STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195618	A. Building B. Wing	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Consolata Rehab and Wellness Center on the Teche	2319 East Main Street New Iberia, LA 70560

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure that resident or resident's RP (Responsible Party) were invited to, attended, or participated in quarterly care plan meetings for 1 (Resident #47) resident out of 28 sampled residents. Findings: Review of facility document titled admission Agreement, dated 01/15/2025 revealed in part, family members are encouraged to visit often and participate in the resident's plan of care. Each quarter the Responsible Party will be invited to attend the resident's care plan conference. Review of Resident # 47's admission Record revealed she was admitted to the facility on [DATE] and had diagnoses which included, but were not limited to, congestive heart failure, dementia and cognitive communication deficit. Review of Resident #47's Quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 03/13/2025 revealed the resident had a BIMS (Brief Interview for Mental Status) score of 2, indicating Resident #47's cognition was severely impaired. On 03/31/2025 at 12:18 p.m., a telephone interview was conducted with Resident #47's RP. He stated he was invited to and attended a care plan meeting when Resident #47 was first admitted to the facility. He stated he has not received another invitation or attended a care plan meeting since December of 2024. On 04/01/2025 at 4:20 p.m., an interview was conducted with S3ADON (Assistant Director of Nursing). S3ADON presented documentation of Resident #47's last care plan meeting which was conducted on 12/24/2024. Resident #47's RP was in attendance at this care plan meeting. S3ADON confirmed care plan meetings should be conducted quarterly and as needed. S3ADON stated there was no staff member at the facility in charge of or conducting care plan meetings in March of 2025. No documentation was provided of Resident #47 having a care plan meeting in March of 2025. On 04/02/2025 at 1:05 p.m., an interview was conducted with S17AD (Activities Director), She stated she compiles the facility's monthly newsletter. She stated she would receive a list of the names of residents who had care plan meetings for the month and she would put the names of the residents in the newsletter. S17AD confirmed that she did not put any names of residents on the March 2025 newsletter because the facility did not conduct any care plan meetings in March of 2025. (continued on next page)

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

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

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/02/2025 at 2:07 p.m., an interview was conducted with S2DON/FormerNFA (Director of Nursing/Former Nursing Facility Administrator) and S1Adm (Administrator). S2DON/FormerNFA stated the Social Services Director is in charge of scheduling care plan meetings. S2DON/FormerNFA stated the facility did not have a Social Services Director from 02/21/2025 to 03/24/2025. S2DON/FormerNFA confirmed no care plan meetings were conducted with residents, resident's RP, and with Interdisciplinary Team (IDT) members from 02/21/2025 to 03/24/2025. S1Adm confirmed that Resident #47 did not have quarterly care plan meeting in March of 2025 and should have.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on observations, interviews, and record reviews, the facility failed to ensure the residents' right to participate in the facility's residents group, Resident Council, as evidenced by administrative staff failing to consider and act upon voiced grievances during monthly Resident Council meetings for 3 of 3 residents (#2, #6 and #16) actively involved in the facility's Resident Council. This deficient practice had the potential to affect the 60 residents who resided in the facility. Findings: Review of the facility's resident council meeting minutes from October 2024 through March2025 revealed: Dated 10/03/2024 per S17AD (Activity Director) revealed Resident #16 accepted the President position and Resident #6 accepted the [NAME] President position. New issues voiced by one of the 13 residents in attendance was to please make sure the CNAs (Certified Nursing Assistants) make sure the lifter battery is on charge correct, so they can be charged for when needed the next day. There was no evidence that the voiced concern was neither addressed nor was a rationale provided by facility staff to the residents during the following five monthly meetings. Dated 11/05/2024 per S17AD revealed a guest was also present during the meeting. The old issues voiced by the residents during the previous meeting on 10/03/2024 were reviewed. There was no evidence facility staff addressed the voiced concern at the previous month's meeting. There was no rationale or response from the facility staff as to why the concern was not addressed. Further review of the minutes from meeting dated 11/05/2024 per S17AD revealed new issues voiced by 4 of the 12 residents in attendance, including Residents #2 and #16: the food is not good, request to meet with the guest after meeting, CNAs not picking up dirty clothes-it has not gotten any better, CNAs on their cell phones and don't get off, whirlpool issues, and smoking on the weekend. New issues given to S20FormerDON (Former Director of