STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465129	A. Building B. Wing	10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health Center	55 South Professional Way Payson, UT 84651

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38031 Based on observation, interview, and record review it was determined, for 1 out of 34 sampled residents, that the facility did not ensure that the resident could exercise their rights without interference, coercion, discrimination, or reprisal from the facility. Specifically, a resident was denied access to their cigarettes and had their quantity of cigarettes limited when the resident asked for more. Resident identifier: 8. Findings included: Resident 8 was admitted to the facility on [DATE] with diagnoses which included dementia without behavioral disturbance, hypokalemia, type 2 diabetes mellitus, chronic pain syndrome, hypertension, hypothyroidism, urinary tract infection, muscle weakness, abnormalities of gait and mobility, and hyperlipidemia. On 6/16/22, resident 8's Admission Minimum Data Set assessment documented a Brief Interview of Mental Status of 8/15, which indicated moderately cognitively impaired. The assessment did not address the short-term and long-term memory. The assessment documented that resident 8 was a limited one person assistance for walking in room and in the corridor and was supervision with setup assistance for locomotion on and off the unit. The mobility devices used were documented as a walker and wheelchair. On 8/15/22, a Smoking Risk assessment was completed for resident 8. Resident 8's assessment documented that resident 8 borrowed cigarettes and a lighter from others and smoked every few hours. The assessment documented that resident 8 scored a 1, which indicated a minimal problem for the following areas: smoking in unauthorized areas; was careless with smoking materials - drops cigarette butts or matches on floor, furniture, self or others; burns finger tips; burns clothes; smokes near oxygen; smokes in the facility; inappropriately provided smoking materials to others; general awareness and ability to understand the facility safe smoking policy; and capability to follow the safe smoking policy. The assessment documented that resident 8 scored a 3 or severe problem with begging or stealing smoking materials from others. The assessment documented a total score of 10 which indicated a potentially unsafe smoker. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A second undated smoking assessment documented that resident 8's total score of 6, which would indicate safe to smoke. The assessment documented that resident 8 scored a 3 or moderate problem for smokes cigarettes/butts from the ash tray and begs or steals smoking materials from others. The assessment documented a score of 1 which indicated a minimal problem for general behavior and interpersonal interaction, and mobility. The assessment documented that resident 8 was not ready to accept smoking cessation materials. No documentation could be found that indicated that resident 8 had a Power of Attorney (POA). Review of resident 8's progress notes revealed the following: a. On 8/25/22 at 1:25 PM, the nurse practitioner's (NP) note documented that resident 8 was pleasantly confused. will often forget where she's going or where she is at. b. On 8/25/22 at 5:21 PM, the nurse's note documented, pt [patient] given baggie of 7 cigarettes this morning at 0700 [7:00 AM] and within two hours had smoked all 7 and trying to borrow cigarettes' from other patients and redirected multiple times, other patients stating she only gets two cigarettes a day and pt educated again on how many she gets and counted baggies in med [medication] cart with her with 7 in each bag for the week days. c. On 9/4/22 at 10:31 AM, the nurse's note documented, pt is out of cigarettes since Friday and son will not bring her cigarettes or money for cigarettes, patient notified and appears not happy. circling the outside building and outside trash cans looking for cigarette butts and unable to re-direct, tiger text sent to all staff r/t [related to] the above. d. On 9/9/22 at 10 :56 AM, the nurse's note documented, Cigarettes in nursing cart. Pt. has had 2 as of 11am; one at 8:30am, one at 10:30am. e. On 9/15/22 at 5:35 AM, the NP note documented, . remains confused. she continues to lack her own safety awareness. no new falls or other events. f. On 9/18/22 at 3:58 PM, the nurse's note documented, pts [family member] came in and brought one pack of cigarettes labeled and in top drawer and try to space them out he said one every few hours and pt educated again, pts [family member] says he plans on taking her home soon but trying to figure out logistics first and then will notify social worker and facility. Review of resident 8's care plan revealed a care area for tobacco use that was initiated on 9/27/22. Interventions identified were to distract with an activity or conversation of choice when it was not smoking time; offer cessation information as desired; involve support person or Ombudsman as needed; praise the resident for being safe and responsible; resident will be able to follow the smoking policy with staff assistance; and resident will not share or borrow tobacco products or paraphernalia from other. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/26/22 at 10:21 AM, an interview was conducted with Certified Nurse Assistant (CNA) 1. CNA 1 stated that resident 8 was confused and had some short-term memory deficits. CNA 1 stated that resident 8 knew where she was at and understood what was going on. CNA 1 stated that resident 8 wandered and went for walks around the building. CNA 1 stated that resident 8 used a cane for a mobility device. CNA 1 stated that resident 8 was frequently outside smoking and would wander to the other side of the building to look at the baby horse. On 9/27/22 at 1:30 PM, an observation was made of resident 8 asking the Registered Nurse (RN) for a cigarette. The RN was observed to tell resident 8 that they just had one and that they had to wait until 4:00 PM for the next one. On 9/27/22 at 1:32 PM, an interview was conducted with RN 4. RN 4 stated that resident 8 asked for a cigarette and was told that she had to wait until 4:00 PM because she had one at 1:00 PM already. RN 4 stated that she told resident 8 that she had nine cigarettes remaining. RN 4 stated that resident 8's cigarettes were kept inside the medication cart, but not the lighter. RN 4 stated that resident 8 went through packs of cigarettes fast so they were trying to limit the amount she smoked. RN 4 stated that resident 8 had a cigarette at 1:00 PM and then returned immediately to ask for a second one. RN 4 stated that she reminded resident 8 that she had just smoked a cigarette and that she needed to wait until 4:00 PM for the next one. RN 4 stated that she was told in report by the previous nurse that resident 8 was to only have one cigarette every three hours. RN 4 stated that resident 8 smoked independently and that she was alert and oriented to person and place. RN 4 stated she was not sure if resident 8 was able to make her own decisions, or if she had that capacity. RN 4 stated that resident 8 did not have all her faculties. RN 4 stated that she was not sure if resident 8 was her own responsible party or if she had a POA. RN 4 stated that resident 8 wandered and went outside to smoke. On 9/28/22 at 8:41 AM, an interview was conducted with RN 5. RN 5 stated that resident 8 could only have one cigarette every two hours. RN 5 stated that resident 8 would forget that she had smoked. RN 5 stated that resident 8's family were in control of the cigarettes and had set the schedule for smoking. On 9/29/22 at 8:27 AM, an interview was conducted with CNA 2 and Restorative Nurse Assistant (RNA) 1. CNA 2 stated that resident 8 had a fall outside three or four months ago. CNA 2 stated the staff made sure to keep an eye on where resident 8 was going and made sure she did not go into the construction site that was nearby. CNA 2 stated that the staff would keep track of resident 8 by looking out the windows to find her. CNA 2 stated that resident 8 had wandered into the construction area before to ask for cigarettes. CNA 2 stated that this had happened multiple times within a two week period. CNA 2 stated that this occurred before resident 8 had her own cigarettes. CNA 2 stated that since resident 8 had access to her own cigarettes she had not wandered back over to the construction site. CNA 2 stated that resident 8 was an independent smoker and had her lighter in her possession. RNA 1 stated that resident 8's routine was to walk around the parameter of the building. RNA 1 stated that resident 8's family made the smoking schedule and limited her cigarettes. RNA 1 stated that resident 8 would smoke the whole pack because she forgets. RNA 1 stated she was not aware of resident 8's POA status. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/29/22 at 11:06 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that resident 8's cognitive status was that she was alert and able to answer questions. The DON stated that resident 8 had aphasia and had difficulty with her speech. The DON stated that resident 8 was able to ask for things that she needed, could speak using more than one word, but did not talk with full sentences. The DON stated that resident 8 frequently asked for Pepsi but did not necessarily mean Pepsi when asked if that was what she wanted. The DON stated that the staff would then have to go through other items that may be wanted. The DON stated that resident 8 was able to make decisions about her care and could express her wants and needs. The DON stated that she was not sure if resident 8 had a POA. The DON stated that the family were involved in resident 8's care but did not know if they made decisions about resident 8's care for her The DON stated she did not know if the family directed the smoking schedule for resident 8. The DON stated she was not aware of any smoking schedule or cigarette limitations for resident 8. The DON stated that every resident who smoked should have a smoking assessment completed. On 9/29/22 at 12:36 PM, a follow-up interview was conducted with the DON, the Corporate Social Service Worker (CSSW), and the Resident Advocate (RA). The DON stated that she had observed that the second smoking assessment was not dated. The DON stated that the smoking assessment with a score of 6 was dated on 7/14/22, and the most recent assessment was on 8/15/22. The DON stated that the smoking assessment that scored a 10, which indicated that resident 8 was potentially an unsafe smoker, was the most recent assessment. The CSSW stated that the RA conducted resident 8's smoking assessments. The DON stated that it should be an Interdisciplinary Team decision on resident 8's interventions for smoking. The DON stated that the biggest challenge was that resident 8 tried to get smoking materials from others and the ashtrays. The DON stated that resident 8 would seek cigarettes when they were not available. The CSSW stated that resident 8 did not have a POA. The CSSW stated that a family member had said they were resident 8's POA, but they had not provided the documents for it. The CSSW stated that the family purchased the cigarettes for resident 8 and had asked the facility to limit the amount that was provided to resident 8. The RA stated that she conducted the smoking assessment and observed resident 8 to safely light, smoke, and dispose of the cigarette. The RA stated that based on the observation she determined that resident 8 would need staff supervision for smoking to ensure that she did not dig through the ashtray seeking more cigarettes. The RA stated that she educated the staff to manage resident 8's cigarettes, so she was not blowing through them. The RA stated that a family member requested that they manage resident 8's cigarettes because they could not afford to bring her packs every day. The RA stated that the family member would bring two packs in and say that they needed to last until a certain day. The RA stated that resident 8 would be able to recall that those two packs had to last a certain amount of time. The RA stated, I don't think we restricted them. The RA stated that per the family request if resident 8 smoked them all in two days so be it.

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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** 45470 Based on observation and interview, the facility did not provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Specifically, the carpets in the facility had multiple stains and the couches were worn and had holes in the cushions. Findings included: On 9/27/22 at 10:15 AM, a walk through of the facility was conducted. The following observations were made; a. Multiple large stains were observed on the carpet between the 300 and 400 hallway. b. Multiple large stains were observed on the carpet in the 300 hallway near the dining room area. c. Multiple large stains were observed on the carpet outside of room [ROOM NUMBER]. d. Multiple large stains were observed on the carpet outside of room [ROOM NUMBER] and 408. e. Multiple large stains were observed on the carpet in the 200 hallway near the dining room. f. Multiple large stains were observed on the carpet in the 100 hallway. g. A couch in the lounge area in between the 300 and 400 hallway had multiple small tears in the cushion. h. The couches in the lounge area between the 300 and 400 hallway were darkened and worn in the seats and the armrests. On 10/3/22 at 9:15 AM, an interview with Certified Nursing Assistant (CNA) 2 was conducted. CNA 2 stated that the stains on the carpet have been there since she started working at the facility approximately five months ago. CNA 2 stated that the carpet occasionally got shampooed, but the stains always remained on the carpet. On 10/3/22 at 9:35 AM, an interview with the Housekeeping Supervisor (HS) was conducted. The HS stated that the couches get disinfected daily, and once a month the couches get a deep clean. The HS stated that the couches would get a deep clean if they become soiled for any reason. The HS stated that the couches were darkened and had tears because the couches were old, and need replaced. On 10/3/22 at 9:23 AM an interview with the Administrator (ADMIN) was conducted. The ADMIN stated that the facility was planning on a remodel which would include replacing the floors. The ADMIN stated that he was not sure when the remodel was going to happen.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 observation, interview, and record review it was determined, for 2 out of 34 sampled residents, that the resident did not have the right to voice grievances to the facility or other agencies or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. In addition, the facility did not maintain evidence demonstrating the results of all grievances for a period of no less than three years from the issuance of the grievance decision. Specifically, there were no grievances for a period of time during transition of staff into the Resident Advocate position. In addition, residents reported grievances that were not followed up. Resident identifiers: 16 and 29. Findings included: The grievance log was reviewed. There was a grievance dated 5/2/22, regarding call lights. There were two grievances dated 9/12/22, regarding call lights not being answered and meal cards not being followed. There were no grievances between 5/3/22 through 9/12/22. The Administrator provided Resident Council Minutes dated 4/5/22, 5/3/22, 6/7/22, 7/12/22, 8/2/22, and 9/12/22. The Resident Council Minutes dated 9/12/22, revealed long call light times and there was no follow-up documented. 1. Resident 29 was admitted to the facility on [DATE] with diagnoses which included low back pain, injury to left lower leg, hypothyroidism, edema, chronic pain, and nausea. An admission Minimum Data Set, dated dated dated [DATE], revealed resident 29 had a Brief Interview of Mental Status score of 15 which revealed resident 29 was cognitively intact. On 9/26/22 at 12:32 PM, an interview was conducted with resident 29. Resident 29 stated she was missing fifteen dollars and had reported to staff but no one had followed-up with her about it. On 10/3/22 at 10:30 AM, an interview was conducted with the Director of Nursing (DON). The DON stated there should be a grievance or complaint process. The DON stated that she heard about something with resident 29 a week ago. The DON stated it was something about being provided a lock box for her things. On 10/3/22 at 9:21 AM, an interview was conducted with the Administrator. The Administrator stated that his best guess was that the Resident Advocate (RA) was training the Business Office Manager (BOM) so there might have not been enough time to complete grievances. The Administrator stated that the Resident Council Minutes were used to address grievances between 5/3/22 and 9/12/22. On 10/3/22 at 10:04 AM, an interview was conducted with Certified Nursing Assistant (CNA) 2. CNA 2 stated if a resident reported missing items, then she looked for the missing item. CNA 2 stated if she was unable to find the item, then she notified the RA. CNA 2 stated that the RA then went through her process. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/3/22 at 12:12 PM, an interview was conducted with the RA. The RA stated she obtained grievance forms in care conference meeting, resident council, and through the staff. The RA stated residents had her phone extension so they could call her to tell her about any grievances they have. The RA stated recently staff got resident 29 a lock box because resident 29 was concerned her things were going missing. The RA stated resident 29 was provided a lock box for her own security. The RA stated she had not heard that resident 29 was missing fifteen dollars. The RA stated when staff gave resident 29 the lock box, resident 29 was educated on keeping funds in her room. The RA stated that the admission agreement stated that the facility was not responsible for missing items and that money should be stored in the personal funds account. The RA stated that the previous RA that was here left. The RA stated she was the BOM and had to train a new BOM before being trained to be the RA. The RA stated she trained the BOM for about a month and the Corporate Social Service Worker (CSSW) helped remotely daily and was at the facility once a week. The RA stated she was not sure who was handling grievances before she became the RA full time. The RA stated if she received staffing grievances so took them to the nursing leadership, who pulled call light reports, and educated staff on importance of answering a call light. The RA stated she had a few complaints regarding staffing when she transitioned into the RA position. On 10/3/22 at 12:21 PM, an interview was conducted with the CSSW. The CSSW stated the previous RA was at the facility until about June 2022. The CSSW stated that the current RA transitioned to the RA from being the BOM. The CSSW stated the prior BOM left after a couple months and the current RA had to train a new BOM. The CSSW stated she helped out at the facility when she could because she had other facilities to oversee. The CSSW stated she was not over the grievances, but if a resident stopped her facility staff would work on them. The CSSW stated she filled out one grievance during the time she was helping. The CSSW stated grievances were generated through, Interdisciplinary team meetings, resident council, residents knew where the RA's offices was, there were some forms at the nurses station, and there was a pocket to put the form in for the RA. The CSSW stated there were no grievances from resident 29. The CSSW stated that the RA told her that resident 29 called her phone the other day and asked for another pill from the nurse. The CSSW stated she did not know resident 29 very well but that she did not come out of her room. 2. Resident 16 was admitted to the facility on [DATE] with diagnoses which included cellulitis of left lower limb, severe protein-calorie malnutrition, lymphedema, anemia, and hypertension. On 10/3/22 at 9:49 AM, an observation was made of resident 16 talking to Physical Therapy Assistant (PTA) 1 and Occupational Therapist (OT) 1. Resident 16 stated the facility was so short staffed on Saturday night that a CNA came in and told him she did not have time to change him. Resident 16 stated a nurse came in later and he told the nurse that if he was not changed he would call the police. Resident 16 stated he told staff it was their choice on what he did. Resident 16 stated the CNA came in and changed him very quickly. Resident 16 stated he hated to be that kind of a guy but he had no other choice. Resident 16 stated he was looking at other facilities because of staffing. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/3/22 at 12:31 PM, an interview was conducted with PTA 1. PTA 1 stated she did not remember talking to resident 16. After being reminded of the conversation, PTA 1 stated that resident 16 stated there was one CNA and one nurse working. PTA 1 stated resident 16 was worried because he had to teach the CNA how to use the hoyer lift to transfer him. PTA 1 stated resident 16 said when it got to the point that he did not feel safe he would call the police. PTA 1 stated resident 16 said he needed to have a brief change and someone went in to change him but said they needed to come back. PTA 1 stated that resident 16 said the nurse came into his room and he told the nurse if he did not get changed he would call the police. PTA 1 stated she had not reported the information to management. PTA 1 stated she was planning on talking to the DON about it. On 10/3/22 at 12:31 PM, an interview was conducted with OT 1. OT 1 stated that resident 16 claimed that every time that he had a new CNA working with him, the CNA did not know how to transfer him. OT 1 stated if resident 16 was not in the exact right spot then he did not think the CNA knew what they were doing. OT 1 stated some of resident 16's complaints might be warranted. OT 1 stated resident 16 was very sensitive to any new staff. OT 1 stated there had been times when staffing was poor over the weekends and it feeds into the fact that it had not been fixed and might not be going away. OT 1 stated he usually talked to the RA, DON, and Administrator and the concerns were discussed in the morning meeting throughout the day.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33215 Based on observation, interview, and record review, it was determined, the facility did not provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. Specifically, for 5 out of 34 sampled residents, residents did not receive the bathing assistance they required and showers were missed. In addition, a resident with dirty fingernails did not receive the assistance they required to clean their fingernails. Resident identifier: 8, 22, 25, 47, and 53. Findings included: 1. Resident 22 was admitted to the facility on [DATE] with diagnoses which included, but not limited to, nontraumatic intracerebral hemorrhage, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, type 2 diabetes mellitus, essential hypertension, muscle weakness, and chronic pain syndrome. On 9/26/22 at 10:31 AM, an interview was conducted with resident 22. Resident 22 stated that her shower days were every Tuesday, Thursday, and Saturday. This surveyor observed a sign in resident 22's room with the posted shower days. Resident 22 stated that sometimes she did not get showered due to there not being enough staff. Resident 22's medical record was reviewed on 9/27/22. An admission Minimum Data Set (MDS) assessment dated [DATE], documented that resident 22 required physical help in part of the bathing activity by two persons physical assistance. Resident 22's shower sheets were reviewed and the following showers were documented: a. On 7/11/22, a shower was provided. b. On 7/23/22, a shower was provided. [Note: Resident 22 went 11 days without a shower.] c. On 7/30/22, a shower was provided. [Note: Resident 22 went 6 days without a shower.] d. On 8/6/22, the shower sheet provided was blank. e. On 8/9/22, a shower was provided. [Note: Resident 22 went 9 days without a shower.] f. On 9/7/22, a shower was provided. [Note: Resident 22 went 28 days without a shower.] g. On 9/15/22, a shower was provided. [Note: Resident 22 went 7 days without a shower.] h. On 9/27/22, a shower was provided. [Note: Resident 22 went 11 days without a shower.] (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/27/22 at 1:35 PM, an interview was conducted with Certified Nursing Assistant (CNA) 5. CNA 5 stated that resident showers were documented in the resident medical record and a shower sheet would be completed for each shower. CNA 5 stated that the shower sheets were signed off by the nursing staff. CNA 5 stated after the nursing staff signed the shower sheets they were uploaded into the resident's medical record by the Medical Record staff member. CNA 5 stated that a shower sheet would be completed after every shower and refusal. On 9/27/22 at 2:26 PM, an interview was conducted with CNA 6. CNA 6 stated that resident 22 had never refused a shower for her. CNA 6 stated that resident 22 was showered three times a week on Tuesday, Thursday, and Saturday. CNA 6 stated that resident 22 was able to complete approximately 75% of the shower on her own. CNA 6 stated that most days there was enough staff to complete showers. CNA 6 stated if the hallway was short staffed she would find someone to help with call lights so she could make sure that the residents were taken care of. On 9/29/22 at 12:34 PM, an interview was conducted with CNA 7. CNA 7 stated that the facility was short on staff. CNA 7 stated that she had seven showers to complete today with two CNAs staffed on the 100 and 200 hallway. CNA 7 stated that five of the seven residents were a two person extensive assistance. CNA 7 stated that the 100 and 200 hallway did not have a shower CNA and sometimes the showers got missed. CNA 7 stated that two showers had been completed today and one resident refused. CNA 7 stated that her goal was to get three showers completed each day. CNA 7 stated if a shower was missed she would pass it on in report and see if the next shift could complete the showers. CNA 7 stated if the next shift could not complete the showers she would try and complete the showers the next day. CNA 7 stated that resident 22 was a set up for showers. CNA 7 stated that after she set resident 22 up for a shower she would leave and give resident 22 privacy. CNA 7 stated that resident 22 needed assistance to wash her back and get dressed. CNA 7 stated that resident 22 was very involved in her care. CNA 7 stated that the shower sheets were getting missed because a lot of the staff did not know that they had to complete a shower sheet. CNA 7 further stated that the shower book did not have any shower sheets available and staff did not have a master copy to make copies. CNA 7 stated that she had a hard time answering resident call lights when there were only two CNAs staffed because most of the residents were a two person assistance. CNA 7 further stated the willingness of other staff to answer call lights was also a concern. 30563 2. Resident 25 was admitted to the facility on [DATE] with diagnoses which included hypothyroidism, hyperlipidemia, depression, hypertension, borderline personality disorder, pain, and edema. On 9/26/22 at 12:32 PM, an interview was conducted with resident 25. Resident 25 stated she should get a shower today, but did not get one because staff did not show up. Resident 25 stated she got a shower on 9/24/22, but did not have one for two weeks prior to that. Resident 25 stated she took showers by herself because she became very disgusted by herself. Resident 25's medical record was reviewed on 9/29/22. An admission MDS assessment dated [DATE], revealed resident 25 had a Brief Interview of Mental Status (BIMS) score of 11 which revealed mild cognitive impairment. The MDS further revealed resident 25 required one person limited assistance to transfer only and physical assistance with bathing. (continued on next page)

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Parkway Health Center	55 South Professional Way Payson, UT 84651

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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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A care plan with a problem start date of 7/29/22, and created on 7/31/22, revealed [Resident 25] is at risk for altered ADL [activities of daily living] function secondary to limited mobility. The goal was to not have any unaddressed complications secondary to decreased ADL self-performance, through next review. Approaches included assistance in completing ADL tasks each day, provide dignity and respect, and encourage independence; encourage us of call lights when ADL assistance was needed. There were shower sheets in resident 25's medical record dated 8/15/22 and 9/9/22. On 10/3/22 at 9:53 AM, an interview was conducted with CNA 2, CNA 9, and CNA 8. The CNA's stated there were shower schedules and a shower CNA that worked Tuesday through Saturday. CNA 2 stated there were shower sheets completed and charted in the computer after a shower was completed. CNA 8 stated they were out of shower sheets and the printer was not working to print out the shower sheets. CNA 2 stated there was a tab to document when ADLs were performed in the electronic medical record. On 10/3/22 at 12:08 PM, an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated resident 25 required two person supervision assistance with showers. The ADON stated there were enough staff to help resident 25 get a shower. The ADON stated for supervised residents, the staff provided the towels and if the resident wanted someone in the shower room the staff stayed in the shower room. 3. Resident 47 was admitted to the facility on [DATE] with diagnoses which included convulsions, severe intellectual disabilities, major depressive disorder, and dementia. On 9/26/22 at 10:41 AM, an observation was made of resident 47. Resident 47 was in the hallway with messy hair. Resident 47 stated she combed her hair on her own. At 12:05 PM, resident 47 was observed in the dining room with messy hair and with what appeared to be mucus on her chest. At 3:07 PM, resident 47 was observed with what appeared to be mucus on her shirt sitting in the television area. On 9/28/22 at 9:30 AM, an observation was made of resident 47. Resident 47 was observed in the salon getting her hair done. Resident 47's medical record was reviewed on 9/29/22. A quarterly MDS assessment dated [DATE], revealed resident 47 had a BIMS score of 4 which revealed severe cognitive impairment. The MDS further revealed resident 47 required one person physical assistance with physical help in part of bathing activity. A care plan with a problem start date of 1/31/22, revealed resident 47 was at risk for altered ADL function secondary to cognitive deficit and limited mobility. The goal was resident 47 would not have any unaddressed complications secondary to decreased ADL self-performance, through the next review. The approaches included to assist resident 47 to apply ankle foot orthosis to bilateral legs when out of bed; assist in completing ADL tasks each day; and encourage to use call lights when ADL assistance was needed. According to shower sheets in resident 47's medical record. Resident 47 was provided a shower on 7/5/22, 8/27/22, 9/10/22, 9/17/22, and 9/24/22. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/3/22 at 12:04 PM, an interview was conducted with the ADON. The ADON stated resident 47 did not usually refuse showers. The ADON stated resident 47 was good about getting into the shower. The ADON stated resident 47 required one person assistance with showers. 4. Resident 53 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included surgical aftercare following surgery, muscle weakness, lack of coordination, diabetes mellitus, sleep apnea, and generalized anxiety. On 9/26/22 at 2:41 PM, an interview was conducted with resident 53. Resident 53 stated he was scheduled for showers on Tuesday, Thursday, and Saturday but he did not always get his shower. Resident 53 stated he asked for a bed bath sometimes. Resident 53's medical record was reviewed on 9/29/22. A quarterly MDS assessment dated [DATE], revealed resident 53 required one person physical assistance in part of bathing. The MDS further revealed resident 53 had a BIMS score of 14 which revealed he was cognitively intact. A care plan dated problem onset of 8/1/22, and created on 9/19/22, revealed resident 53 was at risk for altered ADL function secondary to limited mobility and obesity. The goal was to not have any unaddressed complications secondary to decreased ADL self-performance, through the next review. Approaches included assistance bars to bed as least restrictive turning and repositioning device; assist in completing ADL tasks each day; encourage PT/OT [Physical Therapy/Occupational Therapy] services as prescribed. not applicable; encourage use of call lights when ADL assistance was needed. According to shower sheets in resident 53's medical record. Resident 53 was provided a shower on 1/26/22, 9/10/22, and 9/24/22. Resident 53's progress notes revealed the following entries: a. On 8/4/22, Pt [patient] complaining of not getting showered today and shower aide [CNA] has left for the day but will pass on report to be done tomorrow. b. On 8/26/22 at 2:00 PM, .got shower aide to help and give him a thorough shower. c. On 9/15/22 at 3:38 PM, the patient took a shower today. On 10/3/22 at 10:25 AM, an interview was conducted with the Director of Nursing (DON). The DON stated she knew staff had a shower schedule for residents and a shower CNA worked Tuesday through Saturday. The DON stated there were shower sheets that CNA's documented on after a shower was completed. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/3/22 at 12:04 PM, an interview was conducted with the ADON. The ADON stated residents had scheduled shower days. The ADON stated the Restorative Nursing Assistant (RNA) provided showers to residents if she had RNA services to provide to the resident that day. The ADON stated there was also a shower CNA. The ADON stated there had been times the shower CNA had been pulled to the floor to help with call lights instead of showers. The ADON stated CNA's fill out a shower sheet and would check off if there were any skin problems. The ADON stated if a resident refused a shower, it was offered three times, different CNA's offered, the CNA would let the nurse know, and the CNA charted the resident refused. 38031 5. Resident 8 was admitted to the facility on [DATE] with diagnoses which included dementia without behavioral disturbance, hypokalemia, type 2 diabetes mellitus, chronic pain syndrome, hypertension, hypothyroidism, urinary tract infection, muscle weakness, abnormalities of gait and mobility, and hyperlipidemia. On 9/26/22 at 12:42 PM, an interview was conducted with resident 8. Resident 8 stated yah when asked if she received assistance with showers, but was not able to recall or state what days they were scheduled for. An observation was made of a black/brown substance packed under all of resident 8's fingernails on the left hand. On 9/26/22, resident 8's medical record was reviewed. On 6/16/22, resident 8's admission MDS assessment documented a BIMS of 8/15, which indicated moderately cognitively impaired. The assessment documented that the resident was a limited one person assistance for walking in room and in the corridor and was supervision with setup assist for locomotion on and off the unit. The resident was an extensive one person assistance for toileting, a one person limited assistance for personal hygiene, and required a one person assistance with physical help in bathing. The mobility devices used were documented as a walker and wheelchair. Review of resident 8's care plan revealed a care area for at risk for altered ADL function secondary to limited mobility and cognitive deficits and was initiated on 9/26/22. Interventions included assist in completing ADL tasks each day; provide dignity and respect and encourage independence; and encourage use of call lights when ADL assistance was needed. Review of resident 8's shower sheets revealed the following: a. On 7/4/22, resident 8 refused a shower. b. On 7/21/22, the shower sheet documented that oral care, nail care, shaving, lotion application, comb hair out, and a shower was provided. c. On 8/12/22, the shower sheet documented that oral care, nail care, shaving, lotion application, comb hair out, and a shower was provided. It should be noted that 22 days had lapsed since the last documented shower. d. On 8/15/22, the shower sheet documented that oral care, nail care, shaving and a shower were provided. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	e. On 9/7/22, the shower sheet was dated but did not document if any bathing or hygiene was provided. It should be noted that 22 days had lapsed since the last documented shower. f. On 9/15/22, the shower sheet documented that oral care, nail care, shaving, lotion application, comb hair out, and a shower was provided. It should be noted that 8 days lapsed since the last documented shower. g. On 9/26/22, resident 8 refused a shower. It should be noted that 11 days had lapsed since the last documented shower was offered. h. On 9/28/22, resident 8 refused a shower. On 9/28/22 at 8:28 AM, resident 8's fingernails on the left hand were observed dirty and packed with a black/brownish substance underneath. On 9/29/22 at 8:13 AM, an interview was conducted with Registered Nurse (RN) 5. RN 5 stated that the facility had a shower CNA Tuesday through Saturday. Resident 8 was observed talking to RN 5. Resident 8 was observed wearing the same shirt that was worn since 9/27/22. On 9/29/22 at 8:14 AM, an interview was conducted with CNA 4. CNA 4 stated that she was the shower CNA on Tuesdays through Saturday. CNA 4 stated that resident 8 was scheduled for showers on Monday, Wednesday, and Fridays. CNA 4 stated that resident 8 required limited assistance with showers, and she provided the resident with towels and supplies. CNA 4 stated that she assisted with washing resident 8's back, legs and hair, and then assisted the resident with dressing after the shower was completed. CNA 4 stated that sometimes if resident 8 refused a regular shower then a bed bath would be offered. CNA 4 stated that resident 8 usually refused showers but they would approach a few times a day. CNA 4 stated that documentation of showers that were provided and any refusals were completed on the shower sheet. CNA 4 stated that when she assisted with the showers she cleaned the resident's hands with a wash cloth and also cut the resident's fingernails. A shower sheet was observed taped to the nurse's station, and was dated 9/25/22 to 10/2/22. Resident 8's shower schedule was documented as a morning shower on Sunday, Monday, Wednesday, and Friday. The form documented that resident 8 refused on Monday (9/26/22) and Wednesday (9/28/22).

