STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235471	A. Building B. Wing	12/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Plainwell	320 Brigham St Plainwell, MI 49080

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47659 Based on interview and record review the facility failed to ensure that staff treated residents with dignity and respect in 1(Resident #23) of 7 residents reviewed for dignity, resulting in feelings of frustration and the potential for depression, loss of self-worth and an overall deterioration of psychological well-being. Findings include: Resident #23 Review of an Admission Record revealed Resident #23, was originally admitted to the facility on [DATE] with pertinent diagnoses which included depression. Review of a Minimum Data Set (MDS) assessment for Resident #23 with a reference date of 10/3/23, revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #23 was cognitively intact. During an interview on 12/06/23 at 10:08 AM, Resident #23 reported that he had a bad interaction with a nurse the day before. Resident #23 reported that Registered Nurse (RN) ZZZ entered his room with his medication in a pill cup that she had her fingers in. Resident #23 reported that he asked RN ZZZ to dispose of the pills and provide pills that had not been touched by her since she was not wearing gloves and he did not observe her sanitize her hands. Resident #23 reported that RN ZZZ refused Resident #23's request and placed the medication cup in front of Resident #23's face, while repeating the words are you going to take them or not. Resident #23 reported that he felt like RN ZZZ just wanted to argue with him, and was not willing to hear his concerns related to taking medications that she had touched. Resident #23 reported that RN ZZZ had raised her voice to him, and he felt disrespected. Resident #23 began to cry when talking about the interaction, and said I am just so sick of being treated poorly by staff and nothing gets done about it. Resident #23 reported that RN F observed this interaction between RN ZZZ and Resident #23, and informed Resident #23 that she would be reporting the actions of RN ZZZ to the Nursing Home Administrator (NHA). (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/06/23 at 11:17 AM, RN F reported that she had been training RN ZZZ the day before when she overheard RN ZZZ raising her voice at Resident #23. RN F reported she entered Resident #23's room and heard RN ZZZ say You can either take it (the medications) or not. RN F reported that she intervened and told RN ZZZ that it was not appropriate to argue with residents or treat them like that. RN F reported that Resident #23 was visibly upset. RN F reported that she did report the incident to the NHA shortly after. RN F reported that she cared for Resident #23 the remainder of the evening because Resident #23 did not feel comfortable with RN ZZZ. During an interview on 12/06/23 at 11:22 AM, NHA reported that she was made aware of the interaction between Resident #23 and RN ZZZ by RN F. NHA reported that she spoke with Resident #23 and informed him that she would be completing education with RN ZZZ. On 12/7/23 at 10:32 AM, this surveyor requested the education that was completed by NHA with RN ZZZ. Review of Education Acknowledgments Form dated 12/5/23, revealed, Training Topic: Resident interaction/communication. Type of training requested/needed: Stay calm, do not take it personally when resident upset; take opportunity to ask resident their preferences for care delivery so care can be delivered in a manner that makes resident comfortable/feel safe with care giver. Summary of training (to be completed by the trainer): (Resident #23) is very concerned about infection risk in general, has excessive cleanliness. As a new nurse to facility, he will have to develop trust. Give resident feeling of control by asking how he wants care given/meds delivered. If what he is asking doesn't sound right, ask nursing leadership for guidance. How objectives of training will be applied (to be completed by the associate): This section of form was not completed. Associate Acknowledgement Statement: I have been trained on communication with (Resident #23) and I understand the policies, procedures, and/or guidelines regarding said training. I have read and agree that the above summary of training was provided to me. I will apply this training as stated above. I agree that I am responsible for notifying my supervisor if additional training is needed. By signing this, I commit to follow the company's standards of performance and conduct to implement training provided herein. Additional comments: I plan to do as education above. Signed by RN ZZZ and Director of Nursing B on 12/7/23. During an interview on 12/11/23 at 9:37 AM, Resident #23 reported that he had not spoken with NHA regarding the interaction that had happened between him and RN ZZZ. Resident #23 reported that he had not talked to any other staff members but RN F regarding the interaction between him and RN ZZZ and he had not been made aware of the NHA or anyone else in the facility addressing the issue. Review of Facility's Dignity Policy last reviewed 9/25/23 revealed, Each resident has the right to be treated with dignity and respect. Interactions and activities with residents by staff, temporary agency staff, or volunteers must focus on maintaining and enhancing the resident's self-esteem, self-worth, and incorporating the resident's goals, preferences, and choices. Staff must respect the resident's individuality as well as, honor and value their input .

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47659 Based on observation, interview, and record review, the facility failed to ensure call lights were in reach for 2 (Resident #53, and #78) of 3 residents reviewed for accommodation of needs resulting in resident's inability to call for staff assistance with the potential for unmet care needs. Findings include: Resident #53 Review of an Admission Record revealed Resident #53, was originally admitted to the facility on [DATE] with pertinent diagnoses which included muscle weakness and difficulty in walking. Review of a Minimum Data Set (MDS) assessment for Resident #53, with a reference date of 11/1/23 revealed a Brief Interview for Mental Status (BIMS) score of 10/15 which indicated Resident #53 was moderately cognitively impaired. Review of Resident #53's Care Plan revealed, (Resident #53) is at risk for falls d/t (due to) muscle weakness, difficulty walking, impaired balance, unsteady gait, incontinence, impaired cognition with poor safety awareness, pain, medications and h/o (history of) falls. Date Initiated: 07/28/2023. Interventions: .Call light within reach. Date Initiated: 07/28/2023 . During an interview and observation on 12/04/23 at 11:05 AM, Resident #53 was sitting in her recliner watching television with a tray table in front of her. Resident #53 reported that she usually had a call light at her tray table, but she could not find it. Resident #53's call light was hanging up over the light in her room and out of Resident #53's reach. During an observation on 12/04/23 at 1:30 PM, Resident #53's was in the same location as previous observation, and out of Resident #53's reach. During an interview on 12/06/23 at 2:39 PM, Certified Nursing Assistant FF reported that Resident #53 did use a call light when she needed assistance from staff. 41424 Resident #78: Review of an Admission Record revealed Resident #78 was a female with pertinent diagnoses which included pressure ulcer of sacral region, stage 4, pressure ulcer of right ankle, stage 3, pressure ulcer of left heal, unstageable, stiffness of right hand, contracture right foot, contracture left foot, multiple sclerosis, urosepsis, gangerene, chronic pain, and cognitive communication deficit. Review of current Care Plan for Resident #78, revised on 3/14/23, revealed the focus, .Resident is at risk for falls r/t (related to) MS (multiple sclerosis), decreased mobility, narcotic pain medication, cognitive/communication deficits . with the intervention .Call light within reach . (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 12/5/23 at 8:26 AM, Resident #78 was observed lying in her bed on her back with her legs bent to the left side. Resident #78 does have a contracted right leg. She does have water today on the rolling table next to her bed but it was not over the bed and unreachable by the resident. There was a post it note on the side of the cup with Juven with a notation of 12/4/23 on it. Observed the call light draped over the overhead light above the head of the bed, which was way out of her reach. During an observation on 12/5/23 at 2:00 PM, Resident #78 was observed in her room lying in her bed. Observed the call light draped over the overhead light above the head of her bed, which was way out of her reach. During an observation on 12/05/23 05:00 PM, Resident #78 observed lying in her bed with her call light hung over the overhead light over her bed, which was out of reach for Resident #78. During an observation on 12/07/23 03:13 PM observed Resident #78 lying in bed, supine position, right leg contracted, up and turned some to the left. she had a foot cradle under her feet with the bed sheet which was hung over the foot board of the bed with no tenting at the foot of the bed. Call light was hung over the overhead light above her bed, which was way out of reach for the resident. In an interview on 12/11/23 at 2:37 PM, Director of Nursing (DON) B reported for the DON to ensure the facility nursing staff were following orders and interventions, the aides were supposed to be checking on the residents, completed the check and changes, and ensured the resident's need were met and the nurses when they administered medications, completed assessments, performed treatments were all visually assessing the resident which were documented in the medical record, The Unit manager, night supervisors, assistant director of nursing complete visual observations and reviewing documentation of the staff were completing, assessing, and monitoring the resident's care. The care plans were modified during the IDT team meetings ensuring focuses and interventions were updated and triggered for the CNAs and Nurses to complete accurate documentation. According to https://journals.lww.com/ regarding call light use, It is one of the few means by which patients can exercise control over their care on the unit. When patients use the call light, it is usually to summon the nurse .Patients expect that when they push the call light button, a nursing staff member will answer or come to them.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 41424 Based on observation, interview, and record review, the facility failed to accommodate a resident's right to make choices that were consistent with their assessment and plan of care for 1 of 2 sampled residents (Resident #5) reviewed for resident choices, resulting in the resident not meeting their highest practicable level of well-being. Findings include: Review of an Admission Record revealed Resident #5 was a female with pertinent diagnoses which included multiple sclerosis, paraplegia, stage 4 pressure ulcer of right buttock, tobacco use, anxiety and depression. Review of a Minimum Data Set (MDS) assessment for Resident #5, with a reference date of 9/20/23, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated Resident #5 was cognitively intact Review of current Care Plan for Resident #5, revised on 03/08/22, revealed the focus, .(Resident #5) has a history of being a smoker, she is aware of the risk vs benefits of being a smoker and has been educated on health concerns associated with smoking . with the intervention .Educate her and her family on non-smoking facility .Encourage her to not smoke if using medications/patches .Independent Resident will be encouraged to secure smoking paraphernalia . In an interview on 12/4/23 at 12:05 PM, Resident #5 reported the facility had talked to her about her smoking and being out of her chair for long periods of time. Review of Smoking Safety Evaluation dated 10/8/23, revealed, Resident #5 had demonstrated ability to safely smoke. Review of Behavior Note dated 10/21/2023 at 6:37 PM, revealed, .STAYS IN W/C MOST OF THE SHIFT OUT SIDE SMOKING. DOES NOT EAT SAYS THAT SHE DRINKS ENSURE WHICH IS AS GOOD AS THE MEAL .EDUCATING THE RESIDENT IS NOT EFFECTIVE . Review of Care Management dated 10/27/2023 at 2:37 PM, revealed, SS and DON talked to resident about her smoking and advised she would receive 30 day notice of discharge if she continued. DON also emphasized if she quit it would help her wounds. Resident agreed that she will no longer smoke . Review of Behavior Note dated 11/3/2023 at 3:47 PM, revealed, .SS and ED met with resident to discuss recent incidents related to vaping and smoking. We let her know we were looking at issuing 30 day notice of discharge. Resident understood. We discussed possible placement options and she indicated she would like tolook in (Area by the lake) area . Review of Behavior Note dated 11/6/2023 at 10:50 AM, revealed, .This writer drove by the facility on Saturday, November 4th at approximately 3:55pm and witnessed resident on the sidewalk that is in front of the (facility) sign smoking a cigarette . (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Behavior Note dated 11/17/2023 at 5:06 PM, revealed, .Resident seen smoking in front of facility. ED and SS talked to her about it and said we are still looking for a smoking facility. She said she quit her vape pen and is down 3 cigarettes a day . Review of Behavior Note dated 11/19/2023 at 03:45 PM, revealed, .(Resident #5) was outside smoking in front of the (Facility) sign by the road. Resident was on the sidewalk. I reminded resident that she knew the rules and that she was not supposed to be smoking. She said that that only reason she was sitting where she was, was because she wanted to sit in the sun. I explained that she was not supposed to be smoking. She said I know . In an interview on 12/11/23 at 8:48am, Social Services Director (SSD) VV reported he was present when multiple residents were told they would be discharged from the facility if they continued to smoke on the public sidewalk in front of the facility. SSD VV reported the facility targeted the residents who smoked on the public sidewalk because the facility had complaints from other community members. SSD VV reported the local police department had spoken to those residents in the building who smoke. According to Your Rights and Protections as a Nursing Home Resident revealed, .At a minimum, Federal law specifies that nursing homes must protect and promote the following rights of each resident. You have the right to .Be Treated with Respect: You have the right to be treated with dignity and respect, as well as make your own schedule and participate in the activities you choose . https://downloads.cms.gov/medicare/your_resident_rights_and_protections_section.pdf

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38384 This citation pertains to intake MI00140935. Based on interview, and record review, the facility failed to notify the responsible party of a change in resident condition in 1 of 19 residents (R45) reviewed for notification of changes, resulting in the resident representative not being made aware immediately of an accident resulting in the lack of ability to participate in timely medical decision-making. Findings include: Review of the policy/procedure Changes in Resident's Condition or Status, dated 8/9/23, revealed .This facility will notify the resident, his/her primary care provider, and resident/resident representative of changes in the resident's condition or status .A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is .An accident involving the resident which results in injury and has the potential for requiring physician intervention . According to the Minimum Data Set (MDS) dated [DATE], R45 scored 4 out of a scale of 15 (severely cognitively impaired) on her BIMS (Brief Interview Mental Status), required the use of a wheelchair to self-ambulate around the facility with diseases that included Alzheimer's, dementia, and schizophrenia. Review of R45's Incident Report (IR) #1810 dated 10/22/2023 18:50 (6:50 PM), reported the resident's wheelchair's left wheel got caught in the leg of a mechanical lift. A skin tear (layers of skin separate or peel back) was noted to her LFA (left forearm). A message was left for the resident's representative. Agencies/People Notified .Family Member at 18:50 (6:50 PM). Review of R45's Progress Note 10/23/2023 02:30 (AM) Event Note reported the resident's wheelchair's left wheel got caught in the leg of a mechanical lift. A skin tear (layers of skin separate or peel back) was noted to her LFA (left forearm). A message was left for the resident's representative. Review of R45's Physician Note dated 10/23/2023 revealed, .Reason for Evaluation: I am asked by the nursing staff to evaluate patient's left forearm after a fall . Assessment: Dirty wound. Plan .Start doxycycline 100 mg b.i.d. (twice daily) x 7days . Review of R45' Medication Administration Record (MAR) 10/1/2023-10/31/2023 reported an order date 10/23/2023 1431 (2:31 PM) Doxycycline Hyclate Oral Tablet 100 mg give 1 tablet my mouth two times a day for skin tear for 7 days During an interview on 12/5/2023 at 12:08 PM, Family Member (FM) OOO stated, I was not notified that my mother had recently got a skin tear. In a second interview on 12/06/23 at 3:59 PM, FM OOO stated, I was not notified (R45) was placed on antibiotics. It surprises me that I was not notified because they have notified me of lesser important things.

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47659 Based on interview and record review, the facility failed to ensure that physician orders for immediate care were in place for 1(Resident #442) of 1 resident reviewed for new admission orders, resulting in missed assessments and monitoring for potential side effects related to use of psychotropic and pain medications. Findings include: Resident #442 Review of an Admission Record revealed Resident #442, was originally admitted to the facility on [DATE] with pertinent diagnoses which included type 2 diabetes mellitus and chronic kidney disease. Review of Resident #442's Medication and Treatment Administration Orders revealed, Order: Ativan Oral Tablet 1 MG (Lorazepam) (anti-anxiety medication) Give 1 tablet by mouth every 4 hours as needed for anxiety Order Date: 12/01/2023. Order: Haloperidol Lactate Oral Concentrate 2 MG/ML (Haloperidol Lactate)(antipsychotic medication) Give 0.25 ml by mouth every 6 hours as needed for anxiety. Order Date 12/01/2023. Order: SEROquel Oral Tablet 50 MG (Quetiapine Fumarate) (antipyschotic medication) Give 1 tablet by mouth two times a day related to cerebrovascular disease. Order date: 12/01/2023. Gabapentin Oral Capsule 300 MG (Gabapentin) (Medication used to treat nerve pain). Give 1 capsule by mouth every 12 hours as needed for nerve pain. Order date: 12/01/2023. Morphine Sulfate (Concentrate) Solution (medication used for pain management) 20 MG/ML Give 5 milligram by mouth every 2 hours as needed for Pain .25 ml. Order Date: 12/01/2023. Review of Resident #442's Medication and Treatment Administration Orders did not reveal orders for monitoring for potential side effects related to Resident #442's use of psychotropic and pain medications. Review of Resident #442's Care Plan did not reveal any care plan focuses related to Resident #442's use of psychotropic and pain medications. During an interview on 12/06/23 at 10:57 AM, LPN M was unable to report any orders that the facility had in place to assess and monitor for potential side effects related to Resident #442's use of psychotropic and pain medications. During an interview on 12/06/23 at 3:08 PM, Unit Manager E reported that there were not orders in place for nursing staff to monitor for potential side effects of antipsychotic or pain medication for Resident #442. Unit ManagerE reported that Resident #442's care plan did not address his use of psychotropic and pain medications. Unit Manager E was not able to report any interventions that staff had in place to help guide Resident #442's care related to his use of psychotropic and pain medications. Unit Manager E was not able to report how nurses were assessing for potential side effects that Resident #442 may have experienced related to his use of psychotropic and pain medications. Unit Manager E reported that the orders and care plan should have been reviewed by the admitting nurse and himself, and that this was missed. (continued on next page)

