSW 1 stated that resident 99 was seeing the mental health specialist weekly. SSW 1 stated she was not involved in care planning. SSW 1 stated she talked to management and the CNA coordinator about not allowing the Agency CNA back in the building. SSW 1 stated that the CNA coordinator contacted Agency CNAs. SSW 1 stated that she had discussed staffing issues with the management team. SSW 1 stated she provided some training for staff on how to deal with emotional and mental issues with residents. B. The following examples were cited at a potiental for harm related to sufficent staffing: 1. Resident 56 was admitted to the facility on [DATE] with diagnoses which included cardiomyopathy, muscle weakness, difficulty walking, need for assistance with personal care, cognitive communication deficit, dysphagia, atrial fibrillation, type 2 diabetes mellitus, and dementia. On 5/25/21 [TRUNCATED]

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22992 Based on interview and record review, the facility did not have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment. Specifically, an agency staff member transferred a resident by themselves instead of using two staff members, resulting in the resident falling and sustaining a head laceration. Another resident sustained a burn after facility staff heated a wet wash cloth in a microwave and applied it to the resident's skin. In addition, agency staff were not provided training prior to providing cares to residents and agency staff were not provided radios to alert them of call lights alarming. Resident identifiers: 1 and 103. Findings include: 1. Resident 1 was admitted on [DATE] with diagnoses that included functional quadriplegia, diabetes melitus, chronic respiratory failure with hypoxia, dysphagia, muscle weakness, hypertension, difficulty walking, atrial fibrillation, and morbid obesity. Resident 1's medical record was reviewed on 5/23/21. Resident 1's quarterly Minimum Data Set (MDS) admission assessment dated [DATE] was reviewed. The MDS indicated that resident 1 required extensive assistance with 2 staff members for bed mobility, and was totally dependent on 2 staff members for transferring. Nurses notes for resident 1 revealed the following: a. On 5/12/21 at 8:00 PM, CNA (Certified Nursing Assistant) found RN (Registered Nurse) and alerted her that patient had fallen out of bed during a brief change and was on the floor. CNA states she was changing the resident when she ran out of wipes. She told the resident to go ahead and roll back while she went and got more wipes. The resident then rolled forward rolling off the bed and onto the floor instead of rolling backwards onto her back. CNA returned to the room to find the resident on the floor. Resident head was resting on the stand holding the ventilator and posterior head was actively bleeding . Res (Resident) c/o (complains of) pain all over body and especially her head. Res was assisted back into Bed and Posterior head was clean and area assessed. 1.5 inch laceration and goose bump noted to posterior head . NP (Nurse Practitioner) notified and gave orders to transport Res to [name of local emergency room] . b. On 5/13/21 at 1:20 AM, Resident was transferred back to facility via [name of ambulance company] 3 staples noted to laceration on posterior head. Res Noted to have bruised ribs. Staples to be removed 5/19/21. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 1's Medication Administration Record (MAR) indicated that resident 1 received a Tramadol for pain on the following dates and times: a. On 5/13/21 at 12:46 PM for pain 10/10 b. On 5/14/21 at 7:57 AM for pain 2/10 c. On 5/14/21 at 7:48 PM for pain 5/10 [Note: Resident 1 did not receive any other Tramadol during the month of May 2021 as of 5/26/21.] The MAR also indicated that resident 1 complained of pain 9/10 during the night shift on 5/12/21. Physical therapy notes dated 5/12/21 documented that resident 1 required maximum assistance for bed mobility training. Physical therapy notes dated 5/14/21 documented that resident 1 was still not feeling like herself after falling out of bed; body aches due to fall. Physical therapy notes dated 5/18/21 documented that resident 1 was extremely anxious and did not want to attempt sitting EOB (end of bed) today either; has taken a big step back since her fall a week ago. On 5/23/21 at 7:45 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that after the incident on 5/12/21 with resident 1, we took all agency staff off that hall. Now all staff that are up there are our people or are agency who have trained for that hall and know how to reposition those residents. The DON also stated that the CNA left the resident on her side when she left the room and that the CNA should not have left the resident on her side. She should have laid her (resident 1) back down on her back and taken all of the supplies in with her. On 5/24/21 at 10:30 AM, an interview was conducted with CNA 3. CNA 3 stated that resident 1 needs two people to change her. She's a total assist. CNA 3 further stated that when he changed resident 1's briefs, he always used two people because the bed is kind've small so I can pull her over to the side to give me enough space, so in case she falls forward she falls into the bed. On 5/24/21 at 10:55 AM, an interview was conducted with resident 1. Resident 1 stated that she was unable to move herself around in bed. When asked about the incident on 5/12/21, resident 1 stated that there were usually two people that changed her brief, but on 5/12/21 it was only one. Resident 1 stated that the lone staff member had rolled the resident to her right side on the edge of the bed and left the room. Resident 1 stated that she had subsequently fallen out of the bed and hit her head on the equipment next to her bed. Resident 1 stated that it was scary. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/23/21, a confidential staff interview was conducted with SM 2. SM 2 stated that the facility was poorly staffed. SM 2 stated that all the residents on the 500 hall should be 2 person assistance with brief changes. SM 2 stated that it's dangerous how low the staffing was for the 500 hall. SM 2 stated that there was one agency CNA for the 500 hall one day, and that resident 1 had an accident because there was only one CNA. SM 2 stated that resident 1 was rolled to her side for a brief change. SM 2 stated that the agency CNA left the room to get wipes and resident 1 rolled out of bed. SM 2 stated that when resident 1 rolled out of bed she hit her head and ended up with stitches. SM 2 stated when Agency CNAs worked on the 500 hall there were a lot more accidents. On 5/26/21 a confidential staff interview was conducted with SM 11. SM 11 stated that all the residents on the 500 hall should be assisted by two staff members with brief changes, transfers etc. SM 11 stated that he/she had worked on the 500 hall alone multiple times. SM 11 stated that if there was not another staff member to assist him/her, then he/she would ask the resident, and if the resident says they are ok with me doing stuff by myself I do it. SM 11 stated that after resident 1's fall on 5/12/21, resident 1 doesn't trust anyone [to work with her] by themselves anymore. 2. Resident 103 was admitted to the facility on [DATE] with diagnoses which included multiple sclerosis, mild cognitive impairment, hyperlipidemia, and edema. Resident 103's medical record was reviewed on 5/24/2021 through 5/28/2021. A nursing progress notes dated 2/11/21 at 2:48 PM by RN 6, revealed, Has burns on the back of her neck. Stated that resident heat up a wet wash rag in the microwave and put it on her neck unsupervised. resident education about hot pack use with supervision was completed and she understood well. abx (antibiotic) ointment for burns was applied. she tol (tolerated) well. MD (Medical Doctor) notified. DON notified. Resident 103's Treatment Administration Record (TAR) and Medication Administration Record (MAR) for February 2021 were reviewed. There was no documentation of treatment for the burn. Resident 103's orders were reviewed and there were no orders for a burn treatment. On 5/24/21 at 1:15 PM, an interview was conducted with resident 103. Resident 103 stated she asked staff to put a wash rag on her back because she was unable to get a hot pack from the therapy department. Resident 103 stated a CNA warmed up a wet wash cloth and did not check with the nurse. Resident 103 stated that her skin was red. On 5/27/21 at 5:44 PM, an interview was conducted with RN 6. RN 6 stated that the therapy staff members have hot packs for residents. RN 6 stated CNAs should not provide any heated item for residents to put on their bodies. RN 6 stated that she heard from the night shift nurse that resident 103 had sustained a burn on her shoulders. RN 6 stated she was unable to remember who the night shift nurse was. RN 6 stated that she explained to resident 103 to not let CNAs heat up things to place on her body. RN 6 stated that she applied an ointment to the red skin. RN 6 stated resident 103 stated it was painful and felt better after the ointment was applied. RN 6 stated that resident 103 stated she was not aware of how hot the wash cloth was until the washcloth was removed. RN 6 stated that she reported to MD and they said to apply the ointment until healed. RN 6 stated that she notified the DON and did not hear back from the DON. RN 6 stated she educated CNAs not to heat wash cloths and all hot packs were to be applied by therapy staff. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/27/21 6:04 PM, an interview was conducted with the DON. The DON stated there were no incident reports or investigation information regarding resident 103's burn. The DON stated he was not aware of the incident. The DON stated that if it was documented that he was notified then he had been notified. The DON stated that he did not complete any systemic changes after the incident. The DON stated that he would have told nurse to notify the MD. The DON stated that he would have educated staff and resident. 30563 STAFF INTERVIEWS: 1. On 5/27/21, a confidential staff interview was conducted with SM 5. SM 5 stated that the residents on the 200 had extensive routines for bed time and sometimes it took an hour to get the each resident ready for bed. SM 5 stated when getting a new CNA, never worked over here, or agency CNAs it took double the time. SM 5 stated that it was fine doing that but sometimes it was overwhelming because I usually can't get everyone to bed. SM 5 stated I will stay till 10:15 or after midnight because I don't want to leave things for the next shift. SM 5 stated I work 12 hours shifts 7 days a week because we are short staffed. SM 5 stated that resident were so happy to see her and SM 16 when they had a day or two off. SM 5 stated it was hard because so many residents were extensive assistance. SM 5 stated that incontinence cares were not completed every 2 hours, showers were not completed, 5:00 PM rounds were not usually completed until 7:00 PM, when there was not another seasoned CNA scheduled with her. SM 5 stated that Agency CNAs were not provided radios, so she was unable to call for assistance and had to leave resident rooms to find agency CNAs for help. 2. On 5/27/21, a confidential staff interview was conducted with SM 16. SM 16 stated that there were multiple residents that complained of not feeling safe with CNA 11. SM 16 stated that the concerns were discussed with the CNA coordinator but the CNA coordinator stated that other halls did not like CNA 11 either so We just have to make due. SM 16 stated when CNA 11 worked night shift multiple residents refused to use the bathroom and held their bowel movements or urine all night. SM 16 stated that residents did not feel safe with CNA 11 operating the lift or transferring them because she was small. 3. On 5/27/21 at 4:16 PM, a confidential staff interview was conducted with SM 9. SM 9 stated that she had a walkie talkie, for communication with other staff and call light notification, but that it was not charged. SM 9 stated that the agency aides did not get a walkie talkie. Its kind of a big deal, I'm not sure why they don't get one. On 5/23/21 at 7:33 PM, an interview was conducted with the Administrator (Admin). The Admin stated that newly hired CNAs had a skills check list and company trainings depending on license. The Admin stated that Agency staff typically had a lead or a trainer to show them around the hall and where to access linens and about the residents. The Admin stated that there was a contract with the agency company that required they were trained. 38031