Nursing). Late entry: S17AD attempted to notify S2DON/FormerNFA (Director of Nursing/Former Nursing Facility Administrator) but was unsuccessful due to S2DON/FormerNFA being on a phone call. There was no evidence of the facility addressing or rationale for not addressing the residents' voiced concerns regarding whirlpool issues and smoking on the weekend. Dated 12/03/2024 at 2:15 p.m. per S17AD revealed 11 residents in attendance, including Residents #2, #6 and #16. Old issues reviewed- picking up clothes is still not any better, phone issues are not any better. New issues voiced included staff parking in handicap spaces Will follow up with Department Heads and S20FormerDON concerning old and new issues. Attached was an in-service training for facility staff dated 12/04/2024 including phone use in resident care areas and handicap parking was for visitors not for facility staff. There was no evidence of S2DON/FormerNFA addressing the resident council's request to be present nor was there evidence of rationale as to why there was no response from S2DON/FormerNFA. Dated 01/07/2025 at 2:01 p.m. per S17AD revealed a guest was present in addition to othe 17 residents in attendance, including Residents #2, #6 and #16. Old issues were reviewed and handicap parking issues was not resolved. New issues voiced by residents included: beds are not being stripped, what time does whirlpool start, they feel that whirlpool should not be cancelled because they are short; (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	there should be a replacement. Dietary issues voiced by residents of why there is not enough coffee in the morning, why is milk not given at supper time. Housekeeping issues with trash not being emptied. Maintenance concerns were voiced regarding not having a maintenance staff in the facility on the weekends, inquired if maintenance was on call on the weekends. Resident council president, Resident #16, requested S2DON/FormerNFA be present at the next meeting. Response from S20FormerDON revealed whirlpool is cancelled when CNA is needed to cover the floor with explanation of using agency staff to help assist with the staffing. Response from dietary department failed to include rationale as to why consumption of coffee was being monitored and why it was restricted to one canister of coffee at 7:00 a.m. and one at 2:00 p.m. Maintenance department's response included a maintenance staff is on call on the weekends. Response from maintenance failed to include rationale as to why maintenance staff is not present in the building on the weekend. Dated 02/04/2025 at 2:00 p.m. per S17AD revealed a guest was present. A total of 20 residents were in attendance, including Residents #2, #6 and #16, as well as S2DON/FormerNFA. Old issues were reviewed of cell phone issue has not improved and input from residents for facility to let the whole area in the front parking lot where handicap sign is be used for handicap parking. There was only evidence of S2DON/FormerNFA addressing the coffee and residents said ok. There was no response to the old issues nor was there a rationale for the response addressing the coffee. Dated 03/05/2025 at 2:10 p.m. per S17AD revealed 12 residents in attendance, including Residents #2, #6 and #16. Old issues were reviewed of staff still using their cell phones-not gotten any better and would one side of circle be used for visitor handicap parking. Attached was response from housekeeping department. There was no evidence of a facility addressing the old issues of staff cell phone use or consideration of handicap parking for visitors. On 04/01/2025 at 11:15 a.m., surveyor conducted a resident council meeting with Residents #2, #6, and #16. Residents voiced complaints with the facility's call bell system. They reported that when corporate took over on July 1, 2022 that the previous call bell system that was working was removed and replaced with a cheaper call bell system. They explained the old call bell system had the audio capability where when they pressed their call bell, staff at the nursing desk would answer and ask what type of assistance was needed. The current call bell system does not have audio capability to speak to the desk. The residents also voiced frustration with whirlpool as they were supposed to have whirlpool three times a week but now only have it one day a week if the staff showed up. They also reported a guest had to come to some of their meetings. Review of the facility's policy and procedure titled, Answering the Call Light with a revised date of 02/03/2025 revealed: The purpose of this procedure is to ensure timely responses to the resident's requests and needs. Steps in the procedure 1. Answer the resident call system immediately. When answering an auditory request for assistance, identify yourself and politely respond to the resident by his/her name . On 03/31/2025 at 01:00 p.m., an interview was conducted with Resident #46, who stated there are times when I push the button and it takes a few hours for someone to reply. They are out on the side smoking and I can hear them. On 04/01/2025 12:50 p.m., Resident #260's call bell was triggered by pressing the button and a light was activated, there was no audio capability nor was there any noise indicating the call bell was activated. Call bell response time was at 1:22 p.m. Resident stated it takes staff approximately 30 minutes to answer his call light, sometimes they