STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165441	A. Building B. Wing	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunny View Care Center	410 N W Ash Drive Ankeny, IA 50023

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** Based on observations, interviews, and record review, the facility failed to ensure dignity was promoted for 2 out of 2 residents (Resident #1 and Resident #12). The facility had ongoing issues with batteries not staying charged in stand lifts used for daily transferring of residents. Resident #1 waited 30 minutes after staff answered her call light to toilet her related to 2 different batteries not working and the need to go get another stand lift from the other side of the building. A stand lift battery died after staff raised Resident #12 to a standing position and could not lower her due to the lift's battery dying. She remained in the standing position until staff could retrieve another battery. The facility reported a census of 86 residents. Findings include: 1. A Annual Minimum Data Set (MDS) dated [DATE], documented diagnoses for Resident #1 included Multiple Sclerosis (MS), anxiety and depression. A Brief Interview for Mental Status (BIMS) documented a score of 15 out of 15, which indicated intact cognition. This resident was dependent on staff for toilet transfers, sit to stand, and for chair/bed to chair transfers. A Care Plan for Resident #1 had the following interventions: -assist Resident #1 to toilet upon request revised on [DATE]. -Toileting: Assist Resident #1 to the stool with use of sit to stand and 2 assist. She requests to not have staff be in the bathroom when she is toileting. Crack the door open to her bathroom for observation to ensure safety and to maintain her privacy as much as possible. Staff to make sure needed personal supplies are within reach. Wheelchair positioned as she requests. Initiated on [DATE] and revised on [DATE]. -if aides are unable to toilet this resident at a specific time she desires, Resident #1 is to notify administrator or other available management staff member. Corporate nurse if in the facility for an additional intervention. Revised on [DATE]. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 10:59 a.m., Resident #1's call light was on. Staff D, Certified Nurse Aide (CNA), shut off the call light at 11:00 a.m., Staff D stated she was going to get a second person and the lift stand. After Staff D left the room, Resident #1, who was sitting in her wheel chair, stated that there is one thing that she forgot to mention. She stated there are not enough lifts in the facility. She stated that the battery dies a lot on them. She said when they get the stand lift to the room, much of the time the battery dies. She voiced frustration, as she has to wait for staff before she can transfer to the toilet. She said the machines are so old the batteries don't stay charged. On [DATE] at 11:12 a.m., Staff D returned to this resident's room with the stand lift. She stated Staff E, Certified Medication Aide (CMA)/CNA will come in to help. On [DATE] at 11:15 a.m., Staff E came in to the room and asked if Resident #1's legs were too tired from doing the exercise and she said no. On [DATE] at 11:18 a.m., they started to transfer this resident but the battery died. Staff E left the room with the battery. She stated she would be right back. Staff D confirmed the battery had died. She stated they just had charged the battery. On [DATE] at 11:20 a.m., Staff E returned to the room with a different battery. She placed the battery on the EZ stand, washed her hands and grabbed new gloves. The battery did not work. Staff E said We probably are going to have to use the (non-standing lift) . They removed the sling used with the stand lift from behind Resident #1. Staff E stated she could run up to the front end of the building and grab the other stand lift. Staff E stated there were 2 stand lifts in the building. Staff E appeared upset. Resident #1 stated it's not your fault (Staff E). On [DATE] at 11:23, Staff E left and said she would be right back. Resident #1 stated If it would have happened (the lift worked) the first time it would have been a shock, that's the way it works. On [DATE] at 11:29 a.m., Staff E returned with a different stand lift. Resident #1's feet were placed on the stand and sling placed behind her and under her arms. They raised this resident off her wheelchair. Resident holding on to the stand lift handles, and they transferred this resident to the toilet. This resident's adult brief was removed and disposed of while resident was still standing in the lift prior to lowering her to the toilet. The adult brief was saturated and drooped under the weight of its contents. Staff D and Staff E stepped outside of the bathroom into the bedroom to allow privacy for this resident. When asked if this happens often with the battery dying, they both were hesitant to answer, but then said it hadn't happened recently with the battery, but it was happening though. Staff D and E both said they thought it had been fixed. On [DATE] at 3:04 p.m., Staff E stated they have had problems with the batteries off and on for months. The maintenance man fixes it right away when he finds out, but they just keep not working. Staff E stated she felt bad for the residents. She stated for example what happened with Resident #1 today. It's frustrating for them to have to sit in soiled clothing. The residents that are cognizant have been getting frustrated with this ongoing situation. On [DATE] at 2:35 p.m., the Chief Nursing Officer (CNO), Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON), acknowledged this concern regarding the battery dying, delaying the resident being able to use the toilet. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. The Quarterly MDS dated [DATE], documented diagnoses for Resident #12 included Parkinson's, depression, and chronic pain. A BIMS documented a score of 15 out of 15, which indicated intact cognition. This resident was dependent on staff for toilet transfers, sit to stand, and for chair/bed to chair transfers. On [DATE] at 12:55 a.m., This resident verified staff transferred her with the stand lift. When asked if she had any concerns with her transfers, she said staff do a great job. She stated the only problem is the batteries. They will die and the staff have to run and get another battery. She said your kind of standing there on the machine like you are in outer space or something. When asked how that made her feel, Resident #12 stated she doesn't like the feeling when that happens. She stated she didn't know if they don't have enough batteries, or the chargers are not working or what, but it happens a lot. On [DATE] at 2:35 p.m., Nurse consultant, LHNA, and DON, acknowledged this concern regarding the battery dying while resident was in the standing position and with the resident not liking being left in the standing position. On [DATE] at 10:43 a.m., the Director of Operations verified they have had issues with batteries and charges holding on the facility lifts. We have found that staff were not plugging them in to charge. If we need to replace them we do. He stated staff are to charge the batteries overnight and if the batteries do not work then the batteries are pitched and replaced. The Director of Operations acknowledged concerns regarding Resident #1 and Resident #12. The Resident Council minutes dated [DATE], documented that an EZ Stand was out of commission. An undated Right to Dignity policy, directed the following: Policy: This facility will promote care for residents of the facility in a manner and in an environment that maintains and enhances each resident's dignity and respect in full recognition of the elder's individuality. Procedure: Residents will be groomed as they wish including hair care and styled, facial hair shaved/trimmed as the resident wishes, nail care as the resident chooses. Each resident will be encouraged and assisted to dress in his/her own clothing appropriate to the time of day and the individual's preferences. Unless specifically requested by the resident and/or Responsible Party. The resident will always be addressed by the name preferred by the resident and staff will not call the resident by terms such as sweetie, honey, grandma, etc,. without the permission of the resident and/or Responsible Party. If the residents prefer and choose to be called by a term of endearment, the practice will be included in the residents individualized comprehensive plan of care. Each resident will be provided and will be encouraged to attend activities of his/her own choosing. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Clothing and personal items will be labeled in a manner that respects the resident dignity by placing all labeling on the inside of shoes and all clothing items. Each resident will be provided with independence and dignity during dining experiences regardless of the amount of assistance the resident requires Bibs (clothing protectors) will be used if the resident desires to have one. Each resident requiring staff assistance or encouragement with eating will be provided with that assistance by staff being seated next to the resident, at eye level, facing the same direction as the resident. Staff assisting any resident with a meal will interact/converse with the resident. Staff members will respect each resident's private space and property at all times Staff will knock on the door and wait for permission to enter when entering the elder's personal space. Staff will close doors and utilize privacy curtains during provision of care. Staff will not move or inspect the personal possessions without permission of the elder. Staff will exhibit respect for each resident. Staff will speak respectfully to each resident. Staff will address the residents by the name of the resident choice. Staff will not label residents i.e., diagnosis, feeder, etc. Staff will not exclude residents from conversations or discussing residents in community settings in which others can overhear private information. Staff will provide dignity to each resident by maintaining the residents' privacy of body including: Keep the resident covered while transporting residents outside the residents room All staff will refrain from any practice which could be considered demeaning to a resident including: Urinary catheter bags uncovered Refusing to comply with a resident's request for toileting assistance during meals (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Restricting residents from use of common areas open to the public such as lobbies and restrooms unless the residents is restricted related to an infective process or are restricted according to the resident care-planned needs Failure to focus on the resident as individuals when talking with the resident or failure to address the resident as an individual during care and services

