STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175255	A. Building B. Wing	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plaza West Healthcare and Rehab	1570 SW Westport Drive Topeka, KS 66604

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. The facility had a census of 130 residents, with three reviewed for Center for Medicare and Medicaid Services (CMS) Beneficiary Liability notices. Based on record review and interview, the facility failed to provide form CMS 10055 Advanced Beneficiary Notice (ABN), which included the estimated cost to continue services for skilled services to the resident or their representative for one of three residents, Resident (R) 2. This deficient practice placed R2 at risk for uninformed decisions and unanticipated costs related to skilled services. Findings included: - The Medicare ABN form informed the beneficiaries that Medicare may not pay for future skilled therapy and did not provide an estimated cost to continue their services. The form included an option for the beneficiary to (1) receive specified services listed, and bill Medicare for an official decision on payment, but can appeal to Medicare. (2) receive therapy listed, but do not bill Medicare, I am responsible for payment of services. (3) I do not want the listed services. The facility lacked documentation staff provided R2 (or their representative) the ABN form 10055 when the resident's skilled services ended on 01/10/25. On 03/18/25 at 01:30 PM, Social Service Y stated the facility had not provided R2 the CMS form 10055. Social Service Y stated the previous SS X no longer worked at the facility and had not given him the 10055 form. On 03/19/25 at 02:55 PM, Administrative Nurse D stated that R2 should have received the CMS 1005 form with the estimated cost. The facility's Advance Beneficiary Notices policy, dated 03/19/25, documented the facility would provide timely notices regarding Medicare eligibility and coverage. The facility would provide the resident a Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN), Form CMS-10055. The Facility failed to provide R2 with the appropriate non-coverage notice and cost estimate for further services, placing the resident at risk for uninformed decisions regarding skilled services.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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. The facility had a census of 130 residents. Based on observation and interview, the facility failed to maintain a clean homelike environment free of odor-free environment for one of the nine halls. This deficient practice placed the resident at risk for unhomelike, unsanitary conditions. Findings included: - On 03/17/25 at 08:30 AM the entirety of Hall 400 emanated a strong urine odor which continued throughout the day. The odor could be detected before entering the hallway in the commons area. On 03/18/25 at 07:05 AM the entirety of Hall 400 emanated a strong urine odor which continued throughout the day. The odor could be detected before entering the hallway in the commons area. On 03/17/25 at 08:30 AM, the Hall 400 commons area had two blue-colored couches that had brown stains on both. On 03/19/25 at 02:31 PM, Administrative Staff A verified the odor. Administrative Staff A stated he would notify the floor maintenance staff and housekeeping to check and clean where the possible odor was coming from and the couches. Administrative Staff A stated the facility had purchased 30 new mattresses and would check to see if the mattress had been put into place. Upon request, the facility failed to provide a clean environment policy. The facility failed to provide the residents located on hall 400 with a clean, odor-free environment. This deficient practice placed the residents at risk for an unhomelike stay.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 130 residents. The sample included 27 residents. Based on observation, record review, and interview, the facility failed to ensure Resident (R) 121's sexually aggressive behaviors were addressed. This placed the residents of the facility at risk of sexual abuse. Findings included: The Electronic Medical Recorded (EMR) documented R121 had diagnoses of cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), spastic hemiplegia (paralysis of one side of the body) affecting the nondominant side, dysphagia (swallowing difficulty), cognitive-communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), and difficulty in walking. The admission Minimum Data Set (MDS), dated [DATE], documented R121 had intact cognition, felt down, depressed, and hopeless, and social isolation. The resident had no signs or symptoms of delirium (sudden severe confusion, disorientation, and restlessness), psychosis (any major mental disorder characterized by a gross impairment in reality perception), or exhibited behaviors. R121 had a functional range of motion impairment of one side upper extremity, was dependent on toileting, and lower body dressing, and required substantial/maximal assistance with mobility. The resident had frequent incontinence of urine. The MDS further documented that R121 had occasional mild pain and two non-injury falls since admission. The resident received speech, occupational, and physical therapy. The Functional Abilities Care Area Assessment (CAA), dated 06/29/24, documented R121 had been admitted following hospitalization with a diagnosis of cerebral infarction, requiring assistance of one to two staff members for activities of daily living and transfers, worked with physical and occupational therapies for strengthening and returning to his prior level of function. He used a wheelchair for mobility. The Quarterly MDS, dated 01/15/25, document R121 had intact cognition, a mood score of 01 with feeling down, depressed, or hopeless, and socially isolated. The resident exhibited no delirium, psychosis, or behaviors. The MDS further documented R121 was dependent with toileting, bathing, and upper and lower body dressing, and required substantial/maximal assistance with mobility. R121 was always incontinent of urine and bowel, had pain frequently which occasionally interfered with day-to-day activities, and had one non-injury fall. R121's Care Plan on 07/03/24, documented R121 had a behavior problem and could be sexually inappropriate to female staff and had allegations of abuse when he was not tended to immediately when requested and of only allowing assistance from certain staff members. The Care Plan directed staff to provide care in pairs only, due to sexually inappropriate behaviors and history of allegations of staff abuse. The Care plan further stated R121 sometimes would touch female staff in inappropriate places and would make sexually inappropriate statements and staff was to encourage him not to do so. On 03/8/25 the care plan documented R121 placed on one-to-one care of staff. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Progress Note dated 07/02/24 at 02:57 PM, documented R121 had exhibited inappropriate behaviors during care in the morning, groping the nurse aide, pulling the aide into bed during the bed bath, calling the aide baby and getting upset when the nurse aide talked to other people, and would make inappropriate comments to the aide. The Progress Note dated 08/09/24 at 05:52 AM, documented when nursing staff went into R121 to give medication R121 was holding his penis and made two sexually inappropriate remarks. The Progress Note dated 08/09/24 at 06:09 AM, documented a nurse aide reported R121 made inappropriate sexual comments. The Progress Note dated 03/08/25 at 06:52 PM, documented R121 had inappropriately touched another R71. R121 was immediately placed on one-to-one care. R121's family member was notified of the situation. The police department spoke to the resident and a family member. Staff explained appropriate touch and the family member told R121 not to be touching any women and inquired about transferring to a facility that only had men and asked that this would be discussed with the physician. The Progress Note dated 03/17/25 at 04:24 PM, documented facility staff spoke with R121's Durable Power of Attorney (DPOA) about new medication order and permission for the resident to receive the medication and to have staff chart any sexual behaviors over the next 48 hours and would reassess the need for one-to-one care. The EMR lacked physician notification of sexual behaviors involving staff. On 03/18/25 at 07:08 AM, Activity Staff Z was seated in the hallway outside of R121 room. Activity Aide stated she was assigned to monitor R121. She stated she was not sure of the reason R121 was being monitored, reporting her supervisor had been also providing one-to-one observation. On 03/18/25 at 12:21 PM, R121 was brought to the dining room by staff. R121 was placed at a meal table which seated several male residents. Staff sat at the table with R121 throughout the meal. On 03/19/25 at 09:37 AM, Certified Nurse Aide (CNA) N reported R121 had been respectful and told the CNA often he appreciated the assistance. On 03/19/25 at 03:15 PM, Administrative Nurse D reported the nursing management went with R121 physician, and the physician was made aware of the behaviors. Administrative Nurse D thought the physician had made note of the sexual behaviors but was not able to find information regarding behaviors in the medical record. The facility's Abuse, Neglect, and Exploitation Policy, dated 03/17/25, documented it is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prevent abuse, neglect, exploitation, and misappropriation of resident property. Identifying, correcting, and intervening in situations in which abuse, neglect, and exploitation were more likely to occur with the deployment of trained and qualified, registered, licensed, and certified staff on each shift in sufficient numbers to meet the needs of the residents and assure that the staff have knowledge of the individual residents' care needs and behavioral symptoms. The identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs that might lead to conflict or neglect. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to ensure R121's sexually aggressive behaviors were addressed. This placed the residents of the facility at risk of sexual abuse.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 130 residents. The sample included 27 residents who were reviewed for comprehensive assessments and timing. Based on observation, record review, and interview, the facility failed to ensure the admission comprehensive Minimum Data Set (MDS) was completed for Resident (R) 98, R112, and R13 using the Centers for Medicaid and Medicare (CMS) - specified Resident Assessment Instrument (RAI) guidelines. This deficient practice placed these residents at risk for inaccurate reflections of the resident's status and needed to develop an individualized comprehensive person-centered plan of care. Findings included: - R98 admitted to the facility on [DATE]. R98's admission MDS had an assessment reference date (ARD) of 02/12/25 and a completion date of 03/02/25. R98's Care Area Assessments were not completed until 03/02/25. R112 re-admitted to the facility on [DATE]. R112's admission MDS had a date of 03/03/25 but had been completed. R13 admitted to the facility on [DATE]. R13's admission MDS with an ARD of 03/11/25 had not been completed. On 03/19/25 at 12:50 PM, Licensed Nurse (LN) I stated that she completed the MDSs. LN I stated she had been working on the floor to cover for them being short of help. LN I stated she had gotten behind on completing some of the MDS assessments, so she was to blame for that. On 03/19/25 at 03:15 PM, Administrative Nurse D stated she was aware that some of the MDS assessments had not been completed when they should have. Administrative Nurse D stated she was working on getting more facility staff so the MDS coordinator could get back to focusing on only doing the MDS assessments. The Assessment Frequency/Timeliness policy dated 02/01/20 documented the MDS/RAI coordinator would be responsible for tracking due dates for all MDS assessments, whether scheduled or unscheduled. The comprehensive admission assessment would be completed within 14 days after admission, excluding readmissions in which there was no significant change. Medicare PPS assessments, scheduled or unscheduled, would be completed within 14 days of ARD. The type of assessment and ARD would adhere to Medicare guidelines for each assessment. The facility failed to ensure the admission comprehensive MDS was completed for R98, R112, and R13 using the CMS-specified RAI guidelines. This deficient practice placed these residents at risk for inaccurate reflections of the resident's status and needed to develop an individualized comprehensive person-centered plan of care.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** - Resident (R) 295 Electronic Medical Record (EMR) included diagnoses of fracture (broken bone) of left tibia (bone of the lower leg), arteriovenous fistula (AV - a surgically created connection between an artery and a vein), dependence on renal (pertaining to kidneys) dialysis, end-stage renal disease, bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) disorder. The Minimum Data Set (MDS) had not been completed due to recent admission and had not met the criteria for completion or submission. R295's Baseline Care Plan dated 03/12/25, lacked documentation regarding R295's dialysis process or directed staff of care. The Physician Orders lacked orders for dialysis. The Progress Notes lacked documentation of the need or participation in the dialysis process. On 03/18/25 at 07:43 AM, Certified Medication Aide (CMA) S reported that R295 went to dialysis on Mondays and Fridays. On 03/18/25 at 08:29 AM, R295 stated she had been at the facility for over three weeks and went to dialysis on Mondays and Fridays. R295 stated the facility staff had not assessed the AV shunt when returning to the facility following dialysis treatment. R295 also reported the facility had not sent a communication sheet with her to dialysis. On 03/19/25 at 03:15 PM, Administrative Nurse D verified the baseline care plan should include R295's dialysis care and treatment. The facility's Baseline Care Plan policy, dated 02/01/20, documented the facility would develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meets professional standards of quality care. The facility failed to include R295's dialysis care and treatment in the care plan. This deficient practice placed the resident at risk of unmet care needs. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility identified a census of 130 residents. The sample included 27 residents reviewed for baseline care plans. Based on observation, record review, and interview, the facility failed to ensure Resident (R) 78, R98, and R13 baseline care plans were developed and implemented to provide effective and person-centered care that included interventions with staff direction for the resident's needed cares of their activities of daily living (ADL). The facility failed to develop a baseline care plan that included care areas and interventions for R295's ADLs and her dialysis (a procedure where impurities or wastes are removed from the blood) care. The facility failed to develop a baseline care plan that included dialysis care and treatment. This deficient practice placed these residents at risk of delayed care, possible decline, and injuries. Findings included: - R78 admitted to the facility on [DATE]. R78's baseline care plan in the Electronic Medical Record (EMR) that was initiated on 02/11/25 lacked a care area for ADLs and interventions to direct staff for basic care needs for the resident. R98 admitted to the facility on [DATE]. R98's baseline care plan in the EMR that was initiated on 02/13/25 lacked a care area for ADLs and interventions to direct staff for basic care needs for the resident. R13 admitted to the facility on [DATE]. R13's baseline care plan initiated in the EMR that was on 02/26/25 but lacked a care area for ADLs and interventions to direct staff for basic care needs for the resident. R346 admitted to the facility on [DATE]. R346's baseline care plan in the EMR was initiated on 03/08/25 but lacked a care area for ADLs and interventions to direct staff for basic care needs for the resident. R346's baseline care plan lacked a care area for dialysis. R347 admitted to the facility on [DATE]. R347's baseline care plan in the EMR that was initiated on 03/12/25 lacked a care area for ADLs, colostomy care, wound vac care, and interventions to direct staff for the care needs of the resident. On 03/19/25 at 10:30 AM, Certified Nurse Aide (CNA) O stated each resident's care plan should have how much assistance was needed with their ADLs for each resident. CNA O stated the nurses would typically tell staff when a new resident arrived how much assistance that resident needed or if a lift was required for transfers. CNA O could not state why these residents did not have ADL interventions in their care plans but did say that staff did complete ADLs on these residents that included toileting, bathing, and other basic needs. On 03/19/25 at 12:30 PM, Licensed Nurse (LN) J stated she was the nurse on the unit for these residents. LN J stated she was not the staff that did the baseline care plans for the residents, but she did know that the residents had received the basic care needed to be cared for. LN J stated the unit manager was typically responsible for getting the care plan completed and she would inform the staff of the resident's ADLs during their morning meeting. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/19/25 at 02:53 PM, Administrative Nurse D stated the unit manager, or the Minimum Data Set (MDS) Coordinator was responsible for completing and putting the baseline care plan into the EMR. Administrative Nurse D expected new admission residents to have a baseline care plan that included ADL care, and any specific care areas for dialysis, or wound care and colostomy care. Administrative Nurse D said she would speak with her staff to ensure that this was being completed. The facility's Baseline Care Plans policy implemented on 02/01/20 documented the facility would develop and implement a baseline care plan for each resident that included the instructions needed to provide effective and person-centered care of the resident that meet the professional standards of quality care. The baseline care plan would be developed within 48 hours of the resident's admission and would include the minimum healthcare information necessary to properly care for a resident including, but not limited to: initial goals based on admission orders; physician orders; dietary orders; therapy orders; and social services. The admitting nurse, or supervising nurse, shall gather information from the admission physical assessment, hospital transfer information, physician order, and discussion with the resident and resident representative, if applicable. Once gathered initial goals shall be established that reflect the resident's stated goals and objectives. Interventions shall be initiated that address the resident's current needs including any health and safety concerns to prevent decline or injury; any identified needs for supervision, behavioral interventions, and assistance with ADL; and any special needs such as for intravenous (IV) therapy, dialysis, or wound care. The facility failed to ensure staff developed and implemented a baseline care plan that included the instruction needed to provide effective and person-centered care that included ADL care for dialysis care, wound care, and colostomy care for residents. This deficient practice placed these residents at risk of delayed care, possible decline, and injury.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 130 residents. The sample included 27 residents. Based on observation, record review, and interview, the facility failed to revise the care plan for Resident (R) 117 with interventions to prevent skin tears and failed to [NAME] R78's care plan with interventions to prevent pressure ulcers. This placed the residents at risk of further injury and uncommunicative care needs. Findings included: - The Electronic Medical Record (EMR) for R117 documented diagnoses of vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and epilepsy (brain disorder characterized by repeated seizures). The Annual Minimum Data Set (MDS), dated [DATE], documented R117 had severely impaired cognition. R117 was dependent upon staff for all activities of daily living (ADL). R117 had upper one-side functional impairment and had no skin issues. The Quarterly MDS, dated 01/14/25, documented R117 had severely impaired cognition. R117 was dependent upon staff for all ADLs. R117 had lower functional impairment on both sides and had no skin issues. R117's Care Plan, dated 01/20/25, initiated on 08/05/23, documented R117 was at risk for alterations in skin integrity and directed staff to educate R117 and her family of the causes of skin breakdown. The staff were directed to encourage R117 to report any pain with repositioning, wear pressure relief boots as tolerated, obtain a low air loss mattress, and provide treatment as ordered. The care plan lacked direction to staff on interventions to prevent skin tears and bruises. On 03/18/25 at 09:20 AM, observation revealed R117 had a red, bloody area on her left forearm. The area had a clear bandage on top of it that wrapped around the inner aspect of her forearm. R117's EMR lacked documentation of an assessment of the area or a description of what caused the area. On 03/18/25 at 09:25 AM, Licensed Nurse G stated R117 she was unsure what happened to R117's arm. LN G stated, that R117 often scratched herself and that the area had been there for a couple of days. On 03/18/25 at 09:30 AM, Administrative Staff A stated he was unable to find an assessment or paperwork regarding the skin tear. Administrative Staff A had talked with LN G who was aware of the skin tear and an assessment would be completed and the physician notified. On 03/19/25 at 02:55 PM, Administrative Nurse D stated staff should complete skin assessments when there are skin tears or bruises, and the care plan should be updated with interventions to prevent skin tears. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Care Plan Revisions Upon Status Change policy, dated on 02/01/20, documented the comprehensive care plan would be reviewed and revised as necessary when a resident experienced a status change. The team met and discussed the resident's condition and collaborated on intervention options. The facility failed to revise R117's care plan with interventions to prevent skin tears and bruises. This placed the resident at risk for further injury and uncommunicative care needs. - R78's Electronic Medical Record (EMR) documented diagnoses of atrial fibrillation (A-Fib rapid, irregular heartbeat), congestive heart failure (CHF - a condition with low heart output and the body becomes congested with fluid), embolism (an obstruction in a blood vessel due to a blood clot or other foreign matter that gets stuck while traveling through the bloodstream), and thrombosis (a clot that develops within a blood vessel) of lower extremities. R78's admission Minimum Data Set (MDS) dated 02/09/25 documented both short and long-term memory problems. R78 had moderately impaired cognitive skills for daily decision-making. R78 had impairment on both sides of his upper extremity. R78 required a wheelchair for mobility. R78 was dependent on staff for all functional abilities. R78 was always incontinent of bowel and bladder. R78 was at risk of pressure ulcer development. R78 had no pressure ulcers on admission. R78 had a pressure-reducing device for the bed. R78 had application ointments and medications other than to feet. R78's Pressure Ulcer Care Area Assessment (CAA) dated 03/01/25 documented pressure ulcers would be addressed in R78's care plan. Staff were to assist with repositioning per protocol and as needed to help maintain skin integrity. Licensed nursing staff were to monitor skin integrity every week to help monitor for any skin issues. Incontinence creams were to be used as needed to help maintain skin integrity. A pressure redistributing surface was in place to the resident's bed and to the wheelchair to help maintain skin integrity. R78's Care Plan dated 02/08/25 directed staff to educate family and caregivers of causative factors and measures to prevent skin injury. Staff were directed to encourage good nutrition and hydration to promote healthier skin. Staff were directed that R78 preferred to bathe and shower on Wednesday and Saturday evenings. R78's care plan had not been updated and revised to direct staff on his wound care or how much assistance R78 required from staff. R78's Braden Scale Pressure for Predicting Pressure Sore Risk (a tool used to assess the risk of developing a pressure ulcer) admission assessment dated [DATE] documented a score of nine that indicated a high risk of pressure ulcer development. R78's Orders tab of the EMR documented an order dated 02/07/25 for weekly skin assessments by the licensed nurse. Document the findings on the weekly skin UDA every Thursday. R78's 'Weekly Skin Check under the Assessment tab of the EMR revealed skin checks had been completed on 02/12/25, 02/19/25, 02/20/25, 02/27/25, 02/28/25, and 03/06/25. R78's Weekly Skin Check under the Assessments tab dated 02/28/25 documented a new skin issue, pressure related to the right buttock. The skin check lacked any documentation of the skin area characteristics or measurements. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R78's Skin/Wound Note under the Progress Notes tab of the EMR dated 02/28/25 at 02:40 PM documented R78 had an open were to the right buttock noted. The area was cleansed and venelex (an ointment used to treat skin wounds) was applied and covered with a border foam dressing. The nurse practitioner and R78's spouse was notified. The Orders tab documented an order dated 02/28/25 for comfort border foam dressing to the right buttock wound. Change twice daily and as needed. R78 had been seen by the Advance Practice Registered Nurse (APRN) on 03/03/25, 03/10/25, 03/13/25, and 03/17/25 but the provider had not addressed R78's pressure wound. A Wound Evaluation completed on 03/19/25 under the Skin and Wound tab of the EMR documented a Stage 3 (a full-thickness pressure injury extending through the skin into the tissue below) pressure ulcer. The wound measured a length of 4.33 centimeters (cm), width of 1.51 cm, depth of 0.1 cm, and total area of 5.01 cm squared. On 03/18/25 at 09:42 AM, R78 laid in bed as nursing staff prepared the resident for care. On 03/19/25 at 10:30 AM, Certified Nurse Aide (CNA) O stated the aides were to look over the resident's skin at each bath given. CNA O stated if any skin changes had been noted it was to be documented on the shower sheet and the nurse was notified immediately. CNA O stated the resident's care plan should list any care for the resident or if cream should be applied. On 03/19/25 at 12:33 PM, Licensed Nurse (LN) J stated a R78's care plan should have staff direction for skin issues and how much assistance was needed for the resident. R78 was dependent on staff for his care. LN J stated the unit manager or the MDS coordinator was who updated orders and the care plan when new issues arose. LN J stated she had not noticed that R78 did not have interventions in place to address his pressure ulcer care. LN J stated she did do the daily dressing changes on R78. LN J stated that R78 did have a wound on his bottom that had just opened a few days ago. LN J stated the wound nurse did see R78 today. On 03/19/25 at 12:50 PM, LN I stated she and the unit manager had gotten behind on getting the care plans and MDSs updated lately. LN I stated a resident's care plan should be updated with any new interventions. R78's care plan should have interventions in place for his wound, but they had not been added yet. On 03/19/25 at 02:53 PM, Administrative Nurse D stated she would expect that a resident would have interventions in place and revised for a resident that had pressure wounds. Administrative Nurse D stated the staff that had updated the care plans had gotten a little behind on getting them updated or completed since those staff had been helping on the floor. Administrative Nurse D would expect that staff had been doing weekly skin assessments and making sure that measurements had been recorded for those wounds. Administrative Nurse D stated she would speak with staff to ensure a resident got the care needed. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Care Plan Revisions Upon Status Change policy implemented on 02/01/20 documented the comprehensive care plan would be reviewed, and revised as necessary when a resident experienced a status change. Upon identification of a change in status, the nurse would notify the MDS Coordinator, the physician, and the resident representative. The care plan would be updated with the new or modified interventions. Care plans would be modified as needed by the MDS Coordinator or other designated staff member. The Unit Manager or other designated staff member would communicate care plan interventions to all staff involved with the resident's care. The facility failed to ensure a care area and interventions were put in place and implemented to care for R78's Stage 3 pressure ulcer on his buttock. This deficient practice placed R78 at risk of complications and possible infection.