do not answer the call light at all. Resident (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated one night he was on the toilet using the restroom, he pulled the call bell string and after he received no answer from the staff, he called his wife and she called the facility to ask someone to please go and assist him off the toilet. Resident #260 stated the facility's call light system was not a system where it alerted the nurse's station or made any type of noises when pressed. He stated the call light system only displayed a light on the outside of his door when activated. Resident #260 further stated the facility staff does not sit at the nurse's station down Hall D so they are not able to always see when the call bell has been activated. On 04/02/2025 at 09:39 a.m., an interview was conducted with S18RCNA (Restorative Certified Nursing Assistant) who stated she had been staffed at the facility for approximately three weeks. She explained that when a resident's call light went off, the ward clerk announced overhead which room number needed to be seen at that moment. S18RCNA verified the resident's call light system did not have audio capability nor did the call bell make noise when activated. She state that there was simply the light activated above the resident's door to signal activation. On 04/02/2025 at 2:45 p.m., an interview was conducted with S21CNA who stated she really wished the facility's corporation would bring back the old call light system because the current call light system was not effective. The current call light system doesn't make any noise so if working on a separate wing, she sometimes was unable to hear the overhead page. S21CNA explained if she was assisting a resident in their room and needed additional help then she called staff from her personal cell phone due to the inability to speak through the call light system. On 04/02/2025 at 2:55 p.m., an interview was conducted with S22CNA who stated she preferred the old call light system because it had the audio capability. S22CNA added the current call bell system was not effective and she was not sure why the old call bell system was replaced. S22CNA stated sometimes the overhead page was not heard if working on a separate wing. On 04/02/2025 at 3:04 p.m., an interview was conducted with S17AD who has been working at the facility for approximately 40 years. S17AD explained she was the secretary maintaining the Resident Council's monthly meeting minutes by handwriting old issues and new issues voiced by the residents and guest(s) in attendance and after the meeting she shared her notes with the designated department heads. S17AD confirmed a guest was present during the monthly meetings that took place on 11/05/2024, 01/05/2025 and on 02/04/2025. S17AD stated at the January 2025 meeting, she was instructed to use a specific form titled, Resident Council Meeting Minutes, moving forward. S17AD verified there was not a process in place when voiced concerns were not addressed or a response failed to include a rationale to the voiced concerns. On 04/02/2025 at 3:45 p.m., an interview was conducted with S2DON/FormerNFA. She explained that she started working at the facility in August 2024 as the facility's administrator until February 2025 she then became the facility's DON. S2DON/Former NFA explained multiple nursing department heads were terminated or resigned and she was in the process of hiring new nursing department head staff. She explained S3ADON (Assistant Director of Nursing), S4MDS/LPN (Minimum Data Set Licensed Practical Nurse) and S5SSD (Social Services Director) were all new to the facility. She stated she identified problems with the previous staff and was currently investigating how to educate staff to perform duties correctly and efficiently. However, she verified due to nursing and CNA staff not showing up to work, she had to pull S3ADON and S4MDS/LPN to work on the floor to care for the residents. S2DON/FormerNFA explained she identified the ward clerk's position included other duties besides monitoring the call light system and paging the need for assistance overhead; therefore leaving the call light system unwatched at times. S2DON/FormerNFA was monitoring the call light system earlier in the shift (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	because the system was unattended. She also stated that it was impossible to correct a year's worth of issues in six weeks. S2DON/FormerNFA was not made aware by staff or residents that the current call light system was not working effectively nor that the system was not audio capable.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. Based on observations and interviews, the facility failed to maintain privacy and confidentiality of 4 Residents (#13, #23, #27, and #39) medical records. This deficient practice had the potential to affect all of the 60 residents in the facility. Findings: A review of the facility's policy titled, Confidentiality of Information and Personal Privacy with a last review date of 01/15/2025, read in part, Our facility will protect and safeguard resident confidentiality and personal privacy. The policy also indicated general guidelines, The facility will safeguard the personal privacy and confidentiality of all resident personal and medical records. Computer screens will be closed or in locked position when not in use or in the presence of a nurse or unauthorized personnel. On 04/01/2025 at 8:14 a.m., an observation on Hall W revealed that the laptop on top of Med Cart A was unattended. Further observation revealed Resident #13, #23, #27, and #39's first and last name, their picture, room number, and MRN (Medical Record Number) was visible on the laptop screen. On 04/01/2025 at 8:22 a.m., an observation and interview was conducted with S3ADON (Assistant Director of Nursing). She confirmed that S13LPN (Licensed Practical Nurse) should have initiated the privacy screen before she left Hall W to protect the resident's private medical information.