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to follow document and/or carry out physician orders for 2 of 16 residents reviewed (Resident #2 and Resident #3). Resident #2 had an order to check her oxygen saturation (POx) once per shift. She had a second PRN (as needed order) to apply oxygen if the oxygen saturation was below 90%. There was no documentation of oxygen application for oxygen saturation below 90%. Resident #3 had an order to check Hgb A1c (a test that measures the average blood sugar) every 6 months. This was not done. The facility reported a census of 86 residents. Findings include: 1. A Quarterly Minimum Data Set (MDS) dated [DATE], documented Resident #2's diagnoses included heart failure and non-Alzheimer's dementia. A Brief Interview for Mental Status (BIMS) documented a score of 4 out of 15, which indicated severely impaired cognition. This resident received oxygen treatment. A Treatment Administration Record (TAR) for June 2025 and printed on 6/25/25 at 3:33 p.m., directed to check spo (oxygen saturation level) every shift for shortness of breath. It documented that on 6/21/25 on the evening shift her oxygen saturation was 89%. It documented that on 6/25/25 on the day shift Resident #2's oxygen saturation was at 89%. Both of these entries were initialed/signed by Staff A, Licensed Practical Nurse (LPN). A Doctor's Order dated 10/6/24, directed to apply oxygen at 2 liters via nasal prongs to keep oxygen saturations above 90% as needed related to heart failure. The June 2025 TAR lacked staff initials documenting the administration of oxygen on 6/21/25 and 6/25/25. On 6/25/25 at 2:00 p.m., it was noted that this resident had not been observed having any oxygen administered up to this point of the survey. The survey was initiated on 6/23/25. On 6/25/25 at 4:00 p.m., Staff A stated on this morning Resident #2's POx was 89% and the CNA put O2 on her. She stated they always do if Resident #2's POx was lower than 90%. When told there wasn't an observation this morning with this resident having oxygen administered via nasal cannula, this LPN stated that's because Resident #2 takes the oxygen off all the time. When this LPN was asked about the order for PRN oxygen on the TAR not being signed, she stated she didn't even know there was an order. This LPN acknowledged the POX readings of 89% on 6/21/25 evening shift and on 6/25/25 day shift were signed by her. Staff A acknowledged that she did not sign for PRN oxygen on 6/21/25 nor did she sign for PRN oxygen for this morning 6/25/25. On 6/25/25 at 4:31 p.m., Staff B, Certified Medication Aide (CMA), stated that Staff A had asked Staff B to check Resident #2's oxygen saturation as Staff A was busy. Staff B stated she went and checked the oxygen saturation with the POx and it was 88%. Staff B stated she then put oxygen on Resident #2. Staff B stated she did not know there was a PRN order for oxygen. She stated they were told to put oxygen on Resident #2 whenever her POx reading was below 90% because her O2 levels fluctuated during the dayshift. Staff B did not know when they were told to do this but a bunch of CMAs and nurses were told to do this for Resident #2. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A late entry Progress Note dated 6/25/25 at 9:49 a.m., documented 'Late Entry' Resident was at 89 % on room air, prn oxygen applied. This entry was not in the progress notes prior to the above 2 interviews. The TAR dated 7/1/25 on the day shift, documented Resident #2's oxygen saturation was at 81%. The PRN oxygen was not signed for as being applied. Progress Notes from 6/2/25 to 72/25, revealed that no nursing assessment was documented on 7/1/25 nor on 6/21/25. On 7/2/25 at 10 a.m., the Director of Clinical Services stated that nurses could put oxygen on without doctor's orders per nursing assessment and based on their clinical assessments. She stated that staff should be documenting when PRN oxygen is applied. She and the DON acknowledged that the oxygen saturation was documented at 81% and felt it must have been done in error. The Director of Clinical Services asked if this should be addressed further. 2. The Quarterly MDS Assessment, dated 5/23/25, revealed Resident #3 with a BIMS of 9, indicating moderate cognitive impairment. Diagnoses included diabetes mellitus, hyperlipidemia, hypertension, and non-Alzheimer's dementia. The Order Summary Report, obtained on 6/25/25, included a lab order for a Hemoglobin (Hbg) A1c to be obtained every 6 months on the 10th day related to Type 2 Diabetes. This was initiated on 5/2/22. Review of diabetic medication history revealed the following: a. Glargine insulin was initiated on 5/3/22 and discontinued on 8/2/24 b. Metformin HCl 500mg twice daily was initiated on 5/24/25 c. Glargine insulin 10 units in the morning was initiated on 5/28/25 Review of TARs revealed the following: a. May'24 a Hgb A1c was due on the 10th of the month, Staff documented as complete b. Jun'24-Oct'24 indicated a Hgb A1c was not due in these months c. Nov'24 indicated a Hgb A1c was due on the 10th of the month. No staff documentation identified on the TAR or in Progress Notes if the lab had been drawn or not d. Dec'24-Apr'25 indicated a Hgb A1c was not due in these months e. May'25 indicated a Hgb A1c was due on the 10th of the months. No staff documentation identified on the TAR or in Progress Notes if the lab had been drawn or not Paper health record review documented a Hgb A1c 5.8 on 5/10/24 and 9.1 on 5/21/25, which was obtained during Resident #3's hospitalization. No further Hgb A1c were identified during this timeframe. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/25/25 at 1:45 PM, the Chief Nursing Officer explained the floor nurses would see lab draw orders as they are listed out on the TARs. It would be the Charge Nurse responsibility to ensure the labs were drawn. During an interview on 6/26/25 at 9:15 AM, Staff F, LPN, explained after the provider writes a lab order, the nurse completes the first order check, write the lab in the Lab Order Book, and enter into MARS/TARS. The nursing staff complete the Double and Triple order check to ensure the order is processed. Night shift nursing review the Lab Order book for labs needed on the upcoming day shift. Lab requisitions completed. The day shift obtains the lab and sends out. All nursing staff should see lab orders as they print out on the MAR/TAR and any nurse can address. Staff F obtained the Lab Order book and discussed the book is divided up by months/days. Jun'25 and Jul'25 were in the book but no lab sheets identified for future month/lab needs. Past months lab sheet/request are not kept and ultimately placed in the confidential shred bin. The undated policy Physician Orders for Medications and Treatments stated all medications will be administered as ordered by a health care professional authorized by the state to order medications.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to ensure doctor's orders for oxygen (O2) were being followed for 3 out of 3 residents reviewed (Residents #2, #8 and #9. Resident #2 had an order for PRN (as needed) oxygen to be placed when her oxygen saturation was below 90%. Documentation showed she had a least 2 occasions when her oxygen saturation read by a pulse oximeter (Pox) was 89% and oxygen was not documented as being applied. Staff reported not knowing there was an order for PRN oxygen, but they were applying oxygen without clarifying the order. Residents #8 and #9 were observed to have oxygen administered at flow rates that differed from their doctor ordered oxygen flow rates. The facility was not documenting what the liter flow was for oxygen saturation readings on an oxygen order that was to be titrated between 2 and 4 liters(L) per Resident #8's needs. The facility reported a census of 86 residents. Findings include: 1. A Quarterly Minimum Data Set (MDS) dated [DATE], documented Resident #2's diagnoses included heart failure and non-Alzheimer's dementia. A brief Interview for Mental Status (BIMS) documented a score of 4 out of 15, which indicated severely impaired cognition. This resident received oxygen treatment. A Treatment Administration Record (TAR) for June 2025 and printed on 6/25/25 at 3:33 p.m., directed to check pox every shift for shortness of breath. It documented that on 6/21/25 on the evening shift her oxygen saturation was 89%. It documented that on 6/25/25 on the day shift Resident #2's oxygen saturation was at 89%. Both of these entries were initialed/signed by Staff A, Licensed Practical Nurse (LPN). A Doctor's Order dated 10/6/24, directed to apply oxygen at 2 liters via nasal prongs to keep oxygen saturations above 90% as needed related to heart failure. The June 2025 TAR lacked staff initials documenting the administration of oxygen on 6/21/25 and 6/25/25. On 6/25/25 at 2:00 p.m., it was noted that this resident had not been observed having any oxygen administered up to this point of the survey. The survey was initiated on 6/23/25. On 6/25/25 at 4:00 p.m., Staff A stated on this morning Resident #2's POx was 89% and the CNA put O2 on her. She stated they always do if Resident #2's POx was lower than 90%. When told there wasn't an observation this morning with this resident having oxygen administered via nasal cannula, this LPN stated that's because Resident #2 takes the oxygen off all the time. When this LPN was asked about the order for PRN oxygen on the TAR not being signed, she stated she didn't even know there was an order. This LPN acknowledged the POX readings of 89% on 6/21/25 evening shift and on 6/25/25 day shift were signed by her. Staff A acknowledged that she did not sign for PRN oxygen on 6/21/25 nor did she sign for PRN oxygen for this morning 6/25/25. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/25/25 at 4:31 p.m., Staff B, Certified Medication Aide (CMA), stated that Staff A had asked Staff B to check Resident #2's oxygen saturation as Staff A was busy. Staff B stated she went and checked the oxygen saturation with the POx and it was 88%. Staff B stated she then put oxygen on Resident #2. Staff B stated she did not know there was a PRN order for oxygen. She stated they were told to put oxygen on Resident #2 whenever her POx reading was below 90% because her O2 levels fluctuated during the dayshift. Staff B did not know when they were told to do this but a bunch of CMAs and nurses were told to do this for Resident #2. On 7/2/25 at 10 a.m., the Director of Clinical Services stated that nurses could put oxygen on without doctor's orders per nursing assessment and based on their clinical assessments. She stated that staff should be documenting when PRN oxygen is applied. 