STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185261	A. Building B. Wing	02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wurtland Nursing and Rehabilitation	100 Wurtland Avenue Wurtland, KY 41144

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review, the facility failed to develop and/or implement a comprehensive person-centered care plan to meet the needs of five (Resident (R) 80, R27, R52, R36, and R124) of 32 sampled residents The facility failed to develop specific, effective interventions for staff to follow and /or ensure that approaches were implemented to meet each resident's needs. The findings include: Review of the facility policy, Comprehensive Care Plan, dated 11/01/2024, revealed the facility was to develop and implement a comprehensive person-centered care plan for each resident to meet the resident's medical, nursing, mental, and psychosocial needs as identified in the comprehensive assessment. Further review revealed the comprehensive care plan was to describe the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. 1. During interview on 01/26/2025 at 3:04 PM with R80, she stated her head was itching, and it was driving her crazy. R80 stated she had a history of plaque psoriasis (a skin condition in which skin cells build up and form itchy, dry patches) on her scalp that caused her head to bleed and scab and she did not know what the solution was. R80 further stated she had told the nurse, and a shampoo was ordered; however, her head continued to itch. Observation of R80's head revealed an approximate one-inch lesion in the hairline near the forehead on the right with skin and blood on the pillowcase and sheet under her head. (Refer to F684). a. Review of R80's Comprehensive Care Plan (CCP) for risk of skin breakdown revealed on 12/13/2024, an intervention for medicated shampoo as ordered was documented. Further review of the CCP revealed that the CCP did not address specific instructions for the use of the medicated shampoo. Review of R80 ' s Medication Administration Record (MAR) dated 12/2025 revealed the order for Ketoconazole Shampoo 2%, apply to scalp topically one time a day every Wednesday and Sunday for dry scalp had a start date of 12/15/2024 was administered. However, review of R80 ' s Progress Note dated 01/28/2025 at 3:37 PM (after surveyor initiation of the concern) revealed R80 had reported her head was still really itchy and her scalp is full of scabs, Review of the facility provided package leaflet for Nizoral (ketoconazole) 2% shampoo, revised in 01/2024, under the section labeled how to apply revealed the hair was to be wet thoroughly, apply a (continued on next page)

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

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F 0656 Level of Harm - Actual harm Residents Affected - Few	small amount of shampoo to the scalp and massage into a lather, leave the lather on the scalp for three to five minutes and rinse thoroughly. During an interview on 01/31/2025 at 5:07 PM with R80, she stated the State Registered Nurse Aides (SRNAs), not the nurses, applied her shampoo and rinsed it out, but they never left it in for three to five minutes. Interviews on 01/30/2025 at 10:42 AM with SRNA12 and SRNA13, as well as with SRNA11 on 01/31/2025 at 5:10 PM, revealed they were unaware of the instructions for use, and used medicated shampoo like it was regular shampoo, rather than leaving it on for three - five minutes. b. Review of R80 ' s Comprehensive Care Plan (CCP) for Risk of Skin Breakdown initiated on 10/11/2023 and revised on 10/20/2023, revealed R80 was at risk for skin breakdown related to incontinent episodes and decreased mobility. Although the intervention for medicated shampoo as ordered was initiated on 12/13/2024, review of the CCP revealed it was not until 01/28/2025 that a care plan with goals and interventions specific to her scalp was developed. 2. Review of R27's admission Record revealed the facility admitted the resident on 05/23/2023 with diagnoses including mild cognitive impairment, osteoarthritis, and depression. Review of R27's Comprehensive Care Plan (CCP), dated 12/10/2024 revealed the facility identified R27 had a pressure ulcer on her left buttock and listed interventions including assisting the resident with bed mobility to turn and reposition routinely, as well as providing incontinence care as needed. (Refer to F686). Review of R27's Bedside Kardex Report, dated 02/01/2025 revealed the interventions to check routinely for incontinence and provide care as needed. Further review revealed the Kardex listed R27 as requiring assistance with repositioning in bed. Observation on 02/01/2025 at 9:50 AM revealed SRNA5 and SRNA 18 changed R27's draw sheet, which was soiled with urine. Further observation revealed neither SRNA offered to assist R27 with repositioning. Interview with SRNA5 at this time revealed since she started her shift at 6:00 AM, she had not changed R27's briefs or repositioned the resident. She further stated SRNAs could access the resident's Kardex, which was generated from the care plan, to know what specific needs each resident had. In continued interview, SRNA5 stated it was important to provide care as described on the care plan. In an additional interview on 02/01/2025 at 8:04 PM, SRNA5 stated the facility was short staffed and the SRNAs did not typically get the support they needed to take care of the residents according to their care plans. In an interview on 02/01/2025 at 3:18 PM, the Assistant Director for Nursing Services (ADNS) stated all staff needed to follow care planned interventions for pressure ulcer prevention and treatment. Per interview, the ADNS stated she conducted audits, but was unable to verify if any of those audits covered turning and repositioning. interview on 02/01/2025 at 5:06 PM, the Director of Nursing Services (DNS) revealed that, depending on the number of SRNAs assigned to a hallway, it would be difficult for them to get to each resident room to perform incontinence care and turning and repositioning as outlined in the resident's care plan to treat and prevent pressure ulcers. Per interview, the DNS stated there was not a process in place to communicate when the resident was last turned so that different team members could (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	contribute to ensuring adequate repositioning. 3. Review of R52's admission Record revealed the facility admitted the resident on 06/10/2024 with diagnoses including early onset Alzheimer's Disease, depression, and osteoarthritis. a. Review of R52's Comprehensive Care Plan (CCP) dated 06/11/2024 revealed the facility identified the resident as needing assistance with activities of daily living (ADLs), including toileting and personal hygiene. Review of R52's Bedside Kardex Report, dated 02/01/2025 revealed facility staff were to provide toileting to R52 frequently, as well as checking for incontinence routinely and as needed. In an interview on 01/27/2025 at 9:47 AM, Family Member (F)52 stated she asked for R52's care plan to include the intervention that she needed to be checked for incontinence and offered toileting more often than every two hours because R52 can still use a commode at times. In interview on 01/30/2025 at 9:42 AM, SRNA3 stated aides were supposed to change incontinent resident's briefs at least every two hours. She further stated if staff knew the resident had a history of soaking through briefs, they needed to check them more frequently than every two hours. In continued interview, SRNA3 stated she had seen R52 urinate through a brief but knew that the resident could use the toilet if staff assisted her in time. In an interview on 02/01/2025 at 9:50 AM, SRNA 5 stated staff should follow the Kardex, which was generated from the care plan, to know what care needs each resident had. Observation on 02/01/2025 at 11:04 AM revealed SRNA5 changed R52's brief, which was soaked with urine. Further observation revealed the resident also had a small amount of stool. Per observation, when SRNA5 cleaned R52's stool, the skin in the gluteal fold was reddened, with the appearance of previously broken-down skin in the area where the buttocks meet. In an interview on 02/01/2025 at 11:07 AM, SRNA5 stated this was the first round of incontinence care she had provided to her residents, and she had not had time to get to everyone. (Refer to F677.) In an interview on 02/01/2025 at 5:06 PM, the Director of Nursing Services (DNS) stated she attended care plan meetings with F52 and had observed the interventions related to R52's dining needs, but she could not verify incontinence care had been provided according to the care plan for R52. The DNS further stated not following the care plan related to incontinence care needs could lead the resident to feel embarrassed and like they did not have their dignity. b. Further review of R52's Comprehensive Care Plan (CCP) dated 06/11/2024 revealed the facility identified the resident had her own teeth in poor condition and listed interventions including providing mouth care or encouraging the resident to perform oral care twice daily and as needed. Observation on 01/29/2025 at 10:17 AM revealed State Registered Nurse Aide (SRNA) 9 assisted R52 with ADL care, including getting dressed. Further observation revealed SRNA9 told the resident she was finished with helping her get ready and the resident could go to activities. Continued observation revealed SRNA9 failed to remind or assist R52 with performing oral care before leaving her room. (Refer to F677.) In an interview on 01/29/2025 at 10:44 AM, SRNA9 stated she forgot to assist R52 with oral care (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	because she had been busy taking care of a large number of residents that morning. She further stated she had not seen a toothbrush in R52's room and that someone might have thrown it away. In an interview on 02/01/2025 at 5:06 PM, the Director of Nursing Services (DNS) stated she attended care plan meetings with F52 and had observed the interventions related to R52's dining needs, but she could not verify R52 received oral care according to the care plan. The DNS further stated a resident not receiving care planned oral care interventions could result in the resident getting an infection and having oral pain. 4. Review of R36's admission Record found in the resident's electronic health record (EHR) revealed the facility admitted the resident on 12/31/2020 with diagnoses to include Alzheimer's disease, dementia, and presence of artificial eye. Review of R36's CCP, undated, revealed the facility identified R36 as having impaired visual function due to an artificial left eye on 11/24/2015. Care plan interventions initiated included to perform artificial eye care as ordered. However, the care plan did not include specific details of how to clean the artificial eye, including whether or not the eye was to be removed. Although the CCP stated to perform artificial eye care as ordered, review of physician's orders revealed that there were no orders for eye care until 01/27/2025, after the initiation of the survey. During an observation on 01/27/2025 at 3:46 PM, R36 was seated in her wheelchair in the day room, positioned in front of the nurse's station. Two nurses were seated in the nurse's station. Observation of R36's eye revealed green, pus-filled drainage was weeping from the resident's left eye. The eyelid and lashes were coated with a thick, crusty material, causing the eye to be matted shut. (Refer to F684.) During an interview with the Nurse Practitioner (NP) on 01/29/2025 at 7:30 AM, he stated that [R36's] eye should absolutely come out for proper cleaning. During an interview with Licensed Practical Nurse (LPN) 1 on 01/27/2025 at 4:55 PM, she stated that prior to a new order (which was received after the initiation of the survey, staff just knows to clean it [the eye]. Interviews with SRNA3 on 01/30/2024 at 9:40 AM, SRNA13 on 01/30/2024 at 10:41 AM, and SRNA11 on 01/30/2024 at 10:48 AM, revealed each cleaned the resident's eye with warm water and soap and were unaware that R36 had a prosthetic left eye that needed to be removed for cleaning. 5. Review of R124's medical record revealed the facility admitted the resident on 01/16/2025 with diagnoses including sepsis related to septic knees and intravenous (IV) antibiotic therapy. Review of R124's care plan, initiated on 01/17/2025, revealed an intervention for the left arm midline dressing to be changed as ordered. Review of R124's physician orders revealed an order dated 01/19/2025 with instructions for the resident's midline dressing to be changed once a week and as needed. Review of R124's Medication Administration Record (MAR)/Treatment Administration Record (TAR) for the month of January 2025 revealed the dressing was not changed between admission on [DATE] and 01/30/2025 (Refer to F684). (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Observation on 01/28/2025 at 10:16 AM revealed R124 with a left upper arm (LUA) midline covered with an intact transparent adhesive dressing dated 01/16/2025. An additional observation made at 2:14 PM revealed the dressing was dated 01/16/2025. Observation of R124's LUA midline dressing on 01/29/2025 at 4:47 PM also revealed the transparent adhesive dressing with a date of 01/16/2025. In an interview with R124 on 01/28/2025 at 10:16AM, she stated staff flushed her midline before and after she received antibiotics, but the dressing had not been changed since she was admitted to the facility. In an interview with LPN3 on 01/30/2025 at 4:54 PM, she stated care plans were in place so residents received the care they needed and should be followed. In an interview with LPN4 on 01/31/2025 at 11:37 AM, she stated a resident's care plan included dressing changes and the ordered frequency of those changes. In an interview with the Assistant Director of Nursing Services (ADNS) on 02/01/2025 at 4:11 PM, she stated it was her expectation nursing changed midline dressings as ordered and per a resident's care plan. She further stated it was important a resident's care plan was followed because that was how his/her care needs were met. In an interview with Minimum Data Set (MDS) Coordinator 1 on 02/01/2025 at 4:59 PM, she stated care plans were in place, so staff knew the appropriate care needed for each individual resident. In an interview on 02/01/2025 at 3:18 PM, the ADNS stated she expected staff to implement care planned interventions to ensure residents received the care they needed. In an interview with the DNS on 02/01/2025 at 5:58 PM, she stated it was her expectation staff followed care plan interventions. She further stated it was important to follow a resident's care plan because it served as a guideline for care team members and the facility's goal was that each resident received quality care. In interview on 02/01/2025 at 6:28 PM, the DNS added that not following the care plan could lead the resident not getting the care they needed, and it was important for staff to follow the care plans to ensure the residents received good care.