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45470 Based on observation, interview, and record review it was determined, for 5 out of 34 sampled residents, that the facility failed to ensure that the resident environment remained as free of accident hazards as was possible and each resident received adequate supervision and assistance devices to prevent accidents. Specifically, multiple residents did not receive preventative interventions and/or adequate supervision to prevent future falls. In addition, a resident with a history of wandering did not receive adequate supervision to prevent accidents and the resident did not receive adequate supervision due to being an unsafe smoker. Resident identifiers: 8, 43, 49, 53, and 155. Findings included: 1. Resident 155 was admitted to the facility on [DATE] with diagnoses which included unspecified fracture of left femur, hyperkalemia, nonrheumatic aortic stenosis, and acute on chronic combined systolic and diastolic heart failure. On 9/27/22, resident 155's medical record was reviewed. A progress note dated 9/11/22 at 3:33 PM, revealed that resident 155 was here with a L [Left] hip fx [fracture] after a fall. Resident 155's care plan was reviewed, and it revealed that there was no care plan related to falls. On 9/7/22 at 5:19 PM a Nursing Progress Note revealed, Res [resident] had fall, called to shower by CNA [Certified Nursing Assistant] res was lying on back. Res said he slipped. Fall was not witnessed. Res denied pain at this time. Assessed, no apparent injury at time. Neuro [neurological] checks started and were wnl [within normal limits] . [Note: A fall care plan was not developed.] On 9/27/22 at 3:18 PM, an interview with the Director of Nursing (DON) was conducted. The DON stated that if a resident came to the facility with recent falls, there should be a baseline care plan for falls. 2. Resident 43 was admitted to the facility on [DATE] with diagnoses which included dehydration, major depressive disorder, anxiety disorder, orthostatic hypotension, muscle weakness, and abnormalities of gait and mobility. On 9/27/22, resident 43's medical record was reviewed. A care plan dated 8/20/22, and revised 8/30/22, revealed that resident 43 was at risk for falls related to a history of falls, history of Parkinson's Disease, and hypertension. The goal was the resident would have no unaddressed falls through next review. Approaches included monitoring for orthostatic hypotension which was created on 8/20/22, encourage to use the call light and ask for assistance when transferring or ambulating which was created on 8/24/22, and to encourage resident to increase fluid intake which was created on 8/25/22. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A progress note dated 8/19/22 at 6:42 PM, revealed, Res is fall risk, uses walker, unsteady gait. Resident has confusion and is scared and afraid to be here without family . A progress note dated 8/20/22 at 10:46 AM, revealed, Pt [patient] was in room this morning on own, staff was doing regular duties when housekeeping told CNA that pt had fallen in room and was bleeding. Upon staff entering room pt was back in bed. With further inspection a pool of blood was noted on bathroom floor but pt was able to get self into bed. Upon initial assessment pt was confused on where he was or why he was here but knew who he was. Wound on right back of head was bleeding - nurse cleaned up and notified DON [Director of Nursing] . Neuro checks are in place and pt is in front sitting room in view of nursing station to be watched until further information is gained. A progress note dated 8/24/22 at 11:12 AM, revealed, Aid [CNA] went into residents room to check on him, resident was found in bed, resident was on the phone with his wife who told aid that he had fallen. Neuros started. A progress note dated 8/25/22 at 11:59 PM, revealed, Patient was found on the floor. He stated that he did not hit his head. He has an abrasion on lower back. Nurse did an assessment before he was transferred to his bed. Patient is alter and oriented. Resident 43's face sheet revealed that resident 43 was discharged to home on 9/10/22. On 9/28/22 at 9:45 AM, an interview with CNA 2 was conducted. CNA 2 stated that there was not enough staff at the facility to prevent residents from falling. CNA 2 stated that the facility often staffed two or three CNAs for the entire building, which was not enough to adequately supervise residents who were a fall risk. CNA 2 stated that in addition to not having enough staff, communication between nurses and CNAs was lacking, and CNA's were often not aware if resident were a fall risk. On 9/28/22 at 10:00 AM, an interview with CNA 8 was conducted. CNA 8 stated that on some shifts there were only two CNAs in the facility. CNA 8 stated that the facility needed more CNAs to supervise residents who were a fall risk because there was not enough staff to prevent residents from falling. 30563 3. Resident 53 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included surgical aftercare following surgery, muscle weakness, lack of coordination, diabetes mellitus, sleep apnea, and generalized anxiety. On 9/26/22 at 2:33 PM, an interview was conducted with resident 53. Resident 53 stated he was transferring from the wheelchair to bed and his ankle gave out and he fell to the ground. Resident 53 stated his left shoulder always hurts but it hurt more since the fall. Resident 53 stated he was waiting for staff but staff did not come. Resident 53 stated he waited for 15 to 20 minutes and was tired from returning from a doctors appointment so he transferred himself. Resident 53 stated it took 20 to 30 minutes for someone to come and he did not want to wait. Resident 53's medical record was reviewed on 9/29/22. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A quarterly Minimum Data Set (MDS) dated [DATE], revealed resident 53 had a Brief Interview of Mental Status (BIMS) score of 14 which indicated he was cognitively intact. The MDS revealed that resident 53 required extensive assistance with two plus person physical assistance. The MDS revealed resident 53 had not had a fall in the last month, the last two to six months, or since admission. A care plan dated 5/10/19, and revised on 10/5/21, revealed resident 53 was at risk for falls related to impaired mobility, morbid obesity, and weakness. The goal was the resident would be free of falls through the review date. Approaches included anticipate and meet the resident's needs; call light within reach; resident needs prompt response to all requests for assistance; educate what to do if a fall occurs; and review information on past falls and attempt to determine cause of fall. An approach dated 9/22/20, revealed change position slowly to reduce change of hypotensive episodes. An updated fall care plan with a problem start date of 8/1/22, and created on 9/19/22, revealed that resident 53 was at risk for falls secondary to limited mobility and weakness. The goal was resident 53 would have no untreated injuries related to falls through next review. The approaches included encourage the use of call light and keep room free of clutter and tripping hazards. Progress notes revealed the following entries: a. On 6/3/22 at 12:20 PM, [Incident Report] Three CNA's were trying to reposition the patient in bed around 11am. [CNA name] and [CNA name] where pulling the patient in one direction and the agency CNA was pulling the patient in another. During the transition, I was told by [CNA name] that he fell off of the bed. I went in and assessed him. He didn't have any skin tares (sic) or abnormalities. He was oriented times four. He said his left hip hurts when he moves. He said it was an achy muscle pain. I checked it out and there was no bruise present at the time. I informed the other agency nurse working on his hall to continue to check on him by the hour even though I was told that he didn't hit his head. I notified [Nurse Practitioner's name] via tiger text and havent heard a response back as of yet. b. On 6/3/22 at 12:24 PM, CNA and 300 hall nurse reported that patient fell while transferring from his w/c [wheelchair] to his bed. Pt returned back from the appointment and got helped by CNA to his bed and slid down on his buttocks to the ground. physical assessment completed that no changes of cognitively, no skin issues noted without redness or bruise, no changes ROM [range of motion], but pt c/o [complains of] pain 6 out of 10 to left hip, scheduled norco 2 tablets given. notified 300 hall nurse about the assessment including pain and she will notify to NP [Nurse Practitioner]today, will continue to monitor any changes. [Note: An incident report was not completed.] c. On 7/29/22 at 6:57 PM, Pt had Dr [doctor] appt [appointment] today., after returning CNA was getting him into bed via hoyer and pt slipped out of chair. Pt did not report any pain from the fall and did not hit head. Has no new pain from the witness fall and bs [blood sugar] & vitals are normal for pt post fall. Event report was made and signed. There was a incident report completed for the fall on 7/29/22 at 5:53 PM. The report revealed resident 53 had a witnessed fall. Resident 53 slipped out of the chair onto the floor onto his buttocks. The immediate action taken was nurse and additional two CNA's assisted patient back into bed with a hoyer lift. No issues and patient reported to be fine. Vital signs were obtained and all were normal. The incident report revealed that there were no interventions developed after the fall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/3/22 at 11:37 AM, an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated if a resident fell , the nurses completed a risk management report, assessed the resident, obtained vital signs, assessed for injuries, then started a neurological check sheet. The ADON stated the nurses should contact the DON, physician, and family. The ADON stated once the fall was reported to the physician, the staff would send the resident to the hospital if there was a major injury. The ADON stated if there was a minor fall then neurological checks were completed, a change of condition, a progress note, and the risk management report were completed. The ADON stated that agency staff were made aware at shift changes about resident falls. The ADON stated there was also a binder at the nurses station for agency staff members but mostly information was provided from the nurse to nurse report. The ADON stated the management team completed an Interdisciplinary Team (IDT) meeting with the family, nursing team, social services, and therapy. The ADON stated the IDT team looked for fall trends and then referred to the Restorative Nursing Assistant (RNA) program or therapy. The ADON stated new interventions were care planned. The ADON stated that resident 53 had a new care plan dated 8/1/22, in the new electronic medical record. The ADON observed the previous care plans and stated there were no interventions after the the two falls on 6/3/22. The ADON stated for the fall on 7/29/22, the CNA was transferring resident 53 to his wheelchair when resident 53's legs gave out. The ADON stated resident 53 usually used the sit to stand lift and not a hoyer lift for transfers. The ADON stated the CNA could have used the hoyer lift if resident 53 was to weak to stand up on his own. The ADON stated according to the incident report resident 53 slid out of his chair and onto the floor. The ADON stated that the staff used a hoyer lift to get resident 53 off the floor and into bed. [Note: The nursing progress note on 7/29/22, revealed .after returning CNA was getting him into bed via hoyer and pt slipped out of chair.] On 10/3/22 at 11:26 AM, an interview was conducted with CNA 9. CNA 9 stated there was a CNA chart that had which residents fell and which residents were a high fall risk. CNA 9 stated the residents had signs inside their rooms and it was in the electronic charting system. CNA 9 stated she had no idea how Agency staff knew a residents transfer status or if the resident was a fall risk. CNA 9 stated Agency had a binder but she did not know what was in the binder. CNA 9 stated resident 53 required one person assistance with transfers, bed mobility, and showering. CNA 9 stated there was no reason that three people would be providing bed mobility. On 10/3/22 at 3:41 PM, an interview was conducted with the DON. The DON stated there were no incident reports after the falls on 6/3/22. 33215 4. Resident 49 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included, but not limited to, hemorrhage of anus and rectum, dementia, history of falling, type 2 diabetes mellitus with hyperglycemia, displaced fracture of second cervical vertebra, major depressive disorder, systolic congestive heart failure, secondary hypertension, and edema. On 9/26/22 at 12:04 PM, an interview was conducted with resident 49. Resident 49 stated that he had fallen three times since he was admitted to the facility. Resident 49 was unable to give any details regarding the three falls and resident 49 could not remember if he had any injuries with the three falls. Resident 49 stated that he had fallen at home and was in a back brace when he admitted to the facility. Resident 49 stated that recently he was taken out of the back brace and given a neck brace. Resident 49 was observed to have a neck brace on. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 49's medical record was reviewed on 9/27/22. An admission MDS assessment dated [DATE], documented that resident 49 had a BIMS score of 3. A BIMS score of 0 to 7 indicates severely impaired cognition. In addition, resident 49 was documented as requiring extensive assistance of two persons for bed mobility. Resident 49 required extensive assistance of one person for transfers, locomotion on and off the unit, dressing, toilet use, and personal hygiene. Resident 49 required limited assistance of one person for walk in room and walk in corridor. Resident 49 was not steady moving from a seated to standing position, walking, turning around and facing the other direction while walking, moving on and off the toilet, and surface to surface transfers between bed and chair or wheelchair. Resident 49 was only able to stabilize with human assistance. The MDS Care Area Assessment (CAA) Summary dated 7/13/22, documented a Care Area Triggered for falls. In addition, the CAA Summary documented that falls were addressed in the care plan. [Note: A fall care plan was not created until 9/22/22.] On 7/6/22 at 12:59 PM, a Social Services Note documented Admit [Admission] Note: [Name of resident 49 removed] is an 80 YO [year old] widower who admitted from [name of hospital removed] on 6/30 [22] after sustaining an unwitnessed fall resulting in a C1-2 [cervical vertebrae] fx. On 7/29/22 at 1:30 AM, a Morse Fall Scale was completed and resident 49 was assessed as High Risk for falling with a score of 65. A Morse Fall score 45 or higher indicates a high risk for falls. [Note: Additional fall risk assessments were unable to be located for resident 49.] On 7/29/22 at 2:21 AM, a Nurses Note documented Patient had an injury fall this shift at 0130 [1:30 AM], assisted to the fall by CNA. CNA notified this Nurse. Pt states he lost his balance. Denies pain at this time. Offered medication. Skin tear on right elbow (1cm [centimeter] X [by] 1xcm) and abrasion on right knee (3. 5cm X 2cm). New injuries cleansed with wound cleanser, pat dry, and bacitracin applied. MD [Medical Director] Notified. [Note: A care plan was not created addressing falls after resident 49 had a fall on 7/29/22.] On 9/1/22 at 8:45 PM, a Nursing progress note documented Patient fell on his back while attempting to get off the toilet. The fall was unwitnessed. Patient has a skin tear R [right] wrist. His neuro check are normal and vitals [vital signs] are at baseline. Physician and family has been contacted. Patient is complaining of back pain but is refusing to get checked at the hospital. [Note: A care plan was not created addressing falls after resident 49 had a fall on 9/1/22.] On 9/5/22 at 10:26 PM, a Nursing note documented Resident had an assisted fall at 2200 [10:00 PM]. CNA was with resident in the bathroom. Resident was transferring to the toilet. CNA had already pulled wheelchair away. Resident had decided to sit down, not on the toilet. CNA caught resident and helped resident to the floor. 