2. A Quarterly MDS dated [DATE], documented Resident #8's diagnoses included cancer, schizophrenia, chronic obstructive pulmonary disease (COPD), and Chronic respiratory failure with hypoxia (low oxygen levels in your body tissues). A BIMS documented a score of 5 out of 15, which indicated this resident's cognition was severely impaired. Resident #2 had shortness of breath or trouble breathing with exertion. This resident received oxygen therapy. A Doctor's Order initiated on 4/9/25, directed that Resident #8 was to have oxygen at 2L per nasal cannula every shift for oxygenation. On 6/23/25 at 2:19 p.m., an oxygen sign was noted hanging outside Resident #8's door. This resident was not wearing oxygen. Staff C, Certified Nurse Aide (CNA), stated that Resident #8 takes his oxygen off all of the time. She stated that he will probably get mad at her because she constantly was putting the oxygen back on him. This CNA went into Resident #8's room and talked with him, he allowed her to put the oxygen via nasal cannula back on him. When Resident #8 was asked if he takes the oxygen tubing off, he stated 'yeah, I really don't like it'. Resident stated that he really didn't like the breathing treatments either but the oxygen (administration) was okay. This resident stated that he liked to keep the oxygen (liter flow) at 2. It was noted at that time the oxygen liter flow was on between 3.5 and 4 liters. After leaving the room, this CNA stated that Resident #8 was going through chemotherapy and had been confused. On 6/23/25 at 3:15 p.m., noted Resident #8's oxygen liter flow was still at 3.5 to 4 liters. Asked the MDS Nurse what oxygen flow liter rate should this resident have oxygen administered. This MDS Nurse looked this up in Resident #8's chart then stated it should be at 2 liters. When told the doctor's order directed that it be at 2 liters, this nurse said okay. This MDS Nurse was then asked if she would verify the liter flow. This nurse went into this resident's room and stated the oxygen flow rate was at 4 liters. She then turned the oxygen rate down to 2 L. This nurse then checked his oxygen saturation and it was at 90%. She asked the resident if he was short of breath and he denied being short of breath. She stated Resident #8 had lung cancer and was being treated for it. On 6/23/25 at 3:30 p.m., the Chief Nursing Officer stated Resident #8 changes the setting (liter flow) on the oxygen concentrator. She added that they put a note on the concentrator to remind him not to change it. She acknowledged the concern. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ON 6/24/25 at 10:32 a.m., Resident was lying in bed. Oxygen tubing on the floor. He stated he took it off as he wanted to take a nap. Sign on concentrator reads: (Resident's name) Please do NOT adjust your oxygen! Please ask your nurse for help with any oxygen needs! Your order is for 2-4 liters. Oxygen was at 2 Liters. A Doctor's Order dated 6/23/25, directed that oxygen via nasal cannula 2-4L continuously. May titrate to keep pulse ox above 90%. The previous Doctor's Order for oxygen to be administered at 2L was discontinued on 6/23/25. The June TAR had Resident #8's oxygen titration order on it with signature spaces for Pox readings and a signature box for each shift. There was no place to document the oxygen liter flow. On 6/25/25 at 2:48 p.m., the Chief Nursing Officer stated they got the order for titration of oxygen as Resident #8 changed his oxygen liter flow all the time and they just wanted to make sure they could cover it. She agreed that Resident #8 had confusion and stated she couldn't say for sure if he was turning it up because he felt like he needed more oxygen. When asked about the liter flow not being documented on the TAR, she stated the facility had never done that. She stated she understood why the liter flow should be recorded with the titration of oxygen. The Chief Nursing Officer stated she understood the concern and stated she would get this changed. 3. The 5-day scheduled MDS assessment dated [DATE] revealed Resident #9 with a BIMS score of 12 indicating moderate cognitive impairment. Diagnoses include coronary artery disease, chronic obstructive pulmonary disease with acute exacerbation, heart failure, hemiplegia, and non-Alzheimer's dementia. The Order Summary Report, obtained on 6/24/25, documented Resident #9 with an order for oxygen at 2 liters (L) via nasal cannula; May titrate to keep oxygen saturation levels above 90%. This was initiated on 6/12/25. During an observation and interview on 6/24/25 at 1:05 PM, Resident #9 sat in a wheelchair in the dining room with oxygen. The portable oxygen tank, placed in the back of the wheelchair, was set at 1.5 L. Staff G, CMA/CNA, acknowledged the oxygen was set at 1.5 L and voiced it should be set at 2 L. Staff G increased the oxygen setting to 2 L. During an observation and interview at 6/24/25 at 2:15 PM, Resident #9 was asleep in their recliner with oxygen. The portable oxygen concentrator was located several feet away from the resident. The oxygen was set at 1.5 L. Staff F, LPN, was present in the room, acknowledged the oxygen setting, and voiced it was incorrect. Staff F increased the oxygen setting to 2 L, as per order. Staff F explained the oxygen was at 2 L earlier in the morning and was not aware of the change. Staff F would expect the aides to alert nursing of any breathing or medical concerns which may need a nursing assessment and oxygen adjustment. The undated policy Administration of Oxygen stated the initiation of oxygen therapy will be performed by a licensed nurse. Direct care staff may reapply the nasal cannula and replace distilled water in the humidifier. Oxygen therapy will be administered or supplied on prescription from the resident's primary care physician and will be administered as prescribed with full details recorded in each resident's clinic record.