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interviews, and maintenance log review, the facility failed to provide a homelike environment, by failing to address a concern regarding bed repairs for 1 (#11) of 4 (#11, #13, #27, and #260) residents investigated for environment. Findings: On 04/01/2025, a review of the facility's policy titled Resident equipment with a reviewed date of 01/14/2025, read in part, Purpose: The purpose of this policy is to ensure resident equipment is properly maintained. Procedures .2. Maintenance director will assess any repairs needed and will report any equipment that is inoperable to the nursing facility administrator. On 03/31/2025 at 10:30 a.m., an observation was made of Resident #11 in her room. She stated the button on the head of her bed had not been working for over 2 months, and she had reported it to maintenance. She stated she could not lower or lift her head making it uncomfortable to sleep. During an interview on 03/31/2025 at 10:30 a.m., S9CNA Certified Nursing Assistant), stated she worked two weeks ago and the remote wasn't picking the resident's head up and she had reported it to maintenance. During an interview with S10Maint (Maintenance) on 03/31/25 at 12:56 p.m., he confirmed he was aware the resident's bed wasn't working but he needed her to get out of bed to fix it. S10Maint was asked if he reported to anyone that the resident needed to get up to repair the bed and he stated he told Resident #11 and the CNA. When asked which CNA he reported the incident to, S10Maint stated he did not remember because they come and go. On 04/01/2025 at 2:29 p.m., an interview and review of maintenance log was conducted with S11Maint (Maintenance.), who stated he was aware the resident's bed was not working three or four weeks ago. S11Maint stated that the bed could have been changed out at the time the resident reported it because they had spare beds on Hall D. On 04/02/2025 at 3:12 p.m., an interview was conducted with S2DON/FormerNFA (Director of Nursing/Former Administrator), who stated the facility had daily morning meetings and maintenance had not reported to her that the resident was having a problem with her bed.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on interview and record review, the facility failed to ensure that the Minimum Data Set (MDS) assessment accurately reflected the resident's status, for 1(#7) of 28 sampled residents. Findings: A review of Resident #7's medical records revealed an admission date of 02/14/2024 with diagnoses which included but were not limited to schizoaffective disorder. A review of Resident #7's Pre admission Screening and Assessment Resident Review (PASRR) revealed a Level 11 determination that read, The individual has a serious mental illness . A review of Resident #7's annual MDS with an Assessment Reference date of 02/12/2025, revealed the following in section A1500: Is the resident currently considered by the state level 11 PASRR process to have serious mental illness and/or intellectual disability or a related condition? The answer was coded 0 for no. On 04/02/2025 at 1:37 p.m., an interview and review of Resident #7's MDS was conducted with S4MDS/LPN (Minimum Data Set/Licensed Practical Nurse). She confirmed that the PASRR was incorrectly coded and did not reflect that the resident was considered by the state level 11 PASRR process to have serious mental illness, and should have.

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F 0656 Level of Harm - Minimal harm or potential for 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 interview and record review, the facility failed to ensure that a resident received services according to the person-centered plan of care for 1 (#14) of 28 sampled residents. Findings: Review of Resident #14's Electronic Health Record (EHR) revealed the resident was admitted to the facility on [DATE] with diagnoses which included but were not limited to Asthma, acute respiratory failure with hypoxia, acute ischemic heart disease, obstructive sleep apnea and chronic systolic (congestive) heart failure. Review of Resident #14's care plan revealed a focus area indicating the resident was at risk for falls, r/t (related to) decrease mobility, depression, respiratory failure and history of falls. Interventions included in part, refer to therapy dept (department) as needed, and refer to restorative program as needed . Review of S19PT (Physical Therapy) notes revealed Resident #14's discharge summary for dates of services 02/28/2024- 03/08/2024 with discharge reason maximum Potential achieved. Referred for RNP (Restorative Nursing Program) .Discharge status and recommendations: Prognosis to Maintain Resident's Level of Function=Excellent with consistent staff support . During an interview on 03/31/2025 at 11:35 a.m., Resident #14 stated she was