STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165198	A. Building B. Wing	12/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Iowa City Rehab & Health Care	3661 Rochester Avenue Iowa City, IA 52245

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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 - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 45338 Based on observation, interview, record review, and facility policy review, the facility failed to ensure residents had been treated in a dignified manner for three of five residents reviewed for dignity (Resident #4, #11, and #16) and additional unidentified residents. The facility reported a census of 53 residents. Findings Include: 1. Review of a Facility Reported Incident documentation for an event dated 10/21/22 revealed the following: A Potential Witness/Statement dated 10/21/22 documented by Staff D, former Director of Nursing (DON), documented, 10/21/22, Resident #4, [Date of Birth Redacted] came into office crying. Resident stated-Staff I, Certified Nursing Assistant (CNA) is very mean & I don't like her. She takes my stuff away all the time. She took my chocolate & chips, she said I was too fat & I didn't need them. She calls me & my roommate fatso all the time. She is not a nice person. Review of a 5 day Investigation Summary for Resident #4 documented the following about an incident which had occurred on 10/21/22: a. Description of Incident: Resident #4 reported to Staff D that Staff I, CNA, is mean and she does not like me, takes my chocolate and my chips and calls me and my roommate fat. b. Facility Investigative Findings: interview with roommate states that she has not called me fat, but states I eat to much. Other residents had no concerns. c. Corrective Actions/Actions to be taken: CNA will be provided Customer Service Education prior to returning to work. Review of census documentation for Resident #4 and Resident #11 revealed the residents had been roommates at the time of the Facility Reported Incident. The Quarterly Minimum Data Set (MDS) Assessment for Resident #4 dated 11/30/22 lacked assessment of the resident's cognition. (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 - Some	The Significant Change MDS Assessment 11/17/22 for Resident #11 lacked assessment of the resident's cognition. On 11/21/22 at 9:59 PM, Resident #4 observed in their room in a wheelchair, and explained the following in regard to Staff I: Per Resident #4, Staff I had taken a picture of her (the resident), and the resident had told a previous Administrator. Resident #4 explained they ate what they wanted to eat. Per Resident #4, Staff I picked on her and her roommate. Resident #4 explained she had said to take that picture off your phone. Resident #4 explained it had made her feel horrible. Per Resident #4, the staff member had said, look, and shoved the picture in their face and said this is you. During the interview, Resident #4 started to cry and explained she did not know why the staff had done it, Resident #4 explained she tried to take care of herself in the facility, and explained Staff I, CNA had been the only person with whom she had not gotten along. On 11/22/22 at 1:09 PM, Staff H, Certified Medication Aide (CMA) explained the following in regard to Staff I, CNA: Per Staff H, she did not like Staff I's approach all around. Staff H explained one time she had been doing meds, and she (Staff H) had told a resident to turn on the call light if they needed anything. Per Staff H, a family member assisted with the resident's cares. Staff H explained Staff I had come and yelled at her that the call light had been on. Staff H explained they had asked Staff I if they (Staff I) had gone and asked the resident about the call light on, and this had not happened. Staff H went and answered the call light, and when she had come out Staff H explained Staff I had started in. Staff H explained she had told Staff I if they had responded, Staff I would have known the call light had been bumped. Per Staff H, there had been no reason for Staff I to have feelings about the call light having been on. Staff H explained she had voiced her concerns before. Staff H explained even if the resident had been independent and turned their light on, Staff I would get hateful as she had been asked to do something. Per Staff H, Staff I would say something like, you're independent you can do it to a resident. On 11/22/22 at approximately 1:45 PM, Staff K, CNA explained the following in regard to Staff I: Per Staff K, Staff I would joke with the residents. Staff K provided an example when the residents did not want to shower. Staff K explained Staff I would say you're kind of stinky you need to go shower. Per Staff K, some of the residents took it in a bad manner. Staff K explained she believed Staff I had done it with everyone. On 11/22/22 at 2:06 PM, Staff J, CNA, had been queried about concerns with staff treatment to residents. Staff J explained a lot of the staff were too comfortable with a lot of the residents, overshared their personal life, gave out their cell phone numbers, and further explained there had been some things residents had known about that they should not, for example information about compensation and staff contracts. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/28/22 at 2:05 PM, when queried about concerns with staff treatment of residents, Staff P, Dietary Manager, acknowledged a concern with the way staff talked and with the body language by staff. Staff P explained staff said things to them (residents) like you ain't getting that because we are short staffed and they are the only aide on the floor. Staff P acknowledged residents did not need to hear that. Per Staff P, staff were not quiet about it and everyone was going to hear about it. Per Staff P, with the way that some staff talked and approached residents they did not have a bedside manner. When queried as to who they had been referring to, Staff P explained this had occurred with a CNA from an Agency. Staff P had been queried how residents reacted, and explained they almost fed into it talking about the facility. Staff P explained he had brought up things to the previous Administrator. On 12/6/22 at 1:00 PM, Staff N, Administrator explained on a supervisory level, she had not been made aware of concerns with Staff D and the residents. Staff N explained the following about when the resident used the call light: Staff would knock on the door and ask how can we help you. Staff would also evaluate the residents needs. If they could not help the resident, they would say let me get the nurse or aide and explained they would get right back to them. The example of joking that staff reported had been shared with Staff N. Staff N acknowledged it would not be appropriate to joke with the residents as it could be taken in the wrong way. The reported concern with staff having been too comfortable with residents had been shared with Staff N. Staff N reported they had encouraged staff not to share that, and were posting a sign to explain things that were not acceptable. Staff N explained if staff were the only aide, they should say they were not able to do (something) right at the moment and if they hang tight, then staff could get (need) for (resident). Staff N further explained staff were encouraged to make Department Heads assist if they were short staffed to help with the shortness. Staff N explained taking photos of resident had not come up. The Facility Policy titled Resident Rights & Responsibilities dated 2/15 documented, The facility strives to assure that each resident/patient has a dignified existence, self-determination, and communication with, and access to, persons and services inside and outside the center. 35434 2. The Minimum Data Set (MDS) Assessment Tool, dated 10/12/22, listed diagnoses for Resident #16 which included diabetes, dysuria (difficulty or painful urination), and urinary retention. The MDS documented the resident required limited assistance of 1 staff for toilet use and personal hygiene and stated the resident was occasionally incontinent of urine and frequently incontinent of bowel. The MDS section related to cognition was incomplete. During an interview on 11/22/22 at 1:18 p.m., Staff L Certified Nursing Assistant (CNA) stated that Resident #16 had an urge where he stated that he had to urinate all the time. Staff L stated he felt like staff were too harsh with him, telling him to stop saying this. He stated the worst incident was when Staff B, Certified Medication Aide (CMA) told the resident to shut up. He stated when staff said things like this, it affected the resident and Staff L stated he needed to give him some prn (as needed) hugs. Staff L stated after this occurred with Staff B, he informed Staff A Licensed Practical Nurse (LPN) and Staff A told Staff B not to do this. Staff L stated he heard from other staff members that Staff B did not have a good bedside manner. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Care Plan entries, dated 4/21/22, stated the resident had a behavior problem related to anxiety and attention seeking behavior and directed staff to provide the opportunity for positive interaction and attention and to stop and talk with him/her as passing by. During an interview on 11/28/22 at 1:45 p.m., Resident #16 stated a female staff member told him to shut up and stated other staff told him he didn't count. He stated when this happened it made him feel not good. During an interview on 12/6/22 at 12:19 p.m., the Director of Nursing (DON) stated she expected staff to be nice to the residents and help them with what they needed. During an interview on 12/6/22 at 12:42 p.m., Staff N, Administrator stated staff should treat residents like this was their home and with dignity and respect.

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. 45338 Based on record review, staff interviews, and facility policy review the facility failed to ensure the deposit of monthly funds into the resident's trust account for a resident with a primary payer source of Medicaid for one of one resident reviewed for resident funds. The facility reported a census of 53 residents. Findings Include: The Minimum Data Set (MDS) for Resident #6 dated 8/17/22 lacked assessment of the resident's cognition. Review of the Resident Fund Management Service (RFMS) Resident Statement Landscape revealed Resident #6 had an account opened on 10/17/22, and documented the resident's allowance of $50.00. During an interview on 11/17/22 at 2:28 p.m., Resident #6 stated he did not have his $30 from Social Security and he did not know why. On 11/29/22 at 12:36 PM, review of the RFMS log revealed $50.00 had been deposited on 10/19/22, and $25.00 had been deducted on 10/21/22. An entry dated 11/01/22 documented the description, interest paid. No entries had been present on the log following 11/01/22. On 11/29/22 at 11:28 AM, Staff T, Business Office Manager (BOM) had been queried about Resident #6's trust fund deposits. Staff T explained they would need to look into the situation further. On 11/29/22 at 2:19 PM, Staff N, Administrator explained the resident had a payee. Per Staff N, the payee would send the monthly check, and they were waiting on a new check to come from the payee. Staff N further explained a regular payment schedule had not been set up. When queried as to what they would do in that situation, Staff N explained the facility could reach out to the payee and see where the check was. Staff N acknowledged Resident #6 had a trust account, and the facility needed to call the payee and see where the resident's check had been. When queried as to the general process, Staff N further explained they would try to follow up within that month, and if they had not received the check in the first week they would try to call by the second week to see where it had been. On 11/29/22 at 2:30 PM, Staff T explained the resident had a payee and she had tried to contact the payee. Per Staff T, if there had been an account, then normally a check would be sent for $50.00 to RFMS, and the facility would give cash once it had been deposited into the account. Per Staff T, she had been unaware the resident had a payee until today (11/29/22), and acknowledged it had been the first time she had contacted the payee. The Facility Policy titled, Resident Trust Fund dated 2/17 and revised 11/21 documented, The Administrator is responsible to ensure the Resident Trust Account is always in perpetual balance and reconciled.