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews and facility policy review, the facility failed to maintain complete and accurate medical records for 2 of 3 residents reviewed for discharge planning (Resident #15 and Resident #16). The facility reported a census of 86. Findings include: 1. The Quarterly Minimum Data Set (MDS) of Resident #15 dated 4/8/25 recorded a Brief Interview for Mental Status (BIMS) Score of 12, which indicated moderate cognitive impairment. The Care Plan, last reviewed on 4/22/25, failed to reflect a discharge plan for Resident #15. The Care Conference Review Notes dated 1/10/25 recorded the presence of the social services representative at the care conference. The Notes revealed Resident #15's daughter requested a referral to be made to another facility in the resident's home town for the resident to move to. The Care Conference Review Notes dated 4/15/25 recorded the presence of the social services representative at the care conference. The Notes revealed Resident #15's daughter requested a second referral to be made to an additional facility in the same town as the last request. Review of the Progress Notes of the resident, performed on 7/1/25, revealed no progress notes had ever been entered by the facility Social Services Representative since his admission in June of 2024. On 7/1/25 at 2:33 PM, the Social Services Representative stated sometime in mid to late June, she had reached out to an out of town facility to place a referral for transfer per the request of Resident #15's family member. She stated the transfer was denied due to financial issues and she notified the Business Office Manager of this. On 7/1/25 at 2:40 PM, the Social Services Representative stated she had never documented anywhere on Resident #15 since his admission. She stated she does not document when a resident or resident representative requests to transfer out of the facility and unless a big event occurs, she does not document anywhere in the resident's electronic health record (EHR) at all. On 7/1/25 at 3:17 PM, the Social Services Representative supplied emails she had exchanged with Res #15's daughter regarding her request for assistance to transfer the resident to another facility. Three emails in June of 2025 were provided. No communication prior to June was provided. 2. The Annual MDS assessment dated [DATE] revealed Resident #16 with a BIMS score of 11 indicating moderate cognitive impairment. The Care Conference Review Note dated 6/11/25 recorded the presence of the social services representative, the MDS Coordinator, and Resident #16's sister at the Care Conference. The notes revealed a discussion of Resident #16 transferring to a smoking facility. The Social Services Representative would assist the sister in search and paperwork. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/1/25 at 1:35 PM, Resident #16's sister confirmed having conversations with the facility's Social Services Representative since June's care conference regarding a possible change in facility. The last contact occurred 1-2 weeks ago. Review of Progress Notes for Resident #16, performed on 7/1/25, revealed no Progress Note had been entered by the facility Social Services Representative summarizing conversations with the sister regarding updates on a facility transfer. The last Progress Note identified was from 8/19/24 notifying the sister of a room change. During an interview on 7/1/25 at 2:20 PM, the Social Services Representative acknowledged Resident #16's desire to move to a different facility and keeps in touch with the sister. The Social Services Representative stated she typically does not document resident or family interactions in the EHR unless it is something big. During an interview on 7/1/25 at 4:15 PM, the Chief Nursing Officer acknowledged the lack of Social Services Representative EHR documentation. The Chief Nursing Officer noted all resident and family interactions be recorded in the EHR. The undated policy Documentation noted the following under Procedure: As needed to provide care, treatment and services, the clinical record will contain: a. Any advance directive b. Order, renewal of orders, and documentation that resuscitative services are to be withheld or life-sustaining treatment withdrawn c. Any informed consent, when required (Antipsychotic/psychoactive medications; Side rails and other potential restraints; Signed declination of recommended vaccinations) d. Any records of communication with the resident and/or surrogate decision-maker such as telephone calls or email communication e. Any resident-generated information such as choices, habits, and routines f. Referrals or communication made to external or internal care providers and community agencies g. Any physician's summary and final diagnosis when the resident is admitted either from a hospital or from another health care organization h. The discharge plan or the reason for lack of an on-going plan when discharge potential does not exist

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to maintain mechanical and electrical patient care equipment in safe operating condition for 5 out of 5 residents reviewed (Residents #1, #7, #10, #11, and #12). Resident's #1 and #12 had care delayed related to batteries not working in stand lifts. Resident #7's bed would raise but not lower (beds in low position are a standard of safety). During separate observations of Residents #10 and #11 it was observed that 1 of the 4 wheels on the mechanical lift used to transfer the residents came off of the ground during the transfer. The facility reported a census of 86 residents. Findings include: 1. The Annual Minimum Data Set (MDS) dated [DATE], documented diagnoses for Resident #1 included multiple sclerosis (MS), anxiety and depression. A Brief Interview for Mental Status (BIMS) documented a score of 15 out of 15, which indicated intact cognition. This resident was dependent on staff for toilet transfers, sit to stand, and for chair/bed to chair transfers. A Care Plan for Resident #1 had the following interventions: -Toileting: Assist Resident #1 to the stool with use of sit to stand (lift) and 2 