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/11/23 at 1:03 PM, Assistant Director of Nursing (ADON) C reported that she had updated Resident #442's orders on 12/5/23, but she did not notice that Resident #442 did not have orders or care plans in place to guide Resident #442's care related to his use of psychotropic and pain medication. ADON C confirmed that Resident #442 should have had orders and a care plan in to help guide Resident #442's care related to his use of psychotropic and pain medications, and that this was missed.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47955 Based on observation, interview, and record review the facility failed to ensure that Minimum Data Set (MDS) assessments were accurate in 1 resident (Resident #54) of 18 sampled residents reviewed for Minimum Data Set (MDS) quarterly assessment, resulting in the potential for inaccuracy of treatments, interventions, and cares. Findings include: Review of an Admission Record revealed Resident #54 had pertinent diagnoses which included other frontotemporal neurocognitive disorder (disorder affecting the frontal and temporal lobe of the brain), adjustment disorder with mixed disturbance of emotions (feeling sad and anxious both), unspecified dementia (disease that affects memory and thinking), and anxiety. Review of Health Status Note for Resident #54 dated 9/18/23 revealed .grunting loudly. Redirection ineffective .Face red and diaphoretic. Unable to comfort. Review of Behavior Note for Resident #54 dated 9/24/23 revealed .non-stop yelling out loudly . Review of Minimum Data Set for Resident #54 dated 9/29/23 revealed .section E related to behaviors indicated Resident #54 did not display any behaviors . Review of Care Plan for Resident #54 revealed Focus: . dx (diagnosis) of anxiety disorder .s/s (signs and symptoms) include yelling and restlessness .Goal: . free from discomfort or adverse reactions . Intervention: . may wear a weighted vest AS NEEDED when having verbal outbursts/anxiety. Does not have to wear longer than 4 hours at a time . Initiated on 10/4/23 During an interview on 12/11/23 at 1:08 PM., Registered Nurse/Minimum Data Set Coordinator (RN/MDSC) YYY reported the behavior information was directly inputted into the MDS assessment by the social worker. During an interview on 12/11/23 RN/MDSC YYY reported that Resident #54's MDS quarterly assessment dated [DATE] was inaccurate. During an observation on 12/4/23 at 12:24 PM., Resident #54 was yelling out while rolling independently in her wheelchair around the unit hallway. During an observation on 12/4/23 at 1:53 PM., Resident #54 was sitting in her wheelchair by the Woods Unit nursing station, eating chips, wearing a weighted vest weights resting on her legs, and occasionally yelling out.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41424 Based on observation, interview, and record review, the facility failed to confirm the Pre-Admission Screening and Resident Review (PASARR) Level II determination request was sent to the Community Mental Health Services Program (CMHSP) for a Level II OBRA review and/or evaluation for 2 residents (Resident #60 and #45) of 3 residents reviewed, resulting in the potential for the residents to not receive or have delayed mental health services. Findings include: Review of OBRA - Specialized Nursing Homes dated 2023, revealed, .This review process begins with the completion of a screening form (Level I DCH-3877) usually by a nursing facility, hospital, or community agency/provider. If the responses to the questions on the form indicate the presence of a mental illness and/or an intellectual/developmental disability (or a related condition), the person is referred to the local community mental health services program (your local OBRA Coordinator) to assess if a comprehensive evaluation (Level II) is needed. This evaluation and the evaluator's recommendation are reviewed by the State OBRA office and a final determination is made as to whether the person is appropriate for nursing facility admission/stay and whether specialized services mental health care is required . https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mentalhealth/obra Review of OBRA - Specialized Nursing Homes dated 2023, revealed, .If the facility does not receive a written determination within thirty (30) days of an admission, the facility must send a written reminder to the CMHSP and the MDHHS OBRA Office within forty-five (45) days of the admission. A copy of this notification must be retained in the resident's medical record . Resident #60: Review of an Admission Record revealed Resident #60 was a female with pertinent diagnoses which included hallucinations, anxiety, mood disorder, depression, and dementia. Review of PreAdmission Screening (PAS)/Annual Resident Review (ARR), Level I Screening for Resident #60, revealed, .Section II: Screening Criteria revealed, Resident #60 had 1. Current diagnosis or mental illness and 2. had received treatment for mental illness, 3. was prescribed antipsychotic or antidepressant medications within the last 14 days, and 4. presenting evidence of mental illness or dementia, including significant disturbances in thought, conduct, emotions, or judgemnet. Presenting evidence may include, but is not limited to, suicidal ideations, hallucinations, delusions, serious difficulty completing tasks, or serious difficulty interacting with others .Explain any Yes Anxiety, depression. Pt (patient) is seeing hallucinations. Medications include: Buspar (5mg/bi-daily), Zyprexa (2.5 mg/daily) .DISTRIBUTION: If any answer to items 1 - 6 in SECTION II is Yes, send ONE copy to the local Community Mental Health Services Program (CMHSP), with a copy of form DCH-3878 if an exemption is requested. The nursing facility must retain the original in the patient record and provide a copy to the patient or legal representative . (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Mental Illness/Intellectual Disability/Related Condition Exemption Criteria Certification Level II Screening completed on 7/4/23, revealed, Exemption Criteria: Dementia: Yes, I certify the patient under consideration has dementia as established by clinical examination and evidence of meeting ALL 5 criteria below . Review of Resident #60's medical record revealed a PASARR Level II was completed on 7/4/2023, with no documentation indicating it had been sent to OBRA, and a letter had been received which indicated review of the submitted documentation granting the exemption or a completed Level II evaluation by the OBRA. In a interview on 12/11/23 at 8:39 AM, Social worker (SW) VV reported the he kept a binder of OBRA information and/or it was scanned into the resident' electronic medical chart. SW VV reported the Level I & Level II documents would be sent to the local OBRA for review. SW VV reported if the OBRA didn't get back to him within 30 days for the review to be processed, he would reach out to her again. SW VV reported he was unable to keep up with the PASARRs while at the facility and his experience while there was incredibly frustrating with the lack of support and education provided. 38384 R45 According to the Minimum Data Set (MDS) dated [DATE], R45 scored 4 out of a scale of 15 (severely cognitively impaired) on her BIMS (Brief Interview Mental Status), required the use of a wheelchair to self-ambulate around the facility with diseases that included Alzheimer's, dementia, and schizophrenia. During an interview on 12/11/2023 at 1:55 PM, Clinical Quality Coordinator DDD stated, The PASARRs, if done, should be found in the document section of the resident's medical chart. Review of R45's 2/25/2022 form DCH-3877 (Rev (revision) 8-19) (Mental Illness/Intellectual Developmental Disability/Related Conditions Identification) Level I Screening, reported, SECTION II-questions 1-6, Screening Criteria reported, the resident had YES to questions 1, 2, 3, and 4 with diagnoses that included Alzheimer's, dementia, major depressive disorder, and schizophrenia. Further review of the 2/25/2022 form DCH- 3877, reported, DISTRIBUTION: If any answer to items 1-6 in SECTION II is Yes, send ONE copy to the local Community Mental Health Services Program (CMHSP), with a copy of form DCH-3878 if an exemption is requested. The nursing facility must retain the original in the patient record and provide a copy to the patient or legal representative. Review of R45's medical record revealed a PASARR Level II was completed on 3/22/2022, with no documentation indicating it had been sent to OBRA requesting an exemption or that a letter from OBRA had been received, granting an exemption. Review of R45's medical record revealed on 2/8/2023 form DCH-3877 (Rev (revision) 8-19) (Mental Illness/Intellectual Developmental Disability/Related Conditions Identification) Level I Screening had been completed, reporting, SECTION II-questions 1-6, Screening Criteria reported, the resident had YES to questions 1, 2, 3, and 4 with diagnoses that included Alzheimer's, dementia, depression, and schizophrenia. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of R45's medical record revealed a PASARR Level II had not been completed for 2023 as indicated it should have been following the criteria indicated on the resident's 2/8/2023 form DCH 3877 Level I Screening.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47955 Based on interview and record review the facility failed to ensure residents received annual Level 1 and follow up Level II PASARR (pre-admission screening/annual resident review) to ensure appropriate mental health services were provided in 1 resident (Resident #71) reviewed for PASARR, resulting in the potential for Resident #71 not being placed in an appropriate setting or receive treatment specific for his mental health needs. Findings include: Resident #71 Review of an Admission Record revealed Resident #71 was admitted on [DATE] and had pertinent diagnoses which included schizophrenia, anxiety disorder, and Parkinson's disease (a progressive disorder that affects the nervous system). Review of Resident #71 electronic record on 12/5/23 at 9:10 AM., revealed no PASARR Level I available. During an interview on 12/6/23 at 10:03 AM., Director of Nursing (DON) B reported that PASSAR should be located under the documents tab in a resident's record. DON B unable to locate PASSAR Level I in Resident #71's record. During an interview on 12/6/23 at 10:08 AM., DON B reported Resident #71's PASARR Level I screening was available on the OBRA (Ombudsman Budget Reconciliation Act) website, but was not in his medical record at this time. DON B reported that Resident #71 did not require a PASARR Level II screening due to Resident #71 being deemed exempt with a diagnosis of dementia. Review of Resident #71's electronic record revealed no diagnosis of dementia noted. During an interview on 12/6/23 at 10:08 AM., DON B provided a copy of Resident #71's PASARR Level I screening, dated 11/22/22, which indicated Resident #71 had diagnoses of schizophrenia. DON B reported Resident #71 should have had a Level II screening completed and was completed 12/9/22, but still on the OBRA website awaiting provider signature. During an interview on 12/6/23 at 10:15AM., DON B was unable to provide a copy of the required annual Level I due 11/2023 or proof of a completed Level II screening. During this interview, Corporate Business Manager (CBM) CCC reported that Resident #71 did not have a completed PASARR Level II nor an exemption letter from OBRA with a provider signature. During an interview on 12/11/23 at 8:33 AM., Social Service Assistant (SSA) VV reported that PASARR Level II screenings were sent to OBRA coordinators for processing. SSA VV reported that PASARR Level II screenings that needed signature(s) from either OBRA, or a provider were kept in a binder. SSA VV reported that he was responsible for the follow up and completion of the PASSAR Level II screening exemptions for residents with a diagnosis of dementia.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47659 Based on interviews and record review, the facility failed to ensure a baseline care plan was in place for 1 (Resident #442) of 19 sampled residents, resulting in the potential for ineffective care to be provided to the resident. Findings include: Resident #442 Review of an Admission Record revealed Resident #442, was originally admitted to the facility on [DATE] with pertinent diagnoses which included type 2 diabetes mellitus and chronic kidney disease. Review of Resident #442's Care Plan on 12/4/23 revealed, Focus areas: At risk for elopement. Date Initiated: 12/01/2023. Interventions: Add resident to the Elopement Book. Date Initiated: 12/01/2023. Encourage to participate in activities to divert from exit seeking behavior. Date Initiated: 12/01/2023. Frequent monitoring (specify frequency) Date Initiated: 12/01/2023. The resident has (Specify: impaired cognitive ability /impaired thought processes r/t) (sic) Date Initiated: 12/01/2023. Interventions: Allow extra time for resident to respond to questions and instructions. Date Initiated: 12/01/2023. Face and speak clearly when communicating with resident. Date Initiated: 12/01/2023. Speech Language Pathology referral. Date Initiated: 12/01/2023. Diabetes Mellitus: Date Initiated: 12/01/2023. Interventions: Diet as ordered. Date Initiated: 12/01/2023. Resident is at risk for falls. Date Initiated: 12/01/2023. Interventions: Assist with ADL as needed. Date Initiated: 12/01/2023. Call light within reach. Date Initiated: 12/01/2023. Complete fall risk assessment. Date Initiated: 12/01/2023. At risk for change in mood or behavior due to medical condition. Date Initiated: 12/01/2023. Interventions: Medications as ordered. Date Initiated: 12/01/2023. The resident has a terminal prognosis. Date Initiated: 12/01/2023. Interventions: Medication as ordered. Date Initiated: 12/01/2023. Offer diet and liquids as ordered. Date Initiated: 12/01/2023. Reposition for comfort as needed. Date Initiated: 12/01/2023. Treatment as ordered. Date Initiated: 12/01/2023. It was noted that Resident #442's Care Plan did not include dietary orders, therapy orders, social services, dietary instructions, Resident #442's transfer and mobility status, skin conditions, pain and psychotropic medication use, ADL (Activities of daily living care), discharge goals, or initial goals based on admission orders. During an interview on 12/06/23 at 10:57 AM, LPN M was unable to report any care plan interventions that the facility had in place for Resident #442 based on his initial goals. During an interview on 12/06/23 at 3:08 PM, Unit Manager E reported that Resident #442's baseline care plan was inadequate, and did not provide enough details for staff to effectively guide care for Resident #442. Unit Manager E reported that the admitting nurse missed entering the pertinent information needed for a baseline care plan. Unit Manager E reported that the unit manager was responsible for reviewing care plans, and that Resident #442's care plan was missed. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/07/23 at 10:54 AM, MDS Coordinator YYY reported that baseline care plans for residents should include pain, falls, skin conditions, dietary orders, and ADL care. MDS Coordinator YYY reported that Resident #442's care plan was inadequate and did not include all areas needed to guide care for staff. During an 12/07/23 11:38 AM, Director of Nursing (DON) B reported that the admitting nurse was responsible for completing the baseline care plan within 24 hours, and that this was missed for Resident #442. DON B confirmed that Resident #442's care plan was not complete or adequate enough to guide care for Resident #442.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 47659 Based on observation, interviews, and record review, the facility failed to develop and implement person centered comprehensive care plans for 5 (Resident #79, #27, #51, #45 and #8) of 5 residents reviewed for care plans, resulting in the potential for residents not being able to achieve their highest practicable level of physical and psychosocial wellbeing. Findings include: Resident #79 Review of an Admission Record revealed Resident #79, was originally admitted to the facility on [DATE] with pertinent diagnoses which included unspecified dementia with other behavioral disturbance. Review of Resident #79's Care Plan did not reveal a focus area related to Resident #79's dementia diagnosis. During an interview on 12/06/23 at 3:08 PM, Unit Manager E reported that Resident #79 did not have a care plan related to his dementia diagnosis. Unit Manager E was not able to report any interventions that the facility had in place to help guide care related to Resident #79's dementia diagnosis. Unit Manager E reported that the unit managers and MDS nurse were responsible for reviewing resident care plans, and that this had been missed. During an interview on 12/07/23 at 10:54 AM, MDS Coordinator YYY reported that Resident #79 did not have a dementia care plan in place. MDS Coordinator YYY reported that the Unit Manager and MDS Coordinator were responsible for reviewing and updating resident care plans, and that this was missed for Resident #79. During an interview on 12/07/23 at 11:38 AM, Director of Nursing (DON) B reported that the MDS Coordinator was responsible for creating care plans, and that Resident #79 should have had a dementia care plan in place, and this was missed. 41424 Review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual V1.17, Chapter 4, revealed, .the facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . Resident #27 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of an Admission Record revealed Resident #27 was a female with pertinent diagnoses which included dementia, macular degeneration (loss in the center of the field of vision), heart failure, stroke, anxiety, osteoporosis (bones become weak and brittle), and cyst in right knee. Review of current Care Plan for Resident #27, revised on 6/27/23, revealed the focus, .Resident #27 is at risk for falls r/t (related to) deconditioning, h/o CVA, muscle weakness, limited vision, demetia with impaired cognition poor safety awareness & delusions/hallucinations at times due to dementia with the intervention . Blue mat to the floor surface next to the bed when in bed to decrease the risk of injury. Blu mat to wall to prevent injury d/t (due to) increased restlessness . During an observation on 12/04/23 at 11:30 AM, Resident #27 was lying in her bed on her left side facing the wall, behind her was a long body pillow or multiple pillows tucked in between the fitted sheet and the mattress. No blue mat was secured to the wall. During an observation on 12/5/23 at 8:23 AM, Observed Resident #27 lying in her bed, facing the wall with a body pillow tucked in between the sheet and the mattress, reaching up to the sky while mumbling. This writer noted her water was placed on the tv stand in front of the window to the room way out of reach for Resident #27. There was no blue mat observed on the way next to Resident #27's bed. During an observation on 12/5/23 at 1:51 PM, Resident #27 was lying in her bed yelling out, CNA EE was in the room waiting for additional staff to come assist with repositioning and provide peri care for Resident #27. No blue mat was noted on the wall next to Resident #27's bed. CNA EE reported she was lying on her left side facing the wall. CNA EE reported the resident's family comes on the weekends to visit with her. CNA Y came to the room to assist CNA EE with Resident #27. CNA Y reported she was a fighter and her yelling like that was us not hurting her, she was very hard of hearing and that was part of why she yells like that. During an observation on 12/07/23 at 11:06 AM, Resident #27 was observed lying in her bed, supine position, with the rolling bedside table over her lap in the bed, with the head of the bed positioned at approximately 45 degrees. Resident #27's water was placed on the tv stand by the window well out of Resident #27's reach. R#27's water was full. During an observation on 12/07/23 at 03:18 PM, Resident #27 was observed lying in her bed, fall mat next to the bed, water on the tv stand out of reach and it had not been drunk yet today, still almost full, bed was in low position, body pillow was on the right side of her bed. No blue mat was noted on the left side of her bed on the wall. Resident #51: Review of an Admission Record revealed Resident #51 was a female with pertinent diagnoses which included dementia, Alzheimer's disease, contracture, left hand, muscle weakness, and adult failure to thrive. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of current Care Plan for Resident #51, revised on 3/8/21, revealed the focus, .(Resident #51) is at risk for falls r/t (related to) cognitive impairment with poor safety awareness, impaired communication, impaired vision, imcontinence of bowel and bladder, impaired balance, muscle weakness, left hand contracture . with the intervention .If (Resident #51) is up for meals, then offer to lay down for a nap in between as she fatigues quickly .(Resident #51) needs total assist with all care needs, anticipate her needs . During an observation on 12/04/23 at 11:30 AM, Resident #51 was observed seated in her wheelchair at the head of her bed, located by the privacy curtain between her and her roommate. Resident #51 had dirty pants on the front of them she had dried food and food smears on them. Her water was placed on the night stand near the doorway to her room out of reach from Resident #51. During an observation on 12/04/23 at 11:34 AM, Resident #51 was grimacing and when this writer queried if she was in pain and wanted to staff to lay her down, she nodded her head which indicated a yes answer. During an observation on 12/04/23 at 11:36 AM, Unit Care Coordinator (UCC) H responded to the call light activated for Resident #51. This writer shared Resident #51 had indicated she wanted to lay down and appeared painful based on her grimace. UCC H reported to Resident #51 the staff would lay her down after lunch as she grabbed her glasses from R51's lap and took them to the restroom to rinse them off. Not mentioning the food droplets and smeared streaks on Resident #51's pants. UCC H stated, Alright sweety, sound like a plan, proceeded to place the resident's feet on the foot pedals of her wheelchair and proceeded out of the room down the hallway to the dining room. UCC H did not offer her any water prior to ambulating her to the dining room. In an interview on 12/04/23 at 11:36 AM, UCC H reported Resident #51 UCC H reported Resident #51 required was very limited on her abilities, depends on her alertness and where she is at if she was able to perform some activities of daily living for herself with the food to be scooped into the spoon and cuing to take a bite of her food. Otherwise, she does require staff to feed her for her meals. During an observation on 12/5/23 at 8:31 AM, Resident #51 was observed seated in the dining room with no water or other drinks. There was noted to be water on her night stand right by the entry way to her room. Breakfast was finished. During an observation on 12/5/23 at 1:51 PM, Resident #51 was being propelled down the hallway to the dining room. Her water was observed on the night stand near the entry wany to her room. During an observation on 12/07/23 at 11:06 AM, Resident #51 was observed in her room seated in her wheelchair, she had a blanket over her, she was dressed, foot pedals up on her chair. She was next to her foot of her bed by the privacy curtain between her and her roommate. Resident #51's water was observed on the night stand over by the doorway to the room well out of the reach of Resident #51. Resident #51's water was full. During an observation on 12/11/23 at 8:12 AM, Resident #51 was not observed in her room at this time. Resident #51 was observed seated in the dining room eating breakfast. During an observation on 12/11/23 at 11:23 AM, Resident #51 was observed seated in the dining room with no water or other fluids in front of her. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 12/11/23 at 2:37 PM, Director of Nursing (DON) B reported for the DON to ensure the facility nursing staff were following orders and interventions, the aides were supposed to be checking on the residents, completing the check and changes and the nurses when they administered medications, completed assessments, performed treatments were all visually assessing the resident which were documented in the medical record, The Unit manager, night supervisors, assistant director of nursing complete visual observations and reviewing documentation of the staff were completing, assessing, and monitoring the resident's care. DON B reported she participated in the daily huddles, morning meetings, and the Interdisciplinary team meetings where any changes were discussed and follow up was determined. The care plans were modified during the IDT team meetings ensuring focuses and interventions were updated and triggered for the CNAs and Nurses to complete accurate documentation. 38384 R45 According to the Minimum Data Set (MDS) dated [DATE], R45 scored 4/15 (severely cognitively impaired) on her BIMS (Brief Interview Mental Status), required the use of a wheelchair to self-ambulate around the facility with diseases that included Alzheimer's, dementia, and schizophrenia. Review of R45's Incident Report (IR) #1810 dated 10/22/2023 18:50 (6:50 PM), reported the resident's wheelchair's left wheel got caught in the leg of a mechanical lift. A skin tear (layers of skin separate or peel back) was noted to her LFA (left forearm). Review of R45's Physician Note dated 10/23/2023 revealed, .Reason for Evaluation: I am asked by the nursing staff to evaluate patient's left forearm after a fall . Assessment: Dirty wound. Plan .Start doxycycline 100 mg b.i.d. (twice daily) x 7 days . Review of R45' Medication Administration Record (MAR) 10/1/2023-10/31/2023 reported an order date 10/23/2023 1431 (2:31 PM) Doxycycline Hyclate Oral Tablet 100 mg give 1 tablet my mouth two times a day for skin tear for 7 days. Review of R45's Care Plan did reveal a person-centered treatment plan for the resident's skin tear and use of antibiotics. 46999 Resident #8 Review of an Admission Record dated 5/1/23 revealed Resident #8 was admitted to the facility with the following pertinent diagnoses: muscle weakness, attention, and concentration deficit, alzheimer's disease (progressive mental deterioration), and polyneuropathy (nerve damage in multiple areas of the body causing a change in sensation). Review of a Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #8 requires maximal assistance to self-propel a wheelchair 50- 150'. Section M of the MDS revealed Resident #8 had one or more skin injuries at the time of the assessment. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a Care Plan for Resident #8 dated 11/24/23 revealed a focus/goal/intervention(s) as follows: Focus: (Resident name) is at risk for break in skin integrity. Goal: Maintain intact skin with no skin breaks. Interventions: Treatment as ordered. Geri-sleeves as resident allows to prevent skin tears. Review of a Kardex for Resident #8 revealed no direction for nurses/nursing assistants regarding use of geri-sleeves. Review of physician's orders for Resident #8 revealed an order that stated: geri-sleeves, both arms, when up in wheelchair, start date 11/10/23. Review of a progress note dated 11/10/23 revealed statement: Resident with additional skin tears, started geri-sleeve for protection .Resident self-propels wheelchair around facility and has a history of getting arms caught between wheelchair and handrail. During an observation on 12/5/23 at 10:09am, Resident #8 had 3 2x3 bandages on his forearms, mild bruising noted on both forearms. During an observation on 12/5/23 at 1:51pm, Resident #8 was up in his wheelchair, no protective geri-sleeves on his arms. In an interview on 12/5/23 at 1:53pm, Family Member (FM) AAAA reported Resident #8 often had open areas on his arms and that his skin was so thin, if he bumps his arms on anything they bleed. During an observation on 12/6/23 at 12:48pm, Resident #8 was self-propelling his wheelchair, using both arms that were not covered by geri-sleeves, outside the dining room. Resident #8's wheelchair was parallel to the wall, with a 3' gap between the wall and his wheelchair tire. Resident 8's right arm was against the surface of the wall as he continued to push the wheelchair. A staff member continuing walking but stated (Resident's name) watch your arm, you're going to get it stuck, as she passed by. During an observation on 12/6/23 at 1:03pm, Resident #8 was self-propelling his wheelchair using both arms, in the hallway near his room, not wearing the protective geri-sleeves, and attempting to navigate around multiple obstacles in the hallway. In an interview on 12/7/23 at 3:53pm, Certified Nursing Assistant (CENA) Z reported Resident #8 wore geri-sleeves for his circulation and she did not know how often/when he was supposed to wear them. In an interview on 12/7/23 CENA BBBB reported it was his understanding Resident #8 wore geri-sleeves to avoid him picking at his skin. CENA BBBB reported he did not know when the resident was supposed to wear the geri-sleeves.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38384 This citation pertains to intake MI0040935 Based on observation, interview, and record review, the facility failed to follow professional standards of practice by 1.) not following McGeer's criteria for ordering an antibiotic for 1 resident (R45), 2.) documenting completion of wound dressing changes when they were not done for 2 residents (R53 and R57), 3.) not ensuring neurological checks were completed after unwitnessed falls for 1 resident (R79) of 19 residents reviewed for professional standards, resulting in the increase chance of R45 developing medicine-resistant bacteria, potential of R53 and R57 developing infection and R57, R53, and R79 developing worsening conditions and unmet care needs. Findings include: R45 According to the Minimum Data Set (MDS) dated [DATE], R45 scored 4/15 (severely cognitively impaired) on her BIMS (Brief Interview Mental Status), required the use of a wheelchair to self-ambulate around the facility with diseases that included Alzheimer's, dementia, and schizophrenia. Review of R45's Incident Report (IR) #1810 dated 10/22/2023 18:50 (6:50 PM), reported the resident's wheelchair's left wheel got caught in the leg of a mechanical lift. A skin tear (layers of skin separate or peel back) was noted to her LFA (left forearm). Review of R45's Physician Note dated 10/23/2023 revealed, .Reason for Evaluation: I am asked by the nursing staff to evaluate patient's left forearm after a fall . Assessment: Dirty wound. Plan .Start doxycycline 100 mg b.i.d. (twice daily) x 7days . Review of R45's Medication Administration Record (MAR) 10/1/2023-10/31/2023 reported an order date 10/23/2023 1431 (2:31 PM) Doxycycline Hyclate Oral Tablet 100 mg give 1 tablet my mouth two times a day for skin tear for 7 days. During an interview on 12/7/2023 at 4:10 PM Unit Manager/Licensed Practical Nurse (UM/LPN) H stated, I am the Unit Manager for (R45). I have trained nurses on how and why to use McGeer's Criteria for antibiotic use. The medical director has also been told how to use McGeer's when ordering antibiotics. I do not know why an antibiotic was ordered for (R45) on the same day she got a skin tear. During an interview on 12/7/2023 at 4:12 PM, LPN VVV stated, (Medical Director (MD)EEE) was in the facility on 10/23/2023 and saw R45's skin tear. It was on her left forearm. (MD EEE) saw it and gave me an order to enter for an antibiotic. I do not know why he ordered the antibiotic. I do not know if he looked or followed McGeer's Criteria. 47659 Resident #53 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an Admission Record revealed Resident #53, was originally admitted to the facility on [DATE] with pertinent diagnoses which included muscle weakness and difficulty in walking. Review of Resident #53's Medication and Treatment Administration Record (MAR/TAR) revealed, Order: Left hand skin tear- cleanse with NS (normal saline), cover with Opsite (type of dressing pad) every 7 days and PRN (as needed). This order was last documented as completed on 12/3/23 by Licensed Practical Nurse (LPN) I. During an observation on 12/04/23 at 11:05 AM, Resident #53 was sitting in her recliner watching television. Her left hand cut was covered with an opsite pad which was dated 11/27/23. During an observation on 12/06/23 02:34 PM, Resident #53's left hand had the same opsite pad as previous observation which was dated 11/26/23. During an interview on 12/11/23 at 2:16 PM, LPN I reported that she had not changed the opsite pad on Resident #53's left hand on 12/4/23. LPN I reported that she did not know why she had documented that she had completed the opsite pad, when she had not. Resident #57 Review of an Admission Record revealed Resident #57, was originally admitted to the facility on [DATE] with pertinent diagnoses which included muscle weakness. Review of a Minimum Data Set (MDS) assessment for Resident #77, with a reference date of 10/27/23 revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #57 was cognitively intact. Review of Resident #57's Medication and Treatment Administration Record (MAR/TAR) revealed, Order: Bilary drain (drain that allows flow out from a blocked bile duct into a collection bag outside of the body). Carefully remove old bandage covering the tube. Only remove the tape holding the tube in place if it is loose. If loose, replace tape to secure the tube. Wash surrounding skin with warm soap and water. Pat dry. Apply antibiotic ointment, place new gauze pad over the site and cover with tape. every day shift for wound care. This order was documented as completed on 11/30/23, 12/1/23, 12/2/23, 12/3/23 and 12/4/23. During an interview on 12/06/23 at 9:57 AM, Resident #57 reported that nursing staff were not monitoring his bilary drain, and were not changing the dressing that covered the drain site as often as they were suppose to, which made him feel frustrated. The dressing on Resident #57's bilary drain dressing was dated 11/29/23. Resident #57 reported that nursing staff were suppose to change the dressing daily. During an interview on 12/07/23 at 4:17 PM, LPN Q reported that she had not changed Resident #57's bilary drain dressing 12/4/23, but that she had documented that she had completed the dressing change. LPN Q was unable to explain why she had documented a treatment as completed even though she had not completed it. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/07/23 at 3:53 PM, Registered Nurse (RN) F reported that she had not changed Resident #57's dressing on 11/30/23, 12/5/23, or 12/6/23. RN F was unable to explain why she documented the dressing change as completed when she had not completed the dressing changes. Review of the facility's Nursing Documentation policy, last reviewed 8/10/23, revealed, The facility must ensure that nursing documentation is consistent with professional standards of practice, the state nurse practice act, and any state laws governing the scope of nursing practice . Medical Records: The medical record shall reflect a resident's progress toward achieving their person-centered plan of care objective and goals and the improvement and maintenance of their clinical, functional, mental and psychosocial status. Staff must document a resident's medical and non-medical status when any positive or negative condition change occurs, at a periodic reassessment and during the annual comprehensive assessment. The medical record must also reflect the resident's condition and the care and services provided across all disciplines to ensure information is available to facilitate communication among the interdisciplinary team. The medical record must contain an accurate representation of the actual experience of the resident and include enough information to provide a picture of the resident's progress, including his/her response to treatment and/or services, and change in his/her condition, plan of care goals, objectives and/or interventions . Resident #79 Review of an Admission Record revealed Resident #79, was originally admitted to the facility on [DATE] with pertinent diagnoses which included unspecified dementia with other behavioral disturbance, muscle weakness, and personal history of traumatic brain injury. Review of Resident #79's Incident Reports revealed that Resident #79 had unwitnessed falls on the following dates: 6/29/23, two falls on 8/2/23, 8/21/23, 8/29/23, 9/17/23, 9/24/23, 9/30/23, and 10/19/23. Review of Resident #79's Neurological Checks (Neuro checks) revealed that neuro checks were not documented on 8/2/23 at 5:45 PM, 8/3/23 at 11:45 AM, 8/3/23 and 3:45 PM, 8/4 at 7:45 AM, 3:45 PM, and 11:45 PM, 8/5/23 at 11:45 PM, 8/20/23 at 4:45 PM, 8/23/23 at 8:45 PM, 8/30/23 at 9:00 AM, 1:00 PM and 5:00 PM, 8/31/23 at 9:00 PM, 9/18/23 at 6:15 PM, 9/19/23 at 10:15 AM, and 6:15 PM, 9/20/23 at 2:15 AM, 9/21/23 at 2:15 am, 10/3/23 at 9:15 PM and 10/19/23 at 12:00 AM. During an interview on 12/07/23 at 11:38 AM, Director of Nursing (DON) B reported that nursing staff were to complete neuro checks on all unwitnessed falls. DON B reported that after the unit manager reviewed each incident report, that she was responsible for reviewing and confirming each incident report had all required assessments and documentation completed. DON B confirmed that she was unaware that Resident #79 had missed several neuro checks, and that they had not been documented. DON B confirmed that she had not reviewed all of Resident #79's falls/incidents reports since June 2023. During an interview on 12/11/23 at 11:15 AM, Unit Manager E reported that he was responsible for reviewing incident reports before the DON. Unit Manger E reported that he was not aware that Resident #79 had several missing neuro assessments. Unit Manager E reported that the facility had issues with nurses completing neuro checks, and he had previously educated nursing staff on this. Unit Manager E reviewed the nursing documentation with this surveyor and confirmed that the assessments were not documented as completed, and Resident #79 had missed several neuro checks. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/11/23 at 11:48 AM, LPN M reported that if nurses did not enter the neuro assessments in EHR, then they were not completed. LPN M reviewed the documentation with this surveyor and reported that the neuro assessments had been missed as nothing was documented. During an interview on 12/11/23 at 12:03 PM, LPN L reported that if the neuro checks were not completed in the EHR, she had missed them. Review of the facility's Neurological Assessment last reviewed on 8/10/23 revealed, Policy: The Neurological Assessment (UDA) in (facility's EHR system) shall be initiated by a written physician's order for neurological checks or when indicated by a resident assessment (e.g., head injury, post fall, neurological decompensation). Procedure: The assessing nurse initiates the Neurological Check List UDA in the electronic health record and completes as indicated. 2. The nurse must initial/sign each documentation entry. 3. The nurse documents and reports any pertinent changes in the resident's neurological status immediately to the physician. 4. Interventions takes as a result of the assessment, as well as the initiation and completion of the assessment should be notes in the nurses' notes .

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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** 41424 Based on interview and record review, the facility failed to ensure a resident was consistently provided with showers/bathing for 1 of 4 residents (Resident #78) reviewed for activities of daily living, resulting in unmet personal hygiene needs with the potential for isolation, psychosocial harm, skin breakdown, harboring infection, and decreased self-esteem. Findings include: According to [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME]; Hall, [NAME]. Fundamentals of Nursing - E-Book (Kindle Locations 50742-50744). Elsevier Health Sciences. Kindle Edition.Personal hygiene affects patient's comfort, safety, and well-being. Hygiene care included cleaning and grooming activities that maintain personal body cleanliness and appearance. Personal hygiene activities which as taking a bath or shower and brushing and flossing the teeth also promote comfort and relaxation foster a positive self-image, promote healthy skin, and help prevent infection and disease . Resident #78: Review of an Admission Record revealed Resident #78 was a female with pertinent diagnoses which included pressure ulcer of sacral region, stage 4, pressure ulcer of right ankle, stage 3, pressure ulcer of left heal, unstageable, stiffness of right hand, contracture right foot, contracture left foot, multiple sclerosis, urosepsis, gangerene, chronic pain, and cognitive communication deficit. Review of Care Plan for Resident #78, revised on 03/19/2023, revealed, .The resident has an ADL self-care performance deficit r/t (related to) MS (Multiple Sclerosis) bedfast . with the interventions . BATHING/SHOWERING: Provide sponge bath when a full bath or shower cannot be tolerated .Date Initiated: 03/19/2023 . BATHING/SHOWERING: total assist with bathing as scheduled Revision on: 03/19/2023 . During an observation on 12/04/23 at 10:52 AM, Resident #78 was in a gown still, face was greasy, hair appeared greasy and was in a short pony tail on top of her head. Resident #78 had a long thumb fingernail there was a dark brown streak in the bed of her thumb nail as well as her other fingernails . During an observation on 12/5/23 at 8:26 AM, Resident #78 was observed lying in her bed her hair appeared greasy still, it was in a short pony tail on the top of her head. Does not appear it had been combed as of yet. Resident #78's fingernails still contained dark brown streaks in the nail bed. During an observation on 12/07/23 at 11:12 AM, Resident #78 was observed lying in her bed. There was a noted odor in the room when this writer entered the room. Resident #78's hair appeared greasy and she had flakes in her hair. Review of Health Status Note dated 11/30/2023 at 8:01 PM, revealed, .Shampoo and shower given this afternoon . (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Task: ADL - Bathing Monday and Thursday dated 12/06/23, revealed, the last time documented a shower was on 11/30/23, Thursday .12/4/23 not applicable - not given shower .11/28/23 - Bed bath . 11/23/23: Sponge bath .11/21/23: Shower .11/20/23: not applicable; 11/16/23: Resident not available (Surgery day) .11/13/23: not applicable .11/10/23: bed bath .11/9/23 not applicable .11/8/23: not applicable . 11/7/23: shower . In an interview on 12/06/23 10:17 AM, Certified Nursing Assistant (CNA) DDDD reported if the resident prefers to have a bed bath. CNA DDDD reported if the resident refused the shower/bath, the shower aide would reapproach, if the resident refused again then would inform the nurse. The nurse would then approach the resident about the refusal. CNA DDDD reported the CNAs would document in the electronic medical record if the resident had a shower, bed bath, sponge bath or refused. CNA DDDD reported if the resident refused the shower/bed bath but allowed us to wash their face, hands, peri areas, but not the full bed bath we would put it as a sponge bath. She reported they do a skin shower sheet as well to document any changes in the resident's skin. In an interview on 12/07/23 at 12:16 PM, Unit Clincal Coordinator (UCC) H reported if a resident refused to have a shower or a bed bath, the nurse would document in the progress notes of the refusal. UCC H reviewed the task section for the previous 30 days from this date for Resident #78 and reported from 11/7/23 to now, Resident #78 had a shower on 11/7, bed bath on 11/19, a shower on 11/21, bed bath on 11/23, bed bath on 11/28, and a shower on 11/30. In an interview on 12/11/23 at 2:37 PM, Director of Nursing (DON) B reported for the DON to ensure the facility nursing staff were following orders and interventions, the aides were supposed to be checking on the residents, completing the check and changes and the nurses when they administered medications, completed assessments, performed treatments were all visually assessing the resident which were documented in the medical record, The Unit manager, night supervisors, assistant director of nursing complete visual observations and reviewing documentation of the staff were completing, assessing, and monitoring the resident's care.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41424 Based on observation, interview and record review, the facility failed to provide consistent, meaningful and person-centered activities for 7 of 7 residents (Resident #27, #51, #78, #63, #82, #21, and #29) reviewed for activities provided by the facility, resulting in the potential for loss of interaction, joy, self-esteem, growth, sense of wellbeing, autonomy, connectedness, identity, creativity, independence, pleasure, and comfort. Findings include: Resident #27: Review of an Admission Record revealed Resident #27 was a female with pertinent diagnoses which included dementia, macular degeneration (loss in the center of the field of vision), heart failure, stroke, anxiety, osteoporosis (bones become weak and brittle), and cyst in right knee. Review of current Care Plan for Resident #27, revised on 6/1/23, revealed the focus, .(Resident #27) is able to express her wants and needs. Confusion noted at times, identifies as Catholic .She enjoys being outdoors, watching television, and being around dogs. She receives frequent visits from family. She often declines invites to scheduled group activities, but at times will attend socials/parties, outdoor activities, and music activities, with encouragement .(Resident #27) enjoys wheeling herself around the facility .(Resident #27) receives invites and assistance to scheduled group activities, as well as, 1:1 visits, as tolerated, from activity staff . with the intervention .Check often with (Resident #27) to see if any additional supplies are needed for independent activities of choice .Continue 1:1 visits two times per week, as tolerated .Continue to invite (Resident #27) to scheduled activities .(Resident #27) needs assistance/escort to activity functions .Establish and record (Resident #27's) prior level of activity involvement and interests by talking with (Resident #27) caregivers, and family on admission and as necessary .Explain to (Resident #27) the importance of social interaction, leisure activity time, Encourage (Resident #51's) participation by inviting (Resident #27) to scheduled group activities .Provide (Resident #27) with activities calendar .Provide (Resident #27) with materials to facilitate independent activities .Remind (Resident #51) of activities and upcoming events . During an observation on 12/04/23 at 11:30 AM, Resident #27 was lying in her bed on her left side facing the wall, behind her was a long body pillow or multiple pillows tucked in between the fitted sheet and the mattress. The TV was not on in the room. During an observation on 12/5/23 at 8:23 AM, Observed Resident #27 lying in her bed, facing the wall with a body pillow tucked in between the sheet and the mattress, reaching up to the sky while mumbling. This writer noted her water was placed on the tv stand in front of the window to the room way out of reach for Resident #27. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 12/5/23 at 1:51 PM, Resident #27 was lying in her bed yelling out, CNA EE was in the room waiting for additional staff to come assist with repositioning and provide peri care for Resident #27. No blue mat was noted on the wall next to Resident #27's bed. CNA EE reported she was lying on her left side facing the wall. CNA EE reported the resident's family comes on the weekends to visit with her. CNA Y came to the room to assist CNA EE with Resident #27. CNA Y reported she was a fighter and her yelling like that was us not hurting her, she was very hard of hearing and that was part of why she yells like that. During an observation on 12/06/23 at 11:00 AM, Resident #27 was self-ambulating down the hallway yelling. During an observation 12/06/23 at 2:05 PM, Resident #27 was observed self-ambulating down the hallway in her wheelchair, feet up on the footrests, with a stuffed animal on her lap as she was yelling, .get her off, go up the back way, to the ground . During an observation on 12/07/23 at 11:06 AM, Resident #27 was observed lying in her bed, supine position, with the rolling bedside table over her lap in the bed, with the head of the bed positioned at approximately 45 degrees. Resident #27's water was placed on the tv stand by the window well out of Resident #27's reach. R#27's water was full. Her TV was not on in the room. During an observation on 12/07/23 at 03:18 PM, Resident #27 was observed lying in her bed, fall mat next to the bed, water on the tv stand out of reach and it had not been drunk yet today, still almost full, bed was in low position, body pillow was on the right side of her bed. Review of Record of One to One Activities revealed, .10/09 read daily devotion to her .10/11 talked about how much she crying misses her parents & siblings .12/04 read daily devotion together .2/21 walked the halls together .4/03 spent time in activity room, chatted .4/27 walked around facility very upset .5/22 walked around facility then calming down very upset .10/15 family visit .1128 hand massage .12/1 read to resident . Note: No year documented. Review of Individual Resident Daily Participation Record for September 23, revealed, .9/14, outdoors .9/15, cooking and baking .9/19, music, social/parties, food/drink .9/21, family/friend visits . Review of Individual Resident Daily Participation Record for October 23, revealed, .10/4, bingo .10/15, family/friend visits . Review of Individual Resident Daily Participation Record for November 23, revealed, .11/9, movies, television, food/drink .11/12, family/friends visit, 11/15, social/parties .11/19, religious services .11/22, gardening .1125, social parties . Review of Individual Resident Daily Participation Record for December 23, revealed, none documented as of 12/6/23. Resident #51: Review of an Admission Record revealed Resident #51 was a female with pertinent diagnoses which included dementia, Alzheimer's disease, contracture, left hand, muscle weakness, and adult failure to thrive. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of current Care Plan for Resident #51, revised on 6/1/23, revealed the focus, .(Resident #51) has difficulty expressing her wants and needs .She identifies as Protestant and attended United Church in (Local town). She participates in some scheduled group activities including socials/parties, music activities, sensory activities, and sometimes playing the keyboard .(Resident #51) received 1:1 visits, as tolerated, from activity staff, and frequent visits from sons . with the intervention .Check often with (Resident #51) to see if any additional supplies are needed for independent activities of choice .Establish a record (Resident #51's) prior level of activity involvement and interests by talking with the resident, caregivers, and family on admission and as necessary .Introduce (Resident #51) to residents with similar background, interests, and encourage/facilitate interaction .Invite (Resident #51) to scheduled activities .Provide a program of activities that is of interest and empowers (Resident #51) by encouraging/allowing choice, self-expression and responsibility,. Provide activities that are: Compatible with physical and mental capabilities, compatible with known interests, and preferences, adapted as needed (such as large print, holders if resident lacks hand strength, task segmentation, compatible with individual needs and abilities and age appropriate .Provide (Resident #51) with activities calendar .Provide (Resident #51) with materials to facilitate independent activities .Remind (Resident #51) of activities and upcoming events . During an observation on 12/04/23 at 11:30 AM, Resident #51 was observed seated in her wheelchair at the head of her bed, located by the privacy curtain between her and her roommate. Resident #51 had dirty pants on the front of them she had dried food and food smears on them. Her water was placed on the night stand near the doorway to her room out of reach from Resident #51. During an observation on 12/04/23 at 11:36 AM, Unit Care Coordinator (UCC) H responded to the call light activated for Resident #51. This writer shared Resident #51 had indicated she wanted to lay down and appeared painful based on her grimace. UCC H reported to Resident #51 the staff would lay her down after lunch as she grabbed her glasses from R51's lap and took them to the restroom to rinse them off. Not mentioning the food droplets and smeared streaks on Resident #51's pants. UCC H stated, Alright sweety, sound like a plan, proceeded to place the resident's feet on the foot pedals of her wheelchair and proceeded out of the room down the hallway to the dining room. UCC H did not offer her any water prior to ambulating her to the dining room. During an observation on 12/5/23 at 8:31 AM, Resident #51 was observed seated in the dining room with no water or other drinks. There was noted to be water on her night stand right by the entry way to her room. Breakfast was finished. During an observation on 12/5/23 at 1:51 PM, Resident #51 was being propelled down the hallway to the dining room. Her water was observed on the night stand near the entry wany to her room. During an observation on 12/05/23 at 4:58 PM, Resident #51 was observed in the dining room at the same table she was at at approximately 2:00 PM. During an observation on 12/07/23 at 11:06 AM, Resident #51 was observed in her room seated in her wheelchair, she had a blanket over her, she was dressed, foot pedals up on her chair. She was next to her foot of her bed by the privacy curtain between her and her roommate. Resident #51's water was observed on the night stand over by the doorway to the room well out of the reach of Resident #51. Resident #51's water was full. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Plainwell	320 Brigham St Plainwell, MI 49080