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F 0677 Level of Harm - Actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, record review, and review of the facility's policies, the facility failed to provide necessary services to maintain good personal and oral hygiene for six (Resident (R)362, R27, R90, R52, R79, and R22) of 14 sampled residents investigated for activities of daily living care, The facility failed to provide timely incontinence care for R362, R27, R90, R52, and R79, with residents expressing feelings of embarrassment and humiliation due to the facility's failure to provide incontinence care as needed to meet the needs of the residents. Interviews with the residents and their family members revealed they complained the residents often waited a long time (approximately 4 hours) before staff could change the residents resulting in the residents urinating in their beds and lying in urine for long periods. Additionally, the facility failed to provide daily oral care as needed for R52 and R22, who had plaque build-up as noted by the dentist. The findings include: Review of the facility policy titled, Activities of Daily Living (ADLs), dated 01/02/2024 revealed care and services will be provided for the following ADLs, including bathing, dressing, grooming, and oral care; transfer and ambulation; and toileting. Per policy review, a resident who is unable to carry out ADLs will receive the necessary services to maintain good grooming, and personal and oral hygiene. Review of the facility policy titled, [Name of Facility] Nursing & Rehabilitation, Position Summary-State Registered Nurse Aide (SRNA), dated 02/2020, revealed the SRNA essential responsibilities (not comprehensive) include; To perform or assist the resident with completing ADLs; Respond to residents call lights to provide maximum comfort, safety, and privacy. 1. Review of the Face Sheet found in R362's EMR revealed the facility admitted the resident on 01/14/2025, with diagnoses including unspecified fracture of lower end of right femur, subsequent encounter for closed fracture with routine healing, chronic combined systolic (congestive) and diastolic (congestive) heart failure, and type II diabetes mellitus with other specified complications. Review of R362's Annual MDS Assessment, with ARD of 01/23/2025, revealed the facility assessed the resident to have a BIMS score of 15/15, indicating no cognitive impairment. Per review, the facility assessed R362 to require substantial/ maximal assistance for toileting hygiene and lower body dressing. Further review revealed R362 required partial moderate assistance for shower/bathe self and personal hygiene. Review of the CCP dated 01/15/2025 for R362, revealed the facility identified a problem for the resident relating to risk for incontinence of bowel and bladder. Per review the goal dated 01/15/2025 and revised on 01/31/2025, for the resident to be assisted with routine toileting as needed, check routinely for incontinence, and provide incontinence care as needed. Further review revealed additional focus on ADLs with staff providing substantial assistance for toileting, with fluctuations in need, and provide additional assistance as needed. The Care plan instructed staff to assist as needed for toileting. During interview on 01/26/2025 at 1:58 PM with R362, she stated, On 01/24/2025 I had to wait over four hours from 6:00 PM till after 10:00 PM to be changed. It is humiliating and nasty. She added, I (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Few	have a leg brace on my right leg, and it became soiled because I was not changed. The staff had to clean the brace because it got dirty. 2. Review of R27's admission Record revealed the facility admitted the resident on 05/23/2023 with diagnoses including mild cognitive impairment, osteoarthritis, and depression. Review of R27's physician's orders revealed they included furosemide (a diuretic) 20 milligrams by mouth twice daily. Review of R27's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/22/2025 revealed the facility assessed the resident with a Brief Interview for Mental Status (BIMS) score of 13/15, indicating the resident was cognitively intact. Further review revealed R27 required partial to moderate assistance with turning side to side in the bed and with bed to chair transfers. Continued review revealed R27 was always incontinent of bowel and bladder. Additional review revealed the facility also assessed R27 as having one Stage III pressure ulcer that was not present on admission. Review of R27's Comprehensive Care Plan (CCP), dated 12/10/2024 revealed the facility identified R27 had a pressure ulcer on her left buttock and listed interventions including providing incontinence care as needed. In an interview on 01/27/2025 at 5:13 PM, R27 stated she knew staff were trying their best, but the facility was often short staffed, and she had to wait long periods of time to get incontinence care. R27 further stated she would often soak through her briefs onto her sheets after receiving her water pill. Per interview, R27 reported having to lay in a wet bed for over two hours at least once per week while waiting for staff to change her, which made her feel embarrassed. In continued interview, R27 stated she developed problems with her skin in the past few months, including a pressure ulcer (Refer to F686). Observation on 02/01/2025 at 9:50 AM revealed State Registered Nurse Aide (SRNA) 5 changing R27's draw sheet, which was soiled with urine. In an interview at that time, SRNA5 stated she had not changed R27's briefs since she started her shift at 6:00 AM. In an additional interview on 02/01/2025 at 8:27 PM, SRNA5 stated she had asked another aide around 8:00 AM that day to check on the residents she had not yet changed, including R27, and the other aide told her everyone was fine. She further stated that even if the other aide had checked on the residents between 8:00 AM and 8:30 AM, that would still have left over 2.5 hours since the residents had been checked for incontinence. In an interview on 01/30/2025, SRNA10 stated R27 skin breakdown had worsened due to being left wet for long periods of time several days per week. In further interview, SRNA10 stated when the facility was short staffed, residents do not get the care necessary to be well groomed, including incontinence care. Per interview, SRNA10 felt bad when he knew residents were receiving poor care. 3. Record review revealed the facility admitted R90 on 02/14/2024 with diagnoses of unspecified dementia, incontinence, muscle weakness, depression, and adult failure to thrive. Review of R90's MDS Annual Assessment, with an ARD of 01/27/2025, revealed a BIMS score of 14/15, indicating intact cognition. Per the MDS, the resident was always incontinent and required substantial/maximum assistance with toileting. (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Few	Review of R90's CCP, initiated on 02/15 2024, revealed R90 required assistance with activities of daily living which included personal hygiene and provision of good peri care after each incontinent episode. During an interview with R90 on 01/26/2025 at 4:40 PM she stated she had been sitting in a wet bed for a couple hours and had her call light on twice. R90 stated she had been told by an SRNA they had a new admission and were busy, but she would come back with help, but she had not returned. R90 also stated she was unable to get out of bed on her own. Observation during this interview revealed the resident was wearing a brief which appeared heavy with urine. During an interview on 01/30/2025 at 9:41 AM with SRNA3, she stated on one occasion, she answered R90's call light and found her to be soaked in urine, requiring a complete bed bath and brief change. R90 had also stated she had her call light on for a while, but no one had answered it. SRNA3 stated R90 was not her assigned resident but R90 told her she was expecting her daughter for a visit and was anxious her daughter would arrive and find her soiled and that would embarrass her, so SRNA3 stated she bathed and changed her. 4. Review of R52's admission Record revealed the facility admitted the resident on 06/10/2024 with diagnoses including early onset Alzheimer's Disease, depression, and osteoarthritis. Review of R52's Quarterly MDS, with an ARD of 12/30/2024, revealed the facility assessed the resident with a BIMS score of 3/15, indicating severe cognitive impairment. Further review revealed R52 required substantial/maximal assistance for toileting hygiene. Continued review revealed R52 required moderate assistance with transfers from sitting to standing and from the bed to the wheelchair. Review of R52's Comprehensive Care Plan (CCP) dated 06/11/2024 revealed the facility identified the resident as needing assistance with Activities of Daily Living (ADLs), including toileting and personal hygiene. Additionally, the facility assessed R52 as always incontinent of bladder and frequently incontinent of stool. a. Review of a facility document titled, Report of Concern, dated 11/02/2024, revealed a family member (F52) filed the grievance when she found R52 sitting in briefs and clothes soiled with urine and noted urine dripping into the floor beneath R52's wheelchair. Further review revealed the Executive Director (ED) marked the grievance as confirmed and noted the care team member was terminated on 11/04/2024. Review of a photograph provided by F52 on 01/30/2025 and takenn on 01/14/2025 revealed the resident was in maroon athletic shorts that were wet from the top of her buttocks to her knees. In an interview on 01/27/2025 at 9:47 AM, F52 stated she came in to visit R52 in the afternoon on 01/14/2025, 01/15/2025, and 01/16/2025 and found the resident's briefs saturated and her pants wet with urine to the knees. Per interview, F52 believed the facility was short staffed those days. In further interview, F52 stated on 11/02/2024, she came in to find R52's briefs, clothing, and wheelchair saturated with urine and urine puddled in the floor beneath R52's wheelchair. F52 continued to state she asked an aide, whose name she could not recall, to clean R52 up. F52 stated the staff member told her she could not help until she had picked up dinner trays. When the staff member did come back to clean the resident, F52 reported she was rude and slammed the door, which F52 reported to the administrator. (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Few	In an interview on 01/29/2025 at 3:40 PM, SRNA9 stated that when there was insufficient staff. she did not have time to do ADL care. SRNA9 stated she remembered occasions when she had come in to start her shift and found R52 in a urine-soaked brief and urine-soaked sheets. Additionally, SRNA9 stated F52 had come to her in the past and told her R52 needed her brief changed, but SRNA9 was feeding another resident at the time and was unable to assist her. SRNA9 continued to state that if a resident was known to urinate heavily, staff needed to check on the resident more frequently than every two hours, but that was often not possible when there were only three aides on the hallway. b. Observation on 02/01/2025 at 11:04 AM revealed SRNA5 changed R52's brief, which was soaked with urine. Further observation revealed the resident had a small amount of stool. Per observation, when SRNA5 cleaned R52's stool, the skin in the gluteal fold was reddened, with the appearance of previously broken-down skin in the area where the buttocks meet. In an additional observation of R52's skin with the Director of Nursing Services at 8:27 PM, the skin in R52's gluteal fold was pinker than the surrounding skin. In an interview on 02/01/2025 at 11:07 AM, SRNA5 stated this was the first round of incontinence care she had provided to her residents as she had 12 rooms in her assignment, one of which had four residents in it. Per interview, this meant she was responsible for 24 residents, and she had not had time to get to everyone. In an additional interview on 02/01/2025 at 8:27 PM, SRNA5 stated she had asked another aide around 8:00 AM that day to check on the residents she had not yet changed, including R52, and the other aide told her everyone was fine. She further stated if the other aide had checked on the residents between 8:00 AM and 8:30 AM, that would still have left over 2.5 hours since the residents had been checked for incontinence. In interview on 01/30/2025 at 9:42 AM, SRNA3 stated aides were supposed to change incontinent resident's briefs at least every two hours. She further stated if staff knew the resident had a history of soaking through briefs, they needed to check them more frequently than every two hours. In continued interview, SRNA3 stated she had seen R52 urinate through a brief but knew that the resident could use the toilet if staff assisted her in time. Per interview, SRNA3 stated it was often not possible to assist R52 before she urinated in her briefs due to short staffing. In an interview on 01/30/2025 at 3:32 PM, SRNA10 stated he worked primarily on the back hall, where R52 lived, and getting residents' briefs changed timely was a challenge due to staffing. He further stated it was often three or three and a half hours between checks because of the time it took to clean each resident and address their needs. He continued to state residents who could speak up for themselves had told him they were upset at being left wet and their skin would hurt if they were left soiled. Per interview, SRNA 10 stated the nurses on the floor would come to tell aides that call lights were ringing rather than answer the light themselves. In continued interview, SRNA10 stated a resident in their right mind would cry at the lack of care in the facility. In an interview on 02/01/2025 at 3:18 PM, the Assistant Director of Nursing Service (ADNS) stated she was aware F52 had concerns about R52 not getting timely incontinence care. Per interview, the facility identified that the SRNA caring for R52 that day had not been completing care rounds on residents and was terminated. In further interview, the ADNS stated, after F52 filed grievances, the ADNS personally rounded on R52 during the day and had not seen the resident visibly wet with urine. (continued on next page)

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Wurtland Nursing and Rehabilitation	100 Wurtland Avenue Wurtland, KY 41144