assist. On [DATE] at 10:59 AM, Resident #1 stated that the battery dies a lot on the lifts. She said when they get the stand lift to the room, much of the time the battery dies. She voiced frustration, as she has to wait for staff before she can transfer to the toilet. She said the machines are so old the batteries don't stay charged. On [DATE] at 11:12 AM , Staff D, Certified Nurse Aide (CNA) returned to this resident's room with the stand lift. She stated Staff E, Certified Medication Aide (CMA)/CNA will come in to help. On [DATE] at 11:18 AM, they started to transfer this resident but the battery died. Staff E left the room with the battery. She stated she would be right back. Staff D confirmed the battery had died. She stated they just had charged the battery. On [DATE] at 11:20 AM, Staff E returned to the room with a different battery. She placed the battery on the EZ stand and the battery did not work. On [DATE] at 11:29 AM, Staff E returned with a different stand lift and transferred this resident to the toilet. On [DATE] at 2:35 PM, the Chief Nursing Officer (CNO), Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON), acknowledged this concern regarding the battery dying, delaying the resident being able to use the toilet. 2. The Quarterly MDS dated [DATE], documented diagnoses for Resident #12 included Parkinson's, depression, and chronic pain. A BIMS documented a score of 15 out of 15, which indicated intact cognition. This resident was dependent on staff for toilet transfers, sit to stand, and for chair/bed to chair transfers. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 12:55 PM, this resident verified staff transferred her with the stand lift. When asked if she had any concerns with her transfers, she stated the only problem is the batteries. They will die and the staff have to run and get another battery. She said she has been left standing there on the machine while they go and get another battery. This resident stated she didn't know if they don't have enough batteries, or the chargers are not working or what, but it happens a lot. On [DATE] at 2:35 PM, Nurse consultant, LHNA, and DON, acknowledged this concern regarding the battery dying while resident was in the standing position and with the resident not liking being left in the standing position. On [DATE] at 10:43 AM the Director of Operations verified they have had issues with batteries and charges holding on the facility lifts. We have found that staff were not plugging them in to charge. If we need to replace them we do. He stated staff are to charge the batteries overnight and if the batteries do not work then the batteries are pitched and replaced. The Director of Operations acknowledged concerns regarding Resident #1 and Resident #12. The Resident Council minutes dated [DATE], documented that an EZ Stand was out of commission. 3. The Quarterly MDS assessment dated [DATE] revealed Resident #7 with a BIMS score of 5, indicating severe cognitive impairment with disorganized thinking and difficulty focusing attention. Resident #7 has a cerebrovascular accident (stroke) diagnosis and dependent on staff for chair/bed to chair transfers. The Care Plan with a target date of [DATE] listed Focus Areas related to communication problem and Activities of Daily Living (ADL) self-care performance deficit related to limited mobility and stroke. Interventions include the use of a mechanical lift to/from wheelchair with the assist of 2 staff members and keeping bed in a low position with wheels locked. During on observation on [DATE] at 1:20 PM Staff H, CNA, completed personal cares on Resident #7 in bed, which was in a higher position. Staff H voiced the resident's bed is broken as it does not lower down. Staff H was not sure how long the bed had been broken. During an interview on [DATE] at 10:25 AM Staff G, CNA, acknowledged Resident #7's bed not working properly. Explained the head and foot bed can be adjusted but the up and down function does not. Staff G estimated this has been on-going for a week/week and a half and had been reported. During an interview on [DATE] at 10:35 AM, Staff I, CNA, acknowledged Resident #7's bed not working properly. They explained it had not been working since late last week. During an interview on [DATE] at 10:45 AM, Staff J, CMA (certified medication aide)/CNA, acknowledged Resident #7's bed not working properly as it does not go down to a lower position. They believe it wasn't working over the weekend and unsure how long it has not worked properly. During an interview on [DATE] at 10:50 AM, Staff L, Maintenance, voiced this morning was the first they had received a work order regarding Resident #7's bed not working. They suspect it may be an issue with the remote but will asses the situation. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 11:30 AM, Staff K, CNA, acknowledged Resident #7's bed not working properly as does not go up/down. They believe the bed was this way when last worked the hallway three days ago. Staff K explained Resident #7 likes her bed in a higher position so she may see the television better. During an interview on [DATE] at 10:05 AM, Staff L acknowledged Resident #7's bed was not working properly as it did not go down to a lower position. The remote was changed out and it is working properly. Staff L explained the bed work order was placed by the Quality Assurance nurse on [DATE]. Staff L along with the LNHA voiced any staff member (aides, housekeeping) can enter a work order electronically through the TELS maintenance program. Routine bed maintenance completed monthly. 