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 12/11/23 at 8:12 AM, Resident #51 was not observed in her room at this time. Resident #51 was observed seated in the dining room eating breakfast. During an observation on 12/11/23 at 11:23 AM, Resident #51 was observed seated in the dining room with no water or other fluids in front of her. No activities currently happening. Review of Record of One to One Activities for the last 6 months revealed, .6/2, attended movie & concession, attended lyric challenge, watched tv in dining room .6/3, attended bingo - passive engagement . 6/5, watched [NAME], read daily devotion .6/14, read daily devotion to her .6/16, attended movie & popcorn . 6/19, read daily devotion to her .6/20, visit with son .6/23, attended movie & popcorn .6/26, read daily devotion to her .6/27, attended coffee social, watched movie in dining room, listened to music - active engagement .6/28, visit with son .7/3 tuned tv to catholic mass and read daily devotion .8/09, assisted her with lunch .11/13, played on the keyboard and participated in hymn singing - happy .12/04, read daily devotion to her .11/30, back rub .12/2 .Attempted to ask resident about Christmas gift ideas - no answer - talked to her . Review of Individual Resident Daily Participation Record for September 23, revealed, .9/17, social/parties . 9/26, music . Review of Individual Resident Daily Participation Record for October 23, revealed, .10/4, bingo, television . 10/13, current events/news, group discussion .10/14, food drinks .10/15, religious studies, sing along . Review of Individual Resident Daily Participation Record for November 23, revealed, .11/15, beauty/barber, social/parties .11/19, music, religious services .11/22, board games, gardening .11/30, shopping . Review of Individual Resident Daily Participation Record for December 23, revealed, .12/4, arts/crafts, bingo, nails . Resident #78: Review of an Admission Record revealed Resident #78 was a female with pertinent diagnoses which included pressure ulcer of sacral region, stage 4, pressure ulcer of right ankle, stage 3, pressure ulcer of left heal, unstageable, stiffness of right hand, contracture right foot, contracture left foot, multiple sclerosis, urosepsis, gangrene, chronic pain, and cognitive communication deficit. Review of current Care Plan for Resident #51, revised on 3/8/21, revealed the focus, .(Resident #78) is dependent on staff for meeting emotional, intellectual, physical, and social needs due to physical limitations. Identifies as Christian .(Resident #78) noted in assessment that she enjoys time with her dog, arts/crafts, beauty/barber, bingo, board games, cards, computer use, cooking/baking, cultural events, dominoes, family/friends visits, gardening, knitting/crocheting, music, radio, religious services, shopping, social/parties, sports, TV, and walking . with the intervention .All staff to converse with resident while providing care .Assist with arranging community activities. Arrange transportation. Encourage ongoing family involvement, Invite the resident's family to attend special events, activities, meals .Establish and record the resident's prior level of activity involvement and interests by talking with the resident, caregivers, and family on admission and as necessary . (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 12/04/23 at 10:52 AM, Resident #78 was lying in her bed, supine position with a slight tilt to the left side. There was a noted odor in the room upon entry. There was a rolling bedside table near the left side of the bed which was not easily reached from her positioning in the bed. There was a cup on the table labeled Juven (therapeutic nutrition powder for wound healing) with a post it note stated, Please do not throw out. There were observed to be multiple signs in the room prompting staff to place the rolling beside table near Resident #78 so she could reach the drinks. On the rolling bedside table, next to the mirror where staff would wash their hands, etc. Resident #78 was observed to have a prevalon boot on her right foot. Resident #78's lips were dry, and skin was flaking off her lips with no water on the rolling bedside table. There was a blue foot cradle propped against the wall by the window in her room. No activities on the rolling table, no music, and the tv was not on. During an observation on 12/5/23 at 8:26 AM, Resident #78 was observed lying in her bed on her back with her legs bent to the left side. Resident #78 does have a contracted right leg. Resident #78's foot cradle was propped up against the wall by her dresser near the window in her room. There were no noted pillows under her legs. A styrofoam cup with water and a straw was on the rolling bedside table this morning. Her catheter still looks the same as yesterday with more cloudiness to it, tons of sediment in the tubing and calcification all over the top of the opening in the bag. Bag is touching the floor. She does have water today on the rolling table next to her bed. The hair still looks kind of greasy still the same ponytail yesterday. No activities on the rolling table, no music, and the tv was not on. During an observation on 12/5/23 at 2:00 PM, Resident #78 was observed lying in the same position she was lying in this morning. Her table is out of reach, which has her water and her Juven on it. She is still dressed in a hospital gown; right hand is contracted. Resident #78's foot cradle was still propped up against the wall in the same position as yesterday. No activities on the rolling table, no music, and the tv was not on. During an observation on 12/6/023 at 8:51 AM, Resident #78 was in bed without a wedge to either side, no foot cradle under her heels, or a pillow between her knees. It was noted, the resident's knees were touching each other. No activities on the rolling table, no music, and the tv was not on. During an observation on 12/06/23 at 02:30 PM, Resident #78 was lying in her bed supine position with a slight angle on to her left side. There was a sheet over her which was draped over the end of the foot board but not tented over her feet with the sheet laying on top of her feet. her catheter it does have pinkish red in the catheter tubing and at the entry of the catheter bag on top of the bag there were remnants of blood, granulation/calcification whitish substance. There was white granulated sediment on the bottom of the catheter tubing where it looped down. There were reddish/pinkish streaks on the inside of the catheter urine collection bag as well as granulation coating the inside of the bag from the entry point at the top of the bag. Observed the sheet draped over the end of the foot board of the bed but not tented over her feet, foot bolster in place, and prevalan boots were on her feet but he sheet laid on the top of the boots. Resident #78 was lying at an angle with weight on her left side. No activities on the rolling table, no music, and the tv was not on. During an observation on 12/07/23 at 11:12 AM, Resident #78 was observed lying in her bed. Blue wedges were observed stuffed in the open spaces of the folded up camping chairs her family had brought in to sit in as there were no other chairs in the room. No activities on the rolling table, no music, and the tv was not on. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 12/07/23 at 03:13 PM, Resident #78 was observed in bed supine position, right leg contracted, up and turned some to the left. Resident #78's bed sheet which was hung over the foot board of the bed with no tenting at the foot of the bed. No activities on the rolling table, no music, and the tv was not on. During an observation on 12/11/23 at 11:12 AM, Resident #78 was lying in a supine position in her bed, the sheet was touching her feet even though it was tented over the edge of the foot board. Both her water and Juven cups were full. Resident #78 reported she was painful, and her pain level was at a 10 and it was her whole body. This writer informed the LPN J of Resident #78's current pain level. During an observation on 12/11/23 at 11:17 AM, LPN J provided Resident #78 pain medications in a small container mixed in chocolate pudding. LPN J asked Resident #78 if she would like a drink of water, resident declined. This writer was informed LPN J, Resident #78 did not care for water. LPN J offered Resident #78 the Juven she had on the table and the resident accepted the Juven. No activities on the rolling table, no music, and the tv was not on. Review of Record of One to One Activities since admission 3/10/23 revealed, .3/20, met to discuss activities and preferences .4/27, assisted with lunch chatted about how she's doing .11/23, attempted to talk about what she is thankful for .11/30, stopped to see how she was doing. She said good . Review of Individual Resident Daily Participation Record for September 23, revealed, .11/19, family/friends visit . Review of Individual Resident Daily Participation Record for October 23, revealed, no documented activity participation. Review of Individual Resident Daily Participation Record for November 23, revealed, .11/16, family/friends visit .11/19, family/friends visit, religious services .11/22, family/friends visit . Review of Individual Resident Daily Participation Record for December 23, revealed, .12/1, family/friends visit .12/4, family/friends visit . Resident #63: Review of an Admission Record revealed Resident #63 was a female with pertinent diagnoses which included dementia with behavioral disturbances, physical debility, delusional disorder, muscle weakness, history of falling, dysphagia (damage to the brain responsible for production and comprehension of speech), and polyneuropathy (multiple peripheral nerves become damaged, numbness, burning pain, pins and needles sensation). Review of current Care Plan for Resident #63, revised on 11/13/23, revealed the focus, .I want to be invited to group activities such as, manicures, socials/parties, food activities, and music activities .I will need assistance to and from activities. I will receive 1:1 visits, as needed . with the intervention .For 1:1 visits, I would enjoy: music, manicures, being outdoors, snacks, being read to and reminiscing .I prefer the following TV channels: Western channel .I would like to be invited to the following group activities: manicures, church services, food activities, social parties/events, and musical programs .Independently: I love music, being outdoors, being around animals, wheeling myself around the building, phone calls with family, and watching old television/movies .Introduce me to residents with similar background, interests, and encourage/facilitate interaction . (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Order Summary revealed, no order for isolation due to COVID positive on 11/24/23. During an observation on 12/04/23 at 12:25 PM, observed signs on the door to Resident #63's room indicated PPE donning and doffing, sign to Keep the door closed, Stop sign to see the nurse. During an observation on 12/06/23 10:00 AM Resident #63 was observed lying in her bed, on her left side, with her eyes closed. During an observation on 12/06/23 03:00 PM, Resident #63 was observed in her room seated in her wheelchair, dressed, tennis shoes, eyes were closed. During an observation on 12/11/23 at 8:09 AM, Resident #63 was observed lying in her bed on her left side, eyes closed. Breakfast was on the rolling table out of her reach. Fall mat next to her bed. Review of Record of One to One Activities since admission July 23 revealed, .7/6, walked the halls chatted about family .7/10, walked the halls & chatted .7/11, sat & chatted before lunch .7/17, walked the halls and chatted .7/26, sat and chatted about her kids .7/31,walked the halls & chatted .8/12, assisted with phone call - upset .8/07, walked the halls together & chatted .8/9, walked the halls & chatted about the morning .11/23, asked her what she is thankful for .1/23, stopped to see how she was doing - isolation .12/1, check in doing well . Review of Individual Resident Daily Participation Record for September 23, revealed no documentation of participation. Review of Individual Resident Daily Participation Record for October 23, revealed .10/3, music, sing alongs . 10/4, music .10/8, social/parties .10/19, beauty/barber . Review of Individual Resident Daily Participation Record for November 23, revealed .11/2, social/parties, television, food/drink .11/3, food/drink .11/5, music, religious service .11/9, movies, television .11/18, social/parties .11/19, religious services, food/drink . Review of Individual Resident Daily Participation Record for December 23, revealed no documentation as resident was in isolation. 46999 Resident #82 Review of an Admission Record dated 6/2/23 revealed Resident #82 was admitted to the facility with the following pertinent diagnoses: Alzheimer's disease (progressive mental deterioration due to generalized degeneration of the brain), and major depressive disorder. Review of a Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #82 scored 6/15 on a Brief Inventory for Mental Status (BIMS) assessment which indicated he had severe cognitive impairment. Section B of the assessment revealed the resident was usually able to make himself understood and usually understood others. Section E of the MDS revealed Resident #82 had no behavioral symptoms during the 14-day assessment period. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a Care Plan dated 6/19/23 revealed a focus/goal/intervention(s) as follows: Focus: (Resident #82) is dependent on staff for meeting emotional, intellectual, physical, and social needs due to cognitive deficits and physical limitations. Goal: Resident will maintain involvement in cognitive stimulation, social activities as desired. Interventions: all staff to converse with resident while providing care, assist with arranging community activities, encourage ongoing family involvement. Leisure interests listed in Resident #82's care plan included: animals, drawing, fancy lettering, fast card games, computer use, writing, exercise, upbeat music, educational programs, volunteering, board games, dominoes. Review of an Activities Evaluation dated 6/4/23 revealed Resident #82 had a lifelong pattern of engaging in social interaction. The resident worked as a Customer Relations Manager, belonged to a social club, and indicated cultural events and group discussions were very important to him. Resident #82 also reported listening to music and volunteering were very important activities in his life. Review of physician orders revealed an order for Resident #82 to be in medical isolation from 11/29/23-12/6/23 due to a respiratory infection. Review of a progress note dated 12/5/23 revealed Resident #82 was confused and upset, reported he was being held hostage and confined, that he felt everything was being taken from him and that he doesn't get to see anyone anymore. The resident began to cry at that point. During on observation on 12/5/23 at 11:28am, Resident #82 was lying on his bed, dressed for the day, awake, with his hands folded across his chest. His facial expression was flat with furrowed eyebrows. The television was on in his room, no source for music was present, no leisure supplies noted. In an interview on 12/5/23 at 11:30am, Resident #82 reported he was frustrated and bored to death because he had nothing to do and could not leave the room. Resident reported he normally enjoyed assisting with activities, greeting visitors in the lobby, walking around the facility and he liked to stay busy. Resident #82 reported he had to move to a temporary room when his isolation began, and he wanted his activity supplies from his room, but no one brought them. Resident #82 stated if I had the things from my room, at least I'd have something to do. Resident #82 reported no one had visited him regularly during his medical isolation. Resident #82 reported the staff came to check on him from time to time, but they were busy and could not stay to socialize. In an interview on 12/6/23 at 1:24pm, Licensed Practical Nurse (LPN) M was queried about Resident #82's emotional state during his isolation. LPN M stated It's killing him to be in there. He's a social butterfly. LPN M reported the resident had gotten more confused, was experiencing periods of anger which was unusual for him. LPN M reported she reached out to the activities department to get Resident #82 some word puzzles because she was concerned about his psychosocial well-being. LPN M reported she had not seen any other interventions implemented to address Resident #82's psychosocial needs during his period of isolation. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 12/7/23 at 11:29 am, Activities Director (AD) UU reported Resident #82 was a little social butterfly. AD UU reported she thought Resident #82 had been a police officer and as a result he enjoyed patrolling the facility. The resident enjoyed walking around the facility daily, liked to be around people, enjoyed group activities and loved to help others. AD UU reported during his isolation, Resident #82 received an activity packet, of which he completed portions of 2 wordsearch puzzles and activities staff had helped another resident call Resident #82. AD UU was not able to provide documentation of these interventions. When queried about the possibility of using an electronic device to allow Resident #82 to socialize and participate in group activities virtually, AD UU reported the facility had devices that would support Resident #82 participating virtually but she did not think of that. Review of a Record of One-to-One Activities document for Resident #82 revealed 2 interactions: 12/1 dropped off activity packet. Happy. 12/4 checked in with (Resident #82)- ready to be out of iso (sic). A column labeled time spent next to these entries was blank. Review of Revolutionizing the Experience of Home by Bringing Well-Being to Life: The [NAME] Alternative Domains of Well-Being, Copyright 2012, Rev. 2020, revealed The [NAME] Alternative defined one domain of wellness as Connectedness- the state of being connected; alive .engaged, involved . without meaningful interactions the individual can become disconnected .develop loneliness, helplessness, and boredom. 47955 Resident #21 Review of an Admission Record revealed Resident #21 had pertinent diagnoses which included: major depressive disorder (persistent feelings of sadness), muscle weakness, and dementia (neurocognitive disorder that affects the memory and thinking). During an observation on 12/4/23 at 10:32 AM., Resident #21 was in bed, awake, and counting out loud. No other noise noted in her room. During an observation on 12/4/23 at 1:28 PM., Resident #21 was sitting in her wheelchair in her room in silence. During an observation on 12/5/23 at 10:00 AM., Resident #21 was lying in bed, sleeping. No other noise noted in room. Review of Activity Log (2023) for Resident #21 revealed .recorded entry for one-to-one activities included on 8/13 asked MDS questions . 11/23 attempted to talk to her about what she's thankful for .12/4 checked in and talked to her . Review of Group Activity Log for Resident #21 revealed .group activity attendance on 4 days in the month of September 2023, 6 days in the month of October 2023, 3 days in the month of November 2023, and no attendance during December 2023. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Care Plan for Resident #21 revealed Focus area .I participate in some scheduled group activities . I will need 1:1 visits if there is a decrease in activity attendance: Goal includes I will attend group activities 2-3 times a week, I will be offered 1:1 activities as needed: Interventions include .Independently I enjoy listening to the television and music . Revision on 11/21/23 by Activities Director (AD) UU. Review of activity log and group activity log 2023' for Resident #21 revealed inconsistent activity offering and participation. During an observation on 12/6/23 at 9:12 AM., Resident #21 was in bed eating breakfast in silence. Resident #29 Review of an Admission Record revealed Resident #29 had pertinent diagnoses which included: cerebrovascular disease (stroke), aphasia (inability to form words), and anxiety disorder. During an observation on 12/4/23 at 12:29 PM., Resident #29 was in bed sleeping. Television was on and turned up. During an observation on 12/5/23 at 10:10 AM., Resident #29 was sitting in wheelchair in room watching television. Review of Activity Log (2023) for Resident #29 revealed .recorded entry for one-to-one activities included on 10/25 Resident sleeping . 11/13 Talked to Resident #29 about helping to pass out itinerary for the am . 11/23 attempted to ask him what he was thankful for .11/25 talked to him and calmed him down .12/1 attempted to read to him . Review of Group Activity Log for Resident #2 revealed .group activity attendance on no days in the month of September 2023, no days in the month of October 2023, 1 day in the month of November 2023, and no attendance during December 2023. Review of Care Plan for Resident #29 revealed . focus area . (Resident #29) declines invites to most scheduled group activities and prefers to independent activity of choice in room .goal - will maintain involvement in cognitive stimulation, social activities .interventions- continue 1:1 visits two time per week as tolerated . Review of activity log and group activity log 2023' for Resident #29 revealed inconsistent activity offering and participation. During an interview on 12/6/23 at 3:41 PM., AD UU reported that the expectations for residents who did not attend group activities was to participate in one-to-one activities. AD UU reported that she evaluated the group participation documentation from the week before on Monday and created the one-to-one schedule for the current week. During an interview on 12/7/23 at 11:29 AM., AD UU reported that one-to-on [TRUNCATED]

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41424 Based on observation, interview, and record review, the facility failed to: 1.)monitor and complete documentation of weights for 1 residents (Resident #8), 2. obtain orders and complete wound dressing changes for 3 residents (Resident #53, Resident #442, and Resident #57) and, 3.) complete neurological checks following a fall for 1 resident (Resident 79) of 6 residents reviewed for quality of care, resulting in potential for negative resident outcomes. Findings include: 46999 Resident #8 Review of an Admission Record dated 5/1/23 revealed Resident #8 was admitted to the facility with the following pertinent diagnoses: acute on chronic combined systolic and diastolic congestive heart failure (weakened and stiff heart muscle condition causing the heart to not contract normally, resulting in fluid collecting in the body), adult failure to thrive (state of decline that is multifactorial and may be caused by chronic concurrent conditions), venous insufficiency (improper functioning of the vein valves in the leg, causing swelling). Review of a Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #82's primary reason for admission was his cardiorespiratory condition. Active diagnoses included: coronary artery disease (condition causing narrowing of arteries thus reducing blood flow), heart failure, renal insufficiency (condition in which the kidneys don't remove fluid properly). Review of a Care Plan for Resident #8 dated 9/21/23, revealed the following focus/goal/intervention(s): (Resident name) has Congestive Heart Failure. May experience weight fluctuations related to diuretic medications. Goal: The resident will verbalize less difficulty breathing through the review date. Interventions: Cardiac medications as ordered. Weight monitoring as ordered. Review of physician orders for Resident #8 revealed an order that stated: CHF (congestive heart failure): weekly weight, every day-shift Tuesday. Start date 10/24/23. Review of a weight summary document for Resident #8 revealed no weights recorded from 10/20-11/8/23. Based on the physician orders, the resident should have been weighed twice during that period. The weight summary reflected no weights recorded between 11/8-11/21/23. Based on the physician orders, the resident should have been weighed twice during that period. The weight summary reflected no weights recorded between 11/22-12/4/23. Based on physician orders, Resident #8 should have been weighed once during that period. In an interview on 12/6/23 at 9:54am, Registered Dietitian (RD) RR reported the physician ordered weekly weights for Resident #8 to monitor the potential for hypervolemia (condition in which the liquid portion of the blood is too high causing weight gain, swelling, shortness of breath). RD RR reported without weekly weight documentation there was a potential for Resident #8 to gain or lose a significant amount of weight and not receive the indicated medical interventions. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME]; Hall, [NAME]. Fundamentals of Nursing - E-Book (Kindle Locations 20717-20719). Elsevier Health Sciences. Kindle Edition, The health care provider (physician or advanced practice nurse) is responsible for directing medical treatment. Nurses follow health care providers' orders unless they believe that the orders are in error, violate agency policy, or are harmful to the patient. 47659 Resident #53 Review of an Admission Record revealed Resident #53, was originally admitted to the facility on [DATE] with pertinent diagnoses which included muscle weakness and difficulty in walking. Review of Resident #53's Medication and Treatment Administration Record (MAR/TAR) revealed, Order: Left hand skin tear- cleanse with NS (normal saline), cover with Opsite (type of dressing pad) every 7 days and PRN (as needed). This order was last documented as completed on 12/3/23 by Licensed Practical Nurse (LPN) I. During an observation on 12/04/23 at 11:05 AM, Resident #53 was sitting in her recliner watching television. Her left hand cut was covered with an opsite pad which was dated 11/26/23. During an observation on 12/06/23 02:34 PM, Resident #53's left hand had the same opsite pad as previous observation which was dated 11/26/23. During an observation and interview on 12/06/23 at 3:05 PM, Unit Manager E observed the bandage on Resident #53's left hand, and reported that the date on the opsite pad should have reflected the last date that LPN I had documented that is was changed, which was 12/4/23, and that the bandage had not been changed. During an interview on 12/11/23 at 2:16 PM, LPN I reported that she had not changed the opsite pad on Resident #53's left hand on 12/4/23. LPN I reported that she did not know why she had documented that she had completed the opsite pad, when she had not. Resident #442 Review of an Admission Record revealed Resident #442, was originally admitted to the facility on [DATE] with pertinent diagnoses which included type 2 diabetes mellitus. Review of Resident #442's Hospice Physician Order dated 12/1/23 revealed, Order Description: Facility nurse to cleanse wound to right hand with normal saline 0.9%, pat dry with gauze. Apply dry gauze to wound and secure with paper tape. Change daily and if soiled. Hospice nurse to assess weekly. Review of Resident #442's Active Orders did not reveal any wound care orders for Resident #442's right hand. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/11/23 10:00 AM, Unit Manager E confirmed that the facility never entered the wound care order for Resident #442's right hand. Unit Manager E reported that the order should have been entered by the nurse that pulled the order from the fax machine. Unit Manger E reported that he was not sure which nurse was responsible for pulling the order from the fax machine, or how this was missed. Resident #57 Review of an Admission Record revealed Resident #57, was originally admitted to the facility on [DATE] with pertinent diagnoses which included muscle weakness. Review of a Minimum Data Set (MDS) assessment for Resident #77, with a reference date of 10/27/23 revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #57 was cognitively intact. Review of Resident #57's Medication and Treatment Administration Record (MAR/TAR) revealed, Order: Bilary drain (drain that allows flow out from a blocked bile duct into a collection bag outside of the body). Carefully remove old bandage covering the tube. Only remove the tape holding the tube in place if it is loose. If loose, replace tape to secure the tube. Wash surrounding skin with warm soap and water. Pat dry. Apply antibiotic ointment, place new gauze pad over the site and cover with tape. every day shift for wound care. This order was documented as completed on 11/30/23, 12/1/23, 12/2/23, 12/3/23 and 12/4/23. During an interview on 12/06/23 at 9:57 AM, Resident #57 reported that nursing staff were not monitoring his bilary drain, and were not changing the dressing that covered the drain site as often as they were suppose to, which made him feel frustrated. The dressing on Resident #57's bilary drain dressing was dated 11/29/23. Resident #57 reported that nursing staff were suppose to change the dressing daily. During an interview on 12/06/23 at 3:08 PM, Unit Manager E reported that Resident #57's dressing should have been dated for 12/6/23. Unit Manager E confirmed that nursing staff were documenting the dressing change as completed but that they were not completing the dressing change. During an interview on 12/07/23 at 4:17 PM, LPN Q reported that she had not changed Resident #57's bilary drain dressing 12/4/23, but that she had documented that she had completed the dressing change. LPN Q was unable to explain why she had documented a treatment as completed even though she had not completed it. During an interview on 12/07/23 at 3:53 PM, Registered Nurse (RN) F reported that she had not changed Resident #57's dressing on 11/30/23, 12/5/23, or 12/6/23 RN F was unable to explain why she documented the dressing change as completed when she had not completed the dressing changes. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's Nursing Documentation policy, last reviewed 8/10/23, revealed, The facility must ensure that nursing documentation is consistent with professional standards of practice, the state nurse practice act, and any state laws governing the scope of nursing practice . Medical Records: The medical record shall reflect a resident's progress toward achieving their person-centered plan of care objective and goals and the improvement and maintenance of their clinical, functional, mental and psychosocial status. Staff must document a resident's medical and non-medical status when any positive or negative condition change occurs, at a periodic reassessment and during the annual comprehensive assessment. The medical record must also reflect the resident's condition and the care and services provided across all disciplines to ensure information is available to facilitate communication among the interdisciplinary team. The medical record must contain an accurate representation of the actual experience of the resident and include enough information to provide a picture of the resident's progress, including his/her response to treatment and/or services, and change in his/her condition, plan of care goals, objectives and/or interventions . Resident #79 Review of an Admission Record revealed Resident #79, was originally admitted to the facility on [DATE] with pertinent diagnoses which included unspecified dementia with other behavioral disturbance, muscle weakness, and personal history of traumatic brain injury. Review of Resident #79's Incident Reports revealed that Resident #79 had unwitnessed falls on the following dates: 6/29/23, two falls on 8/2/23, 8/21/23, 8/29/23, 9/17/23, 9/24/23, 9/30/23, and 10/19/23. Review of Resident #79's Neurological Checks (Neuro checks) revealed that neuro checks were not documented on 8/2/23 at 5:45 PM, 8/3/23 at 11:45 AM, 8/3/23 and 3:45 PM, 8/4 at 7:45 AM, 3:45 PM, and 11:45 PM, 8/5/23 at 11:45 PM, 8/20/23 at 4:45 PM, 8/23/23 at 8:45 PM, 8/30/23 at 9:00 AM, 1:00 PM and 5:00 PM, 8/31/23 at 9:00 PM, 9/18/23 at 6:15 PM, 9/19/23 at 10:15 AM, and 6:15 PM, 9/20/23 at 2:15 AM, 9/21/23 at 2:15 am, 10/3/23 at 9:15 PM and 10/19/23 at 12:00 AM. During an interview on 12/07/23 at 11:38 AM, Director of Nursing (DON) B reported that nursing staff were to complete neuro checks on all unwitnessed falls. DON B reported that after the unit manager reviewed each incident report, that she was responsible for reviewing and confirming each incident report had all required assessments and documentation completed. DON B confirmed that she was unaware that Resident #79 had missed several neuro checks, and that they had not been documented. DON B confirmed that she had not reviewed all of Resident #79's falls/incidents reports since June 2023. During an interview on 12/11/23 at 11:15 AM, Unit Manager E reported that he was responsible for reviewing incident reports before the DON. Unit Manger E reported that he was not aware that Resident #79 had several missing neuro assessments. Unit Manager E reported that the facility had issues with nurses completing neuro checks, and he had previously educated nursing staff on this. Unit Manager E reviewed the nursing documentation with this surveyor and confirmed that the assessments were not documented as completed, and Resident #79 had missed several neuro checks. During an interview on 12/11/23 at 11:48 AM, LPN M reported that if nurses did not enter the neuro assessments in EHR, then they were not completed. LPN M reviewed the documentation with this surveyor and reported that the neuro assessments had been missed as nothing was documented. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/11/23 at 12:03 PM, LPN L reported that if the neuro checks were not completed in the EHR, she had missed them. Review of the facility's Neurological Assessment last reviewed on 8/10/23 revealed, Policy: The Neurological Assessment (UDA) in (facility's EHR system) shall be initiated by a written physician's order for neurological checks or when indicated by a resident assessment (e.g., head injury, post fall, neurological decompensation). Procedure: The assessing nurse initiates the Neurological Check List UDA in the electronic health record and completes as indicated. 2. The nurse must initial/sign each documentation entry. 3. The nurse documents and reports any pertinent changes in the resident's neurological status immediately to the physician. 4. Interventions takes as a result of the assessment, as well as the initiation and completion of the assessment should be notes in the nurses' notes .