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** - R71's Electronic Medical Record (EMR) documented she had diagnoses of vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain), osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk), urge incontinence (involuntary passage of urine occurring soon after a strong sense of urgency to void), and intellectual disabilities (involuntary passage of urine occurring soon after a strong sense of urgency to void). R71's Annual Minimum Data Set(MDS), dated [DATE], documented that R71 had a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS also documented that the resident required partial, moderate staff assistance with bathing, and it was very important to choose the type of bathing. R71's Urinary Incontinence Care Area Assessment (CAA), dated 07/06/24, documented urinary incontinence, which would be addressed in the resident's care plan. The CAA instructed staff to monitor for signs and symptoms of incontinence complications, such as infection. The CAA instructed staff to encourage R71 to drink fluids to help prevent infection, and provide incontinence care as needed (PRN). R71's CAA lacked triggering for bathing. R71's Activities of Daily Living (ADL) Care Plan, revised 12/23/24, documented R71 preferred a shower twice a week in the evening and required substantial, maximal staff assistance with showering. The EMR Bathing Sheets revealed R71 was scheduled for showers/baths every Tuesday and Friday days and received a bath on the following dates: 01/16/25 01/24/25 01/28/25 01/31/25 02/07/25 02/14/25 02/28/25 03/07/25 03/14/25 R71 refused on the following dates: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	01/14/25 01/15/25 02/04/25 02/11/25 02/21/25 02/25/25 03/04/25 On 03/17/25 at 03:55 PM, R71 sat in a chair at the dining room table with greasy hair. On 09/11/23 at 01:19 PM, Certified Nurse Aide (CNA) M stated R71 frequently refused baths and said she would try to get R71 to bathe at least once a week. On 03/19/25 at 12:25 PM, Licensed Nurse (LN) L stated R71 had refused showers and if a resident refused a shower staff have them sign a bathing sheet, then offer on a different day. On 03/19/25 at 03:05 PM, Administrative Nurse D stated R71 refused baths, and administration had recently employed a bath aide. Administrative Nurse D stated if a resident refused a bath, staff should offer other forms of bathing. The facility's Bathing a Resident Policy, implemented 03/19/25, documented it was the practice of the facility to assist residents with bathing to maintain proper hygiene and help prevent skin issues. The facility failed to provide R71 provide bathing on a regular basis. This deficient practice placed the resident at risk for poor personal hygiene. The facility had a census of 130 residents. The sample included 27 residents, with 15 reviewed for bathing. Based on observation, record review, and interview, the facility failed to provide consistent bathing for seven sampled residents, Resident (R) 48, R99, R117, R125, R71, and R121. This placed the residents at risk for poor hygiene. Findings included: - The Electronic Medical Record (EMR) for R48 documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion) without behavioral disturbance, depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), hypertension (high blood pressure), and chronic kidney disease (the kidneys are damaged and can't filter blood as well as they should) stage three. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The admission Minimum Data Set (MDS), dated [DATE], documented R48 had severely impaired cognition. R48 required partial assistance from staff for toileting hygiene, dressing, and personal hygiene, and R48 refused showers. The Quarterly MDS, dated 02/14/24, documented R48 had severely impaired cognition. R48 required set-up assistance from staff for eating, oral hygiene, toilet hygiene, and partial assistance with bathing. R48's Care Plan, dated 01/28/25, initiated on 12/24/24, documented R48 often refused bathing/showers and directed staff to continue to offer and remind her of the importance of hygiene. R48 could request a bath or shower at any time and staff would do their best to accommodate her. Staff were directed to offer R48 wash clothes and soapy water for sponge bathing if she continued to refuse a bath or shower. The January 2025 Bathing and Facility Bathing Sheets, documented R48 had requested showers on Monday and Thursday dayshift and documented R48 had not received a bath or shower during the following days from 01/10/25 through 01/31/25 (22 days). The EMR documented R48 refused her baths on 01/16/25, 01/20/25, 01/23/25, 01/27/25, and 01/30/25 and was not offered other bathing alternatives or different times to take a bath or shower. The February 2025 Bathing and Facility Bathing Sheets, documented R48 had requested showers on Monday and Thursday dayshift and documented R48 had not received a bath or shower during the following days from 02/01/25 through 02/28/25 (28 days). The EMR documented R48 refused her baths on 02/03/25, 02/06/25, 02/10/25, 02/17/25, 02/20/25, 02/24/25, 02/27/25 and was not offered other bathing alternatives or different times to take a bath or shower. The March 2025 Bathing and Facility Bathing Sheets, documented R48 had requested showers on Monday and Thursday dayshift and documented R48 had not received a bath or shower during the following days from 03/01/25 through 03/18/25 (18 days). The EMR documented R48 refused her baths on 03/03/25, 03/10/25, 03/13/25, and 03/17/25 and was not offered other bathing alternatives or different times to take a bath or shower. On 03/18/25 at 09:15 AM, R48 had on a gray top and pants, her hair was greasy and slicked back out of her face. On 03/19/25 at 08:52 AM, R48 had on the same gray top and pants as the previous day, her hair was greasy and slicked back out of her face. On 03/18/25 at 08:00 AM, Certified Nurse Aide (CNA) M stated if R48 refused her shower, they try again later. CNA M further stated shower sheets were filled out and given to the charge nurse. On 03/19/25 at 12:00 PM, Licensed Nurse (LN) H stated some residents refused and would get angry with staff. R48 was more independent, and she would wash her face and armpits but was unsure if her perineal area was being washed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/19/25 at 2:55 PM, Administrative Nurse D stated she expected staff to follow R48's care plan and to offer her a washcloth so she could wash up. Administrative Nurse D further stated there should be follow-up documentation of the attempts taken to give her a shower. The facility's Bathing a Resident policy, dated 03/19/25, documented the facility assisted the residents with bathing to maintain proper hygiene and help in the prevention of skin issues. The policy directed staff to assist the residents with showering as needed and have the residents participate as much as possible. Staff were to provide clean washcloths to cleanse the perineal area. The facility failed to provide consistent bathing for cognitively impaired R48. This placed her at risk for poor hygiene. - The Electronic Medical Record (EMR) for R99 documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), atrial fibrillation (rapid, irregular heartbeat), adult failure to thrive (includes not doing well, feeling poorly, weight loss, and poor self-care that could be seen in elderly individuals), and chronic obstructive pulmonary disease (COPD - a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing). The Annual Minimum Data Set (MDS), dated [DATE], documented R99 had severely impaired cognition. R99 required supervision with eating, oral hygiene, and toileting hygiene. R99 was dependent upon staff for bathing. The Quarterly MDS, dated 01/28/25, documented R99 had severely impaired cognition. R99 required substantial assistance with dressing and personal hygiene. R99 was dependent upon staff for bathing. R99's Care Plan, dated 01/07/25, initiated on 12/24/24 documented R99 often refused bathing/showers and directed staff to continue to offer and remind her of the importance of hygiene. R99 could request a bath or shower at any time and staff would do their best to accommodate her. Staff were directed to offer R99 wash clothes and soapy water for sponge bathing if she continued to refuse a bath or shower. The March 2025 Bathing and Facility Bathing Sheets, documented R99 had requested showers on Tuesday and Friday dayshift and documented R99 had not received a bath or shower during the following days from 03/01/25 through 03/18/25 (18 days). The EMR documented R99 refused her shower on 03/04/25 and 03/07/25. R99 was not offered other bathing alternatives or different times to take a bath or shower. On 03/19/25 at 08:46 AM, for three of three days onsite, R99 had on the same purple sweatshirt and gray pants. R99's hair was smashed down to the back of her head, and not combed. On 03/18/25 at 08:00 AM, Certified Nurse Aide, (CNA) M stated if R99 refused her shower, they try again later. CNA M further stated shower sheets are filled out and given to the charge nurse. On 03/19/25 at 12:00 PM, Licensed Nurse (LN) H stated some residents refused, would get angry with staff, and staff would try again later. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/19/25 at 2:55 PM, Administrative Nurse D stated she expected staff to follow R99's care plan. Administrative Nurse D further stated there should be follow-up documentation of the attempts taken to give her a shower. The facility's Bathing a Resident policy, dated 03/19/25, documented the facility assisted the resident with bathing to maintain proper hygiene and help in the prevention of skin issues. The policy directed staff to assist the resident with showering as needed and have the resident participate as much as possible. Staff were to provide clean washcloths to cleanse the perineal area. The facility failed to provide consistent bathing for cognitively impaired R99. This placed her at risk for poor hygiene. - The Electronic Medical Record (EMR) for R117 documented diagnoses of vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and epilepsy (brain disorder characterized by repeated seizures). The Annual Minimum Data Set (MDS), dated [DATE], documented R117 had severely impaired cognition. R117 was dependent upon staff for all activities of daily living (ADL). R117 was always incontinent of bladder and bowel. The Quarterly MDS, dated 01/14/25, documented R117 had severely impaired cognition. R117 was dependent upon staff for all ADLs. R117 was always incontinent of bladder and bowel. R117's Care Plan, dated 01/20/25, initiated on 02/07/24, documented R 117 often refused bathing/showers and directed staff to continue to offer and remind her of the importance of hygiene. R 117 could request a bath or shower at any time and staff would do their best to accommodate her. Staff were directed to offer R117 washcloths and soapy water for sponge bathing if she continued to refuse a bath or shower. The February 2025 Bathing and Facility Bathing Sheets, documented R117 had requested showers on Sunday and Thursday dayshift and documented R117 had not received a bath or shower from 02/07/25 through 02/19/25 (13 days). The EMR lacked documentation R117 refused her shower and lacked documentation R117 was not offered other bathing alternatives or different times to take a bath or shower. On 03/18/25 at 07:40 AM, R117's hair was uncombed, disheveled, and in her face. On 03/18/25 at 08:00 AM, Certified Nurse Aide (CNA) M stated if R117 refused her shower, they try again later. CNA M further stated shower sheets are filled out and given to the charge nurse. On 03/19/25 at 12:00 PM, Licensed Nurse (LN) H stated some residents refused, would get angry with staff, and staff would try again later. On 03/19/25 at 2:55 PM, Administrative Nurse D stated she expected staff to follow R117's care plan. Administrative Nurse D further stated there should be follow-up documentation of the attempts taken to give her a shower. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Bathing a Resident policy, dated 03/19/25, documented the facility assisted the resident with bathing to maintain proper hygiene and help in the prevention of skin issues. The policy directed staff to assist the resident with showering as needed and have the resident participate as much as possible. Staff were to provide clean washcloths to cleanse the perineal area. The facility failed to provide consistent bathing for cognitively impaired R117. This placed her at risk for poor hygiene. - The Electronic Medical Record (EMR) for R125 documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), hyperlipidemia (condition of elevated blood lipid levels), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). The admission Minimum Data Set (MDS), dated [DATE], documented R125 had severely impaired cognition. R125 required set-up assistance from staff for eating, dressing, personal hygiene, and supervision with showers. R125's Care Plan, dated 01/28/25, initiated on 12/24/24, documented R125 often refused bathing/showers and directed staff to continue to offer and remind her of the importance of hygiene. R125 could request a bath or shower at any time and staff would do their best to accommodate her. Staff were directed to offer R125 washcloths and soapy water for sponge bathing if she continued to refuse a bath or shower. The February 2025 Bathing and Facility Bathing Sheets, documented R125 had requested showers on Thursday and Sunday dayshift and documented R125 had not received a bath or shower from 02/07/25 through 02/28/25 (22 days). The EMR lacked documentation refused her shower and lacked documentation R125 was not offered other bathing alternatives or different times to take a bath or shower. On 03/18/25 at 07:27 AM, R125 wore the same shirt as the day before and her hair was greasy with white, flaky substance throughout her hair. On 03/18/25 at 08:00 AM, Certified Nurse Aide, (CNA) M stated if R125 refused her shower, they try again later. CNA M further stated shower sheets are filled out and given to the charge nurse. On 03/19/25 at 12:00 PM, Licensed Nurse (LN) H stated some residents refused, would get angry with staff, and staff would try again later. On 03/19/25 at 2:55 PM, Administrative Nurse D stated she expected staff to follow R125's care plan. Administrative Nurse D further stated there should be follow-up documentation of the attempts taken to give her a shower. The facility's Bathing a Resident policy, dated 03/19/25, documented the facility assisted the resident with bathing to maintain proper hygiene and help in the prevention of skin issues. The policy directed staff to assist the resident with showering as needed and have the resident participate as much as possible. Staff were to provide clean washcloths to cleanse the perineal area. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility failed to provide consistent bathing for cognitively impaired R125. This placed her at risk for poor hygiene. - Resident (R) 121's Electronic Medical Recorded (EMR) documented diagnoses of cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), spastic hemiplegia (paralysis of one side of the body) affecting the nondominant side, dysphagia (swallowing difficulty), cognitive-communication deficit (an impairment in the organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), and difficulty in walking. The admission Minimum Data Set (MDS), dated [DATE], documented that R121 had intact cognition, felt down, depressed, and hopeless, and social isolation. R121 had no signs or symptoms of delirium (sudden severe confusion, disorientation, and restlessness), psychosis (any major mental disorder characterized by a gross impairment in reality perception), or exhibited behaviors. R121 had a functional range of motion impairment of one side upper extremity, was dependent on toileting, and lower body dressing, and required substantial/maximal assistance with mobility. The resident had frequent incontinence of urine. The MDS further documented that R121 had occasional mild pain and two non-injury falls since admission. The resident received speech, occupational, and physical therapy. The Functional Abilities Care Area Assessment (CAA), dated 06/29/24, documented R121 had been admitted following hospitalization with a diagnosis of cerebral infarction, requiring assistance of one to two staff members for activities of daily living and transfers, worked with physical and occupational therapies for strengthening and returning to his prior level of function. He used a wheelchair for mobility. The Quarterly MDS, dated 01/15/25, document R121 had intact cognition, had mood score of 01 with feeling down, depressed, or hopeless and socially isolated. The resident exhibited no delirium, psychosis, or behaviors. The MDS further documented R121 was dependent with toileting, bathing, upper and lower body dressing, and required substantial/maximal assistance with mobility. R121 was always incontinent of urine and bowel, had pain frequently which occasionally interfered with day-to-day activities, and had one non-injury fall. The Care Plan dated 06/21/24, documents R121 needed assistance with Activities of Daily Living (ADL) related to cerebral infarction and would like to shower on Wednesday and Sunday evenings, the care plan further instructed staff R121 required substantial/maximal assistance with his bathing task. On 03/17/25 at 10:38 AM, R121 looked disheveled and unshaven reporting it had been a while since his last bath/shower, and he would like them more frequently. Upon review of January 25, February 25, and up to 03/17/2025 bathing records revealed R121 had only received a bath on 01/08/25 and 01/22/25, but lacked bathing for February 25, and refused a bath on 03/12/2025. On 03/18/25 at 08:01 AM, Certified Nurse Aide (CNA) MM stated the resident who has a bath during the shift would show up on the dashboard of the computerized medical record, they check when they come to work. CNA MM reported the bath aide or the staff assigned to the hall were to give baths and if the resident refused a bath, they were to offer a different type of bath like a bed bath before recording the resident refusal. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/19/25 at 03:20 PM, Administrative Nurse D stated the facility's implementation of a bath aide to the nursing schedule. Administrative Nurse D verified the nurse aides assigned to the hall were also to give baths for the assigned days. The nursing staff were to offer alternative bathing options if the resident refused before recording if the resident refused. Upon request, the facility failed to provide a bathing policy. The facility failed to provide R121 assistance with bathing, which placed the resident at risk for poor hygiene.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 130 residents. The sample included 27 residents, with five residents sampled for assessments, interventions placed timely, and follow-up for Resident (R) 35, R117, R128, R142, and R13. This placed the residents at risk for lack of quality of care. Findings included: - R35's Electronic Medical Record (EMR) documented R35 had diagnoses of cerebral infarction (stroke - the sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), atrial fibrillation (rapid, irregular heartbeat), and gastrostomy tube (G-tube - tube surgically placed through an artificial opening into the stomach). R35's Quarterly Minimum Data Set (MDS), dated [DATE], documented R35 had. The MDS documented R9 required extensive staff assistance with short and long-term memory problems and severely impaired cognition. The MDS documented R35 dependent on staff assistance with activities of daily living (ADL). The MDS documented R35 received 51% of total calories and fluid intake through tube feedings. R35's Care Plan, dated 03/09/25, documented R35 was dependent on staff with ADLs. The plan documented R35 required tube feedings and instructed staff to check for tube placement and gastric contents/residual (the amount of fluid or contents remaining in the stomach after a feeding) volume per facility protocol, record findings, and hold feeding if the residual was greater than 60 cubic centimeters (cc). The plan instructed staff to monitor, document, and report as needed (PRN) any signs or symptoms of fever, tube dislodged, infection at tube site, abnormal breath/lung sounds, abnormal lab values, abdominal pain, and distension. The Nurse's Note dated 01/17/25 at 02:30 PM documented the resident being hospitalized . The Progress Note dated 01/22/25 at 07:55 PM documented Social Service Staff X e-mailed the discharge transfer and bed hold form to a family member. The EMR lacked a nurse assessment or note regarding why or when the resident was discharged to the hospital. The Nutrition/Dietary Note dated 1/24/2025 at 12:15 PM documented R35 readmitted from the hospital. On 03/17/25 at 03:50 PM, R35 rested quietly in bed with eyes closed. On 03/19/25 at 03:05 PM, Administrative Nurse D stated she would expect the nurse to complete an interactive transfer form in the progress notes, which addressed an assessment of the resident before transferring a resident to the hospital. The facility's Transfer and Discharge Policy, revised 01/09/24, documented for emergency transfers, and discharges, staff would document resident assessment findings and other relevant information regarding the transfer in the medical record. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility staff failed to document R35's assessment with relevant information regarding her transfer to the hospital on [DATE]. This placed R35 at risk for lack of quality of care.- The Electronic Medical Record (EMR) for R117 documented diagnoses of vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and epilepsy (brain disorder characterized by repeated seizures). The Annual Minimum Data Set (MDS), dated [DATE], documented R117 had severely impaired cognition. R117 was dependent upon staff for all activities of daily living (ADL). R117 had upper one-side functional impairment and had no skin issues. The Quarterly MDS, dated 01/14/25, documented R117 had severely impaired cognition. R117 was dependent upon staff for all ADLs. R117 had lower functional impairment on both sides and had no skin issues. R117's Care Plan, dated 01/20/25, initiated on 08/05/23, documented R117 was at risk for alterations in skin integrity and directed staff to educate R117 and her family about the causes of skin breakdown. The staff were directed to encourage R117 to report any pain with repositioning, were pressure relief boots as tolerated, obtain a low air loss mattress, and provide treatment as ordered. The care plan lacked direction to staff on interventions to prevent skin tears and bruises. On 03/18/25 at 09:20 AM, observation revealed R117 had a red, bloody area on her left forearm. The area had a clear bandage on top of it that wrapped around the inner aspect of her forearm. R117's EMR lacked documentation of an assessment of the area or a description of what caused the area. On 03/18/25 at 09:25 AM, Licensed Nurse G stated R117 she was unsure what happened to R117's arm but stated, R117 often scratched herself and that the area had been there for a couple of days. On 03/18/25 at 09:30 AM, Administrative Staff A stated he was unable to find an assessment or paperwork regarding the skin tear. Administrative Staff A had talked with LN G who was aware of the skin tear and an assessment would be completed and the physician notified. On 03/19/25 at 02:55 PM, Administrative Nurse D stated staff should complete skin assessments when there are skin tears or bruises. The facility's Skin Assessment, policy, dated 03/19/25, documented, that the policy of the facility was to perform a thorough examination of the resident's skin, looking for any skin conditions Staff are to pay close attention and note any skin conditions such as redness, bruising, rashes, skin tears, blisters, open areas, ulcers, and lesions. The policy directed staff to document observations of the skin condition, type of wound, description of wound, and any other information as indicated or appropriate. The facility failed to identify, assess, and implement interventions to prevent skin tears for R117, who obtained a skin tear to her left forearm. This placed the resident at risk of further injury. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- The Electronic Medical Record (EMR) documented R128 was admitted into the facility on [DATE] with Hospice- specialized care that mainly aims to provide comfort and dignity to the patients, by providing physical comfort and emotional, social, and spiritual support for people nearing the end of life.) services. R128 had diagnoses of diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin) type two, hypertension (high blood pressure), and bradycardia (low heart rate, less than 60 beats per minute). A Minimum Data Set was not completed as R128 was only in the facility two days before he transferred out of the facility. The EMR lacked an admission nursing assessment as well as any nursing assessments, including a baseline care plan, prior to his discharge from the facility on 02/22/25 On 03/12/25 at 0:39 AM, Administrative Nurse D verified she was unable to find any nursing assessment or nursing documentation related to R128's care while in the facility. Administrative Nurse D stated the nurse on duty, Licensed Nurse (LN) GG, was a new nurse and did not understand that she needed to document everything. Administrative Nurse D was unable to provide a reason that the EMR lacked any nursing assessments or documentation of care provided while R128 was in the facility. On 03/19/25 at 11:28 AM, Licensed Nurse (LN) I stated nursing assessments were completed upon admission, and for at least every shift for the first three days. LN I verified there were no nursing assessments in the EMR for R128. The facility's admission of a Resident policy, dated 02/01/20, documented the admission process was intended to obtain all the information possible about the resident, for the development of comprehensive plans of care, and to assist the resident in becoming comfortable with the facility. Residents are admitted to the facility under the orders of the attending physician. The facility failed to obtain a nursing admission assessment and obtain the necessary nursing assessment to provide care and services for R128. This placed R128 at risk for inappropriate care and decline. - The Electronic Medical Record (EMR) for R142 documented diagnoses of epilepsy (brain disorder characterized by repeated seizures), dementia (a progressive mental disorder characterized by failing memory and confusion), obsessive-compulsive disorder (OCD - an anxiety disorder characterized by recurrent and persistent thoughts, ideas, and feelings of obsessions severe enough to cause marked distress, consume considerable time, or significantly interfere with the resident's occupational, social, or interpersonal functioning), and depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). The Annual Minimum Data Set (MDS), dated [DATE], documented R142 had severely impaired cognition. R142 was dependent upon staff for all activities of daily living (ADL). R142 had upper and lower functional impairment on both sides, was short of breath when lying flat, and was always incontinent of bladder and bowel. The Quarterly MDS, dated 11/30/24, documented R142 had moderately impaired cognition. R142 was dependent upon staff for all ADLs. R142 had upper and lower functional impairment on both sides, was short of breath when lying flat, and was always incontinent of bladder and bowel. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R142's Care Plan, dated 11/20/24, initiated on 02/15/22, documented R142 was prescribed medication for her seizure disorder. Staff were directed to monitor for seizure activity, frequency, duration, and type. The staff were directed to monitor for anxiety (anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), drowsiness, and lethargy (lack of energy and motivation). Take medication as ordered, and monitor labs as ordered by the physician. The Hospital Transfer Form, dated 02/10/24 at 07:00 AM, documented R142 was transferred to the hospital for abnormal pulse oximetry (low oxygen saturation). Her vital signs (clinical measurements that indicate the state of the patient's essential body functions) were blood pressure (the pressure of the blood in the system), 118/67 millimeters of mercury (mmHg), heart rate was 110 beats per minute (bpm), oxygen saturation (percentage of oxygen in the blood) 74% (normal range is 95-100%). Review of the EMR lacked documentation of any nursing assessments prior to R142's discharge to the hospital or at the time of discharge. On 03/12/25 at 09:30 AM, Administrative Nurse D stated there had been some staffing changes related to the nurses that had been on duty for this resident. Administrative Nurse D further stated the nurse on duty when R142 went to the hospital was a new nurse and was unsure about what to document in the EMR. Administrative Nurse D further stated she thought R142 had been having respiratory issues and that there should have been nursing assessments on the resident. The facility's Transfer and Discharge (including AMA) policy, dated 02/01/20, documented that if the transfers were initiated by the facility for medical reasons, or the immediate safety and welfare of a resident, they would obtain a physician order, notify the family, and contact an ambulance service. The resident's current status, including baseline and current mental, behavioral, and functional status and recent vital signs. The facility would document assessment findings and other relevant information regarding the transfer in the medical record. The facility failed to document in the EMR, any nursing assessments prior to her hospital discharge, this placed R142 at risk for physical decline.