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 35434 Based on clinical record record review, staff interviews, resident interview, and policy review, the facility failed to ensure 3 of 5 residents reviewed for abuse were free from verbal abuse and/or neglect (Residents #3, #24, and #25) and failed to keep residents free of physical abuse related to a resident to resident altercation for 2 of 2 residents reviewed for a resident to resident altercation (Residents #27 and #30). The facility reported a census of 53 residents. Findings Include: 1. The Minimum Data Set (MDS) Assessment Tool, dated 10/22/22, listed diagnoses for Resident #3 which included cancer, non-Alzheimer's dementia, and muscle weakness. The MDS documented the resident required limited assistance of 1 staff for toileting assistance and was occasionally incontinent of urine and always incontinent of bowel. The MDS Section C Cognitive Patterns was incomplete. 11/21/19 Care Plan entries stated the resident had a non-pressure radiation burn to the left of his anal area and directed staff to keep skin clean an dry. A 9/6/22 Care Plan entry stated the resident had incontinence of the bowel and required assistance with toileting. The entry directed staff to check the resident with rounding, wash, rinse, and dry the perineum, and change clothing as needed after incontinence episodes. During an interview on 11/22/22 at 1:18 p.m., Staff L Certified Nursing Assistant (CNA) stated some staff had qualms with assisting Resident #3. He stated at the Nursing Station, staff stated that they did not want to assist him and had the new CNA's complete the task. During an interview on 11/22/22 at 1:40 p.m., Staff K, CNA stated she never saw staff in Resident #3's room. She stated she did not see staff go into his room to care for him and stated they did not want to go into his room due to his condition. She stated he was incontinent of bowel and there was often fecal material on the floor. She stated he tried to clean himself up but self-isolated because he was incontinent of bowel. She stated one day she went into care for him and his pants were so soiled it looked like staff had not changed him for a week. She stated his pants were so soiled she had to ask the nurse if she could throw them away. She stated she wanted to throw away his shoes but he didn't have another pair. She stated if staff approached him in a kind way, he would agree to a shower or getting cleaned up. During an interview on 11/28/22 at 8:44 a.m., Staff F, Licensed Practical Nurse (LPN) stated the CNA's would not enter Resident #3's room due to him being incontinent of bowel and there being fecal material all over the room. She stated when she helped him, there was dried on fecal material present, like it had been there a while. A 10/10/2022 Provider Progress Note stated the resident had difficulty managing his loose stools and was involuntary at times. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An 11/4/22 Health Status Note stated fecal matter got into the resident's wound due to the location on the buttocks. 2. The MDS assessment tool, dated 8/16/22, listed diagnoses for Resident #24 which included cerebrovascular accident(stroke), anxiety, and depression. The MDS listed the resident's Brief Interview for Mental Status (BIMS) score as 12 out of 15, indicating moderately impaired cognition. An 11/21/22 Behavior Note stated the resident was verbally abusive toward other residents and staff and called staff a b*****. The note stated staff redirected the resident to exit the dining room and the resident refused. The note stated other staff were asked to ignore the resident's behavior. During an interview on 11/28/22 at 8:44 a.m., Staff F stated on 11/21/22 Resident #24 called Staff M, Dietary Aide a b****. She stated Resident #24 and Staff M were yelling back and forth and Staff M then called Resident #24 a b****. She stated Staff M then called her (Staff F) a dumb b****. She stated she told Staff N, Administrator and Staff N stated she would do something but Staff M continued to work throughout the weekend. She stated she spoke to Staff P, Dietary Manager and he did not know anything about the situation. A Care Plan entry, dated 3/28/22 stated the resident had a behavior problem and would yell and threaten staff. A Care Plan entry, dated 3/29/22, directed staff to provide opportunity for positive interaction and to stop and talk with him when passing by. 3. The MDS Assessment Tool, dated 9/16/22, listed diagnoses for Resident #25 which included heart failure, diabetes, and muscle weakness. The MDS documented the resident required limited assistance of 1 staff for bed mobility, transfers, toilet use, and personal hygiene, and extensive assistance of 1 staff for dressing and bathing, also the resident had a non-surgical dressing. Section C of the MDS Cognitive Patterns was incomplete. During an interview on 11/28/22 at 8:44 a.m., Staff F, LPN stated Resident #25 had a dressing related to his gall bladder and when she went in to change it, staff had not changed it for 3 days. The November 2022 Treatment Administration Record (TAR) listed a 5/19/22 order to change the dressing to the right lower abdomen daily and prn (as needed) and to cover with ABD (abdominal dressing) and secure with transparent dressing or tape one time a day related to calculus of the gallbladder (gallbladder stones) with acute and chronic cholecystitis (inflammation of the gall bladder). The following entries were blank and lacked staff initials to indicate the completion of the dressing change: 11/3/22 and 11/5/22. The November 2022 TAR listed a 11/9/22 order to cleanse the right lower quadrant with soap and water or wound cleanser and gauze and cover with silicone border dressing daily and cover with ABD and secure with tape. The following entries were blank and lacked staff initials to indicate the completion of the dressing change: 11/11/22, 11/12/22, 11/17/22, 11/18/22, and 11/26/22. Care Plan entries, dated 9/2/21, stated Resident #25 had actual impairment to the skin related to a previous drain site on his abdomen and stated the resident had a treatment in place. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/28/22 at 11:44 a.m., Resident #25 stated staff sometimes did not change his abdominal dressing daily and said he had gone 3 days without it being done. He stated when that happened the area got yucky. During an interview on 12/6/22 at 12:19 p.m., the Director of Nursing (DON) stated she expected staff to be nice to the residents and help them with what they needed. She stated Resident #3 required assistance with perineal care and toileting and stated the resident did refuse care assistance but staff should reapproach him repeatedly. She stated if staff had concerns with the resident not receiving cares they should report it to her. She stated staff should complete dressing changes for Resident #25 at least every day. During an interview on 12/6/22 at 12:42 p.m., Staff N Administrator stated she expected staff to treat residents like this was their home and with dignity and respect and stated the situation regarding Resident #3 not receiving cares was concerning. She stated the facility suspended Staff M on 11/28/22. 45338 4. Resident #27 and Resident #30: The Minimum Data Set (MDS) Assessment for Resident #24 dated 11/12/22 revealed Resident #24 scored 11 out of 15 on a BIMS exam, which indicated moderately impaired cognition. Per this assessment, resident #24 experienced hallucinations, delusions, and verbal behavioral symptoms towards others. The Care Plan dated 3/28/22 documented, Resident #24 has a behavior problem related to (r/t) sharing his room and bathroom. Will yell and threaten staff when he doesn't get something he wants or wants to do. Refuses medications and cares at times, refuses weights, refuses vital signs, refuses showers. The Minimum Data Set (MDS) Assessment for Resident #30 dated 10/22/22 documented the resident scored 10 out of 15 on a BIMS exam, which indicated moderately impaired cognition. Review of the Behavior Note dated 11/30/22 at 6:47 AM, present in Resident #24's record documented, a housekeeping alerted nurse that resident was in dining room fighting another resident (Resident #30). Upon assessment resident was standing up swinging at the other resident (Resident #30) and yelling at him. Resident #30 was walking towards Resident #24 attempting to swing at him. Resident screaming, I don't give a f**k, I will do it again. Residents separated and redirected to each others rooms. Review of the Provider Progress Note for Resident #30 dated 11/30/22 at 2:45 PM documented, Patient (Pt.) seen today for follow-up (f/u) after altercation with other resident in facility this morning. Pt. was accosted by another resident, unprovoked per resident. Pt. states he was slapped on his right forehead by another resident x 1. Denies any current pain. Pt states he clocked him back. No staff witnessed Pt hitting other resident, and other resident does not recall being hit or the altercation in general. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Progress Note for Resident #24 dated 12/1/22 at 7:27 AM, documented, Resident yelling, help me in his room. When entering resident's room, the resident was standing next to bedside near a wheelchair yelling out. Resident asked what he needed help with and could not verbalize a response appropriately. Resident then got into wheelchair and proceeded to come out of his room towards the dining room telling staff, get out of my way. Resident #30 was sitting in dining room so staff barricaded off dining area so this resident could not gain access to Resident #30. Resident yelling at staff, get the f**k out of my way. Resident standing up out of wheelchair attempting to swing at staff. Resident yelling out, help me. Resident assisted into wheelchair. Resident kept away from other resident (Resident #30) that he was threatening to hit again. 911 called and asked to come out to the facility to assist with physical aggression of resident. Per Emergency Medical Technicians (EMT's) and police, the resident unable to be taken to hospital due to cognitive status and no medical condition needing attention. On 12/1/22 at 12:33 PM, Staff U, Certified Medication Aide (CMA) had been queried if anyone had been on one to one, and acknowledged Resident #30 was on one to one and had been for a few days related to an incident yesterday and today. On 12/5/22 at 8:00 AM, Staff Y, Housekeeper, had been queried about any incidents which involved Resident #24. Staff Y reported last week Resident #24 and Resident #30 had a verbal altercation in the dining room. Per Staff Y, he had not seen a physical altercation, but had seen a verbal altercation. Staff Y reported he got the nurses. Per Staff Y, he had been in the South dining room mopping and Resident #24 had been doing a lap in the morning in their wheelchair. Staff Y explained Resident #30 had said something to Resident #24 that he shouldn't be in there, and there had been a verbal back and forth. Staff Y had been unsure if there had been previous altercations between Resident #24 and Resident #30. On 12/6/22 at 12:49 PM, Staff N, Administrator, explained that Resident #24 and Resident #30 had not been getting along, and there had been a few incidents where there had been outbursts, and a couple physical incidents as well. The Administrator explained they'd been in the dining room when Resident #24 and Resident #30 yelling to one another. The Administrator explained that Resident #24 and Resident #30 had police reports for each one of those incidents noted. When queried if there had been actual physical contact, Staff N explained Resident #24 had hit Resident #30. Review of a 5 Day Investigation Summary for a resident to resident altercation dated 11/30/22 documented, Facility Investigative Findings: Two residents were in the dining area and had a verbal exchange that resulted in Resident #24 with an open hand making contact with Resident #30 on the forehead. Upon interview, Resident #24 reported he doesn't like Resident #30 and he has no right to tell him what to do. Resident #30 confirmed that Resident #24 used an open hand and made contact with Resident #30's forehead. On 12/7/22 at 12/7/22, Resident #30 observed in their room sitting on their bed. Resident #30 acknowledged they had been involved in two physical altercations with Resident #24. Per Resident #30, the first time he (Resident #30) had been smacked across the face, and he did not do anything because staff told him not to do anything. The second time, identified by Resident #30 as the next day, the resident had been smacked upside the head, and per Resident #30, he had defended himself. Resident #30 acknowledged staff had been present both times. Resident #30 further explained he was not the kind of person who allowed people to smack him around. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Facility Policy titled Abuse Prevention Program & Reporting Policy dated 9/14 and revised 8/19 documented, The facility prevents the mistreatment, neglect, and abuse of residents/patients and misappropriation of resident/patient property by anyone including but not limited to: staff, family, or friends. Residents have the right to be free from verbal, sexual, and mental abuse, neglect, misappropriation of resident property, corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms.