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F 0742 Level of Harm - Actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30563 Based on observation, interview and record review it was determined, for 1 of 51 sample residents, that the facility did not ensure that a resident who displayed or was diagnosed with mental disorder or psychosocial adjustment difficulty, or who had a history of trauma and/or post-traumatic stress disorder, received appropriate treatment and services to correct the assessed problem or to attain the highest practical mental and psychosocial well-being. Specifically, a resident that attempted suicide was not provided mental health services. This was found to have occurred at a harm level. Resident identifier: 99. Findings include: Resident 99 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included multiple sclerosis, post-traumatic stress disorder, muscle weakness, anxiety disorder and major depressive disorder. On 5/26/21 at 11:22 AM, an interview was conducted with resident 99. Resident 99 stated that she attempted suicide after an agency Certified Nursing Assistant (CNA) treated her terrible. Resident 99 stated there were not enough staff and she felt like a burden on staff. Resident 99 stated that she tried to cut my throat. Resident 99 stated that she used a knife and put a hole in my neck. Resident 99 stated she was supposed to see a counselor after she returned from the hospital. Resident 99 stated that a counselor came into her room and said he was in a hurry and would come back to talk. Resident 99 stated she wanted to talk to a counselor but the counselor had not returned. Resident 99 stated that she had attempted suicide prior to admission as well. Resident 99's medical record was reviewed 5/26/21 through 5/28/21. A care plan dated 5/11/21 revealed, Resident has a history of suicide attempts. A goal developed was Resident will have no incidents of self harm. Interventions were Administer medications as ordered. Monitor/document for side effects and effectiveness, encourage to express feelings, Monitor/record/report to MD prn (as needed) risk for harm to self: suicidal plan, past attempt at suicide, risky actions (stockpiling pills, saying goodbye to family, giving away possessions or writing a note), intentionally harmed or tried to harm self, refusing to eat or drink, refusing med (medications) or therapies, sense of hopelessness or helplessness, impaired judgment or safety awareness, provide [local] Mental Health crisis number, resident followed by [local] Mental health. The Emergency Department History and Physical Report dated 3/19/21 at 3:41 PM revealed that resident 99 was .brought in by EMS (Emergency Medical Services), VS (vital signs) normal but pt (patient) unresponsive. Superficial self inflicted abrasion on right arm and chest/neck. The report further revealed, According to caregivers at the facility patient was in her normal state this morning. Her normal state is bedbound only moves right upper extremity and is conversant. Patient had mentioned to some of the workers that she wanted to kill herself. She had a visitor at the facility today. This afternoon patient was found unresponsive with superficial cut marks to her neck. (continued on next page)

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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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F 0742 Level of Harm - Actual harm Residents Affected - Few	Resident 99's progress notes revealed the entries: a. On 3/19/21 at 1:00 PM, At 1205 (12:05 PM) Aid reported that she went to check in on resident and noticed that resident had a pocket knife in her left hand and noticed that she had a cut on her lower R (right) forearm and bloody smear just below the front side of her neck. She immediately called out to the nurse who was outside the door and while nurse was with the resident she alerted another nurse for help. Upon arriving in residents room, writer noted that the first nurse was holding on to left hand to prevent resident from cutting herself and talking calmly to her. Resident was not combative and was not attempting to attack the staff. She appeared withdrawn, somewhat lethargic but was still coherent to answer appropriately. Staff was able to talk resident into letting the pocket knife go. Resident refused to answer specifically why she was upset. She said repeatedly 'I just want to die', 'I want to be with [name removed]', '[name removed] wants me to be with him', 'Put me in the ground next to [name removed]'. Resident was placed on one on one watch with staff. Provider, DON (Director of Nursing) and Administrator alerted to situation. Provider ordered to send resident to [local hospital] ED (Emergency Department) for further psychiatric and medical eval (evaluation) and treatment for suicidal ideation and action. Family notified of concerns. One of the daughters mentioned that resident has had suicidal ideation and attempts in the past at home and the reason why she was placed in a care center. Resident picked up by [local non-emergent ambulance company] [at] 1250 (12:50 PM) and transported to hospital via stretcher. b. On 3/22/21 at 3:42 PM, MD (Medical Doctor) recommended psych (psychological) evaluation, [local mental health company] notified and coordinating a visit for evaluation. c. On 3/26/21 at 9:43 AM, Late Entry: SW (Social Worker) spoke to [resident 99] about her SI (suicidal ideation) hospitalization and how she was feeling. [Resident 99] stated that she felt better and explained her attempt and what brought her to the ED. SW asked if she had met with the therapist and APRN (Advanced Practice Registered Nurse) that week and she said yes. SW asked if she had any SI ideation that week since returning and she said no. [Resident 99] spoke candidly with SW about her attempts.SW feels she is stable at this time. SW talk to nursing about possible plastic utensils. An Investigation regarding resident 99 suicide attempt was provided to the State Survey Agency. The undated form revealed that on 3/19/21 resident 99 had a suicide attempt. The follow up information revealed, .Resident requested a psychiatric visit to evaluate her mental state. [Local mental Health Company] Mental Health was coordinated to perform visit. Provider did write a new medication order to assist with her psychosocial well-being. House provider was updated on recommendation and order from psychiatric provider to which it was agreed to follow those recommendations. On 5/28/21 at 9:18 AM, a list was provided by the facility Discharge Planner. The list was resident names that the local mental health company was providing services to. Resident 99 was not on the list. The facility Discharge Planner responded that resident 99 was not receiving services but paperwork was being sent today to have resident 99 be on services the following week. On 5/27/21 at 12:45 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that there was no incident report for resident 99's suicide attempt. (continued on next page)

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F 0742 Level of Harm - Actual harm Residents Affected - Few	On 5/27/21 at 12:26 PM, an interview was conducted with CNA 12. CNA 12 stated that she was not working when resident 99 tried to hurt herself. CNA 12 stated that she worked the following day. CNA 12 stated that resident 99 told her that an agency CNA had told her she was a burden, like her husband always did. CNA 12 stated that resident 99 told her she had a knife or something sharp she pressed into her neck. CNA 12 stated that resident 99 told her that a nurse came in and found her. CNA 12 stated that resident 99 told CNA 12 that she was in the wrong head space. CNA 12 stated that resident 99's routine in the morning was usually an hour long and agency CNAs have been upset her routine was so long and told her she was a burden. On 5/27/21 at 2:00 PM, an interview was conducted with SSW 1. SSW 1 stated she started at the facility February 2021. SSW 1 stated resident 99 had a suicide attempt. SSW 1 stated she spoke with resident 99 after her suicide attempt. SSW 1 stated that resident 99 stated that she grabbed her knife from home after an agency CNA that was working with her was not very kind with her. SSW 1 stated that resident 99 told her she tried to stab herself with the knife. SSW 1 stated resident 99 was sent to hospital and was there for a bit and then came back. SSW 1 stated that when resident 99 returned to the facility a mental health company was contacted to work with resident 99. SSW 1 stated that resident 99 was seeing the mental health specialist weekly. SSW 1 stated she was not involved in care planning. SSW 1 stated she talked to management and the CNA coordinator about not allowing the Agency CNA back in the building. SSW 1 stated that the CNA coordinator contacted Agency CNAs. SSW 1 stated that she had discussed staffing issues with the management team. SSW 1 stated she provided some training for staff on how to deal with emotional and mental issues with residents.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22992 Based on interview and record review, the facility did not ensure that for 3 of 51 sample residents, the facility's medical director acted upon the pharmacist consultant reports in a timely manner. Resident identifiers: 1, 90 and 101. Findings include: 1. Resident 1 was admitted on [DATE] with diagnoses that included functional quadriplegia, diabetes mellitus, chronic respiratory failure with hypoxia, dysphagia, muscle weakness, hypertension, difficulty walking, atrial fibrillation, and morbid obesity. Resident 1's medical record was reviewed on 5/28/21. On 5/11/21, the pharmacist consultant (PC) completed a Pharmacist Consultant Therapeutic Recommendation form for resident 1. The PC recommended that resident 1 have her prednisolone eye drops discontinued, as ophthalmic steroid use was usually limited to 14 days. The physician did not indicate that he had reviewed the PC's recommendations and agreed with them, until 5/26/21, more than 2 weeks later. 