2 cnas and nurse helped resident get back into bed using hoyer lift. Resident did not hit head nor any other parts of his body. Resident is resting in bed. Vitals wnl. [Note: A care plan was not created addressing falls after resident 49 had a fall on 9/5/22.] (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A care plan Problem created on 9/22/22, documented Category: Falls [name of resident 49 removed is at risk for falls secondary to Weakness. A care plan Goal created on 9/22/22, documented Long Term Goal Target Date: 12/22/2022 [Name of resident 49 removed] will have no untreated injuries r/t [related to] falls, through next review. The care plan interventions created on 9/22/22, included: a. One on one activities evaluation and treatments if appropriate. b. Assist resident 49 with visual needs and visual appliance application and removal, as needed. c. Encourage the use of the call light. d. Evaluate the need to pace activities and plan rest periods, as tolerated. e. Keep room free of clutter and tripping hazards. f. Low bed without mat. g. Non-skid socks on at all times, as tolerated. h. Resident 49 had been educated on the call light function and use. A care plan Problem edited on 9/26/22, documented a Problem start date of 9/5/22. Category: Falls [Name of resident 49 removed] had an actual fall 9/1/22 and 9/5/22. A care plan Goal created on 9/26/22, documented Long Term Goal Target Date: 12/05/2022 [Name of resident 49 removed] will have no unaddressed complication or injury r/t fall through next review. The care plan interventions created on 9/26/22, documented an Approach start date of 9/5/22. The interventions included: a. Encourage resident 49 to use call light for assistance. b. Lowered to floor: continue plan of care with staff assistance with cares and toileting. On 9/27/22 at 1:35 PM, an interview was conducted with CNA 5. CNA 5 stated that he had only worked at the facility for four days but CNA 5 was familiar with resident 49's cares. CNA 5 stated that resident 49 would use the call light if he needed to use the bathroom. CNA 5 stated that resident 49 was a one person assistance with toileting. CNA 5 stated that resident 49 required a boost to get off the toilet but resident 49 would use the safety bar for stability. CNA 5 stated that resident 49 thought that he was continent and more often then not resident 49 was soaked. CNA 5 stated that staff check on resident 49 every two hours so that resident 49 was not soaked through his clothes but resident 49 usually was. CNA 5 stated that resident 49 required meal set up and finding where everything was on the tray. CNA 5 stated that he would assist resident 49 with opening small items. CNA 5 stated that resident 49 would ask the same question over and over. CNA 5 stated that resident 49 was a fall risk but resident 49 wound not try to get up on his own. CNA 5 stated that if resident 49 did get up on his own resident 49 would fall. CNA 5 stated there was nothing posted in resident 49's room regarding fall interventions. CNA 5 stated that resident 49 would always ask for help and was previously a fall risk. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/27/22 at 3:12 PM, an interview was conducted with the DON. The DON stated that the MDS coordinator would help get baseline care plans started. The DON stated that baseline care plans were basic care plans. The DON stated the comprehensive assessment CAA Summary areas should be care planned by the MDS coordinator. The DON stated the nursing team should be looking at resident change of condition or something specific to the resident that needed to be care planned. The DON stated that the administrative nursing team would complete the care plan updates. The DON stated if a resident came from the hospital with a fall she would expect the fall to be care planned. The DON stated if a resident had a fall or change in elevation, the staff were to assess the resident prior to moving the resident off what ever surface they were on. The DON stated staff were to look for obvious injuries, conduct range of motion prior to moving the resident, and complete a pain assessment. The DON stated that staff were to notify the practitioner if the resident had complaints of pain to see if anything additional should be implemented for the resident. The DON stated that staff were to notify the responsible party. The DON stated that the responsible party could be the resident or a family member. The DON stated that staff were to notify the practitioner, and an Event or incident report should be documented, and any new orders should be implemented. The DON stated the Event or incident report should have documentation of notification. The DON stated if the resident had an unwitnessed fall the staff should be doing neuro checks on the resident. The DON further stated if a resident needed to be transferred out of the facility staff should complete a change of condition transfer form. 38031 5. Resident 8 was admitted to the facility on [DATE] with diagnoses which included dementia without behavioral disturbance, hypokalemia, type 2 diabetes mellitus, chronic pain syndrome, hypertension, hypothyroidism, urinary tract infection, muscle weakness, abnormalities of gait and mobility, and hyperlipidemia. On 9/26/22 at 10:21 AM, an interview was conducted with CNA 1. CNA 1 stated that resident 8 was confused and had some short-term memory deficits. CNA 1 stated that resident 8 knew where she was and understood what was going on. CNA 1 stated that resident 8 wandered and went for walks around the building. CNA 1 stated that resident 8 used a cane for a mobility device. CNA 1 stated that resident 8 was frequently outside smoking and would wander to the other side of the building to look at the baby horse. On 9/26/22, resident 8's medical record was reviewed. On 8/15/22, a Smoking Risk assessment was completed for resident 8. Resident 8's assessment documented that the resident borrowed cigarettes and a lighter from others and smoked every few hours. The assessment documented that resident 8 scored a 1, which indicated a minimal problem for the following areas: smoking in unauthorized areas; was careless with smoking materials - drops cigarette butts or matches on floor, furniture, self or others; burns finger tips; burns clothes; smokes near oxygen; smokes in the facility; inappropriately provided smoking materials to others; general awareness and ability to understand the facility safe smoking policy; and capability to follow the safe smoking policy. The assessment documented that resident 8 scored a 3 or severe problem with begging or stealing smoking materials from others. The assessment documented a total score of 10 which indicated a potentially unsafe smoker. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A second undated smoking assessment documented that resident 8's total score of 6, which would indicate safe to smoke. The assessment documented that resident 8 scored a 3 or moderate problem for smokes cigarettes/butts from the ash tray and begs or steals smoking materials from others. The assessment documented a score of 1 which indicated a minimal problem for general behavior and interpersonal interaction, and mobility. The assessment documented that resident 8 was not ready to accept smoking cessation materials. On 6/16/22, resident 8's admission MDS assessment documented a BIMS of 8/15, which indicated moderately cognitively impaired. The assessment did not address the short term and long-term memory. The assessment documented that resident 8 was a limited one person assistance for walking in room and in the corridor and was supervision with setup assistance for locomotion on and off the unit. The mobility devices used were documented as a walker and wheelchair. Review of resident 8's progress notes revealed the following: a. On 7/9/22 at 5:56 PM, the nurse's note documented, Resident noted with bright red sunburn and purple areas to both arms. Resident enjoys spending a lot of time outside and was asked if she would like to come in and give her skin a rest for a little while. She refused. Nurse offered to bring her a long sleeve shirt to protect her arms which she also refused. Ointment applied to both arms. Resident denies pain. Nurse requested Sunscreen for resident. b. On 8/10/22 at 3:34 PM, the nurse's note documented, Patient doing well after her fall on 8/9/22. She has not had any signs of neurological issues and all her vitals have been normal. c. On 8/13/22 at 10:31 AM, the nurse's note documented, No change since pt. had fall on 8/9/22. Pt. asking staff for help when needed and using cane for mobility when walking. Will continue to monitor. d. On 8/20/22 at 10:15 AM, the nurse's note documented, Pt's family member pointed out a bruise on the pt's right shoulder, assuming it's from the fall. it's a god (sic) size bruise. e. On 8/25/22 at 1:25 PM, the NP note documented that resident 8 was pleasantly confused. will often forget where she's going or where she is at. f. On 8/25/22 at 5:21 PM, the nurse's note documented, pt given baggie of 7 cigarettes this morning at 0700 [7:00 AM] and within two hours had smoked all 7 and trying to borrow cigarettes' from other patients and redirected multiple times, other patients stating she only gets two cigarettes a day and pt educated again on how many she gets and counted baggies in med cart with her with 7 in each bag for the week days g. On 9/4/22 at 10:31 AM, the nurse's note documented, pt is out of cigarettes since Friday and [family member] will not bring her cigarettes or money for cigarettes, patient notified and appears not happy. circling the outside building and outside trash cans looking for cigarette butts and unable to re-direct, tiger test sent to all staff r/t the above h. On 9/15/22 at 5:35 AM, the NP note documented, . remains confused. she continues to lack her own safety awareness. No new falls or other events. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/11/22, the Physical Therapy discharge summary documented that resident 8 had met the goal of decreased risk for falls as evidenced by (AEB) decreased score on the Timed Up and Go test to 18 seconds. The resident was safely able to ambulate 300 feet with supervision and occasional verbal and tactile cues. The patient was independent with supervision times one for walking after donning shoes, able to ambulate inside and outside of facility and navigate around obstacles with supervision. Discharge recommendations were to continue to walk with supervision and use of quad cane. On 8/9/22 at 1:43 PM, an incident report documented that resident 8 had an unwitnessed fall. The form documented that the patient was out in the courtyard alone. A resident noticed resident 8 and notified staff that she had fallen. Resident 8 stated that she did not hit her head nor have any wounds. Factors identified at the time of the fall were that resident 8 had lost balance, and was attempting to self-transfer. The report documented that resident 8 did not complain of pain and no injuries were noted. No documentation was found of an elopement or wander risk assessment for resident 8. Review of resident 8's care plans revealed the following: a. On 9/27/22, a care area of cognitive loss/dementia was initiated. The care plan documented that resident 8 had memory/recall problems related to dementia AEB a poor BIMS score. Interventions identified were engage resident in conversations or activity of choice; and reorient as tolerated and do not criticize. b. On 9/27/22, a care area of exhibits alteration in thought process manifested by cognitive impairment r/t dementia; needs reminders/prompts/cues to choose activities was initiated. Interventions identified were to invite, encourage and involve resident 8 in activities of importance; post calendar in room; provide with opportunities to recall long/short term memories during activities; and provide adaptations to activities as needed. c. On 9/27/22, a care area for tobacco use initiated. Interventions identified were to distract with an activity or conversation of choice when it was not smoking time; offer cessation information as desired; involve support person or Ombudsman as needed; praise resident 8 for being safe and responsible; resident will be able to follow the smoking policy with staff assist; and resident will not share or borrow tobacco products or paraphernalia from others. d. On 9/26/22, a care area for at risk for falls secondary to limited mobility, poor balance and poor safety awareness was initiated. Interventions identified were encourage to utilize cane when ambulating, encourage to use the call light, keep room free of clutter and tripping hazards. It should be noted that no care plan or interventions were developed for resident 8's wandering. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/27/22 at 1:32 PM, an interview was conducted with Registered Nurse (RN) 4. RN 4 stated that resident 8 asked for a cigarette and was told that she had to wait until 4:00 PM because she had one at 1:00 PM already. RN 4 stated that she told resident 8 that she had nine cigarettes remaining. RN 4 stated that resident 8's cigarettes were kept inside the medication cart, but not the lighter. RN 4 stated that resident 8 went through packs of cigarettes fast so they were trying to limit the amount she smoked. RN 4 stated that resident 8 had a cigarette at 1:00 PM and then returned immediately to ask for a second one. RN 4 stated that she reminded resident 8 that she had just smoked a cigarette and that she needed to wait until 4:00 PM for the next one. RN 4 stated that resident 8 smoked independently and that she was alert and oriented to person and place. RN 4 stated she was not sure if resident 8 was able to make her own decisions, or if she had that capacity. RN 4 stated that resident 8 did not have all of her faculties. RN 4 stated that resident 8 wandered and went outside to smoke. On 9/28/22 at 8:41 AM, an interview was conducted with RN 5. RN 5 stated that resident 8 could only have one cigarette every two hours. RN 5 stated that resident 8 would forget that she had smoked. 09/29/22 at 8:13 AM, a follow-up interview was conducted with RN 5. Resident 8 was observed to ask RN 5 for a cigarette. RN 5 stated that she did not have any cigarettes left in the medication cart and told resident 8 that she would go look for more. On 9/29/22 at 8:27 AM, an interview was conducted with CNA 2, RNA 1, and RN 5. CNA 2 stated that resident 8 had a fall outside the facility three or four months ago. CNA 2 stated they made sure to keep an eye on where resident 8 was going and made sure she did not go into the construction site that was nearby. CNA 2 stated that they would keep track of resident 8 by looking out the windows to locate her. CNA 2 stated that resident 8 had wandered into the construction area before to ask for cigarettes. CNA 2 stated that this had happened multiple times within a two-week period. CNA 2 stated that this occurred before resident 8 had her own cigarettes. CNA 2 stated that since resident 8 had access to her own cigarettes she had not wandered back over to the construction site. CNA 2 stated that resident 8 was an independent smoker and had her lighter in her possession. RNA 1 stated that resident 8's routine was to walk around the parameter of the building. RNA 1 stated that resident 8 would smoke the whole pack because she forgets. RN 5 stated that she had called resident 8's family member to inform them that resident 8 did not have anymore cigarettes at the facility. RN 5 stated that the family member was not going to bring anymore to resident 8 because she would be discharging home on Saturday. On 9/29/22 at 10:16 AM, an interview was conducted with RN 5. RN 5 stated that resident 8 had not h [TRUNCATED]