supposed to have therapy. The resident further stated that insurance denied her when she was admitted but the facility was supposed to start restorative but it hasn't been consistent. During an interview on 04/02/2025 at 9:39 a.m. with S18RCNA (Restorative Certified Nursing Assistant) she stated she had been working at the facility for three weeks. S18RCNA stated she was unsure if restorative nursing was being done prior to her. During an interview on 04/02/2025 at 11:03 a.m., S19PT (Physical Therapy) stated restorative program just restarted again because all the department heads resigned 02/2025. S19PT stated the previous department heads were not ensuring that restorative services were being done as ordered. S19PT explained Resident #14 had managed care insurance which did not cover physical therapy and the facility's corporation preferred resident have restorative because the facility does not get reimbursed financially if Resident #14 had PT services.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews, the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good grooming by failing to trim and clean a resident's fingernails for 1 (Resident #39) of 28 sampled residents. The deficient practice had the potential to affect a census of 60. Findings: A review of the facility's policy titled, Care of Fingernails/Toenails with a last review date of 02/03/2025, read in part, The purpose of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections. The policy also indicated general guidelines, Nail care includes daily cleaning and regular trimming. A review of Resident #39's electronic medical record revealed he was admitted to the facility on [DATE] with diagnoses that included in part, Type 2 Diabetes Mellitus without Complications and Vitamin D Deficiency. A review of Resident #39's Annual MDS (Minimum Data Set) dated 02/25/2025 revealed he had a BIMS (Brief Interview for Mental Status) of 11, indicating his cognition was moderately impaired. Section GG: Functional Abilities revealed personal hygiene 2. Substantial/maximal assistance. A review of Resident #39's Comprehensive Care Plan revealed a focus that read, Requires assistance for ADL's (Activities of Daily Living). A review of Resident #39's physician orders revealed an order date of 02/21/2024 that read, Diabetic Nail Care Q (every) Wednesday. On 03/31/2025 at 12:42 p.m., an observation was made of Resident #39's fingernails. His fingernails were long with brown debris noted underneath the nails. Resident #39 stated that he would like his fingernails cut and cleaned, and the last time they were cut and cleaned was approximately 2 - 3 months ago. On 04/01/2025 at 11:47 a.m., a second observation was made of Resident #39's fingernails and they remained long with brown debris noted underneath the nails. On 04/02/2025 at 8:29 a.m., a third observation was made of Resident #39's fingernails and they remained long with brown debris noted underneath the nails. On 04/02/2025 at 9:03 a.m., an interview was conducted with S8TXLPN (Treatment Licensed Practical Nurse). She stated all nail care for residents including diabetic residents are to be completed weekly by her. On 04/02/2025 at 10:03 a.m., an interview and observation of Resident #39's fingernails was made with S8TXLPN. She confirmed that Resident #39's fingernails were long, not cleaned, and needed to be trimmed.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Consolata Rehab and Wellness Center on the Teche	2319 East Main Street New Iberia, LA 70560

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview and record review, the facility failed to ensure a resident received enteral feedings as ordered by the physician for 1 (Resident #51) out of 28 sampled residents. Findings: Review of Resident #51's admission Record revealed she was admitted to the facility on [DATE] and had diagnoses which included, but were not limited to, dysphagia, adult failure to thrive, and cachexia. Review of Resident #51's Quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 03/20/2025 revealed the resident had a BIMS (Brief Interview for Mental Status) score of 0, which indicated the resident had a severe cognitive impairment. Further review revealed in Section K: Swallowing/Nutritional Status Resident #51 had a feeding tube. Review of Resident #51's Order Summary Report revealed an order dated 03/27/2025 that read: Enteral feed order every shift, Jevity 1.2 70 ml/hr (milliliters per hour) with water flushes of 100 ml (milliliters) every four hours free flushes with pump. Review of Resident #51's Care Plan Report revealed the resident was at risk for inadequate nutritional intake, weight loss/gain related to depression, dementia, adult failure to thrive, and dysphagia. Further review revealed resident required a PEG (Percutaneous Endoscopic Gastrostomy) tube for supplemental nutrition. On 04/01/2025 at 8:52 a.m., an observation of Resident #51's enteral feeding delivery system revealed the enteral feeding pump was noted to be turned off at this time. On 04/01/2025 at 9:57 a.m., an observation of Resident #51's enteral feeding delivery system revealed the enteral feeding pump was noted to be turned off at this time. On 04/01/2025 at 11:32 a.m., an observation of Resident #51's enteral feeding delivery system revealed the enteral feeding pump was noted to be turned off at this time. On 04/01/2025 at 12:36 p.m., a concurrent observation of Resident #51's enteral feeding delivery system and interview was conducted with S6LPN (Licensed Practical Nurse). S6LPN confirmed that the enteral feeding pump is turned off at this time and it should not have been.