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Iowa City Rehab & Health Care	3661 Rochester Avenue Iowa City, IA 52245

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 45338 Based on personnel file review, staff interviews, and facility policy review the facility failed to complete background checks prior to employment and failed to await the response for record check evaluations to indicate the employee could work at the facility prior to employment for two of five Contracted Direct Care Staff files reviewed for background checks (Staff W and Staff F) and also failed to ensure one of five staff members reviewed for Dependent Adult Abuse Training had current training (Staff A, Licensed Practical Nurse (LPN).The facility reported a census of 53 residents. Findings Include: 1. On 11/30/22 at approximately 3:00 PM, the personnel file for Staff W, Certified Nursing Assistant (CNA), revealed a contract between Staff W, referred to as a contractor, and the name of the facility and corporation effective 10/28/22 to 11/20/22. Review of the background check information for Staff W revealed the Single Contact License and Background Check (SING) had been run 10/28/22, and the results of a Record Check Evaluation dated 11/4/22 indicated the staff member may work. 2. On 11/30/22 at 3:08 PM, the personnel file for Staff F, Licensed Practical Nurse revealed a contract between Staff F, referred to as a contractor, and the name of the facility effective 10/31/22 to 12/1/22. Review of background check information for Staff F revealed the SING had been run 11/10/22, and the results of a Record Check Evaluation dated 11/17/22 indicated the staff member may work. On 12/5/22 at 1:45 PM, Staff O, Administrator from a sister facility, explained a background check should be completed upon hire, and acknowledged the staff should not be be placed on the schedule until after the Record Check Evaluation came back and the Department of Public Health and Human Services (Formerly DHS) had verified the person could work. 3. On 11/30/22, review of the personnel file for Staff A, LPN documented the employee had been hired 3/26/19. Review of the Dependent Adult Abuse (DAA) Training for Mandatory Reporters certificate present in Staff A's file revealed the training had been completed 12/28/16. The certificate documented the training met the 5 year training requirements. On 12/5/22 at 10:03 AM, Staff N, Administrator, provided a DAA training certificate for Staff A which revealed training completion on 12/3/22. On 12/05/22 at 1:43 PM, Staff O, Administrator from a sister facility, acknowledged DAA training was to be completed within six months of hire. When queried in regard to the frequency after this, Staff O explained they need to go check. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Facility Policy titled Abuse Prevention Program & Reporting Policy dated 9/14 and reviewed 8/19 documented, Screen all potential employees prior to hire for a history of abuse, neglect, or mistreating residents/patients, exploitation and/or misappropriation of resident property during the hiring process. Screening will consist of, but not be limited to: a. Inquiries into State licensing authorities. b. Inquiries into State nurse aide registry/Dependent adult/child abuse registry. c. Reference checks from previous and/or current employers. d. Criminal background checks. The policy also documented the following pertaining to Iowa: Each employee shall be required to complete two hours of training relating to the identification and reporting of Dependent Adult Abuse within six months of initial employment. Each employee shall complete at least two hours of additional Dependent Adult Abuse identification and reporting training every three years. The policy also documented, Mandatory Reporter Training completed prior to July 1, 2019 will still be valid for five years from the date of completion.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 35434 Based on clinical record record review, staff interview, resident interview, and policy review, the facility failed to report allegations of abuse to the State Survey Agency for 4 of 6 residents reviewed for abuse and neglect (Residents #3, #16, #24, and #25). The facility reported a census of 53 residents. Findings Include: 1. The Minimum Data Set (MDS) Assessment tool, dated 10/22/22, listed diagnoses for Resident #3 which included cancer, non-Alzheimer's dementia, and muscle weakness. The MDS documented the resident required limited assistance of 1 staff for toileting assistance and was occasionally incontinent of urine and always incontinent of bowel. The MDS Section C Cognitive Patterns was incomplete. 11/21/19 Care Plan entries stated the resident had a non-pressure radiation burn to the left of his anal area and directed staff to keep skin clean an dry. A 9/6/22 Care Plan entry stated the resident had incontinence of the bowel and required assistance with toileting. The entry directed staff to check the resident with rounding, wash, rinse, and dry the perineum, and change clothing as needed after incontinence episodes. During an interview on 11/22/22 at 1:18 p.m., Staff L, Certified Nursing Assistant (CNA) stated some staff had qualms with assisting Resident #3. He stated at the Nursing Station staff stated that they did not want to assist him and had the new CNA's complete the task. During an interview on 11/22/22 at 1:40 p.m., Staff K, CNA stated she never saw staff in Resident #3's room. She stated she did not see staff go into his room to care for him and stated they did not want to go into his room due to his condition. She stated he was incontinent of bowel and there was often fecal material on the floor. She stated he tried to clean himself up but self-isolated because he was incontinent of bowel. She stated one day she went into care for him and his pants were so soiled it looked like staff had not changed him for a week. She stated his pants were so soiled she had to ask the nurse if she could throw them away. She stated she wanted to throw away his shoes but he didn't have another pair. She stated if staff approached him in a kind way, he would agree to a shower or getting cleaned up. During an interview on 11/28/22 at 8:44 a.m., Staff F, Licensed Practical Nurse (LPN) stated the CNA's would not enter Resident #3's room due to him being incontinent of bowel and there being fecal material all over the room. She stated when she helped him, there was dried on fecal material present, like it had been there a while. A 10/10/2022 Provider Progress Note stated the resident had difficulty managing his loose stools and was involuntary at times. An 11/4/22 Health Status Note stated fecal matter got into the resident's wound due to the location on the buttocks. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. The MDS assessment tool, dated 8/16/22, listed diagnoses for Resident #24 which included cerebrovascular accident(stroke), anxiety, and depression. The MDS listed the resident's Brief Interview for Mental Status (BIMS) score as 12 out of 15, indicating moderately impaired cognition. An 11/21/22 Behavior Note stated the resident was verbally abusive toward other residents and staff and called staff a b*****. The note stated staff redirected the resident to exit the dining room and the resident refused. The note stated other staff were asked to ignore the resident's behavior. During an interview on 11/28/22 at 8:44 a.m., Staff F stated on 11/21/22 Resident #24 called Staff M, Dietary Aide a b****. She stated Resident #24 and Staff M were yelling back and forth and Staff M then called Resident #24 a b****. She stated Staff M then called her (Staff F) a dumb b****. She stated she told Staff N, Administrator and Staff N stated she would do something but Staff M continued to work throughout the weekend. She stated she spoke to Staff P, Dietary Manager and he did not know anything about the situation. A Care Plan entry, dated 3/28/22 stated the resident had a behavior problem and would yell and threaten staff. A Care Plan entry, dated 3/29/22, directed staff to provide opportunity for positive interaction and to stop and talk with him when passing by. 3. The MDS assessment tool, dated 9/16/22, listed diagnoses for Resident #25 which included heart failure, diabetes, and muscle weakness. The MDS documented the resident required limited assistance of 1 staff for bed mobility, transfers, toilet use, and personal hygiene, and extensive assistance of 1 staff for dressing and bathing. The MDS identified the resident had a non-surgical dressing. Section C of the MDS Cognitive Patterns was incomplete. During an interview on 11/28/22 at 8:44 a.m., Staff F stated Resident #25 had a dressing related to his gall bladder and when she went in to change it, staff had not changed it for 3 days. The November 2022 Treatment Administration Record (TAR) listed a 5/19/22 order to change the dressing to the right lower abdomen daily and prn (as needed) and to cover with ABD (abdominal dressing) and secure with transparent dressing or tape one time a day related to calculus of the gallbladder (gallbladder stones) with acute and chronic cholecystitis (inflammation of the gall bladder). The following entries were blank and lacked staff initials to indicate the completion of the dressing change: 11/3/22 and 11/5/22. The November 2022 TAR listed a 11/9/22 order to cleanse the right lower quadrant with soap and water or wound cleanser and gauze and cover with silicone border dressing daily and cover with ABD and secure with tape. The following entries were blank and lacked staff initials to indicate the completion of the dressing change: 11/11/22, 11/12/22, 11/17/22, 11/18/22, and 11/26/22. Care Plan entries, dated 9/2/21, stated Resident #25 had actual impairment to the skin related to a previous drain site on his abdomen and stated the resident had a treatment in place. During an interview on 11/28/22 at 11:44 a.m., Resident #25 stated staff sometimes did not change his abdominal dressing daily and said he had gone 3 days without it being done. He stated when that happened the area got yucky. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. The MDS Assessment Tool, dated 10/12/22, listed diagnoses for Resident #16 which included diabetes, dysuria(difficulty or painful urination), and urinary retention. The MDS stated the resident required limited assistance of 1 staff for toilet use and personal hygiene and stated the resident was occasionally incontinent of urine and frequently incontinent of bowel. The MDS section related to cognition was incomplete. During an interview on 11/22/22 at 1:18 p.m., Staff L, CNA stated that Resident #16 had an urge where he stated that he had to urinate all the time. Staff L stated he felt like staff were too harsh with him, telling him to stop saying this. He stated the worst incident was when Staff B, Certified Medication Aide (CMA) told the resident to shut up. He stated when staff said things like this it affected the resident and Staff L stated he needed to give him some prn(as needed) hugs. Staff L stated after this occurred with Staff B, he informed Staff A, LPN and Staff A told Staff B not to do this. Staff L stated he heard from other staff members that Staff B did not have a good bedside manner. Care Plan entries, dated 4/21/22, stated the resident had a behavior problem related to anxiety and attention seeking behavior and directed staff to provide the opportunity for positive interaction and attention and to stop and talk with him/her as passing by. During an interview on 11/28/22 at 1:45 p.m., Resident #16 stated a female staff member told him to shut up and stated other staff told him he didn't count. He stated when this happened it made him feel not good. The facility Abuse Prevention Program and Reporting Policy, reviewed 08/19, directed staff to immediately report alleged abuse or neglect to the Administrator and DON and stated the facility would report the incident immediately to the State Agency. During an interview on 12/6/22 at 12:19 p.m., the Director of Nursing (DON) stated stated she expected staff to be nice to the residents and help them with what they needed. She stated Resident #3 required assistance with perineal care and toileting and stated the resident did refuse care assistance but staff should re-approach him repeatedly. She stated if staff had concerns with the resident not receiving cares they should report it to her. She stated staff should complete dressing changes for Resident #25 at least every day. She stated if a staff member witnessed another staff member being unkind, they should write a statement and the facility would investigate. During an interview on 12/6/22 at 12:42 p.m., Staff N, Administrator stated staff should treat residents like this was their home and with dignity and respect. She was not aware of the situation regarding Resident #3 and stated this was concerning. She stated the facility suspended Staff M on 11/28/22. She stated she did not know about the situation with Staff M until 11/28/22 and stated staff should report this right away. She stated if she knew about the situation she would have suspended Staff M on the same day. She stated she also did not know about the situation with Staff B and stated staff should report such things to her and they would investigate and report to the State Survey Agency.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. 35434 Based on clinical record record review, staff interview, resident interview, and policy review, the facility failed to investigate an allegation of abuse and/or separate the alleged perpetrator from residents for 4 of 6 residents reviewed for abuse and neglect(Residents #3, #16, #24, and #25) The facility reported a census of 53 residents. Findings Include:: 1. The Minimum Data Set (MDS) Assessment Tool, dated 10/22/22, listed diagnoses for Resident #3 which included cancer, non-Alzheimer's dementia, and muscle weakness. The MDS documented the resident required limited assistance of 1 staff for toileting assistance and was occasionally incontinent of urine and always incontinent of bowel. The MDS Section C Cognitive Patterns was incomplete. 