4. The Quarterly MDS assessment dated [DATE] revealed Resident #10 with a BIMS score of 5 indicating severe cognitive deficits. Diagnoses include cerebral ischemia (reduced blood flow to the brain) and non-Alzheimer's dementia. Resident #10 dependent on facility staff for chair/bed to chair transfers. The Care Plan with a target date of [DATE] listed a Focus Area related to Activities of Daily Living (ADL) self-care performance deficit due to impaired balanced, limited mobility and chronic pain. Interventions include the use of a mechanical lift to/from wheelchair with the assist of 2 staff members. During an observation on [DATE] at 12:00 PM, Staff I, CNA, and Staff J, CNA, transferred Resident #10 from the bed to a wheelchair utilizing a mechanical lift labeled #4. At the beginning of the transfer, all four wheels of the lift were on the ground. During the transfer, while Resident #10 was in the air, the lift's back-left wheel was seen off the ground approximately 1-2 inches. The other three wheels remained on the ground. The front part of the mechanical lift dipped down during this time. Once Resident #10 was transferred and seated into the wheelchair, the back-left wheel returned to the ground. 5. The Quarterly MDS assessment dated [DATE] revealed Resident #11 with a BIMS score of 13 indicating intact cognition. Diagnoses include coronary artery disease, heart failure, morbid obesity, and peripheral vascular disease. Resident #11 dependent on facility staff for chair/bed to chair transfers. The Care Plan with a target date of [DATE] listed a Focus Area related to Activities of Daily Living (ADL) self-care performance deficit due to weakness, acute on chronic health conditions, debility and cognition. Interventions include the use of a mechanical lift between surfaces with the assist of 2 staff members. During an observation on [DATE] at 11:45 AM, Staff I, CNA, and Staff J, CNA, transferred Resident #11 from the bed to a wheelchair utilizing a mechanical lift labeled #4. At the beginning of the transfer, all four wheels of the lift were on the ground. During the transfer, while Resident #11 was in the air, the lift's back-left wheel was seen off the ground approximately 1-2 inches. The other three wheels remained on the ground. The front part of the mechanical lift dipped down during this time. Once Resident #11 was transferred and seated into the wheelchair, the back-left wheel returned to the ground. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 11:30 AM, Staff K, CNA, explained the mechanical lift used for the front hallways typically will tilt during transfers. Staff will have to stand on it so it doesn't tip. Staff K stated the lift tips up on the left side. No timeframe provided on how long this had been happening. During an interview on [DATE] at 11:55 AM, Staff I and Staff J both acknowledged the back-left wheel of the mechanical lift coming off the ground. Neither staff could recall how long this had been happening. Staff I voiced it had been called-in. During an interview on [DATE] at 10:05 AM, Staff L, Maintenance explained they were not aware of the left-back wheel lifting up off the ground until yesterday. Staff L examined the mechanical lift, without a resident/not actively in-use, and could not see where the wheel was off the ground. It was further explained that the wheel came up when residents were in the sling, in the air, and being transferred. The facility Work Order #16 was the only Work Order related to mechanical lifts (standing or sitting) identified within the past six months. Work Order #16, created [DATE], was for a Hoyer lift not functioning on North (2). No further details provided. The Work Order was closed out [DATE]. A facility document summarizing Work Orders from [DATE]-[DATE] documented Resident #7's bed not working properly. The entry did not specify the date the Work Order was submitted or closed out. The undated policy Preventative Maintenance and Inspections outlined the following: a. Preventive Maintenance is completed in accordance with the defined procedure. When manufacturer's guidelines are available, Preventive maintenance is completed in accordance with the manufacturer's guidelines b. Record Keeping (1). Documents will be uploaded to the TELS system by the environmental supervisor and/or designee in his/her absence. (2). In the event that maintenance cannot be completed, the reason is noted along with the action plan for completion (3). Records are retained for five (5) years unless a different requirement has been established by state/federal regulations and statutes c. Inspections (1). Inspections verify that all equipment and furnishings are in working order, esthetically pleasant, clean and free from safety hazards (2). Each resident's room will be inspected routinely and through the Guardian Angel Program. Work orders shall be completed and uploaded to TELS. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. A system for work orders is established among all staff, residents, and employees that provides rapid communication regarding equipment problems. The work order system includes documentation of: (1). The problem (2). Date the problem was identified (3). Correction action (servicing, repair or replacement) (4)Completion date e. Work orders are written and uploaded to TELS (The facilities electronic system for environmental services) for the environmental supervisor to complete. The environmental supervisor is responsible for prioritizing work orders which always include safety concerns first. f. The Environmental supervisor will document the completion of work orders into TELS.