2. Resident 90 was admitted to the facility on [DATE] with diagnoses that included chronic respiratory failure with hypercapnia, need for assistance with personal care, cognitive communication deficit, tracheostomy status, dependence on respirator status, pain, and severe protein calorie malnutrition. Resident 90's medical record was reviewed on 5/28/21. On 5/11/21, the PC completed a Pharmacist Consultant Therapeutic Recommendation form for resident 90. The PC documented that resident 90 was receiving clonazepam and temazepam at 8:00 PM, which appears to be unnecessary duplication. The PC recommended that resident 90's clonazepam and temazepam administration times be separated by at least one hour. The PC also recommended that the physician consider changing resident 90's temazepam to be administered as needed if the resident was unable to sleep after the clonazepam administration. The physician did not indicate that he had reviewed the PC's recommendations and ordered a medication change until 5/26/21, more than 2 weeks later. 3. Resident 101 was admitted to the facility on [DATE] with diagnoses that included chronic respiratory failure with hypoxia, hypertension, spina bifida, tracheostomy status, multiple sclerosis, and functional quadriplegia. Resident 101's medical record was reviewed on 5/28/21. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/11/21, the PC completed a Pharmacist Consultant Therapeutic Recommendation form for resident 101. The PC documented that resident 101 was no longer receiving medications for diabetes, and recommended that glucagon and hypoglycemia protocol orders be discontinued. The physician did not indicate that he had reviewed the PC's recommendations and agreed with them, until 5/26/21, more than 2 weeks later. On 5/28/21 at 9:45 AM, an interview was conducted with the Director of Nursing (DON). The DON confirmed that the physician had not reviewed the PC recommendations until more than 2 weeks after the recommendations were made.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **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 51 sample residents were free of significant medication errors. Specifically, residents' insulin was administered more than one hour after the scheduled administration time. Resident identifiers: 17, 96, and 108. Findings include: 1. Resident 108 was admitted to the facility on [DATE] with diagnoses that included pneumonia, muscle weakness, difficulty in walking, need for assistance with personal care, cognitive communication deficit, heart failure, dementia, urinary tract infection, hyperlipidemia, hypertension, diabetes, and chronic pain. On 5/24/21 at 1:23 PM, a staff member entered resident 108's room and obtained a blood glucose sample, while resident 108 was eating lunch. The staff member stated to the resident that the blood glucose level was 213. At 1:41 PM, a staff member entered resident 108's room and administered resident 108's insulin. On 5/24/21 at 2:43 PM, an interview was conducted with Licensed Practical Nurse (LPN) 4. LPN 4 stated that resident 108's blood glucose level was checked at 7:00 AM that day, and it was 208. LPN 4 stated that she did not administer resident 108's insulin until 8:30 to 9:00 AM (90 minutes to 2 hours after checking the blood glucose level) because LPN 4 was behind. LPN 4 confirmed that staff had checked resident 108's blood glucose again at 1:23 PM, and that it was 213. LPN 4 confirmed that she had administered resident 108's insulin at 1:41 PM. When asked why the blood glucose levels and insulin administration were not completed per the physician orders, LPN 4 stated to be honest, we are short staffed. It's normal for us to be late with our meds because there's not enough staff. We need another nurse that floats between halls because so many residents have so many meds. We need more CNAs and more nurses to take care of the residents. We need another nurse on the 500 hall too. Resident 108's medical record was reviewed on 5/23/21. Resident 108's physician orders included an order dated 4/29/21 for Insulin Lispro to be injected per a sliding scale subcutaneously before meals (scheduled at 7:00 AM, 11:00 AM, 4:00 PM) and at bedtime (8:00 PM) for her diagnosis of diabetes. Review of resident 108's May 2021 Medication Administration Record (MAR) revealed the following: a. On 5/4/21 the 8:00 PM insulin was not administered until 10:26 PM b. On 5/5/21 the 11:00 AM insulin was not administered until 12:32 PM c. On 5/5/21 the 4:00 PM insulin was not administered until 5:32 PM d. On 5/6/21 the 8:00 PM insulin was not administered until 9:24 PM (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	e. On 5/7/21 the 11:00 AM insulin was not administered until 12:30 PM f. On 5/8/21 the 8:00 PM insulin was not administered until 9:51 PM g. On 5/11/21 the 8:00 PM insulin was not adminstered until 9:58 PM h. On 5/12/21 the 7:00 AM insulin was not administered until 8:39 AM i. On 5/13/21 the 7:00 AM insulin was not administered until 9:47 AM j. On 5/13/21 the 11:00 AM insulin was not administered until 12:25 PM k. On 5/13/21 the 8:00 PM insulin was not administered until 10:39 PM l. On 5/14/21 the 11:00 AM insulin was not administered until 12:35 PM m. On 5/14/21 the 8:00 PM insulin was not administered until 10:22 PM n. On 5/16/21 the 11:00 AM insulin was not administered until 12:42 PM o. On 5/16/21 the 4:00 PM insulin was not administered until 5:33 PM p. On 5/16/21 the 8:00 PM insulin was not administered until 10:43 PM q. On 5/18/21 the 7:00 AM insulin was not administered until 10:16 AM r. On 5/18/21 the 11:00 AM insulin was not administered until 1:07 PM s. On 5/19/21 the 7:00 AM insulin was not administered until 9:47 AM t. On 5/21/21 the 8:00 PM insulin was not administered until 10:28 PM u. On 5/22/21 the 11:00 AM insulin was not administered until 12:35 PM v. On 5/24/21 the 7:00 AM insulin was not administered until 8:47 AM Resident 108's physician orders also included an order dated 4/29/21 for Insulin Glargine 30 units subcutaneously at bedtime for her diagnosis of diabetes. Review of resident 108's May 2021 MAR revealed that the insulin was scheduled at 8:00 PM. The MAR also revealed the following: a. On 5/4/21 insulin was not adminstered until 10:26 PM b. On 5/6/21 insulin was not administered until 9:24 PM c. On 5/8/21 insulin was not administered until 9:52 PM (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. On 5/11/21 insulin was not administered until 9:57 PM e. On 5/13/21 insulin was not administered until 10:41 PM f. On 5/14/21 insulin was not administered until 10:23 PM g. On 5/16/21 insulin was not administered until 10:46 PM h. On 5/21/21 insulin was not administered until 10:30 PM 2. Resident 96 was admitted to the facility on [DATE] with diagnoses that included chronic respiratory failure with hypoxia, severe protein calorie malnutrition, diabetes, and chronic obstructive pulmonary disease. Resident 96's medical record was reviewed on 5/25/21. Resident 96's physician orders included an order dated 4/29/21 for Insulin Lispro to be injected per a sliding scale subcutaneously before meals (scheduled at 7:00 AM, 11:00 AM, 4:00 PM) and at bedtime (8:00 PM) for his diagnosis of diabetes. Review of resident 96's May 2021 MAR revealed the following: a. On 5/2/21 the 8:00 PM insulin was not administered until 9:21 PM b. On 5/4/21 the 4:00 PM insulin was not administered until 5:44 PM c. On 5/6/21 the 11:00 AM insulin was not administered until 2:34 PM d. On 5/7/21 the 4:00 PM insulin was not administered until 5:39 PM e. On 5/7/21 the 8:00 PM insulin was not administered until 9:26 PM f. On 5/8/21 the 4:00 PM insulin was not administered until 6:00 PM g. On 5/9/21 the 7:00 AM insulin was not administered until 9:42 AM h. On 5/9/21 the 11:00 AM insulin was not administered until 1:04 PM i. On 5/9/21 the 4:00 PM insulin was not administered until 6:13 PM j. On 5/10/21 the 7:00 AM insulin was not administered until 9:20 AM k. On 5/10/21 the 11:00 AM insulin was not administered until 1:28 PM l. On 5/11/21 the 7:00 AM insulin was not administered until 8:23 AM m. On 5/11/21 the 11:00 AM insulin was not administered until 12:40 PM (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	n. On 5/11/21 the 4:00 PM insulin was not administered until 5:43 PM o. On 5/11/21 the 8:00 PM insulin was not administered until 9:12 PM p. On 5/12/21 the 7:00 AM insulin was not administered until 9:20 AM q. On 5/13/21 the 7:00 AM insulin was not administered until 9:39 AM r. On 5/14/21 the 7:00 AM insulin was not administered until 8:55 AM s. On 5/15/21 the 7:00 AM insulin was not administered until 8:25 AM t. On 5/15/21 the 11:00 AM insulin was not administered until 12:18 PM u. On 5/15/21 the 4:00 PM insulin was not administered until 5:24 PM v. On 5/16/21 the 11:00 AM insulin was not administered until 12:20 PM w. On 5/16/21 the 8:00 PM insulin was not administered until 9:45 PM x. On 5/18/21 the 7:00 AM insulin was not administered until 8:37 AM y. On 5/18/21 4:00 PM insulin was not administered until 6:10 PM z. On 5/19/21 the 7:00 AM insulin was not administered until 10:14 AM aa. On 5/19/21 the 8:00 PM insulin was not administered until 9:25 PM bb. On 5/20/21 the 7:00 AM dose did not indicate what time it was administered. cc. On 5/20/21 the 4:00 PM insulin was not administered until 5:58 PM dd. On 5/22/21 the 7:00 AM insulin was not administered until 8:58 AM ee. On 5/23/21 the 7:00 AM insulin was not administered until 8:59 AM ff. On 5/23/21 the 8:00 PM insulin was not administered until 9:47 PM gg. On 5/24/21 the 7:00 AM insulin was not administered until 9:00 AM hh. On 5/24/21 the 11:00 AM insulin was not administered until 12:59 PM ii. On 5/24/21 the 4:00 PM insulin was not administered until 5:45 PM Resident 96's physician orders also included an order dated 4/25/21 for Insulin Glargine 55 units subcutaneously in the morning (scheduled at 7:00 AM) for his diagnosis of diabetes. Resident 96's May 2021 MAR revealed the following: (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. On 5/3/21 insulin was not administered until 8:43 AM b. On 5/8/21 insulin was not administered until 9:49 AM c. On 5/9/21 insulin was not administered until 9:42 AM d. On 5/10/21 insulin was not administered until 9:20 AM e. On 5/11/21 insulin was not administered until 8:24 AM f. On 5/12/21 insulin was not administered until 9:20 AM g. On 5/13/21 insulin was not administered until 9:41 AM h. On 5/14/21 insulin was not administered until 8:55 AM i. On 5/15/21 insulin was not administered until 8:25 AM j. On 5/18/21 insulin was not administered until 8:38 AM k. On 5/19/21 insulin was not administered until 10:15 AM l. On 5/20/21 insulin was not administered until 10:22 AM m. On 5/22/21 insulin was not administered until 8:59 AM n. On 5/23/21 insulin was not administered until 9:00 AM o. On 5/24/21 insulin was not administered until 9:00 AM 30563 3. Resident 17 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included left femur fracture, type 2 diabetes with diabetic neuropathy, long term insulin use, morbid obesity and anxiety disorder. Resident 17's medical record was reviewed on 5/27/21. A physician's order dated 11/5/20 revealed, Insulin Aspart Solution to inject as per sliding scale: if 70-150 = 0 units;BS (blood sugar) less than 60 Notify MD (Medical Doctor); 151-200 = 2 units; 201-250 = 4 units; 251-300 = 6 units; 301-350 = 8 units; 351-400 = 10 units; BS over 400 to notify MD. Resident 17's May 2021 MAR revealed the following administration time. a. On 5/1/21 the 8:00 PM insulin was not administered until 9:43 PM b. On 5/3/21 the 8:00 PM insulin was not administered until 5/4/21 at 12:52 AM. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. On 5/4/21 the 8:00 PM insulin was not administered until 10:27 PM. d. On 5/5/21 the 8:00 PM insulin was not administered until 5/6/21 at 12:39 AM. e. On 5/6/21 the 8:00 PM insulin was not administered until 9:05 PM. f. On 5/7/21 the 8:00 PM insulin was not administered until 5/8/21 at 12:25 AM. g. On 5/9/21 the 11:00 AM insulin was not administered until 12:54 PM. h. On 5/9/21 the 8:00 PM insulin was not administered until 9:23 PM. i. On 5/10/21 the 11:00 AM insulin was not administered until 12:30 PM. j. On 5/10/21 the 8:00 PM insulin was not administered until 10:55 PM. k. On 5/11/21 the 11:00 AM insulin was not administered until 12:11 PM. l. On 5/11/21 the 8:00 PM insulin was not administered until 9:29 PM. m. On 5/12/21 the 8:00 PM insulin was not administered until 11:12 PM. n. On 5/13/21 the 8:00 PM insulin was not administered until 11:06 PM. o. On 5/14/21 the 8:00 PM insulin was not administered until 5/15/21 at 12:41 PM. p. On 5/15/21 the 8:00 PM insulin was not administered until 11:31 PM. r. On 5/16/21 the 8:00 PM insulin was not administered until 9:35 PM. s. On 5/16/21 the 8:00 PM insulin was not administered until 9:35 PM. t. On 5/17/21 the 8:00 PM insulin was not administered until 5/18/21 at 1:08 AM. u. On 5/18/21 the 8:00 PM insulin was not administered until 5/18/21 at 11:51 PM. v. On 5/19/21 the 8:00 PM insulin was not administered until 11:18 PM. w. On 5/20/21 the 11:00 AM insulin was not administered until 12:09 PM. x. On 5/21/21 the 8:00 PM insulin was not administered until 5/22/21 at 12:28 AM. y. On 5/21/21 the 8:00 PM insulin was not administered until 5/22/21 at 12:28 AM. z. On 5/22/21 the 7:00 AM insulin was not administered until 8:24 AM. aa. On 5/22/21 the 11:00 AM insulin was not administered until 12:34 PM. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bb. On 5/22/21 the 8:00 PM insulin was not administered until 11:28 PM. cc. On 5/23/21 the 8:00 PM insulin was not administered until 11:41 PM. dd. On 5/24/21 the 8:00 PM insulin was not administered until 5/25/21 at 12:08 AM. ee. On 5/25/21 the 8:00 PM insulin was not administered until 11:48 PM. ff. On 5/26/21 the 8:00 PM insulin was not administered until 11:31 PM. (Cross refer to 725)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 30563 Based on observation, interview and record review it was determined, for 9 of 51 sample residents, that the facility did not provide food and drink that was palatable, attractive and at a safe and appetizing temperature. Specifically, residents complained of food quality, a sample tray was not palatable and resident council minutes revealed a complaint of food quality. Resident identifiers: 28, 33, 54, 78, 82, 94, 98, 105 and 117. Findings include: 1. On 5/26/21 at 11:49 AM, an interview was conducted with resident 117. Resident 117 stated that there was not enough food and the food was served cold. 2. On 5/24/21 at 4:41 PM, an interview was conducted with resident 82. Resident 82 stated the food was not good and needed to order her own food on-line from a local grocery store. Resident 82 stated that food was served cold. 3. On 5/24/21 at approximately 10:21 AM, an interview was conducted with resident 78. Resident 78 stated that the food was not very good. Resident 78 stated that the facility did provide alternate options and snacks. 4. On 5/27/21 at approximately 11:40 AM, an interview was conducted with resident 28. Resident 28 stated that the food sucks. Resident 28 stated that the food had no taste, and was missing some 'finishing touches . such as they serve a taco and don't add cheese to the taco. Resident 28 stated that the kitchen staff has no creativity. Resident 28 stated that breakfasts were plain with no flavor. Resident 28 stated that they also did not serve what the resident ordered. Resident 28 stated that the alternates for food were not appetizing or tasty. Resident 28 stated that her husband brought her food to meet her needs. 5. On 5/23/21 at 3:45 PM, an interview was conducted with resident 94. Resident 94 stated, I'm eating out more than I eat here because the food quality was poor. 6. On 5/26/21 at 12:00 PM, an interview was conducted with resident 105. Resident 105 stated that the food was not great. When asked to elaborate, resident 105 stated its cold and it tastes bad. Resident 105 stated that she was unable to feed herself due to severe rheumatoid arthritis. Resident 105 stated that by the time staff arrived to assist her with her meal, her food was cold. Resident 105 then stated that staff would reheat the food, but its not the same. 7. On 5/25/21 at 1:41 PM, an interview was conducted with resident 33. Resident 33 stated that he did not care for the facility food too much. Resident 33 stated that a lot of times it was cold when it was delivered to him. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8. On 5/26/21 at 10:46 AM, an interview was conducted with resident 98. Resident 98 stated that the food was horrible. Resident 98 stated that the vegetables were overcooked, gray, and mushy. Resident 98 stated that they put gravy on everything, even though he had requested to put the gravy on the side. Resident 98 stated that the facility did not provide him with enough protein, since he was on a special diet due to dialysis. Resident 98 stated that he spent a lot of his personal money on his own groceries because the facility's food was horrible in taste and quality. 9. On 5/27/21 the lunch meal was observed in the main dining room. Resident 54 was served at 12:07 PM, but not assisted until 12:22 PM, approximately 15 minutes later. At 12:16 PM, an interview was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 stated that resident 54 could not feed himself. 10. Resident council minutes revealed on 2/24/21 that resident complained the food was bland and would like more seasonings on their trays. 11. On 5/28/21 at 12:04 PM, a test tray was obtained from the facility kitchen. The following items were observed and tasted by two surveyors: a. Pureed broccoli: The broccoli had a glue-like texture to it, and had brown gravy over it. b. Regular broccoli: Nearly white in color, bland to the taste, and with a mushy texture. c. Pureed crab and pasta salad: Had a brown gravy over it. d. Pureed roll: Had a glue-like texture that tasted like flour and water. The texture and flavor caused surveyors to gag. e. Cinnamon pear dessert: Was bland in taste with a soggy texture. There appeared to be an oily residue on the dessert. On 5/28/21 at 12:47 PM, an interview was conducted with [NAME] 1 and the Dietary Manager (DM). [NAME] 1 stated that the pureed white substance was a dinner roll that was pureed with butter and water. [NAME] 1 stated that usually there was gravy on all the pureed food. [NAME] 1 stated that the white color was cauliflower that caused the broccoli to have a white tint to it. The DM stated that the cooks tasted their pureed foods before the foods were served. The DM stated that the apples were baked with cinnamon and butter. The DM stated that the mechanical soft apples were baked longer to make them mushy.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 30563 Based on observation, interview and record review it was determined that the facility did not store, prepare, distribute and serve food in accordance with professional standards for food service safety. Specifically, there was a black substance on the walls in the dishmachine room, Teflon was torn and missing from pans, the trayline was soiled, the ceiling had splatter, vents were dirty on the ceiling, there were tiles missing and gashes in the dry wall. Findings include: 1. On 5/27/21 at 10:41 AM, an initial tour of the kitchen was conducted. An observation was made of the facility dishmachine room. There was a black substance on the ceiling and 3 walls around the dishmachine. The black substance was from the dishmachine to the ceiling. The fan was observed with a tissue and was not pulling the tissue upward. The fan above the food preparation area was running and the tissue flapped toward the ceiling. Cook 1 was immediately interviewed. [NAME] 1 stated the black substance was Mold. The Dietary Manager (DM) was interviewed. The DM stated that the dishmachine room needed to be painted. The DM stated that she noticed the black substance about 2 weeks ago. The DM stated that the Maintenance Director was aware and told her the dishmachine room needed to be painted. The DM stated that the dishmachine room was painted every year. The DM stated the black substance was very concerning because it could have bacteria and could fall into the clean dishes. On 5/27/21 at 11:12 AM, an interview was conducted with the Maintenance Director. The Maintenance Director stated that the black substance was not mold but was mildew. The Maintenance Director stated that he painted the dishmachine room twice a year and was planning to paint it in June. The Maintenance Director stated that the black substance was from the dishmachine steam. The Maintenance Director stated that dietary staff did not turn on the fan to vent out the steam when the dishmachine was running. The maintenance Director stated that the fan was working. On 5/27/21 at 11:15 AM, an interview was conducted [NAME] 1. [NAME] 1 stated staff turned the fan on when doing dishes. [NAME] 1 stated she did not hear the fan. An observation was made of the fan in the dishmachine room. A tissue was held near the fan and the tissue pulled toward the fan. On 5/27/21 at 11:45 AM, an interview was conducted with the Maintenance Director. The Maintenance Director stated he went on the roof and made adjustments to the fan in the dishmachine room. The Maintenance Director stated that the fan was running. According to the United Stated Environmental Protection Agency Mildew refers to certain kinds of mold or fungus. The term mildew is often used generically to refer to mold growth, usually with flat growth habit. Referenced from: https://www.epa.gov/mold/what-difference-between-mold-and-mildew#:~:text=Mildew%20refers%20to%20certain%20kinds,of%20multicellular%20filaments%2C%20called%20hyphae (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. On 5/27/21 at 10:41 AM, the following observations were made in the kitchen: a. There were 13 frying pans with the Teflon coating cracked or missing. There was built up black substance on the outside of the pans. b. The steam table glass was soiled. The shelf above the food on the steam table was soiled under the shelf. c. There was a brown substance on the ceiling above the food preparation area. d. There was brown substance on the ceiling in the hallway outside the dishmachine room. e. There was a vent on the ceiling above the food preparation table that had black substance on it. f. An electrical plug by the mixer had debris on it. g. There was a grease trap that had a metal piece sticking through it. h. There were missing tiles with a wooden beam and insulation exposed in the dishmachine room. i. There were gashes in the wall with drywall pealing away behind the drying rack in the dishmachine room. j. There were missing baseboard tiles in the dishmachine room. An interview was immediately conducted with [NAME] 1. [NAME] 1 stated that the Teflon from the pans had been missing for a while. [NAME] 1 stated the trayline needed to be cleaned and she was scheduled to clean it. [NAME] 1 stated the trayline was scheduled to be cleaned monthly. On 5/28/21 at 12:47 PM, the above observations were made. The DM was interviewed. The DM stated that the ceilings needed to be cleaned. The DM stated she did not know when the ceilings were last cleaned. The DM stated the trayline was scheduled to be cleaned monthly. The DM stated that the Registered Dietitian (RD) had not been to the facility for over a month. The DM stated that the Diet Tech (DT) was out on sick leave. The DM stated she was completing the assessments and food preferences for the facility. The DM stated she had a busy week.