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 3. Review of Resident #14's Electronic Health Record (EHR) revealed the resident was admitted to the facility on [DATE] with diagnoses which included but were not limited to Asthma, acute respiratory failure with hypoxia, acute ischemic heart disease, obstructive sleep apnea and chronic systolic (congestive) heart failure. Review of the physician's orders revealed an order written on [DATE] for O2 (Oxygen) @ (at) 2L (liter) via (through) NC (nasal cannula) continuous every shift. Review of Resident #14's person-centered care plan revealed the following: At risk for SOB (shortness of breath) r/t (related to) respiratory failure. Interventions included, provide with humidification, change O2 humidifier and tubing every week on Wednesday and prn as need, and administer oxygen therapy as ordered 2L /NC. On [DATE] at 11:35 a.m., Resident #14 was observed in his wheelchair receiving oxygen at 4L via NC. The tubing and humidifier bottle were not labeled or dated. On [DATE] at 8:44 a.m., Resident #14 was observed in bed receiving Oxygen at 4L via NC and the tubing and humidifier bottle remained undated and not labeled. On [DATE] at 8:50 AM S13LPN (Licensed Practical Nurse) confirmed Resident #14 was receiving 4L oxygen via NC. She also confirmed the tubing and humidifier bottle were not labeled or dated. S13LPN stated night shift was responsible for changing tubing on Wednesdays. On [DATE] at 8:52 a.m., S3ADON confirmed that oxygen tubing should be labeled and dated and O2 delivered according the physician's orders. Based on observations, interviews and record reviews, the facility failed to ensure that residents received respiratory care according to professional standards of practice, the physician's order, and the comprehensive person-centered care plan for 3 (#11, #14, and #19) of 3 (#11, #14, and #19) residents investigated for respiratory care, as evidenced by failing to: 1. Ensure Resident #11's humidifier bottle was changed when it was empty, and Oxygen tubing changed weekly; 2. ensure Resident #19's oxygen nebulizer mask, nasal cannula, and suction cannula were stored in a bag when not used; and 3. date and label oxygen tubing and ensuring oxygen was delivered at the ordered rate for Resident #14. Findings: On [DATE], a review of the facility's policy titled Oxygen Administration, read in part, Policy: Oxygen shall only be administered by physician order .All safety precautions and care of equipment shall be performed according to recommended State and Federal guidelines and facility procedures. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prefilled humidifier bottles and nasal cannulas/masks will be changed every week and prn. All tubing and bottles are to be labeled each week when changed. When the tubing is not being used, it should be stored properly in a zip lock bag .Oxygen equipment .humidifier bottles and other related items should be checked prn for proper functions. 1. Resident #11 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease, and morbid obesity with alveolar hypoventilation. A review of Resident #11's care plan revealed a focus area dated [DATE]: COPD/SOB (chronic obstructive pulmonary disease/shortness of breath) (Albuterol, O2 (oxygen) therapy. Goal: Exhibits no shortness of breath. Interventions included, but were not limited to: Provide humidification, ensure that supply is available at all times, and change tubing per facility protocol. On [DATE] at 10:30 a.m., an observation was made of Resident #11 in her room. The resident was receiving oxygen via nasal cannula with the tubing attached to an empty humidifier bottle on an oxygen compressor. On [DATE] at 10:30 a.m., an interview was conducted with S9CNA (Certified Nursing Assistant). She confirmed the humidifier bottle was empty and tubing was labeled 03/22. On [DATE] at 10:32 a.m., an interview was conducted with S8TXLPN, (Treatment Licensed Practical Nurse). S8TXLPN stated she was not responsible for oxygen care. She also stated the night nurse handled the changing of tubes and humidifiers. On [DATE] at 9:25 a.m., an interview was conducted with S3ADON (Assistant Director of Nursing), who stated that she was made aware of the outdated oxygen tubing and empty humidifier bottle on [DATE]. S3ADON stated that the night nurse is responsible for making any changes that need to be done on Wednesdays, but if the tubing is expired and the humidifier bottle is empty, anyone can change it, and that includes the treatment nurse and the resident's hall nurse. 