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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** 30563 Based on interview and record review it was determined, for 2 out of 34 sampled residents, the facility did not ensure residents who were incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. Specifically, a resident had a urinalysis (UA) test completed with no follow up and the resident went to hospital for treatment. In addition, a resident with signs and symptoms of a urinary tract infection (UTI) went to the hospital for treatment. Resident identifiers: 29 and 44. Findings included: 1. Resident 29 was admitted to the facility on [DATE] with diagnoses which included low back pain, injury to left lower leg, hypothyroidism, edema, chronic pain, and nausea. Resident 29's medical record was on 9/28/22. An admission Minimum Data Set assessment dated [DATE], revealed that resident 29 was occasionally incontinent of bowel and bladder and was not on a toileting program. The MDS further revealed resident 29 required two plus person extensive assistance with toileting. A care plan dated 8/1/22, revealed Infection. [Resident 29] is at risk for infection secondary to presence in a skilled nursing facility. The goal was [Resident 29] will have no untreated s/s [signs and symptoms] of infection through next review. The approaches included Monitor labs as prescribed, Notify MD [Medical Director] of s/s of infection, Universal precautions. A physician's order dated 8/19/22, written by Registered Nurse (RN) 3 revealed resident 29 was to have a UA, urine culture, and urine culture and sensitivity. The Laboratory Analysis results collected on 8/19/22, were received on 8/21/22. The laboratory (lab)results revealed resident 29 had Escherichia Coli, Peptostreptococcus prevotti, and Staphylococcus aureus. The form revealed that Macrobid 100 milligrams (mg) twice daily for 5 to 7 days was the appropriate treatment. Resident 29's August 2022 Medical Administration Record (MAR) revealed there were no antibiotics administered. There were no progress notes from 8/16/22 until 8/21/22. The progress notes revealed the following entries: (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	a. On 8/21/22 at 3:25 AM, PT (patient) kept complaining about pain, and requested to talk to the doctor's about her medication regimen, she feels her current regimen isn't working. Pt was extremely upset. Pt did state she was at a 9 out of 10 and was still able to sleep. On the 1800 [6:00 PM] - 0600 [6:00 AM] shift, the CNA's [Certified Nursing Assistant] went to do their rounds and the pt was wearing the same brief from the previous night, stamped 0425 [4:25 AM] and when the CNA changed her, there was evidence of a BM [bowel movement], but not actual BM present, the pt wasn't cleaned well, and she was upset about it. b. On 8/21/22 at 10:28 AM, Resident 29 complained of pain and was requesting to go to the hospital emergency room . Resident 19 was angry narcotics had been spaced further out and Tramadol had been discontinued. Resident 19's vital signs were taken and as needed pain medication had been administered. The Assistant Director of Nursing (ADON) was notified and resident 19 was transferred to the hospital. c. On 8/21/22 at 11:55 AM, Resident 29 was taken by ambulance to the hospital emergency room . d. On 8/21/22 at 4:16 PM, Resident 29 returned to the facility with new orders for Tramadol 100 mg every 6 hours. e. On 8/24/22 at 12:35 PM, Resident 29 informed the nurse of the hospital situation. Resident 29 was happy to have her pain medication back. Resident 29 was frustrated that she had not gotten any results back from the hospital. An Emergency provider report dated 8/21/22 at 11:48 AM, revealed Resident 29 was in increased pain over the last day or so and she coordinates this with increasing urination and dysuria. The patient apparently had a catheter urine specimen obtained a day or 2 ago and they do not have the results as of yet. She is worried she has a kidney infection. According to the lab results interpretation section resident 29 had trace of leukocyte esterase, 1-3 bacteria per high-power field (hpf), [NAME] Blood Cells, and a few bacteria. The Discussion/Course section revealed complaints of a possible UTI and pain radiating into the right hip and knee. The lab tests were fairly unremarkable. The section revealed that she did not have evidence of a UTI today. Medications administered included Ceftriaxone Sodium 1 gram on 8/21/11 at 11:51 AM, through Intravenous route. [Note: There was no culture and sensitivity completed according to the lab results from the emergency department.] A Nurse Practitioner (NP) note dated 8/26/22, revealed that resident 29 was in pain over the weekend and she went to the hospital to have her Tramadol increased to every 6 hours. [Note: There was no information regarding resident 29's UA that was collected on 8/19/22.] On 9/29/22 at 10:44 AM, an interview was conducted with the Director of Nursing (DON). The DON stated symptoms of a UTI were increased urination, frequent urination, change in vital signs, fever, and a lot more. The DON stated if a resident had symptoms the a UA would be obtained. The DON stated there should be documentation in the progress notes as to why a UA was obtained. The DON stated physician's were notified through the UA results being placed in the box for the physician when they came to the facility. The DON stated nurses also sent a tiger text to the physician with the results. The DON stated the NP was at the facility on Mondays and Thursdays and the physician on Wednesdays. The DON stated she was unable to obtain the tiger texts unless she was in on the text, so she would not be able to provide information that the physician was notified. The DON stated when the physician was notified the nurse should write a progress note. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	On 9/29/22 at 11:00 AM, an interview was conducted with RN 3. RN 3 stated when a lab value or UA was ordered, she would contact the NP, an order was placed in the residents electronic medical record, and the lab company was contacted. RN 3 stated that the results of the laboratory were faxed to the facility or the lab contacted the NP. RN 3 stated that sometimes the lab did not send results so the nurse had to follow up with the lab. RN 3 stated if the nurse who ordered the labs was gone for a week the nurse on shift may not be aware of what labs had been ordered and which results had been sent to the facility. RN 3 stated the lab process had resulted in missed lab results. RN 3 stated that she tried to document in the progress notes when a lab was obtained. RN 3 stated on 8/19/22, she obtained a UA for resident 29 because she was probably acting confused or had a symptom like pain or burning when urinating. RN 3 stated she did not know if the physician was notified of the UA results. RN 3 stated she did not know if there was follow up because if it was not written in the medical record it was not done. RN 3 observed the UA results from 8/19/22, and stated it was a 6 on a scale of 1 to 7 which indicated resident 29 had an infection. RN 3 stated the results revealed resident 29 had a UTI that needed to be treated with Macrobid. RN 3 stated that things get very busy and I forget to get everything done. RN 3 stated there were not enough staff in the building. RN 3 stated there needed to be a nurse for each hallway because it's just crazy. RN 3 stated It's so stressful for me, because at the end of the day I sent the order and did not follow up on it and did not get treatment. RN 3 stated there were so many things to do and follow up on and with almost 40 residents it was impossible to get everything done. RN 3 stated that charting did not get done. On 9/29/22 at 12:38 PM, a follow up interview was conducted with the DON. The DON stated she did not have any notes about the UA. The DON stated according to the UA in the medical record, Macrobid was the antibiotic that should have been used to treat resident 29's UTI. On 9/29/22 at 1:00 PM, an interview was conducted with resident 29. Resident 29 stated that the facility obtained a UA on 8/19/22, but she did not know the results. Resident 29 stated she got a shot at the hospital because of her UTI on 8/21/22. Resident 29 stated she was in a lot of pain at the facility, so she had to go to the hospital to get treatment. Resident 29 stated she wonders if the facility ever received the results because she had asked a bunch of times and no staff knew about the results. On 10/3/22 at 12:01 PM, an interview was conducted with the ADON. The ADON stated lab results were sent to the main fax line in the facility. The ADON stated that the physician then provided medication orders and nurses had access to antibiotics in the pixus system. 33215 2. Resident 44 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included, but not limited to, acute kidney failure, diabetes mellitus type 2, anxiety disorder, essential hypertension, and UTI. Resident 44's medical record was reviewed on 9/28/22. On 7/22/22 at 4:04 PM, a Nurses Note documented LAB - Called [name of lab removed] to pick up a urine swab for the pt [patient] who thinks that she may have a UTI. Left swab and order with paperwork at the nurses station and let them know to pick it up there. They said that they will come today or tomorrow. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	On 7/22/22 at 11:14 PM, a Nurses Note documented Pt has been crying on and off throughout shift. Pt requests Ativan frequently, nurse has contacted MD multiple times, MD has not responded, nurse told pt about communication with MD, pt seems really upset and frustrated, pt said 'I hope he gets COVID [Coronavirus Disease-2019] real bad.' Pt c/o [complains of] urinary tract pain, asked for pain med [medication], asked about results of UA. Will cont [continue] to monitor throughout shift. On 7/24/22, a urinalysis report documented that resident 44 had a UTI. The common organisms detected were candida species, Enterococcus faecium, Enterococcus faecalis, Escherichia coli, and Peptostreptococcus prevotti. The report further documented the antibiotic of choice as Amoxicillian 875/125 mg by mouth twice a day for 7 days for possible acute UTI. On 7/26/22, a physician's order documented Amoxicillin-Pot [Potassium] Clavulanate Tablet 875-125 MG Give 1 tablet by mouth two times a day for UTI for 7 Days. A review of the July 2022 MAR revealed that resident 44 received the first dose of Amoxicillian on 7/27/22 at 7:00 AM. [Note: The first dose of Amoxicillin was administered three days after the UA report was received.] A review of the August 2022 MAR revealed that resident 44 did not receive a dose of Amoxicillian on 8/1/22 between 6:00 AM to 10:00 AM. [Note: Resident 44 received the last dose of Amoxicillian on 8/2/22 between 6:00 PM to 10:00 PM. Resident 44 missed one dose of Amoxicillian.] On 8/5/22 at 4:08 AM, a Nursing progress note documented Pt has been tearful for most of shift. Pt c/o R [right] abd [abdomen] pain, described as 'stretching,' guarding upon assessment, reports increased pain on laying down, passing gas, last BM 8/4 [22] AM. Pt then c/o 'kidney pain,' when nurse percussed flank, pt c/o pain. DON and provider notified, tylenol given (see emAR [electronic Medication Administration Record]), will get a UA. Pt called multiple times about Ativan, nurse said she couldn't give d/t [due to] med d/c'd [discontinued] and provider hasn't answered yet. Pt hears screaming, staff asked pt what was wrong, pt c/o bilat [bilateral] foot pain, nurse assessed, feet looked baseline, pt c/o 'feel like they are going to explode,' pt said it was d/t increased sodium in diet, nurse explained that pt was getting renal diet so this would not be the reason. Pt requested ice packs and lotion rubbed into feet, staff applied both. Pt reported treatment effective. Pt has been tearful and c/o different pains/ailments throughout shift. Provider and DON notified. [Note: A physician's order and the results of the UA were unable to be located.] On 8/6/22 at 5:37 PM, a Nursing progress note documented Pt was found calling out for people that weren't there in her room around 4pm today. I checked her vitals [vital signs]. Her oxygen was at 60, RR [respiratory rate] 18 Temp [temperature] 98 bp [blood pressure] 122/88. I put oxygen on her and it wouldn't get to 90 until I put it to about 5 Liters. I informed NP and Dr [doctor] of the facility via tiger text. There was no response back on the matter. Kept her on oxygen because when I take it off, she dips back down to below 90. She stopped calling out to unseen others after I put the oxygen on. Its almost end of shift, she is at 93 and has oxygen on. I will give this information in report at the end of shift. Lungs sounds clear in all lobes. Pt stated that even though I was giving her, her blood sugar, that she didn't feel like taking her self administered insulin. Her bs [blood sugar] around 5pm was 497. She gave me permission to give her 10 units of fast acting insulin. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	On 8/8/22 at 3:01 AM, a Nursing progress note documented 8/7/22 2200 [10:00 PM]-This Nurse called non emergency transport to send Pt to [name of hospital removed] to be evaluated d/t change in condition .such as: increase in oxygen therapy, is a feeder, edematous, and change in mentation. 2220 [10:20 PM]-EMS [Emergency Medical Services] arrived to facility 2228 [10:28 PM]-Pt left facility on Stretcher Family notified and MD 8/8/22 0217 [2:17 AM]- UPDATE- admitted to ICU [Intensive Care Unit] On 8/7/22, the hospital notes documented . The patient presents by ambulance from a nursing home with acute confusion. She is unable to provide a thorough history. Her exam is concerning for diffuse anasarca with depleted intravascular volume, including dry mucous membranes. She has a history of prior urinary tract infections. She was treated with IV [intravenous] and Rocephin shortly after arrival. Labs are notable for severe anemia. The patient also apparently has liver disease, and she has hypoalbuminemia, which could contribute to the interstitial edema. Her chemistry panel is concerning for significant elevations of the BUN [blood urea nitrogen], creatinine, and potassium. She was immediately started on treatment for hyperkalemia, including calcium gluconate, insulin and dextrose, and albuterol. I spoke with the nephrologist, who states that he knows the patient has chronic renal insufficiency, she is now in acute renal failure and will likely require dialysis. The patient will go to the ICU for emergent management of her renal failure and hyperkalemia with metabolic encephalopathy. On 8/8/22, the hospital notes documented . The patient is conversant but not oriented to year or situation. Per report, she has been having worsening confusion over the past two days. She has had a dry mouth and decreased UOP [urinary output] over this timeframe as well. She has generalized swelling. She reports nausea and vomiting over the last few days as well, and non-bloody diarrhea. She is unsure what her renal disease is from but follow with [name of doctor removed]. On 8/25/22 at 1:50 PM, a NP progress note documented . SUBJECTIVE: [Name of resident 44 removed] is seen today as a readmit. She has a medical history significant for T2DM [type 2 diabetes mellitus] on insulin, CKD [chronic kidney disease], HTN [hypertension], HLD [hyperlipidemia], and multiple wounds. She was sent to [name of hospital removed] with nausea and decreased by mouthintake [sic] where she was found to have hyperkalemia and a GFR [glomerular filtration rate]< [less than] 10. She was started on dialysis, is followed by Nephrology. On 10/3/22 at approximately 12:40 PM, an interview was conducted with RN 1. RN 1 stated that she was an agency nurse and it was her first day working at the facility. RN 1 stated she had no knowledge regarding the circumstances of resident 44's hospitalization . On 10/3/22 at 12:58 PM, an interview was conducted with the ADON. The ADON stated that resident 44 was diagnosed at the hospital with a urinary tract infection. The ADON stated when resident 44 was readmitted to the facility resident 44 had a new diagnoses of renal failure and was put on dialysis. The ADON stated that resident 44 was possibly sent out to the hospital due to a change in mental status. On 10/3/22 at 1:59 PM, an interview was conducted with the DON. The DON stated she had no knowledge regarding the circumstances of resident 44's hospitalization . On 10/3/22 at 3:43 PM, a follow up interview was conducted with the DON. The DON stated that she could not see that the UA was completed for resident 44 on 8/5/22.