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41424 Based on observation, interview and record review, the facility failed to prevent the further development of pressure ulcers for 1 (Resident 78) of 3 residents reviewed for pressure ulcers, resulting in the development of 7 facility acquired pressure ulcers and worsening of existing pressure ulcers resulting in surgical intervention. Findings include: Review of an Admission Record revealed Resident #78 was a female with pertinent diagnoses which included pressure ulcer of sacral region, stage 4, pressure ulcer of right ankle, stage 3, pressure ulcer of left heal, unstageable, stiffness of right hand, contracture right foot, contracture left foot, multiple sclerosis, urosepsis, gangrene, chronic pain, and cognitive communication deficit. Review of Care Plan for Resident #78, revised on 11/08/2023, revealed the focus, .(Resident #78) has actual skin impairment r/t (related to) MS (muscular sclerosis), poor oral intake, bed bound, and contractures . with the intervention .Foot cradle to the end of the bed, float blankets/sheets over the top to maintain pressure off the tops of her toes/feet .date initiated: 09/07/23 .Has a small pillow or standard pillow placed between knees to alleviate pressure .date initiated: 09/07/23 .Heelz up device, stack of pillows at the end of the bed to prop her LE (lower extremity), heels off the bed surface .date initiated: 07/14/23 .Prevalon boots to bilateral fee except with care as she will allow .date initiated: 09/07/23 .Turn and reposition as resident allows .date initiated: 3/23/23 .Wedge cushion to either side of (Resident #78) to assist with offloading pressure, reposition .(Resident #78) is staying in bed and not getting up in chair due to were her stage 4 is located on the buttocks .date initiated: 04/21/23 . Review of Skilled Note dated 3/11/23 at 2:43 PM, revealed, .Pt has MS without ability to use her right arm and requires total care .She is unable to move herself/feed herself. She is not able to communicate needs. Pt has a very large wound on her sacrum/stage 4 .Pt is very painful to touch . Review of Skilled Note dated 3/12/23 at 4:17 PM, revealed, .Takes two staff to turn her from side to side. She has a stage four wound that is a 75% of her buttocks/coccyx region with an area that is tunneled . Review of Skilled Note dated 3/15/23 at 12:43 PM, revealed, .Resident is receiving wound care with a wound vacto sacral/coccyx area. The right foot has an ulcer and the left heel is necrotic. These wounds were acquired prior to arrival to facility .Requires max assistance for ADLs, including feedings for meals . Review of Health Status Note dated 4/19/23 at 7:22 PM, revealed, .Found open area outer aspect right calf, appear to be a pooped (sic) blister .Measures: 3.2x1.7x0.1 . (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of Wound Assessment Details dated 4/20/23, revealed, .1. Medial coccyx .Stage 3 .2. Right Lateral Shin .Stage 2 .3. Right Ankle .Stage 2 .4. Right Lateral Foot .Stage 2 .5. Left Heel .Unstageable .6. Right Heel .Unstageable .Additional Orders: Off-Loading: Use/Wear offloading when in bed: - offload heels in bed and legs as much as possible. Wear prevalon boots at all times, even for transport .Specialty Bed/ Mattress for Pressure Reduction. - Please try to get patient sand bed, it will offload ulcer to promote healing .Turn every 2 hours. Avoid position directing pressure to wound site. Limit side lying to 30 degrees tilt. Limit HOB (head of bed) elevation to 30 degrees in bed .Turn Frequently .Avoid pressure at wound site . Review of Nutrition/Dietary Note dated 4/24/23 at 1:09 PM, revealed, .RD skin review: Facility acquired US to her right heel and her right inner foot; Stage IV to her sacrum; Stage IV to her left heel; stage III to her right ankle; Wounds are dressed and followed by her nurse .Diet: Regular .PO intake poor @ 0-25% most of the time .Dependent on staff for feeding .Resident has MS .She is bedbound .Wgt: 3/10 190#/69, BMI: 28.1 . Resident face appears thinner than her admission picture. Est. needs @ ABW 160#/73kg x 25- 30cal/kg = 1800-2190cal .Protein @ 1.3gm = 94.9gm Fluids: @ 30ml/kg = 2190ml PO intake does not appear to be meeting her needs .Writer spoke with resident during her noon meal, her tray was sitting at bedside. When asked if she was going to eat her lunch she stated no. She had Ensure, Milk, and Juice at bedside she had not drank her Ensure. It does appear that resident would need 1:1 feeding assistance even for her fluids. Both hands are curled into her palms. She answered only yes no questions and did not elaborate on any one subject. Due to poor intake weight loss is anticipated . Review of Health Status Note dated 4/27/23 at 2:34 PM, revealed, .Noted to have a new wound to her right palm, stage 2 noted . Review of Wound Assessment Details dated 4/28/23, revealed, .1. Medial coccyx .2. Right Lateral Shin .3. Right Ankle .(Worsened) .4. Right Lateral Foot .5. Left Heel .6. Right Heel .Additional Orders: Off-Loading: Use/Wear offloading when in bed: - offload heels in bed and legs as much as possible. Wear prevalon boots at all times, even for transport .Specialty Bed/ Mattress for Pressure Reduction. - Please try to get patient sand bed, it will offload ulcer to promote healing .Turn every 2 hours. Avoid position directing pressure to wound site. Limit side lying to 30 degrees tilt. Limit HOB (head of bed) elevation to 30 degrees in bed .Turn Frequently .Avoid pressure at wound site . Review of Skin/Wound Note dated 5/10/23 at 3:42 PM, revealed, .Dr. made aware of the change in rt (right) ankle wound and other skin disturbances noted upon skin assessment . Review of Wound Assessment Details dated 5/12/23, revealed, .1. Medial coccyx .2. Right Lateral Shin . (Worsened) .3. Right Ankle .4. Right Lateral Foot .5. Left Heel .(Worsened) .6. Right Heel .Additional Orders: Please order bilateral x-rays of heels .Off-Loading: Use/Wear offloading when in bed: - offload heels in bed and legs as much as possible. Wear prevalon boots at all times, even for transport .Order second set of prevalon boots if able so patient has set when additional set is being laundered .Specialty Bed/ Mattress for Pressure Reduction. - Please try to get patient sand bed, it will offload ulcer to promote healing .Turn every 2 hours. Avoid position directing pressure to wound site. Limit side lying to 30 degrees tilt. Limit HOB (head of bed) elevation to 30 degrees in bed .Turn Frequently .Avoid pressure at wound site . Note: After each Additional Order there were check marks indicating review with initials on the paper. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of Wound Assessment Details dated 5/25/23, revealed, .1. Medial coccyx .2. Right Lateral Shin .3. Right Ankle .4. Right Lateral Foot .5. Left Heel .6. Right Heel .Additional Orders: Please order bilateral x-rays of heels .Off-Loading: Use/Wear offloading when in bed: - offload heels in bed and legs as much as possible. Wear prevalon boots at all times, even for transport .Order second set of prevalon boots if able so patient has set when additional set is being laundered .Specialty Bed/ Mattress for Pressure Reduction. - Please try to get patient sand bed, it will offload ulcer to promote healing .Turn every 2 hours. Avoid position directing pressure to wound site. Limit side lying to 30 degrees tilt. Limit HOB (head of bed) elevation to 30 degrees in bed .Turn Frequently .Avoid pressure at wound site . Review of Health Status Note dated 6/8/23 at 5:45 PM, revealed, .Enabler bars removed. Resident makes no movement to reposition self. Dependent upon staff for all ADL care, transfers, and mobility . Review of Wound Assessment Details dated 6/8/23, revealed, .1. Medial coccyx .2. Right Lateral Shin .3. Right Ankle .4. Right Lateral Foot .5. Left Heel .(Worsened) .6. Right Heel .Additional Orders: Off-Loading: Use/Wear offloading when in bed: - offload heels in bed and legs as much as possible. Wear prevalon boots at all times, even for transport .Order second set of prevalon boots if able so patient has set when additional set is being laundered .Specialty Bed/ Mattress for Pressure Reduction. - Please try to get patient sand bed, it will offload ulcer to promote healing .Turn every 2 hours. Avoid position directing pressure to wound site. Limit side lying to 30 degrees tilt. Limit HOB (head of bed) elevation to 30 degrees in bed .Turn Frequently . Avoid pressure at wound site . Review of Skin/Wound Note dated 6/14/23 at 1:40 PM, revealed, .Rt and left wound have worsened this week . Review of Wound Assessment Details dated 6/22/23, revealed, .1. Medial coccyx .2. Right Lateral Shin .3. Right Ankle .4. Right Lateral Foot .5. Left Heel .6. Right Heel . Review of Wound Assessment Details dated 7/6/23, revealed, .1. Medial coccyx .2. Right Lateral Shin .3. Right Ankle .5. Left Heel .6. Right Heel .(Worsened) . Review of Skin/Wound Note dated 7/7/23 at 2:14 PM, revealed, .1 wound worsen which was the right heel, note place in Dr. book to inform him of the change . Review of Skin/Wound Note dated 7/14/23 at 1:32 PM, revealed, .N.O. (new order) to d/c (discontinue) the prevalon boots and will continue with the heels up device and pillows as needed to prop her heels, feet off the bed surface. Dr. notified of the decline in the rt (right) heel wound . Review of Wound Assessment Details dated 7/27/23, revealed, .1. Medial coccyx .(Worsened) .2. Right Lateral Shin .3. Right Ankle .(Worsened) .5. Left Heel .6. Right Heel .(Worsened) .#7. Left Hip (New Wound-Acquired 7/27/23) .Additional Orders: PLEASE TURN EVERY 2 HOURS AND KEEP PREVALON BOOTS ON AT ALL TIMES . Review of Discharge Instructions dated 7/27/23, revealed, .Off-Loading: Specialty Bed/Mattress for Pressure Reduction .Turn every 2 hours. Avoid position directing pressure to Wound site. Limit side lying to 30-degree tilt. Limit HOB elevation to 30 degrees in bed. -when turning, make sure catheter is not under patient, it will cause a new wound .Turn frequently .Do not sit for long periods of time .Avoid pressure at wound site . (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of Skin/Wound Note dated 7/28/23 at 3:51 PM, revealed, .A new wound to the left hip area is present which is an intact blister . Review of Wound Assessment Details dated 8/9/23, revealed, .1. Medial coccyx .3. Right Ankle .5. Left Heel . 6. Right Heel .#7. Left Hip .#8. Right Lateral Food: New - Acquired on 8/9/23 . Review of Nutrition/Dietary Note dated 8/11/2023 at 12:33 PM, revealed, .IDT RAR: Resident with several pressure injuries. On regular diet, Ensure BID with snack offer. Weight has remained stable at 182.4 lbs. x 3 months. BMI 26.9. PCC shows snack intake typically 0-50%. Eating avg 50% of meals. Sister and mom visit each night, bring food/supplements to resident. Total assist when eating . Review of Skilled Note dated 8/20/2023 at 00:31 AM, revealed, .Regular diet, Regular texture, Thin consistency. No s/s pain or discomfort noted. Routine Neurontin and morphine given @ HS .Right heel wound: cleanse with normal saline. Apply silvasorb to wound bed and apply mepilex dressing. Change daily. Right ankle: cleanse wound with normal saline. pat dry. Apply Silvasorb to wound. Cover with mepilex dressing. Medial coccyx wound care: Cleanse with normal saline. Apply hydrofera blue to wound bed, ABD pads(x3-4) over the hydrofera and cover with foam dressing. Change daily and when soiled or dislodged. if unable to get hydrofera blue initially apply Dakins soaked gauze to wound and cover with foam dressing .Left heel wound: cleanse with normal saline. Apply silvasorb gel to wound. Cover with Mepilex foam. Change Three times a week for wound care.Res Alert. Confusion noted. Most needs anticipated by staff. Dependent for ADLS, transfers, toileting and feeding. Foley in place and draining clear yellow urine. Colostomy Intact. Res turned every two hours as she allows. Prevalon boots in place to bilateral feet. One assist with feeding. Will eat finger foods. Accepted HS meds without difficulty. Resting in bed with eyes closed. Fluids and call light within reach . Review of (Local Hospital) Wound Healing and Hyperbaric Center Progress Note dated 08/30/23, revealed, . (Facility) was not able to keep a good seal on her wound vac, so they have been packing the wound with dakins moistened gauze for the past few weeks instead .She is no longer on a clinitron bed (sand bed - filled with silicone coated microspheres which resemble sand, warm air is forced up through those to create a fluid like state) but does have an air mattress .She does have access to prevalon boots, but does not always have them on .4/28: Right heel wound healed .5/12: New wound on left upper thigh from catheter .5/25: Xrays of heels negative for osteomyelitis .7/6: .Sacral wound .a few areas do probe close to bone at base in middle of wound .Wound #9 Right Hip (New) . Review of Order dated 8/16/23, revealed, .Bilateral Prevalon boots to be worn as resident allows every day and night shift for wounds. Review of Order dated 8/15/23, revealed, .Regular diet: Regular texture, Thin consistency, for diet . Review of Health Status Note at 8/18/2023 at 6:51 PM, revealed, .Note Text: Alert to self. Appetite and fluid intake remains poor. Refused lunch tray. Drinks within reach but resident makes no attempts to drink them herself . (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of Skilled Note dated 8/20/2023 at 00:31 AM, revealed, .Regular diet, Regular texture, Thin consistency .Right heel wound: cleanse with normal saline. Apply silvasorb to wound bed and apply mepilex dressing. Change daily .Right ankle: cleanse wound with normal saline. pat dry. Apply Silvasorb to wound. Cover with mepilex dressing. Medial coccyx wound care: Cleanse with normal saline. Apply hydrofera blue to wound bed, ABD pads(x3-4) over the hydrofera and cover with foam dressing. Change daily and when soiled or dislodged. if unable to get hydrofera blue initially apply Dakins soaked gauze to wound and cover with foam dressing .Left heel wound: cleanse with normal saline. Apply silvasorb gel to wound. Cover with Mepilex foam. Change Three times a week for wound care Res Alert. Confusion noted. Most needs anticipated by staff. Dependent for ADLS, transfers, toileting and feeding .One assist with feeding. Will eat finger foods .Fluids and call light within reach . Note: No further documentation of monitoring to determine appropriateness of finger foods. Review of Resident #78's food preferences for Breakfast: no eggs, ham; Lunch & Dinner: beets, chicken strips, ham, lemon/lime Jello, melon (except watermelon), pot pie, rice, sweet potato, vegetables . Preferences: Extra sauce, gravy, butter, cottage cheese, yogurt, juice of choice: (4 oz), 2 milk whole (8 oz) . Review of Menu - Week 1 provided on 12/4/23 the current menu rotation, revealed for Breakfast eggs were offered 5 out of the 7 days, 1 of the 7 days; Lunch: Sunday: Apple pork chop, honey roasted sweet potatoes, broccoli casserole, dinner roll, pie of the day, beverage of choice; Monday: Beef stew, tossed salad, biscuit, fruit crisp; Tuesday: Tuna noodle casserole, Italian vegetables, garlic bread, banana pudding w/topping; Wednesday: Fried chicken, mashed potatoes/gravy, seas cut green beans, dinner roll, fruit pie; Thursday: Catch of the day, French fries, creamy [NAME] slaw, dinner roll, golden bread pudding; Friday: Roast beef/gravy, baked potato, lemon butter broccoli Florentine, dinner roll, brownie; Saturday: BBQ Chicken, mashed potatoes, herb cut green beans, dinner roll, frosted cupcake; Dinner: Sunday: Baked chicken, potatoes [NAME], saute summer squash, garlic toast, ice cream, beverage of choice, milk; Monday: Garlic pepper pork, macaroni & cheese, vegetable blend, breadstick, SL cheesecake; Tuesday: Baked honey glazed ham, green peas, seas SL carrots, cornbread, fresh baked cookies; Wednesday: Shrimp fettucine, marinated tomato, dinner roll, strawberry shortcake; Thursday: Turkey pot pie, seasoned zucchini, dinner roll, fruit cup; Friday: Soup [NAME] jour, crackers, egg salad sandwich, carrot raisin salad, peach fluff; Saturday: Tamale pie, seasoned beans, chop lettuce/tomatoes, dinner roll, fruit cobbler . In an interview on 12/04/23 at 12:30 PM, Certified Nursing Assistant (CNA) X reported the staff would pass out the meal trays to all the residents and when they were finished passing the trays, they would come back around and feed everyone who needed assistance. Review of Skin/Wound Note dated 8/23/2023 at 1:13 PM, revealed, .Noted that her rt ankle, lateral wound has reopened and is scabbed over . Review of Health Status Note dated 9/1/23 at 12:17 PM, revealed, .New wound on right hip, stage 2 pressure injury . Review of Health Status Note dated 9/1/23 at 2:58 PM, revealed, .Slow to respond, stares. Facial grimacing present. Each movement states Ouch .water within reach but no observation of her attempting to drink herself . (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of Health Status Note dated 9/4/23 at 10:12 AM, .States Ouch with repositioning or during care . Water within reach at bedside, makes no attempt to drink herself . Review of Nutrition/Dietary Note dated 9/5/23 at 7:46 AM, revealed, .Sister states that Juven isn't touched from the time she leaves it to when she arrives the next day .Resident loves the Juven .does not like to drink water .Will enter order for 120 m: fluid offer with med passes (milk, supplement drink, Juven, etc.) . Review of Order dated 9/5/23, revealed, .Magic cup one time a day for supplement . Review of Medication Administration Record (MAR) for November 2023, revealed, Resident #78 was offered the magic cup 13 days out of 30 days. The other days of the month were noted with an x in the box . Review of Medication Administration Record (MAR) for December 2023, revealed, .12/3/23, 12/4/23, 12/5/23, 12/6/23 was documented with an x . Review of Order dated 9/5/23, revealed, .Offer Peanut Butter and Jelly sandwich if resident consumes less than 25% of a meal .with meals for PO (by mouth) intake <25% . Review of Medication Administration Record (MAR) for November 2023, revealed, .0900: 11/24/23: O .1300: Refused on 11/24/23, 11/27/23 .1900: Refused on 11/24/23, 11/26/23, 11/27/23, and 11/28/23 . The other entries for the month at those times were noted with an x in the box . Review of Medication Administration Record (MAR) for December 2023, revealed, .0900, 1300, and 1900 times it was documented with an R on 12/7/23 1900, 12/8/23 1900, 12/9/23 1900, 12/10/23 1900 .other notation were completed with an x . Review of Order dated 9/5/23, revealed, .Arginaide Extra one time a day for supplement . Review of Skin/Wound Note dated 9/7/23 at 6:40 PM, revealed, .Noted changes to the right foot, heel, and new breakdown to her rt great toe . Review of Wound Clinic noted dated 9/13/23, revealed, .She was evaluated by (Medical Doctor) and (Wound Clinic) team. No surgery performed, but irrigating vac was placed in addition to use of a dinitron bed. Her sister (First Name) is with her today. States that (Facility) was not able to keep a good seal on the wound vac, so they have been packing the wound with dakins moistened gauze for the past few weeks instead. She is no longer on a clinitron bed but does have an air mattress. She does have access to prevalon boots but does not always have them on. Eating a general diet. She is diverted . Review of Wound Assessment Details dated 9/14/23, revealed, .1. Medial coccyx .3. Right Ankle .5. Left Heel .6. Right Heel .(Worsened) .8. Right Lateral Foot .(Worsened - Stage 3) .9. Right Hip .New - Acquired on 8/23/23 . (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of (Local Hospital) Wound Healing and Hyperbaric Center Progress Note dated 09/14/23, revealed, . 4/28: Right heel wound healed .5/12: New wound on left upper thigh from catheter .9/13: New right heel and right lateral foot pressure wound .Assessment and Plan: New unstageable right heel wound and stage 3 right lateral foot wound. Surgical debridement of lateral foot wound with lodoflex placed. Foam over all open areas. Change dressings every 2 days and prn drainage. Of utmost importance is reducing pressure, continue air flow mattress. Continue prevalon boots at all times. Continue good protein intake. Recheck in 2 weeks . Review of Health Status Note dated 9/15/23 at 12:38 PM, revealed, .IDT RAR: Several wounds. DTI unchanged .unstageable on r (right) 5th toe worsening, unstageable on R heel worsening, stage 4 on coccyx worsening . Review of Nutrition /Dietary Note dated 9/15/23 at 2:43 PM, revealed, .RD offered pig in a blanket to the resident .resident able to eat them without assistance. RD checked in a few minutes later, and most were gone. Resident agreed to a second serving . Review of No Type Specified dated 9/22/23 at 12:19 PM, revealed, .Unstageable pressure wound on r 5th toe unchanged, unstageable pressure wound on right heel worsening . Review of Heath Status Note dated 9/24/23 at 2:44 PM, revealed .Fluids within reach on bedside table, no observation of resident attempting to drink herself . Resident Health Status Note dated 10/7/23 at 11:15 AM, revealed, .Up in cardiac chair for approximately 2 hours .Tolerated well .Weight via hoyer .153.6 pounds . Review of Wound Assessment Details dated 10/11/23, revealed, .1. Medial coccyx .6. Right Heel .8. Right Lateral Foot .10. Right Lateral ankle .New - Acquired on 9/29/23 .Stage 3 . Review of Visit Report Discharge Instruction Details dated 10/25/23, revealed, .Culture of right heel wound, no current antibiotic use .Wound #11: Left Heel (New) .Wound #13: Left buttock .Additional Orders: Please send patient on stretcher . Review of Health Status Note dated 10/23/23 at 6:54 PM, revealed, .Sister informed this writer resident refused supper tray provided here but sister brought here (sic) a philly cheese steak and corn - which she consumer 100% . Review of Wound Assessment Details dated 10/25/23, revealed, .1. Medial coccyx .6. Right Heel .8. Right Lateral Foot .10. Right Lateral ankle .New - Acquired on 9/29/23 .Stage 3 .11. Left Heel .New -Acquired 10/23/22 .Unstageable .12. Right Knee: New - Acquired on 10/23/22 .13. Left Buttock .New - Acquired on 10/23/23 .Stage 2 . Review of Physician Progress Note dated 10/25/23, revealed, .Patient presents for recheck of multiple wounds .Right heel gangrenous changes with cellulitis present, foul odor .Unstageable .Left Heel unstageable pressure wound .Sacrum chronic wound stable but new right buttock stage 2 pressure wound . Assessment and Plan: 1. Right heel: Augmentin x 10 days, urgent referral to (medical doctor) this will require surgical debridement .2. Sacral Wound with new buttock wound: Transport on stretcher .Rotate Q (every) 2 hours .Hydrofera blue on wounds .3. Recheck in 1-2 weeks. If right heel worsens, needs eval in ER (emergency room) . (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of Health Status Note 10/27/2023 at 09:01 AM, revealed, .Call received from (Physician Assistant) PA w/ the wound clinic. She stated that the culture returned that she did while (Resident #78) was at the Wound Clinic earlier this week. The culture shows proteus mirabilis and MRSA. N.O. received to d/c the Augmentin and start Bactrim DS 1 po q12 hours x 14 days. Call placed to (Power of Attorney), sister to inform her of the above. Review of Order dated 10/27/23, revealed, .Isolation: Enhanced Barrier Precautions Diagnosis: Phone infected wound every shift for infected wound . Review of (Local Hospital) Foot & Ankle Surgery Clinic Note dated 10/31/23, revealed, .Concern for nonhealing, exposed bone and inability to heal .Objective: On her right lower extremity she has a roughly half dollar size full-thickness right heel ulcer to bone. She has ankle joint contracture she has a palpable dorsalis pedis and posterior tibial pulse. No appreciable motor function but she sensate and painful. She has right fifth and first MTP joint ulcers as well. On the left side she has a heel ulcer .Assessment #1: chronic osteomyelitis right heel with likely involvement of the Achilles tendon and plantarflexion/ankle joint contracture .#2: right fifth and first MTP joint ulcers .#3 left heel ulcer .#4 multiple sclerosis .We discussed possible treatment options which could include continued conservative treatment and antibiotics/palliative care .Another option may be a partial calcanectomy (Amputation of the back part of the foot for the treatment of large ulcerations and osteomyelitis) and likely Achilles tendon debridement with attempt at secondary wound closure. Another option could be a below-knee amputation. I think a below-knee amputation would be the most reliable operation. I think continued expectant/conservative treatment is essentially palliative in nature and would ultimately lead to sepsis and possible death. Calcanectomy explained to the patient and her sister may be a 50-50 success rate given the extent of her ulcer. They wish, short of a below-knee amputation, to attempt a partial calcanectomy and debridement .Problem list: Methicillin resistant Staphylococcus aureus .MRSA collected from wound at 10/25/23 . Review of Skin/Wound Note at 11/1/2023 1:39 PM, revealed, .Per the assessments it is noted that the coccyx, right heel wound, and right foot (new) wound have worsened from the previous week . Review of Physician Orders Details dated 11/08/23, revealed, .Other Orders: Please send patient on stretcher .PATIENT NEED TO BE WEARING OFFLOADING PROTECTIVE BOOTS AT ALL TIMES. THESE NEED TO BE FOUND OR REPLACED IMMEDIATELY. PRESSURE MUST BE OFFLOADED FROM HEELS . Review of Wound Assessment Details dated 11/8/23, revealed, .1. Medial coccyx .6. Right Heel .(Worsened) .8. Right Lateral Foot .10. Right Lateral ankle .11. Left Heel .12. Right Knee .13. Left Buttock . Review of Health Status Note dated 11/11/23 at 3:13 PM, revealed, .Alert to self. Uncooperative with repositioning. Grabbing onto staff and bed linen. Pm pain medication adm. prior to wound care. All treatments completed as ordered. Coccyx dressing saturated thru linen. All linen changed .HOB (head of bed) elevated. Heel protectors on. Call light within reach. Fluids on bedside table in front of resident. She continues to make no effort to drink fluids herself . (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of Nutrition Quaterly Nutrition Data Collection dated 11/13/23, revealed, .Not drinking unless someone goes in there. Sister states that the resident does not like a lot of the food served, sister brings meals/snacks in to the resident. Sister provides high protein coffee/yogurt. Per sister, she is eating dinner every night as she is there with her Dining Assistance: Full-assist resident does not typically make attempts to eat or drink herself . Review of (Local Hospital) Progress Note Details dated 11/29/23, revealed, .9/27: Right heel wound worse . Patient drinking protein shakes and eating a good dinner daily .10/25: Patient isn't feeling well, transported via wheelchair van rather than stretcher and has been sitting up in a chair for hours. Has a new right buttock/perianal wound, stage .Of greatest concern is right heel unstageable wound. Odor present with cellulitis and boggy (sponginess, high fluid content), gangrenous changes. Left heel also with unstageable pressure wound .Wound #1 (Pressure Ulcer) Is located on the medial coccyx. A non-selective mechanical debridement with a total area debrided of 90 sq cm. was performed By (Physician Assistant),PA. Non-viable tissue was removed. The procedure was tolerated well with a pain level of 9 throughout and a pain level of 7 following the procedure. Post Debridement Measurements: 7.5cm length x 12cm width x 0.1cm depth; with an area of 90 sq cm and a volume of 9 cubic cm .Additional Orders: please send patient on stretcher . PATIENT NEEDS TO BE WEARING OFFLOADING PROTECTIVE BOOTS AT ALL TIMES. PRESSURE MUST BE OFFLOADED FROM HEELS .Assessment and Plan: Of utmost importance is reducing pressure, continue air flow mattress. Continue prevalon boots at all times . Review of Wound Clinic Progress Note dated 11/29/23, revealed, .Wound #14 Right Heel Is an acute Partial Thickness Surgical Wound and has received a status of Not Healed, initial wound encounter measurements are 9.5cm length x 0.2cm width x 0.1 cm depth, with an area of 1.9 sq cm and a volume of 0.19 cubic cm. No tunneling has been noted. No sinus tract has been noted. No undermining has been noted. There 5 a Scant amount of serous drainage noted which has no odor, The patient reports a wound pain of level 10/10. The wound margin is regular .Wound bed has No granulation, No slough. No eschar. No epithelialization .The periwound skin texture is normal, The periwound skin moisture Is normal. The periwound skin color is normal . Review of Skin/Wound Note daed 5:22 PM, revealed, .Blood blister noted to left hip 0.9x0.3 (Medical Doctor) notified. Order received for skin prep Q shift . During an observation on 12/04/23 at 10:52 AM, Resident #78 was lying in her bed, supine position with a slight tilt to the left side. There was a noted odor in the room upon entry. There was a rolling bedside table near the left side of the bed which was not easily reached from her positioning in the bed. There was a cup on the table labeled Juven (therapeutic nutrition powder for wound healing) with a post it note stated, Please do not throw out. There were observed to be multiple signs in the room prompting staff to place the rolling beside table near Resident #78 so she could reach the drinks. On the rolling bedside table, next to the mirror where staff would wash their hands, etc. Resident #78 was observed to have a prevalon boot on her right foot. Resident #78's lips were dry, and skin was flaking off her lips with no water on the rolling bedside table. There was a blue foot cradle propped against the wall by the window in her room. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an observation on 12/5/23 at 8:26 AM, Resident #78 was observed lying in her bed on her back with her legs bent to the left side. Resident #78 does have a contracted right leg. Resident #78's foot cradle was propped up against the wall by her dresser near the window in her room. There were no noted pillows under her legs. A styrofoam cup with water and a straw was on the rolling bedside table this morning. Her catheter still looks the same as yesterday with more cloudiness to it, tons of sediment in the tubing and calcification all over the top of the opening in the bag. Bag is touching the floor. She does have water today on the rolling table next to her bed. The hair still looks kind of greasy still the same ponytail yesterday. During an observation on 12/5/23 at 2:00 PM, Resident #78 was observed lying in the same position she was lying in this morning. Her table is out of reach, which has her water and her Juven on it. She is still dressed in a hospital gown; right hand is contracted. Resident #78's foot cradle was still propped up against the wall in the same position as yesterday. During an observation on 12/6/023 at 8:51 AM, Resident #78 was in bed without a wedge to either side, no foot cradle under her heels, or a pillow between her knees. It was noted, the resident's knees were touching each other. During an observation on 12/6/23 at 10:20 AM, Licensed Practical Nurse/ Unit Care Coordinator (LPN/UCC) H removed the soiled dressing from Resident #78's right foot, cleansed wound with dakins solution (antiseptic wound cleanser), dried wound with gauze, and applied aquacel (antimicrobial wound dressing), wrapped right foot with kerlix (gauze wrap), and secured dressing with tap [TRUNCATED]