2. Resident #19 was admitted to the facility on [DATE], with diagnoses which included but were not limited to, atherosclerotic heart disease of native coronary artery without angina pectoris and Hemiplegia and hemiparesis following cerebral infarction affecting left dominant side. A review of physician orders revealed an order written on [DATE] for Xopenex Nebulization Solution 0.63 MG (milligram)/3 ML (milliliter) (Levalbuterol HCL [hydrochloride]) 1 vial inhale orally via nebulizer as needed for wheezing. A review of the facility's standing orders revealed the following: Oxygen: O2 at 2L (liter) via nasal cannula prn (as needed) for dyspnea, hypoxia (O2 saturation < (less than) 90% [percent]) or acute angina to keep O2 saturations > (greater than) 90% . On [DATE] at 11:34 a.m., an observation was made of Resident #19 in his room. The resident was lying in his bed. The resident's O2 nasal cannula is observed on his over bed table which is pushed up (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	against the wall. The resident's shoes were on top of the tubing on his over bed table. Further observation revealed a nebulizer mask on the floor underneath the resident's rolling table, and a suction tube connected to a portable suction machine on the floor. The nasal cannula, nebulizer mask, and suction cannula were not stored in a bag. During an interview with S12LPN (Licensed Practical Nurse) on [DATE] at 11:41 a.m., she confirmed the above findings and stated the nasal cannula, the nebulizer mask, and the suction cannula were used by the resident and should have been stored in a bag.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure that a resident receiving dialysis received services consistent with professional standards of practice and the comprehensive person-centered care plan for 1 (#260) of 1 (#260) resident receiving dialysis out of a total sample size of 28 residents. Findings: On 04/02/2025, a review of the facility's policy titled Weight Assessment and Intervention with a last reviewed date of 01/15/2025, read in part, Policy statement: Resident weights are monitored for undesirable or unintended weight loss or gain: Policy Interpretation and implementation: Weight assessment: 1. Residents are weighed upon admission and at intervals established by the interdisciplinary team or the resident's physician. Resident #260 was admitted on [DATE] with diagnoses which included but were not limited to end stage renal dialysis and dependence on renal dialysis. A review of Resident #260's physician's orders revealed an order written on 03/20/2025 which read, Weights - Daily x 3, then weekly every day shift for 3 days and every shift every 7 day(s). During an interview with Resident #260 and his wife on 04/01/2025 at 12:13 p.m., the resident stated he had his weight checked two times, on admission and a week later. A review of Resident #260's weight log revealed two weights were documented. On 03/21/2025 the resident weighed 174.5 pounds, and on 03/28/2025 the resident weighed 174.6 pounds. During an interview and review of Resident #260's medical records with S3ADON (Assistant Director of Nursing) on 04/01/2025 at 1:00 p.m., she confirmed the weights were not done as ordered by the resident's physician. She stated the resident should have weights measured and documented on 03/22/2025 and 03/23/2025 and were not.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations and interviews, the facility failed to ensure drugs and biologicals used in the facility were stored in accordance with currently accepted professional principles. The facility failed to ensure: 1. Medication carts were locked when unattended for 1 (Med Cart A and Med Cart B) out of 2 (Med Cart A and Med Cart B) medication carts reviewed; 2. Medication carts were free of loose pills for 2 (Med Cart A and Med Cart B) out of 2 (Med Cart A and Med Cart B) medication carts reviewed; 3. Medication carts were free of expired medications for 2 (Med Cart A and Med Cart B) out of 2 (Med Cart A and Med Cart B) medication carts reviewed; and 4. One Ozempic Syringe (medication that helps lower blood sugar) was stored appropriately. This deficient practice had the potential to affect all of the 60 residents in the facility. Findings: A review of the facility's policy titled, Storage of Medications with a last review date of 01/15/2025, read in part, The facility stores all drugs and biologicals in a safe, secure, and orderly manner. The policy also indicated general guidelines, Unlocked medication carts are not left unattended. Medications requiring refrigeration are stored in a refrigerator located in the drug room at the nurses' station or other secured location. On 03/31/2025 at 10:29 a.m., an observation was conducted of Med Cart A in Hall E. Med Cart A was parked in Hall E against the wall with the doors and drawers facing the hall. Med Cart A was unlocked and left unattended. On 03/31/2025 at 10:45 a.m., an interview and observation of Med Cart A was conducted with S7RN (Registered Nurse). S7RN confirmed that she was responsible for Med Cart A and it was unlocked and left unattended. She confirmed that she did not lock Med Cart A because she was notified by the night staff to not lock Med Cart A due to the lock malfunctioning. On 04/01/2025 at 9:30 a.m., an interview was with S3ADON (Assistant Director of Nursing). S3ADON confirmed that medication carts are to be locked at all times when left unattended. She stated if the lock was malfunctioning on Med Cart A it should have been placed in the locked medication room. On 03/31/2025 at 10:50 a.m., observation was conducted of Med Cart A with S7RN which revealed the following: 1. 55 loose pills; 2. 1 Saline Nasal Spray with an expiration date of 01/2025; and (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. 1 Ozempic 2 mg (milligram)/3 mL (milliliter) in a sealed package with Refrigerate on the packaging noted. An interview with S7RN was conducted at this time and confirmed the findings above. She stated there should not be loose pills or expired medication in Med Cart A, and Ozempic was unused and should be stored in the medications refrigerator. On 04/01/2025 at 9:00 a.m., observation was conducted of Med Cart B with S6LPN (Licensed Practical Nurse) which revealed the following: 1. 