11/21/19 Care Plan entries stated the resident had a non-pressure radiation burn to the left of his anal area and directed staff to keep skin clean an dry. A 9/6/22 Care Plan entry stated the resident had incontinence of the bowel and required assistance with toileting. The entry directed staff to check the resident with rounding, wash, rinse, and dry the perineum, and change clothing as needed after incontinence episodes. During an interview on 11/22/22 at 1:18 p.m., Staff L Certified Nursing Assistant (CNA) stated some staff had qualms with assisting Resident #3. He stated at the Nursing Station staff stated that they did not want to assist him and had the new CNAs complete the task. During an interview on 11/22/22 at 1:40 p.m., Staff K, CNA stated she never saw staff in Resident #3's room. She stated she did not see staff go into his room to care for him and stated they did not want to go into his room due to his condition. She stated he was incontinent of bowel and there was often fecal material on the floor. She stated he tried to clean himself up but self-isolated because he was incontinent of bowel. She stated one day she went into care for him and his pants were so soiled it looked like staff had not changed him for a week. She stated his pants were so soiled she had to ask the nurse if she could throw them away. She stated she wanted to throw away his shoes but he didn't have another pair. She stated if staff approached him in a kind way, he would agree to a shower or getting cleaned up. During an interview on 11/28/22 at 8:44 a.m., Staff F, Licensed Practical Nurse (LPN) stated the CNA's would not enter Resident #3's room due to him being incontinent of bowel and there being fecal material all over the room. She stated when she helped him, there was dried on fecal material present, like it had been there a while. A 10/10/2022 Provider Progress Note stated the resident had difficulty managing his loose stools and was involuntary at times. An 11/4/22 Health Status Note stated fecal matter got into the resident's wound due to the location on the buttocks. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. The MDS Assessment Tool, dated 8/16/22, listed diagnoses for Resident #24 which included cerebrovascular accident(stroke), anxiety, and depression. The MDS listed the resident's Brief Interview for Mental Status (BIMS) score as 12 out of 15, indicating moderately impaired cognition. An 11/21/22 Behavior Note stated the resident was verbally abusive toward other residents and staff and called staff a b*****. The note stated staff redirected the resident to exit the dining room and the resident refused. The note stated other staff were asked to ignore the resident's behavior. During an interview on 11/28/22 at 8:44 a.m., Staff F stated on 11/21/22 Resident #24 called Staff M Dietary Aide a b****. She stated Resident #24 and Staff M were yelling back and forth and Staff M then called Resident #24 a b****. She stated Staff M then called her(Staff F) a dumb b****. She stated she told Staff N, Administrator and Staff N stated she would do something but Staff M continued to work throughout the weekend. She stated she spoke to Staff P, Dietary Manager and he did not know anything about the situation. A Care Plan entry, dated 3/28/22 stated the resident had a behavior problem and would yell and threaten staff. A Care Plan entry, dated 3/29/22, directed staff to provide opportunity for positive interaction and to stop and talk with him when passing by. 3. The MDS Assessment Tool, dated 9/16/22, listed diagnoses for Resident #25 which included heart failure, diabetes, and muscle weakness. The MDS documented the resident required limited assistance of 1 staff for bed mobility, transfers, toilet use, and personal hygiene, and extensive assistance of 1 staff for dressing and bathing. The MDS identified the resident had a non-surgical dressing. Section C of the MDS Cognitive Patterns was incomplete. During an interview on 11/28/22 at 8:44 a.m., Staff F, LPN stated Resident #25 had a dressing related to his gall bladder and when she went in to change it, staff had not changed it for 3 days. The November 2022 Treatment Administration Record (TAR) listed a 5/19/22 order to change the dressing to the right lower abdomen daily and prn (as needed) and to cover with ABD (abdominal dressing) and secure with transparent dressing or tape one time a day related to calculus of the gallbladder (gallbladder stones) with acute and chronic cholecystitis (inflammation of the gall bladder). The following entries were blank and lacked staff initials to indicate the completion of the dressing change: 11/3/22 and 11/5/22. The November 2022 TAR listed a 11/9/22 order to cleanse the right lower quadrant with soap and water or wound cleanser and gauze and cover with silicone border dressing daily and cover with ABD and secure with tape. The following entries were blank and lacked staff initials to indicate the completion of the dressing change: 11/11/22, 11/12/22, 11/17/22, 11/18/22, and 11/26/22. Care Plan entries, dated 9/2/21, stated Resident #25 had actual impairment to the skin related to a previous drain site on his abdomen and stated the resident had a treatment in place. During an interview on 11/28/22 at 11:44 a.m., Resident #25 stated staff sometimes did not change his abdominal dressing daily and said he had gone 3 days without it being done. He stated when that happened the area got yucky. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. The MDS Assessment Tool, dated 10/12/22, listed diagnoses for Resident #16 which included diabetes, dysuria(difficulty or painful urination), and urinary retention. The MDS documented the resident required limited assistance of 1 staff for toilet use and personal hygiene and stated the resident was occasionally incontinent of urine and frequently incontinent of bowel. The MDS section related to cognition was incomplete. During an interview on 11/22/22 at 1:18 p.m., Staff L, CNA stated that Resident #16 had an urge where he stated that he had to urinate all the time. Staff L stated he felt like staff were too harsh with him, telling him to stop saying this. He stated the worst incident was when Staff B, Certified Medication Aide (CMA) told the resident to shut up. He stated when staff said things like this it affected the resident and Staff L stated he needed to give him some prn(as needed) hugs. Staff L stated after this occurred with Staff B, he informed Staff A Licensed Practical Nurse (LPN) and Staff A told Staff B not to do this. Staff L stated he heard from other staff members that Staff B did not have a good bedside manner. Care Plan entries, dated 4/21/22, stated the resident had a behavior problem related to anxiety and attention seeking behavior and directed staff to provide the opportunity for positive interaction and attention and to stop and talk with him/her as passing by. During an interview on 11/28/22 at 1:45 p.m., Resident #16 stated a female staff member told him to shut up and stated other staff told him he didn't count. He stated when this happened it made him feel not good. The facility Abuse Prevention Program and Reporting Policy, reviewed 08/19, stated the facility would immediately separate the resident from an alleged perpetrator and conduct an investigation. During an interview on 12/6/22 at 12:19 p.m., the Director of Nursing (DON) stated she expected staff to be nice to the residents and help them with what they needed. She stated Resident #3 required assistance with perineal care and toileting and stated the resident did refuse care assistance but staff should re-approach him repeatedly. She stated if staff had concerns with the resident not receiving cares they should report it to her. She stated staff should complete dressing changes for Resident #25 at least every day. She stated if a staff member witnessed another staff member being unkind, they should write a statement and the facility would investigate. During an interview on 12/6/22 at 12:42 p.m., Staff N, Administrator stated stated staff should treat residents like this was their home and with dignity and respect. She was not aware of the situation regarding Resident #3 and stated this was concerning. She stated the facility suspended Staff M on 11/28/22. She stated she did not know about the situation with Staff M until 11/28/22 and stated staff should report this right away. She stated if she knew about the situation she would have suspended Staff M on the same day. She stated she also did not know about the situation with Staff B and stated staff should report such things to her and they would investigate and report to the State Survey Agency.

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy. 35434 Based on clinical record review, policy review, and staff interview, the facility failed to facilitate residents able to return to the facility after hospitalization s for 3 of 3 residents discharged (Resident #9, #22, and #23). The facility reported a census of 53 residents. Findings Include: 1. The Minimum Data Set (MDS) Assessment Tool, dated 10/19/22, documented the Resident #9 discharged to the hospital and his return was not anticipated. A 10/19/22 Provider Progress Note stated the resident requested to go to the hospital due to low oxygen saturation and not feeling well. A 10/21/22 Health Status Note stated the resident admitted to the hospital with a diagnosis of aspiration pneumonia. A 10/27/22 Health Status Note stated the facility called the hospital for an update and a Hospital Nurse stated the resident had COVID-19 and they would keep him in until his isolation period was completed on 10/29/22. Facility Progress Notes contained no further documentation regarding the resident including the resident's post-discharge status or information regarding the resident returning to the facility. 2. The MDS Assessment Tool, dated 10/27/22, documented Resident #22 discharged and his return was anticipated. The MDS lacked documentation of where the resident discharged to. A 10/27/22 Health Status Note stated the resident was sent to the hospital from a physician's appointment. Facility Progress Notes contained no further documentation regarding the resident including the resident's post-discharge status or information regarding the resident returning to the facility. 3. The MDS assessment tool, dated 10/29/22, documented Resident #23 discharged to the hospital and his return was not anticipated. A 10/29/22 3:54 a.m. Health Status Note stated restlessness continued. A 10/29/22 10:27 a.m. Health Status Note stated the facility received new orders to sen the resident to the emergency room for evaluation. Facility Progress Notes contained no further documentation regarding the resident in including the resident's post-discharge status or information regarding the resident returning to the facility. (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy Transfer/Discharge, dated 02/15, did not address resident readmission from a hospital stay. During a phone interview on 11/22/22 at 2:36 p.m., Staff Z, Hospital Social Work Department Supervisor stated she did not know specific names but stated staff at the facility told hospital staff they could not take residents back due to staffing issues. During an interview on 11/28/22 at 8:58 a.m., Staff F, Licensed Practical Nurse (LPN) stated that a resident's family member told her the resident could not return to the facility after being at the hospital because the facility did not have enough staff. During an interview on 12/6/22 at 12:42 p.m., Staff N, Administrator stated at the time of discharge for Resident #22 and #23, the facility did not accept residents back from the hospital due to staffing shortages. She stated at the beginning of November 2022 she received a call from the hospital asking what their discharge policy was. She stated before this, she did not know that the facility did not accept residents back and stated they have now changed this and were actively taking residents back. She stated the facility was the resident's home and they should be able to return.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. 45338 Based on clinical record review, staff interview, and facility policy review the facility failed to seek further guidance when blood sugar levels had been above the sliding scale range, failed to consistently obtain and monitor International Normalized Ratio (INR) laboratory values, failed to administer Morphine per physician order, and failed to obtain and have a resident utilize a chest physiotherapy device per physician order for five of nine residents reviewed for medications/orders (Residents #3, #13, #14, #15, and #27). Findings Include: 1. Review of the Minimum Data Set (MDS) Assessment for Resident #13 dated 10/11/22 revealed the resident's Brief Interview for Mental Status (BIMS) exam had not been assessed. Per this assessment, the resident had received anticoagulant medication for seven of the last seven days. The Care Plan dated 11/3/16 documented, Resident #13 utilized an Anticoagulant (Coumadin). The intervention dated 1/24/20 documented, International Normalized Ratio (INR) per the Medical Doctor (MD) order and call results to MD. The Physician Order dated 3/3/22 documented, Prothrombin Time (PT)/INR 3/9/2022. The Health Status Note dated 3/9/22 at 2:57 PM documented, PT = 26/8 and INR =2.6. New order to continue current dose of 6 milligrams (mg) daily and recheck PT/INR one week. The Physician Order dated 3/9/22 documented, PT/INR 03/16/2022. On 11/16/22 at 10:32 AM, PT/INR test results and physician recommendation for Coumadin dosing following the lab result on 3/16/22 had been requested from the facility via email. PT/INR laboratory test results provided by the facility lacked PT/INR laboratory results for March 2022 after the date of 3/9/22. Review of the Health Status Note dated 4/6/22 at 1:28 PM documented, This nurse received a call from [Name Redacted] with (Lab Company Name) stating that the resident had a critical lab of 5.1. Results provided to resident's Nurse. The Health Status Note dated 4/7/22 at 2:31 PM documented, On Wednesday 4/6 received message from the Director of Nursing (DON) that the DON had received message from Lab that the resident had Critical INR of 5.1. This writer called phone number for Dr. [Name Redacted] and received no answer and left a message stating that I was calling in reference to resident and told critical lab value and current dose of Coumadin and left call back phone number. This writer called Dr. [Name Redacted's] number 2 more times before end of shift with no response or call back and reported to oncoming Night Nurse. Will continue to monitor. The Health Status Note dated 4/7/22 at 3:15 PM documented, New Orders via Advanced Registered Nurse Practitioner (ARNP) [Name Redacted]: Hold Warfarin-today 4/7 INR on Friday 4/8. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Health Status Note dated 4/28/22 at 3:54 PM documented,Spoke with Dr. [Name Redacted] new Coumadin order received and recheck INR on Monday (It was noted Monday would have been 5/2/22). The Provider Progress Note dated 4/28/22 at 8:39 PM documented, in part, 1. Increase Warfarin to 7 mg PO (orally) Daily. 