- R13's Electronic Medical Record (EMR) documented an admission to the facility on [DATE] with diagnoses of fracture (broken bone) of the third lumbar vertebrae (spine bone), unsteadiness on the feet, and congestive heart failure (CHF - a condition with low heart output and the body becomes congested with fluid). R13's admission Minimum Data Set (MDS) was still in progress. R13's Care Plan initiated on 02/26/25 directed staff that she was a full code. Staff was directed to review the discharge plan quarterly in the care plan meetings. Staff were directed to assist with the goal of going home. R13's care plan lacked staff direction for her activities of daily living (ADL). R13's care plan lacked staff direction for care regarding her care for her vertebrae fracture. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A hospital Discharge Summary dated 02/26/25 documented R13 had been admitted to the hospital on [DATE] after sustaining a closed compression fracture (occurs when one or more bones in the spine weaken and crumple) of the lumbar third (L3) vertebrae after a fall and hitting her back. Neurosurgery was consulted and placed a thoracic-lumbar-sacral orthosis (TLSO a brace that limits movement in your spine from the mid back to your tailbone) brace with recommendations to wear the brace when she was out of bed. Physical therapy and occupational therapy evaluation and therapy to be provided to maintain functional mobility. An inpatient post-acute setting is recommended. Patient to follow up with a physician in seven days following discharge and with neurosurgery in 12 weeks. R13's Order Summary documented an order dated 02/27/25 for physical therapy (PT) clarification order: PT to evaluate and treat five to seven times a week for 30 days. Treatment may include therapeutic exercises, therapeutic activities, neuromuscular reeducation, gait, and group therapy. R13's Order's tab of the EMR reviewed on 03/18/25 lacked a physician's order on admission for a back brace or instructions for its application and removal. On 03/17/25 at 02:17 PM, R13 sat in her wheelchair in her room. In the chair beside R13 was some sort of back brace. R13 stated she was supposed to wear the brace because she had a fracture to one of her bones in her spine. R13 stated she did not like to wear the brace. On 03/18/25 at 08:43 AM, R13 sat in her wheelchair at the dining table and had a back brace on. On 03/19/25 at 12:33 PM, Licensed Nurse (LN) J stated R13 has had the brace since she was admitted and was told she was to wear it when she was out of bed. LN J stated there should be an order or mention of the brace in the care plan. LN J could not say for certain without looking in R13's chart if there was in fact an order for the brace or if R13's care plan had staff direction for the use of the brace. On 03/19/25 at 02:53 PM, Administrative Nurse D stated R13 has had the brace since her admission and would expect there to be an order for the brace. Administrative Nurse D stated she would expect R13's care plan to reflect her lumbar fracture and the need for staff to put on and take off the brace. The facility policy admission of a Resident implemented on 02/01/20 documented that the admission process was intended to obtain all the information possible about the resident, for the development of comprehensive plans of care, and to assist the resident in becoming comfortable in the facility. Residents were admitted to the facility under the orders of the attending physician. The facility failed to ensure staff entered R13's physician's order for her TLSO back brace and included instructions on when to put it on and when to remove the brace. This placed R13 at risk of unmet goals and delays in her recovery.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 130 residents. The sample included 27 residents, with four sampled residents reviewed for pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, as the result of pressure, or pressure in combination with shear and/or friction). Based on observation, record review, and interview, the facility failed to ensure interventions were in place and implemented for Resident (R) 78 to prevent skin breakdown which resulted in an avoidable pressure ulcer development. This deficient practice placed R78 at risk for complications and possible infection-associated pressure wounds. Findings included: - R78 ' s Electronic Medical Record (EMR) documented diagnoses of atrial fibrillation (A-Fib rapid, irregular heartbeat), congestive heart failure (CHF - a condition with low heart output and the body becomes congested with fluid), embolism (an obstruction in a blood vessel due to a blood clot or other foreign matter that gets stuck while traveling through the bloodstream), and thrombosis (a clot that develops within a blood vessel) of lower extremities. R78 ' s admission Minimum Data Set (MDS) dated 02/09/25 documented both short and long-term memory problems. R78 had moderately impaired cognitive skills for daily decision-making. R78 had impairment on both sides of his upper extremity. R78 required a wheelchair for mobility. R78 was dependent on staff for all functional abilities. R78 was always incontinent of bowel and bladder. R78 was at risk of pressure ulcer development. R78 had no pressure ulcers on admission. R78 had a pressure-reducing device for the bed. R78 had application ointments and medications other than to feet. R78 ' s Pressure Ulcer Care Area Assessment (CAA) dated 03/01/25 documented pressure ulcers would be addressed in R78 ' s care plan. Staff were to assist with repositioning per protocol and as needed to help maintain skin integrity. Licensed nursing staff were to monitor skin integrity every week to help monitor for any skin issues. Incontinence creams were to be used as needed to help maintain skin integrity. A pressure redistributing surface was in place to the resident ' s bed and to the wheelchair to help maintain skin integrity. R78 ' s Care Plan dated 02/08/25 directed staff to educate family, and caregivers of causative factors and measures to prevent skin injury. Staff were directed to encourage good nutrition and hydration to promote healthier skin. Staff were directed that R78 preferred to bathe and shower on Wednesday and Saturday evenings. R78 ' s care plan had not been updated and revised to direct staff on his wound care or how much assistance R78 required from staff. R78 ' s Orders tab of the EMR documented an order dated 02/07/25 for weekly skin assessments by the licensed nurse. Document findings on the weekly skin UDA every Thursday. The Orders tab documented an order dated 02/28/25 for comfort border foam dressing to the right buttock wound. Change twice daily and as needed. R78 ' s Braden Scale Pressure for Predicting Pressure Sore Risk (a tool used to assess the risk of developing a pressure ulcer) admission assessment dated [DATE] documented a score of nine that indicated a high risk of pressure ulcer development. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R78 ' s ' Weekly Skin Check under the Assessment tab of the EMR revealed skin checks had been completed on 02/12/25, 02/19/25, 02/20/25, 02/27/25, 02/28/25, and 03/06/25. R78 ' s Weekly Skin Check under the Assessments tab dated 02/28/25 documented a new skin issue, pressure related to the right buttock. The skin check lacked any documentation of the skin area characteristics or measurements. R78 ' s Skin/Wound Note under the Progress Notes tab of the EMR dated 02/28/25 at 02:40 PM documented R78 had an open area to the right buttock noted. The area was cleansed and venelex (an ointment used to treat skin wounds) was applied and covered with a border foam dressing. The nurse practitioner and R78 ' s spouse was notified. R78 was seen by the Advance Practice Registered Nurse (APRN) on 03/03/25, 03/10/25, 03/13/25, and 03/17/25, but the provider failed to address R78 ' s pressure wound. A Wound Evaluation completed on 03/19/25 under the Skin and Wound tab of the EMR documented a Stage 3 (a full-thickness pressure injury extending through the skin into the tissue below) pressure ulcer. The wound measured a length of 4.33 centimeters (cm), width of 1.51 cm, depth of 0.1 cm, and total area of 5.01 cm squared. This evaluation was the first time the wound had been measured. On 03/18/25 at 09:42 AM, R78 laid in bed as nursing staff prepared the resident for care. On 03/19/25 at 10:30 AM, Certified Nurse [NAME] (CNA) O stated the aides were to look over the resident ' s skin when each bath was given. CNA O stated if any skin changes were found it was to be noted on the shower sheet, and the nurse notified immediately. CNA O stated the resident's care plan should list any care for the resident or if cream should be applied. On 03/19/25 at 12:33 PM, Licensed Nurse (LN) J stated a R78 ' s care plan should have staff direction for skin issues and how much assistance was needed for the resident. R78 was dependent on staff for his care. LN J stated the unit manager or the MDS coordinator was who updated orders and the care plan when new issues arose. LN J stated she had not known there were no interventions in place to address R78 ' s pressure ulcer care. LN J stated she did do the daily dressing changes on R78. LN J stated that R78 did have a wound on his bottom that had just opened a few days ago. LN J stated the wound nurse had seen R78 today. On 03/19/25 at 12:50 PM, LN I stated she and the unit manager had gotten behind on getting the care plans and MDSs updated lately. LN I stated a resident's care plan should be updated with any new interventions. R78 ' s care plan should have interventions in place for his wound, but they had not been added yet. On 03/19/25 at 02:53 PM, Administrative Nurse D stated she would expect that a resident would have interventions in place and revised for a resident that had pressure wounds. Administrative Nurse D stated the staff that updated the care plans had gotten a little behind on getting them updated, or completed since those staff had been helping on the floor. Administrative Nurse D would expect that staff had been doing weekly skin assessments and making sure that measurements had been recorded for those wounds. Administrative Nurse D stated she would speak with staff to ensure a resident got the care needed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Pressure Injury Prevention and Management policy implemented 03/19/25 documented the facility shall establish and utilize a systematic approach for pressure injury prevention and management, including prompt assessment and treatment; intervening to stabilize, reduce, or remove underlying risk factors; monitoring the impact of the interventions; and modifying the interventions as appropriate. Licensed nurses would conduct a pressure injury risk assessment on all residents upon admission/re-admission, weekly for four weeks, then quarterly or whenever the resident ' s condition changed significantly. Findings would be documented in the medical record. Assessments of the pressure injuries would be performed by a licensed nurse and documented. The staging of pressure injuries would be clearly identified to ensure correct coding on the MDS. After completing a thorough assessment, the interdisciplinary team (IDT) shall develop a relevant care plan that included measurable goals for the prevention and management of pressure injuries with appropriate interventions. The unit manager would review relevant documentation regarding skin assessments and document a summary of findings in the medical record. The attending physician would be notified of the presence of the new injury, and the progression toward healing weekly. The facility failed to ensure interventions were put in place and implemented to prevent the avoidable development of R78 ' s Stage 3 pressure ulcer on his buttock. This deficient practice placed R78 at risk of complications and possible infection.

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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. The facility identified a census of 130 residents. The sample included 27 residents with two sampled residents reviewed for respiratory care. Based on observation, record review, and interview, the facility failed to ensure that Resident (R) 346 had a physician's order for supplement oxygen (O2) therapy. The facility failed to ensure staff monitored and documented the effectiveness of R346's supplemental O2. The facility failed to ensure R346's nasal cannula (NC - a thin hollow tube that assists in providing supplemental eO2) was appropriately stored when not used. This deficient practice placed R346 at risk of respiratory complications and possible infection. Findings included: - R346's Electronic Medical Record (EMR) recorded an admission dated 03/01/25 and documented diagnoses of end-stage renal disease (ESRD - when the kidney lose their ability to function and filter waste and excess fluid from the blood), congestive heart failure (CHF - a condition with low heart output and the body becomes congested with fluid), and respiratory failure (inadequate gas exchange by the respiratory system). R346's admission Minimum Date Set (MDS) had not been completed yet due to her admission dated 03/01/25. R346's Care Plan initiated on 03/03/25 lacked a care area for O2 therapy. R346's Orders tab of the EMR reviewed on 03/18/25 lacked a physician's order for supplemental oxygen. R346's Treatment Administration Record (TAR) lacked staff direction to check and monitor R346's O2 saturation level each shift. On 03/17/25 at 12:05 PM, R346 laid in bed resting. R346 had NC in her nose. An O2 concentrator (a machine that provides supplemental oxygen) was in her room and turned on. The wheelchair in her room had an oxygen canister on the back of it. An NC was connected to the canister but was not stored in a bag. On 03/18/25 at 09:15 AM, R346 laid in her bed, had NC in her nose. On 03/19/25 at 10:30 AM Certified Nurse Aide (CNA) O stated the O2 cannula should be stored in a bag when not in use. On 03/19/25 at 12:33, Licensed Nurse (LN) J stated if a resident was on O2 there should be an order for it in the EMR and the saturation levels should be monitored each shift. R346's order might not have been re-entered when she had come back from the hospital. On 03/19/25 at 12:50 PM, Licensed Nurse (LN) I stated she had put in R346's orders when she returned from her hospital visit and she must have overlooked that she omitted getting the O2 order put in. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/19/25 at 02:53 PM, Administrative Nurse D stated any resident that received supplemental oxygen needed an order to have it. Administrative Nurse D stated staff should be monitoring the O2 saturation level each shift. Administrative Nurse D could not state why R346 did not have the order for her O2 entered in the EMR. The Medication Orders policy implemented on 01/01/20 documented that medications should be administered only upon the signed order of a person lawfully authorized to prescribe. Elements of the medication order were the date and time the order was written; the resident's full name; the name of the medications; the dosage-strength of the medicated; the time or frequency of administration; type/formulation (if applicable); the hour of administration; and the diagnosis or indication for use. Each medication order should be documented with the date, time, and signature of the person receiving the order. The order should be recorded on the physician's order sheet, and the Medication Administration Record (MAR). The facility that R346 had a physician's order for supplemental O2. The facility failed to ensure staff monitored and documented the effectiveness of R346's supplemental O2. The facility failed to ensure R346's NC was appropriately stored when not used. This deficient practice placed R346 at risk of respiratory complications and possible infection.