10 loose pills; 2. 1 Refresh Relieva with an expiration date of 2023 (unable to see month on the label due to it being faded); 3. 1 Refresh Relieva with an expiration date of 07/2022; 4. 1 Retaine Ointment with an expiration date of 02/2023; 5. 1 Systane Lubricant with an expiration date of 02/2023; and 6. 1 Refresh Relieva with an expiration date of 08/2022. An interview with S6LPN was conducted at this time who confirmed the findings above. She stated there should not be loose pills or expired medications in Med Cart B. On 04/01/25 at 9:30 a.m., an interview was conducted with S3ADON. S3ADON stated medication carts should be checked daily by the nurse, loose pills should not be in the medication carts, all expired medications should have been discarded, not left in the medication carts, and Ozempic should have been refrigerated at all times.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and record review, the facility failed to maintain the kitchen in accordance with professional standards for food service safety as evidenced by: 1. Failing to ensure food items were covered in the walk in cooler; 2. Failing to ensure expired food items were removed from the dry goods storage room; 3. Failing to ensure the dishwasher reached 120 degrees Fahrenheit during the wash cycle; and 4. Failing to ensure clean dishes were not stored in the dishwashing area. This deficient practice had the potential to effect the 62 residents that received nourishment from the kitchen: Findings: Review of the facility's policy titled Food Receiving and Storage, with a last revised date of 02/13/2025, read in part; Policy Statement; Foods shall be received and stored in a manner that complies with safe food handling practices .8. All foods stored in the refrigerator or freezer will be covered, labeled, and dated 'use by date'. Review of the facility's policy titled Cleaning Policies and Procedures, with a last reviwed date of 02/13/2025 read in part; Once utensils and equipment and utensils have been sanitized, they should be handled and stored to protect the equipment and utensils from re-contamination .Procedures . 3. Equipment and supplies will be available for proper cleaning and sanitizing of dishes. a. wash temperature ; 1. 120 degrees manual 2. 140 degrees mechanical. On 03/31/2025 9:00 a.m., an observation of the kitchen's walk-in cooler was conducted with S14DM (Dietary Manager). Ten bowls of fruit cocktail were observed uncovered in the cooler. S14DM confirmed the bowls should have been covered. An observation was then made of dry goods storage room with S14DM. Three packages of cheesecake mix were observed with expiration dates of 02/01/2025. S14DM confirmed they were expired. On 03/31/2025 at 9:27 a.m. an observation was made of the dishwashing area. S14DM was asked to run a dishwashing cycle. She stated that it was a low temperature dishwasher with chemical sanitization. Observation was made of the temperature gauge during the dish washing cycle. The temperature gauge read 100 degrees Fahrenheit. She confirmed that the temperature was not at 120 degrees Fahrenheit during the wash cycle, and stated the water booster that helped to maintain the dishwasher at the (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	appropriate temperature was broken. She further stated the water booster had been broken for two weeks, however they still continued to use the dishwasher. Further observation of the dishwashing area revealed a tray of clean coffee mugs and a two trays of clear drinking glasses stored on a rack across from the dishwasher, where soiled dishes were being washed. S14DM stated she was not aware that the clean dishes could not be stored in the dishwashing area. On 03/31/2025 at 11:04 a.m., a follow up observation was made of the kitchen. A tray of glasses filled with water and ice was observed in the dishwashing area. S15Dietary confirmed that she prepared the glasses of water and was unaware they could not be placed in the dishwashing area. On 03/31/2025 at 1:15 p.m., an observation was made of S15Dietary washing dishes using the dishwasher. At 1:30 p.m., an observation was made of the dishwasher with S14DM and S2DON (Director of Nursing). S14DM confirmed that the dishwasher continued to be used even though the water booster was broken and was not reaching 120 degrees Fahrenheit during the wash cycle. When asked why the dishwasher was still being used although it was not reaching the minimum wash temperature of 120 degrees, S16Cook stated that the dishwasher could get to the appropriate temperature, however the dishwasher had to be ran constantly. She further stated that it had to be ran for three cycles prior to using it to wash dishes so that it could heat up. S16Cook proceeded to run the dishwasher three times. On the fourth cycle, S2DON and S14DM confirmed that the temperature gauge was at 115 degrees Fahrenheit and did not read at 120 degrees. S14DM confirmed that she had no way of ensuring that all of her staff were running the dishwasher for multiple cycles prior to using it to ensure the temperature was up to 120 degrees and confirmed that she had no way to ensure that the staff were checking to make sure it reached 120 degrees Fahrenheit.