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F 0677 Level of Harm - Actual harm Residents Affected - Few	5. Review of the Face Sheet found in R79's electronic medical record (EMR) revealed the facility admitted the resident on 12/24/2024, with diagnoses including chronic obstructive pulmonary disease (COPD) unspecified (primary), muscle weakness (generalized), and personal history of transient ischemic attack (TIA), and cerebral infarction without residual deficits. Review of R79's Annual MDS Assessment, with an ARD of 01/02/2025, revealed the facility assessed the resident to have a BIMS score of 15/15, indicating no cognitive impairment. Per review, the facility assessed R79 to be dependent on staff for toileting hygiene and shower/bathing. Review of the facility's Comprehensive Care Plan (CCP) developed for R79 revealed the resident was care planned for requiring assistance with self-care and mobility tasks to include assist with ADL tasks as needed. Per the CCP, R79 was dependent on staff for toileting, and needed assistance with incontinence care. Further review of the CCP, dated 12/26/2024 for R79, revealed the facility identified a problem for the resident relating to episodes of incontinence of bowel and bladder. Per review, the goal dated 12/24/2024 and revised on 01/30/2025, for the resident to be assisted with routine toileting and as needed, check routinely for incontinence, and provide incontinence care as needed. Review revealed additional interventions encouraging the resident to sit on the toilet to evacuate bowels if possible. Interview on 01/26/2025 at 1:53 PM with R79 she stated the staff does not have time to change me. She stated, It feels nasty to lay in bed and being dirty. R79 expressed frustration with having to wait for a long time. She stated, I had a stroke and am not able to move in bed very well. During interview on 01/29/2025 at 2:35 PM with SRNA 10, he stated he did not have enough time to change all of his residents. In an interview on 02/01/2025 at 5:06 PM, the Director of Nursing Services (DNS) stated a reasonable person would be embarrassed and would feel like they did not have their dignity if their family members visited and saw them soaked in urine. She stated if there were only three aides per hall, they might not be able to get to all residents for incontinence within two hours. She further stated nurses should change and reposition a resident if they were in the room and find the resident dirty. She stated she hoped a nurse would not leave a resident dirty but did not audit or observe for this practice. In an interview on 02/01/2025 at 6:28 PM, the Executive Director (ED1) stated she was not aware of residents not getting their briefs changed for 3.5 hours or longer. She further stated the team members, including SRNAs would ask for help if their assignment was too heavy to be able to meet resident needs and management would pitch in. In continued interview, ED1 stated she could not provide an estimate for how long it would take for an aide to complete a routine rounding visit with one resident, including incontinence care, and therefore could not provide an estimate for how many residents an aide could have in an assignment before they could no longer provide incontinence care and repositioning every two hours. Review of the facility's policy titled, Oral Care, dated 01/02/2024 revealed it was the practice of the facility to provide oral care to prevent plaque-associated diseases. 6. Review of R52's Quarterly MDS, with an ARD of 12/30/2024, revealed the facility assessed as (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Few	totally dependent on staff for oral care. Review of R52's CCP. dated 06/11/2024 revealed the facility identified the resident as needing assistance with ADLs, including personal hygiene. Further review revealed the facility identified R52 had her own teeth in poor condition and listed interventions including providing mouth care or encouraging the resident to perform oral care twice daily and as needed. Review of the facility document Summary Report for [R52], dated 01/15/2025, revealed the dentist examined R52 on that date and noted a bridge of calculus [hardened plaque on teeth] on the front of the resident's lower teeth. Further review revealed the dentist noted heavy plaque and heavy calculus on the resident's teeth and recommended daily assistance from staff for oral hygiene. Observation on 01/29/2025 at 10:17 AM revealed SRNA 9 assisted R52 with ADL care, including getting dressed. Further observation revealed SRNA9 told the resident she was finished with helping her get ready and the resident could go to activities. Continued observation revealed SRNA9 failed to remind or assist R52 with performing oral care before leaving her room. In an interview on 01/29/2025 at 10:44 AM, SRNA9 stated she forgot to assist R52 with oral care because she had been busy taking care of a large number of residents that morning. She further stated she had not seen a toothbrush in R52's room and that someone might have thrown it away. In an interview on 02/01/2025 at 3:18 PM the Assistant Director of Nursing Services (ADNS) stated she was aware F52 complained about R52 not getting oral care and the ADNS rounded on R52 to assist with this. Per interview, the only indicator the ADNS used to determine if R52 had oral care was to see if she was still in bed. The ADNS stated if she found the resident still in bed after breakfast, she would perform oral care, however, she had not done this recently. After review of the findings from R52's dental notes from 01/15/2025 which indicated the presence of calculus and recommendation for the resident to receive assistance with oral hygiene twice daily, the ADNS stated the presence of calculus indicated R52 had not received sufficient oral hygiene. In an interview on 02/01/2025 at 5:06 PM, the Director of Nursing Services (DNS) stated the presence of calculus would indicate R52 had not received adequate oral care, which could result in pain and infection. In an interview on 02/01/2025 at 6:28 PM, the Executive Director (ED) stated she expected staff to assist residents with oral care. She stated her process for ensuring proper dental care as recommended by the dentist that visited the facility was to review the dentist's notes. Per interview, she had not reviewed the dentist's note for the visit with R52 on 01/15/2025. After being told the note described heavy buildup of plaque, the ED stated that could indicate the resident had not received adequate oral care or that she had a disease, and she was not aware of a disease R52 might have that would explain the plaque. 7. Review of R22's admission Record revealed the facility admitted the resident on 11/13/2013 with diagnoses to include cerebral palsy and dysphagia. Review of R22's Quarterly MDS, with an ARD of 01/10/2025 revealed the resident had both short- and long-term memory problems. Continued review of the MDS revealed R22 was dependent (helper does all of the effort) on staff for all oral hygiene. (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Few	Review of R22's CCP, revealed the facility identified R22 as having no natural teeth or dentures on 03/13/2019, and on a revised date of 12/11/2019. Interventions initiated on 12/11/2019 included the coordination of arrangements for dental care and to provide mouth care or encourage resident to perform oral care twice daily and as needed. Review of R22's Dental Patient Summary Note, dated 02/13/2024, found in the resident's EMR, revealed the provider recommended assistance from staff for daily hygiene. Review of R22's Dental Patient Summary Note, dated 05/23/2024, found in the resident's EMR, revealed that R22 presented for a routine oral examination. The exam revealed that R22 had partial dentition and required assistance with daily tooth brushing. According to the provider's notes, oral hygiene instructions were provided, which included brushing any existing teeth, the tongue, and oral tissues. The instructions also stated the importance of rinsing or swabbing the mouth daily to reduce bacteria. Observation of R22, on 01/27/2025 at 9:01 AM, revealed the resident had partial dentition and food in the mouth. The resident's tongue showed a white coating, and their breath had a foul odor. During an interview with SRNA3 on 01/30/2025 at 9:40 AM, she stated that aides assist residents with brushing their teeth and taking care of their gums. SRNA3 explained that R22 does not have any teeth, so she used an oral foam swab to provide oral care for R22. She stated further that R22 keeps food in her mouth and has bad breath. During an interview with SRNA12 on 01/30/2025 at 10:42 AM, she stated she tried to provide oral care as frequently as possible, even when they were short-staffed. SRNA13 stated further that R22 does not have teeth, and she used an oral foam swab for the resident's oral care. During an interview with SRNA13 on 01/30/2025 at 10:42 AM, she stated she performed oral care as several times a day and after meals. SRNA13 stated that R22 does not have teeth, and she used oral foam swab for the resident's oral care. During an interview with SRNA11 on 01/30/2025 at 11:46 AM, she stated that R22 does not have teeth, and she used an oral foam swab to perform oral care on residents without teeth. Review of the resident's Dental Patient Summary Note, dated 05/23/2024, however, revealed the resident had partial dentition and required assistance with daily tooth brushing. Further, interview with SRNA2 on 01/30/2025 at 2:33 PM confirmed that R22 had some teeth. SRNA2 stated the resident would allow staff to brush her teeth and it was important to provide R22's oral care because she kept food in her mouth. In an interview on 02/01/2025 at 5:06 PM, the DNS stated that aides should perform oral care as ordered and as needed, and nursing staff should assess the residents for any changes in oral health. The DNS added that oral care was important to prevent tooth decay and preserve the residents' teeth. During an interview with ED1 on 02/01/2025 at 9:30 AM, she stated that R22 had partial dentation and was unaware of the staff's confusion regarding R22's teeth. ED1 stated it was important for residents to receive proper oral care, including brushing their teeth. She stated that the nurses assess oral care during their evaluations; however, she had not reviewed the specific notes related to R22. The ED stated further that that heavy plaque could indicate inadequate oral care or potential health (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Few	issues.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. Based on observation, interview, record review, and review of facility policy, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for three residents (Resident (R)124, R80, and R36) reviewed for quality of care. Facility staff failed to ensure medicated shampoo was applied correctly for R80, who had ongoing itching from a scalp condition. In addition, staff failed to provide appropriate services when providing care to R36's prosthetic eye. Staff failed to ensure a dressing was changed according to physician orders for R124. The findings include: 1. Review of the facility policy titled, Wound Care Policy, effective date 05/30/2024 under the section labeled, Promotion of Treatment and Healing of Skin Integrity Impairment, revealed the facility would have a system in place to identify impaired skin integrity development early to prevent further damage and treat the condition as soon as it was identified. Review of the facility policy titled, Medication Administration, approved 12/12/2023, revealed medications were to be administered by licensed nurses, or other staff legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Review of the same policy under the section titled, Procedure, item 14, instructed to administer the medication as ordered in accordance with manufacturer specifications. During observation and interview on 01/26/2025 at 3:04 PM with R80, she stated her head was itching. The resident added that it was driving her crazy. R80 stated she had a history of plaque psoriasis on her scalp that caused her head to bleed and scab and she did not know what the solution was. R80 further stated she had told the nurse, and she was now being treated with a shampoo; however, the treatment was not helping. R80 added that she had not seen the doctor or the nurse practitioner in more than a month, and no one had looked at her scalp. Observation of R80's head at this time revealed an approximately one inch sized lesion in hairline near the forehead on the right with skin and blood on the pillowcase and sheet under her head. Review of the Face Sheet revealed the facility admitted R80 on 05/07/2024 with diagnoses including anxiety. Review of R80's Quarterly Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 11/04/2024, revealed the resident was cognitively intact, based on a Brief Interview for Mental Status (BIMS) score of 15/15. Per the MDS, the resident required substantial/maximum assistance for showering/bathing and personal hygiene. Review of R80's Progress note, dated 12/10/2024 at 1:31 PM by the Nurse Practitioner (NP) revealed R80 was seen for a routine evaluation, had complaints of significant psoriasis (a skin condition in which skin cells build up and form itchy, dry patches) to her scalp and was documented as stating she had special shampoo ordered recently, and she was awaiting its arrival so that she may begin using it once again. R80 was also documented as having described quite a bit of itching and flaking. The assessment and plan was documented as Psoriasis to her scalp, shampoo was on order and recheck as per routine. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of R80's Skin Evaluation dated 12/12/2024 and signed as completed by Licensed Practical Nurse (LPN) 1 revealed after completing the head-to-toe skin assessment, no new areas had been noted. Also, on 12/12/2024 at 12:02 PM, new orders were received and noted for ketoconazole shampoo to scalp with showers. R80 was made aware of the new orders, which were received two days after the resident's initial complaints. Review of Skin Evaluations for R80 dated 12/19/2024, 12/26/2024, 01/02/2025, 01/09/2025, 01/16/2025, and 01/23/2025 revealed no documentation of the condition of R80's scalp or any evidence of evaluation addressing the effectiveness of the ordered medicated shampoo. Further review of R80's progress notes through 01/28/2025 confirmed the resident's interview that after she was seen by the NP on 12/10/2024 (when the scalp condition was identified), she had not been seen again. Further review of the Progress notes revealed no further mention of the scalp condition until 01/28/2025 (after surveyor intervention) when a nurses note dated 01/28/2025 revealed that R80 complained of continued itching and scabs to her scalp. Review of R80's Medication Administration Record (MAR) dated 12/2025 revealed the order for Ketoconazole Shampoo 2%, apply to scalp topically one time a day every Wednesday and Sunday for dry scalp, with the start date of 12/15/2024. The documented start date was five days after R80's initial complaints and the shampoo had been documented as applied on 12/15/2024, 12/18/2024, 12/22/2024, 12/25/2024, 12/29/2024, 01/01/2025, 01/05/2025, 01/08/2025, 01/12/2025, 01/15/2025, 01/19/2025, 01/22/2025, and 01/26/2025. Although review of the MAR revealed that the medicated shampoo was being applied on the ordered schedule, interviews with the resident and staff revealed that it was not being applied for the length of time specified in the manufacturer's instructions. Review of the facility provided package leaflet for Nizoral (ketoconazole) 2% shampoo, revised in 01/2024, under the section labeled how to apply revealed the hair was to be wet thoroughly, apply a small amount of shampoo to the scalp and massage into a lather, leave the lather on the scalp for three to five minutes and rinse thoroughly. Further review of the leaflet revealed the shampoo was to be used every three to four days for two to four weeks. During an interview on 01/31/2025 at 5:07 PM with R80, she stated the State Registered Nurse Aides (SRNAs), not the nurses, applied her shampoo and rinsed it out, but they never left it in for three to five minutes. R80 stated SRNA11 had washed her hair today. During an interview on 01/31/2025 at 5:10 PM with SRNA11, she confirmed she had washed R80's hair and stated she did not know to leave the shampoo on for three to five minutes. She stated the Infection Preventionist Staff Development Nurse (IPSD) had given her the shampoo for R80 and sometimes nurses would give her a shampoo or a cream for a resident and ask her to come back and tell them what the resident's skin looked like. During an interview on 01/30/2025 at 10:42 AM with SRNA12 and SRNA13, they also stated that at times, different nurses would hand them the shampoo for R80 for her scalp with no direction on how to use it, The SRNAs stated they used the medicated shampoo like it was regular shampoo, rather than leaving it on for three - five minutes. During an interview on 02/01/2025 at 1:30 PM with the IPSD, she stated it was the job of the nurses (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	to apply medicated creams and shampoos and they should not be handed to the aides for use. Interview on 01/30/2025 at 7:32 PM with LPN1 revealed she was not sure when the scalp condition for R80 began but she knew R80 had a shampoo ordered that was usually applied during her shower. LPN1 stated she had not applied the shampoo and was not sure how long to leave it in but was sure it was to be rinsed out. She further stated she did not chart the scalp condition as a new skin condition on R80's 12/12/2024 skin assessment because it was not new; however, if the previous skin evaluation dated 12/05/2024 had been marked no new areas and the scalp condition was determined to be present on 12/10/2024, then the scalp condition should have been documented on the 12/12/2024 skin evaluation as a new area. LPN1 indicated she was not sure why she marked no new areas on R80's skin evaluation. During an interview with the Director of Nursing Services (DNS) on 01/28/2025 at 3:36 PM she stated she was not aware until that morning (after surveyor initiation of investigation into this care area) that R80 was in continued discomfort and the NP needed to be contacted to ask about increasing the frequency of treatment to her scalp or review the medications for it. During interview on 01/29/2025 at 7:31AM with the Nurse Practitioner (NP), he stated R80 first complained of her scalp itching a little over a month ago and he had ordered Ketoconazole 2% Shampoo to be applied twice a week. He stated during rounds he determined R80 had run out of the shampoo and was waiting for it to be replaced. He further stated after two weeks with no improvement to R80's scalp, he ordered the frequency of the shampoo to be increased to three to four times a week, but could not remember the date, and then determined there was no record of that order so the application frequency of the shampoo had not been increased. Further interview with the NP revealed that, after the survey was initiated, he re-wrote the order for Ketoconazole 2% Shampoo to be applied more frequently, and the resident was started on Terbinafine 250 milligram (mg) tablet (an oral antifungal) once a day for 14 days The NP stated his expectation was all orders for residents be carried out as ordered and the shampoo would be used per manufacturer instructions. The NP continued that he was not sure which staff applied it or if the order was being carried out per protocol, but since the shampoo was considered a medication, it would be a nursing duty. He stated his expectation was the shampoo be applied, left on for three - five minutes then rinsed out, and that he would be made aware of any resident refusals of medication, acute changes in resident condition and anything that affected resident care. During an additional interview on 02/01/2025 at 4:56 PM with the DDNS, she stated the nurses should not be handing an aide a medicated shampoo or topical treatment to be applied to a resident. Instead, the nurses should be applying medications to assess its effectiveness or if a change was needed. The DNS stated it was her expectation the nurses would administer and apply all medications and assess for effectiveness as ordered and as needed. 2. Review of R36's admission Record revealed the facility admitted the resident on 12/31/2020 with diagnoses to include Alzheimer's disease, dementia, and presence of an artificial eye. Per the admission Record, the resident had a legal Resident Representative (RR). Review of R36's Quarterly MDS, with an ARD of 12/30/2024, revealed the resident had long and short-term memory issues. Review of the MDS revealed the resident did not exhibit any rejection of care. Further review of R36's MDS revealed the resident was dependent (helper does all the work) with activities of daily living (ADLs) including personal hygiene. Review of R36's undated Comprehensive Care Plan (CCP), revealed the facility identified R36 as (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	having impaired visual function due to an artificial left eye on 11/24/2015. Care plan interventions in place as of 01/26/2025 included: 1. arrange consultation with eye care practitioner as required; 2. perform artificial eye care as ordered; and 3. observe for signs of acute eye problems. Further review of the CCP revealed that it did not include specific instructions on the need to remove the artificial eye when performing eye care. Although the CCP stated to perform artificial eye care as ordered, review of physician's orders revealed that there were no orders for eye care until 01/27/2025, after the initiation of the survey. Further review of 01/2025 physician orders revealed that the resident was not being treated for any eye infection. Review of R36's EMR revealed no evidence through Progress Notes that the resident had any type of eye infection as of 01/26/2025. During an observation on 01/27/2025 at 3:46 PM, R36 was seated in her wheelchair in the day room, positioned in front of the nurse's station where two nurses were seated. Observation of R36's face revealed green, pus-filled drainage was weeping from the resident's left eye. The eyelid and lashes were coated with a thick, crusty material, causing the eye to be matted shut. An attempt was made to interview R36 on 01/27/2025 at 3:46 PM, however, the resident did not respond to questions. Although review of R36's EMR revealed no evidence that the resident had drainage, weeping, or signs of eye infection, interviews with staff revealed that this was an ongoing problem for the resident. During an interview with the Social Service Director (SSD) on 01/27/2025 at 3:47 PM, she stated R36 always had an eye infection. She did not know if the resident was being treated for an infection. Interview with Licensed Practical Nurse (LPN) 1 on 01/27/2025 at 4:55 PM revealed she was R36's nurse. She also stated that she was aware of issues with R36's eye. She stated she was unsure how long R36's eye had been draining, but she stated that it continuously discharged green, purulent drainage, often causing the eyelids to stick together. LPN1 was unaware if R36 had been seen by a specialist for this condition. During an interview with SRNA3 on 01/30/2024 at 9:40 AM, she stated she wiped R36's eye with warm water and soap from the dispenser using a washcloth. However, she added, the eye continued to weep and drain. SRNA3 stated further that R36's left eyelids remained crusted together. During an interview with SRNA13 on 01/30/2024 at 10:41 AM, she stated R36's eye constantly drained and teared. She stated that even after it was cleansed with warm water using a washcloth, the eye continued to weep thick green drainage. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview with SRNA11 on 01/30/2024 at 10:48 AM, she stated that R36's eye persistently drained thick green discharge even after it was cleansed with soap and warm water. During an interview with the NP on 01/29/2025 at 7:30 AM, he stated that R36 had received treatments in the past for infections. He stated R36 was referred to an Optometrist over the summer; however, R36's guardian refused care. He emphasized that his expectation was to follow the protocol to ensure the safety and well-being of the resident. During an interview with the NP on 01/29/2025 at 7:30 AM, he stated the treatment protocol for R36's eye care was to keep it clean. He stated that [R36's] eye should absolutely come out for proper cleaning but added that it was his understanding that it had never been removed while in the facility. The NP stated that R36 seldom exhibits behavioral issues and he emphasized that his expectation was for staff to follow the protocol to ensure the safety and well-being of the resident. The NP revealed that after surveyor intervention, he gave new orders for eye care. Review of R36's new Physician Orders, revealed nursing staff received verbal orders on 01/27/2025 to cleanse the (artificial) left eye with baby shampoo, pat dry, every shift as needed, and every shift as a preventative. Interview with LPN 1 on 01/27/2025 at 4:55 PM, revealed she was R36's nurse. She stated that R36 was care planned for having an artificial left eye; however, she was unsure of what the interventions were for R36 related to her prosthesis. LPN1 stated R36's eye was cleansed using soap and water. The LPN stated to her knowledge, the staff had never removed the eye prosthesis for cleaning purposes. She indicated R36 was non-compliant with care and would probably not allow staff to remove the prothesis. LPN1 stated that the resident's care plan should be followed to ensure she received person-centered care. During an interview with SRNA3 on 01/30/2024 at 9:40 AM, she stated she wiped R36's eye with warm water and soap from the dispenser using a washcloth. SRNA3 was unaware that R36 had a prosthetic left eye that needed to be removed for cleaning. During an interview with SRNA13 on 01/30/2024 at 10:41 AM, she stated R36's eye was cleansed with warm water using a washcloth, but the eye continued to weep thick green drainage. Further interview revealed SRNA13 was unaware R36 had a prosthetic left eye that needed to be removed for care. During an interview with SRNA11 on 01/30/2024 at 10:48 AM, she stated that R36's eye persistently drained thick green discharge even after it was cleansed with soap and warm water. SRNA11 was also unaware that R36 had a prosthetic left eye that needed to be removed for cleaning. During an interview with the Assistant Director of Nursing Services (ADNS) on 02/01/2025 at 3:18 PM, she stated all staff need to follow each residents' care planned interventions. She stated she was unsure of why R36 did not have a treatment to address her eye drainage, or when she last saw an ophthalmologist. She stated further the nurses should do the baby shampoo treatment, not the SRNAs. The ADNS stated it was her expectation the nurses would administer and apply all treatments as ordered and assess for effectiveness. During an interview with the DNS on 02/01/2025 at 4:56 PM, she stated nurses should not have allowed SRNAs to apply treatments; instead, nurses should perform the treatments as ordered. She stated it was important for nurses to assess the effectiveness of the treatments and determine if changes (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	were needed. The DNS stated it was her expectation that nurses would follow the orders as written, administer and apply all medications, and assess their effectiveness as instructed and as necessary. 