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F 0725 Level of Harm - Actual harm Residents Affected - Few	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** 30563 Based on observation, interview, and record review, it was determined, 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, for 13 out of 34 sampled residents, resident's complained of not having enough staff to meet there needs, staff complained there were not enough staff to complete their job duties, residents laboratory (lab) results were not followed up with after a urinalysis (UA) was completed, showers were not completed, residents administered their own medications because there were not enough staff, there were no grievances, residents sustained falls, resident's complained of pain, and medications were not administered according to physician's orders. Resident identifiers: 1, 7, 8, 16, 22, 23, 25, 29, 36, 38, 45, 53, and 156. Findings included: 1. On 9/29/22 at 11:00 AM, an interview was conducted with Registered Nurse (RN) 3. RN 3 stated when a lab value or UA was ordered, she would contact the Nurse Practitioner (NP), an order was placed in the residents electronic medical record, and the lab company was contacted. RN 3 stated that the results of the laboratory were faxed to the facility or the lab contacted the NP. RN 3 stated that sometimes the lab did not send results so the nurse had to follow up with the lab. RN 3 stated if the nurse who ordered the labs was gone for a week the nurse on shift may not be aware of what labs had been ordered and which results had been sent to the facility. RN 3 stated the lab process had resulted in missed lab results. RN 3 stated that she tried to document in the progress notes when a lab was obtained. RN 3 stated on 8/19/22, she obtained a UA for resident 29 because she was probably acting confused or had a symptom like pain or burning when urinating. RN 3 stated she did not know if the physician was notified of the UA results. RN 3 stated she did not know if there was follow up because if it was not written in the medical record it was not done. RN 3 observed the UA results from 8/19/22, and stated it was a 6 on a scale of 1 to 7 which indicated resident 29 had an infection. RN 3 stated the results revealed resident 29 had a urinary tract infection that needed to be treated with Macrobid. RN 3 stated that things get very busy and I forget to get everything done. RN 3 stated there were not enough staff in the building. RN 3 stated there needed to be a nurse for each hallway because it's just crazy. RN 3 stated It's so stressful for me, because at the end of the day I sent the order and did not follow up on it and did not get treatment. RN 3 stated there were so many things to do and follow up on and with almost 40 residents it was impossible to get everything done. RN 3 stated that charting did not get done. [Cross Reference F690 and F773] 2. On 9/26/22 at 10:31 AM, an interview was conducted with resident 22. Resident 22 stated that her shower days were every Tuesday, Thursday, and Saturday. This surveyor observed a sign in resident 22's room with the posted shower days. Resident 22 stated that sometimes she did not get showered due to there not being enough staff. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	On 9/26/22 at 12:32 PM, an interview was conducted with resident 25. Resident 25 stated she should get a shower today, but did not get one because staff did not show up. Resident 25 stated she got a shower on 9/24/22, but did not have one for two weeks prior to that. Resident 25 stated she took showers by herself because she became very disgusted by herself. On 9/29/22 at 12:34 PM, an interview was conducted with CNA 7. CNA 7 stated that the facility was short on staff. CNA 7 stated that she had seven showers to complete today with two CNAs on the 100 and 200 hallway. CNA 7 stated that five of the seven residents were a two person extensive assistance. CNA 7 stated that the 100 and 200 hallway did not have a shower CNA and sometimes the showers got missed. CNA 7 stated that two showers had been completed today and one resident refused. CNA 7 stated that her goal was to get three showers completed each day. CNA 7 stated if a shower was missed she would pass it on in report and see if the next shift could complete the showers. CNA 7 if the next shift could not the showers completed she would try and complete the showers the next day. CNA 7 stated that resident 22 was a set up for showers. CNA 7 stated that after she set resident 22 up for a shower she would leave and give resident 22 privacy. CNA 7 stated that resident 22 needed assistance to wash her back and get dressed. CNA 7 stated that resident 22 was very involved in her care. CNA 7 stated that the shower sheets were getting missed because a lot of the staff did not know that they had to complete a shower sheet. CNA 7 further stated that the shower book did not have any shower sheets available and staff did not have a master copy to make copies. CNA 7 stated that she had a hard time answering resident call lights when there were only two CNAs staffed because most of the residents were a two person assistance. CNA 7 further stated the willingness of other staff to answer call lights was also a concern. [Cross Reference F676] 3. On 9/26/22 at 12:32 PM, an observation was made of resident 25. Resident 25 had an inhaler in a box on her over bed table. Resident 25 was interviewed. Resident 25 stated she needed the inhaler off and on. Resident 25 stated she had the inhaler in her purse and brought it out so she had it when she needed it. Resident 25 stated she could not rely on staff to provide the inhaler when she needed it because there were not enough staff. [Cross Reference F554] 4. The grievance log was reviewed. There was a grievance dated 5/2/22, regarding call lights. There were two grievances dated 9/12/22, regarding call lights not being answered and meal cards not being followed. There were no grievances between 5/3/22 through 9/12/22. The Administrator provided Resident Council Minutes dated 4/5/22, 5/3/22, 6/7/22, 7/12/22, 8/2/22, and 9/12/22. The Resident Council Minutes dated 9/12/22, revealed long call light times and there was no follow-up documented. On 10/3/22 at 9:49 AM, an observation was made of resident 16 talking to Physical Therapy Assistant (PTA) 1 and Occupational Therapist (OT) 1. Resident 16 stated the facility was so short staffed on Saturday night that a CNA came in and told him she did not have time to change him. Resident 16 stated a nurse came in later and he told the nurse that if he was not changed, he would call the police. Resident 16 stated he told staff it was their choice on what he did. Resident 16 stated the CNA came in and changed him very quickly. Resident 16 stated he hated to be that kind of a guy, but he had no other choice. Resident 16 stated he was looking at other facilities because of staffing. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	On 10/3/22 at 12:31 PM, an interview was conducted with PTA 1. PTA 1 stated she did not remember talking to resident 16. After being reminded of the conversation, PTA 1 stated that resident 16 stated there was one CNA and one nurse working. PTA 1 stated resident 16 was worried because he had to teach the CNA how to use the Hoyer lift to transfer him. PTA 1 stated resident 16 said when it got to the point that he did not feel safe he would call the police. PTA 1 stated resident 16 said he needed to have a brief change, and someone went in to change him but said they needed to come back. PTA 1 stated that resident 16 said the nurse came into his room and he told the nurse if he did not get changed, he would call the police. PTA 1 stated she had not reported the information to management. PTA 1 stated she was planning on talking to the Director of Nursing (DON) about it. On 10/3/22 at 12:31 PM, an interview was conducted with OT 1. OT 1 stated that resident 16 claimed that every time that he had a new CNA working with him, the CNA did not know how to transfer him. OT 1 stated if resident 16 was not in the exact right spot then he did not think the CNA knew what they were doing. OT 1 stated some of resident 16's complaints might be warranted. OT 1 stated resident 16 was very sensitive to any new staff. OT 1 stated there had been times when staffing was poor over the weekends, and it feeds into the fact that it had not been fixed and might not be going away. OT 1 stated he usually talked to the Resident Advocate (RA), DON, and Administrator and the concerns were discussed in the morning meeting throughout the day. [Cross Reference F585] 5. On 9/26/22 at 2:33 PM, an interview was conducted with resident 53. Resident 53 stated he was transferring from the wheelchair to bed and his ankle gave out and he fell to the ground. Resident 53 stated his left shoulder always hurts but it hurt more since the fall. Resident 53 stated he was waiting for staff but staff did not come. Resident 53 stated he waited for 15 to 20 minutes and was tired from returning from a doctors appointment so he transferred himself. Resident 53 stated it took 20 to 30 minutes for someone to come and he did not want to wait. On 9/28/22 at 9:45 AM, an interview with CNA 2 was conducted. CNA 2 stated that there was not enough staff at the facility to prevent residents from falling. CNA 2 stated that the facility often staffed two or three CNAs for the entire building, which was not enough to adequately supervise residents who were a fall risk. CNA 2 stated that in addition to not having enough staff, communication between nurses and CNAs was lacking, and CNA's were often not aware if resident were a fall risk. On 9/28/22 at 10:00 AM, an interview with CNA 8 was conducted. CNA 8 stated that on some shifts there were only two CNAs in the facility. CNA 8 stated that the facility needed more CNAs to supervise residents who were a fall risk because there was not enough staff to prevent residents from falling. On 10/3/22 at 11:26 AM, an interview was conducted with CNA 9. CNA 9 stated there was a CNA chart that had which residents fell and which residents were a high fall risk. CNA 9 stated the residents had signs inside their rooms and it was in the electronic charting system. CNA 9 stated she had no idea how Agency staff knew a residents transfer status or if the resident was a fall risk. CNA 9 stated Agency had a binder but she did not know what was in the binder. CNA 9 stated resident 53 required one person assistance with transfers, bed mobility, and showering. CNA 9 stated there was no reason that three people would be providing bed mobility. [Cross Reference F689] (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	6. On 9/26/22 at 10:47 AM, an interview was conducted with resident 45. Resident 45 stated she had a seizure and was transferred to the hospital. Resident 45 stated that she was having issues with staffing, and getting assistance. Resident 45 stated that she had a stress induced seizure. Resident 45 also stated that she had pain in the left foot. Resident 45 stated that she wrapped the foot herself with an ace bandage to help alleviate the pain. Resident 45 stated that the foot pain had been present since May. Resident 45 also reported chronic pain all over her body with diagnoses of fibromyalgia and complex regional pain syndrome. On 9/26/22 at 12:32 PM, an interview was conducted with resident 29. Resident 29 stated she was unable to stand her pain last night and was groaning. Resident 29 stated there was no nurse on her hallway from 12:00 AM until 6:00 AM. Resident 29 stated she needed Tramadol at 2:00 AM but the nurse told resident 29 it was not her problem because she would not be there. Resident 19 stated the nurse continued to tell her she would not be the nurse to administer the Tramadol. Resident 29 stated she had scoliosis that made a hole in her spine and she has no control over her left lower extremities. Resident 29 stated she needed her Tramadol regularly because her pain never quit. Resident 29 stated her Tramadol was not administered at 2:00 AM when she wanted it. Resident 29 stated that her pain was at a 10 and she was crying and sick to her stomach. Resident 29 stated the nurse administered three pills to her early in the morning that morning and she did not know what the medications were. [Cross Reference F697] 7. On 9/26/22 at 10:32 AM, an interview was conducted with resident 22. Resident 22 stated that staff were not bringing her medications timely. Resident 22 stated that she would ask for her anxiety medication and it would take along time for the staff to bring the medication. Resident 22 stated the staff would tell her there was only one nurse. Resident 22 stated that some staff were better than others. Resident 22 stated that she did not always get her diabetic medications before meals. On 9/26/22 at 12:32 PM, an interview was conducted with resident 29. Resident 29 stated she was unable to stand her pain last night and was groaning. Resident 29 stated there was no nurse on her hallway from 12:00 AM until 6:00 AM. Resident 29 stated she needed Tramadol at 2:00 AM but the nurse told resident 29 it was not her problem because she would not be there and there was not a nurse to administer the medication. Resident 29 stated she had scoliosis that made a hole in her spine and she had no control over her left lower extremities. Resident 29 stated she needed her Tramadol regularly because her pain never quit. Resident 29 stated her Tramadol was not administered at 2:00 AM when she wanted it. Resident 29 stated that her pain was at a 10 and she was crying and sick to her stomach. Resident 29 stated the nurse administered three pills to her early that morning and she did not know what the medications were. [Cross Reference F755 and F757] (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	On 9/26/22 at 12:22 PM, an interview was conducted with resident 23. Resident 23 stated that the weekend staff were kind of stretched, with only one licensed nurse and two CNA's on shift. Resident 23 stated she had to wait two hours for pain medicine to be administered, and this occurred her last night. Resident 23 stated that there was just one nurse on shift. Resident 23 stated that the medication can only be administered every six hours and then she had to wait an additional two hours after that before it was administered. Resident 23 stated that her pain was located in the femur and feet. Resident 23 stated that no one could help me because they were so busy. Resident 23 stated that the pain was a 10/10, on a scale of 1 to 10. Resident 23 stated that it made her mad as hell, and no one provided help. Resident 23 stated that they have had to wait for assistance usually between 6:00 PM to 10:00 PM, and the last couple of nights it had been really bad. 19. On 09/27/22 at 10:03 AM, an interview was conducted with Restorative Nurse Assistant (RNA) 1. RNA 1 stated that she was the only RNA for the facility, and she worked Monday through Friday. RNA 1 stated that she was trying to work on getting the RNA program going. RNA 1 stated that she started providing RNA services at the beginning of September 2022, and prior to September they were working on rebuilding the program. RNA 1 stated that she began working at the facility in January 2022, and that there was not a RNA program until she began doing it. RNA 1 stated that in April or May 2022 there was one other RNA who was providing RNA services Monday through Friday. 20. On 10/3/22 at 9:06 AM, an interview was conducted with RN 6. RN 6 stated that she worked for an agency, and that this was the third shift at the facility. RN 6 clarified that this was her third shift working as an agency nurse period. RN 6 stated that she was an emergency room (ER) nurse and working agency in Long Term Care settings was new to her. RN 6 stated that when a resident had a change in condition she was not sure what the process would be, but she called the DON. RN 6 provided an example of a resident who had sustained a fall the prior day. RN 6 stated that the resident was on an anticoagulant and believed that they should be evaluated in the ER after the fall. RN 6 stated that they attempted to contact the resident's provider. RN 6 stated that they had left a voicemail for the NP, but never heard a response back. RN 6 stated that she then notified the DON and they agreed to send the resident to the hospital. RN 6 stated that the DON instructed her to document the incident in a fall report. RN 6 stated stated she would have liked to do a progress note, but that she did not know how to use the electronic medical records system. RN 6 stated that she was not provided any instructions on how to use the medical records system and she had not used it prior to coming to this facility. RN 6 stated that she had received no orientation to the facility. RN 6 stated she was provided the DON's phone number and login credentials for the electronic medical records. RN 6 stated that the previous nurse gave her the medical records website to login and access the Medication Administration Record (MAR). RN 6 stated that she was able to navigate the system, but it took longer to educate herself on the system. RN 6 stated that she would have liked to have had some sort of orientation. RN 6 stated that she did not know how to navigate beyond the MAR. RN 6 stated that she did not know how to access the resident's care plan until today when another nurse showed her. RN 6 stated she would have liked to know the patients diagnoses and plan of care. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	On 9/28/22 at 12:48 PM, an interview was conducted with the Administrator. The Administrator stated that he guessed an unassigned was picked up by a staff member but not written on the schedule. The Administrator stated that other staff members that filled in for CNA shifts were the RA, Housekeepers who were Nursing Assistants and other staff. The Administrator stated that he signed a contract with another agency service on 9/15/22, when he started as the Administrator. The Administrator stated there were not enough staff so that was his first thing as an Administrator to get better staffing.