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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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. The facility had a census of 130 residents. The sample included 27 residents. Based on observation, record review, and interview, the facility failed to ensure Resident (R) 295 who received care and services for dialysis (a procedure where impurities or wastes were removed from the blood), was consistent with professional standards of practice, which included ongoing assessments of residents' condition, communication, and collaboration with the dialysis facility. This placed R295 at risk of complications and unmet care needs related to dialysis treatment. Findings included: - The Electronic Medical Record (EMR) for R295 documented diagnoses of fracture (broken bone)of the left tibia (bone of the lower leg), arteriovenous fistula (AV - a surgically created connection between an artery and a vein), dependence on renal (pertaining to kidneys) dialysis, end-stage renal disease, bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) disorder. The Minimum Data Set (MDS) had not been completed due to recent admission had not met the criteria for completion or submission. R295's Baseline Care Plan, dated 03/12/25, lacked documentation regarding R295 dialysis process or directed staff of care. The Physician Orders lacked orders for dialysis. The Progress Notes lacked documentation of the need or participation in the dialysis process. On 03/18/25 at 07:43 AM, Certified Medication Aide (CMA) S reported that R295 went to dialysis on Mondays and Fridays. On 03/18/25 at 08:29 AM, R295 stated she had been at the facility for over three weeks and went to dialysis on Mondays and Fridays. R295 stated the facility staff had not assessed the AV shunt when returning to the facility following dialysis treatment. R295 also reported the facility had not sent a communication sheet with her to dialysis. On 03/18/25 at 08:39 AM, Licensed Nurse (LN) K reported not working on Mondays and Fridays. LN K stated dialysis residents' vital signs, changes of condition, or medications to be sent were on a communication sheet with a resident who received dialysis treatments. LN K was unable to locate any dialysis communication for R295. On 03/19/25 at 03:15 PM, Administrative Nurse D stated dialysis residents should have assessments before and after dialysis treatments and a communication sheet should accompany the resident at each treatment and verified this had not been completed for R295. Administrative Nurse D stated that R295's care plan should reflect R295's dialysis with directions for care. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Hemodialysis policy, dated 03/19/25, documented the facility will ensure that each resident receiving care and services for the services for the provision of hemodialysis is consistent with professional standards of practice. This would include ongoing assessment and oversight of the resident before, during, and after dialysis treatments, including monitoring of the resident's condition during treatments, monitoring for complications, implementation of appropriate interventions, and using appropriate infection control practices, with ongoing communication and collaboration with the dialysis facility regarding dialysis care and services. The facility failed to provide care and services consistent with professional standards of practice which included ongoing assessment of condition, communication, and collaboration with the dialysis treatment center. This placed R295 at risk for complications and unmet care needs related to dialysis treatment.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. The facility had a census of 130 residents. The sample included 27 residents. Based on observation, record review, and interview, the facility failed to ensure adequate daily nursing staff were always available to meet the needs of the residents who resided in the facility. Findings included: - The Facility Assessment, revised 12/19/24, documented staffing needs and assignments vary based on the census and acuity level of the resident in the facility. Resident preference additional staffing during certain times as indicated and as available per resident preferences. The facility would designate consistent hall assignments for individual staff as able to ensure continuity of care. Full-time staff would work weekend days as well as weekdays to ensure continuity of care throughout the week. Review of the nursing daily staffing schedules from 12/01/24 to 03/18/25 revealed numerous slots in the schedule with open in app in different halls at different times for nurses, certified nurse aides (CNA), and certified medication aides (CMA). The schedules lacked documentation these slots were filled with another staff member. 03/19/25 at 07:37 AM, CMA T stated she was responsible for completing the facility's daily nursing staffing. CMA T stated if she is not on duty in the facility and staff call in, or do not show up, or there is a need for nursing staff the charge nurse or Administrative Nurse D would call or text staff to replace them. Sometimes they fail to add the replacement staff to the schedules. 03/19/25 at 02:50 PM, CMA RR she was usually scheduled as administrating medications but must help CNAs because the facility is short-staffed 50% of the time. Upon request, the facility failed to provide a staffing policy. The facility failed to ensure adequate nursing staff was available daily to meet the needs of the residents who resided in the facility. This placed the 130 residents at risk of waiting a long time for their needs.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. The facility had a census of 130 residents. The sample included 27 residents. Based on observation, record review, and interview, the facility failed to provide an accurate reconciliation of controlled drugs during the daily work shift. This placed residents at risk for misappropriation of medication by staff. Findings included: - On 03/17/25 at 08:06 AM, observation of the 400-hall treatment cart revealed the count for controlled medication lacked 03/13/25 and 03/14/25 of the going off-shift signatures, and the 03/15/25 coming on shift staff signature. On 03/17/25 at 08:06 AM, Licensed Nurse (LN) G stated staff should sign at the beginning and end of shifts to ensure the accuracy of the controlled medication count. On 03/17/25 at 08:09 AM, observation of the 400-hall medication cart revealed the count for controlled medication lacked 03/15/25 and 03/16/25 both coming on shifts and going off shift staff signatures. On 03/17/25 at 08:09 AM, Certified Medication Aide (CMA) S stated the count for controlled medications should be signed. On 03/19/25 at 03:15 PM, Administrative Nurse D stated she expected staff to sign the controlled medication log with the on-coming and off-shift signatures. The facility's Controlled Substance Administration and Accountability policy dated 01/01/20, documented it was the policy of the facility to promote safe, high-quality patient care, compliant with state and federal regulations regarding monitoring the use of controlled substances. The facility will have safeguards in place to prevent loss, diversion, or accidental exposure. In an inventory count without automated dispensing systems, two licensed nurses account for all controlled substances and access keys at the end of each shift. The facility failed to provide an accurate reconciliation of controlled medication at the end and beginning of daily work shifts, placing the residents at risk for misappropriation of medications by staff.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 130 residents. The sample included 27 residents, with six reviewed for unnecessary medications. Based on observation, record review, and interview, the facility's Consultant Pharmacist (CP) failed to identify and report to facility administration the staff had not notified the physician of out-of-parameter accu-checks (blood glucose monitoring test) for one resident, Resident (R) 29. This placed the resident at risk for physical decline and an ineffective medication regimen. Findings included: - The Electronic Medical Record (EMR) for R29 documented diagnoses of diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain), hypertension (high blood pressure), and epilepsy (epilepsy (brain disorder characterized by repeated seizures). The Annual Minimum Data Set (MDS), dated [DATE], documented R29 had moderately impaired cognition. R29 required supervision of staff with eating, showers, and ambulation. The MDS documented R29 received insulin daily. The Quarterly MDS, dated 12/13/24, documented R29 had moderately impaired cognition. R29 required set-up assistance with eating, personal hygiene, and showers. R29 was independent with mobility, and transfers, and did not ambulate. The MDS documented R29 received insulin daily. R29's Care Plan dated 01/07/25, initiated on 10/11/23, directed staff to administer medications as ordered and monitor for side effects and effectiveness, fasting blood sugars as ordered, monitor for signs and symptoms of hyperglycemia (high blood sugar), and identify areas of non-compliance. The Physician's Order, dated 10/30/24, directed staff to administer Lantus (a long-acting insulin), inject 12 Units (U), subcutaneously (under the skin), in the morning, and call the physician if the fasting blood sugar was greater than 160 milliliters (ml) per deciliter (dl), for diabetes mellitus type two. The order was discontinued on 03/10/25. Review of the EMR revealed the following times the accu-checks were outside of the physician-ordered parameters and the physician was not notified: January 2025: 25 out of the 31 administrations. February 2025: 17 out of the 28 administrations. March 2025: six out of the 18 administrations. The Medication Regimen Review, for the months of January, and February 2025, lacked documentation the CP identified and notified the facility administration of the outside of the physician-ordered parameters and the physician had not been notified. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/1825 at 08:00 AM, Certified Medication Aide (CMA) R administered her medications prior to the breakfast meal. On 03/19/25 at 12:14 PM, Licensed Nurse (LN) H stated she would notify the physician if the blood sugar was below 60 or above 400 and did not know why the order had not been followed. On 03/19/24 at 02:55 PM, Administrative Nurse D stated, that staff needed to follow the physician's orders and stated the CP had not notified her of any concerns. The facility's Pharmacy Services policy, dated 03/19/25, documented the facility would employ or obtain the services of a licensed pharmacist (in accordance with state requirements) who would provide consultation on all aspects of the provision of pharmacy services in the facility. The facility's CP failed to identify and report to facility administration the staff had not notified the physician of out-of-parameter accuchecks for R29. This placed the resident at risk for physical decline and an ineffective medication regimen.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 130 residents. The sample included 27 residents, with six reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to notify the physician for an Accu-check (blood glucose monitoring test) outside of physician-ordered parameters, for one resident, Resident (R) 29. The facility failed to document in the Medication Administration Record (MAR) after administering medication for R295. This placed the residents at risk for adverse effects related to medications. Findings included: - The Electronic Medical Record (EMR) for R29 documented diagnoses of diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain), hypertension (high blood pressure), and epilepsy (epilepsy (brain disorder characterized by repeated seizures). The Annual Minimum Data Set (MDS), dated [DATE], documented R29 had moderately impaired cognition. R29 required supervision of staff with eating, showers, and ambulation. The MDS documented R29 received insulin daily. The Quarterly MDS, dated 12/13/24, documented R29 had moderately impaired cognition. R29 required set-up assistance with eating, personal hygiene, and showers. R29 was independent with mobility, and transfers, and did not ambulate. The MDS documented R29 received insulin daily. R29's Care Plan dated 01/07/25, initiated on 10/11/23, directed staff to administer medications as ordered and monitor for side effects and effectiveness, fasting blood sugars as ordered, monitor for signs and symptoms of hyperglycemia (high blood sugar), and identify areas of non-compliance. The Physician's Order, dated 10/30/24, directed staff to administer Lantus (a long-acting insulin) inject 12 Units (U), subcutaneously (under the skin), in the morning, and call the physician if the fasting blood sugar was greater than 160 milliliters (ml) per deciliter (dl), for diabetes mellitus type two. The order was discontinued on 03/10/25. Review of the EMR revealed the following times the accu-checks were outside of the physician-ordered parameters and the physician was not notified: January 2025: 25 out of the 31 administrations. February 2025: 17 out of the 28 administrations. March 2025: six out of the 18 administrations. On 03/1825 at 08:00 AM, Certified Medication Aide (CMA) R administered her medications prior to the breakfast meal. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/19/25 at 12:14 PM, Licensed Nurse (LN) H stated she would notify the physician if the blood sugar was below 60 or above 400 and did not know why the order had not been followed. On 03/19/25 at 02:55 PM, Administrative Nurse D stated, staff should follow physician orders. The facility's Unnecessary Drugs policy, dated 03/19/25, documented that each resident's entire drug/medication regimen was managed and monitored to promote or maintain the resident's highest practicable mental, physical, physical, and psychosocial well-being free from unnecessary drugs. The facility failed to notify the physician for Accu-checks outside of the physician-ordered parameters for R29. This placed the resident at risk for physical decline.- The Electronic Medical Record (EMR) for R295 documented diagnoses of fracture (broken bone) of the left tibia (bone of the lower leg), arteriovenous fistula (AV - a surgically created connection between an artery and a vein), dependence on renal (pertaining to kidneys) dialysis, end-stage renal disease, bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) disorder. The Minimum Data Set (MDS) had not been completed due to recent admission had not met the criteria for completion or submission. R295's Baseline Care Plan dated 03/12/25, had not included medication. The Physician Orders dated 02/28/25 directed staff to administer: Bupropion (a class of medications used to treat mood disorders) 150 milligrams (mg) Extended Release tablet daily in the morning for depression. Levothyroxine (a medication to treat an underactive thyroid- (an organ at the front of the neck that secretes hormones) 200 micrograms (mcg) tablet one time a day for hypothyroidism. Upon review of the 03/2025 MAR, the Bupropion lacked documentation of administration on March 3rd, 4th, 5th, 6th, 8th, and 9th, and Levothyroxine on March 2nd, 3rd, 7th, 11th, 12th, 15th, and 17th without documentation of reason of unsigned administration. The documentation lacked physician notification. On 03/19/25 at 12:01 PM, Certified Medication Aide (CMA) S reported the night shift nurse was scheduled to give the Levothyroxine but did not know why it had not been signed for as administered. The bupropion may not have been available from the pharmacy but was unsure of that also. On 03/19/25 at 03:20 PM, Administrative Nurse D stated medications should be given as ordered and signed in the MAR. The nursing staff were to record why the medication was not administered. The facility's Medication Administration policy, dated 03/19/25, documented that medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice. The Medication Administration Record (MAR) is reviewed to identify the medication to be administered, observe the resident's consumption of medication, and sign the MAR after administration. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to ensure that R295 had documentation of the administration of his medications. This placed the resident at risk of not receiving prescribed medications.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 130 residents. The sample included 27 residents. Based on observation, record review, and interview, the facility failed to prevent medication administration errors for Resident (R) 29, who received the wrong dosage of a medication supplement for six out of six administrations. This placed the resident at risk for physical decline and other related complications. Findings included: - The Electronic Medical Record (EMR) for R29 documented diagnoses of diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain), hypertension (high blood pressure), and epilepsy (epilepsy (brain disorder characterized by repeated seizures). The Quarterly Minimum Data Set (MDS), dated [DATE], documented R29 had moderately impaired cognition. R29 required set-up assistance with eating, personal hygiene, and showers. R29 was independent with mobility, and transfers, and did not ambulate. The MDS documented R29 received insulin (a hormone produced by the pancreas, that helps your boy use sugar from food as energy), diuretic (a medication to promote the formation and excretion of urine), hypoglycemia (less than normal amount of sugar in the blood) medication daily. R29's Care Plan, dated 01/07/25, initiated on 10/11/23, directed staff to administer medications as ordered and monitor for potential side effects related to the current medication regimen. The Physician's Order, dated 03/12/25, directed staff to administer Zinc (a supplement), 30 milligrams (mg), by mouth, in the morning for Respiratory Syncytial Virus (RSV), until 03/28/25. The Medication Administration Record (MAR), dated March 2025, documented R29 received six doses of the Zinc supplement at the wrong dose. On 03/18/25 at 8:00 AM, Certified Medication Aide (CMA) R prepared R29's morning medication pass. CMA R looked at the over-the-counter bottle of Zinc and then looked at the physician's order in the EMR and stated, that the Zinc in the bottle was 50 mg, which was higher than what R29 was prescribed. CMA R notified Licensed Nurse (LN) G that there was a discrepancy and LN G stated she would look at the original order. LN G stated she notified the physician of the error and he discontinued the medication. CMA R stated she had given R29 the medication since it had been ordered and should have read the order more carefully. On 03/19/25 at 02:55 PM, Administrative Nurse D stated the CMA had been educated to check the physician's order before she administered the medication. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Medication Errors policy, dated 01/01/20, documented the facility should ensure medications would be administered per physician's orders and in accordance with accepted standards and principles that apply to professionals providing services. Medication errors, once identified, would be evaluated to determine if considered significant or not by utilizing the guidelines of residents' condition, drug category, and frequency of error. The facility failed to prevent medication administration errors for R29, who received the wrong dosage of a medication supplement for six out of six administrations. This placed the resident at risk for physical decline and other related complications.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. The facility had a census of 130 residents. The sample included 27 residents. Based on observation, record review, and interview, the facility failed to store and label biologicals as required in one of seven medication carts, when staff failed to place a stop date on R31's Humalog (rapid-acting) Insulin (a hormone that lowers the level of glucose in the blood) Kwik pen (a prefilled, disposable insulin pen). Findings included: - On 03/17/25 at 07:41 AM, on hall 700, 800, and 900 hall treatment cart R31's Humalog insulin Kwik pen lacked an open date. Licensed Nurse (LN) J verified the pen had been opened and stated staff should have placed an open date when they opened it. On 03/19/25 at 03:05 PM, Administrative Nurse D stated she would expect staff to place an open date on an insulin pen when they open it. Upon request, the facility did not provide a policy regarding opening Humalog pens. The facility failed to place an open date on R31's Humalog insulin pen. This placed the residents at risk of receiving an ineffective dose of the medication.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. - On 03/17/25 at 12:00 PM, residents were seated in the Memory Care Unit dining room. Staff provided residents with their drinks and health supplements. On 03/17/25 at 12:15 PM, the residents were still seated in the Memory Care Unit dining room without food. On 03/17/25 at 12:45 PM, residents continue to wait for their food in the Memory Care unit. Two residents at a table questioned staff when the food would be delivered, and staff could not provide an answer. On 03/17/25 at 01:15 PM, residents still had not received their food in the Memory Care Unit. On 03/17/25 at 01:40 PM, the residents received their meal in the Memory Care Unit. On 03/18/25 at 08:30 AM, residents were seated in the Memory Care Unit dining room. Staff provided their drinks to the residents. On 03/18/25 at 09:00 AM, R 125 stated, Come on, come on, let's go! Certified Nurse Aide (CNA) M stated, Where do you want to go? R125 stated, I want to go get something to eat. R125 repeated this request over and over. On 3/18/25 at 09:05 AM, R124 clapped her hands together, and screamed I want to eat! R124 did this multiple times. On 03/18/25 at 09:15 AM, Resident's in the Memory Care Unit received their food. On 03/18/25 at 09:15 AM, Certified Nurse Aide (CNA) M stated that the meals were late more than they were on time. Upon request, a policy for mealtimes and meal service was not provided by the facility. The facility failed to provide regular times comparable to normal mealtimes for the residents in the Memory Care Unit. This placed the residents at risk of meals by resident needs, preferences, requests, and plans of care for having to wait extended periods before receiving meals. The facility had a census of 130 residents. The sample included 27 residents. Based on observation, record review, and interview, the facility failed to provide at regular times comparable to normal mealtimes for two dining room and room meal trays. This placed the residents at risk of meals by resident needs, preferences, requests, and plans of care for having to wait extended periods before receiving meals. Findings included: - The facility's posted lunch mealtime of 11:45 AM to 01:30 PM. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/17/25 at 11:57 AM, facility residents had been entering the large dining room toward the entrance of the facility independently and with staff assistance. One unidentified dietary staff provided residents with beverages and paper-wrapped silverware. Several residents lifted their arms and hands to gain attention from the one dietary staff member but would become fatigued and could not keep their hands and arms raised. On 03/17/25 at 12:11 PM, some residents asked when the food would be served. Dietary staff continued to provide beverages of choice and take the menu of some of the residents. On 03/17/25 at 12:17 PM, no food had been served to the residents, and dietary staff informed residents the computer system for taking their meal choices was not working correctly. On 03/17/25 at 01:04 PM, the first meal was brought out of the kitchen for the residents in the large dining room. On 03/17/25 at 01:09 PM, a table of three male residents left the dining room commenting it was taking too long to get their meal. On 03/17/25 at 01:13 PM, residents asked dietary staff about getting their menu order so they could receive their meal. Dietary Staff began taking meal preferences with paper and pencils. On 03/17/25 at 01:15 PM, staff walked by the dining room with two pizza boxes, and the front receptionist was the dietary staff to provide meal plates to the residents. Numerous residents voiced frustration about not having their meals by this time or being furnished with beverages. On 03/17/25 at 01:30 PM, most of the residents had been served their meal in the large dining room. Residents who had come to the dining room at later times got food before the residents who came early. Observation further revealed residents at the same table did not get served their meal at the same time. Residents would finish their meals and leave while the other residents at the table watched without getting their meals to eat. Meals were served randomly to tables. On 03/18/25 at 11:48 AM, observation of the large dining room revealed residents already in the dining room and staff assisting the residents to the dining room. Drink preferences were provided by two dietary staff. Some of the residents received disposable cups and silverware. One unidentified dietary member announced to several of the residents who inquired about the dishes, the dishwasher had conked out. Dietary staff were also taking menu selections on their tablets. On 03/18/24 at 12:10 PM, residents continued to enter the dining room. No food was served from the kitchen at that time. On 03/18/25 at 12:17 PM, one resident had been served their meal. On 03/18/25 at 12:30 PM, Resident (R) 19 who had been present in the dining room since before 11:48 AM was served. Residents were observed holding their arms and hands up to get the attention of staff in the room, but again the residents would become fatigued and lower their arms before staff would respond. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/18/25 at 12:49 PM, R298 and R250 who had been sitting in the dining room since 11:30 AM had not received their meal, reporting late meal serving was usual and it did not matter who came to the dining room early or later. At this time several residents had asked for a second soft beef taco and dietary staff informed the residents they would have to wait and see if there was enough for everyone to be served. On 03/18/25 at 01:38 PM, the room tray meal cart left the kitchen and was taken to Hall 400. Further observation revealed not all residents in the dining room had received their meal. Upon request, the facility failed to provide a policy for serving meals. The facility failed to provide regular times comparable to normal mealtimes for two dining rooms and room meal trays. This placed the residents at risk of meals by resident needs, preferences, requests, and plans of care for having to wait extended periods before receiving meals.