3. Review of R124's medical record revealed the facility admitted the resident on 01/16/2025 with diagnoses including rehab following myocardial infarction (MI) with life vest, sepsis related to septic knees, and intravenous (IV) antibiotic therapy. Review of R124's admission MDS, with an ARD of 01/16/2025, revealed the resident had a BIMS score of 15/15, indicating the resident was cognitively intact. Further review revealed R124 admitted to the facility with IV access. Review of R124's care plan, initiated on 01/17/2025, revealed the resident had a midline IV access to her left arm, with an intervention for the midline dressing to be changed as ordered. Review of R124's physician orders revealed an order dated 01/19/2025 with instructions for the resident's midline dressing to be changed once a week and as needed. Review of R124's Medication Administration Record/Treatment Administration Record (MAR/TAR) for the month of 01/2025 revealed the entry on 01/23/2025 for R124's weekly dressing change was marked as not completed. Review of R124's progress notes dated 01/16/2025-01/30/2025 revealed that although nursing staff assessed the midline site for edema and redness, there was no evidence the dressing was changed per R124's physician orders and plan of care prior to the line being pulled on 01/30/2025. Observation on 01/28/2025 at 10:16 AM revealed R124 with a left upper arm (LUA) midline, covered with an intact transparent adhesive dressing dated 01/16/2025. An additional observation made at 2:14 PM revealed the dressing was dated 01/16/2025. Observation or R124's LUA midline dressing on 01/29/2025 at 4:47 PM revealed the transparent adhesive dressing was dated 01/16/2025. In an interview with R124 on 01/28/2025 at 10:16AM, she stated she received IV antibiotics for a knee infection through her midline. She further stated staff flushed the line before and after she received antibiotics, but the dressing had not been changed since she was admitted to the facility. In an interview with the NP on 01/29/2025 at 7:45 AM, he stated he expected nursing and/or other appropriate staff to carry out orders that were written. In an interview with LPN3 on 01/29/2025 at 3:45 PM, she confirmed R124 was admitted with a midline to her LUA and received antibiotics for an infection. LPN3 further stated she flushed the line daily, but the Registered Nurses (RNs) performed dressing changes. LPN3 stated she was not aware the dressing had not been changed as ordered. In an additional interview with LPN3 on 01/30/2025 at 4:54 PM, she stated care plans were in place so residents received the care they needed and should be followed. In an interview with LPN4 on 01/31/2025 at 11:37 AM, she stated the RNs at the facility changed midline dressings, but if she personally identified an outdated dressing, she reported it to an RN. She (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	further stated a resident's care plan included dressing changes as well as the ordered frequency of those changes, and that information was documented on the MAR/TAR. Further interview revealed that LPN4 had not identified that the resident's dressing was outdated. In an interview with Registered Nurse (RN) 2 on 01/31/2025 at 4:10 PM, he stated he had not changed R124's midline dressing and was not aware the dressing was outdated. In an interview with the ADNS on 02/01/2025 at 4:11 PM, she stated it was her expectation that nursing changed midline dressings as ordered and per a resident's care plan. She further stated it was important a resident's care plan was followed because that was how his/her care needs were met. The ADNS stated midline dressing changes were an RN responsibility because LPNs at the facility were not trained for those dressing changes. When asked why R124's dressing had not been changed since she was admitted , the ADNS stated that would need to be investigated further because dressing changes were reviewed in morning meetings and also flagged on the TAR when due to be changed. However, no further information about the failure to change the dressing as ordered was provided prior to exit. In an interview with the DNS on 02/01/2025 at 5:58 PM, she stated it was her expectation staff followed care plan interventions and physician orders. She further stated if R124's orders specified the dressing should be changed weekly, she expected that nursing followed the order. The DNS stated it was important to maintain midlines for residents on IV antibiotics to prevent infection. She further stated it was the facility's goal that residents received quality care.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interview, record review and review of facility policy, the facility failed to ensure residents received appropriate treatment and services to prevent complications of enteral feeding for one (Resident (R) 62) of two sampled residents reviewed for tube feeding. After failing to receive all ordered nutrition and fluids via gastrostomy tube (g-tube), R62 was hospitalized with severe dehydration and hypernatremia (elevated blood sodium levels). The findings include: Review of the facility's policy Enteral Feeding, dated 01/02/2024, revealed the facility would ensure enteral feedings would be administered in accordance with current clinical standards of practice, with interventions to prevent complications. Review of R62's admission Record revealed the facility admitted the resident on 07/12/2023, with an original admission date of 04/14/2022. R62's diagnoses included epilepsy, vascular disorder of the intestine, dysphagia, and intellectual disabilities. Per the admission Record, the resident also had a diagnosis of gastrostomy, with an onset date of 10/16/2023. Observation on 01/26/2025 at 1:16 PM, revealed R62 resting with his eyes closed in bed. His bed was elevated. The resident was receiving an enteral feeding via g-tube of Vital 1.5 at 65 milliliters (ml) /hour by pump. Attempts to interview the resident were unsuccessful, due to the resident's cognition. Review of R62's Quarterly Minimum Data Set [MDS] with an Assessment Reference Date (ARD) of 11/14/2024 revealed the resident was assessed by the facility as severely cognitively impaired, based on a Brief Interview for Mental Status (BIMS) score of 1/15. Further review of the MDS revealed R62 was dependent (helper does all of the effort) for activities of daily living (ADLs). Review of R62's Comprehensive Care Plan [CCP], undated, revealed the facility identified R62 as being at risk for dehydration on 04/27/2022. Care plan interventions revised on 12/02/2024 included administer medications as ordered and observe for side effects, document intake, encourage and assist with fluid intake, notify physician if persistent symptoms of diarrhea, nausea, or vomiting, and observe for signs and symptoms of dehydration to include decreased urine output, concentrated urine, cracked lips. Review of the Physician Orders, dated 08/29/2024, revealed R62 was to receive Vital 1.5 enteral feed at 65 mL/h for 23 hours for a total of 1495 mL per day, via g-tube. Per the orders, the resident was to receive nothing by mouth (NPO). Additionally, there was an order dated 12/29/2023 for a water flush with 50 mL every two hours for a total of 600 mL per day. All nutrition was from enteral feeding. Record review revealed on 11/03/2024 an order for a stat (immediate) x-ray (medical imaging) of the resident's kidney, ureter, and bladder (KUB) was done for abdominal distention. However, review of R62's electronic medical record revealed no evidence from 10/22/2024 to 11/01/2024 of distention. On 11/06/2024 orders were received for a chest x-ray and blood work due to cough, congestion and confusion, although there was no corresponding documentation of the resident's condition. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Hydration Risk Assessment - V2, dated 11/06/2024, revealed R62 scored an 11, which indicated the resident was at high risk for dehydration. Additionally, on 11/07/2024 at 1:11 AM, an order was obtained for Ativan (a medication used to treat anxiety) for agitation although there was no corresponding nursing documentation explaining the specifics of the resident's condition. Review of a Hydration Risk Assessment - V2, dated 11/06/2024, revealed R62 scored an 11, which indicated the resident was at high risk for dehydration. Review of an unsigned Physician Progress Note, dated 11/07/2024 at 11:22 AM, revealed R62 was seen for a routine examination. R62 was assessed as being alert, impaired at baseline. No cough or shortness of breath. The notes stated the resident did not appear to be in any distress or discomfort and staff had no concerns. Review of an Order Note, dated 11/08/2024 at 6:55 AM, revealed R62 was experiencing increased agitation and aggression. According to the note, the resident pulled out his feeding tube, colostomy bag, and Foley (brand of indwelling catheter). The note stated the Nurse Practitioner (NP) was notified and orders were obtained to increase the resident's anti-anxiety dosage. Review of a No Type Specified Note, dated 11/10/2024 at 9:10 PM, revealed R62 had an urinalysis that was positive for infection. An antibiotic (medication to kill bacteria) was ordered. Review of an Order Note, dated 11/15/2024 at 4:30 AM, revealed R62 experienced increased lethargy and altered mental status, elevated blood pressure, elevated pulse, and lungs sounds were noted with rhonchi (low-pitched, gurgling sounds) bilaterally. Per the note, R62 was difficult to arouse at this time. Additionally, R62 experienced increased behaviors and agitation and displayed aggression toward staff. According to the documentation, orders were obtained to send the resident out for evaluation. Review of the local Emergency Department's (ED) Hospital Medicine admission History and Physical, dated 11/15/2024, revealed the hospital physician stated the resident presented with confusion worse than his baseline. Per the record, the nursing home facility reported the resident had been treated for urinary tract infection recently and staff stated the resident had been sick for a week. The physician assessed R62 as very unkempt on arrival, clinically dry on exam, chronically ill appearing overall. According to the note, R62 was admitted for hypernatremia (increased sodium concentration in the blood). Further review of lab values taken in the ED revealed R62's was noted to be severely dehydrated with sodium levels at 164 milliequivalents per liter (mEQ/L) (normal value is between 135 and 145 mEQ/L). Review of a No Type Specified Note, dated 11/15/2024 at 9:10 PM, revealed the local hospital called the facility to inquire about the resident's condition on arrival to the ED. The note stated the caller asked about the resident being clinically dry on examination. The nurse stated in her note the reason was that R62 did not take fluids or meals by mouth and was a mouth breather. Review of the local hospital's Physician Discharge Summary, dated 11/22/2024, revealed R62's discharge diagnosis was hypernatremia with additional problems to include dehydration, and a urinary tract infection (UTI). (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the recorded intake for tube feeding was reviewed for the two weeks prior to the resident's hospitalization for dehydration and hypernatremia. Based on physician orders, from 11/01/2024 to 11/14/2024, R62 should have received 16,800 mL of water flushes. However, review of the intake records for 11/01 - 11/14/2024, revealed the resident only received 12,200 mL (deficit of 4,600 ml.) In addition, based on physician orders, the resident should have received 20,944 mL of enteral feed. Review of the intake records for 11/01 - 11/14/2024 revealed R62 received only 13,045 mL over the course of the 14 days (deficit of 7899 mL). Review of nursing documentation indicated that the enteral feed was turned off during this time period on 11/06/2024 at 8:21 PM, 11/09/2024 at 5:01 AM, and 11/10/2025 at 5:21 AM, due to the resident vomiting or feelings of fullness. There was no evidence of how long the enteral feed was turned off each of these times. During an interview with Licensed Practical Nurse (LPN) 1 on 01/27/2025 at 4:55 PM, she stated she remembered that R62 had gone to the hospital but did not recall the specifics. She stated R62 has bouts of nausea and vomiting and could decline quickly. She stated his tube feed was turned off due to distention and nausea and vomiting. She stated prior to his admission to the hospital in November 2024, he also had bouts of diarrhea, which were being addressed. She stated she did not know why more information about the resident's symptoms was not documented but she thought it was communicated to the providers and nurses in shift report. LPN1 stated it was important to document any change in condition. An attempt to interview LPN5, who was the nurse on duty the day the resident was transferred to the hospital was unsuccessful, as the nurse no longer worked at the facility. During an interview with MDS Nurse 1 on 02/01/2025 at 4:55 PM, she stated that the nurses caring for R62 should have documented his decline and communicated this based on his symptoms. She stated that if R62 was not receiving tube feedings as ordered, he should have been evaluated to prevent dehydration and malnourishment. During an interview with the Nurse Practitioner (NP) on 01/29/2025 at 7:30 AM, he stated he was in the facility full time. The NP stated R62 was treated for a UTI, and then was transferred to the hospital for evaluation and admitted . The NP stated that nurses communicated changes in condition (CIC) by calling the provider. When interviewed about the lack of nursing documentation in the progress notes related to R62, he stated changes should be documented. The NP stated that he would like the nurses to increase nursing documentation as the providers review all notes. He stated that while nurses chart by exception, this was inadequate. He emphasized that any changes in patients' (residents') conditions should be documented in the nursing notes. During an interview with the Director of Nursing Services (DNS) on 01/27/2025 at 3:35 PM, she stated there should be documentation in the chart if nausea and vomiting occurred and the tube feeding needed to be stopped. The DNS stated that if the feeding was withheld, the nurse practitioner should be notified, as ensuring proper nutrition was important to the health of the resident. She stated that if an order was not carried out, nurses need to communicate with the physician or nurse practitioner to maintain continuity of care. The DNS stated that the nurse leaders audited progress notes from the past 24 to 72 hours and stated no issues were found with the nursing documentation. The Executive Director (ED1) was interviewed on 02/01/2025 at 9:30 AM about the resident's admission to the hospital for dehydration, UTI, and hypernatremia. ED 1 stated the reason R62 appeared dehydrated on presentation to the ED was that he was a mouth breather. During interview with ED1 on 02/01/2025 at 6:28 PM, she stated she expected staff to provide care according to the resident's plan of (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care. She stated further that it was her expectation the nurses would administer and apply all treatments as ordered.