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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. 30563 Based on observation, record review and interview the facility was not administered in a manner that enabled 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, deficient practices were identified during the survey regarding abuse, neglect, falls, incontinence cares, pain, treatment for psychosocial concerns, and staffing. There were multiple residents who were identified to have outcomes cited at a harm level. Resident identifiers: 1, 8, 17, 37, 56, 61, 82, 84, 85, 88, 94, 96, 98, 99, 101, 102, 103, 105, 108, and 112. Findings include: 1. The facility administration did not ensure that for 7 out of 51 residents, the residents were free from abuse and neglect. Specifically, a resident was not provided catheter care and required treatment at a local hospital for acute sepsis, a resident sustained a fall resulting in a head laceration due to a one person assist when two people were required, a resident with pressure ulcers (PU) located on the bilateral heels did not have the heels floated as ordered and repositioning did not occur for an observed 3 hour time period, and a resident was not provided incontinence care resulting in moisture associated skin damage (MASD) with an open area and a bloody presentation. These examples of neglect were cited at a harm level. Additionally, a resident reported an allegation of verbal and physical abuse from a licensed nurse with medication administration, a resident reported an allegation of physical abuse from a Certified Nurse Assistant (CNA) during incontinence care, and a resident reported an allegation of rough treatment during incontinence care in September 2020 followed by an allegation of verbal abuse with cares by the same nurse in May 2021. Resident identifiers: 1, 17, 84, 101, 105, 108 and 112. [Cross refer to F600] 2. The facility administration did not ensure that for 1 of 51 sample residents, that the facility provided care to prevent unavoidable pressure ulcers, nor did they provide timely treatment and services for the resident's pressure ulcer. Specifically, a resident developed an unstageable pressure sore and was not provided interventions to prevent the pressure sore. In addition, after the pressure sore was developed treatment and services were not provided in a timely manner to heal the pressure sore. This resulted in a finding of harm. Resident identifier: 108. [Cross refer to F686] (continued on next page)

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F 0835 Level of Harm - Actual harm Residents Affected - Some	3. The facility administration did not ensure that for 3 of 51 sample residents, residents did not receive adequate supervision and assistance devices to prevent accidents. Specifically, one resident was assisted with a brief change with only one staff member instead of two, resulting in the resident falling out of bed and sustaining a head laceration. This incident was found to have occurred at a harm level. In addition, a resident sustained a burn after a staff member placed a wet wash cloth from the microwave on the resident. This incident was found to have occurred at a harm level. Another resident was not assessed to determine if he was safe to smoke independently. Resident identifiers: 1, 37, and 103. [Cross refer to F689] 4. The facility administration did not ensure that for 6 of 51 sample residents, that 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, the facility failed to ensure proper care for a resident with a urinary catheter which resulted in the resident being hospitalized . This finding was cited at a harm level. In addition, a resident was not toileted timely, resulting in the resident having skin breakdown. This finding was also cited at a harm level. In addition, residents were not placed on a bowel and bladder training program despite requests and staff assessment of appropriateness Resident identifiers: 37, 82, 84, 99, 102, and 112. [Cross refer to F690] 5. The facility administration did not ensure that for 16 of 51 sampled residents, the facility had sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Specifically, a resident was not provided catheter care and required treatment at a local hospital for acute sepsis, a resident sustained a fall resulting in a head laceration due to a one person assist when two people were required, a resident with pressure ulcers (PU) was not repositioned for an observed 3 hour time period, a resident was not provided incontinence care resulting in moisture associated skin damage (MASD) with an open area and a bloody presentation. These findings were cited at a harm level for 4 residents. In addition, a resident reported attempting to hold their bowel movements at night due to safety concerns with a one person assistance with incontinence care, and a resident reported being left unattended on a commode for 90 minutes. Additionally, multiple residents reported delayed incontinence care and being left for extended periods of time in soiled and wet briefs which resulted in skin irritation, typical call light response times of two hours, and residents reported needing assistance with eating and none was provided. Furthermore, multiple staff members reported staffing shortages that resulted in unsafe conditions for residents and the inability to complete the necessary cares, medication administration, and services for residents. Resident identifiers: 1, 8, 37, 56, 61, 84, 85, 88, 94, 96, 98, 99, 101, 105, 108, 112. [Cross refer to F725] (continued on next page)

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F 0835 Level of Harm - Actual harm Residents Affected - Some	6. The facility administration did not ensure for 1 of 51 sample residents, that a resident who displayed or was diagnosed with mental disorder or psychosocial adjustment difficulty, or who had a history of trauma and/or post-traumatic stress disorder, received appropriate treatment and services to correct the assessed problem or to attain the highest practical mental and psychosocial well-being. Specifically, a resident that attempted suicide was not provided mental health services. This was found to have occurred at a harm level. Resident identifier: 99. [Cross refer to F742] On 5/24/21 at 3:44 PM, an interview was conducted with the facility Administrator (Admin). The Admin stated that there was a formal QA for staffing that started on 5/12/21 after resident 1 fell and sustained a laceration. The Admin stated that as of 5/24/21 he felt that the facility was fully staffed, but the staff were newer and would need to receive additional training. The Admin stated that the facility had been short staffed for a long time and that staff were still frustrated even though the facility was now fully staffed.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30563 Based on interview and record review it was determined, for 2 of 51 sample residents, that the facility did not maintain medical records on each resident that were complete, accurate, and readily accessible. Specifically, Restorative Nursing Assistant (RNA) notes were not in the individual medical records. Resident identifiers: 99 and 102. Findings include: 1. Resident 99 was admitted to the facility on [DATE] with diagnoses which included multiple sclerosis, major depressive disorder, histrionic personality disorder, and muscle weakness. On 5/26/21 at 11:17 AM, an interview was conducted with resident 99. Resident 99 stated she had limited range of motion (ROM) to the right side of her body. Resident 99 stated she was without therapy for about 4 to 5 months at a time. Resident 99 stated that she had only recently started therapy. Resident 99's medical record was reviewed on 5/24/21 through 5/28/21. There was no documentation in resident 99's medical record regarding the Restorative services resident 99 was receiving. The Minimum Data Set (MDS) coordinator provided a Restorative Weekly Log for resident 99. However, the form had hand written notes for resident 99, as well as other residents on it. 2. Resident 102 was admitted to the facility on [DATE] with diagnoses which included hemiplegia affecting left non-dominant side, hypertension, anemia, morbid obesity, cerebral infarction due to thrombosis of right vertebral artery and intellectual disabilities. On 5/26/21 at 9:19 AM, an interview was conducted with resident 102. Resident 102 stated she was walking last year before the pandemic. Resident 102 stated she was no longer able to walk outside. Resident 102 stated she was using a walker when she walked outside. Resident 102 stated that she walked a little in her room but was unable to go very far and usually used a wheelchair. Resident 102's medical record was reviewed on 5/25/21 through 5/28/21. There were no therapy notes or restorative notes in resident 102's electronic medical record. There was no Restorative Weekly Log provided for resident 102. On 5/28/21 at 11:30 AM, an interview was conducted with Restorative Nursing Aide (RNA) 1. RNA 1 stated that he documented his notes on a list that had all the resident names of residents receiving RNA services. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/28/21 at 10:45 AM, an interview was conducted with the MDS coordinator. The MDS coordinator stated that the RNA program has been broken. The MDS coordinator stated that the RNAs documented on paper and it was supposed to be in the electronic medical record for each resident. The MDS coordinator stated that there was not a consistent system with regard to the documentation.