2. INR Friday 4/29/22. The Physician Order dated 4/28/22 documented, INR on 5/2/2022. This had been signed as completed on the resident's Treatment Administration Record (TAR). On 11/16/22 at 10:32 AM, PT/INR test results and physician recommendation for Coumadin dosing following the lab result on 4/29/22 and 5/2/22 had been requested from the facility via email. PT/INR laboratory test results provided by the facility lacked PT/INR laboratory results for 4/29/22 or 5/2/22. No Progress Notes had been observed in Resident #13's clinical record between 4/28/22 and 5/4/22. Review of the laboratory test results for INR, collection date 5/5/22 at 4:30 AM documented the resident's INR had been 3.7. Handwritten on the lab result was the following: Hold Coumadin dose on 5/6 decrease to 6.5 mg on 5/7 repeat INR on 5/11/22. On 11/16/22 at 10:32 AM, PT/INR test results and physician recommendation for Coumadin dosing following the lab result on 5/11/22 had been requested from the facility via email. PT/INR laboratory test results provided by the facility lacked PT/INR laboratory results for 5/11/22. The Health Status Note dated 5/13/22 at 4:03 PM documented, INR of 5.2 received from [Lab Company] at this time. New orders received from ARNP to hold 6.5 mg Coumadin dose until 05/16/22 and redraw on 05/16/22. The Medication Administration Record (MAR) updated and resident aware at this time. On 11/16/22 at 10:32 AM, PT/INR test results and physician recommendation for Coumadin dosing following the lab result on 5/16/22 had been requested from the facility via email. PT/INR laboratory test results provided by the facility lacked PT INR laboratory results for 5/16/22. The Health Status Note dated 5/17/22 at 4:44 AM documented, INR to be drawn today. The Physician Order dated 5/27/22 documented, PT/INR every Wednesday (lab day). The MAR for June 2022 revealed the following dates when the order had not been acknowledged as completed: 6/8/22, 6/15/22, and 6/22/22. Review of Progress Notes for the month of June 2022 lacked documentation about PT/INR results or scheduling following the date of 6/1/22. On 11/16/22 at 10:32 AM, PT/INR test results and physician recommendation for Coumadin dosing following the lab result on 6/8/22, 6/15/22, and 6/22/22 had been requested from the facility via email. PT/INR laboratory test results provided by the facility lacked PT/INR laboratory results for the above dates. The Progress Note dated 7/6/22 at 3:27 PM documented, Writer received results from PT/INR results were transmitted; ARNP gave order to hold Coumadin x 3 days and repeat there INR on Friday, Responsible Party (RP) was notified via voicemail to contact the facility for update. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the laboratory test results for INR, collection date 7/6/22 at 9:05 AM, received date 7/6/22 at 1:30 PM, documented the resident's INR had been 5.4. On 11/17/22 at 8:52 AM, Resident #13 had been observed in their room in bed. 2. Review of the MDS assessment for Resident #14 dated lacked assessment of the resident's cognition. Per this assessment, Resident #14 had taken an anticoagulant for seven of the last seven days. The Care Plan dated 3/8/22 documented, Resident #14 required the use of an Anticoagulant medication. The intervention also dated 3/8/22 documented, Obtain and monitor labs as directed. Notify provider of results. Medical diagnoses for Resident #14 included cerebral infarction and atrial fibrillation. The Physician Order, start date 10/27/22, documented, Draw PT/INR every Wednesday one time a day every Thursday related to chronic pulmonary embolism. Review of the MAR for November 2022 revealed blank spaces had been left on the MAR for the dates of 11/3/22, 11/10/22, and 11/17/22. Another order on the MAR documented the resident had an INR done on 11/2/22. The Lab and Diagnostic Nursing Note dated 11/3/22 at 2:47 PM documented, Residents PT/INR results 3.1. ARNP acknowledged and stated to continue on current dose and recheck in one week. On 11/22/22 at 9:52 AM, INR labs for the month of November 2022 had been requested from the facility. The facility provided labs dated 11/2/22 and 11/17/22, however lacked documentation of a lab result dated 11/10/22. 3. Review of the MDS assessment for Resident #15 dated 9/22/22 revealed Resident #15 scored 15 out of 15 on a BIMs exam, which indicated intact cognition. Per this assessment, Resident #15 had received anticoagulant medication for seven of the last seven days. Diagnoses for Resident # 15 included chronic pulmonary embolism (PE) and atrial fibrillation. The Care Plan for Resident #15 dated 12/28/21 documented, Resident #15 requires the use of an Anticoagulant medication r/t diagnosis of chronic pulmonary embolism (PE) and deep vein thrombosis (DVT). The intervention also dated 12/28/21 documented, obtain and monitor labs as directed. Notify provider of results. Review of Physicians Orders for Resident #15 revealed the resident currently had been prescribed Warfarin, also known as Coumadin, an anticoagulant medication. The Health Status Note dated 6/1/22 at 6:10 PM documented, Writer received labs, notified oncall ARNP, who gave new orders to discontinue (d/c) current orders start Coumadin 10 mg and repeat INR on 6/3, Responsible Party aware and agree with changes. Progress Notes lacked documentation the lab work had been completed on 6/3, and lacked documentation of results. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Physician Order dated 6/1/22 documented, PT/INR one time a day related to chronic pulmonary embolism .until 6/3/22 at 11:59 (PM). Review of Resident #15's MAR lacked documentation the order had been completed, as documentation on the MAR had been left blank. On 11/16/22 at 3:36 PM, PT/INR results from the dates of 6/3/22, 6/8/22, and 6/15/22 had been requested from the facility via email, as well as physician recommendations for Coumadin dosing following lab results. Review of labs provided lacked documentation for the above dates. The Progress Note dated 6/23/22 documented, It was brought to this DON's attention that this resident's PT/INR did not get drawn yesterday. Resident is currently on 1 mg of Coumadin and has been since 6/08/22 per orders given to the Licensed Practical Nurse (LPN). The PT/INR was 1.9 on 6/8/22 and 1.7 on 6/15/22 which she states is basically the level of someone that is not taking Coumadin. ARNP gives orders to restart this resident on 10 mg of Coumadin nightly as of today, and to recheck her PT/INR next Wednesday, 06/29/22. MAR updated at this time and Charge Nurse aware of new orders. The Provider Progress Note dated 7/16/22 at 2:16 PM documented, INR 1.5 today. 1.4 on Wednesday and patient has been receiving 8 mg daily. Increase warfarin to 9 mg daily with repeat INR next Wednesday. The Health Status Note dated 7/20/22 at 5:06 PM documented, it was brought to this DON's attention that this resident's PT/INR draw was missed today. This writer arranged for the Lab Staff to come back in the morning to draw. ARNP aware with no concerns or new orders given at this time. The Health Status Note dated 7/21/22 at 6:14 PM documented, PT/INR not collected today. ARNP aware that lab collection to be attempted again tomorrow. No concerns and no new orders given at this time states to continue same dose until drawn. The Health Status Note dated 8/3/22 at 5:41 PM documented, resident had INR labs drawn, results received called in to ARNP , who gave new orders to D/C Coumadin 8 mg and start Coumadin 4 mg po x 2 days and repeat INR on 8/5/22, resident INR is 4.4, ARNP notified no answer at this time, will continue to monitor. The August 2022 Treatment Administration Record (TAR) documented Resident #15 had their INR checked on 8/5/22. The INR lab reports for 8/1/22 to 8/5/22 had been requested from the facility, and lab documentation provided by the facility lacked information for the date range. Review of the MAR revealed Resident #15 did not receive Coumadin between 8/6/22 and 8/10/22. The Order Note dated 8/10/22 at 8:42 PM documented, ARNP gave new orders to continue on the same dose of 4 mg recheck in one week. The Physician's Order, start date 9/21/22, documented, PT/INR every Wednesday. The Plan of Care Summary note dated 11/4/22 at 11:26 AM documented the resident's INR was to be rechecked in one week. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Provider Progress Note dated 11/14/22 at 1:06 PM documented, Patient (PT) on warfarin therapy, overdue for INR check. On 11/16/22, review of the MAR for November 2022 revealed the INR check for 11/9/22 had not been documented as completed. On 11/16/22 at 3:36 PM, PT/INR results from 8/1/22 through 8/5/22 and any INR results for November 2022 had been requested from the facility via email, as well as physician recommendations for Coumadin dosing following lab results. Lab results provided lacked results for the above date ranges. On 12/1/22 at 10:13 AM, the Director of Nursing (DON) explained the day that they had started, noted to be approximately three weeks ago, the facility had said they were using a Hospital lab. The DON explained they had drawn some labs and had sent them to Hospital. The Hospital said that they didn't work with the facility any more due to improper documentation, and the lab orders and tubes had not been filled out correctly. Per the DON, it had been described as a safety issue to use had been discontinued. The DON explained they had been trying to fix this and asked if then they could continue to use [Hospital Name], and the response had been no. Per the DON, she had called the facility's corporate and had said they needed a lab now. The DON explained the current lab company had been coming in this current week and it would be the first week they were going to actually draw. When queried about a gap in labs, the DON acknowledged there had been a week and a half when the facility had not been able to draw labs from when they learned [Hospital Name] had not been drawing for the facility to when the current lab company had been coming in. The DON acknowledged they were unsure as to how long prior to when they took their position that the [Hospital Name] had not been accepting from the facility. The Care Plan for Resident #15 dated 12/28/21 documented, Resident #15 had type 2 Diabetes Mellitus and requires use of insulin. The Physician Order start date 10/28/22 documented, HumaLOG KwikPen Solution Pen-injector 200 UNIT/ML (Insulin Lispro) Inject as per sliding scale: if 151 - 200 = 5 units; 201 - 250 = 10 units; 251 - 300 = 15 units; 301 - 350 = 20 units over 400 notify MD, subcutaneously with meals related to Type 2 Diabetes Mellitus without complications. Review of the Medication Administration Record (MAR) dated October 2022 revealed the following documentation per the 5:00 PM time for 10/29/22: Resident #15's blood sugar had been documented as 392, and a code of 7 had been marked on the MAR, which meant no insulin required. Review of Progress Notes dated 10/29/22 lacked rationale to explain why insulin had not been administered to Resident #15. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/22/22 at 2:32 PM, Staff A, Licensed Practical Nurse (LPN) had been queried about labs at the facility. Per Staff A, the lab had not been paid and had been lost entirely. Per Staff A, another location had been used, however staff had not filled out the information properly on the tubes. Staff A further explained in some instances an alternate location had been used as well, and said they believed the first lab had been supposed to resume in the current week. When queried if residents missed lab draws, Staff A explained sometimes they did as the first lab mentioned said they were done coming. Per Staff A, the resident would get drawn, and if they would miss the Wednesday then they would try to draw the lab late. When queried about INRs, Staff A explained the Director of Nursing (DON) had been working to get things organized, explained usually the lab had been done on Wednesdays with lab coming Monday, Wednesday, and Friday, and if the lab had been missed on Wednesday the would try to get it on Friday. When queried as to what they would do if a resident's blood sugar had been above the range of sliding scale (insulin), Staff A acknowledged she had experienced that scenario last week. Per Staff A, she would follow up with the Nurse Practitioner, who could then put in a one time order and give further instruction. On 11/30/22 at approximately 1:05 PM, Staff V, Nurse Practitioner (NP) had been queried if residents on Coumadin had missed INRs. Staff V explained they had been late(ish), and had always been within two weeks when the adjustment could be completed. Per Staff V, the last one had been within two weeks. When queried about INR frequency, Staff V explained if the lab came and titrating it would be done weekly until the therapeutic level had been achieved. Staff V explained at the facility it had been weekly getting them, and was dependent on the provider. Staff V explained they had seen every two weeks or monthly depending on if the medication needed to be titrated or not. Staff V acknowledged she was still becoming familiar with the residents, and regularly they had been trying to get it weekly. On 11/30/22 at 1:09 PM, when queried as to where orders went for Coumadin, Staff V explained they had been trying to figure out a strategy. Per Staff V, when they had come in staff had been calling in non-therapeutic values and adjusting it from there. Staff V explained staff had previously received verbal orders. Staff V explained since they were at the facility, she wanted to do them if possible. Per Staff V, there was a PT/INR book, and nothing was it it. Staff V acknowledged trying to get better documentation in terms of weekly INRs and dosage change. Staff V further explained there had been individual records with their dosages and progress notes in the records. Staff V explained the last time she titrated Coumadin she had put notes in documentation which included the dosage change. Per Staff V, if the level had been between 2 and 3 the dose would be maintained. On 11/30/22 at 1:11 PM, Staff V, had been queried as to how staff would address a blood sugar that fell above the level of sliding scale insulin and not at the point to call the Physician. Staff V explained that issue had been corrected for Resident #15. When queried if the blood sugar had fallen in the gap range, Staff V explained ideally staff would have notified a provider that they did not know what to do. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/1/22 at 10:27 AM, the Director of Nursing (DON) had been queried about concerns with sliding scale insulin for Resident #15. The DON explained there had been an agency nurse at the facility who had not been giving insulin. Per the DON, this had been about a week and a half to two weeks ago. The DON explained she had gone down to give insulins and one of the medication techs said, you're actually going to give them and said the other staff never gave them. The DON explained the resident's insulin had keep increasing because they could not figure out why the resident's blood sugar kept going up and up, and there had been conversation about putting in a pump. The DON explained the resident's blood sugar had not been going up any more. When asked if the agency nurse would have cared for Resident #15, the DON acknowledged the nurse would have been down there. When queried about the gap observed between blood sugar or 350 and notification at 400 when the resident's blood sugar had been 392 on 10/29/22, the DON acknowledged they would hope the doctor had been called as it had been so close to 400. 4. The Minimum Data Set (MDS) assessment for Resident #27 dated 9/15/22 revealed the resident scored 13 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated intact cognition. Diagnoses for Resident #27 included chronic obstructive pulmonary disease (COPD)with acute exacerbation and chronic pancreatitis. The Care Plan for Resident #27 lacked a topic to address COPD. The Provider Progress Note dated 9/12/22 at 12:29 PM documented, Readmit status post hospitalization for acute exacerbation of pancreatitis and acute on chronic hypoxic respiratory failure complicated by hospital acquired pneumonia and left sided lung collapse. The section of the note for COPD documented, in part, ordered chest physiotherapy with flutter device three times a day (TID). The Director of Nursing (DON) notified of need to order. The Physician Order dated 9/13/22 documented, chest physiotherapy with flutter valve device three times a day related to chronic obstructive pulmonary disease with (acute) exacerbation Please obtain flutter valve device. Instruct patient how to use. Monitor and document use. Review of the Treatment Administration Record (TAR) for November 2022 documented 27 times administration of chest physiotherapy had been left blank, 23 times when it had been marked as completed, 36 times a code of 9, which indicated other/see progress notes had been selected, and 2 times a code of 2, which indicated refusal, had been selected. On 11/29/22, review of Progress Notes for Resident #27 revealed it had been documented 11/2/22, 11/4/22, 11/6/22, 11/7/22, 11/8/22, 11/14/22, 11/15/22, 11/16/22, 11/20/22, 11/21/22, 11/22/22, 11/23/22, 11/24/22, 11/25/22, 11/28/22, and 11/29/22 that the device had not been available, had been unable to be located, the resident had not had the device, or had been awaiting supplies. On 12/1/22 at 10:32 AM, the DON queried about the flutter valve device for Resident #27. Per the DON, the resident used to have the device and she had not been sure if the resident currently had one. The DON explained they had looked on the internet to get the resident one. Per the DON, Staff V, Nurse Practitioner (NP) had told her last week that the resident needed one, and it had been on the DON's order list. The DON explained the knew they had the incentive spirometer, and when asked if Resident #27 had an incentive spirometer, the DON acknowledged they were unaware. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Charge Nurse /Registered Nurse (RN) Job Description dated 1/13 documented the primary purpose of the Charge Nurse is to provide direct nursing care to the residents, and to supervise the day-to-day nursing activities performed by Nursing Assistants. Such supervision must be in accordance with current federal, state, and local standards, guidelines, and regulations that govern our facility, and as may be required by the Director of Nursing or Unit Manager to ensure the highest degree of quality care is maintained at all times. Review of the Charge Nurse/Licensed Practical Nurse/Licensed Vocational Nurse (LPN/LVN) Job Description documented, Requisition and arrange for diagnostic and therapeutic services, as ordered by the physician, and in accordance with our established procedures. 35434 5. The MDS Assessment Tool, dated 10/22/22, listed diagnoses for Resident #3 which included cancer, non-Alzheimer's dementia, and muscle weakness. The MDS sections related to cognition and pain were incomplete. The November 2022 MAR(Medication Administration Record) listed the following orders: a. Morphine Sulfate (a narcotic pain medication) ER (Extended Release) 30 milligrams (mg) by mouth three times per day. The MAR lacked documentation staff administered the medication on 11/2/22 at 2:00 p.m. and 9:00 p.m., 11/3/22 at 9:00 a.m., 11/8/22 at 2:00 p.m. and 9:00 p.m., and 11/14/22 at 9:00 a.m. and 2:00 p.m b. Gabapentin (used for nerve pain) 600 mg by mouth 4 times per day. The MAR lacked documentation the resident received the evening dose on 11/4/22. Progress Notes, dated 11/2/22 and 11/8/22, and 11/14/22 documented the resident's Morphine Sulfate was unavailable. The facility policy Medication Administration revised 2/27/20, directed staff to administer medications according to the principles of medication administration including the right medication, resident, time, dose, and route. During an interview on 12/6/22 at 12:19 p.m., the Director of Nursing (DON) stated there should not be a break in a resident receiving morphine. She stated the nurses needed retraining with regard to the pharmacy reordering process. During a phone interview on 11/15/22 at 11:26 a.m., Staff E, former Director of Nursing (DON) stated the facility did not have lab services because the facility had an outstanding bill. She stated there were days when they were unable to complete lab draws for Coumadin for Residents #13, #14, and #15. During an interview on 11/28/22 at 8:58 a.m., Staff F, Licensed Practical Nurse(LPN) stated Resident #27 did not have an ordered chest physiotherapy device but nurses signed off they completed the treatment.

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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. 35434 Based on clinical record review, staff interview, resident interview, and policy review, the facility failed to provide, based on the Comprehensive Assessment, Care Plan and the preferences of each resident, an ongoing program to support residents in their choice of activities for 4 of 4 residents reviewed for activities (Resident #3, #6, #10, and #21). The facility reported a census of 53 residents. Findings Include: 1. The Annual Minimum Data Set (MDS) Assessment for Resident #3, dated 11/3/21, stated the following activities were very important: books, music, news, going outside. The resident's clinical record lacked documentation of activities offered during the period of 8/28/22 -11/28/22. A 8/9/22 Care Plan entry directed staff to invite to scheduled activities. 2. The Admission MDS Assessment for Resident #6, dated 8/17/22, had an incomplete Activity Preferences section. During an interview on 11/17/22 at 2:28 p.m., Resident #6 stated the facility did not have activities and he was bored. The resident's clinical record lacked documentation of activities offered during the period of 8/28/22-11/28/22. An 8/14/22 Care Plan entry directed staff to explain the activity program to the resident and encourage the resident to participate in activities of choice. 3. The Admission MDS Assessment for Resident #10, dated 8/30/22, had an incomplete Activity Preferences section. During an interview on 11/17/22 at 3:45 p.m., Resident #10 stated there were no activities since the Activity Director transferred to the kitchen. The resident's clinical record lacked documentation of activities offered during the period of 8/28/22 -11/28/22. A 8/26/22 Care Plan entry directed staff to provide activities to maintain engagement while providing a calming an supportive atmosphere and listed the following examples: music, aromatherapy, movies and audiobooks. 4. The Admission MDS Assessment for Resident #21, dated 10/5/21, stated the following activities were very important: books, newspapers, animals, news, and going outside. (continued on next page)

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Iowa City Rehab & Health Care	3661 Rochester Avenue Iowa City, IA 52245

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Care Plan entry, dated 10/4/21, stated the resident's preferred activities were: cards, family time, movies, music, gardening, sports, shopping, reading, fishing, camping, The resident's clinical record lacked documentation of activities offered during the period of 8/28/22 -11/28/22. The facility policy Recreational and Therapeutic Activities Manual, dated 1/13/22, stated activity staff would provide opportunities for a variety of activities for residents. During an interview on 11/28/22 at 1:54 p.m., the Dietary Manager stated the facility did not have Activity Staff. He stated he was in that position until he moved to the Dietary Department. He stated the last time he completed activities with the residents was in May of 2022. During an interview on 12/6/22 at 12:19 p.m., the Director of Nursing (DON) stated she expected staff to provide activities for the resident and stated a new Activity Director started on 12/1/22.

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the activities program is directed by a qualified professional. 35434 Based on clinical record review, staff interview, resident interview, and policy review, the facility failed to employ Activities Department Staff to support residents in their choice of activities for 4 of 4 residents reviewed for activities(Resident #3, #6, #10, and #21). The facility reported a census of 53 residents. Findings Include: 1. The Annual Minimum Data Set (MDS) Assessment for Resident #3, dated 11/3/21, stated the following activities were very important: books, music, news, going outside. The resident's clinical record lacked documentation of activities offered during the period of 8/28/22 -11/28/22. A 8/9/22 Care Plan entry directed staff to invite to scheduled activities. 2. The Admission MDS Assessment for Resident #6, dated 8/17/22, had an incomplete Activity Preferences section. During an interview on 11/17/22 at 2:28 p.m., Resident #6 stated the facility did not have activities and he was bored. The resident's clinical record lacked documentation of activities offered during the period of 8/28/22-11/28/22. An 8/14/22 Care Plan entry directed staff to explain the activity program to the resident and encourage the resident to participate in activities of choice. 3. The Admission MDS Assessment for Resident #10, dated 8/30/22, had an incomplete Activity Preferences section. During an interview on 11/17/22 at 3:45 p.m., Resident #10 stated there were no activities since the Activity Director transferred to the kitchen. The resident's clinical record lacked documentation of activities offered during the period of 8/28/22 -11/28/22. A 8/26/22 Care Plan entry directed staff to provide activities to maintain engagement while providing a calming an supportive atmosphere and listed the following examples: music, aromatherapy, movies and audiobooks. 4. The Admission MDS Assessment for Resident #21, dated 10/5/21, stated the following activities were very important: books, newspapers, animals, news, and going outside. (continued on next page)

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Care Plan entry, dated 10/4/21, stated the resident's preferred activities were: cards, family time, movies, music, gardening, sports, shopping, reading, fishing, camping, The resident's clinical record lacked documentation of activities offered during the period of 8/28/22 -11/28/22. The facility policy Recreational and Therapeutic Activities Manual, dated 1/13/22, stated activity staff would provide opportunities for a variety of activities for residents. During an interview on 11/28/22 at 1:54 p.m., the Dietary Manager stated the facility did not have Activity Staff. He stated he was in that position until he moved to the Dietary Department. He stated the last time he completed activities with the residents was in May of 2022. During an interview on 12/6/22 at 12:19 p.m., the Director of Nursing (DON) stated she expected staff to provide activities for the resident and stated a new Activity Director started on 12/1/22.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45338 Based on observation, interviews, and record review the facility failed to thoroughly assess and monitor for changes in condition for one of five residents reviewed for assessment and intervention (Resident #2). The facility reported a census of 53 residents. Findings Include: 1. The Minimum Data Set (MDS) Assessment for Resident #2 dated 9/29/22 revealed the resident scored 14 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated intact cognition. Diagnoses for Resident #2 included COVID-19, added 8/28/22, major depressive disorder, and chronic kidney disease stage 3. The Care Plan for Resident #2 dated 1/19/22 documented, Resident #2 tested positive for COVID-19. Two interventions per the Care Plan, both dated 1/19/22, documented the following: a. Respiratory assessment(s) completed every shift. b. Vital Signs every shift. Report any vital signs outside parameters to the Medical Doctor/Nurse Practitioner (MD/NP). The Health Status Note dated 1/19/22 at 10:00 AM documented, Resident #2 tested positive for Covid. Placed on contact/droplet isolation. Review of documentation of oxygen saturation for 1/20/22 per the weights/vitals section of the electronic health record documented the following: a. 1/20/22 at 3:51 AM: 97%. b. 1/20/22 at 2:31 PM: 94%. c. 1/20/22 at 9:44 PM: 70%. The Health Status Note dated 1/20/22 at 4:43 AM, documented. Resident #2 resting comfortably this shift. Vital Signs (VS) within normal limits (WNL). Lung sounds clear to auscultation (CTA)). Denies any needs at this time. Will continue to monitor for any changes. Documentation for 1/20/22 present in the resident's Progress Notes did not address the resident's documentation oxygen saturation of 70%. Review of COVID-19 Observation Assessment history revealed none had been completed on 1/20/22. The Nursing Daily Skilled assessment dated [DATE] at 11:19 PM documented the resident had a regular breathing rhythm, and the resident's lungs had been clear bilaterally. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of documentation of oxygen saturation for 1/24/22 per the weights/vitals section of the electronic health record revealed the following: a. 1/24/22 at 5:12 AM: 94%. b. 1/24/22 at 2:35 PM: 94%. Documentation of oxygen saturation in the weights/vitals section for 1/24/22 lacked documentation after 2:35 PM. Review of the Nursing Daily Skilled assessment dated [DATE] at 5:13 PM documented Resident #2's skin color had been normal, had a regular breathing rhythm, and lung sounds had been documented as within normal limits. The assessment documented the resident had been positive for COVID. Review of COVID-19 Observation Assessment history revealed none had been completed on 1/24/22. Review of the Progress Note dated 1/24/2022 at 10:07 PM documented, Physical therapist reported that resident was slow to respond and dusky in color. Nail beds are dusky and lips bluish in color. Pulse ox was 80-81 percent on room air. Oxygen was started at four liters per nasal cannula. Pulse ox increased to 84 percent. Alert and orientated to self. Eyes darting. Appears to be actively hallucinating both auditory and visual. 