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility's policies, it was determined the facility failed to ensure pain management was provided as ordered for one (Resident (R) 119) of five sampled residents reviewed for pain. The facility failed to ensure pain medication was reordered timely and available to the resident per the physician's orders and comprehensive care plan. The findings include: Review of the facility's policy, Medication Administration, dated 01/02/2024, revealed medications were administered by licensed nurses, or other staff who were legally authorized to do so in the state, as ordered by the physician and in accordance with professional standards of practice. Further review revealed staff were expected to keep the medication cart stocked with adequate supplies. The policy stated the expectation that medication was administered within 60 minutes prior to or after its scheduled time unless otherwise ordered by the physician. Additional review revealed medications that were readily available for administration will be obtained from the Emergency Kit, drop shipped from the pharmacy or obtained from an alternative pharmacy. Per the policy, the physician will be notified timely of medication omissions. Review of the facility's policy titled, Pain Management, dated 12/02/2024, revealed the facility must ensure pain management was provided to residents who required such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. Further review revealed in order to help a resident attain or maintain the highest practicable level of physical, mental, and psychosocial well-being and to prevent or manage pain, the facility will do so consistent with the comprehensive assessment and plan of care, current professional standards of practice and the resident's goals and preferences. The policy stated that assessment of pain by the interdisciplinary team may necessitate gathering information such as the resident's current conditions, characteristics of the pain, activities that exacerbate the pain, impact of pain on quality of life, current prescribed pain medications, including dosage and frequency. Additional review revealed the interventions for pain management would be incorporated into the comprehensive care plan, including to consider administering medication around the clock instead of on demand (PRN) or combining longer acting medications with PRN medications for breakthrough pain. Further review revealed opioids would be prescribed and dosed in accordance with current professional standards of practice and manufacturer's guidelines to optimize their effectiveness and minimize their adverse consequences. Per the policy, facility staff will notify the practitioner, if the resident's pain was not controlled. Review of R119's closed record revealed the facility admitted the resident on 02/09/24 from an acute care facility with a principal diagnosis of right acetabulum fracture with delayed healing, as well as atherosclerotic heart disease of native coronary artery, type 2 diabetes mellitus, and generalized osteoarthritis. Further review of R119's admission Record revealed R119 was discharged home on [DATE] and the resident was unavailable for interview. Review of R119's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/19/2024, revealed the resident was taking, and had a documented indication, for opioid medication. Review of the admission MDS revealed he was receiving a scheduled pain medication regimen, had received as needed pain medications, and that the Pain Assessment Interview should be conducted. Review of the ensuing Pain Assessment Interview revealed R119 had experienced frequent pain in the past five (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	days, to include occasional inability to sleep and frequent inability to participate in therapy due to pain. Review of R119's Comprehensive Care Plan, dated 02/12/2024, revealed a focus that he was at risk for pain related to the right acetabulum fracture, arthritis, and back pain. Interventions including for staff to administer pain medications as ordered, assist with distracting attention off of his pain with music, television, audio books, counting, drawing or coloring, and notify the physician of unrelieved or worsening pain. Review of R119's physician orders revealed an admission order for oxycodone, 10 mg tablet every four hours as needed (PRN), dated 02/09/2024. This was followed by an order on 02/15/2024 to change the oxycodone 10 mg tablet orders to every four hours (routine, not PRN). Further review revealed that this order was discontinued on 04/16/2024. A new order for Oxycodone 10 mg every four hours was initiated on 04/16/2024 at 1:00 PM. Additional review revealed no orders for retrieval of oxycodone, if needed, from the Emergency Kit. a. Review of R119's Medication Administration Record (MAR) for 04/2024 revealed the Oxycodone order dated 02/15/2024 was documented as having been administered on 04/16/2024 at 3:00 AM and 7:00 AM. The 11:00 AM dose was marked as Other - see progress notes. Further review of the 04/2024 MAR revealed the new order of Oxycodone, as of 04/16/2024, was marked at 1:00 PM and 5:00 PM as Other - see progress notes. Review of the associated note for the missed 11:00 AM dose documented by State Registered Nursing Assistant/Qualified Medication Aide (SRNA/QMA) 8 revealed they were waiting on script [prescription]. Review of the associated note for the new order of oxycodone revealed that the 04/16/2024 doses scheduled for 1:00 PM and 5:00 PM were not given as the medication was documented as on order. Continued review of the MAR revealed the ordered pain medication was not given until 9:00 PM on 04/16/2024. Review of R119's Controlled Drug Administration Record (CDAR) for the 30 tablets of Oxycodone, 10 mg, received 04/09/2024, revealed the last of the 30 tablets was signed out on 04/16/2024 at 3:00 AM. Review of the CDAR for the 30 tablets of Oxycodone, 10 mg, which was received after the new order on 04/16/2024, confirmed the first tablet was signed out on that date at 9:00 PM . Review of R119's medical record progress notes revealed no evidence that non-pharmacological pain relief interventions were applied/attempted during the time that the resident was without pain medication, Further review of the record revealed the only pain assessment for 04/16/2024 was completed prior to the resident missing any scheduled doses of medication Review of R119's Pain Level Summary, completed on 04/16/2024, at 6:40 AM, revealed that the resident was experiencing pain at a score of 7/10 on the scale. Further review of R119's progress notes revealed no evidence indicating the provider was notified that the medication was unavailable or requested an authorization for medication retrieval from the Emergency Kit. b. Review of R119's MAR for 05/2024 revealed the Oxycodone 10 mg tablets scheduled for 1:00 AM and 5:00 AM on 05/02/2024 were not administered and were marked as Other - see progress notes. Review of the associated notes revealed both were documented as Waiting on delivery. Review of the Weights and Vitals section of R119's medical record revealed only one pain assessment was completed on 05/02/2024. During this assessment, at 10:01 AM, R119 reported pain at 5/10. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During telephone interview with SRNA8 on 01/31/2025 at 8:55 PM, she stated she tries to order when residents' medications get down to 15 pills. For pain medication, she stated she must relay the need to the nurse because only they could get on the pharmacy online system (Mediprocity), to communicate with them and put in narcotic orders. She stated if she found a resident was out of a narcotic, she would relay that to the nurse who should contact the provider for a one-time dose to retrieve from the Emergency Kit in the Pyxis (a machine storage system for medications). During interview with SRNA22 on 01/31/2025 at 8:19 AM, she stated it was best to prevent running out of medication by ordering by the time a resident's stock was down to about 10 pills. SRNA 22 stated that if she did give the last pill of a resident's prescription, the process should be to alert the nurse to reorder and if the resident needed the next dose before it could be delivered, the nurse should request to obtain a one-time dose from the Emergency Kit in the Pyxis. During interview with SRNA7 on 01/31/2025 at 8:24 AM, she stated to prevent running out of residents' medications, staff should report to the nurse when they were down to about 10 pills, so it could be reordered. SRNA7 stated this gives time for the provider to sign and get the medication delivered before the remaining pills were used. In further interview, she stated if a medication ran out, there was a process for the nurse to contact the provider and get an order to retrieve the medication from the Emergency Kit. She stated it was important that residents received their medication timely. Interview with Licensed Practical Nurse (LPN) 3, on 01/30/2025 at 4:54 PM, revealed that when the Qualified Medication Aides (QMA)s were down to eight pills on a medication card, they were to notify the nurse, and she reordered it. She stated they if they run out, they have pain medications in the Pyxis and that they could call the physician for a one- time order. LPN3 also stated that they could reorder medications online. She stated they received two deliveries every day from the Pharmacy, and there was no reason for anyone to run out of medications. During interview with the Director of Nursing Services (DNS) on 01/31/2025 at 8:05 AM, she stated the staff should be aware of declining stock and order it in time to be delivered before it was needed. She stated the QMAs were expected to alert the nurse to reorder the medications and nurses could message the pharmacy through the online system to check the status of the medications. In further interview, the DNS stated if a resident's medication supply was empty, the nurse could contact the provider for a one time order to retrieve the medication from the Emergency Kit.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, review of facility staffing documentation and review of the facility's Payroll Based Journal (PBJ) [NAME] report, the facility failed to have an effective system in place to ensure sufficient, qualified, nursing staff with the appropriate competencies and skill sets was present in sufficient numbers to provide nursing and related services to residents. The facility failed to provide nursing services to meet the assessed needs of the residents according to each resident's care plan and in a manner that promoted each resident's rights, physical, mental, and psychosocial well-being. A lack of sufficient, competent staff has the potential to affect the total census of 109 residents. The findings include: 1. Based on observation, interview, and record review, dependent residents R25, R52, R90, F79, R36, and R22 failed to receive needed assistance with Activities of Daily Living (ADL) in the areas of incontinence care and dental care. (Refer to F677 for specific findings.) 2. Based on observation, interview, and record review, R124, R80, and R36 failed to receive care as needed. Staff incorrectly applied medicated treatments, failed to properly clean a resident's prosthetic eye, and failed to change a dressing as ordered. (Refer to F684 for specific findings.) 3. Based on observation, interview, and record review, R27 and R10 developed facility-acquired pressure ulcers after staff failed to provide pressure prevention approaches including incontinence care and turning/repositioning. (Refer to F686 for specific findings.) 4. Based on observation, interview, and record review, R1 and R125, who each had a catheter, failed to receive care in a manner to prevent and/or timely treat urinary tract infections. (Refer to F690 for specific findings.) 5. Based on interview and record review, R62 was hospitalized for dehydration and hypernatremia after failing to receive all ordered nutrition and fluids through a feeding tube, (Refer to F693 for specific findings.) 6. Based on interview and record review, R119 failed to receive pain medication as ordered after nursing staff failed to order it in a timely manner. (Refer to F697 for specific findings.) Review of the facility policy titled, Staffing, effective 10/01/2024, revealed the purpose was to provide sufficient care team members with appropriate competencies and skill sets to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. The census, acuity and diagnoses of the resident population would be considered based on the facility assessment. Further review of the facility policy revealed the company would supply services by sufficient numbers of each of the following care team member types on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: licensed nurses and other nursing personnel, including but not limited to State Registered Nurse Aides (SRNAs). Review of the facility document titled, Facility Assessment Tool (FAT) dated 11/2023-12/2024 revealed the purpose was to determine what resources were necessary to care for residents competently (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	during both day-to-day operations and emergencies. The assessment was used to make decisions about direct care staff needs as well as the facility's capability to provide services to the residents in the facility and was focused on ensuring each resident was provided care that allowed the resident to maintain or attain their highest practicable physical, mental, and psychosocial well-being. Continued review of the document, dated 11/2023-12/2024, revealed the intent of the facility assessment was for the facility to evaluate its resident population and identify the resources needed to provide the necessary person-centered care and services the residents require. Additional review of the FAT, Page 3, revealed the facility average daily census was 109 and Page 18 revealed the facility had assessed the need for 12-18 nurse SRNAs per day, four to ten on the day shift and four to eight on the night shift, as well as, the need for four to seven nurses per day, two to five on the day shift and two to four on the night shift. Per the FAT, the facility estimated caring for an average of 35 residents who were dependent of staff for toileting needs with an additional 61 residents requiring assistance of one or two staff members for toileting. Additionally, the facility estimated all residents required some form of assistance with eating, eight of which were totally dependent and an additional three who required substantial/maximal assist. The general facility process section of the FAT outlined to ensure the facility had sufficient staff to meet the needs of the residents at any given time was documented as refer to the Centers for Medicare and Medicaid (CMS) Minimum Staffing Rule. Review of the facility's PBJ [NAME] report for the fourth quarter of the Fiscal Year 2024 (July 1 - September 30) revealed the facility had a One Star Staffing Rating and submitted weekend staffing data was excessively low. Initial review of the Detailed Hours Report (DHR) which documented actual hours staff were punched in for work for hours worked on weekend shifts for 09/07/2024, 09/08/2024, 09/15/2024, 09/21/2024, 10/05/2024, and 10/06/2024, 10/20/2024 revealed: 7. On 09/07/2024, five SRNAs worked from 6:00 AM-6:00 PM and an additional one SRNA worked from 8:00 AM to 2:00 PM, indicating from 6:00 AM to 8:00 AM and from 2:00 PM to 6:00 PM each SRNA was responsible for the care of 22 residents and from 8:00 AM to 2:00 PM each SRNA was responsible for the care of 18 residents. On 09/08/2024, six SRNAs worked from 6:00 AM-6:00 PM indicating each SRNA was responsible for the care of 18 residents. On 09/15/2024 four SRNAs worked from 6:00 AM-6:00 PM indicating each SRNA was responsible for the care of 27 residents. On 09/21/2024 six SRNAs worked from 6:00 AM-6:00 PM indicating each SRNA was responsible for the care of 18 residents. On 10/05/2024 six SRNAs worked from 6:00 AM-6:00 indicating each SRNA was responsible for the care of 18 residents. On 10/06/2024 five SRNAs worked from 6:00 AM-6:00 indicating each SRNA was responsible for the care of 22 residents. On 10/20/2024 four SRNAs worked from 6:00 AM-6:00 PM each SRNA was responsible for the care of 27 (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	residents. Review of