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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. 30563 Based on observation, record review and interview the facility Quality Assessment and Assurance (QAA) Committee did not develop and implement appropriate plans of action to correct identified quality deficiencies. Specifically, deficient practices were identified during the survey regarding abuse, neglect, falls, incontinence cares, pain, treatment for psychosocial concerns, and staffing. There were multiple residents who were identified to have outcomes cited at a harm level. Resident identifiers: 1, 8, 17, 37, 56, 61, 82, 84, 85, 88, 94, 96, 98, 99, 101, 102, 103, 105, 108, and 112. Findings include: 1. The facility QAA Committee did not ensure that for 7 out of 51 residents, the residents were free from abuse and neglect. Specifically, a resident was not provided catheter care and required treatment at a local hospital for acute sepsis, a resident sustained a fall resulting in a head laceration due to a one person assist when two people were required, a resident with pressure ulcers (PU) located on the bilateral heels did not have the heels floated as ordered and repositioning did not occur for an observed 3 hour time period, and a resident was not provided incontinence care resulting in moisture associated skin damage (MASD) with an open area and a bloody presentation. These examples of neglect were cited at a harm level. Additionally, a resident reported an allegation of verbal and physical abuse from a licensed nurse with medication administration, a resident reported an allegation of physical abuse from a Certified Nurse Assistant (CNA) during incontinence care, and a resident reported an allegation of rough treatment during incontinence care in September 2020 followed by an allegation of verbal abuse with cares by the same nurse in May 2021. Resident identifiers: 1, 17, 84, 101, 105, 108 and 112. [Cross refer to F600] 2. The facility QAA Committee did not ensure that for 1 of 51 sample residents, that the facility provided care to prevent unavoidable pressure ulcers, nor did they provide timely treatment and services for the resident's pressure ulcer. Specifically, a resident developed an unstageable pressure sore and was not provided interventions to prevent the pressure sore. In addition, after the pressure sore was developed treatment and services were not provided in a timely manner to heal the pressure sore. This resulted in a finding of harm. Resident identifier: 108. [Cross refer to F686] 3. The facility QAA Committee did not ensure that for 3 of 51 sample residents, residents did not receive adequate supervision and assistance devices to prevent accidents. Specifically, one resident was assisted with a brief change with only one staff member instead of two, resulting in the resident falling out of bed and sustaining a head laceration. This incident was found to have occurred at a harm level. In addition, a resident sustained a burn after a staff member placed a wet wash cloth from the microwave on the resident. This incident was found to have occurred at a harm level. Another resident was not assessed to determine if he was safe to smoke independently. Resident identifiers: 1, 37, and 103. (continued on next page)

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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 0867 Level of Harm - Actual harm Residents Affected - Some	[Cross refer to F689] 4. The facility QAA Committee did not ensure that for 6 of 51 sample residents, that 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, the facility failed to ensure proper care for a resident with a urinary catheter which resulted in the resident being hospitalized . This finding was cited at a harm level. In addition, a resident was not toileted timely, resulting in the resident having skin breakdown. This finding was also cited at a harm level. In addition, residents were not placed on a bowel and bladder training program despite requests and staff assessment of appropriateness Resident identifiers: 37, 82, 84, 99, 102, and 112. [Cross refer to F690] 5. The facility QAA Committee did not ensure that for 16 of 51 sampled residents, the facility had sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Specifically, a resident was not provided catheter care and required treatment at a local hospital for acute sepsis, a resident sustained a fall resulting in a head laceration due to a one person assist when two people were required, a resident with pressure ulcers (PU) was not repositioned for an observed 3 hour time period, a resident was not provided incontinence care resulting in moisture associated skin damage (MASD) with an open area and a bloody presentation. These findings were cited at a harm level for 4 residents. In addition, a resident reported attempting to hold their bowel movements at night due to safety concerns with a one person assistance with incontinence care, and a resident reported being left unattended on a commode for 90 minutes. Additionally, multiple residents reported delayed incontinence care and being left for extended periods of time in soiled and wet briefs which resulted in skin irritation, typical call light response times of two hours, and residents reported needing assistance with eating and none was provided. Furthermore, multiple staff members reported staffing shortages that resulted in unsafe conditions for residents and the inability to complete the necessary cares, medication administration, and services for residents. Resident identifiers: 1, 8, 37, 56, 61, 84, 85, 88, 94, 96, 98, 99, 101, 105, 108, 112. [Cross refer to F725] 6. The facility QAA Committee did not ensure for 1 of 51 sample residents, that a resident who displayed or was diagnosed with mental disorder or psychosocial adjustment difficulty, or who had a history of trauma and/or post-traumatic stress disorder, received appropriate treatment and services to correct the assessed problem or to attain the highest practical mental and psychosocial well-being. Specifically, a resident that attempted suicide was not provided mental health services. This was found to have occurred at a harm level. Resident identifier: 99. [Cross refer to F742] (continued on next page)

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F 0867 Level of Harm - Actual harm Residents Affected - Some	On 5/24/21 at 3:44 PM, an interview was conducted with the facility Administrator (Admin). The Admin stated that there was a formal QA for staffing that started on 5/12/21 after resident 1 fell and sustained a laceration. The Admin stated that as of 5/24/21 he felt that the facility was fully staffed, but the staff were newer and would need to receive additional training. The Admin stated that the facility had been short staffed for a long time and that staff were still frustrated even though the facility was now fully staffed. On 5/24/21 at approximately 12:00 PM, it was observed that as the Director of Nursing (DON) was obtaining average call light times, that there were no call light times recorded for the 100 hall (Memory Care Unit). When asked, he stated that the system did not record the 100 hall's call light times. Therefore, the QA program was not capturing an accurate picture of call light times in order to take to the QA committee.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38031 Based on observation, interview and record review it was determined, for 4 of 51 sampled residents, that the facility did not maintain an infection prevention and control program designed to provide a sanitary environment and to prevent the development and transmission of communicable diseases and infections, including SARS-CoV-2 (COVID-19). Specifically, the facility did not ensure that a symptomatic staff member, who subsequently tested positive for COVID-19, was screened accurately and excluded from work. Additionally, hand hygiene was not performed during a dressing change and medication administration, contact isolation rooms were observed without the cautionary signage alerting staff and visitors, staff were observed to enter isolation rooms without the required Personal Protective Equipment (PPE), staff were observed to remove their mask and eye protection while in resident care areas, and observations were made of bare handed contact with resident food and medications. Resident identifier: 51, 88, 105 and 167. Findings include: 1. On 5/25/21 at 8:46 AM, an observation was made of Certified Nurse Assistant (CNA) 1 on the 300 hallway. The CNA was observed to be wearing a face shield and a surgical mask. The CNA stated that they had no COVID-19 positive staff or residents, and were not in outbreak status. CNA 1 stated that they were wearing eye protection because the county positivity rate had increased to 5.1%. The Director of Nursing (DON) approached and confirmed that all staff in the building were universally wearing a surgical mask and eye protection due to the county positivity rate of 5.1% and that they were just coming off of outbreak status from a COVID-19 positive staff member. On 5/25/21 at 8:54 AM, an interview was conducted with the Corporate Resource Nurse (CRN) 1. CRN 1 stated that they had a COVID-19 positive staff member and that the 14 day post positive outbreak period had ended on 5/24/21. The CRN stated that the staff member was activities staff (AS) 1 and had worked on the memory care unit. The CRN stated that testing of all staff and residents was completed yesterday, 5/24/21, and they were waiting for the final results. Technically we're still on outbreak mode. The CRN stated that they had completed testing of all residents and staff two times with a Polymerase Chain Reaction (PCR) test. The first round of testing, all test results were negative and the second round they were still waiting for the results. The CRN 2 stated that all staff and residents were asymptomatic. The CRN stated that isolation precautions for the memory care unit were removed this morning due to the guidance from the Centers for Disease Control and Prevention (CDC) that it could be removed after 14 days. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/25/21 at 9:05 AM, an interview was conducted with the DON. The DON stated that the memory care unit had dedicated staff and only certain nurses and aides worked that hall. It should be noted that review of the staff schedule revealed that 9 nursing staff members (CNAs and Licensed Nurses) worked on the memory care unit and on other units within the facility during the time period of the outbreak status, 5/10/21 to 5/24/21. The DON stated that AS 1 was COVID-19 positive on 5/10/21 and was not symptomatic per the Simpliscreen questionnaire. The DON stated that the Simpliscreen application alerted him that AS 1 had indicated NO to the question asking if they had received the COVID-19 vaccine. The DON stated that they have since removed that question from the screening questionnaire. The DON stated that they were doing weekly surveillance testing on 5/10/21, and that was when AS 1 was tested . The DON stated that AS 1 tested COVID-19 positive with the [NAME] BinaxNow antigen test. The DON stated that a confirmation PCR test was obtained from AS 1 and was completed in the office. The DON then stated that the PCR test was obtained outside in AS1's car. The DON stated that AS 1 was sent home after testing was completed to quarantine. The DON stated that AS 1 worked on 5/10/21 from 9:30 AM to 11:00 AM, then she was sent home. The DON stated that AS 1 was working in the office next to the DON's office, and then went to memory care unit to obtain paperwork and was distributing flyers to the residents on the 100 hallway. The DON stated that AS 1 did not enter any resident rooms, and was only located in the dayroom on the memory care unit or 100 hallway. The DON stated that he could not recall how many residents were present in the day room with AS 1. The DON stated that AS 1 wore a surgical mask and eye protection as the county positivity rate was greater than 5% at the time AS 1 tested positive. The DON stated that AS 1's positive PCR results were obtained on Tuesday morning, 5/11/21, and were received very quickly. The DON stated that AS 1 had worked the Friday before, 5/7/21, and was assigned to the memory care unit. The DON stated that the residents on the memory care unit were placed on contact/droplet precautions on 5/10/21 and all staff entering the unit wore full PPE that included a gown, gloves, K95 face mask and a face shield. The DON