911 called and resident was transported to the Hospital. The Health Status Note dated 1/24/22 at 10:25 PM documented, the Director of nursing, Administrator and Doctor notified of the residents transfer to the Hospital emergency room (ER). Review of the E-Interact Transfer Assessment History lacked documentation for the resident's transfer to the Hospital on 1/24/22. Review of the Discharge Summary from Hospital Records for an admitted [DATE] and discharge date of [DATE] revealed the reason for the resident's admission had been confusion, cough, and dyspnea. It had also been documented the resident had been admitted to the Medical Intensive Care Unit (MICU) in the setting of acute hypoxic respiratory failure secondary to COVID pneumonia. On 11/15/22 at 8:17 AM, observation revealed Resident #2 had been in their room in bed. The Physician Order for Resident #2 start date 3/30/22, discontinued on 7/1/22, documented, weekly skin assessment to be completed on Wednesday. Documentation to be completed on Weekly Skin Assessment UDA. Review of Weekly Skin Assessment History for Resident #2 per the assessment tab in the resident's electronic health record lacked documentation of assessments completed between the dates of 3/30/22 and 5/11/22. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Health Status Note dated 5/6/22 at 2:47 PM documented, Patient (Pt) complaining of pain at an 8/10 related to toe ulcer. Pt refuses to allow nurse to assess toe and denies ordered nursing interventions. Pt has received all scheduled pain medications and denies Tylenol states that is does nothing for him. He states that no one can touch his foot and if they do he will kick and also has plenty of things to throw. Pt states he has osteomyelitis however his VS (vital signs) are within range, temperature and pulse are not elevated at this time. Pt has a history of gout. Pt also refuses assessment from in house nurse practitioner. Pt states he will just throw myself out of bed so I can go to the hospital and get something for my pain. Review of Progress Notes for May 2022 prior to 5/6/22 lacked a documented description of the wound bed or measurement of the open area. The eMAR Alert; Provider Notification Note dated 5/8/22 at 12:09 AM documented, Resident complained of excruciating/throbbing pain to the left (L) foot with a red stripe appearing on the bottom of his foot. Observed foot, red in color and warm to the touch. Resident requested to go to emergency room . Patient transported to the emergency room by ambulance at 2030 (8:30 PM). Review of Hospital Record History and Physical documentation dated 5/7/22 documented, in part, Patient mentions that for the past 8 days has been having pain and swelling in his left second toe, associated with redness, the pain and redness has been increasing over the past 8 days, he was started on Keflex per the rehab facility without improvement , he notes that the redness was progressing to his midfoot over the past few days, and thus was transferred to our hospital .Patient in the Emergency Department (ED) was found to have an open wound at the tip of the left second toe that was actively draining pus. Patient will be admitted for symptom of purulent cellulitis and failure of outpatient therapy. The Review of Systems section of the note documented the following about the resident's left second toe: Left second toe with open wound and purulent drainage, erythema involving the whole toe extending into the midfoot, with tenderness to palpation. The Assessment and Plan section documented the resident had purulent cellulitis of the second toe of the left foot. On 11/22/22 at approximately 1:15 PM, Staff H, Certified Medication Aide (CMA) had been queried as to what they would do if a resident had an oxygen saturation in the 70's or 80's, and explained the following: If the oxygen saturation had been in the 70's then they would immediately get the nurse and get the resident oxygen. The would do the same thing if the saturation had been in the 80's, and Staff H further explained for anything under 90 she would need the nurse. When queried where she would chart the information, Staff H explained she would write it on paper for the nurse to input. On 11/22/22 at 2:06 PM, Staff J, Certified Nursing Assistant (CNA) had been queried what they would do if they had a resident with an oxygen sat in the 70's or 80's, and explained they would get the nurse right away. On 11/22/22 at 2:41 PM, Staff A, Licensed Practical Nurse (LPN) had been queried about skin assessments. Staff A acknowledged it had been just her on the floor, and she tried to do them when scheduled. Per Staff A, skin assessments were once a week, and were usually on a shower day. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When queried as to what they would do if a resident's oxygen saturation had been in the 70's or 80's (percent), Staff A explained in the resident had a low oxygen sat they would sit the resident up and get them some oxygen. Per Staff A, they would start at 2 Liters, would call the doctor, and would continue to leave the pulse ox on them. Per Staff A, she would listen to the resident ad see if they had as needed Albuterol. Staff A explained she would do a quick assessment of the resident, and would see if their nose had been stuffed up. When queried where this would be charted, Staff A explained it would be in the Progress Note. On 11/28/22 at 11:33 AM, Staff Q, LPN, explained skin assessments were supposed to occur weekly. Staff Q acknowledged due to staffing shortages, sometimes they had not been done as readily as they should have been. Staff Q explained she tried to catch them up. Per Staff Q, COVID Assessments were supposed to be done once a shift. Staff Q, LPN, also explained she recalled an incident where in the middle of the night, Resident #2 had been sent out and had a hard time breathing. Per Staff Q, the resident had been sent out in the middle of the night, and his oxygen had been good. Per Staff Q, the night she had been thinking about when the resident had bee sent out, she and another nurse had sent the resident out because he had even been talking strange, and she and another nurse had ended up sending the resident out as he had not even been talking to the staff right. Staff Q explained the resident had been confused and not tracking right, and had been sent out to the hospital. Per Staff Q, a physical therapist had said the resident had been not acting right and had been blue in the lips, and she and another staff member ended up sending him out per ambulance to the hospital. Per Staff Q, if she was not mistaken, the resident had an infection going on, and the resident had returned within a period of days. On 11/30/22 at 1:13 PM, Staff V, Nurse Practitioner (NP) acknowledged there were standing orders for skin assessments. On 12/1/22 at 10:35 AM, the Director of Nursing (DON) explained skin assessments were to be done weekly with baths unless there had been a major issue. When queried where skin assessments would be documented, the DON explained they would be charted under the Weekly Skin Assessment UDA (in the electronic medical record). When queried about COVID assessments, the DON explained they were to be done at least daily for every resident. When queried about documentation when a resident had been sent out, the DON explained there was a transfer sheet in the electronic medical record, the Iowa Physician Orders for Scope of Treatment (IPOST), and the bed hold policy would be sent. On 12/7/22 at 3:56 PM, the DON explained the first time the resident's oxygen had dropped there should have been a full respiratory assessment done, and follow up assessment and charting should have been done. When queried at what oxygen saturation the Doctor should have been notified, the DON explained anything that had been getting to 88% or 89%. The Facility Policy titled Clinical Change in Condition Management dated 6/2015 documented the following: 1. Assess resident/patient clinical status when a change in condition is identified. This may include but is not limited to: a. Vital signs. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Lung sounds. c. Pulse ox. d. Mental/neurological status. e. Bowel sounds. f. Skin color, turgor, temperature. g. Pain. 2. Review the resident/patient medical record including but not limited to: a. Primary diagnosis and medical history. b. Lab work. c. Medication changes. d. Changes in nutritional status. e. Advance Directives. f. Allergies. The policy also documented under point #4: Contact the Physician and provide clinical data and information about the resident/patient condition. Document notification and physician response in the resident/patient medical record. Initiate any new physician orders.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. 45338 Based on observation, interview, and clinical record review the facility failed to ensure follow-up for identified foot care concerns documented by the Podiatrist (foot doctor) for one of one resident reviewed for foot care (Resident #2). The facility reported a census of 53 residents. Findings Include: 1. The Minimum Data Set (MDS) assessment for Resident # 2 dated 9/29/22 revealed the resident scored 14 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated intact cognition. Diagnoses for Resident #2 included COVID-19, added 8/28/22, major depressive disorder, morbid obesity, and gout. The Podiatry Note, date of service 6/8/22, documented the following Chief Complaint: Established patient seen at request of, self. Patient (Pt) seen for, at risk foot care, corns/calluses, chronic conditions, History of Present Illness (HPI): complains of thick toenails. Complains of constant foot pain on left foot. Pt says he had an appointment with a nearby surgeon and plans to have the left 2nd toe removed, he is just waiting for the call back to set up the surgery. Patient says his left 2nd toe is going to fall off and is extremely painful to touch. Medications were reviewed. Past medical history was reviewed. The Other Findings section of the report documented, Left 2nd toe very tender to even light palpation. Slightly pallor compared to other toes of same foot. Per the Plan section of the report it had been documented, Office Procedures Left written instructions that patient needs to see a nearby podiatrist/surgeon for the left foot. Pt may need to have the callouses debrided under anesthesia in case there is underlying abscess, even though there is no erythema or signs of infection at either location at this time there were small abscesses at last visit. I recommend an X-ray of the left 2nd toe and blood flow test to lower extremities. The Care Plan Follow Up section documented, in part, I recommend visit with local Podiatrist that can debride the left foot under local anesthesia and evaluate the left 2nd toe. The Physician Order active 6/9/22 to 6/10/22 documented, Call Podiatry - resident needs an X-ray of left foot/2nd toe and possible debridement of left heel callouses and 5th styloid process with local anesthetic. Review of the Medication Administration Record (MAR) for June 2022 revealed this order had been documented as completed on 6/9/22. The Health Status Note dated 6/22/22 at 4:30 PM documented, Resident awaiting phone call from Orthopedic Surgeon to schedule surgery for toe. Social Service Designee (SSD) contacted Podiatry, they stated resident requested surgery from a provider outside of Hospital. SSD left voicemail with doctor's office at to request that surgery be scheduled with facility, per resident's request. The Social Service: Quarterly Review dated 6/29/22 at 10:43 AM documented, in part, SSD completed Quarterly Social/Psychosocial Data Collection Assessment - Resident #2 anticipates requiring a surgery on his toe due to cellulitis of second toe of left foot, this has not yet been scheduled. He has had 2 hospitalization s this quarter, one related to toe pain and another related to abdominal pain. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/15/22 at 8:17 AM, observation revealed Resident #2 had been in their room in bed. On 11/17/22 at 12:15 PM, results of any x-rays for Resident #2 for the time period of June 2022 to present as well as documentation of any Podiatry visits following 6/8/22 had been requested via email from the facility. Review of documentation provided lacked Podiatry Notes following 6/8/22. On 12/1/22 at 10:09 AM, the Director of Nursing (DON) had been queried about a Podiatrist for the facility, and explained they knew there was one that came in every three to four months. The DON had been queried about follow-up with Podiatry, a surgeon, and the x-ray following the resident's 6/8/22 podiatry visit. The DON explained they would do some research. On 12/5/22 at 11:57 AM, the DON explained the Medication Technicians had said the resident had foot x-rays done because the resident had broken right above their ankle, and had x-rays of their foot. Review of these x-rays revealed they had been done 9/20/22 due to when the resident had run into a doorframe. On 11/22/22 at 10:29 AM, Staff G, Regional Nurse Consultant explained via email that the facility did not have a policy specific to outside appointments.