the DHR dated 10/14/2024 revealed one nurse was working from 6:00 PM to 12:00 AM and was responsible for the care of all the facility's residents. Review of the facility DHR dated 01/21/2025 revealed five SRNAs were working from 6:00 PM-6:00 AM requiring each SRNA to be responsible for the care of 22 residents. Review of the DHR dated 01/24/2025 revealed four SRNAs worked from 6:00 PM-6:00 AM and one SRNA worked from 6:00 PM to 12:00 AM, requiring each SRNA to be responsible for the care of 21 residents from 6:00 PM to 12:00 AM and 27 residents from 12:00AM to 6:00 AM. Review of the DHR dated 01/25/2025 revealed three SRNAs worked from 6:00 PM-9:00 PM, requiring each SRNA to be responsible for the care of 37 residents until an additional two SRNAs arrived at 9:00 PM, totaling five SRNAs who worked from 9:00 PM-6:00 AM requiring each SRNA to be responsible for the care of 22 residents. Review of the facility document titled Daily Staffing (DS) sheet dated 01/26/2025 revealed the facility scheduled a total of four SRNAs from 6:00 PM-6:00 AM, requiring each SRNA to be responsible for the care of 27 residents. Review of the DS dated 01/28/2025 revealed six SRNAs worked from 6:00 PM-6:00 AM, requiring each SRNA to be responsible for the care of 18 residents. Review of the DS dated 01/29/2025 revealed three SRNAs worked from 1:00 AM-6:00 AM, requiring each SRNA to be responsible for the care of 36 residents. Review of the DS dated 02/01/2025 revealed six SRNAs worked from 6:00 AM-6:00 PM, requiring each SRNA to be responsible for the care of 18 residents. Review of the facility document titled, Engagement Survey Results, dated 11/2024 revealed documented comments from staff citied the chronic frustrations with the need for more SRNAs 17 times. One comment stated, We need more SRNAs, the workload is horrible and to get everyone changed you sometimes have to miss showers. Review of the facility document Detailed Hours, dated 07/23/2024 revealed a total of seven SRNAs working from 6:00 AM until 2:00 PM and six SRNAs working from 2:00PM until 6:00 PM. Further review revealed a total of five SRNAs working 6:00 PM until 6:00 AM. Review of the staffing sheet for 07/23/2024 revealed a facility census of 115. 8. a. Review of a Report of Concern, dated 07/02/2024, Family Member (F) 52 reported a concern of R52's call light not being answered timely. The Executive Director (ED) marked the grievance as confirmed and wrote that nurses were educated about call light wait times. In an interview on 01/27/2025 at 9:47 AM, F52 stated she reported to the facility that there had been multiple times the family had waited with R52 for over 20 minutes after pressing the call light. She further stated when they had been waiting, they would go down to the nurse's desk to find nurses sitting there. Per interview, F52 stated the ED took notes of the concerns and said she would talk to staff. F52 continued to state administration told her they would put it in R52's Care Plan that (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	she needed to be toileted more frequently than every two hours. F52 added that R52 had a doctor's appointment on 07/24/2024 and was supposed to receive a shower on the evening of 07/23/2024 and wear the clean clothes F52 put out on R52's wheelchair. Per interview, when F52 met R52 at the doctor's office, R52 was still wearing the clothes she was wearing during the day on 07/23/2024, not the clean ones. R52's hair was dirty and unbrushed. She stated she filed a grievance with the ED, who told her the aide had not given the shower but had charted that she had by mistake. In further interview, F52 stated the ED told her if she did not like the care provided to R52, she could take R52 home. Review of the facility time punch document, Detailed Hours, dated 11/02/2024 revealed a total of six SRNAs working from 6:00 AM until 6:00 PM. Further review revealed a total of four SRNAs working from 6:00 PM until 6:00 AM. Review of the facility staffing sheet for 11/02/2024 revealed the census was 115. b. Review of a Report of Concern, dated 11/02/2024, revealed F52 filed a grievance when she found R52 sitting in briefs and clothes soiled with urine and noted urine dripping into the floor beneath R52's wheelchair. Further review revealed the ED marked the grievance as confirmed and noted the care team member was terminated on 11/04/2024. In an interview on 01/27/2025 at 9:47 AM, F52 stated on 11/02/2024, she came in to find R52's briefs, clothing, and wheelchair saturated with urine and urine puddled in the floor beneath R52's wheelchair. F52 asked an aide, whose name she could not recall, to clean R52 up. F52 stated the staff member told her she could not help until she had picked up dinner trays. In an interview on 02/01/2025 at 6:28 PM, the Executive Director (ED) stated she recalled F1's grievance related to R52 being left wet on 11/02/2024. She further stated that in investigating the grievance, she confirmed R52 had been wet with urine and the SRNA who responded was rude to F52. c. Review of the facility time punch document, Detailed Hours, dated 11/22/2024 revealed a total of five SRNAs working 6:00 PM until 6:00 AM. Review of the facility staffing sheet dated 11/22/2024 revealed the facility census was 109. In an interview on 01/27/2025 at 9:47 AM, F52 stated that on 11/22/2024, she waited one hour and three minutes for staff to answer R52's call light when the resident needed assistance with toileting/incontinence care. Per interview, F52 timed the wait on her phone and took a video. d. Review of the facility time punch document Detailed Hours, dated 12/04/2024 revealed six SRNAs working from 6:00 AM until 6:00 PM, with two additional SRNAs working 10:00 AM until 4:00 PM, and one SRNA working 6:00 AM until 4:00PM. Further review revealed four SRNAs working 6:00 PM until 6:00 AM. Review of the facility staffing sheet dated 12/04/2024 revealed the facility census was 103. In an interview on 01/27/2025 at 9:47 AM, F52 stated that on the evening of 12/04/2024, she waited a prolonged period of time for staff to answer R52's call light when the resident needed assistance with toileting and incontinence care. e. Review of the facility time punch document, Detailed Hours, dated 01/14/2025, revealed six nurse aides working 6:00 AM until 6:00 PM, one SRNA working 12:30 PM until 5:00 PM, one SRNA working 10:00 AM until 6:00 PM, and the wound care SRNA working 9:00 AM until 5:00 PM. Review of the facility staffing sheet dated 01/14/2025 revealed the census was 108. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on 01/27/2025 at 9:47 AM, F1 stated she came in the afternoon of 01/14/2025 to find R52 in a soaked brief and clothes wet with urine. f. Review of the facility time punch document Detailed Hours, dated 01/15/2025, there were six SRNA working 6:00 AM until 6:00 PM, with two additional SRNAs working partial shifts. Further review revealed five SRNAs working from 6:00 PM until 1:00 AM, and 4 SRNAs working from 11:00 PM until 7:00 AM. Review of the facility staffing sheet for 01/15/2025 revealed the facility census was 109. In an interview on 01/27/2025 at 9:47 AM, F52 stated she came in the afternoon of 01/15/2025 to find R52 in a soaked brief and clothes wet with urine. 9. a. Observation on 01/29/2025 at 4:42 PM revealed three call lights, both visual and audible, were alerting on the back hall. A male resident was overheard stating, Can someone help me, I am a mess. Licensed Practical Nurse (LPN) 2 stated, You will need to wait, buddy. b. Observation, on 01/29/2025 at 4:45 PM, during dining service, revealed the call light for room [ROOM NUMBER], both visual and audible, was alerting on the front hall. LPN6 was observed sitting at the nurse's station with the call light board behind him alarming and illuminated and he did not get up to assist with answering the call light. c. Observation on 01/29/2025 at 4:46 PM during dining service, revealed a call light for room [ROOM NUMBER], both visual and audible, was alerting on the front hall. The Activities Director (AD) walked past the room and did not address the call light. d. Observation on 01/31/2025 at 10:53 AM revealed two call lights illuminated and audible on the South Hall. LPN1 and LPN2 were observed sitting at the nurse's station with the call light board behind nurses' station illuminated and audible. Neither LPN1 nor LPN2 got up to answer the call lights. e. Observation on 01/31/2025 at 4:45 PM of one SRNA in the dining room sorting meal tickets while six meal trays were waiting in the pass through ready to be given to the residents and four call lights on the North Hall were illuminated and audible. f. Observation on 01/31/2025 at 7:50 AM revealed the call light for room [ROOM NUMBER] was lit above the resident's door. Further observation revealed the call light board at the nurse's station displayed a light indicating room [ROOM NUMBER]'s call light was on, as well as making an intermittent beep to alert staff to the call light. Continued observation revealed LPN1 and LPN2 sitting at the nurse's desk, in view of the control board, where the beeping could be heard, Neither LPN looked over at the control board to see which light was on, nor did they get up to look in the hallway. Per observation, the call light for room [ROOM NUMBER] sounded for four minutes without any response from the LPNs. In an interview on 01/31/2025 at 8:00 AM, LPN1 and LPN2 stated it was everyone's responsibility to answer call lights. When asked about the call light that had sounded for several minutes prior to the interview, the LPNs asked the survey team if the sound went off at the nurse's station. When the survey team confirmed that the sound went off, the LPNs failed to provide any response to why they had not acknowledged the call lights. g. Observation on 02/01/2025 at 10:08 AM revealed the call light for room [ROOM NUMBER] was on. No SRNAs were seen in the hallway. Qualified Medication Aide (QMA)8 was present, preparing medicine. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Maintenance Director walked past room [ROOM NUMBER] without turning his head. Observations at 10:12 and 10:13 AM revealed the Social Services Director (SSD) also walked by room [ROOM NUMBER] while the call light was on, without turning her head to look in the resident's room. Observation at 10:17 AM revealed the call light was still going off (nine minutes after first observed) when ED2 entered the room, asked the resident what he needed and stated he would go get the nurse. The call light remained lit until 10:19 AM when LPN4 entered, asked the resident if he wanted a breathing treatment, and began to administer it, then walked away while it was going in. 10. a. During an interview on 01/26/2025 at 4:40 PM with R90, she stated she had been sitting in a wet bed for a couple hours, had put her call light on twice and was told by the SRNAs they had a new admission and were busy. Observation during this interview revealed the resident's brief appeared heavy with urine. Review of the DHR, dated 01/26/2025, revealed six SRNAs worked from 6:00 AM-6:00 PM and one SRNA worked from 8:00 AM to 5:00 PM. During the time that R90 was left sitting in the wet bed, each SRNA was responsible for the care of 18 residents from 8:00 AM to 5:00 PM and 22 residents from 6:00AM to 8:00 AM and from 5:00 PM to 6:00 PM. b. During an interview on 01/26/2025 at 1:58PM with R362, she stated on 01/24/2025 at 6:00 PM during shift change, she requested help having her brief changed. She stated it took staff until after 10:00 PM for them to come and change her brief. R362 stated having to lay in her waste made her feel humiliated/nasty. She stated it took staff so long to come in and change her that some of her body fluid had leaked on her right leg splint where she had broken her leg back in December. R362 also indicated on her cell phone where she had tried to call the facility for help, and no one would answer the phone. c. During an interview on 01/26/2025 at 2:03 PM, R79 stated she also had to wait at least four (4) hours on 01/24/2025 for staff to come in and change her. R79 stated she felt nasty having to lay in bed waiting for help to change her. She stated she had a stroke and needed assistance in cleaning herself. She stated one staff member came in her room and turned off the call light and disappeared without providing assistance. During an interview on 01/28/2025 at 9:06 AM with SRNA4, she stated when there were four SRNA's on the back (North) hall, they had between 12-15 residents apiece. When there were only three SRNAs, they had approximately 20 residents apiece. She stated the back hall had many residents who were overweight and were a higher level of care and she needed SRNA3, who was in training, to help out. During an interview on 01/29/2025 at 10:27 AM with SRNA7, she stated staffing had been an issue at the facility for a while. SRNA7 stated that although she could not remember the exact date, there was one night there were three SRNAs for the entire building. SRNA7 further stated it was hard to get staff to come to work, as well as, retain new staff due to the heavy workload. During an interview on 01/30/2025 at 9:41 AM with SRNA3, she stated she had been at the facility about a month, worked day shift and was typically assigned 16-18 residents. However, one Saturday, the facility was short staffed, and she had 22 residents to care for which she felt was not safe. She stated she often felt like she was drowning and even though residents with behaviors required more care, 22 residents felt like a lot to care for anywhere. SRNA3 stated she tried to answer all the lights and had been told it was the SRNAs job to answer them. SRNA3 stated the Certified Medication Technicians (CMTs) would help when they could, but the nurses did not get up to answer call lights. She (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	further stated residents have complained to her about long waits for their call light to be answered and there had been mealtimes when there was only one SRNA in the dining room when there should be two. During mealtimes, there were four - five residents that needed total assist with eating, and she has had to sit all those residents at the same table and feed two residents at a time. After the meal and upon her return to her assigned hall, SRNA3 stated she would often see several call lights on and no staff visible. SRNA3 stated on this day she had 14 residents and felt like she was rushing around. Further, on 01/30/2025 at 9:41 AM, SRNA3 stated she was supposed to complete check and change rounds every two hours; however, it was easy to fall behind when caring for a resident that urinated more frequently or in larger amounts. SRNA3 stated on her first round before breakfast, she