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46999 Based on observation, interview, and record review, the facility failed to implement interventions to prevent falls after a fall in 1 (Resident #442) of 7 residents reviewed for accidents, resulting in a potential for additional skin tears and falls. Findings include: 47659 Resident #442 Review of an Admission Record revealed Resident #442, was originally admitted to the facility on [DATE] with pertinent diagnoses which included type 2 diabetes mellitus and chronic kidney disease. In an observation on 12/04/23 at 10:39 AM, Resident #442 was sitting in his bed repeatedly calling out Mom. Resident #442's call light was twisted on the right side of his bed and out of his reach. Resident #442 had two skin tears on his left arm, a bandage on his right arm, and bruising noted around his right eye. Resident #442 continued to call out Mom but staff did not come in to assist him. Review of Resident #442's Incident Reports revealed, Incident Description: At 14:45 (2:45 PM) this nurse noted resident on his hands and knees in room on the floor, just inside the door. Resident Description: Resident unable to give description. Immediate action taken: resident was already attempting to stand up so staff assisted him to standing position. Resident ambulated to his bed. body check noted small skin tear on left wrist. noted 1 cm skin tear on right forearm and laceration above the right eye. neuro checks started. and vs (vital signs) wnl (within normal limits) . notes: resident is very confused and states I don't want to stay here . Review of Resident #442's Care Plan did not reveal any updated care plan interventions after Resident #442's fall. During an interview on 12/06/23 at 10:57 AM, Licensed Practical Nurse (LPN) M reported that she was not aware of any care plan intervention that the facility had put in place after Resident #442's fall to attempt to prevent further falls from happening. LPN M reported that she did not know much about Resident #442, but that she had to spend a lot of time with him due to his anxiety and that he (Resident #442) was a major fall risk. LPN M reported that she tried to keep Resident #442 near her as much as she could because she was concerned about him falling. During an interview on 12/07/23 at 11:38 AM, Director of Nursing (DON) B reported that the facility did not update Resident #442's care plan and initiate new interventions to try to prevent Resident #442 from further falls.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 41424 Based on observation, interview, and record review, the facility failed to ensure appropriate indwelling catheter care, monitoring the patency of the tubing, and collection bag for 1 (Resident #78) of 3 residents reviewed for indwelling catheter care, resulting in the potential of a urinary tract infection. Findings include: Review of an Admission Record revealed Resident #78 was a female with pertinent diagnoses which included pressure ulcer of sacral region, stage 4, pressure ulcer of right ankle, stage 3, pressure ulcer of left heal, unstageable, stiffness of right hand, contracture right foot, contracture left foot, multiple sclerosis, urosepsis, gangrene, chronic pain, and cognitive communication deficit. Review of Care Plan for Resident #78, revised on 03/23/2023, revealed the focus, .The resident has indwelling foley catheter r/t (related to) stage 4 decubitus ulcer to the coccyx . with the intervention .Catheter care every shift. Date Initiated: 03/10/2023 .Check tubing for kinks at each encounter .Observe for and document for pain/discomfort due to catheter .Observe for and report to MD for s/sx (signs & symptoms) UTI: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, Urinary frequency, foul smelling urine, fever, chills, altered mental status, change behavior, change in eating patterns . Review of Cognitive Patterns/BIMS dated 3/14/23 at 8:31 AM, revealed, .Resident BIMS 5/15 presents with cognitive deficits r/t (related to) dx (diagnosis) of MS (multiple sclerosis), resident shows flat affect and is oriented x1 . Review of Skilled Note v.2 dated 3/16/23 at 10:10 PM, revealed, .Pts urine is currently a dark amber color this writer will notified the MD. Foley will be changed during final med pass of this writers shift . Review of Health Status Note dated 3/17/23 at 02:31 AM, revealed, .Pt found with 102.2 temp. Her foley was changed and no urine came out .Order obtained to transfer her to (Local Hospital) . Review of Skilled Note v.2 dated 3/17/23 at 2:58 PM, revealed, .She returned after receiving 2 liters of fluid according to family @ BS, ER has ordered Cefidinir 300 mg Q 12 x 10 days for UTI . Review of Health Status Note dated 5/6/23 at 11:30 AM, revealed, .Called to resident's room where this writer observed sheets soaked of what appears to be urine. [NAME] vaginal drainage noted during peri-care. Foley cath changed. Vaginal culture obtained .(Medical Doctor) notified .Order received to start Diflucan 150 mg po q day x 3 days . Review of Health Status Note dated 5/12/23 at 5:16 PM, revealed, .Vaginal culture and sensitivity back, positive for proteus mirabilis .New order received for Cipro 500 mg po BID x 7 days for vaginitis . (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Infection Note dated 5/14/23 at 9:21 AM, revealed, .Continues of ABT for vaginitis, no s/s adverse reactions noted. Continues to have green vaginal discharge . Review of No Type Specified note dated 7/11/23 at 2:01 AM, revealed, .Called into resident's room to observe that resident foley catheter was pulled out and resident incontinent of urine. New foley placed, 18 french with 5 cc balloon . Review of Orders dated 8/16/23, revealed, .Change catheter bag as needed for infection, obstruction or when the closed system is compromised . Review of Orders dated 10/9/23, revealed, .Indwelling catheter to straight drainage. Size: 22 .Bulb: 30_ cc. Change for Infection, obstruction or when the closed system Is compromised as needed . Review of Orders dated 11/28/23, revealed, .Catheter care with soap and water every shift, Keep catheter bag placed below the level of the bladder . Review of Health Status Note dated 8/12/2023 at 5:37 PM, revealed, .Text: T- 99.3, P- 107, BP- 101/62, R-18 .Resident alert and responsive. Family states concern about resident not recognizing her. Resident is nonverbal. (Medical Doctor) notified by message by phone .Cloudy yellow urine in Catheter tubing noted . Review of Health Status Note dated 8/13/2023 at 02:58 PM, revealed, .Received resident in bed not responding to simple commands/questions. Sister at the bedside and voiced concerns that something was not right with her sister. Upon assessment per this writer, resident noted to have a blank stare, was warm to touch and not responding appropriately. Sister demanded she be sent to the hospital. (Medical Doctor) notified. New order received to transfer to ER for evaluation. Notified (UCC H), nurse on call. Spoke to (Registered Nurse) at (Local Hospital) to give report. Phone call to (Transport company) to request transfer . rapid COVID test performed with negative results. EMS arrived with two attendants. With staff assist, res was transferred to their stretcher and exited the building . Review of Urinalysis dated 8/13/23 at 2:33 AM, revealed, .Bacteria, UA: Present .Color, UA: Dark Yellow; Clarity: Cloudy; Protein, UA: 1+; Leuk Esterase: 2+; WBC, UA: .180/HPF - Normal range between (0 and 4); Epl Cell, UA: 3/HPF--Normal range between (0 to 1) . Review of Clinical Discharge Summary dated 8/15/23, revealed, .Diagnoses This Visit: Altered Mental Status .Fever .Sepsis due to Urinary tract infection . Review of History and Physical dated 8/16/23, revealed, .The patient was admitted to the hospital with a change in mental status. She was found to have sepsis, urinary tract infection . Review of Skilled Note v.2 dated 8/18/2023 at 01:37 AM, revealed, .Res alert with confusion. Most needs anticipated per staff. Total assistance with cares and ADL's. Foley patent and draining clear, yellow urine without complication. Hoyer lift with two assists for transfers. Eats meals with one assist. Res is able to eat finger foods at times. Antibiotics continue for UTI without adverse effects noted. Afebrile. Continues on routine meds for pain control. Fluids encouraged. Respirations even and non-labored. No s/s of respiratory distress. Res is currently in bed resting at this time. No c/o voiced . (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Health Status Note dated 8/18/2023 at 6:51 PM, revealed, .Foley cath patent, draining amber colored urine. ATB therapy completed as ordered. No adverse reactions noted . Review of Skilled Note v.2 dated 8/20/2023 at 00:31AM, revealed, .Res Alert. Confusion noted. Most needs anticipated by staff .Foley in place and draining clear yellow urine . Review of Medication Administration Record (MAR) for October 23, revealed, .Indwelling catheter to straight drainage Size 16 .bulb 10cc .change for infection, obstruction, or when the closed system is compromised . changed on 10/5/23 . Review of Health Status Note dated 10/7/2023 at 11:15 AM, revealed, .Note Text: Foley oath changed with assist x4 d/t sheet and bed pads wet. Draining amber colored urine. Dressings changed as ordered. Resident appetite and fluid remains poor. Fluids at bedside. No observation of resident making attempts to drink fluids herself. Up in cardiac chair for approximately 2 hours. Tolerated well. Weight via hoyer 153.6 pounds. Abscess to right chest area resolved. Area open to air. No redness or drainage. Treatment order discontinued . Review of Medication Administration Record (MAR) for October 23, revealed, .Indwelling catheter to straight drainage Size 16 .bulb 10cc .change for infection, obstruction, or when the closed system is compromised . changed on 10/7/23 . Review of Health Status Note dated 10/15/2023 at 5:36 PM, revealed, .Residents sister noticed pink tinged sediment in foley tubing and requesting U/A. (Medical Doctor). Urine collected and taken to (Local Hospital) lab. Resident is a febrile at this time. Will continue to monitor. Review of Orders dated 10/15/23, revealed, .U/A C and S, pink tinged sediment in foley catheter tubing one time only for 1 day . Review of Medication Administration Record (MAR) for October 23, revealed, .Indwelling catheter to straight drainage Size 22 .bulb 30cc .change for infection, obstruction, or when the closed system is compromised . changed on 10/20/23 . Review of Culture Urine revealed, .Collected Date/Time: 10/15/23 at 5:00 PM, Received Date/Time: 10/16/23 at 2:55 PM, .Final Report: Multiple bacteria species present; possible contamination; suggest recollection, with timely delivery to the laboratory .Source: Clean Catch .Color: Yellow .Clarity: Cloudy .Protein, 2+ . Hemoglobin 3+ .Nitrite: Positive .Leuk Esterase: 1+ .RBC: 10 .(Reference Range 0-1) .WBC: 30 (Reference Range 0-9) .Bacteria: Present .Ca Oxal Cry: Present .Epi Cell .<1 . Review of Non-Routine Visit dated 10/23/23, revealed, .I am asked by the nursing staff to evaluate the patient's UA .the patient had a urine culture done. This UA was done after changing the catheter. It has contaminated urine .Plan: Palliative care consult .Will increase Remeron to 15 mg daily . Note: No documentation of follow up of hospice/palliative care services noted in the record. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Health Status Note dated 10/16/2023 at 5:57 PM, revealed, .Note Text: In bed per usual routine. HOB elevated. No s/s (signs and symptoms) of distress or discomfort noted. Foley cath patent, draining amber colored urine. Heels bridged. Repositioned at this time. Appetite and fluid intake poor. Makes no attempts to drink fluids positioned in front of her. Treatments completed as ordered. (Medical Doctor) here this afternoon notified of abnormal UA results. Awaiting C&S .Note: No order written to provide medication for Resident #78 due to the abnormal results. No order for antibiotic ordered for resident. Review of Culture Urine dated 10/20/23, revealed, .Collected: 10/20/23 at 05:40 AM .Received: 10/20/23 at 2:49 PM .Final Report: 50,000 - 100,000 cfu/ml Lactose fermentor .10,000-50,000 cfu/ml Lactose fermentor #2 .50,00 to 100, 00 cfu/ml Entercoccus species .10,000 to 50,000 cfu/ml Normal urogenital flora .Color: Yellow .Clarity: Cloudy .Protein: 2+ .Hemoglobin: 2+ .Nitrite: Positive .Leuk Esterase: 1+ .RBC: 16 . WBC: 30 .Bacteria: Present .Cry Unclass: Mod Amorphous . Review of Orders dated 10/23/23, revealed, .Palliative care consult discontinued on 10/23/23 . Review of Health Status Note dated 10/23/2023 at 3:04 PM, revealed, .No change in appetite or fluid intake. No s/s of distress or discomfort .(Medical Doctor) notified of residents continued poor appetite, fluid intake, non-healing wounds, and UA results. (Medical Doctor) recommended Hospice Services if ok with family. Note: No progress notes or follow through on discussion with family for the recommendation of hospice services. Order for palliative care consult was cancelled on 10/23/23. Review of Medication Administration Record (MAR) for November 23, revealed, Indwelling catheter to straight drainage Size 22 .bulb 30cc .change for infection, obstruction, or when the closed system is compromised .Order dated 10/9/23 . Note: No documentation of catheter changes for November 23. Review of Health Status Note dated 11/4/23 at 08:00 AM, revealed, .Foley catheter was leaking last evening, and small amount of blood noted in drainage bag tubing. Sister here and requesting U/A. Catheter was changed after multiple attempts by multiple nurses. No blood noted in tubing since catheter was changed, urine appears slightly cloudy. (Medical Doctor) notified of all of the above, declined request for U/A D/T resident is asymptomatic. Note: No notation of being changed on Medication Administration Record (MAR). Review of Non-Routine Visit note dated 11/6/23, revealed, .Reason for Evaluation: bladder spasms . Review of Health Status Note dated 11/11/23 at 3:13 PM, revealed, .Alert to self. Uncooperative with repositioning. Grabbing onto staff and bed linen. Pm pain medication adm. prior to wound care. All treatments completed as ordered. Coccyx dressing saturated thru linen. All linen changed. Appetite and fluid intake remains poor. HOB elevated. Heel protectors on. Call light within reach. Fluids on bedside table in front of resident. She continues to make no effort to drink fluids herself . Review of Health Status Note dated 11/27/23 at 04:23 AM, revealed, .Res foley change was effective, 550 out on this shift . Note: Not documented on Medication Administration Record (MAR). Review of Health Status Note dated 12/6/23 at 4:45 PM, revealed, .Foley cath patent, draining concentrated dark amber colored urine. No blood noted. Cath irrigated without difficulty. Foley cath bag changed . (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Medication Administration Record (MAR) for December 23, revealed, .Change catheter bag as needed for infection, obstruction or when the closed system is compromised . Note: No documentation of the catheter bag being changed on 12/6/23. Review of Health Status Note dated 12/6/23 at 11:13 PM, revealed, .Statlock replaced to left leg . Review of Orders dated 12/6/23, revealed, .Irrigate catheter with 30 ml sterile water as needed for obstruction related to pressure ulcer of sacral region, stage 4; other muscle spasm . Note: no previous order for this action. During an observation on 12/04/23 at 10:52 AM, Resident #78's catheter bag was hanging from the bed frame and the tubing is looped down, There was sediment where it dips down and at the opening where it empties into the bag. The urine was an amber color with white cloudiness in it. The connection to the catheter bag from the tubing had sediment and encrustations all around it, there was sediment and encrustation running down the inside of the bag. The sediment and encrustations had varying colors which included white, yellow, and an orange color. During an observation on 12/5/23 at 8:26 AM, Resident #78 was observed lying in her bed. Her urine in the catheter tubing appeared with more whitish cloudiness, with urine that was amber colored. The catheter bag bottom was touching the floor. The tubing contained lots of sediment in the dip of the loop, encrustation lining the tubing, encrustation in the opening of the catheter bag as well as the catheter bag had a line of encrustation running down the inside of the bag. During an observation on 12/5/23 at 2:00 PM, Resident #78 was lying in her bed, same position as this morning. The bottom of the catheter bag was observed to be touching the floor. The catheter tubing has lots of sediment on the bottom of it. The urine was very cloudy, amber colored and streaks of red/orange in it with encrustations coating the top of the catheter bag opening, streaking down into the bag. During an observation on 12/05/23 05:00 PM, Resident #78 was observed lying in her bed, catheter tubing urine was observed to be white milky from the bottom of the dip up on left side leading to the bag and the right side coming down from her body for approximately 9 inches of the tubing. In the tubing there was encrustations lining the length of the tubing, there was sediment in the bottom of the dip of the tubing, encrustations/sediment which drained into the top of the catheter bag lining the top of the bag, and down into the bag lining the side where the urine drained into the bag. The urine was an amber color and had a cloudy appearance with slight tinges on pink streaked in the catheter bag opening and into the catheter bag. During an observation and interview on 12/06/23 at 8:51 AM, R78 was in bed awake. The top portion of the urinary tubing had condensation coating the tubing. Just before the bend of the tubing before it rose up to enter the bag was a collection of a white substance resembling sediment and pink-yellow urine resting in the bend of the tubing. Inside the bag were streaks of a red substance clinging to the sides with approximately 100 ml of dark reddish-pink, yellow urine. R78 reported she did not know why or how long she had the urinary catheter and was not in any pain or discomfort. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 12/06/23 at 9:04 AM, Licensed Practical Nurse (LPN) J entered R78's room, washed her hands with soap and water then donned clean gloves. LPN observed foley catheter tubing at insertion site that ran between the resident's legs, reporting, There is a stat lock, but it has come off and is not holding the tubing. A new one will have to be put on. The tubing has sediment in it and so does the bag. There is about 100 ml of amber colored urine. The bag looks like it could be changed. I believe the bag was changed a week or two to get a sample. There is an order for PRN (as needed) for the bag to be changed. (R78) came to the facility with a stage IV pressure sore. It is still there but it is a lot smaller. During an observation on 12/06/23 at 02:30 PM, Resident #78 her catheter did have pinkish red in the catheter tubing and at the entry of the catheter bag on top of the bag there were remnants of blood, granulation/calcification whitish substance. There was white granulated sediment on the bottom of the catheter tubing where it looped down. There were reddish/pinkish streaks on the inside of the catheter urine collection bag as well as granulation coating the inside of the bag from the entry point at the top of the bag. In an interview on 12/06/23 at 02:46 PM, Licensed Practical Nurse (LPN) J reported it would take 5 people to catheter her, change the bag to get the fresh urine for a urine sample. LPN reported she thought the catheter had been changed recently and she reviewed the medical record which revealed it was last changed on 10/20/23. In an interview on 12/06/23 at 10:50 AM, LPN J reported the resident did have a stat lock that needed to be changed. Catheter tubing was noted to be in stat lock that was not secured to the resident's leg. In an interview on 12/07/23 08:55 AM, Family Member (FM) JJJ reported it was very difficult for Resident #78 to reach her rolling bedside table and that was why she had posted signs to have it moved within reach so she could get a drink with a straw if she needed to. FM JJJ reported they come in and they push the table away and don't place it back to where she can even reach it. FM JJJ reported every night first thing, she gave Resident #78 a drink of Juven. FM JJJ reported she had said something to all of them about lying Resident #78 on that catheter tube. FM JJJ reported the device which attached the tubing to her leg was sometime in place and sometimes it had not been. FM JJJ reported there were days she was so frustrated and dropping the f bomb .went off on the staff due to how she saw her sister like with the table out of reach, the kitchen still sent foods she would not eat time and time again. FM JJJ reported Resident #78 had one leg which was not going straight anymore. FM JJJ reported the catheter tubing appeared to have white stuff, blood in the tubing and Resident #78 has had 3-4 UTIs and in the hospital from them being so bad. FM JJJ reported middle of last week or the week before, the facility had changed her catheter because it was leaking. FM JJJ reported she believed her sister had a vaginal infection as there was a smell coming from her vagina. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 12/07/23 at 11:12 AM, Resident #78 was lying in her bed. The catheter tubing where it had dipped/looped down, approximately 9 inches had contained fluid which appeared to be a thick white milky substance, could not really see urine in the mixture, there were red streaks in the whitish/cloudy fluid and the tubing was covered with encrustations. There was a noted odor in the room, the catheter bag appeared to have been changed as it did not have the amount of sediment and encrustations on the area the tubing drained into the bag and on the inside of the bag. The urine in the bag was a dark amber color. The juven cup on her table was completely empty and the last noted date on the post it was 12/4. The Styrofoam cup on her rolling bedside table, which was not over her in the bed, contained water was completely full. In an interview on 12/07/23 at 11:23 AM, Certified Nursing Assistant (CNA) Y reported the catheter was drained every shift by the CNAs. CNA Y reported the catheter bag would be drained at the bottom of the bag, it gets wiped down with alcohol, her urine had a smell from when it was done this morning. CNA Y reported the stat lock was off of her leg and needed to get replaced. CNA Y reported when they see the cloudy urine, deep color, sediment, and encrustations of the tubing and bag they would report it to the nurse for them to come and perform an assessment. In an interview on 12/07/23 at 11:31 AM, Unit Care Coordinator (UCC) H reported the catheter bag was changed on 12/6/23, reported Resident #78 does not drink enough but she could possibly have had a UTI based on the appearance of the urine, but she did not have a fever at this time. She would need to have two or more symptoms to meet the criteria for a UTI, to call for a urine sample. In an interview on 12/7/23 at 11:59 AM, Unit Care Coordinator (UCC) H reported the facility would change the catheter to obtain a urine sample. In an interview on 12/07/23 at 11:59 AM, UCC H reported the catheter would be changed monthly per the order or per the urologist. we do preference change of the catheter and would obtain a urine sample that way. UCC H reported two back to backs for urine samples would indicate it was probably changed out. UCC H reported while she reviewed the progress notes and reported on 10/15 pink tinge, sedimentation, urine collected and taken to (lab), and reported the note didn't include on how it was performed. UCC H reported on 10/7/23 did a full change as it was leaking, and her sheets and bed were wet from the leaking. UCC H reported the completion of the order for catheter care would be documented on the medication administration record (MAR). UCC H reported the order was change bag as needed .Would change it when the closed system was compromised. In an interview on 12/07/23 at 12:30 PM, Unit Care Coordinator (UCC) H reported a catheter bag should not touch the floor as it is an infection control concern. In an interview on 12/11/23 at 12:53 PM, FM JJ reported she was not aware of the referral for palliative care services or for hospice services for Resident #78. FM JJ reported the facility had not been consistent with contacting her if there were changes in the condition of her sister. FM JJ was not aware of the development of a new wound on Resident #78's left hip. FM JJ reported there was a medication change that occurred and was not aware of it until she was having a conversation with staff about her sister and the information was presented to her. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of document, Site: Urinary Tract: Symptomatic Urinary Tract Infection provided on 12/11/23, revealed, .B. Resident with Catheter: Two or more of: *fever or chills .*flank or suprapubic pain or tenderness .*change in character of urine .*change in mental or functional status .Conditions: Symptoms must be acute and if an appropriately collected and processed urine culture was taken and the resident was not receiving antibiotics at the time, then that culture must be positive .* For catheterized resident, no other source of fever is present .Comment: Asymptomatic bacteriuria (presence of bacteria in a urine sample due to bacterial colonization of the urinary tract and/or indwelling catheter) may be recorded separately . Review of policy Indwelling Urinary Catheter (Foley Management Surveillance Definitions McGreer's Criteria reviewed on 8/24/23, revealed, .4. Insertion, ongoing care, and catheter removal protocols that adhere to professional standards of practice and infection prevention and control procedures; .6. Ongoing monitoring for changes in condition related to potential CAUTI's, recognizing, reporting, and addressing such changes . Additional care practices related to catheterization: 2. Recognizing and assessing whether residents are at risk for other possible complications resulting from the continuing use of the catheter, such as obstruction resulting from catheter encrustation, urethral erosion, bladder spasms, hematuria, and leakage around the catheter .5. Keeping the catheter anchored to prevent excessive tension on the catheter, which can lead to uretheral tears or dislodging the catheter . Review of policy, :Surveillance Definitions for Urinary Tract Infections (UTIs) Revision history: 08/03/2018, revealed, .B. For residents with an indwelling catheter (both criteria 1 and 2 must be present) 1. At least 1 of the following sign or symptom sub-criteria .a. Fever, rigors, or new onset hypotension, with no alternate site of infection .b. Either acute change in mental status or acute functional decline, with no alternate diagnosis and leukocytosis .c. New onset suprapubic pain or costo-vertebral angle pain or tenderness .d. Purulent discharge form around the catheter or acute pain, swelling, or tenderness of the testes, epididymis, or prostate .2. Urinary catheter specimens for culture should be collected following replacement of the catheter (if current catheter has been in place for >14 d) . Note: the urinary catheter specimen for culture collection had not been completed with each catheter change of a catheter placed more than 14 days.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41424 Based on observation, interview, and record review, the facility failed to ensure consistent availability of hydration and/or nutrition based on resident needs in 3 of 3 residents (Resident #27, #51, and #78) reviewed for nutrition/hydration, resulting in the potential for dehydration. Findings include: Resident #27 Review of an Admission Record revealed Resident #27 was a female with pertinent diagnoses which included dementia, macular degeneration (loss in the center of the field of vision), heart failure, stroke, anxiety, osteoporosis (bones become weak and brittle), and cyst in right knee. Review of current Care Plan for Resident #27, revised on 6/27/23, revealed the focus, .Resident #27 is at risk for falls r/t (related to) deconditioning, h/o CVA, muscle weakness, limited vision, demetia with impaired cognition poor safety awareness & delusions/hallucinations at times due to dementia with the intervention . Blue mat to the floor surface next to the bed when in bed to decrease the risk of injury. Blu mat to wall to prevent injury d/t (due to) increased restlessness . During an observation on 12/04/23 at 11:30 AM, Resident #27 was lying in her bed on her left side facing the wall, behind her was a long body pillow or multiple pillows tucked in between the fitted sheet and the mattress. No blue mat was secured to the wall. Her water was placed on the tv stand in front of the window well out of her reach. During an observation on 12/5/23 at 8:23 AM, Observed Resident #27 lying in her bed, facing the wall with a body pillow tucked in between the sheet and the mattress, reaching up to the sky while mumbling. This writer noted her water was placed on the tv stand in front of the window to the room way out of reach for Resident #27. During an observation on 12/07/23 at 11:06 AM, Resident #27 was observed lying in her bed, supine position, with the rolling bedside table over her lap in the bed, with the head of the bed positioned at approximately 45 degrees. Resident #27's water was placed on the tv stand by the window well out of Resident #27's reach. R#27's water was full. During an observation on 12/07/23 at 03:18 PM, Resident #27 was observed lying in her bed, fall mat next to the bed, water on the tv stand out of reach and it had not been drunk yet today, still almost full, bed was in low position, body pillow was on the right side of her bed. During an observation on 12/11/23 at 11:23 AM, observed Resident #27 self propelling down the hallway by the activity room. Resident #27 kept repeating she was looking for water, [NAME] around the block, still no water. Resident #27 proceeded to turn around and head back towards the nurse's station. CNA Y came around the corner and observed Resident #27 and heard what she was repeating. She went to get her some water. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 12/11/23 at 11:29 AM, CNA Y reported Resident #27 had drank half of the cup of the big sytrofoam cups used for waters in the rooms. CNA Y reported she was thirsty. Resident #51: Review of an Admission Record revealed Resident #51 was a female with pertinent diagnoses which included dementia, Alzheimer's disease, contracture, left hand, muscle weakness, and adult failure to thrive. Review of current Care Plan for Resident #51, revised on 3/28/21, (Resident #51) has potential for pain r/t (related to) impaired cognition, left hand contracture, CHF, edema, depression, impaired mobility and general age related changes . with the intervention .Ensure that her drinks are in front of her, within reach . Review of Nutrition: Assessment/Nutritional Data Collection dated 3/14/23, revealed, .9. Feeding/Dining Ability: e. Limited Assist .g. Total Assist .Conditions that would affect Hydration: f. Requires reminder to drink . h. Dependent on staff for fluids . Neither f or h were selected for Resident #51 even though she did require staff assistance for intake. During an observation on 12/04/23 at 11:30 AM, Resident #51 was observed seated in her wheelchair at the head of her bed, located by the privacy curtain between her and her roommate. Resident #51 had dirty pants on the front of them she had dried food and food smears on them. Her water was placed on the night stand near the doorway to her room out of reach from Resident #51. During an observation on 12/04/23 at 11:34 AM, Resident #51 was grimacing and when this writer queried if she was in pain and wanted to staff to lay her down, she nodded her head which indicated a yes answer. During an observation on 12/04/23 at 11:36 AM, Unit Care Coordinator (UCC) H responded to the call light activated for Resident #51. This writer shared Resident #51 had indicated she wanted to lay down and appeared painful based on her grimace. UCC H reported to Resident #51 the staff would lay her down after lunch as she grabbed her glasses from R51's lap and took them to the restroom to rinse them off. Not mentioning the food droplets and smeared streaks on Resident #51's pants. UCC H stated, Alright sweety, sound like a plan, proceeded to place the resident's feet on the foot pedals of her wheelchair and proceeded out of the room down the hallway to the dining room. UCC H did not offer her any water prior to ambulating her to the dining room. In an interview on 12/04/23 at 11:36 AM, UCC H reported Resident #51 UCC H reported Resident #51 required was very limited on her abilities, depends on her alertness and where she is at if she was able to perform some activities of daily living for herself with the food to be scooped into the spoon and cuing to take a bite of her food. Otherwise, she does require staff to assist her for meals. During an observation on 12/5/23 at 8:31 AM, Resident #51 was observed seated in the dining room with no water or other drinks. There was noted to be water on her night stand right by the entry way to her room. Breakfast was finished. During an observation on 12/5/23 at 1:51 PM, Resident #51 was being propelled down the hallway to the dining room. Her water was observed on the night stand near the entry wany to her room. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 12/07/23 at 11:06 AM, Resident #51 was observed in her room seated in her wheelchair, she had a blanket over her, she was dressed, foot pedals up on her chair. She was next to her foot of her bed by the privacy curtain between her and her roommate. Resident #51's water was observed on the night stand over by the doorway to the room well out of the reach of Resident #51. Resident #51's water was noted to be full. During an observation on 12/07/23 at 03:18 PM, Resident #51 was observed in her bed lying on her left side, and she had a rolled up washcloth in her left hand. She had an edge to the side of her bed, water was on the tray table next to her bed, it barely had any water missing out of it. Resident #78: Review of an Admission Record revealed Resident #78 was a female with pertinent diagnoses which included pressure ulcer of sacral region, stage 4, pressure ulcer of right ankle, stage 3, pressure ulcer of left heal, unstageable, stiffness of right hand, contracture right foot, contracture left foot, multiple sclerosis, urosepsis, gangrene, chronic pain, and cognitive communication deficit. Review of Care Plan for Resident #78, revised on 9/5/2023, revealed the focus, .Potential risk for dehydration and alteration in nutritional status AEB: Stage IV pressure area to her coccyx, several wounds, dx of multiple sclerosis/contracted right hand, cognitive decline, poor intakes, significant weight loss, severe malnutrition . with the intervention .120 mL caloric fluid offer with med pass . Review of Care Plan for Resident #78, revised on 3/9/2023, revealed the focus, .The resident has an ADL self-care performance deficit r/t MS Bedfast . with the intervention .EATING: ext (extensive) assist with eating . Review of Nutrition/Dietary Note dated 4/24/23 at 1:09 PM, revealed, .RD skin review: Dependent on staff for feeding .Resident has MS .She is bedbound .Writer spoke with resident during her noon meal, her tray was sitting at bedside. When asked if she was going to eat her lunch she stated no. She had Ensure, Milk, and Juice at bedside she had not drank her Ensure. It does appear that resident would need 1:1 feeding assistance even for her fluids. Both hands are curled into her palms. She answered only yes no questions and did not elaborate on any one subject Review of Health Status Note dated 08/27/2023 at 2:57 PM, revealed, .Takes only sips of water. Cups within reach on table, resident makes no attempts to drink herself. Dependent upon staff forall ADL care, transfers, and mobility . Review of Health Status Note dated 9/1/23 at 2:58 PM, revealed, .Slow to respond, stares. Facial grimacing present. Each movement states Ouch .water within reach but no observation of her attempting to drink herself . Review of Health Status Note dated 9/4/23 at 10:12 AM, .States Ouch with repositioning or during care . Water within reach at bedside, makes no attempt to drink herself . (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Nutrition/Dietary Note dated 9/5/23 at 7:46 AM, revealed, .Sister states that Juven isn't touched from the time she leaves it to when she arrives the next day .Resident loves the Juven .does not like to drink water .Will enter order for 120 m: fluid offer with med passes (milk, supplement drink, Juven, etc.) . Review of Heath Status Note dated 9/24/23 at 2:44 PM, revealed .Fluids within reach on bedside table, no observation of resident attempting to drink herself . Review of Infection Note dated 10/1/23 at 1:11 AM, revealed, .Poor fluid intake .Fluids and call light within reach . Review of Health Status Note dated 10/7/23 at 11:15 AM, revealed, .Fluids at bedside. No observation of resident making attempts to drink fluids herself . During an observation on 12/04/23 at 10:52 AM, Resident #78 was lying in her bed with a gown still on. There was a cup that stated it was Juven (nutrition powder for wound healing), to please do not throw out. There was multiple signs in the room to place the tray table back in her reach so she can reach her drinks. Resident #78's lips were dry and skin was flaking off her lips. Resident had dry patches on the right side of her face by her chin (dime sized) and on her cheek by her ear. During an observation on 12/5/23 at 8:26 AM, Resident #78 was observed lying in her bed on her back with her legs bent to the left side. Resident #78 does have a contracted right leg. She does have water today on the rolling table next to her bed but it was not over the bed and unreachable by the resident. There was a post it note on the side of the cup with Juven with a notation of 12/4/23 on it. During an observation on 12/5/23 at 2:00 PM, Resident #78 was observed in her room lying in the same position she was lying in this morning. Her table is out of reach, which has her water and the cup with Juven in it. During an observation on 12/07/23 at 11:12 AM, Resident #78 was lying in her bed. There was a blue post it note on the side of the cup with Juven with the last date of 12/4. The cup was completely empty. The water on the rolling bedside table was full. The rolling bedside table was out of reach as Resient #78 was not able to reach the water or the juven cup with the use of a straw. During an observation on 12/11/23 at 11:12 AM, Resident #78 was lying in a supine position in her bed, the sheet was touching her feet even though it was tented over the edge of the foot board. Both her water and Juven cups were full. Resident #78 reported she was painful, and her pain level was at a 10 and it was her whole body. This writer informed the LPN J of Resident #78's current pain level. During an observation on 12/11/23 at 11:17 AM, LPN J provided Resident #78 pain medications in a small container mixed in chocolate pudding. LPN J asked Resident #78 if she would like a drink of water, resident declined. This writer was informed LPN J, Resident #78 did not care for water. LPN J offered Resident #78 the Juven she had on the table and the resident accepted the Juven. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Nutrition Quaterly Nutrition Data Collection dated 11/13/23, revealed, .Not drinking unless someone goes in there. Sister states that the resident does not like a lot of the food served, sister brings meals/snacks in to the resident. Sister provides high protein coffee/yogurt. Per sister, she is eating dinner every night as she is there with her Dining Assistance: Full-assist resident does not typically make attempts to eat or drink herself . In an interview on 12/07/23 08:55 AM, Family Member (FM) JJJ reported it was very difficult for Resident #78 to reach her rolling bedside table and that was why she had posted signs to have it moved within reach so she could get a drink with a straw if she needed to. FM JJJ reported they come in and they push the table away and don't place it back to where she can even reach it. FM JJJ reported every night first thing, she gave Resident #78 a drink of Juven. In an interview on 12/11/23 at 11:27 AM, Dietary Aide OO reported Resident #78 did not have on her tray slip for her to receive a sippy cup, two handled cup. In an interview on 12/11/23 at 8:17 AM, Registered Dietician (RD) RR reported the menus were on a 4 week cycle. The dietary slips go out on trays, the CNAs used them to chart acceptance and they were shredded after they were finished. She has water and Juven, which her sister provided, which requires a lot of cueing to be done with her. RD RR reported Resident #78 does not have a sippy cup she used for drinking. Note: no monitoring for use of sippy cup noted in the medical record. In an interview on 12/11/23 at 2:41 PM, Director of Nursing (DON) B reported any time the staff leave the room of a resident, they would ask the resident if they want someting to drink, cued them to drink and reminded them to drink. DON B water was passed twice a day, there were drinks on the trays, and when the aides were picking up the trays if the nothing had been touched they would ask them if they would like them to leave the drink, and if they were seeing a trend they would notify the nurse, nurse would talk to the registered dietician and doctor to see if the facility need to do something differently.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47659 Based on interview, and record review, the facility failed to ensure adequate care for residents who received enteral nutrition (tube feeding) in 1 (Resident #443) of 2 sampled residents reviewed for tube feeding, resulting in the potential for aspiration pneumonia. Findings include: Resident #443 Review of an Admission Record revealed Resident #443, was originally admitted to the facility on [DATE] with pertinent diagnoses which included dysarthria (difficult or unclear articulation of speech) and following cerebral infarction (stroke). Review of Resident #442's Orders revealed, Enteral Feed Order: every shift Head of bed elevated at least 30 degrees. Order date: 11/13/2023. Review of Resident #443's Care Plan revealed, (Resident #443) requires tube feeding r/t (related to) Dysphagia (trouble swallowing), Swallowing problem. Date Initiated: 11/16/2023. Goal: (Resident #443) will be free of aspiration through the review date .(Resident #443) will remain free of side effects or complications related to tube feeding through review date . Interventions: (Resident #443) needs the HOB elevated 45 degrees during and thirty minutes after tube feed. Date Initiated: 11/16/2023 . Review of Resident #443's Progress Notes dated 11/18/23 at 7:21 A.M. and documented by Licensed Practical Nurse (LPN) M revealed, (Resident #443) found in bed at less than 15 degree angle with tube feeding disconnected from PEG tube. Unable to determine how long he was in this position. VSS (vital signs stable) at this time, will continue to monitor (Medical Director)) notified. Review of Resident #443's Progress Notes dated 11/18/23 at 1:23 PM and documented by LPN M revealed, (Resident #443) condition changed since this morning, temp of 99.68 F, diminished lung sounds throughout and greater at bases .Patient coughing but not able to expectorate at this time. (Medical Director) called and notified. Gave orders for Chest X-ray, CBC (complete blood count) ,CMP (comprehensive metabolic panel). Will continue to monitor . Review of Resident #443's Progress Notes dated 11/18/23 at 3:26 PM and documented by LPN M revealed, Attempted to draw (Resident #443) blood for ordered labs; unsuccessful x 3. (Medical Director) notified. Discussed (Resident #443's) condition: decreased response, lethargic, Vitals still the same as previously reported. Since unable to obtain labs and patient's decline, (Medical Director) gave orders to send (Resident #443) to ER for further evaluation . (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 Resident #443's Hospital Report dated 11/18/23 revealed, . Chief Complaint: (Resident #443)coming from (facility) who reports that pt had a fever of 101.2 with new cough, and they had concerns for aspiration r/t administering tube feeds while patient was laying flat just prior to arrival of EMS . During an interview on 12/06/23 at 10:57 AM, LPN M reported when she had found Resident #443 lying flat in his bed and his tube feed had been running. LPN M reported that she had no idea how long Resident #443 had been lying in flat while his tube feed was running, and she was very concerned with the potential for aspiration. LPN M reported that Resident #443 did not look well, and she advocated for him to go to the hospital due to her concerns regarding possible aspiration. During an interview on 12/04/23 at 2:50 PM, Confidential informant (CI) EEEE reported that they were concerned with their family member receiving tube feedings while lying flat. CI EEEE reported that they had observed their family lying flat in bed on multiple occasions while receiving tube feedings. CI EEE reported that they had reported their concerns to the nurse managers on several occasions. During an interview on 12/07/23 at 11:38 AM, Director of Nursing (DON) B reported that she was not aware that Resident #443 was sent to the hospital on 11/18/23 for concerns related to receiving a tube feeding while lying flat. DON B reported that she was responsible for reviewing the resident record after a resident was sent to the hospital, but she had missed reviewing Resident #443's record. DON B reported that she would have completed education with all staff on enteral feeding if she had realized that there was a concern that staff were not administering tube feedings properly. DON B was not able to report the last time that staff in the facility had been educated on enteral (tube) feeds.