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33215 Based on interview and record review, it was determined, that the facility did not provide routine and emergency drugs and biologicals to its residents. Specifically, for 7 out of 34 sampled residents, resident medications were not administered as ordered by the physician due to the medications not being available by the pharmacy. Resident identifiers: 22, 23, 29, 30, 49, 53, and 160. Findings included: 1. Resident 22 was admitted to the facility on [DATE] with diagnoses which included, but not limited to, nontraumatic intracerebral hemorrhage, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, type 2 diabetes mellitus, essential hypertension, muscle weakness, and chronic pain syndrome. On 9/26/22 at 10:32 AM, an interview was conducted with resident 22. Resident 22 stated that staff were not bringing her medications timely. Resident 22 stated that she would ask for her anxiety medication and it would take along time for the staff to bring the medication. Resident 22 stated the staff would tell her there was only one nurse. Resident 22 stated that some staff were better than others. Resident 22 stated that she did not always get her diabetic medications before meals. Resident 22's medical record was reviewed on 9/27/22. The September 2022 Medication Administration Record (MAR) was reviewed. The following entries were documented: a. On 9/3/22 at 6:00 PM - 10:00 PM, heparin solution; 5,000 unit/milliliter twice a day was not administered due to Drug/Item Unavailable. b. On 9/17/22 at 6:00 AM - 10:00 AM, duloxetine capsule delayed release 30 milligrams (mg) was not administered due to Other Comment: medication not available, Pharmacy notified. c. On 9/18/22 at 6:00 AM - 10:00 AM, Acidophilus 1 capsule was not administered due to Drug/Item Unavailable. d. On 9/19/22 at 6:00 AM - 10:00 AM, duloxetine capsule delayed release 30 mg was not administered due to Drug/Item Unavailable. e. On 9/19/22 at 6:00 AM - 10:00 AM, fluoxetine capsule 40 mg was not administered due to Drug/Item Unavailable. f. On 9/20/22 at 6:00 AM - 10:00 AM, duloxetine capsule delayed release 30 mg was not administered due to Drug/Item Unavailable. g. On 9/20/22 at 6:00 AM - 10:00 AM, fluoxetine capsule 40 mg was not administered due to Drug/Item Unavailable. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	h. On 9/21/22 at 6:00 AM - 10:00 AM, fluoxetine capsule 40 mg was not administered due to Drug/Item Unavailable. 2. Resident 49 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included, but not limited to, hemorrhage of anus and rectum, dementia, history of falling, type 2 diabetes mellitus with hyperglycemia, displaced fracture of second cervical vertebra, major depressive disorder, systolic congestive heart failure, secondary hypertension, and edema. Resident 49's medical record was reviewed on 9/27/22. The September 2022 MAR was reviewed. The following entries were documented: a. On 9/5/22 at 6:00 AM - 10:00 AM, Anusol-hydrocortisone acetate suppository 25 mg twice a day was not administered due to Drug/Item Unavailable Comment: MD [Medical Director] and pharm [pharmacy] notified. b. On 9/6/22 at 6:00 PM - 10:00 PM, Miconazorb powder 2% topical twice a day was not administered due to Drug/Item Unavailable Comment: MD and pharm notified. c. On 9/8/22 at 6:00 PM - 10:00 PM, Miconazorb powder 2% topical twice a day was not administered due to Drug/Item Unavailable Comment: MD and pharm notified. d. On 9/23/22 at 5:00 AM, levothyroxine 175 micrograms was not administered due to Drug/Item Unavailable. e. On 9/23/22 at 6:00 AM - 10:00 AM, potassium chloride 10 milliequivalent was not administered due to Drug/Item Unavailable. f. On 9/24/22 at 6:00 AM - 10:00 AM, metoprolol tartrate 25 mg twice a day was not administered due to Drug/Item Unavailable. g. On 9/26/22 at 6:00 AM - 10:00 AM, metoprolol tartrate 25 mg twice a day was not administered due to Drug/Item Unavailable. h. On 9/27/22 at 6:00 AM - 10:00 AM, metoprolol tartrate 25 mg twice a day was not administered due to Drug/Item Unavailable. 30563 3. Resident 29 was admitted to the facility on [DATE] with diagnoses which included low back pain, injury to left lower leg, hypothyroidism, edema, chronic pain, and nausea. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/26/22 at 12:32 PM, an interview was conducted with resident 29. Resident 29 stated she was unable to stand her pain last night and was groaning. Resident 29 stated there was no nurse on her hallway from 12:00 AM until 6:00 AM. Resident 29 stated she needed Tramadol at 2:00 AM but the nurse told resident 29 it was not her problem because she would not be there and there was not a nurse to administer the medication. Resident 29 stated she had scoliosis that made a hole in her spine and she had no control over her left lower extremities. Resident 29 stated she needed her Tramadol regularly because her pain never quit. Resident 29 stated her Tramadol was not administered at 2:00 AM when she wanted it. Resident 29 stated that her pain was at a 10 and she was crying and sick to her stomach. Resident 29 stated the nurse administered three pills to her early that morning and she did not know what the medications were. Resident 29's medical record was on 9/28/22. An admission Minimum Data Set (MDS) assessment dated [DATE], revealed that resident 29 frequently experienced pain. The MDS revealed resident 29 had pain that made it hard for her to sleep at night and limited her day-to-day activities. The MDS revealed resident 29 had as needed pain medications and no scheduled pain medications. A care plan created on 9/19/22, with a problem start date of 8/1/22, revealed resident 29 was at risk for pain secondary to chronic pain. The goal was resident 29 would have no unaddressed pain, through next review. The approaches included educate resident on newly prescribed medications, monitor for side effects, medications as prescribed, monitor pain as prescribed, and other non-pharmacological approaches to pain management. A current physician's order dated 8/2/22, revealed Lidocaine adhesive patch, medicated; 5%; topical apply patch to back daily. The MAR for August 2022 revealed Lidocaine adhesive patch was not administered on the following dates: a. On 8/23/22, Drug/Item Unavailable: Could not find b. On 8/24/22, Drug/Item Unavailable c. On 8/25/22, Drug/Item Unavailable d. On 8/26/22, Drug/Item Unavailable: Notified DON [Director of Nursing] - DON is getting more e. On 8/27/22, Drug/Item Unavailable: Waiting for delivery f. On 8/28/22, Drug/Item Unavailable g. On 8/29/22, Drug/Item Unavailable A current physician's order dated 8/1/22. revealed Voltaren Arthritis Pain (Diclofenac sodium) gel; 1%; topical administered three times per day. The instructions were to apply to knees and ankles. The diagnosis associated with the gel was low back pain. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The MAR for August 2022 revealed Voltaren gel was not administered on the following dates: a. On 8/9/22, No nurse b. On 8/30/22, Drug/Item unavailable c. On 8/31/22, Drug/Item unavailable The MAR for September 2022 MAR revealed the following: a. Acetaminophen 650 mg three times per day were not administered on 9/6/22, 9/7/22, and 9/8/22 because the Drug/Item was unavailable and on order. b. Lidocaine patch adhesive patch 5% topical once per day was not administered on 9/1/22, 9/2/22, 9/26/22, 9/27/22 because the Drug/Item was unavailable and needed to order more. On 10/3/22 at 11:57 AM, an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated if the medication was not available then it was because the pharmacy did not have a supply. The ADON stated medications like Tramadol were in the Pyxus system and he was not sure why the medication was not administered on 8/9/22, because there was always a nurse at the facility. 4. Resident 160 was admitted to the facility on [DATE] and discharged on [DATE] with diagnoses which included hypertension, diabetes mellitus, and atrial fibrillation. On 9/27/22 at 9:21 AM, an interview was conducted with resident 160's family member. Resident 160's family member stated resident 160's medications were all messed up when she was admitted . Resident 160's family member stated she talked to the previous DON about the medications but nothing was done. Resident 160's medical record was reviewed on 9/29/22. The February 2022 MAR revealed resident 160 was not administered Lipitor Tablet 40 mg at bedtime on 2/12/22, 2/14/22, 2/16/22, and 2/23/22. A progress note dated 2/12/22, revealed the medication was Unavailable, pharmacy contacted. On 2/14/22, 2/16/22, and 2/23/22, the medication was pending delivery. The February 2022 MAR further revealed resident 160 was not administered Hydralazine Hydrochloride 25 mg three times a day for hypertension on the following days: a. On 2/11/22 at 7:00 AM. b. On 2/12/22 at 7:00 AM. c. On 2/13/22 at 7:00 AM, 12:00 PM, and 7:00 PM. d. On 2/14/22 at 7:00 PM, e. On 2/15/22 at 7:00 AM and 12:00 PM. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The progress notes revealed on 2/11/22, the medication was Not available. On 2/12/22, Not available, pharmacy contacted. On 2/13/22, medication unavailable Pharmacy contacted. On 2/14/22, Pending delivery. On 2/15/22, Not available pharmacy notified. The February 2022 MAR further revealed resident 160 was not administered Metoprolol Succinate Extended Release (ER) 24 hour sprinkle 50 mg twice daily for hypertension on the following days: a. On 2/2/22 at 7:00 AM. b. On 2/3/22 at 7:00 PM. c. On 2/4/22 at 7:00 PM. d. On 2/14/22 at 7:00 PM. e. On 2/15/22 at 7:00 AM. f. On 2/16/22 at 7:00 AM. The progress notes revealed on 2/2/22, Medication not available. Notified pharmacy. On 2/3/22, Unable to locate medication. On 2/4/22, unable to locate ordered more. On 2/14/22, the medication was pending delivery. On 2/15/22, the medication was not available pharmacy notified. 2/16/22, Medication not available, notified pharmacy. The March 2022 MAR revealed resident 160 was not provided Metoprolol Succinate Capsule ER 24 hour sprinkle 50 mg on the following dates: a. On 3/6/22, at 7:00 PM dose. b. On 3/8/22, at 7:00 AM and 7:00 PM doses. c. On 3/9/22, at 7:00 AM and 7:00 PM dose. d. On 3/10/22, at 7:00 PM dose. e. On 3/11/22, at 7:00 AM dose. f. On 3/12/22, at 7:00 PM dose. g. On 3/13/22, at 7:00 AM dose. The progress notes revealed on 3/6/22, the drug was not on hand. On 3/8/22, the medication was pending delivery. On 3/9/22, Medication was not available. Notified pharmacy. Refill is too soon, notified DON and MD [Medical Director] and Pending Delivery. On 3/10/22, Unable to locate. Ordered more. On 3/11/22, Drug not available. On 3/12/22, medication no on hand pharm notified. On 3/13/22, Medication cannot be filled until the 16th. Notified DON of issue. Notified MD. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The March 2022 MAR further revealed resident 160 was not provided Loradine 10 mg by mouth one time a on 3/11/22. The progress notes revealed on 3/11/22, Drug not available. On 9/27/22 at 12:01 PM, an interview was conducted with Registered Nurse (RN) 5. RN 5 stated she had worked at the facility for two years and was currently an agency nurse. RN 5 stated if medication was not available nurses wrote it down on a sheet and then called the pharmacy. RN 5 stated the new system had a button to push to reorder medications. RN 5 stated that the night shift nurse went through and re-ordered the medications before the medication ran out. RN 5 stated if a resident was not administered Metoprolol, then she would want to make sure their blood pressures were not high. RN 5 stated sometimes Metoprolol was not given because the blood pressure was too low. RN 5 stated the physician provided parameters to hold the medication depending on the blood pressure. On 9/29/22 at 2:11 PM, an interview was conducted with the DON. The DON stated she did not have any additional information on resident 160's medications not being unavailable. 38031 5. Resident 30 was admitted to the facility on [DATE] with diagnoses which included cerebral infarction, abscess of perineum, muscular dystrophy, hypertension, type 2 diabetes mellitus, anxiety disorder, gastro-esophageal reflux disease, major depressive disorder, and cellulitis of the buttocks. On 9/28/22, resident 30's medical record was reviewed. Review of resident 30's physician's orders revealed the following: a. Escitalopram oxalate tablet 5 mg by mouth one time a day. The order was initiated on 8/2/22 and was discontinued on 9/26/22. b. Metoprolol tartrate tablet 100 mg by mouth one time a day. The order was initiated on 8/2/22. Review of resident 30's September 2022 MAR revealed the following: a. On 9/23/22 at 6:00 AM to 10:00 AM, the Escitalopram 5 mg was documented as Not Administered: Drug/Item Unavailable. b. On 9/7/22 and 9/9/22 at 6:00 AM to 10:00 AM, the Metoprolol 100 mg was documented as Not Administered: Drug/Item Unavailable. 6. Resident 53 was admitted to the facility on [DATE] with diagnoses which included surgical aftercare of the digestive system, edema, type 2 diabetes mellitus, morbid obesity, obstructive sleep apnea, anxiety disorder, major depressive disorder, insomnia, hypertension, benign prostatic hyperplasia, and chronic kidney disease. On 9/28/22 at 7:38 AM, an observation was made of RN 3 during the morning medication administration. RN 3 was dispensing medication for resident 53 and stated that the resident's Nystatin cream was not available and needed to be reordered. RN 3 stated she would document the medication as not administered. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/28/22 at 9:25 AM, RN 3 stated she was going to fax the Nystatin refill to the pharmacy and would expect to receive it around 2:00 PM. On 9/28/22 at 3:18 PM, RN 3 stated that she had just received the Nystatin cream from the pharmacy. On 9/29/22 at 11:03 AM, an interview was conducted with the DON. The DON stated that she was not sure if the Nystatin cream was stock item. The DON stated that staff should contact the pharmacy and have the medication reordered before it runs out. The staff should be aware of how much was remaining in the tube. On 10/3/22, resident 53's medical records were reviewed. Review of resident 53's physician's orders revealed the following: a. Daily Multivitamin-Minerals (multivitamin with minerals) one tablet by mouth one time a day. The order was initiated on 8/2/22. b. Macrobid capsule 100 mg by mouth at bedtime. The order was initiated on 8/1/22. c. Pantoprazole tablet 40 mg by mouth one time a day. The order was initiated on 8/2/22. Review of resident 53's September 2020 MAR revealed the following: a. On 9/14/22 and 9/15/22, the multivitamin was documented as Not Administered: Other Comment: ON ORDER. b. On 9/19/22, the Macrobid 100 mg medication was documented as Not Administered: Drug/Item Unavailable. c. On 9/26/22 and 9/27/22, the Pantoprazole 40 mg was documented as Not Administered: Drug/Item Unavailable. On 10/3/22 at 1:42 PM, an interview was conducted with the DON. The DON stated she would have to research why the medications were documented as not administered. The DON stated that if there was a reason to hold the medication, she would expect there to be a progress note documenting why. The DON stated that Multivitamins were a stock item and should be available. 7. Resident 23 was admitted to the facility on [DATE] with diagnoses which included fracture of right femur, congestive heart failure, gastro-esophageal reflux disease, deep vein thrombosis of lower extremity, insomnia, hypothyroidism, alcohol dependence, major depressive disorder, and post-traumatic stress disorder. On 9/26/22 at 12:22 PM, an interview was conducted with resident 23. Resident 23 stated that she had pain in her femur and feet. Resident 23 stated that the pain was a 10/10, on a scale of 1 to 10. Resident 23 stated that the pain in her feet was due to neuropathy and was so painful that she could hardly touch her feet to the ground. On 9/27/22, resident 23's medical record was reviewed. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of resident 23's physician's orders revealed the following: a. Buspirone tablet 5 mg by mouth three times a day. The order was initiated on 8/1/22 and discontinued on 9/26/22 b. Buspirone tablet 10 mg by mouth three times a day. The order was initiated on 9/26/22. c. Furosemide tablet 40 mg by mouth two times a day. The order was initiated on 8/2/22. d. Gabapentin tablet 600 mg by mouth three times a day. The order was initiated on 8/1/22. e. Amoxicillin tablet 500 mg by mouth three times a day. The order was initiated on 8/22/22 and discontinued on 8/29/22. Review of resident 23's August 2020 MAR revealed the following: a. On 8/29/22 at the 6:00 PM to 10:00 PM, administration time, the Amoxicillin 500 mg was documented as Not Administered: Drug/Item Unavailable. b. On 8/16/22 at the 6:00 PM to 10:00 PM, on 8/17/22 at the 6:00 AM to 10:00 AM, and at the 10:00 AM to 2:00 PM, administration time, the Buspirone 5 mg was documented as Not Administered: Drug/Item Unavailable c. On 8/16/22 at the 6:00 PM to 10:00 PM, on 8/17/22 at the 6:00 AM to 10:00 AM, and at the 10:00 AM to 2:00 PM, administration time, the Gabapentin 600 mg was documented as Not Administered: Drug/Item Unavailable Review of resident 23's September 2022 MAR revealed the following: a. On 9/14/22 at the 6:00 PM to 10:00 PM, administration time, the Buspirone 5 mg was not administered due to Drug/Item Unavailable b. On 9/21/22, 9/22/22, and 9/23/22 at the 6:00 AM to 10:00 AM and at the 10:00 AM to 2:00 PM, administration time, the Furosemide 40 mg was documented Not Administered: Drug/Item Unavailable. On 9/27/22 at 10:22 AM, an interview was conducted with RN 4. RN 4 stated that she was an agency nurse. RN 4 stated that this was her first full shift at the facility, and she had worked one other time for half a shift. RN 4 stated that she had noticed that all the staff today were agency. On 9/27/22 at 1:28 PM, a follow-up interview was conducted with RN 4. RN 4 stated that when she came on shift, she was handed a piece of paper to write down any medications that were out of stock. RN 4 stated that she was not informed of the process for ordering medication for a resident. RN 4 stated that she thought the facility had a Pyxis machine, that is how it is at all the facilities. RN 4 stated that she did not have an access code for the Pyxis dispensary, only the facility nurses were granted access. RN 4 stated that she had not been provided any instructions at this facility. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/27/22 at 10:03 AM and again at 1:57 PM, an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated that she was an agency nurse and had worked at the facility prior to becoming an agency staff. LPN 1 stated that if medications were running low, they would order them from the pharmacy. LPN 1 stated that when the blister pack had only the last row or column remaining, she would pull the reorder sticker and place on the refill sheet or check to make sure that it was not too early to refill the medication. LPN 1 stated that she had the ability to reorder some medications through the electronic medical records, but not for all residents. LPN 1 stated that she could also fax the order to the pharmacy. LPN 1 stated that she could also call the pharmacy with any orders. LPN 1 stated a Pyxis was available to pull medication from, and that she had the ability to access the Pyxis. LPN 1 stated that if medications were not available, she would document in the MAR, and include a note that stated she contacted pharmacy. LPN 1 stated that medications would usually arrive at the facility the same day if it was scheduled for a refill, they will put it on the next run. LPN 1 stated sometimes if the medication was not due to be reordered then it would not be refilled. LPN 1 stated that occasionally medications were misplaced or located in another cart, and she would have to locate the medication to administer it. On 9/27/22 at 2:40 PM, an interview was conducted with the DON. The DON stated that the process for reordering medication was to pull the reorder stickers from the blister pack, order through the electronic medical records, or call the pharmacy directly. The DON stated that the electronic medical records reorder was available for all residents, and that they had been training the agency staff on reordering medication for the last two weeks. The DON stated that medications were available in the Pyxis system, but not all staff had access to the medication dispensing system. The DON stated that the pharmacy was coming out this week to give access to all licensed nurses at the facility, including the agency staff. The DON stated that there was usually a nurse at the facility that had Pyxis access and the ADON lived nearby and could run over to get medication from the Pyxis for staff. The DON stated that since she had been at the facility, which was the last two weeks, she had made sure that someone was on shift who had access to the Pyxis. The DON stated that staff should contact the pharmacy to obtain a refill and notify the provider if a medication was not administered. The DON stated that the documentation was located on the MAR or in a progress note. The DON stated that the pharmacy had three deliveries a day and they were very responsive. The DON stated that she had worked a couple of shifts and the pharmacy had medication delivered within two hours yesterday. The DON stated that the licensed nurses should contact the pharmacy to obtain a refill or contact the provider to obtain a new prescription.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33215 Based on interview and record review, it was determined, the facility did not ensure that each resident's drug regimen was free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose; or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Specifically, for 4 out of 34 sampled residents, a resident's beta blocker medication to treat high blood pressure was not monitored according to the physician ordered parameters. A resident's alpha-adrenergic agonists medication to treat low blood pressure was held without physician's orders. In addition, resident medications were not administered per physician's orders due to nursing staff not completing the task. Resident identifiers: 22, 30, 36, and 49. Findings included: 1. Resident 22 was admitted to the facility on [DATE] with diagnoses which included, but not limited to, nontraumatic intracerebral hemorrhage, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, type 2 diabetes mellitus, essential hypertension, muscle weakness, and chronic pain syndrome. On 9/26/22 at 10:32 AM, an interview was conducted with resident 22. Resident 22 stated that staff were not bringing her medications timely. Resident 22 stated that she would ask for her anxiety medication and it would take along time for the staff to bring the medication. Resident 22 stated the staff would tell her there was only one nurse. Resident 22 stated that some staff were better than others. Resident 22 stated that she did not always get her diabetic medications before meals. Resident 22's medical record was reviewed on 9/27/22. The September 2022 Medication Administration Record (MAR) was reviewed. The following entries were documented: a. On 9/5/22 at 6:00 AM - 10:00 AM, Acidophilus 1 capsule was not administered due to Other Comment: Morning nurse did not administer, or complete task. b. On 9/17/22 at 4:30 PM, insulin lispro solution; 100 unit/milliliters per sliding scale was not administered due to Other Comment: Previous shift task. 2. Resident 49 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included, but not limited to, hemorrhage of anus and rectum, dementia, history of falling, type 2 diabetes mellitus with hyperglycemia, displaced fracture of second cervical vertebra, major depressive disorder, systolic congestive heart failure, secondary hypertension, and edema. Resident 49's medical record was reviewed on 9/27/22. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The September 2022 MAR was reviewed. On 9/5/22 at 6:00 AM - 10:00 AM, Anusol-HC (hydrocortisone acetate) suppository 25 milligrams (mg) twice a day was not administered due to Other Comment: Morning nurse did not administer, or complete task. A physician's order dated 8/12/22, documented midodrine tablet; 5 mg; Amount to Administer: 2 tabs (10 mg); oral Three Times A Day for low blood pressure. [Note: There were no physician ordered parameters to hold the midodrine.] The September 2022 MAR was reviewed. The following entries were documented when the midodrine was not administered: a. On 9/6/22 at 6:00 PM - 10:00 PM, Not Administered: On Hold Comment: B/P [blood pressure] ABOVE PARAMETERS. [Note: A B/P was not documented.] b. On 9/7/22 at 6:00 PM - 10:00 PM, Not Administered: Due to Condition. [Note: Resident 49's documented B/P was 126/70.] c. On 9/8/22 at 6:00 PM - 10:00 PM, Not Administered: Due to Condition. [Note: A B/P was not documented.] d. On 9/10/22 at 6:00 AM - 10:00 AM, Not Administered: Other Comment: outside parameters. [Note: Resident 49's documented B/P was 100/68.] e. On 9/11/22 at 6:00 PM - 10:00 PM, Not Administered: Due to Condition Comment: B/P above parameters. [Note: A B/P was not documented.] f. On 9/12/22 at 6:00 PM - 10:00 PM, Not Administered: Due to Condition [Note: Resident 49's documented B/P was 137/74.] On 9/27/22 at 2:10 PM, an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated that she would check the resident's blood pressure prior to administering the midodrine. LPN 1 stated that there were usually parameters in the physician's orders. LPN 1 stated she would contact the Medical Director if no parameters were included with the physician's order. LPN 1 stated that midodrine was administered to increase blood pressure. On 9/27/22 at 3:49 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that Midodrine did not consistently have hold parameters. The DON clarified that midodrine should not be taken after the evening meal within three to four hours before bedtime. The DON stated that the evening administration time would need to be adjusted. 3. Resident 36 was admitted to the facility on [DATE] with diagnoses which included, but not limited to, viral pneumonia, chronic respiratory failure with hypoxia, pulmonary hypertension, anemia, hyperkalemia, pain, and essential hypertension. On 9/26/22 at 2:13 PM, an interview was conducted with resident 36. Resident 36 stated that her pain medication was scheduled. Resident 36 stated that most of the time she received her medications timely. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 36's medical record was reviewed on 9/29/22. On 12/20/21, a Pain Interview documented that resident 36 had frequent pain the last five days. Resident 36 had a pain intensity of 5/10, and received percocet every four hours for pain management. A care plan Problem started on 7/29/22, documented Category: Pain [Name of resident 36 removed] is at risk for pain secondary to decreased mobility, hx [history] pain. The care plan interventions included: a. Created on 7/29/22, monitor pain as prescribed. b. Created on 7/29/22, offer non-pharmacological approaches to pain management. c. Created on 9/28/22, resident 36 requests to use a heat pack at times. Disposable heat packs provided to her. The September 2022 MAR was reviewed. The following entries were documented: a. On 9/24/22 at 5:00 AM, oxycodone-acetaminophen 10-325 mg every three hours was not administered due to Other Comment: Noc [night] nurse did not give. b. On 9/28/22 at 11:00 AM, oxycodone-acetaminophen 10-325 mg every three hours was not administered due to Other Comment: Last nurse did not give med. NP [Nurse Practitioner] notified. 38031 4. Resident 30 was admitted to the facility on [DATE] with diagnoses which included cerebral infarction, abscess of perineum, muscular dystrophy, hypertension, type 2 diabetes mellitus, anxiety disorder, gastro-esophageal reflux disease, major depressive disorder, and cellulitis of the buttocks. On 9/28/22, resident 30's medical record was reviewed. Review of resident 30's physician's orders revealed an order for Metoprolol tartrate tablet 100 mg by mouth one time a day. Special Instructions: Hold for systolic blood pressure (SBP) of less than (<) 100 OR diastolic blood pressure (DBP) < 60. The order was initiated on 8/2/22. Review of resident 30's September 2022 MAR revealed on 9/24/22 at 7:07 AM, the blood pressure was documented as 135/55. The Metoprolol Tartrate 100 mg was documented as administered with physician ordered parameters to hold for a SBP < 100 and a DBP of < 60. On 9/27/22 at 2:40 PM, an interview was conducted with the DON. The DON stated that she would call the NP and verify that the parameters for the Metoprolol were for DBP and not heart rate. The DON stated that based on the parameters in the order the medication should not have been administered.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465129	A. Building B. Wing	10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health Center	55 South Professional Way Payson, UT 84651

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38031 Based on observation, interview, and record review it was determined that the facility did not ensure that the medication error rates was not 5 percent or greater. Observations were made of 28 medication opportunities, on 9/28/22, revealed two medication errors which resulted in a 7.14 percent medication error rate. Specifically, an enteric coated Aspirin (ASA) was administered instead of a chewable and Omeprazole was substituted for Pantoprazole. Resident identifier: 53. Findings included: Resident 53 was admitted to the facility on [DATE] with diagnoses which included surgical aftercare of the digestive system, edema, type 2 diabetes mellitus, morbid obesity, obstructive sleep apnea, anxiety disorder, major depressive disorder, insomnia, hypertension, benign prostatic hyperplasia, and chronic kidney disease. Review of resident 53's physician's orders revealed the following: a. ASA tablet 81 milligrams (mg), chewable by mouth one time a day. b. Pantoprazole tablet 40 mg by mouth one time a day. On 9/28/22 at 8:15 AM, observations were made of Registered Nurse (RN) 3 during morning medication administration. RN 3 was observed to dispense and administer ASA 81 mg tablet, enteric coated (EC) and Omeprazole 20 mg tablet, two tablets to resident 53. On 9/28/22 at approximately 8:15 AM, an interview was conducted with RN 3. RN 3 confirmed that she administered ASA EC instead of a chewable. RN 3 stated that the Omeprazole was the same drug classification as Pantoprazole but was not the same drug. RN 3 was observed to look up the medication Omeprazole and stated that Omeprazole generic was Prilosec and not Pantoprazole.

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	465129	A. Building B. Wing	10/03/2022

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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 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. 45470 Based on observations, interview, and record review it was determined, the facility did not provide food prepared by methods that conserve nutritive value, flavor, and appearance; food and drink that was palatable, attractive, and at a safe and appetizing temperature. Specifically, for 9 out of 34 sampled residents, multiple residents complained about the palatability and temperature of the food, and a sample test tray revealed that the food was not palatable. Resident identifiers: 7, 16, 20, 23, 29, 38, 45, 48, and 53. Findings Included: 1. On 9/26/22 at 11:00 AM, an interview was conducted with resident 48. Resident 48 stated that the food was getting better. Resident 48 stated that there was an alternative menu which she ordered from. Resident 48 stated she ordered a hamburger and received a bun, lettuce, cucumber, and no hamburger patty. 2. On 9/26/22 at 11:00 AM, an interview was conducted with resident 38. Resident 38 stated the food was getting better than it used to be but on the weekends the food was not good. Resident 38 stated that this last weekend the cook added white pepper to macaroni and cheese. Resident 38 stated it was too spicy and she was unable to eat it. 3. On 9/26/22 at 11:19 AM, an interview was conducted with resident 45. Resident 45 stated the food did not arrive warm. Resident 45 stated the eggs were cold and staff had to warm them up. Resident 45 stated it was not worth the time to call for assistance with the food. 4. On 9/26/22 at 11:20 AM, an interview was conducted with resident 16. Resident 16 stated the food was better but still was not good on the weekends. Resident 16 stated on Saturday night he ordered french fries and a hamburger. Resident 16 stated the kitchen sent him lasagna and a wilted salad. Resident 16 stated he asked for what he ordered, and the kitchen staff brought him a piece of sausage, bun, and lettuce. 5. On 9/26/22 at 12:30 PM, an interview was conducted with resident 23. Resident 23 stated the food needed some help. Resident 23 stated that the new cook was trying. Resident 23 stated she was tired of getting the same food every day because there was no variety. Resident 23 stated there were substitutions, but it was hard to get them after dinner was served. Resident 23 stated that sometimes there was a soup or sandwich available. 6. On 9/26/22 at 12:35 PM, an interview was conducted with resident 29. Resident 29 stated the food tasted awful. (continued on next page)

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	465129	A. Building B. Wing	10/03/2022

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. On 9/26/22 at 2:48 PM, an interview was conducted with resident 53. Resident 53 stated he needed a diabetic diet and was told he had a diabetic diet but then his hemoglobin A1c was really high. Resident 53 stated he would like better options for high protein and low carbohydrate foods. Resident 53's lunch meal was observed on his over bed table. Resident 53 had shredded chicken and gravy with no other foods. Resident 53 stated the vegetables were kind of yucky. Resident 53 stated he wished the kitchen staff served seasonal vegetables. Resident 53 stated that some of the way the vegetables were prepared were really bad so he did not usually eat them. 8. On 9/26/22 at 3:05 PM, an interview was conducted with resident 7. Resident 7 stated the food was not good. 9. A progress note dated 8/25/22 at 1:45 PM, located in resident 20's electronic medical record documented, [Resident] is seen today after he walked over to the hospital to get some lunch. He states that he does not enjoy the food at the facility, so he walked to the hospital to get some better food. On 8/29/22 at 9:55 AM, the Nurse practitioner documented, He had another episode of hypoglycemia,. Diet is very irregular, he states the food is not good so he will not eat often. On 7/14/22, resident 20's Interdisciplinary Team care plan meeting documented, food is cold and not good. 10 On 9/27/22, the Resident Council Minutes were reviewed. The Resident Council Minutes dated 9/12/22, documented, meals are still being served cold. Rolls are soggy. Meal cards are not being filled out properly. 11. On 9/27/22 at 12:13 PM, a lunch test tray was obtained. The items served for lunch were garlic marinated pork chops, orzo with lemon and herbs, basil zucchini saute, and a roll. The pork chop texture was chewy with a bland flavor. The orzo with lemon and herbs was bland, mushy, overcooked, and did not have any lemon or herb flavor. The zucchini saute was overcooked, mushy, and very bland with no seasoning. The temperature of the food on the test tray was adequate. 30563 38031