had walked into a resident's room after a night shift SRNA had told her the resident had been changed. However, she found the resident's bed was soaked and it looked like he had been a mess for hours which she could tell because the longer they sit, the darker the yellow ring (urine-soakage) was. SRNA3 stated it was hard to complete every two-hour rounds on every resident and complete four showers. She stated sometimes she did not take a lunch or would have to leave a resident soiled longer while she finished another resident's shower. Ideally, SRNA3 stated she would like to be able to get to every resident before they soiled themselves so she could assist them to the bathroom if possible. She stated she had to prioritize care based on which residents were the heaviest care need and there were some residents that did not get the attention they deserved, and she felt bad about that. SRNA3 stated sometimes residents ask her to sit and talk with them, adding, she does not have time to do it. During an interview on 01/30/2025 at 9:41 AM with SRNA12, she stated she had been at the facility since January 2024. SRNA13, who was present, stated she had been at the facility since July 2024 and neither SRNA had been issued a name tag. Both SRNAs agreed that in an average day, they cared for 15-20 residents and were responsible for meals, baths/showers and changing briefs/clothes/beds as needed, assisting with transportation to activities/smoke breaks, and individual resident care requests. SRNA12 and SRNA13 stated they would lose their bonus if they did not take a lunch, so they would punch out for lunch but then worked through to keep their bonus. SRNA12 and SRNA13 stated many SRNAs have left because of the workload and the nurses did not help out. They further stated they worked short last week, there were only three SRNAs on each hall (18 residents per SRNA) and sometimes they were only staffed for two SRNAs on each hall (27 residents per SRNA). Furnter, SRNA12 and SRNA13 stated, on 01/30/2025 at 9:41 AM, there was usually one SRNA in the dining room who was responsible for sorting the meal tickets, passing the trays, and feeding the assisted diners and there had been times they would have to sit all the assisted diners at the same table and feed one while the others watched and had to wait, which was painful for staff to watch. SRNA12 and SRNA13 stated the facility was short staffed five to seven days a week and especially on the weekend. They stated with three SRNAs on each hall, they would have to split showers and get done as much as they could. They added there was never any time to sit with residents and just talk with them, even with four SRNAs on each hall. SRNA13 stated that most of the nurses were not supportive of the SRNAs and their work but would add tasks like applying a medicated cream or shampoo. They stated Nurses did not come into the room to pause a tube feeding so the SRNA could check and change a resident, they would tell the SRNA to pause the feed and restart it when care was completed. During an interview on 01/30/2025 at 11:47 AM with SRNA11, she stated it was hard to get all her responsibilities of oral care, hair combing, toileting, and feeding done and a lot of times they were short staffed. She stated she usually had to also complete three showers in a day and with four SRNAs on each hall, it was still a struggle. SRNA11 stated on this day she had 14 residents and felt (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	halls, they mostly stayed in their offices and the ADON only came out of her office when there was something wrong. He stated he charted at the end of the shift but knew a lot of SRNAs did all their charting in the morning which he felt was wrong because you should not chart what you had not done. He stated it got so crazy it felt like there was not enough time to get everything done and if charting was not done, staff would lose their bonus for the week. SRNA10 stated it was hard enough to care for 15 residents, let alone 35 residents and he went home feeling bad because he felt like he had given poor care and the residents had not been cared for how they should be. Finally, SRNA 10 stated he has had to use at mechanical lift alone and risk resident injury due to not enough staff to help. In an interview on 02/01/2025 at 11:07 AM, SRNA5 stated at the time of interview, she was finishing the first round of incontinence care for the residents in her assignment. Per interview, she stated she was responsible for 25 residents. In continued interview, SRNA5 stated management did not help with incontinence care, and she had rarely seen a member of management on the floor during a weekend. SRNA5 stated when she was responsible for that many residents, she did not have time to perform oral care or showers, and those tasks would only be completed if there was a float aide working. In an additional interview on 02/01/2025 at 8:04 PM, SRNA5 stated that when the facility was short staffed, the SRNAs did not typically get the support they needed to care for the residents according to their care plans. During an interview on 01/29/2025 at 7:31 AM with the Nurse Practitioner (NP) he stated he had worked at the facility for one year. The NP stated the SRNAs were great, but based on resident condition, he felt they needed more education on the importance of hygiene, position changes, and that relationship to skin breakdown. The NP also stated staffing was an uphill battle across the board and although it was improving, there was still a high turnover. During an interview on 01/29/2025 at 4:22 PM with the Scheduler (SCH) she stated she had been at the facility for thirteen years and had been the scheduler since 2020. SCH stated staffing was census based and the facility was considered full at 100 residents. SCH stated her staffing goal for each of the two halls was one to two licensed nurses on each hall, one Certified Medication Technician (CMT) on each hall and four nurse SRNAs on each hall for the day shift. On night shift, her goal was to have one licensed nurse on each hall, one CMT on each hall, and four SRNAs on each hall. SCH stated she was available 24 hours a day, seven days a week to work the schedule to find coverage for call offs. She stated there was never a time where no one was available to help, and all the staff pitched in, and all staff were responsible for answering call lights. She also stated the company had their own staff float pool as a resource and the facility did not use agency staff. SCH stated during the time of the low staffing indication on the PBJ [NAME] report, nothing unusual was going on but it was warm outside and that may have accounted for increas[TRUNCATED]

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, review of the Centers for Disease Control and Prevention (CDC) guidelines, review of manufacturer's directions for use (DFU), and review of the facility's policies, the facility failed to implement its infection prevention and control policies and procedures and identify and correct problems relating to infection prevention practices to help prevent the development and transmission of communicable diseases and infections. Additionally, the facility failed to ensure that food items used during medication administration were properly dated when opened and kept on ice during use, for 5 of 5 medication carts observed, 3 medication carts on the Back Hall and 2 medication carts on the Front Hall. 1. Observation of room [ROOM NUMBER], a droplet precaution room, on 03/31/2025 revealed a CDC Droplet Precaution sign on the door. However, the facility did not ensure that a personal protective equipment (PPE) cart was available outside the room for staff to use to provide PPE before entering. 2. Observation of room [ROOM NUMBER], a droplet precaution room, on 04/01/2025 revealed staff failed to ensure the door to the room was closed according to CDC guidelines related to transmission-based precautions (TBP). 3. The facility failed to ensure staff cleaned and sanitized shared equipment according to the Environmental Protection Agency (EPA) registered disinfectant manufacturer's DFU. a. Observation of the Front Hall on 04/01/2025 revealed Licensed Practical Nurse (LPN) 9 failed to properly clean and sanitize a glucometer (a blood sugar monitoring device) after use according to the EPA registered disinfectant manufacturer's DFU. Additionally, LPN9 failed to perform hand hygiene after removing her gloves. b. Observation of the Back Hall on 04/01/2025 revealed LPN11 failed to properly clean and sanitize bandage scissors at the point of care and walked through the hall and entered the nurses' station holding the contaminated bandage scissors with bare hands. Additionally, LPN11 failed to properly clean and sanitize the bandage scissors according to the EPA registered disinfectant manufacturer's DFU. 4. Observation of the Back Hall on 04/01/2025 revealed LPN8 failed to properly bag and transport contaminated cups away from her person when she disposed of them. 5. Observations made on 03/31/2025 and 04/01/2025 of the Front and Back Halls, revealed the facility did not ensure that food items used during medication administration were properly dated when opened and kept on ice during use of medication carts. Multiple observations revealed opened pudding and applesauce containers that were neither dated nor stored on ice during or after medication administration. The findings include: Review of the CDC's Guidelines Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings, dated 04/12/2024, revealed hand hygiene should be performed immediately after glove removal. Additionally, the guidelines stated facilities should ensure proper selection and use of PPE based on the nature of the resident interaction and potential for exposure to infectious materials. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	them to use. She stated any equipment used on one resident should be thoroughly cleaned before it was used on another resident. 4. Observation of the Back Hall on 04/01/2025 at 6:25 PM revealed LPN8 took two large stacks of small plastic drink cups off of the medication cart and transported the cups away, holding them against her scrub top. During an interview with LPN8 on 04/01/2025 at 6:27 PM, she stated she had observed a resident approach the medication cart, touch multiple cups, and take some. She stated she was removing the cups because they were contaminated. She further stated to prevent cross-contamination, she should have used a trash bag to dispose of the cups and not transported them against her person. LPN8 stated she had received multiple training modules related to IPCP during her employment at the facility. During continued interview with the IP/SDC on 04/02/2025 at 12:00 PM, she stated while transporting any items, especially items for residents' use or contaminated items, staff should ensure the items were held away from their person to prevent cross-contamination. 5.a. Observation of the Back Hall on 03/31/2025 at 1:35 PM, revealed three of three medication carts observed each had one opened applesauce container that was not dated and was not being stored on ice to keep it chilled. 5.b. Observation of the Front Hall on 03/31/2025 at 1:45 PM revealed two of two medication carts observed each had opened, undated pudding that was not stored on ice to keep it chilled. During additional interview with QMA7 on 03/31/2025 at 1:48 PM, she stated she was in the middle of medication administration and had just opened the pudding but had not yet dated the container. She stated typically, at the end of each medication administration, there was usually no pudding or applesauce left, and any remaining portions were discarded. She also stated she was getting ice to keep the pudding and applesauce cold when she was approached by the State Survey Agency (SSA) Surveyor for an interview. QMA7 stated food used for medication administration should be dated when opened and placed on ice for the remainder of medication administration. She stated unused food should be discarded at the end of administration. She stated she received IPCP education. QMA7 stated properly storing residents' food was important to control infection and prevent foodborne illnesses. During continued interview with the IP/SDC on 04/02/2025 at 12:00 PM, the IP/SDC stated food used for medication administration should be dated when opened and placed on ice for the remainder of the administration. She stated unused food should be discarded. She stated staff members were educated on how to prevent foodborne illnesses. During continued interview with the ADNS on 04/02/2025 at 4:10 PM, she stated food used for medication administration should be dated when opened and placed on ice for the remainder of the administration. She stated nurses should discard unused food at the end of each administration and should replace them with fresh food items. She stated staff members were educated on the prevention of foodborne illness. During additional interview with the DNS on 03/31/2025 at 1:35 PM, she stated food used for medication administration should be dated when opened and placed on ice for the remainder of medication administration. She stated unused food should be discarded at the end of the administration. She stated clinical staff licensed to administer medications were educated on this. She stated it was (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185261	A. Building B. Wing	02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wurtland Nursing and Rehabilitation	100 Wurtland Avenue Wurtland, KY 41144

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	important to prevent foodborne illness. During continued interview with the IP/SDC on 04/02/2025 at 12:00 PM, she stated it was her expectation that all staff adhered to infection control policies and procedures. She stated all facility staff had received infection control training, which she provided and reviewed many times throughout the year. She stated it was important to follow CDC guidelines to prevent the spread of infection and cross-contamination. During continued interview with the DNS on 04/02/2025 at 6:40 PM, she stated adhering to infection control guidelines was important to prevent the spread of infection and disease to both residents and staff. During additional interview with Executive Director 2 on 04/02/2025 at 4:00 PM, he stated it was his expectation that all staff followed facility polices related to infection control to help prevent the spread of infection and diseases. During an interview with the Medical Director on 04/02/2025 at 4:53 PM, he stated it was his expectation that all staff followed facility polices related to infection control to help prevent the spread of infection and diseases.