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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** 47659 Based on interview and record review the facility failed to ensure post dialysis (procedure that removes excess water, solutes, and toxins from the blood in people whose kidneys cannot perform these functions) assessment and monitoring were completed for 1 (Resident #441) of 1 resident reviewed for dialysis care, resulting in the potential of being unprepared for a decline in resident condition, due to adverse effects of dialysis. Findings include: Resident #441 Review of an Admission Record revealed Resident #441, was originally admitted to the facility on [DATE] with pertinent diagnoses which included muscle weakness and end stage renal (kidney) disease. During an interview on 12/04/23 at 10:16 AM, Resident #441 reported that he went to dialysis three days a week, and he was unaware if nursing staff would come in and assess him when he returned from dialysis. During an interview on 12/06/23 at 10:57 AM, LPN M reported that nurses were responsible for completing an assessment when a resident returned from dialysis which included taking vital signs, checking the condition of the dialysis access site, and assessing the resident's overall status. LPN M reported that the nursing staff were required to document their assessment on the dialysis communication form that was sent between the facility and the dialysis facility, as well document their assessment in the electronic health record (EHR) under progress notes. Review of Resident #441's Dialysis Communication Forms revealed 1 communication form dated 12/4/23. The pre-dialysis portion was completed and dated 12/4/23 and the dialysis center communication and post dialysis communication was completed and dated 12/6/23. The facility was unable to provide any more communication forms for any other dialysis appointments that Resident #441 went to. During an interview on 12/11/23 at 9:57 AM, Dialysis Care Manager HHH reported that Resident #441 had gone to the facility for dialysis treatments on 12/1/23, 12/6/23. and 12/8/23. During an interview on 12/11/23 at 11:32 AM, LPN P reported that she was the nurse caring for Resident #441 on 12/1/23 but she did not complete a post dialysis assessment. LPN P reported that she thought another nurse may have completed the assessment, but she was not able to report who the other nurse could have been. During an interview on 12/11/23 at 12:03 PM, LPN L reported that she did not recall completing any recent post dialysis assessments for Resident #441. LPN L reported that if she had not completed the communication form, then she did not do the assessment. During an interview on 12/11/23 at 12:37 PM, Registered Nurse (RN) G reported that she had not completed the post dialysis assessment when she was caring for Resident #441 on 12/1/23. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility was not able to provide any further evidence of completed dialysis communication forms or EHR record of post dialysis assessment by survey exit. Review of the facility's Dialysis policy last reviewed 11/29/23 revealed, .General Guidelines . Post-Dialysis 1. Obtain vital signs of resident upon return from dialysis and complete the Pre/Post Dialysis Communication Form. 2. Follow routine dialysis instructions on dialysis transfer form. 3. Transcribe any diet, medication, and/or orders received with resident from the dialysis facility .

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. 46999 Based on interview, and record review the facility failed to identify PTSD (Post Traumatic Stress Disorder) triggers and implement interventions to mitigate triggers for 1 of 8 residents (Resident # 76) reviewed for trauma informed care, resulting in the potential risk of re-traumatization and unmet care needs. Findings include: Review of an Admissions Record for Resident #76 dated 2/8/23 revealed the resident was admitted to the facility with the following pertinent diagnoses: bipolar disorder (disorder associated with episodes of mood swings ranging from depressive lows to manic highs), anxiety disorder, dissociative disorder (mental disorder characterized by the existence of two or more different personality states), schizoaffective disorder(mental health condition including schizophrenia and mood disorder symptoms), Post Traumatic Stress Disorder (PTSD), and suicidal ideations (thoughts about self-harm). Review of a Minimum Data Set (MDS) assessment for Resident #76 dated 10/17/23 revealed a Brief Inventory for Mental Status (BIMS) assessment score of 15/15, which indicated the resident was cognitively intact. Section I of the MDS indicated Resident #76 had an active diagnosis of Post Traumatic Stress Disorder (PTSD). Review of a Care Plan dated 5/9/23 a focus/goal/interventions as follows: Focus: (Resident #76) is at risk for change in mood or behavior due to Bipolar and Schizoaffective Disorder. Goal: (Resident #76) desires to be consulted with decisions related to care. Interventions: medications as ordered; psychiatric consult as indicated. No focus/goal/interventions present for diagnosis of PTSD. Review of a Nursing Admission Collection Tool for Resident #76 dated 2/9/23, revealed no indication of Resident's diagnosis of PTSD. Review of a Social Service Assessment for Resident #76 dated 10/30/23, section titled Social Service Intervention Status, question 11 indicated the only current medical diagnoses social services was addressing were the resident's schizoaffective disorder and depression. In an interview on 12/7/23 at 3:34pm, Licensed Practical Nurse (LPN) VVV reported she was not aware of Resident #76 having a diagnosis of PTSD and did not know any interventions to use in order to avoid re-traumatization of the resident. LPN VVV reported she cared for Resident #76 regularly several times per week. In an interview on 12/11/23 at 8:19am, Social Services Assistant (SSA) VV reported it was his responsibility to implement interventions to prevent further traumatization of residents who had a diagnosis of PTSD. SSA VV reported he did not know Resident #76 had a diagnosis of PTSD and thus was also not aware of any triggers that might result in the resident suffering re-traumatization while being cared for at the facility. When queried if resident psychosocial needs were going unmet, SSA VV stated 100% needs are not being met. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 12/11/23 at 10:57am, Resident #76 reported she has a diagnosis of PTSD that stemmed from childhood sexual abuse. Resident #76 began crying and stated, I don't want to complain, but I need a little more psychological support than I'm getting. Resident #76 reported she had not experienced any specific situations that had caused her to feel retraumatized at the facility but also didn't feel like the staff were mindful of her psychological needs. Review of a facility policy dated 8/22/23, titled Trauma-Informed Care revealed a policy statement: .Based on comprehensive assessment of a resident, this facility must ensure that residents .who have a history of post-traumatic stress disorder, receive appropriate treatment. Further review revealed under a section titled Implementing resident-driven care a statement: The facility should collaborate with resident trauma survivors . to develop an individualized plan of care .the facility should attempt to identify triggers which may re-traumatize the resident and develop interventions which minimize the effect of the trigger for the resident.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47659 Based on observation, interview, and record review, the facility failed to ensure 6 (Resident #79, #27, #60, #76, #83, and #54) of 8 residents reviewed for behavioral health received behavioral health care services resulting in Resident #79 being hospitalized due to physical aggression and a potential for the other residents to experience a decline in their psychosocial well-being. Findings include: Resident #79 Review of an Admission Record revealed Resident #79, was originally admitted to the facility on [DATE] with pertinent diagnoses which included unspecified dementia with other behavioral disturbance, anxiety, depression and adjustment disorder with mixed disturbance of emotions and conduct. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #79's Care Plan revealed, Focus: (Resident #79) is/has potential to be verbally aggressive with staff during care/activities r/t (related to) dx (diagnosis) of traumatic brain injury that affects his mental and emotional state. He has been noted to make sexual, racial and demining remarks to staff at times. Date Initiated: 04/04/2023. Interventions: Analyze of key times, places, circumstances, triggers, and what de-escalates behavior and document. Date Initiated: 04/04/2023. Assess and anticipate resident's needs: food, thirst. toileting needs, comfort level, body positioning, pain etc. Date Initiated: 04/04/2023. Assess resident's coping skills and support system. Date Initiated: 04/04/2023. Assess resident's understanding of the situation. Allow time for the resident to express self and feelings towards the situation. Date Initiated: 04/04/2023. Give the resident as many choices as possible about care and activities. Date Initiated: 04/04/2023. Observe for behaviors. Document observed behavior and attempted interventions. Date Initiated: 04/04/2023. Provide positive feedback for good behavior. Emphasize the positive aspects of compliance. Date Initiated: 04/04/2023. Psychiatric/Psychogeriatric consult as indicated. Date Initiated: 04/04/2023. Focus: (Resident #79) has a behavior problem false accusations of staff not caring for him/refusing to give care, staff not answering questions, yelling at him and staff being rude, perseverating on past concerns with staff and peers. He also has a behavior problem of throwing items around the room (trays, urinal, ect.) r/t dx of traumatic brain injury. Date Initiated: 04/12/2023. Interventions: Administer medications as ordered. Date Initiated: 04/12/2023. Anticipate and meet The resident's needs. Date Initiated: 04/12/2023. Assist the resident to develop more appropriate methods of coping and interacting. Encourage the resident to express feelings appropriately. Date Initiated: 04/12/2023. Educate the resident/family/caregivers on successful coping and interaction strategies. Date Initiated: 04/12/2023. Explain all procedures to the resident before starting and allow the resident time to adjust to changes. Date Initiated: 04/12/2023. If reasonable, discuss The resident's behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable to the resident. Date Initiated: 04/12/2023. Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. Date Initiated: 04/12/2023. Observe for behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Date Initiated: 04/12/2023. Please explain all care step by step before and during contact, implement other staff as needed, remind resident why specific help is needed. Date Initiated: 04/12/2023. Praise any indication of The resident's progress/improvement in behavior. Date Initiated: 04/12/2023. Provide a program of activities that is of interest and accommodates residents status. Date Initiated: 04/12/2023. Focus: At risk for change in mood or behavior due to medical condition. Date Initiated: 03/27/2023. Interventions: Consult with resident on preferences regarding customary routine. Medications as ordered. Psychiatric consult as indicated. Review of Resident #79's Health Status Note dated 12/1/23 revealed, Resident violent with staff this week during care, sent to ER, no new orders upon readmission. Seen by psychiatrist on 11/28 with instructions to work on coping skills. Psychiatrist reviewing medical history, awaiting recommendations. Resident also continues to call 911 at nighttime Review of Resident #79's Health Status Note dated 11/12/23 revealed, Resident's family member called facility to inform (Resident #79) that his mother had passed away suddenly this morning. No emotional or behavioral changes have been observed at this Social worker notified. Will continue to monitor (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #79's Health Status Note dated 10/27/23 revealed, Resident discussed to to (sic) falls and behaviors. He has made multiple comments that he is bored and just wants someone to talk to. He yells out for help right after you walk out of his room. he is forgetful and asks to use the bathroom [ROOM NUMBER] minutes after you took him. He calls 911 stating he is being held here against his will and when the police show up he tells them to get out of his room. He falls because he doesn't wait for staff to assist him. he needs constant reminding to use his call light and when you tell him to use his call light he gets upset and tells you to get out of his room. Review of Resident #79's Behavior Note dated 12/9/23 revealed, (Resident #79) calling out for help since start of shift. Writer and staff have answered call light and assisted with residents needs. Resident called 911, despite staff in residents room assisting with needs. On call supervisor notified. Will continue to monitor. Review of Resident #79's Behavior Note dated 12/9/23 revealed, (Resident #79) was awake for entire shift, constantly called out loudly, help get me outa here. Several redirections attempted,unsuccessfully. Resident called the police/911 3 times. One time was because he needed the urinal. Patient requested a PB&J sandwich, I gave him one, he complained about it and told me I needed to get him the f*** out of here. Review of Resident #79's Behavior Note dated 11/28/23 revealed, Resident seen by (Local behavioral services) via phone eval with SS (Social services) present. When asked by psych Dr why (Resident #79) acted out on 11/26/23 (Resident #79) said it was because I was depressed and I snapped. (Psychiatrist) asked (Resident #79) what would help and resident said cannabis edibles/gummies. The Dr encouraged (Resident #79) to work on coping skills if he feels that upset again and that the use of edibles could be discussed with nursing and guardian with her main concern related to their use being that we need to make sure their usage is tracked and regulated (mg, quantity, etc). Review of Resident #79's Behavior Note dated 10/26/23 revealed, (Resident #79) made call to 911 to inform them that we were holding him against his will. Uniformed officer arrived at facility and attempted to explain to this resident that he needed the extra help and support that the staff here could give him. Resident told the police officer to get the h*** out of here if you aren't going to help me either Review of Resident #79's Behavior Note dated 10/21/23 revealed, (Resident #79) was sitting at the nurses station yelling Help Can you Please Help Me to visitors walking past him. CNAs on the unit have toileted him, gotten him in and out of bed at least twice in 60 min, gotten him in and out of his room while in the wheelchair, this nurse has pushed him in his wheelchair into his room and from his room to the hallway at least 6 times inside of 30 min. Resident slid himself to the front edge of his wheelchair and started to yell down the hallway because he was falling out of his wheelchair because No one will help me CNA let resident know she had to go grab another CNA because she wasn't able to scootch him back sitting up right in his chair by herself and resident as soon as the CNA turned out of the door and into the hallway slid himself to the floor from his wheelchair provider notified, DPOA notified. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #79's Behavior Note dated 10/21/23, (Resident #79) yelling constantly at the aids and the nurses on the hall wanting in his room and out of his room or in the bathroom resident wants the person to stop what they are doing right now and attend to him after telling this nurse that he was just bored out of his mind this morning. resident will get moved to the hallway from his room or he will move himself to the hallway and start yelling help immediately for someone to move him back into his room. when the second nurse tried to help him on one of the occasions resident looked at her and said ya stupid B****! Nurse asked if he would please not use that language and resident returned with B**** what are you gonna say about it? this nurse spoke with resident letting him know that the staff members are here to try and help him with his needs but do not deserve to be talked to in that direction or with that language he said to this nurse whatever and started yelling Help again. Review of Resident #79's Behavior Note dated 10/17/23 revealed, (Resident #79) is hollering out help somebody please just help me constantly when this nurse or other staff have approached to ask what he is needing help with resident states I'm bored staff has offered to bring resident down for activities that he may enjoy but resident refuses to go this nurse offered to help resident use the urinal due to him being a 2 person transfer and other clinical staff were in other resident rooms at the time helping other residents, resident refused to use the urinal and stated I'll just wait for them to help this nurse stated are you sure resident stated he was and continued to holler out for help. Review of Resident #79's Behavior Note dated 9/22/23 revealed, (Resident #29) once again made a call to 911 to inform them that we were holding him against his will and wouldn't give him any food or water. I explained to the 911 operator about (Resident #79) being a resident in a Nursing Home and that he was NPO (nothing by mouth) in preparation of his upcoming Ultra sound. Review of Resident #79's Behavior Note dated 9/20/23, revealed, Per 2 CENAs working unit . (Resident #79) verbally abusive towards staff, calling staff (explicit names). Resident combative with staff, slapping staff and squeezing their wrists. Left resident safe and staff returned when he is calmer. Review of Resident #79's Behavior note dated 9/7/23 revealed, (Resident #29) has made multiple phone calls to 911 this shift, complaining that he is being held against his will. This nurse spoke to the 911 operator to inform that resident resides in a Nursing home and he is being taken care of by competent staff. Review of Resident #79's Behavior Monitoring Tasks revealed that Resident had documented behaviors on 8 days between the dates of 11/12/23 and 12/12/23. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #79s Incident Reports dated 11/25/23 at 11:13 PM revealed, Incident Description: I was passing medications when I heard our CNA (Certified Nursing Assistant) screamed out for help. I then ran into (Resident #79) room to find (CNA) getting her hair pulled by (Resident #79) in the bathroom. (Resident #79) was on the sit to stand and she was attempting to wipe (Resident #79) while on the toilet. (Resident #79) then grabbed ahold of her hair and would not let go. There was another nurse and aide all trying to get him to let go of her hair. (Resident #79) was extremely aggressive and stating that he was not letting go. We finally got (Resident #79) fist undone enough for her to get away. (CNA) now has a swollen wrist and being seen at (local hospital) for further evaluation. While trying to calm (Resident #79) down myself and other nurse got him onto the bed and he seemed calmer. (Nurse) was trying to put his boxers on when he grabbed ahold of her hair as well and would not let go. I then called for help and two aids came in to assist me with getting him to let go. (Resident #79) said he was going to hurt us all. (Resident #79) was calling the cops and if anyone came close to him he was going to hurt them worse. I made sure (Resident #79) was safe, left the room, made sure all staff were safe, and then notified (Director of Nursing), (Resident #79's DPOA), and (Medical Doctor EEE) of the situation. (Medical Doctor EEE) told me to send him to the ER because he is a danger to our staff and himself. Review of Resident #79's Emergency Visit Note dated 11/26/23 revealed, (Resident #79) presenting to the ED (Emergency Department) with reports of aggressive behavior. (Resident #79) reportedly assaulted multiple staff at (facility), where (Resident #79 has been staying. (Resident #79) reports that he has been frustrated with his living situation and has been trying to get out of there and go somewhere else to stay. (Resident #79) reports that he assaulted staff because he saw it as a way of getting out of his living situation . (Resident #79)presenting with aggressive behaviors toward staff. My resident discussed the symptoms with (Resident #79's) power of attorney. (Resident #79) has been more aggressive. (Resident #79) will be welcome back to (facility) however they are concerned that in 6 hours (Resident #79) the patient will be more aggressive again . Review of Resident #79's Non-Routine Visit dated 11/27/23 completed by Medical Doctor (MD) EEE revealed, .Subjective: (Resident #79) is status post ER visit. (Resident #79) was sent for inappropriate aggressive behavior towards staff. He was pulling the nursing staff's hair . (Resident #79) was sent to the ER and then came back. (Resident #79) has inappropriate behavior with anger issues. I appreciate the ER work up . Assessment: Inappropriate behavior. Plan: Will get ER record of evaluation. During an interview on 12/06/23 at 10:57 AM, Licensed Practical Nurse (LPN) M reported that Resident #79 had frequent behaviors and could become aggressive quickly. LPN M reported that Resident #79 would call 911 often, throw himself onto the floor, and act out towards staff. LPN M was not aware if Resident #79 was working with any behavioral health care providers, or what interventions staff had tried to help with Resident #79's behaviors. During an interview on 12/06/23 at 3:08 PM, Unit Manager E reported that Resident #79 had seen a local behavioral care service provider previously, but he did not know how often. Unit Manager E did not know if the facility was currently collaborating with the local behavioral care service provider. Unit Manager E was not able to report any interventions that were put in place regarding Resident #79's behaviors prior to and after he was sent to the hospital on 11/26/23. Unit Manager E reported that a new medication was started for Resident #79 on 12/4/23, after Genesight testing was completed in October 2023 (Psychotropic test that evaluates DNA to determine potential medication outcomes), but he did not believe this medication change was not recommended by a local behavioral care service provider. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/07/23 at 11:38 AM, Director of Nursing (DON) B reported that Resident #79 was seen by local behavioral care services provider on 11/28/23 which was requested by the facility after Resident #79 returned from the hospital. DON B reported that the psychiatrist that saw Resident #79 on 11/28/23 did not know what medications Resident #79 was on, so she had made a list of the medications and sent that to the psychiatrist on 11/29/23. DON B reported that she did not know if anyone had followed up with the local behavioral care services provider for recommendations after the medication list was sent on 11/29/23. DON B reported that the facility had not made any changes or put new interventions in place for Resident #79's behaviors after Resident #79 returned to the facility on [DATE]. DON B reported that she believed that Resident #70 may have been triggered by the recent passing of his mother. DON B reported that the facility social worker met with Resident #79 was on 11/13/23 to inform Resident #79 that his mother passed away, and she did not know if anyone had been checking in with Resident #79 after that. DON B reported that she did not know how often Resident #79 had seen the local behavioral care services provider prior to 11/28/23 or how often the facility was meeting and collaborating with them to manage Resident #79's behaviors. The facility provided two notes from the local behavioral care service provider which were dated 8/9/23 and 8/29/23. Review of Resident #79's Behavioral care note dated 8/29/23 revealed, . Assessment and Plan: Follow up PRN (as needed). During an interview on 12/11/23 at 10:26 AM, Medical Director EEE reported that he was not aware if Resident #79 was being followed by local behavioral care service provider. Medical Director EEE was not able to report if he had collaborated with local behavioral care service provider regarding Resident #79's behaviors, care, or medications. Medical Director EEE reported that he was aware of Resident #79's behaviors, but could not report any interventions he had recommended to help Resident #79. Medical Director EEE was not able to report if any changes had been made for Resident #79 after he was hospitalized on [DATE]. Medical Director EEE reported that he did feel that Resident #79 was a good candidate for receiving care from the local behavioral care service provider. During an interview on 12/11/23 at 8:19 AM, Social Services Assistant (SSA) VV reported that he was responsible for contacting the local behavioral health care services provider for treatment when referrals were submitted. SSA VV reported that the local behavioral health care services provider would generally see residents within a week of the referral being submitted. SSA VV reported that Resident #79 had only been seen by the local behavioral health care services provider in August and in November after he was sent to the hospital. SSA VV reported that the facility had not been following up with the local behavioral health care services provider for Resident #79. SSA VV was not aware of any intervention that were made for Resident #79 after he returned from the hospital. This surveyor requested the last six months of notes from the local behavioral health care services provider for Resident #79. The facility did not provide further documental by exit. 41424 Resident #27: (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of an Admission Record revealed Resident #27 was a female with pertinent diagnoses which included dementia, anxiety, depression macular degeneration (loss in the center of the field of vision), heart failure, stroke, osteoporosis (bones become weak and brittle), and cyst in right knee. Review of current Care Plan for Resident #27, revised on 9/11/23, revealed the focus, .(Resident #27) has a behavior problem (tearfulness, crying episodes, delusions, sundowning, refusing personal care) r/t dementia, and depression. Has episodes where she is looking for kids . (Resident #27) also is at risk for physical aggression towards peers and staff with increased confusion .(Resident #27) will have fewer than three episodes of tearfulness per month by review date . with the intervention .Administer medications as ordered . Anticipate and meet needs .(Resident #27) tends to sleep in some days, Allow her to sleep until she arises on her own, Then approach to provide care and provide something to eat as she will allow .Explain all procedures before starting and allow time to adjust to changes .If (Resident #27) appears to be agitated, Please remove her from the situation, placement to a calm, quiet area .Observe for behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations . Offer a stuffed animal when she is visibly upset to see if this attempts to calm her .Offer reassurance, support as needed .When (Resident #27) is upset, take to a calm are. sit with her as able to listen to her. Attempt to calm her and allow her to voice her concerns . Review of Orders dated 12/6/23, revealed, .Depakote Tablet Delayed Release 250 mg .Give 1 tablet by mouth three times a day for mood disorder . Review of Orders dated 6/16/23, revealed, .Buspirone HCl tablet 5 mg .Give 1 tablet by mouth two times a day for anxiety related to depression . Review of Orders dated 11/29/23, revealed, .Ativan 1 mg Gel .Apply to wrist or neck topically every 8 hours for agitation/anxiety . Review of Behavior Note dated 6/13/2023 at 00:51 AM, revealed, .Resident very aggressive with staff at HS. Pinching, scratching and yelling when staff were attempting to assist with HS care. Staff made safe and re-approached and resident remained aggressive. Ativan cream given with some effectiveness. Resident was awake off and on throughout the night worried about the kids. Staff attempted multiple ways to calm resident; position change, distraction, offers of food and drink without success. Review of Behavior Note dated 7/7/2023 10:07 AM, revealed, .Extremely agitated/crying/yelling out first thing this am. Unable to redirect/console. Resident was assisted back to bed and eventually cried I herself to sleep. Refused Neuro's/VS. Will continue to monitor . Review of Health Status Note dated 6/26/23 at 6:33 PM, revealed, .No change in behaviors. Increased agitation, tearfulness, combative with staff. Hit CENA across the face knocking off her glasses while transferring her into bed. Resident up in w/c at lunch but began yelling at everyone in the DR. Removed from area and taken to room where staff attempted to feed her-she refused. Hyperverbal. Has been going strong since this writer punched in at 0600. Repositioning self in bed. Bolster pillows in place but resident able to pull out . (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Health Status Note dated 7/1/23 at 2:37 PM, revealed, .No change in behaviors. Talking to self. Episode of tearfulness and yelling out. Son here this AM. Resident had same behaviors during visit with son. Informed this writer it took approximately 20 minutes to calm her down. Consumed snacks and water while sitting with son. Attended lunch in DR. Appetite and fluid intake remains poor . Review of Behavior Note dated 7/7/2023 at 10:07 AM, revealed, .Extremely agitated/crying/yelling out first thing this am. Unable to redirect/console. Resident was assisted back to bed and eventually cried herself to sleep. Refused Neuro's/VS. Will continue to monitor . Review of Health Status Note dated 7/11/23 at 3:00 PM, revealed, .Refused lunch tray d/t increased anxiety and agitation. Climbing out of bed. Refused to stay in DR. PRN liquid Ativan adm. As well as topical Ativan. Took approximately 2 hours for medication to take affect. Currently in bed resting quietly . Review of Health Status Note dated 7/29/23 at 2:02 PM, revealed, .Alert to self .Per son resident lethargic entire visit .Currently screaming grandma, grandpa, just kill me Uncooperative with incontinence care. Body pillows in place . Review of Health Status Note dated 8/26/23 at 3:38 PM, revealed, .Alert to self .Increased behaviors after family left. Refused lunch tray. Refused help from staff to assist with feeding . Review of Health Status Note dated 8/31/23 at 7:25 AM, revealed, .Resident uncooperative with care. Hitting and kicking at CENA. Screaming loudly. Unable to redirect or reassure d/t HOH (hard of hearing) . Review of Health Status Note dated 9/19/23 at 6:01 PM, revealed, .No change in behaviors. Uncooperative with care, hitting, kicking, and pinching staff. Appetite and fluid intake remains poor. Dependent upon staff for all ADL care. Propels self throughout facility talking to self. At times crying. Reminiscing about grandma and grandpa. Unable to redirect or reassure d/t (due to) HOH . Review of Health Status Note dated 9/20/23 at 10:23 AM, revealed, .Note placed in (Medical Doctor) communication book in regards to the behaviors she displayed on 9/19 and behavioral interventions attempted and medication management unsuccessful in changing her mood . Review of Initial Evaluation dated 9/14/23, revealed, gradual dose reductions of medication, the resident was not a candidate for at this time, chart and staff were consulted prior to this evaluation .Nursing, social service, and behavior notes report that the resident exhibits agitation, depressed mood, and delusions . Social work to address the need for follow up following evaluation and behavior management planning. Review of Health Status Note dated 10/22/23 at 11:28 AM, revealed, .Yelling and attempting to hit staff . Review of Health Status Note dated 11/6/23 at 6:19 PM, revealed, .No change in behaviors. Once awake talking to self, calling out random names, uncooperative with care, attempting to hit and scratch staff. Redirection ineffective. HOH. Unable to communicate via writing .Propels self through the facility talking to self . (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Health Status Note dated 12/6/23 at 11:32 AM, revealed, .(Medical Doctor) notified of residents increased behaviors. Restlessness, agitated, talking to self, making statements and then answering herself. Calling out for grandma and grandpa. Unable to redirect or reassure. Resident HOH. (Medical Doctor) notified. Received new order to apply 2 mg three times daily . Review of Health Status Note dated 12/6/23 at 6:30 PM, revealed, .Informed (son) resident received a extra dose of Ativan gel this am. d/t (due to) yelling out. Propelling self throughout facility yelling out Grandma, Grandpa Calling out for (Son) .I'll kill you .No, I won't kill you .Unable to redirect or reassure d/t HOH . During an observation on 12/5/23 at 8:23 AM, Observed Resident #27 reaching out to the sky while lying in her bed. She keeps yelling out. During an observation on 12/5/23 at 1:51 PM, Observed Resident #27 was lying in her bed and yelling out, unable to determine what she said. During an observation on 12/5/23 at 1:51 PM, Resident #27 was lying in her bed yelling out, CNA EE was in the room waiting for additional staff to come assist with repositioning and provide peri care for Resident #27. No blue mat was noted on the wall next to Resident #27's bed. CNA EE reported she was lying on her left side facing the wall. CNA EE reported the resident's family comes on the weekends to visit with her. CNA Y came to the room to assist CNA EE with Resident #27. CNA Y reported she was a fighter and her yelling like that was us not hurting her, she was very hard of hearing and that was part of why she yells like that. During an observation on 12/5/23 at 2:03 PM, Resident #27 was observed self-ambulating in the hallway, talking and telling who she is. She attempted to enter another resident's room and was redirected. During an observation on 12/06/23 at 11:00 AM, Resident #27 was self-ambulating down the hallway yelling. During an observation 12/06/23 at 2:05 PM, Resident #27 was observed self-ambulating down the hallway in her wheelchair, feet up on the footrests, with a stuffed animal on her lap as she was yelling, .get her off, go up the back way, to the ground . During an observation on 12/11/23 at 11:23 AM, observed Resident #27 self-propelling down the hallway by the activity room. Resident #27 kept repeating she was looking for water, [NAME] around the block, still no water. Resident #27 proceeded to turn around and head back towards the nurse's station. CNA Y came around the corner and observed Resident #27 and heard what she was repeating. She went to get her some water. In an interview on 12/11/23 at 11:29 AM, CNA Y reported Resident #27 had drank half of the cup of the big sytrofoam cups used for waters in the rooms. CNA Y reported she was thirsty. Resident #60: (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of an Admission Record revealed Resident #60 was a female with pertinent diagnoses which included dementia, cognitive communication deficit, depression, lack of coordination, anxiety, attention and concentration deficit, mood disorder, falls, and hallucinations. Review of Care Plan for Resident #60, revised on 10/13/23, revealed the focus, .The resident has a behavior problem due to her DX. The Resident has Dementia with Behavioral Disturbances, She is currently on Antipsychotic Medication due to Hallucination, Delusions and other Behavioral Symptoms. Social Service/Nursing will monitor for Behavioral Changes along with BCS Services Frequently thinks that she works and attempts to help other residents by guiding them in a direction she thinks they need to go . with the intervention .Anticipate and meet The resident's needs .(Resident #60) will be reminded that it is good for the other residents to physically move themselves around the building, as this helps with their strengthening . Praise any indication of The resident's progress/improvement in behavior .Provide a program of activities that is of interest and accommodates residents status . Review of Neurobehavioral assessment dated [DATE], was conducted to determine competency and not specifically to address resident's diagnoses of hallucinations, depression, anxiety, and mood disorder. No further follow up by the facility Social worker was conducted to address the behavioral health needs of Resident #60. Review of Health Status Note dated 12/1/2023 at 1:16 PM, revealed, .Review with the IDT in the weekly RAR meeting .Started on risperidone on 11/25 for hallucinations. Resident with increased behaviors and anxiety, not easily redirected. Also, receives melatonin for insomnia, trazadone for depression and depakote for anxiety. Will have added to the psych list for evaluation and potential medication adjustment . Review of Nutrition/Dietary Note dated 11/30/2023 at 5:38 PM, revealed, .Resident continues to have poor PO intakes. In dining room at mealtimes, resident propels herself in wheelchair and does not eat, not easily redirectable. Resident often sleeps in dining room, as well. When encouraged to eat, resident becomes frustrated and often states that she has already eaten. Resident frequently expresses anxiety and asks can somebody help me?, not able to say what she needs help with and cannot be redirected. Started risperidone BID on 11/27 for hallucinations . Review of Behavior Note dated 10/13/23 at 3:12 PM, revealed, .At nursing station desk this afternoon. Resident continuously stating that she was bit and that people were biting staff today. Resident gestured on arm where she was bit Unable to redirect . Review of Health Status Note dated 10/21/2023 at 6:46 PM, revealed, .RESIDENT IS ALERT AND ORIENTED SELF ON ATB FOR UTI NO S/S OF ADVERSE REACTION NOTED .RESIDENT VERY CONFUSED YELLS AT STAFF AT TIMES . FOOD INTAKE S VERY POOR WHEN STAFF ENCOURAGES HER TO EAT SHE GETS VERY ANGRY AND SAYS LEAVE ME ALONE ALL YOU ASK ME TO DO IS EAT, EAT . Review of Behavior Note dated 11/11/2023 at 01:30 PM, revealed, .Yelling, accusing, combative and making negative statements. Staff made several attempts to console and redirect which were all unsuccessful. Eventually fell asleep in her wheelchair and staff was able to assist her to bed . Review of Skilled Note dated 11/18/23 at 02:00 AM, .confused and agitated. Resident is up in w/c most of night, rarely stays in bed, likes to wander the hallways. She is with confusion . (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Nutrition/Dietary dated 11/21/23 at 11:35 AM, revealed, .They state it continues to be Very poor. Report that the resident has stated that people are poisoning her with food and that people are cutting her belly open and putting food in. Expected that cognition/paranoid be [TRUNCATED]