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. The facility identified a census of 130 residents. The sample included 27 residents, with two residents sampled for hospice care. Based on observation, record review, and interview, the facility failed to ensure there was a collaboration of care between Resident (R) 112's hospice provider and the facility. This placed R112 at risk of inadequate end-of-life care. Findings included: - R112's Electronic Medical Record (EMR) documented diagnoses of malignant neoplasm of the right lung (lung cancer), cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), chronic kidney disease (a condition where the kidneys gradually lose their ability to filter waste products from the blood), and peripheral vascular disease (PVD - slow and progressive circulation disorder causing narrowing, blockage, or spasms in a blood vessel). R112's admission Minimum Data Set (MDS) dated 09/28/24 documented she had a Brief Interview for Mental Status (BIMS) score of 10 which indicated moderately impaired cognition. R112 had functional limitation in range of motion (ROM) impairment on both sides of her upper extremity and impairment on one side of the lower extremity. R112 used a wheelchair to assist with mobility. R112 required supervision for toileting, upper body dressing; partial assistance with bathing; and substantial assistance with lower body dressing and putting on and taking off footwear. R112's Functional Abilities Care Area Assessment (CAA) dated 10/07/24 documented functional mobility would be addressed in the resident's care plan. Staff was to assist with activities of daily living (ADL) care as needed, anticipating care, so that care needs were effectively met. Therapy services were to be used as needed to help increase functional mobility. Staff were to encourage the resident to participate in ADL care as much as possible to promote independence. R112's Quarterly MDS dated 11/25/24 documented she had a BIMS score of 10 which indicated moderately impaired cognition. R112 required partial assistance to total dependence on staff for her functional abilities. R112 used a wheelchair to assist with mobility. R112's Care Plan last revised 02/20/25 directed staff that she was on hospice starting 02/20/25. Staff was directed to assess for pain, restlessness, agitation, constipation, and other symptoms of discomfort, medicate as ordered, and evaluate the effectiveness. Staff was directed bereavement service was provided by hospice as needed to help with grief and loss, provided her and her family support. Staff was directed to notify hospice of significant changes, clinical complications needing plan of care change, or need to send to the emergency department or death. Staff was to provide ADL support, companionship, and other interventions as desired to provide comfort. Staff was to provide R112 and her family emotional and social support to address anticipatory grief of end-of-life wishes and planning needs. Staff was to provide medications per hospice and the physician's orders. The care plan did not indicate the medications or supplies provided by hospice. R112's Orders tab documented an order dated 02/26/25 to admit R112 to hospice for hypertensive heart and chronic kidney disease. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R112's hospice provider notebook on 03/19/25 revealed the lack of a hospice plan of care. On 03/18/25 at 12:15 PM, R112 sat in her wheelchair at the dining table waiting for lunch to arrive. On 03/19/25 at 12:33 PM, Licensed Nurse (LN) J stated that R112's hospice book should have her hospice plan of care in it. LN J stated she would contact the hospice provider to request the plan of care from them. On 03/19/25 at 02:53 PM, Administrative Nurse D stated any resident who was on hospice services should have the plan of care, the list of medications hospice provides as well as any equipment provided by hospice in the hospice book. Administrative Nurse D could not state a reason why R112 did not have her hospice plan of care in her book. The Coordination of Hospice Services policy implemented on 03/19/25 documented the facility would coordinate and provide care in cooperation with the hospice staff to promote the resident's highest practicable physical, mental, and psychosocial well-being. The facility would maintain written agreements with hospice providers that specify the care and services to be provided and the process for hospice and nursing home communication of the necessary information regarding the resident's care. The facility and hospice provider would coordinate a plan of care and would implement interventions in accordance with the resident's needs, goals, and recognized standards of practice in consultation with the resident's attending physician and the resident's representative. The plan of care would identify the care and services that each entity would provide to meet the needs of the resident and his/her expressed desire for hospice care. The facility failed to ensure there was a collaboration of care between R112's hospice provider and the facility. This placed R112 at risk of inadequate end-of-life care.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. The facility had a census of 130 residents. The sample included 27 residents. Based on observation., record review, and interview, the facility's Quality Assessment and Assurance (QAA) program failed to provide good faith efforts to identify multiple issues of concern for the 130 residents who resided in the facility. This placed all residents at risk for unidentified and ongoing care issues. Findings included: - The facility failed to provide R2 with the Center for Medicare and Medicaid Services (CMS) Form 10055. Refer to F582. The facility failed to provide a safe, comfortable environment. Refer to F584. The facility failed to address the resident's history of sexually aggressive behavior. Refer to F600. The facility failed to complete comprehensive assessments in a timely manner for R13, R98, and R112. Refer to F636. The facility failed to complete baseline care plans for R13, R78, R98, and R295. Refer to F655. The facility failed to revise care plans for R78 and R117. Refer to F657. The facility failed to provide consistent bathing for R48, R71, R92, R99, R117, R121, and R125. Refer to F677. The facility failed to complete nursing assessments prior to a discharge to the hospital for R35 and R142. The facility failed to complete a nursing assessment following admission for R128. The facility failed to implement intervention to prevent a skin tear for R117, and implement intervention related to R13s back brace. Refer to F684. The facility failed to implement preventative interventions for R78, who had a pressure ulcer. Refer to F686. The facility failed to obtain an order for oxygen therapy and failed to store oxygen tubing in a bag for R346. Refer to F695. The facility failed to obtain orders for R295, who received Dialysis Services. Refer to F698. The facility failed to ensure adequate daily nursing staff were always available to meet the needs of the residents who resided in the facility. Refer to F725. The facility failed to ensure staff possessed the competencies and skill sets necessary to provide nursing and related services for R128 and R142. Refer to F726. The facility failed to ensure physician involvement for R121, who had behaviors. Refer to F742. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility failed to document signatures in the narcotic count boot. Refer to F755. The facility failed to ensure the Consultant Pharmacist identified and reported to the facility R29's out-of-parameters accu-checks. Refer to F756. The facility failed to notify the physician for Accu-check outside of physician-ordered parameters for R29. The facility failed to document in the Medication Administration Record after administering medication for R295. Refer to F757. The facility failed to prevent medication administration errors for R29, who received the wrong dosage of a medication supplement for six out of six administrations. Refer to F760. The facility failed to store and label biologicals as required in one of seven medication carts when staff failed to place a stop date on R31's Humalog Insulin) Kwik pen. Refer to F761. The facility failed to provide, at regular times comparable to normal mealtimes for two dining room and room meal trays. Refer to F809. The facility failed to provide a plan of care for R112, who was on hospice. Refer to F849. The facility failed to provide a safe, sanitary environment to help prevent the development and transmission of communicable diseases and infections. Refer to F880. On 03/19/25 at 05:00 PM, Administrative Staff A stated the team meets monthly and discussed concerns related to the residents. They had been making a lot of changes for the good of the residents and hope to continue improving the quality of life for all of the residents. The facility's Quality Assurance and Performance Improvement (QAPI) policy, dated 03/19/25, documented the facility, develop, implement, and maintain an effective, comprehensive, data-driven QAPI program. The program focused on indicators of the outcomes of care and quality of life and addresses all the care and unique services the facility provides. The facility's Quality Assessment and Assurance (QAA) program failed to provide good faith efforts to identify multiple issues of concern for the 130 residents who resided in the facility. This placed all residents at risk for unidentified and ongoing care issues.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 130 residents. The sample included 27 residents. Based on observation, record review, and interview, the facility failed to ensure a sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections when staff failed to provide enhanced barrier precautions (EBP - infection control interventions designed to reduce transmission of resistant organisms which employ targeted gown and glove use during high contact care) for Resident (R) 8 and R88. This deficient practice placed the residents at risk for possible exposure to infection for R8 and R88. Findings included: - R8's Electronic Medical Record (EMR) documented that R8 had a diagnosis of dysphagia (swallowing difficulty). R8's Quarterly Minimum Data Set (MDS), dated [DATE], documented that R8 had a Brief Interview of Mental Status (BIMS) score of 12, which indicated moderate cognitive impairment. The MDS documented R8 had a feeding tube. R8's Care Plan, revised 03/03/25, documented R8 required supervision with eating, she was on Enhanced Barrier Precautions due to the she had an internal feeding tube. The plan instructed staff to don personal protective equipment while providing care to the affected area. On 03/18/25 at 08:40 AM, Certified Nurse Aide (CNA) Q applied gloves, entered R8's room, and failed to don on gown. CNA Q assisted the resident in standing, using a gait belt, and pivot transferred to a wheelchair, during transfer touched her clothes against R8's clothes. CNA Q assisted R8 in transferring from the wheelchair to the toilet, took off her pajama top, and placed a new blouse on R8. On 03/18/25 at 09:00 AM, CNA Q when asked if R8 was on EBP, replied she did not know, she had not been trained about EBP. On 03/18/25 at 11:19 AM, Administrative Nurse D stated he expected staff to follow the EBP precautions for R8. Administrative Nurse D stated the door had an EBP sign on the side of the entrance room door and supplies were on the back of the R8's entrance door. The facility's EBP policy, implemented 06/14/23, documented EBP referred to the use of gloves and gown for use during high contact resident care activities for residents known to be colonized or infected with a Multi-Drug Resistant Organism (MDRO - bacteria that resist treatment with more than one antibiotic) as well as those at increased risk of MDRO acquisition (residents with a wound or indwelling medical device. High-contact resident care activities included the following: a. dressing, b. bathing (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. transferring d. providing hygiene e. changing linens f. changing briefs or assisting with toileting g. device care or use of central lines, urinary catheters, feeding tubes, tracheostomy (opening through the neck into the trachea through which an indwelling tube may be inserted), ventilator, wound care, and skin opening requiring a dressing. The facility staff failed to ensure staff provided EBP when providing care for R8, who had a feeding tube. This placed the resident at risk for infection. - R88's Electronic Medical Record (EMR) documented R88 had a diagnosis of urine retention (lack of ability to urinate and empty the bladder). R88's admission Minimum Data Set (MDS), dated [DATE], documented R88 had a Brief Interview of Mental Status (BIMs) of 14, which indicated intact cognition. The MDS documented R88 as independent with most activities of daily living (ADL). The MDS documented R88 had a urinary catheter (a tube inserted into the bladder to drain the urine into a collection bag). The Urinary Incontinence Care Area Assessment (CAA), dated 12/03/25, documented urinary incontinence would be addressed in the resident's care plan. Staff to monitor for signs and symptoms of consequences of incontinence, such as infection, to help prevent prolongation of infection. Staff to encourage fluids to help prevent infection. Staff to provide incontinence care as needed to help minimize risks of incontinence. R88's Care Plan, revised 02/24/25, documented R88 required Enhanced Barrier Precautions (EBP) due to having an indwelling medical device. The plan instructed staff to don personal protective equipment (PPE) while providing care to the effected area. On 03/18/25 at 11:50 AM, Licensed Nurse (LN) Q entered R88's room, applied gloves and asked R88 if it was ok to empty her urinary catheter bag, LN Q failed to don a gown. LN Q stated R88's urinary catheter bag had two ports. LN Q retrieved a graduated cylinder from the bathroom, placed it on the floor, took the port from the holder, unclipped it drained the urine into the cylinder, refastened the port, and placed it in the holder. LN Q unscrewed the cap from the other drainage port, drained the urine into the cylinder with the other urine, and placed the cap back on the drainage port without disinfecting either port. LN Q placed the uncovered urinary catheter bag back on the bed, towards the head of the bed, with the uncovered urinary catheter bag touching the floor. LN Q verified the urinary catheter bag was uncovered and touched the floor. When asked if she would normally wipe off the drainage ports with a disinfectant wipe or alcohol pad, LN Q stated she had not been trained to do that, but she could. On 03/18/25 at 01:15 PM, when asked if anyone in the 600 hall was on EBP LN Q stated she was unaware of anyone being on EBP. LN Q verified she had not donned a gown when providing catheter care for R88. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/19/25 at 11:19 AM, Administrative Nurse D stated he expected staff to follow the EBP precautions for R8. Administrative Nurse D stated the door had an EBP sign on the side of the entrance room door and supplies were on the back of the R8's entrance door. The facility's EBP policy, implemented 06/14/23, documented EBP referred to the use of gloves and gown for use during high contact resident care activities for residents known to be colonized or infected with a Multi-Drug Resistant Organism (MDRO-bacteria that resist treatment with more than one antibiotic) as well as those at increased risk of MDRO acquisition (residents with a wound or indwelling medical device. High-contact resident care activities included the following: a. dressing, b. bathing c. transferring d. providing hygiene e. changing linens f. changing briefs or assisting with toileting g. device care or use of central lines, urinary catheters, feeding tubes, tracheostomy (opening through the neck into the trachea through which an indwelling tube may be inserted), ventilator, wound care, and skin opening requiring a dressing. The facility staff failed to ensure staff provided EBP when providing care for R8, who had a feeding tube. This placed the resident at risk for infection.