stated that staff that worked on the unit entered the building on either the 400 hallway entrance or the end of the 300 hallway and clocked in and out in the break room at the end of the 300 hallway. The DON stated that staff had to traverse other resident care areas to get to the 100 hallway, and when they went on break they exited the memory care unit and had their break in the facility break room. On 5/25/21 at 9:25 AM, the facility Administrator was interviewed. The Administrator stated that AS 1 tested positive with the point of care (POC) antigen test and then was confirmed with PCR test. The Administrator stated that initially they performed POC testing all residents residing on the memory care unit. Then, the State Agency Long Term Care Manager advised them to test the entire building on 5/11/21. The Administrator stated that all residents and staff were antigen tested initially on 5/10/21 and 5/11/21 and then PCR tested on [DATE]. The Administrator stated that they had completed one more round of PCR testing of all staff and residents on 5/24/21 and they were awaiting the test results. The Administrator stated that they had conducted contact tracing of those individuals that had come into contact with AS 1 and the DON would have an account of who those individuals were. The Administrator stated that there had been no other changes in the building with the exception of the memory care unit. The Administrator stated that they shut down the building until the first round of antigen testing was completed. Afterwards visitation resumed on all other hallways with the exception of the memory care unit. The Administrator stated that staff coming to work entered through the laundry door at the end of the 300 hallway, screened in at the iPad in the break room with Simpliscreen and dispersed to the rest of the building. The Administrator stated screening also occurred at the end of the 400 hallway and staff then clocked in and out in the break room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/25/21 at 10:30 AM, a telephone interview was conducted with AS 1. AS 1 stated she was pregnant and was not vaccinated. On Monday, 5/10/21, AS 1 stated she was feeling under the weather and had symptoms of a stuffy nose and a headache. AS 1 stated that she had been feeling it (stuffy nose and headache) for awhile, approximately 6 weeks, but that it was worse that morning. AS 1 stated that she had attributed the nasal congestion and headache to pregnancy symptoms, the joys of pregnancy. AS 1 stated that on 5/10/21 during the weekly testing she tested positive for COVID-19. AS 1 stated that they conducted a PCR test and sent her home to quarantine for 10 days. AS 1 stated that when she screened in using the Simpliscreen in the employee break room she had indicated that she was not vaccinated. The screening application prompted her to proceed to the front desk to alert the receptionist or DON. AS 1 stated that when she spoke to the DON she told him that she had not been feeling any other symptoms out of the usual for her. AS 1 stated that the stuffy nose and headache were not out of the usual for her, that she had attributed them to pregnancy symptoms, and had not marked them on the screening questionnaire. AS 1 stated that most people at the facility were aware that she was experiencing those symptoms. AS 1 stated that the DON asked if she had any signs and symptoms and she said no because she thought they were not out of the ordinary. AS 1 stated that she had the PCR test completed in the nursing office across from the main dining room and afterwards was sent home to quarantine for 10 days. AS 1 stated that on Tuesday, 5/11/21, she lost her sense of smell along with the continued nasal congestion and headache. AS 1 stated that all symptoms had resolved or improved when she returned to work with the exception of smell, and she had not had a headache or congestion for at least a week before returning to work. AS 1 stated that on 5/10/21 she entered the facility through east side near the kitchen, went to the employee lounge and screened in, and then reported to the front desk to speak to the DON. AS 1 stated that after she spoke to the DON, she went to her office and prepared materials then went to the memory care unit. AS 1 stated that while on the unit she delivered flyers and menus to all resident rooms on the unit. Afterwards AS 1 reported conducting two activities, an exercise video and concentration game, in the memory care day room. AS 1 stated that during the activities there were approximately 8 residents that participated. AS 1 stated that residents were spaced out in the day room during activities and that the table was in a U shape, and residents were seated a chair apart. AS 1 stated that the unit only had a handful of residents that wandered and would not stay seated. AS 1 stated that the residents that were present for the exercise video remained in their chairs and did not wander. AS 1 stated that for the concentrations game the residents that participated were the same group, and that she recalled a resident wandered in and out of the day room during the activity. AS 1 stated that afterwards she went back to her office and finished charting and then was surveillance tested for COVID-19. AS 1 stated that she arrived on the memory care unit at 9:45 AM and stayed on the unit for approximately 2 hours. AS 1 stated that while on the memory care unit she was able to stay socially distant. AS 1 stated that while she delivered flyers to resident rooms she placed the flyers on the resident nightstand, was 6 feet away from the residents and was in the room for less than 5 minutes. AS 1 stated that the PPE worn was a surgical mask, blue light blocking glasses for the computer, but not goggles or a face shield. AS 1 stated that she shared an office space, desk and computer with 3-4 other recreation staff, and that she was a full time employee at the facility. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/27/21 at 10:50 AM, an interview was conducted with the facility IP. The IP stated that staff screening was done in the break room and 400 hallway entrance with the Simpliscreen application. The IP stated that notification was made to her by text and email immediately if any response was marked yes for signs and symptoms on the screening questionnaire. The IP stated that education was provided to staff on screening at the kiosk by the department heads and by group chat. The IP stated that they educated staff on accurately documenting their signs and symptoms when screening, and that this was also done by group chat. The IP stated that there was no documentation of this education. The IP stated if they should indicate Yes the nurse would test them outside with the antigen test. The IP stated if the antigen test was negative and the staff member was symptomatic they would be sent home to quarantine and a PCR test would be obtained. Review of the CDC's guidance on Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic documented under Screen and Triage Everyone Entering a Healthcare Facility for Signs and Symptoms of COVID-19 stated .symptom screening remains an important strategy to identify those who could have COVID-19 so appropriate precautions can be implemented. The guidance further stated to Establish a process to ensure everyone (patients, healthcare personnel (HCP), and visitors) entering the facility is assessed for symptoms of COVID-19. And Properly manage anyone with suspected or confirmed SARS-CoV-2 infection or who has had contact with someone suspected or confirmed with SARS-CoV-2 infection: Healthcare personnel should be excluded from work The guidance was last updated on February 10, 2021. https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Finfection-control%2Fcontrol-recommendations.html. Review of the CDC's guidance on Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes under New Infection in Healthcare Personnel or Resident the guidance stated to Implement facility-wide testing Continue repeat viral testing of all previously negative residents in addition to testing of HCP, generally every 3 days to 7 days, until the testing identifies no new cases of SARS-CoV-2 infection among residents or HCP for a period of at least 14 days since the most recent positive result. Recommended precautions should be continued for residents until no new cases of SARS-CoV-2 infection have been identified for at least 14 days. The guidance was last updated on March 29, 2021. https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html#healthcare-personnel 2. Resident 88 was admitted to the facility on [DATE] with diagnoses that consisted of chronic respiratory failure, type 2 diabetes mellitus, hypertension, osteomyelitis of vertebra lumbar region, heart failure, and morbid obesity. On 5/25/21 at 1:03 PM, an interview was conducted with resident 88. Resident 88 stated that he had a pressure ulcer (PU) on his coccyx. Resident 88 stated that the wound was treated with stem cell therapy injections 1 time per week and dressing changes. Resident 88 stated that the wound care team came in on Monday, Wednesday and Fridays and changed the dressing and administered the injections. Resident 88's medical record was reviewed on 5/25/21. Review of resident 88's physician orders revealed a treatment order for Wound care to coccyx: -dermal cleanse and pat dry -apply anasept, collagen may mix, dressing -change three times per week The order was initiated on 5/21/21. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/27/21 at 3:54 PM, an observation was made of Registered Nurse (RN) 1 during resident 88's dressing change. RN 1 stated that dressing change to the coccyx wound was cleaned with wound cleaner and antibiotic ointment was applied. RN 1 stated that the ointment was mixed by the wound doctor and was stored in the resident room for the aides to apply with each dressing change. RN 1 was observed to perform hand hygiene and don 2 pairs of gloves. Resident 88's old dressing was removed during incontinence care provided by the aide, and the resident was positioned on the right lateral side. RN 1 sprayed wound cleaner, Puracyn Plus, to a 4 x 4 gauze and cleaned the wound bed. The RN stated that the wound was small and healing. RN 1 then opened the jar of ointment and applied the ointment to the center of the adhesive bordered gauze dressing with the gloved index finger. The dressing was placed over the wound bed. RN 1 was then observed to doff the top layer of gloves. RN 1 was observed to perform hand hygiene upon exit of the resident's room. An immediate interview was conducted with RN 1. RN 1 stated that it was just easier to use her gloved index finger than a applicator to apply the ointment and that was why she had two pairs of gloves on. On 5/27/21 at 5:27 PM, an interview was conducted with the DON and IP. The DON stated that hand hygiene should be performed between going from dirty to clean during dressing changes and that dirty gloves should be doffed. 3. On 5/27/21 at 7:49 PM, an observation was made of CNA 8 seated at the nurse's station on the 200/300 hallway with their eye protection/goggles and surgical mask removed. An immediate interview was conducted with the CNA. CNA 8 stated that she was working on the 300 hallway. CNA 8 stated that while working inside the facility she should be wearing a mask and goggles at all times. Review of the facility policy and procedure for Emerging Infectious Disease (EID): Coronavirus Disease 2019 (COVID-19) documented HCP should wear a facemask at all times while they are in the facility. Review of the CDC's guidance on Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic documented under Implement Universal Source Control Measures that HCP should wear well-fitting source control at all times while they are in the healthcare facility, including in breakrooms or other spaces where they might encounter co-workers. Source control referred to facemasks or respirators. The guidance was last updated on February 10, 2021. https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Finfection-control%2Fcontrol-recommendations.html. 40838 4. On 5/27/21 at 7:30 AM, Registered Nurse (RN) 1 was observed during AM (morning) med pass. RN 1 began withdrawing medication from the med storage unit for resident 17. RN 1 did not sanitize her hands prior to starting. RN 1 withdrew each medication from a blister card and handled each pill or tablet with her bare hands before placing it into a med cup. In the middle of withdrawing meds, RN1 paused to retrieve the group room TV remote control from a drawer in the med storage unit for a CNA. RN 1 did not hand sanitize and immediately went back to handling medication with her bare hands. RN 1 also handled her computer mouse and keyboard bare handed between withdrawing medication. RN 1 was immediately interviewed. RN 1 stated that the TV remote control, computer mouse, or computer keyboard had last been cleaned during the night shift. RN1 stated it was okay to touch medications with her bare hands. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. On 5/27/21 at 10:42 AM, RN 1 was observed checking a resident's blood sugar. RN 1 entered the resident's room without hand sanitizing or donning gloves and moved a bedside table away from the resident's bed with her bare hands. RN1 then donned gloves and checked the residents' blood sugar. Prior to exiting room, RN1 removed her gloves and placed them in the resident's trash can. Once outside the room RN1 handled the glucometer with bare hands. She placed the glucometer into a green, plastic carrying basket without sanitizing it, went directly to the 300 hall nurse's station without hand sanitizing, and started typing on the nurses' station computer. A continual observation was made of RN 1 from 10:42 AM until 10:59 AM. RN 1 was observed not to perform hand hygiene, nor did she sanitize the glucometer or computer station. At 10:59 AM, RN 1 was observed checking another resident's blood sugar. RN 1 did not hand sanitize and did not don gloves prior to getting the green, plastic glucometer carrying basket and carrying it to the resident's room. RN 1 entered the resident's room without hand hygiene or donning gloves and moved a bedside table away from the resident's bed with her bare hands. RN 1 then donned gloves and checked the residents' blood sugar. Prior to exiting room, RN 1 removed her gloves and placed them in the resident's trash can. Once outside the room RN 1 handled the glucometer with bare hands, and then placed the glucometer into a green, plastic carrying basket without sanitizing it. RN 1 was observed to go go the 300 hall nurse's station without hand hygiene, and started typing on the nurses' station computer. RN 1 was asked how often the glucometers were cleaned. RN 1 stated, The nightshift will do that. At 11:04 AM, RN 6 was interviewed. RN 6 stated that the glucometers were cleaned, Between each resident. RN 6 stated the nurse wipes it down with a bleach wipe. Review of the grievance log revealed that on 4/14/21 resident 99 filed a grievance that stated, she (licensed nurse) pulled all my pills out, then complained how their (sic) not in order took her at least a half hour to get all my pills, doesn't have gloves, touched hair, touched butt, pulled up her pants, and was just acting confused about my meds (medication) in general. The corrective action that was documented on the grievance form was that the DON provided education to the nurse related to hygiene and med pass. On 5/27/21 at 2:42 PM, the DON was interviewed. The DON was asked what the expectation was for nurses to perform hand hygiene. The DON stated, Every time they touch a resident or tray they need to hand sanitize. Both before entering and after exiting a resident room the nurse needs to hand sanitize. The DON was asked what he would do if he saw a nurse handling pills with bare hands. The DON stated, If I saw a nurse doing that I would have them throw the pills away and grab new meds. The DON stated Our nurses clean the glucometers in between each resident. 22992 6. On 5/26/21 at 9:10 AM, CNA 3 and CNA 16 were observed to be entering resident 167's room wearing gowns, gloves, face shields, and surgical masks. When asked about what they were doing, CNA 16 stated that she was supposed to put full PPE (Personal Protective Equipment) on before entering the resident's room to provide cares for resident 167. CNA 16 stated that PPE included face shield, gown, gloves, and mask. CNA 3 stated that resident 167 had a superbug, so we have to be careful. There was no sign on the door to indicate that staff and/or visitors should don PPE prior to entering the resident's room. (continued on next page)

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	05/28/2021

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 9:30 AM a Staff Member (SM) 12 was observed to be in resident 167's room with only a surgical mask on. SM 12's mask was positioned below her nose. SM 12 was observed to be at resident 167's bedside adjusting the tubing for resident 167's tube feeding. At approximately 9:40, SM 12 was observed to leave resident 167's room. An interview was immediately conducted with SM 12. SM 12 stated that she was a student nurse. When asked if resident 167 had an infections, SM 12 stated not that I'm aware of. On 5/26/21 at 12:30 PM, an interview was conducted with RN 5. RN 5 stated that when a resident was placed on isolation precautions, a member of central supply placed an isolation cart outside the resident's door, and was supposed to place a sign on the door to indicate that the resident was on isolation precautions. On 5/27/21 at 10:50 AM, an interview was conducted with the facility IP. The IP stated that she placed the signs on the doors notifying staff of the contact/droplet isolation precautions. The IP stated that she also placed the yellow bin/red bin for PPE and linen disposal, the isolation kit with all the required PPE, notified staff and placed the order in the electronic medical records. On 5/27/21 at 3:30 PM, an interview was conducted with the DON. The DON stated that a sign should have been placed on resident 167's room to alert staff and/or visitors to place the appropriate PPE. The DON stated that the resident had been diagnosed with Carbapenem-resistant Acinetobacter baumannii in her sputum. The DON also stated that the student nurse in resident 167's room should have had a face shield on, and that her mask should have been covering her nose. 7. On 5/26/21 at 12:00 PM, an interview was conducted with resident 105. Resident 105 stated that she was concerned about how the staff were doing pericares. Resident 105 stated that she had been diagnosed with urinary tract infections, and she suspected it was because staff often cleaned her periarea in a motion going from back to front, instead of front to back. Resident 105 stated that she had had to correct the staff on the proper technique. 8. On 5/27/21 the lunch meal was observed in the main dining room. At 12:30 PM, CNA 1 was observed to offer a sandwich to resident 51. CNA 1 took the sandwich out of the plastic bag with her bare hands, tore the sandwich into small pieces, removed the crust from the bread, and offered the sandwich pieces to resident 51.

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F 0885 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Report COVID19 data to residents and families. 38031 Based on interview and record review it was determined that the facility did not ensure that residents, their representatives, and families were informed by 5:00 PM the next calendar day following the occurrence of a single confirmed infection of COVID-19. Specifically, the facility identified a COVID-19 positive infection on 5/10/21 and notification was not made to all residents and their representatives until 5/12/21. Findings include: On 5/25/21 at 8:46 AM and at 9:05 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that the facility was just coming off of outbreak status from a COVID-19 positive staff member. The DON stated that the activities staff (AS)1 tested positive for COVID-19 on 5/10/21. On 5/27/21 at 10:50 AM, an interview was conducted with the facility Infection Preventionist (IP). The IP stated that notification of the COVID-19 positive staff on 5/10/21 was made to residents and their representatives by department heads. The IP stated that the residents were notified in person, and the families and representatives were informed by telephone. The IP stated that notification was documented in the resident progress notes. The IP stated that notifications were made for the 100 hallway on 5/10/21 and the remainder of the building was made by 5/12/21. The IP stated that initially she believed that they only had to notify the 100 hallway because that was the only hallway that had been exposed. The IP stated that they had an outbreak in October 2020, and her understanding was that all families were notified because all hallways were affected in that outbreak. On 5/27/21 at 11:50 AM, an interview was conducted with the facility Administrator. The Administrator stated that when they identified the COVID-19 positive staff member on 5/10/21, they determined that individual had worked on the 100 hallway and they shut down that hallway. The Administrator stated that notifications were made to residents, families and their representative of those residents that resided on the affected 100 hallway. The Administrator stated that he contacted the State Agency (SA) Long Term Care (LTC) Manager and informed them of what they had done. The Administrator stated that the SA LTC Manager informed him that notification had to be made to all residents and their representatives. The Administrator stated that this conversation occurred on 5/12/21 and that was when the remainder of the notifications were done. The Administrator stated that he was aware of the regulatory guidelines to notify families by 5:00 PM the following day. The Administrator stated he thought the regulation had changed and only the residents exposed needed to be contacted.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43710 Based on observation, interview and record the review, for 1 of 51 sample residents, it was determined that the facility did not ensure that the call light system was adequately equipped to allow residents to call for staff assistance through a communication system which relayed the call directly to a staff member or to a centralized staff work area. Specifically, a resident's call light was not operating as designed, agency staff were not provided radios, and radios did not alarm when call lights were alarming. Resident identifier: 58. Findings include: 1. Resident 58 was admitted on [DATE] with diagnoses which included Alzheimer's disease, anxiety, diabetes, drug induced dystonia, pseudobulbar affect, schizoaffective disorder, and dementia. On 5/25/21 at 8:49 AM resident 58 was interviewed. Resident 58 stated, My call light wasn't working and I'm not even sure if it works now. The call light button was pushed and it did not light up outside resident 58's door. The call light did not alarm at the nurses' station. When asked if she had informed staff it was not functioning, resident 58 stated, I've told them before but nothing happens On 5/27/21 at 10:21 AM, the Maintenance Assistant (MA) was observed in Resident 58's room repairing the call light. The MA stated, I'm fixing her call light. She found me earlier today and told me it was broken. Normally we have an app (application) where all the facility repair requests are listed. Hers wasn't on it and this is the first I've heard about it. On 5/27/21 at 4:00 PM, the Maintenance Director (MD) was interviewed and asked about broken call lights. The MD stated, If it's not on our list of 'tells' in [the electronic health record] we don't know about it. Usually the CNAs (Certified Nursing Assistants) or nurses will tell me if a bed or call light is out. I have a policy that staff can call me 24 hours a day if a bed or call light breaks. I never heard from [Resident 58] or staff that her call light was out. If I'd have known it would have been fixed the same day. The MD provided a facility list of requested items to fix. The list had 62 items on it. Resident 58's call light was not listed on the current requests and it did not show up in the recent history of facility repairs. 30563 On 5/27/21 at 3:49 PM, an interview was conducted with CNA 15. CNA 15 stated that the call lights lit up outside the rooms and alarmed in the radio. However, CNA 15 stated that the radio did not always alarm for some reason. CNA 15 stated that she heard 1 call light alarming on the 200 hall in her radio. An observation was made of 3 call lights lit up outside resident rooms on the 200 hall. CNA 15 stated that all staff should have radios. On 5/27/21 at 04:16 PM, an interview was conducted with CNA 2. CNA 2 stated that she had a radio but that it was not charged. CNA 2 stated that the agency aides did not get a radio. CNA 2 stated Its kind of a big deal, I'm not sure why they don't get one.