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. 47955 Based on observation, interview, and record review the facility failed to provide dementia care treatment that included individualized care interventions that were monitored in 1 of 2 residents (Resident #54) reviewed for dementia care, resulting in facility staff not knowing if interventions were effective and/or appropriate and the potential for residents to attain or maintain their highest practicable physical, mental, and psychosocial well-being. Findings include: Review of an Admission Record revealed Resident #54 had pertinent diagnoses which included other frontotemporal neurocognitive disorder (disorder affecting the frontal and temporal lobe of the brain), adjustment disorder with mixed disturbance of emotions (feeling sad and anxious both), unspecified dementia (disease that affects memory and thinking), and anxiety. Review of Behavior Notes for Resident #54 dated 7/26/23 revealed .yelled out continuously during am care . Review of Health Status Notes for Resident #54 dated 8/9/23 revealed .behaviors today of screaming/yelling out during care/feeding . Review of Health Status Note for Resident #54 dated 9/18/23 revealed .grunting loudly. Redirection ineffective .Face red and diaphoretic. Unable to comfort. Review of Behavior Note for Resident #54 dated 9/24/23 revealed .non-stop yelling out loudly . Review of Health Status Note for Resident #54 dated 10/4/23 revealed . resident continued grunting noises for hours at a time, uncooperative with care, and combative at times . Review of Care Management Note for Resident #54 dated 10/27/23 revealed . resident (b)ehaviors including wandering and crying out/moaning. Resident went from PRN (as needed) Xanax to BID (twice a day) . Review of Health Status Note for Resident #54 dated 10/30/23 reveals . new order received to increase Xanax to 0.25 to three times daily . Review of Orders-Administration Note for Resident #54 dated 11/24/23 revealed .Alprazolam (Xanax) tablet 0.25 mg give 1 tablet by mouth three times a day related to dementia . Review of Care Plan for Resident #54 revealed Focus: . has a communication problem r/t (related to) dementia . is rarely understood .goal: staff will anticipate needs on a daily basis . revised on 8/24/23. Focus: . dx (diagnosis) of anxiety disorder .s/s (signs and symptoms) include yelling and restlessness .Goal: . free from discomfort or adverse reactions . Intervention: administer anti-anxiety medications as ordered by physician .may wear a weighted vest AS NEEDED when having verbal outbursts/anxiety. Does not have to wear longer than 4 hours at a time . Initiated on 10/4/23 (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 12/4/23 at 12:24 PM., Resident #54 was yelling out while rolling independently in her wheelchair around the unit hallway. Resident #54 had a weighted vest on, with the weights resting in her lap. No staff acknowledged resident. During an interview on 12/4/23 at 1:50 PM., Licensed Practical Nurse (LPN) J reported that Resident #54 would wear the weighted vest for anxiety and could wear it for 4 hours at a time. LPN J did not know what time the vest was applied to Resident #54. During an observation on 12/4/23 at 1:53 PM., Resident #54 was sitting in her wheelchair by the Woods Unit nursing station, eating chips, wearing a weighted vest weights resting on her legs, and occasionally yelling out. During an observation on 12/5/23 at 1:48 PM., Resident #54 was using her feet to propel herself in her wheelchair, along the hallway outside of the therapy room while yelling a single syllable ah. No staff present in the area. During an interview on 12/5/23 at 1:57 PM., Licensed Practical Nurse (LPN) O reported that Resident #54 has a diagnosis of PTSD (Post Traumatic Stress Disorder) and anxiety related to past experiences. LPN O reported that Resident #54's Xanax was increased yesterday and that occupation therapy uses the weight vest to help with anxiety. During an observation on 12/6/23 at 9:14 AM., Resident #54 was sitting in her wheelchair, outside of the dining room doorway, weighted vest was in place with weights resting on her legs, occasionally yelling. No staff present in the area. During an interview on 12/6/23 at 12:52 PM., Director of Rehab Services - OT (DRS-OT) JJ reported that Resident #54 discharged from therapy services on 11/3/23. DRS-OT JJ reported that Resident #54's weighted vest was initiated for anxiety and could be calming to the resident. DRS-OT JJ reported the weighed vest was applied like a shirt and the weights could be moved to the side to not be in contact with the Resident #54's body. DRS-OT JJ reported that orders for the use of the weight vest were not present in Resident #54's record and the use of the weight vest was not being monitored. During an interview on 12/6/23 at 1:19 PM., Licensed Practical Nurse/Unit Care Coordinator (LPN/UCC) H reported that the weighted vest is an intervention for restlessness and anxiety for Resident #54 and is related to her (Resident #54's) PTSD. LPN/UCC H reported the weighted vest was started by therapy, and sometimes it did work to calm her down. LPN/UCC reported that she did not know how Resident #54 was tolerating the use of the weighted vest, or how often it was used as an intervention because there was no monitoring of the weight vest use or effectiveness noted in Resident #54's record.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46999 Based on interview and record review the facility failed to provide medically related social services to 2 resident (Resident #79, Resident #83) of 18 sampled residents resulting in residents not receiving requested psychological support services and the potential for a decline in psychological well-being. Findings include: Resident #76 Review of an Admissions Record for Resident #76 dated [DATE] revealed the resident was admitted to the facility with the following pertinent diagnoses: bipolar disorder (disorder associated with episodes of mood swings ranging from depressive lows to manic highs), anxiety disorder, dissociative disorder (mental disorder characterized by the existence of two or more different personality states), schizoaffective disorder(mental health condition including schizophrenia and mood disorder symptoms), Post Traumatic Stress Disorder (PTSD), and suicidal ideations (thoughts about self-harm). Review of a Minimum Data Set (MDS) assessment for Resident #76 dated [DATE] revealed a Brief Inventory for Mental Status (BIMS) assessment score of ,d+[DATE], which indicated the resident was cognitively intact. Section I of the MDS indicated Resident #76 had active diagnoses of: Post Traumatic Stress Disorder (PTSD), Anxiety Disorder, Bipolar Disorder, and Schizophrenia. Review of a Care Plan dated [DATE] a focus/goal/interventions as follows: Focus: (Resident #76) is at risk for change in mood or behavior due to Bipolar and Schizoaffective Disorder. Goal: (Resident #76) desires to be consulted with decisions related to care. Interventions: medications as ordered; psychiatric consult as indicated. Review of a behavioral health consultation report dated [DATE] revealed Resident #76 reported she was having problems adjusting . and was assessed as having adjustment issues related to her placement and loss of independence. The treatment plan at that time was will follow up as needed. In an interview on [DATE] at 10:57am, Resident #76 reported she had been working with a psychological counselor weekly prior to her admission to the facility. Resident #76 reported she requested SSA VV assist her with scheduling routine psychological services several times since her admission, but no follow up had been done. Resident #76 began to cry and stated, I don't want to complain, but I need a little more psychological support than I'm getting. Before I came here, I was living on my own and driving. I nearly died in the hospital, now I'm on dialysis and living in a nursing home. In an interview on [DATE] at 8:19am, SSA VV reported he could not keep up with the responsibilities of his role and it was likely Resident #76's referral for counseling fell through the cracks. SSA VV reported he had 1 day of training for the role and was flying blind while trying to do the job. Resident #83 (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of an Admission Record dated [DATE] revealed Resident #83 was admitted to the facility with the following pertinent diagnoses: adult failure to thrive (a state of decline that is multifactorial and may be caused by concurrent diseases and functional impairments), anorexia nervosa (eating disorder characterized by disturbed perception of body image), adjustment disorder with mixed anxiety and depressed mood (excessive reactions to stress that involve negative thoughts and strong emotions). Review of a Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #83 earned a Brief Inventory for Mental Status (BIMS) score of ,d+[DATE] which indicated the resident was cognitively intact. Review of a contractual behavioral health consultation report dated [DATE] revealed Resident #83 was experiencing depression and anxiety related to her medical issues and recent loss of independence. Resident #83 described herself as struggling with feelings of irritability, worry, anxiety and sadness. At that time, future sessions were recommended as needed. No additional behavioral health documentation for Resident #83 was present. In an interview on [DATE] at 3:55pm, Resident #83 reported she requested assistance from Social Services Assistant (SSA) VV to receive routine psychological counseling. Resident #83 reported she had benefitted from counseling in the past and felt she needed the support to improve her psychosocial wellbeing. Resident #83 reported feelings of sadness, frustration, and helplessness related to her medical issues. Resident #83 also voiced feeling worried that her mood might worsen and impact her motivation for therapy. Resident #83 reported she asked several times for assistance from SSA VV but had waited more than 6 weeks for follow up and had not received additional counseling. In an interview on [DATE] at 8:19am, SSA VV reported it was the responsibility of his role to coordinate behavioral health care for the residents. SSA VV reported referrals for behavioral care were done via email and usually resulted with an appointment for the resident within a week. SSA VV reported Resident #83's request had fallen through the cracks and had not been fulfilled. SSA VV reported he was unsure how long the resident had been waiting for follow up, but it was likely over a month. Review of a facility policy titled Social Services Personnel dated [DATE] revealed under a section labeled Procedure, item 9. Stated: Provide or arrange for needed mental and psychological counseling services.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38384 Based on interview and record review, the facility failed to ensure resident remained free from unnecessary mediations in 1 (Resident #45) of 19 residents reviewed for antibiotic use, resulting in the potential of developing a medicine-resistant bacteria. Findings include: According to the Minimum Data Set (MDS) dated [DATE], R45 scored 4/15 (severely cognitively impaired) on her BIMS (Brief Interview Mental Status), required the use of a wheelchair to self-ambulate around the facility with diseases that included Alzheimer's, dementia, and schizophrenia. Review of R45's Incident Report (IR) #1810 dated 10/22/2023 18:50 (6:50 PM), reported the resident's wheelchair's left wheel got caught in the leg of a mechanical lift. A skin tear (layers of skin separate or peel back) was noted to her LFA (left forearm). Review of R45's Physician Note dated 10/23/2023 revealed, .Reason for Evaluation: I am asked by the nursing staff to evaluate patient's left forearm after a fall . Assessment: Dirty wound. Plan .Start doxycycline 100 mg b.i.d. (twice daily) x 7 days . Review of R45's Medication Administration Record (MAR) 10/1/2023-10/31/2023 reported an order date 10/23/2023 1431 (2:31 PM) Doxycycline Hyclate Oral Tablet 100 mg give 1 tablet my mouth two times a day for skin tear for 7 days. During an interview on 12/6/2023 at 9:55 AM, Nursing Home Administrator (NHA) A stated, The clinical team uses McGeer's for antibiotic use. I rely on the DON (Director of Nursing) and the Infection Control Preventionist to handle this area. During an interview on 12/6/2023 at 2:32 PM, Infection Preventionist (IP) E stated, When a resident has a wound it should have a culture and sensitivity done because it tells you what is growing (referring to bacteria) and what it is susceptible to so the right antibiotic can be ordered. Otherwise, the antibiotic will not be effective, or a superinfection could grow. The facility uses McGeer's Criteria before an antibiotic is ordered. Technically, the facility should be trying to get a culture and sensitivity I must get an order from the provider for a culture and antibiotic. IP E reviewed R45's medical records including Progress Notes, stating, (Medical Director (MD) EEE) wrote (R45) had a dirty wound. I do not know why the doctor put her on antibiotics. He looked at it the same day it happened. I did not look at the wound. I do not know if he followed McGeer's Criteria. IP E reviewed R45's vital signs dated 10/23/2023 at 06:45 (AM) that reported a temperature of 98.0 degrees F (Fahrenheit) which was within normal limits for the resident. It was noted, no temperature readings were taken between 10/23/2023 and 11/23/2023. IP E stated, (R45) did not have a McGeer's Criteria Infection Assessment Form or an SBAR (Situation, Background, Assessment, Recommendation; used to facilitate prompt and appropriate communication) when placed on the antibiotic) completed when an antibiotic was ordered for her. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/7/2023 at 10:47 AM, MD EEE stated, I follow McGeer's guidelines for antibiotic use. (R45) did not have a cut with sharp edges. There was serosanguineous drainage (a normal thin serum, often slightly yellow fluid that's mostly water, with a light pink tinge drainage of fluid from a wound). Residents have germs on their skin in a place like this. That is why I ordered the antibiotic. Review of an email sent from Nursing Home Administrator (NHA) A on 12/7/2023 at 12:23 PM, stated, The facility follows McGeer's Criteria for antibiotic use. There is not a SBAR for (R45) on 10/22/2023. During an interview on 12/7/2023 at 4:10 PM Unit Manager/Licensed Practical Nurse (UM/LPN) H stated, I am the Unit Manager for (R45). I have trained nurses on how and why to use McGeer's Criteria for antibiotic use. The medical director has also been told how to use McGeer's when ordering antibiotics. I do not know why an antibiotic was ordered for (R45) on the same day she got a skin tear. During an interview on 12/7/2023 at 4:12 PM, LPN VVV stated, (MD EEE) was in the facility on 10/23/2023, the same day she got the skin tear, and saw it on her left forearm. (MD EEE) gave me an order to enter for an antibiotic at that time. I do not know why he ordered the antibiotic. I do not know if he looked or followed McGeer's Criteria. Review of the facility's policy, Antibiotic Stewardship, reviewed 5/19/2023, reported, Policy: The antibiotic stewardship program promotes the appropriate use of antibiotics and includes a system of monitoring to improve resident outcomes and reduce antibiotic resistance. The means that the antibiotic is prescribed for the correct indication, dose, and duration to appropriately treat the resident while also attempting to reduce the development of antibiotic-resistant organisms and/or other adverse events .Antibiotic: a medication used to treat bacterial infections . Assessment of residents suspected of having an infection. The facility will utilize the McGeer Criteria when considering initiation of antibiotics. Provider Communication: It is encouraged that the standardized general SBAR form be used of all change in condition communication. Review of facility policy, Definitions of Infections for Surveillance Activities, reviewed 5/22/2023, revealed, . summary of definitions for long-term care (LTC) is adapted from definitions published by McGeer Criteria in 2018 .Identification of infection should not be based on a single piece of evidence but should always consider the clinical presentation and any microbiologic or radiologic information that is available .diagnosis by a physician alone is not sufficient for a surveillance definition of infection and must be accompanied by documentation of compatible signs and symptoms .Definitions for Constitutional Criteria in Residents of Long-Term Care Facilities (LTCFs) A. Fever 1. Single oral temperature >37.8 degree C (>100 degree F) or 2. Repeated oral temperatures >37.2 degree C (99 degree F) or rectal temperatures >37.5 degree C (99 degree F) or 3. Single temperature .1.1 degree C (2 degree F) over baseline any site (oral, tympanic, axillary) B. Leukocytosis 1. Neutrophilia (>14,000 leukocytes/mm3) or Left shift (>6% bands or >1,500 bands/mm3) (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	C. Acute change in mental status from baseline (all criteria must be present) 1. Acute onset, 2. Fluctuating course (e.g., coming and going or changing in severity during the assessment), 3. Inattention (e.g., unable to keep track of discussion or easily distracted) AND 4. Either disorganized thinking (e.g., rambling conversation, unclear flow of ideas, unpredictable switches in subject) OR Altered level of consciousness (e. g., hyperalert, sleepy, drowsy, difficult to arouse, nonresponsive) D. Acute functional decline 1. A new 3-point increase in total activities of daily living (ADL) score (range 0-28) from baseline, based on the following 7 ADL items, each scored from 0 (independent) to 4 (total dependence) a. Bed mobility b. Transfer c. Locomotion within LTCF d. Dressing e. Toilet use f. Personal hygiene g. Eating Surveillance Definitions for Skin, Soft Tissue, and Mucosal Infections . Criteria Comments A. Cellulitis, soft tissue, or wound infection (at least 1 of the following criteria must be present) Presence of organisms cultured from the surface (e.g., superficial swab sample) of a wound in not sufficient evidence that the wound is infected. 1. Pus present at a wound, skin, or soft tissue 2. New or increasing presence of a least 4 of the following sign or symptom sub-criteria: a. Heat at the affected site b. Redness at the affected site c. Swelling at the affected site d. Tenderness or pain at the affected site e. Serous drainage (a clear fluid that leaks out of wounds) at the affected site f. One constitutional criterion (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Resident Infection Assessment Form, undated and adapted from McGeer's criteria, reported a nurse was to complete the form, use it to contact the doctor, and submit it to the Infection Preventionist when completed.

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Life Care Center of Plainwell	320 Brigham St Plainwell, MI 49080

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 38905 Based on observation, interview, and record review the facility failed to: 1. Clean food and non-food contact surfaces to sight and touch; 2. Ensure the installation of an air gap; 3. Properly datemark and discard food product; and 4. Ensure all hand sinks have hot water. These conditions resulted in an increased risk of contaminated foods and an increased risk of food borne illness that affected 88 residents who consume food from the kitchen. Findings Include: 1. During the initial tour of the facility, at 9:48 AM on 12/4/23, observation of the two door Traulson freezer found accumulation of spotted black debris on the top portion of the door gasket seals. During the initial tour of the facility, at 9:50 AM on 12/4/23, it was observed that the two door true cooler was found with an accumulation of spotted black debris on the top portion of the door gasket seals. During the initial tour of the facility, at 9:52 AM on 12/4/23, it was observed that non-food contact areas of the drink station were found with an accumulation of splash debris on the underside spouts of the coffee machine. During the initial tour of the of the of the ice machine, at 10:15 AM on 12/4/23, an interview with [NAME] NN found that maintenance takes care of the ice machine cleaning. At this time, it was observed that an orange tan colored debris had accumulated along the inside plastic lip that hangs over the ice cubes. This debris was able to be wiped off with a white disposable paper towel. During the initial tour of the bridge kitchenette, at 10:18 AM on 12/4/23, it was observed that the refrigerator was found with some accumulation of debris and juice staining on the inside door and main shelf of the unit. According to the 2017 FDA Food Code section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris. 2. During the initial tour of the kitchen, at 9:50 AM 12/4/23, it was observed that the sanitizer compartment of the three-compartment sink was directly connected to the waste water line. No observed air gap was present and visible. When asked if there was ever an air gap under the three compartment sink, [NAME] NN was unsure. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview with Maintenance Director (MD) PP, at 3:10 PM on 12/6/23, the surveyor found that MD PP was aware that there was no air gap at the three compartment sink, but was told it was grand-fathered in when he brought it up to previous staff after hire. The surveyor asked if there was a spot in the basement or dining room (on the other side of the wall as the three compartment sink) where it could be gapped out of sight, MD PP stated there was not. According to the 2017 FDA Food Code section 5-402.11 Backflow Prevention. (A) Except as specified in (B), (C), and (D) of this section, a direct connection may not exist between the SEWAGE system and a drain originating from EQUIPMENT in which FOOD, portable EQUIPMENT, or UTENSILS are placed . 3. During a tour of the Bridge Kitchenette, at 10:18 AM on 12/4/23, observation of the refrigeration unit found an open container of Butter Pecan Med Pass 2.0 with no discard date, an open container of thicken pomegranate juice with no discard date, and a container of hard boil eggs dated for 12/1 to 12/15. When asked how long hard boil eggs should be dated for , [NAME] NN stated seven days. During a tour of the [NAME] Kitchenette, at 10:25 am on 12/4/23, observation of the refrigeration unit found an open container of thickened pomegranate juice with no discard date, a leftover bag of fast food dated 11/30 to 12/2, and a container of hard boiled eggs dated 11/27 to 12/14. A review of the thickened juice found the manufacture states it .may be kept for up to 7 days. According to the 2017 FDA Food Code section 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. (A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under S 3-502.12, and except as specified in (E) and (F) of this section, refrigerated, READY-TOEAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. (B) Except as specified in (E) -(G) of this section, refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than 24 hours, to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the FOOD ESTABLISHMENT shall be counted as Day 1; and (2) The day or date marked by the FOOD ESTABLISHMENT may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on FOOD safety . According to the 2017 FDA Food Code section 3-501.18 Ready-to-Eat, Time/Temperature Control for Safety Food, Disposition. (A) A FOOD specified in 3-501.17(A) or (B) shall be discarded if it: (1) Exceeds the temperature and time combination specified in 3-501.17(A), except time that the product is frozen; (2) Is in a container or PACKAGE that does not bear a date or day; or (3) Is inappropriately marked with a date or day that exceeds a temperature and time combination as specified in 3501.17(A) . 4. During a revisit tour of the kitchen, at 10:10 AM on 12/6/23, it was observed that the hand sink, closest to the Dietary Managers office, was found to have little to no hot water servicing it. At this time, the temperature of the hot water at the hand sink would only reach 74F when measured with a rapid read thermometer. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An interview with [NAME] MM, at 10:12 AM on 12/6/23 found that the hot water to that hand sink has not worked very well since she started here years ago. Observation of the dry storage room, at 10:13 AM on 12/6/23, found that the hot water line to the hand sink was running through a mixing valve located in the dry storage room ceiling, which most likely had failed. An interview with MD PP, at 3:12 PM on 12/6/23, found that he was unaware of any issues regarding the lack of hot water to the hand sink in the kitchen. According to the 2017 FDA Food Code section 5-202.12 Handwashing Sink, Installation. (A) A HANDWASHING SINK shall be equipped to provide water at a temperature of at least 38C (100F) through a mixing valve or combination faucet .

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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** 47659 Based on observation, interview, and record review, the facility failed to: 1.) implement an effective infection control program 2.) don the appropriate Personal Protective Equipment (PPE) when entering resident rooms which required PPE 3.) provide water needed for hand washing and daily hygiene care in 1 of 2 residents (Resident #57), 4.) follow the infection control protocols when performing resident care in 1 of 2 residents (Resident #78) and, 5.) properly handle storage of open and exposed linens in spa rooms, cleaning products/linens/ and personal hygiene products and 6.) properly clean linen bins in the laundry room per facility infection control protocols, resulting in the potential for further development and transmission of communicable diseases and infections. Findings include: During an interview on 12/5/23 at 2:30 PM with Director of Nursing (DON) B and Infection Preventionist (IP) E, IP E reported that he had been in the position since April 2023, but he was not able to report how often he spent completing infection control tasks every week, or what tasks he was regularly completing for the infection prevention program. IP E reported that the facility had identified their first case of Covid-19 on 11/16/23 when a staff member tested positive. IP E reported that the first case identified among residents in the facility was on 11/18/23 and by 11/21/23, the facility was in what IP E considered widespread status. By 12/5/23 the facility had 21 cases of Covid-19 among the residents in the facility. IP E reported that 4 residents had been hospitalized due to Covid-19. IP E was not able to provide any line listings, maps, contract tracing, or evidence that showed how the Covid-19 infections were being monitored or how the facility had attempted to control the spread of Covid-19. IP E and DON B were not able to report how they were working to mitigate a further spread of Covid-19 in the facility, or why the facility was not able to keep the spread of Covid-19 to isolated incidents. IP E and DON B were not able to report how the facility's current infection prevention standards and polices were based on the facility assessment. IP E reported that the facility was currently moving residents that had been exposed and tested negative to another room if their roommate had tested positive. DON B reported that if they moved a resident that had tested negative, but had been exposed to Covid-19 in with another resident, it would only be if that resident had also been exposed. DON B reported that the facility was passively screening visitors, and requiring all staff to self screen for Covid-19 symptoms before entering the facility. During a follow up interview on 12/06/23 at 9:31 AM, IP E was able to show line listings for all facility infections for the month of November 2023. IP E was not able to provide line listings for any other months, and reported he would have to find them. IP E reported that when a resident tested positive for Covid-19, the resident would begin a course of antiviral's and vitamins if they were experiencing symptoms, and that the facility was not providing antiviral's or vitamins for Covid-19 positive residents without symptoms. IP E reported that he had been reaching out to the health department for each new identified case, but had not received guidance from the health department on ways to mitigate the spread of Covid-19 in the facility. IP E reported that neither he or DON B had reached out to the state of Michigan's Infection Prevention Resource and Assessment team (IPRAT) for guidance on the current Covid-19 outbreak in the facility. On 12/7/23 at 8:32 AM, the facility provided the monthly line listings for September 2023. On 12/7/23 at 11:59 AM, the facility provided the monthly line listings for October 2023. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the (Local County Health department communication) dated 11/22/23 that was sent to DON B revealed, .The (facility) has shared it's current mitigation measures through the (local county health department) mitigation survey, These include: contact tracing, Hvac system updated, UV light for sterilization, isolating residents, private room unless cohorting positive residents, staff will leave and not return for 7 day (7 if they have no symptoms and test negative and 10 days if they test positive at 7 days and have no symptoms), N95 and eye wear, gown, gloves, face shields are used when caring for a resident that has tested positive, housekeeping increasing cleaning on high touched areas, encouraging masks for residents and visitors to wear masks but it is not required for them, staff are required to wear masks and eye wear, signage posted for visitors and email sent out to all family members notifying them of positive cases at the facility, testing will be 3x a week for staff and residents and will test is someone gets symptoms before the time, flu swabs as well if they have symptoms to out that. (The local health care department also recommends the following mitigation strategies to further reduce risk at your facility: Universal masking for residents and staff regardless of the vaccination status, at least 14 days from 11/15/23, which was the last known exposure in this setting. If additional connected cases are identified, our recommendation is to extend this period to that it is at least 14 days from the newest exposure identified, promoting Covid-10 vaccination for staff and residents, improving ventilation in the facility, rigorous handwashing protocols, implementing enhanced cleaning and disinfecting of the facility, daily symptom screening for staff and visitors before entering the facility, ensuring that staff who are experiencing Covid-19 symptoms will remain home or be sent home should they become symptomatic, physical distancing, perform testing for all residents and staff exposed regardless of vaccination status and if negative against 5-7 days later, if additional cases are identified, testing should continue on affected units or facility-wide every 3-7 days in addition to room restriction and full PPE use for care of residents who are not up to date with all recommended Covid-19 vaccine doses until there are no new cases for 14 days, consider an antiviral medication for positive patients in the first 48 hours, Additionally, (the local health department) recommends LTCF (long term care facilities) connect with MDHHS-iPRAT team when a facility is experiencing a large outbreak. The iPRAT team offers expert level of support and assistance that is specific to the type of facility and nature of the outbreak, which provides and strengthens infection prevention, infection control strategies and risk-reducing plans During an interview and observation on 12/04/23 at 11:29 AM, Licensed Practical Nurse (LPN) Q entered into Resident room [ROOM NUMBER] wearing gloves and a face mask. LPN Q was not wearing a gown. LPN Q did not sanitize her hands prior to entering room [ROOM NUMBER]. There was an isolation cart noted outside of room [ROOM NUMBER] which contained masks, gowns, face shields, and gloves. There were two signs noted on the door of room [ROOM NUMBER]. The first sign stated Aerosol-Generating procedure in progress. PPE required to enter: hand hygiene, gown, gloves, N95, eye wear. The second sign stated: Enhanced Barrier Precautions. everyone must: clean their hands, including before entering and when leaving the room. Providers and staff must also: Wear gloves and a gown for the following high-contact resident care activities. Dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy, wound care, any skin opening requiring a dressing. At 11:33 AM, LPN Q exited room [ROOM NUMBER] without performing hand hygiene. LPN Q reported that she did not wear a gown in the room because she was only taking vital signs for the resident in the room, and therefore she was not required to. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/04/23 at 11:40 AM, the resident in room [ROOM NUMBER] turned their call light on and Certified Nursing Assistant (CNA) CCCC and Assistant Director of Nursing (ADON) C was observed sanitizing their hands, and donning a gown, gloves, and mask prior to entering room [ROOM NUMBER]. In an interview on 12/04/23 at 11:55 AM, ADON C reported that all staff were expected to don a gown when entering room [ROOM NUMBER] because the resident was on enhanced barrier precautions and also had an aerosol generating procedure being completed in his room. ADON C reported that she considered taking vitals on a resident as an activity that would require wearing a gown as part of the PPE, and the aerosol generating procedure required wearing a gown. Resident #57 Review of an Admission Record revealed Resident #57, was originally admitted to the facility on [DATE] with pertinent diagnoses which included muscle weakness. Review of a Minimum Data Set (MDS) assessment for Resident #77, with a reference date of 10/27/23 revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #57 was cognitively intact. During an interview and observation on 12/04/23 at 3:00 PM, Resident #57, who was on Covid-19 isolation precautions, reported that the sink in his room had been broken for over a week. The sink had a bag over it with a note that stated not to use it. Resident #57's room was noted to have several pieces of paper, straw wrappers, food particles, and dirt spots on his floor. Resident #57 reported that he had been making due without a sink by using hand sanitizer, but he had not been able to perform daily hygiene activities such as brush his teeth, wash his face, or wash his hands with soap and water. Resident #57 reported that staff had not been bringing him water to complete these tasks. During an observation on 12/05/23 at 1:26 PM, Resident #57's room was noted to be in the same condition as previous observation. Resident #57's sink remained out of order. During an interview on 12/5/23 at 2:30 PM with Director of Nursing (DON) B and Infection Preventionist (IP) E reported that they were unaware that Resident #57's sink remained out of order. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's Infection Prevention and Control Program (IPCP) and Plan last reviewed 5/19/23, revealed, . General Procedures . 2. The facility administration, infection preventionist, and medical director should ensure that current infection control standards of practice are based on recognized guidelines and facility assessment. These standards should be incorporated in the Infection Prevention and Control Program (IPCP). 3. The facility has established/implemented a surveillance plan, based on a facility assessment, for identifying, tracking, monitoring, and/or reporting of infections, communicable diseases and outbreaks. 4. The program includes early detection, management of a potentially infectious, symptomatic resident requires laboratory testing and/or the implementation of appropriate TBP/PPE (the plan may include tracking this information in an infectious disease log). The plan uses evidence-based surveillance criteria (e.g. , revised McGeer Criteria) to define infections and the use of a data collection tool. 5. The plan includes ongoing analysis of surveillance data and documentation of follow-up activity in response. The facility has a process for communicating at time of transfer to an acute care hospital or other healthcare provider the diagnosis to include the infection or multidrug-resistant organism colonization status, special instructions or precautions (eg., antibiotics), laboratory, and/or radiology test results, treatment, and discharge summary . 7. Ensure staff follow the IPCP's standards, policies, and procedures (e.g., hand hygiene and appropriate use of PPE) while other needs are specific to particular roles, responsibilities, and situations . 47955 Resident #78 Review of an Admission Record revealed Resident #78 had pertinent diagnoses which included pressure ulcer of the sacral region, (wound on the lower part of the back and to part of the buttock), multiple sclerosis, (a disease that affects the central nervous system), and a history of sepsis (blood poisoning). During an observation on 12/6/23 at 10:20 AM, Licensed Practical Nurse/ Unit Care Coordinator (LPN/UCC) H removed the soiled dressing from Resident #78's right foot, cleansed wound with dakins solution (antiseptic wound cleanser), dried wound with gauze, and applied aquacel (antimicrobial wound dressing), wrapped right foot with kerlix (gauze wrap), and secured dressing with tape. LPN/UCC H did not changed gloves or perform hand hygiene at any time between the removal of the soiled dressing and the application of a clean dressing. During an observation on 12/6/23 at 10:30 AM., LPN/UCC H removed the soiled dressing from Resident #78's right heel, cleansed wound with dakins solution, dried wound with gauze, and applied aquacel and a padded barrier to the heel, wrapped heel in kerlix and secured dressing with tape. LPN/UCC H did not changed gloves or perform hand hygiene at any time between the removal of the soiled dressing and the application of a clean dressing. During an observation on 12/6/23 at 10:34 AM., LPN/UCC H removed the soiled dressing from Resident #78's sacral region, cleansed wound with dakins solution, dried wound with gauze. LPN/UCC H reported large amount of serosanguinous drainage (fluid discharge from a wound that is pale or pink in color) on the removed dressing. LPN/UCC H applied hydrofera blue (antibacterial wound dressing) to wound bed and covered with a mepilex (foam absorbent dressing). LPN/UCC H did not changed gloves or perform hand hygiene at any time between the removal of the soiled dressing and the application of a clean dressing. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Physician Orders for Resident #78 revealed . isolation enhanced barrier precautions infected wound every shift . Review of facility policy Hand Hygiene with a revised date of 6/13/2023 reveled .procedure 2. Associates perform hand hygiene (even if gloves are used) in the following situations: a. Before and after contact with the resident b. after contact with blood, body fluids, or visibly contaminated surfaces; . e. Before performing a procedure such as an aseptic task (. dressing care). Review of facility policy Wound-Management, long-term care Lippincott procedures with no reference date revealed .routine dressing changes - hand hygiene, yes, gloves clean wound care supplies and instrument maintain supplies as clean and maintain instruments as clean . 38905 During the initial tour of the facility, with Maintenance Director (MD) PP, starting at 1:35 PM on 12/4/23, observation of the medical supply room found an accumulation of paper trash and debris on the floor underneath the open wire storage racks. During the initial tour of the facility, at 1:38 PM on 12/4/23, observation of the 100 hall shower room found two stacks of wash cloths stored open and exposed on a cloth chair next to the whirlpool tub and sink and on top of the head of the tub. An interview with Maintenance Director (MD) PP found that there is a linen closet on the hallway right outside of the door. Further review of the shower room found an open bottle of pop on the sink and an open bag of gummy bears on an overbed stand. During the initial tour of the facility, at 1:48 PM on 12/4/23, observation of the 200 hall spa room found an open and exposed stack of towels stored next to the whirlpool spa, the plastic cabinet used to store personal hygiene products, cleaning products, and clean linens, was found to have these items commingled. Observation of the inside of the cabinet found clean linens next to shampoo, body wash, and menthol relieving gel. During the initial tour of the facility, at 1:58 PM on 12/4/23, observation of the clean utility room found two packages of catheters on the floor underneath the open wire rack shelving. During a tour of the laundry room, at 2:04 PM on 12/4/23, observation of three clean linen bins found an accumulation of washcloths, used gloves, paper trash, a candy wrapper, and dirt and debris under the bottom barriers of the bins. During a revisit to the 200 hall spa room, at 1:13 PM on 12/6/23, found the room with an open and exposed stack of wash cloths and towels stored next to the whirlpool spa. Observation of the plastic cabinet used to store personal hygiene products, cleaning products, and clean linen, found these items commingled and not separated to reduce the risk of contamination.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47659 Based on interview and record review, the facility failed to 1.) Implement and operationalize an antibiotic stewardship program and 2.) failed to ensure appropriate use of an antibiotic for 2 (Resident # 441 and #45) of 5 residents reviewed for antibiotic use, resulting in the potential for inappropriate antibiotic utilization and antibiotic resistance. Findings include: During an interview on 12/5/23 at 2:30 PM with DON B and IP E reported that the facility followed McGeer 's criteria (screening tool to meet criteria for definitive infections) for ordering antibiotics. DON B reported that the facility only prescribed antibiotics after a culture had been completed or if the resident was meeting SIRS criteria (a screening tool used to identify septic patients). IP E was not able to report how he was monitoring antibiotic use in the facility. IP E and DON B were not able to provide any documentation for how the facility was monitoring antibiotic use among residents in the facility. On 12/07/2023 at 7:54 AM, this surveyor requested documentation of antibiotic surveillance that had been completed for the last 3 months for each resident that was on an antibiotic. The facility did not provide this documentation of the antibiotic surveillance by the exit of survey. Review of the facility's Antibiotic Stewardship Report, which was provided by the facility on 12/7/23 at 11:40 AM, revealed, Antibiotic Stewardship Report: This report assist with the outcome measures which can be tracked and trended by nursing homes to monitor the impact of their antibiotic stewardship programs . This report contained the amount of residents receiving antimicrobials each month at the facility. It was noted that the Line Listings and Antibiotic Stewardship Report provided by the facility did not include SBAR (situation, background, assessment, and recommendation) information, if the resident met McGeer's or SIRS criteria, what, if any diagnostic/lab cultures had been initiated, monitoring of the antibiotic use, and response to antibiotic for each resident that was noted to have been on antibiotic therapy. It was also noted that the Antibiotic Stewardship Report noted that 24 residents in the facility had received antibiotics in the month of November 2023, but only 11 residents were listed on the facility's Line Listing report for receiving antibiotics for the month of November 2023. Resident #441 Review of an Admission Record revealed Resident #441, was originally admitted to the facility on [DATE] with pertinent diagnoses which included muscle weakness and end stage renal (kidney) disease. Review of Resident #441's Medication Administration Orders revealed, Order: Sulfamethoxazole-Trimethopim (Bactrim) (antibiotic medication) oral tablet 400-80 MG. Give one tablet by mouth one time a day every Tue, Thu, and Sat for infection. Start date: 11/28/23. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/5/23 at 2:30 PM, IP E was not able to report why Resident #441 was on an antibiotic, or what the antibiotic was being used to treat. DON B reported that Resident #441 was admitted on the antibiotic, but was also not able to report what the antibiotic was being used to treat. Review of the Facility's Line Listings for the month of November revealed that Resident #441 was not listed on the report. During an interview on 12/11/23 at 10:26 AM, Medical Director (MD) EEE reported that he was unaware that Resident #441 was still taking the Bactrim. MD EEE reported that he had asked staff to discontinue the medication over a week ago, because there was no indication for the use. MD EEE reported that he had asked one of the nurses to discontinue the medication, but he did not know which nurse he had asked. MD EEE confirmed that he did not follow up to confirm that the medication had been discontinued. During an interview on 12/11/23 at 11:15 AM, IP E confirmed that Resident #441's Bactrim order was active, and that he was not aware that MD EEE had requested that the order be discontinued. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's Antibiotic Stewardship Program policy last reviewed 5/1/923 revealed, The antibiotic stewardship program promotes the appropriate use of antibiotics and includes a system of monitoring to improve resident outcomes and reduce antibiotic resistance. This means that the antibiotic is prescribed for the correct indication, dose, and duration to appropriately treat the resident while also attempting to reduce the development on antibiotic-resistant organisms and/or other adverse advents. The program will be managed and overseen by the Infection Preventionist .Procedure: 1. Leadership commitment and accountability- The Infection Preventionist, Director of Nursing, Pharmacy Consultant, and Medical Director are the facility leads responsible for promoting and overseeing antibiotic stewardship activities .3. Action. A. prescription record keeping. Dose, duration, and indication of each antibiotic prescription will be documented in the medical record for each resident. B. Assessment of residents suspected of having an infection. The facility will utilize the McGeer Criteria when considering initiation of antibiotics. C. Provider communication. It is encouraged that the standardized general SBAR form be used for all change in condition communication. D. Antibiotic time-out. At 72 hours after antibiotic initiation or first dose in the facility, each resident should be reassessed for consideration of antibiotic need. At this time, each resident should be assessed for consideration of antibiotic need. At this time, laboratory testing results, response to therapy and resident condition will be considered. E. Multi-drug resistant infections. The AST will design and utilize systems to identify residents with multidrug-resistant organisms (MDROs) by review of microbiology culture results, 2) alert staff and providers, and 3) document in cases if inter-facility transfer. F. Interventions for syndrome-specific antibiotic use and antibiotic prophylaxis. The AST will identify actions to directly impact inappropriate antibiotic use for specific syndromes for prophylactic indications. 4. Tracking. A. Process measures for tracking antibiotic stewardship track how and why antibiotics are prescribed. Process measures include review of SBAR's and other clinical documentation during clinical meetings and ongoing reviews of completeness of prescribing documentation to include dose, route, duration, and indication for use. B. Contain a system of reports related to monitoring antibiotic usage and resistance data .C. Summarizing antibiotic resistance (e.g., antibiogram) based on laboratory data from, for example, the 18 months; and/or D. Tracking measures of outcome surveillance related to antibiotic use (e.g., C,difficle, MRSA, and/or CRE) E. Track adverse outcomes associated with inappropriate use of antibiotics that may include but are not limited to adverse drug events and drug interactions (e.g., allergic rash, anaphylaxis or death). 5. Reporting. A. The facility should provide feedback (e.g., verbal, written note in the record) to prescribing practitioners regarding antibiotic resistance data, their antibiotic use and their compliance with facility antibiotic use protocols to improve prescribing practices and resident outcomes. B. Feedback on prescribing practices and compliance with facility antibiotic use protocols may include information from medical record reviews for new antibiotic starts to determine whether the resident had signs or symptoms of an infection; laboratory tests ordered and the results; order documentation including the indication for use (i.e. , whether or not the infection or communicable disease has been documented), dosage, and duration; and clinical justification for the use of an antibiotic beyond the initial duration ordered such as review of laboratory reports/cultures in order to determine if the antibiotic remains indicated or if the adjustments to therapy should be made (e.g., more than narrow spectrum antibiotic) . 38384 R45 (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the Minimum Data Set (MDS) dated [DATE], R45 scored 4/15 (severely cognitively impaired) on her BIMS (Brief Interview Mental Status), required the use of a wheelchair to self-ambulate around the facility with diseases that included Alzheimer's, dementia, and schizophrenia. Review of R45's Incident Report (IR) #1810 dated 10/22/2023 18:50 (6:50 PM), reported the resident's wheelchair's left wheel got caught in the leg of a mechanical lift. A skin tear (layers of skin separate or peel back) was noted to her LFA (left forearm). Review of R45's Physician Note dated 10/23/2023 revealed, .Reason for Evaluation: I am asked by the nursing staff to evaluate patient's left forearm after a fall . Assessment: Dirty wound. Plan .Start doxycycline 100 mg b.i.d. (twice daily) x 7 days . Review of R45's Medication Administration Record (MAR) 10/1/2023-10/31/2023 reported an order date 10/23/2023 1431 (2:31 PM) Doxycycline Hyclate Oral Tablet 100 mg give 1 tablet my mouth two times a day for skin tear for 7 days. During an interview on 12/6/2023 at 9:55 AM, Nursing Home Administrator (NHA) A stated, The clinical team uses McGeer's for antibiotic use. I rely on the DON (Director of Nursing) and the Infection Control Preventionist to handle this area. During an interview on 12/6/2023 at 2:32 PM, Infection Preventionist (IP) E stated, When a resident has a wound it should have a culture and sensitivity done because it tells you what is growing (referring to bacteria) and what it is susceptible to so the right antibiotic can be ordered. Otherwise, the antibiotic will not be effective, or a superinfection could grow. The facility uses McGeer's Criteria before an antibiotic is ordered. Technically, the facility should be trying to get a culture and sensitivity. I must get an order from the provider for a culture and antibiotic. IP E reviewed R45's medical records including Progress Notes, stating, (Medical Director (MD) EEE) wrote (R45) had a dirty wound. I do not know why the doctor put her on antibiotics. He looked at it the same day it happened. I do not know if he followed McGeer's Criteria. IP E reviewed R45's vital signs dated 10/23/2023 at 06:45 (AM) that reported a temperature of 98.0 degrees F (Fahrenheit) which was within normal limits for the resident. It was noted, no temperature readings were taken between 10/23/2023 and 11/23/2023. IP E stated, (R45) did not have a McGeer's Criteria Infection Assessment Form or an SBAR (Situation, Background, Assessment, Recommendation; used to facilitate prompt and appropriate communication) when placed on the antibiotic) completed when an antibiotic was ordered for her. During an interview on 12/7/2023 at 10:47 AM, MD EEE stated, I follow McGeer's guidelines for antibiotic use. (R45) did not have a cut with sharp edges. There was serosanguineous drainage (a normal thin serum, often slightly yellow fluid that's mostly water, with a light pink tinge drainage of fluid from a wound). Residents have germs on their skin in a place like this. That is why I ordered the antibiotic. During an interview on 12/7/2023 at 4:10 PM Unit Manager/Licensed Practical Nurse (UM/LPN) H stated, I am the Unit Manager for (R45). I have trained nurses on how and why to use McGeer's Criteria for antibiotic use. The medical director has also been told how to use McGeer's when ordering antibiotics. I do not know why an antibiotic was ordered for (R45) on the same day she got a skin tear. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R45's Progress Notes reported the resident remained on antibiotics on 10/24/2023 03:35 (AM), 10/24/2023 14:48 (2:48 PM), 10/25/2023 15:30 (1:30 PM), 10/26/2023 1:11 (AM), 10/26/2023 18:30 (6:30 PM), 10/26/2023 22:42 (10:42 PM), 10/28/2023 01:39 (AM), 10/30/2023 03:13 (AM), and 10/30/2023 14:24 (2:24 PM). Review of R45's laboratory results revealed no wound or other source of infection cultures.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47659 Based on interview and record review, the facility failed to ensure residents were screened for eligibility to receive pneumococcal and influenza vaccinations and receive vaccination if eligible for 3 (Resident #19, #53 and #59) of 5 residents reviewed for vaccinations, resulting in the potential of acquiring, transmitting, or experiencing complications from pneumococcal pneumonia and/or influenza. Findings include: Resident #19 Review of an Admission Record revealed Resident #19, was originally admitted to the facility on [DATE] with pertinent diagnoses which included moderate protein calorie malnutrition and muscle weakness. Review of Resident #19's Immunization Record on 12/11/23 revealed that Resident #19 was noted to have received Pneumovax dose 1 on 8/13/2009 as a historical vaccine, and Pneumovax dose #2 on 10/26/16 as a historical vaccine. During an interview on 12/5/23 at 2:30 PM with Director of Nursing (DON) B and Infection Preventionist (IP) E, DON B reported that Resident #19 had already received two doses of the pneumococcal series, so he was not due for any further pneumococcal vaccines. In a follow up interview on 12/06/23 at 9:31 AM, IP E reported that the facility was following current Center for Disease Control (CDC) guidelines for all immunizations. IP E reported that Resident #19 had received PPSV23 (pneumovax) pneumococcal vaccine in 2009, and the PCV13 (Prevnar 13) in 2016. This surveyor and IP E reviewed the current CDC vaccination recommendations together, and IP E reported that based on the current CDC guidance, it was recommended that Resident #19 receive 1 dose of the PCV20 or PPSV23 after 10/2021. IP E reported that he was not aware of this CDC guidance prior to the interview, and that the facility missed screening Resident #19 for pneumococcal vaccine eligibility and offering the vaccination. Resident #53 Review of an Admission Record revealed Resident #53, was originally admitted to the facility on [DATE] with pertinent diagnoses which included muscle weakness and difficulty in walking. Review of Resident #53's Immunization Record on 12/11/23 revealed that Resident #53 had last received an influenza vaccine on 10/5/22, and had received Pnuemovax dose 1 on 11/12/2014 as a historical vaccine, and Pneumovax dose 2 on 5/11/2015. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/5/23 at 2:30 PM with Director of Nursing (DON) B and Infection Preventionist (IP) E, DON B reported that Resident #53 had already received two doses of the Pneumococcal series, so she was not due for any further pneumococcal vaccines. IP E and DON B reported that Resident #53's guardian had given consent for Resident #53 to receive the influenza vaccine on 10/18/23, and they did not know why the influenza vaccine had not been administered. In a follow up interview on 12/06/23 at 9:31 AM, IP E reported that Resident #53 had received PPSV23 (pneumovax) pneumococcal vaccine in 2014, and the PCV13 (Prevnar 13) in 2015. This surveyor and IP E reviewed the current CDC vaccination recommendations together, and IP E reported that based on the current CDC guidance, it was recommended that Resident #53 receive a dose of the PCV20 after 5/2020, and that the facility missed screening Resident #53 for pneumococcal vaccine eligibility and offering the vaccination. Resident #59 Review of an Admission Record revealed Resident #59, was originally admitted to the facility on [DATE] with pertinent diagnoses which included cerebral palsy. Review of Resident #59's Immunization Record on 12/11/23 revealed that Resident #59 had last received an influenza vaccine on 11/25/22. During an interview on 12/5/23 at 2:30 PM with Director of Nursing (DON) B and Infection Preventionist (IP) E, IP E reported that Resident #59's guardian gave consent for Resident #59 to receive the influenza vaccination on 10/18/23. DON B reported that Resident #59's guardian wanted to wait for the facility to administer the vaccine due to Resident #59's recent illness. In an interview on 12/06/23 at 2:52 PM, Family Member (FM) LLL reported that they had expected that the influenza vaccine would be administered after the consent was signed, and that they had not made any requests to delay administering the influenza vaccine. FM LLL reported that they were unaware that Resident #59 had not received an influenza vaccine yet. Review of the Centers for Disease Control and Prevention (CDC) Pneumococcal Vaccine Recommendations, page dated 2/13/23, revealed .CDC recommends routine administration of pneumococcal conjugate vaccine (PCV15 or PCV20) for all adults [AGE] years or older who have never received any pneumococcal conjugate vaccine or whose previous vaccination history is unknown .If PCV15 is used, this should be followed by a dose of PPSV23 one year later. The minimum interval is 8 weeks and can be considered in adults with an immunocompromising condition, cochlear implant, or cerebrospinal fluid leak .If PCV20 is used, a dose of PPSV23 is NOT indicated .Retrieved from https://www.cdc.gov/vaccines/vpd/pneumo/hcp/recommendations.html. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Centers for Disease Control and Prevention (CDC) Morbidity and Mortality Weekly Report (MMWR), Vol. 71 No. 4, dated 1/28/22, revealed .In 2021, 20-valent pneumococcal conjugate vaccine (PCV) (PCV20) .and 15-valent PCV (PCV15) .were licensed by the Food and Drug Administration for adults aged ([AGE] years and older), based on studies that compared antibody responses to PCV20 and PCV15 with those to 13-valent PCV (PCV13) .Antibody responses to two additional serotypes included in PCV15 were compared to corresponding responses after PCV13 vaccination, and antibody responses to seven additional serotypes included in PCV20 were compared with those to the 23-valent pneumococcal polysaccharide vaccine (PPSV23) .On October 20, 2021, the Advisory Committee on Immunization Practices (ACIP) recommended use of either PCV20 alone or PCV15 in series with PPSV23 for all adults aged ([AGE] years and older), and for adults aged 19-[AGE] years with certain underlying medical conditions or other risk factors who have not previously received a PCV or whose previous vaccination history is unknown .Use of PCV20 alone or PCV15 in series with PPSV23 is expected to reduce pneumococcal disease incidence in adults aged ([AGE] years and older) and in those aged 19-[AGE] years with certain underlying conditions. Findings from studies suggested that the immunogenicity and safety of PCV20 alone or PCV15 in series with PPSV23 were comparable to PCV13 alone or PCV13 in series with PPSV23. Cost-effectiveness studies demonstrated that use of PCV20 alone or PCV15 in series with PPSV23 for adults at age [AGE] years was cost-saving. The new policy simplifies adult pneumococcal vaccine recommendations .and is expected to improve vaccine coverage among adults and prevent more pneumococcal disease . Retrieved from https://www.cdc.gov/mmwr/volumes/71/wr/pdfs/mm7104a1-H.pdf.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47659 Based on interview and record review, the facility failed to ensure COVID-19 immunization were offered to 2 (Resident #53 and #59) out of 5 residents, reviewed for COVID-19 immunizations, resulting in the increased likelihood of severe infection and complications/death related to COVID-19. Findings include: Resident #53 Review of an Admission Record revealed Resident #53, was originally admitted to the facility on [DATE] with pertinent diagnoses which included muscle weakness and difficulty in walking. Review of Resident #53's Immunization Record on 12/11/23 revealed that Resident #53 had last received SARS-COV-2 (Covid-19) Pfizer bivalent booster vaccine on 10/5/22. During an interview on 12/5/23 at 2:30 PM with Infection Preventionist (IP) E reported that Resident #53's guardian had given consent for Resident #53 to receive a Covid-19 vaccine on 10/18/23, and he did not know why the vaccine had not been administered. IP E reported that it had just been missed. Resident #59 Review of an Admission Record revealed Resident #59, was originally admitted to the facility on [DATE] with pertinent diagnoses which included cerebral palsy. Review of Resident #59's Immunization Record on 12/11/23 revealed that Resident #59 had last received SARS-COV-2 (Covid-19) Moderna bivalent booster vaccine on 9/6/22. During an interview on 12/5/23 at 2:30 PM with Director of Nursing (DON) B and Infection Preventionist (IP) E, IP E reported that Resident #59's guardian gave consent for Resident #59 to receive the Covid-19 vaccination on 10/18/23. DON B reported that Resident #59's guardian wanted to wait for the facility to administer the vaccine due to Resident #59's recent illness. In an interview on 12/06/23 at 2:52 PM, Family Member (FM) LLL reported that they had expected that the Covid-19 vaccine would be administered after the consent was signed, and that they had not made any requests to delay administering the Covid-19 vaccine. FM LLL reported that they were unaware that Resident #59 had not received an Covid-19 vaccine yet.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47955 Based on interview and record review, the facility failed to ensure Certified Nurse Aides (CNA's) completed the required 12 hours of training to ensure continued competence in 1 of 5 CNA's reviewed for competency, resulting in the potential for a decrease in resident safety. Findings include: Review of Facility assessment dated [DATE], revealed . all education is prepared by (facility name) for quality consistency and adherence to standards of practice across all sites .Training includes: communication, resident rights, abuse/neglect/exploitation, infection control, culture change, required standard training, resident change in conditions, cultural competency . Review of employee file for CNA V revealed a hire date of 6/22/22. Review of Training Course Assignment for CNA V revealed all annually required in-services were assigned and all but one was listed as incomplete or not attempted. During an interview on 12/11/23 at 12:18 PM., HR Director (HRD) YY reported that CNAs are required to complete in-services annually. HRD YY reported that in-services are assigned by both the HR director and by a corporate individual. HRD YY reported that a corporate individual would assign annual required in-services to CNAs on their work anniversary date and those assigned were sufficient to meet the required 12 hours per year. HRD YY reported that CNAs should complete assigned in-services within 30 days of assignment. Review of Staff development annual planning calendar dated 2023 revealed .the following courses would be auto assigned to employees on their work anniversaries, code of conduct, HIPPA, TIPS. QAPI, resident rights, communication, dementia, survey preparedness, infection control, antibiotic stewardship, abuse prevention, abuse, neglect and exploitation, cyber security, Life Care 401k, respect in the workplace, psychosocial needs of the resident, person-centered admission, trauma informed care, and drug division . During an interview on 12/11/23 at 11:49 AM., Staff Development Coordinator (SDC) D reported that staff training was coordinated between human resources and corporate. SDC D reported that she did not have anything to do with the online in-service program. SDC D reported that the annual assigned in-services met the 12 hours needed for certification renewal for CNAs. During an interview on 12/11/23 at 12:38 PM., HDR YY reported that she would get an email monthly that included a list of employees that were overdue on their required in-services. HRD YY reported that she was the only person who received emails regarding overdue employee in-services and that she relied on the monthly communication to keep track of overdue employee in-services. HRD YY reported there was a report that could be run regarding overdue employee in-services and that she did not have any kind of tracking system for assigned or completed in-services. HRD YY reported monitoring of in-service completion was a dual role by human resources and staff development coordinator. (continued on next page)

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Facility assessment dated [DATE], revealed . staff educator/development-Employee Health . This position is an R.N whose responsibilities include the planning, development, and coordination of new nurse/CENA orientation. Also, the organization, evaluation, tracking and in-services of mandatory education and competencies of the staff . Review of facility policy, Education and Training Requirements with a revision date of 9/21/23 revealed .the facility will maintain an effective in-service and orientation program for all associates . The Staff Development Coordinator or designed plans and directs an effective orientation, training, and evaluation program . The training program includes orientation for new staff and ins-service education for staff .The facility will need to ensure staff are trained to be able to interact in a manner that enhances the resident's quality of life and quality of care . training requirements should be met prior .providing services to residents, annually, and as needed .