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** 35434 Based on observation, clinical record review, policy review, and staff interviews, the facility failed to ensure the functioning of a wanderer alert device worn by a resident with a known history of leaving the building, in order to prevent an elopement for 1 of 3 residents reviewed for elopement (Resident #3). Resident #3's wanderer alert device was not in functioning order allowing Resident #3 to exit the facility on [DATE] and staff only became aware of the elopement when another resident observed Resident #3 walking down a highly traveled street in front of the facility. The facility also failed to check the wanderer alert device on a regular basis to know the resident's wanderer alert device was not in working order due to the fact the device was expired. Staff who were interviewed stated they had minimal training as to what to check regarding wanderer alert devices and were checking for placement but not function. This failure resulted an Immediate Jeopardy (IJ) to the safety of a resident who resided at the facility. The facility reported a census of 53 residents. Findings Include: 1. The Minimum Data Set (MDS) Assessment Tool, dated [DATE], listed the Resident #3's Brief Interview for Mental Status (BIMS) score as 7 out of 15, indicating severely impaired cognition. The MDS dated [DATE], listed diagnoses for Resident #3 which included non-Alzheimer's dementia, difficulty walking, and muscle weakness. The MDS documented the resident was independent with transfers and walking. The MDS section on cognitive patterns was blank and lacked documentation regarding the resident's cognitive status. The MDS dated [DATE], lacked documentation staff completed the assessment. A [DATE] Progress Note stated the resident eloped from the building around 8:00 a.m. and a Certified Nursing Assistant (CNA) heard the alarm sounding and found the resident walking up the driveway. A [DATE] Progress Note stated the facility received an order for a WanderGuard (an electronic wanderer alert device). The resident's Elopement Risk, dated [DATE], stated the resident was at high risk for elopement. [DATE] Care Plan entries directed staff to check the placement and function of the WanderGuard each shift and stated if the resident was actively exit seeking staff should redirect his attention or walk with him outside. A [DATE] Progress Note stated the resident exited the facility and a nurse and CNA saw him and ran and caught him. A [DATE] Progress Note stated the resident had increased wandering in the halls and into other resident rooms and stated staff redirected him multiple times. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The [DATE] Treatment Administration Record (TAR) directed staff to check the placement and function of the WanderGuard every shift. The TAR included Staff A's, Licensed Practical Nurse (LPN) initials documented for 3 shifts and Staff C's, LPN initials documented for 12 shifts. The TAR lacked staff initials to indicate the completion of the checks for 13 shifts. A [DATE] Progress Note stated another resident notified the facility by phone that Resident #3 was walking up the street. The Note stated staff immediately went up the street in a car and saw the resident approximately 5 blocks to the left of the facility walking on the sidewalk. The staff members drove him back to the facility. A [DATE] Care Plan entry stated the resident required 1:1 supervision. An [DATE] Progress Note stated the resident remained on 1:1 supervision. An [DATE] Progress Note stated the resident remained 1:1 for supervision. An [DATE] 12:43 p.m. Progress Note stated the facility applied a new WanderGuard to the resident and it was activated and tested prior to placement. An [DATE] 12:47 p.m. Progress Note stated the resident's WanderGuard worked properly and 1:1 supervision was discontinued. During an observation on [DATE] at 4:00 p.m., Staff F, Licensed Practical Nurse (LPN) checked Resident #3's WanderGuard bracelet with the WanderGuard Universal Tester and the tester flashed green. The undated WanderGuard Universal Tester Operating Instructions, utilized as education by the facility, stated it was important to test WanderGuard bracelets before putting into use and daily thereafter. The instructions stated failure to do so could result in injury or death and instructed staff to hold the tester within one foot of the bracelet. The instructions stated if the bracelet was operational, the LED would flash green four times. The facility policy Elopement dated [DATE], stated the facility would evaluate residents for the risk of elopement and Care Plan appropriately. During an interview on [DATE] at 12:49 p.m., the Maintenance Supervisor stated when Resident #3 eloped the WanderGuard system on the door was working but the resident's bracelet was not due to being outdated. He stated there were 3 residents who had the bracelets and they were all outdated and stated after the elopement the facility ordered new bracelets but could not get them right away due to the facility having an outstanding bill with the WanderGuard company. He stated he checked the doors daily but the Nursing Staff checked the WanderGuard bracelets. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a phone interview on [DATE] 1:13 p.m., Staff A, LPN stated there were 3 residents who had a WanderGuard bracelet. She stated the orders directed staff to check the placement of the bracelets. She stated she did not look that closely at the WanderGuard and she just made sure it was on. Staff A reported she knew there was a remote to check the function but she was not walked through that process. She explained after Resident #3 eloped, corporate made a procedure of what to if anyone eloped but stated she was not sure if there were any instructions on how to use the remote to check function. Staff A stated on the day Resident #3 eloped she had just started her shift. She stated someone notified the nurse that someone saw the resident out on [street name in front of the facility] past the 4 way stop. She stated she got in the car with Staff D, former Interim Director of Nursing (DON) and Staff B, CMA (Certified Medication Aide) and the staff members picked up the resident. During an interview on [DATE] at 1:31 p.m., Staff B, stated the facility had a device to check the WanderGuard bracelets to see if they were working. She stated staff was supposed to check this every day but she had not seen it done. She stated she was working the day that Resident #3 eloped. She stated when Resident #12 returned back to the facility after an outing, stated he saw Resident #3 walking down the street. Staff B stated, she, along with Staff D and Staff A got into Staff A's car and drove down [name of street in front of the facility] and picked the resident up in the car. She stated she thought the resident got out the front door but she did not hear it alarm. She stated when they brought the resident back to the facility his WanderGuard bracelet did not work. During an interview on [DATE] at 2:21 p.m., Resident #12 stated on the day Resident #3 eloped he was on a bus coming back to the facility. He stated he was about a mile away and saw Resident #3 on [street name]. He stated the resident looked disheveled and had no shoes on. Resident #12 stated he was not exactly sure where the resident was but it was not within walking distance. He stated he reported it to facility staff when he returned to the facility and stated staff started to leave and look for the resident on foot but he informed them they needed a car because it was not in walking distance. During a phone interview on [DATE] at 10:17 a.m., Staff C, LPN stated she was not sure who checked the WanderGuard bracelets. She reported she did not have to do this and did not know how staff checked the bracelets for functionality. During a phone interview on [DATE] at 11:26 a.m., Staff E, former DON stated at some point between May and October of 2022, the facility ran out of WanderGuards and stated the company would not send them new ones because of outstanding bills. During a phone interview on [DATE] at 12:55 p.m., Staff D, former Interim DON stated on the day of the resident's elopement after they returned to the facility with the resident, his WanderGuard was not functioning and she did not know why. During an interview on [DATE] at 12:19 p.m., the Director of Nursing(DON) stated she reeducated staff regarding the WanderGuards and answering the door alarm in a timely manner. The State Agency informed the facility of the Immediate Jeopardy (IJ) on [DATE] at 11:30 a.m. The facility removed the Immediate Jeopardy on [DATE] through the following actions: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. Resident #3 was assessed by Director of Nursing (DON)/Designee upon return to the facility on [DATE] with no injuries noted and placed on one-on-one supervision. 2. A resident head count was completed by DON/Designee on [DATE] and all residents were accounted for. The DON or designee completed an audit on [DATE] of door alarms and residents with wander guard devices to ensure alarms and devices are functioning properly. Residents at risk for elopement received new wander guard devices on [DATE]. 3. Staff received re-education on or before [DATE] by DON/Designee on missing Resident protocol. Licensed Nurses and Certified Medication Aides (CMA's) will be educated on how to check function and placement on wander guard devices beginning [DATE]. Any staff that have not receive this education by [DATE] will receive this education prior to the beginning of their next shift. 4. DON/Designee will complete audits weekly for 4 weeks and then monthly for 2 weeks to ensure staff continue to check the function and placement of wander devices as required and continue to follow the missing resident protocol. Results of these audits will be presented to the Quality Assurance and Performance Improvement (QAPI) meeting monthly for 3 months for review and recommendations as needed. The DON is responsible for monitoring and follow up as needed. The scope lowered from a J to D at the time of the survey after ensuring the facility implemented education and their policy and procedures.

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F 0729 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Verify that a nurse aide has been trained; and if they haven't worked as a nurse aide for 2 years, receive retraining. 45338 Based on personnel file review, staff interview, and facility policy review, the facility failed to check the Certified Nurse Aide (CNA) registry prior to hire for one of four contracted CNA's reviewed (Staff W). The facility reported a census of 53 residents. Findings Include: On 12/05/22, review of the Personnel File revealed a Contract for Professional Nursing Services for Staff W active for the time period of 10/28/22 through 11/20/22. Review of the background check form for Staff W revealed professional license verification on 11/1/22. On 12/5/22 at 1:45 PM, Staff O, Administrator from a sister facility, acknowledged CNA registry verification was to occur upon hire. The Facility Policy titled, Abuse Prevention Program & Reporting Policy dated 9/14, revised 8/19, documented, For those prospective employees and other individuals engaged to provide services who hold certificates-(e.g.-certified nurses' aides), the facility will conduct a check with the appropriate registry to assure that there is no finding of abuse, neglect, exploitation, or mistreatment of residents,

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 35434 Based on record review, interview, and facility policy review, the facility failed to maintain an accurate system of records for disposition of controlled drugs for 2 of 3 residents reviewed for controlled drugs (Resident #3 and #5). The facility reported a census of 53 residents. Findings Include:: 1. The Minimum Data Set (MDS) Assessment Tool, dated 10/22/22, listed diagnoses for Resident #3 which included cancer, non-Alzheimer's dementia, and muscle weakness. The Controlled Medication Utilization Record, documenting usage for September 2022, listed an order for Morphine Sulfate (a narcotic pain medication) 15 milligrams (mg), 1 tablet every 4 hours as needed and documented the resident received the medication on the following dates: 9/7/22 at 7:00 a.m. and 2:00 p.m., 9/12/22 at 3:00 p.m., 9/16/22 at 3:00 p.m., 9/28/22 at 1:00 a.m., 9:00 a.m., and 6:00 p.m., and a dose which the time was not documented, and 9/30/22 at 11:00 a.m. The September 2022 Medication Administration Record (MAR) listed an order for Morphine Sulfate 15 mg every 4 hours as needed but lacked documentation the resident received the above doses. The September 2022 MAR listed an order for Morphine Sulfate 30 mg three times per day and documented the resident received the following number of doses during the period of 9/15/22 - 9/30/22: 3 doses on 9/15/22 and 9/16/22, and 9/27/22 and 2 doses on 9/28/22 and 9/29/22. The Controlled Medication Utilization Record, documenting usage for this time period, lacked documentation of all doses administered on the MAR. The record documented the resident received 2 doses on 9/15/22, 9/16/22, and 9/27/22 and 1 dose on 9/28/22 and 9/29/22. 2. The MDS assessment tool, dated 10/12/22, listed diagnoses for Resident #5 which included diabetes, traumatic brain injury, and schizophrenia. The November 2022 MAR listed an order for Oxycodone (a narcotic pain medication) 10 mg four times a day. The MAR documented the resident received 4 doses on 11/18/22 and 11/19/22. The Controlled Drug Administration Record, documenting usage for the above dates, documented the resident received 6 doses on 11/18/22 and 2 doses on 11/19/22. The untitled facility policy related to the storage of controlled substance, dated 8/2020, stated controlled substances were stored under double lock and stated the facility would utilize individual resident controlled drug records (Count Sheets). During an interview on 12/6/22 at 12:19 p.m., the Director of Nursing (DON) stated the Narcotic Sheets should match the MARs.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 35434 Based on observation, record review, and interview, the facility failed to ensure the medication error rate did not reach 5 percent or greater. The medication pass observation revealed 3 errors out of 25 opportunities for errors resulting in a medication error rate of 12%. The facility reported a census of 53 residents. Findings Include: 1. During a Medication Pass observation on 11/17/22 at 11:32 a.m., Staff R, Certified Medication Aide (CMA) administered Resident #28's medications but stated she could not administer the residents magnesium oxide due to it not being available in the building. She stated she did not have it yesterday either. The November 2022 Medication Administration Record (MAR) listed a 4/18/22 order for magnesium oxide tablet 400 milligrams (mg), give 2 tablets by mouth in the afternoon for hypomagesemia (low magnesium in the blood). The entries for the following dates had the entry of 9 referring to the Progress Notes: 11/16/22, 11/17/22, 11/18/22, 11/20/22. Progress Note entries for 11/16/22, 11/17/22, 11/18/22, and 11/20/22 stated the the medication was on order from the Pharmacy/unavailable. 2. During a Medication Pass observation on 11/21/22 at 8:50 a.m., Staff S, CMA prepared Resident #14's metoprolol 100 mg and obtained the resident's pulse and it was 47 beats per minute. Staff S stated she was about to administer the medication and was stopped prior to administering the medication. The November 2022 MAR listed a 6/23/22 order for metoprolol tartrate (for high blood pressure) 100 mg and directed staff to hold for heart rate (HR) under 50 beats per minute. 3. During a Medication Pass observation on 11/29/22 at 8:45 a.m., Staff U, CMA administered Resident #29's morning medication but stated the resident's fludrocortisone (a steroid) was on order from the pharmacy. The November 2022 MAR listed a 11/17/22 order for fludrocortisone 0.1 mg daily for hypotension and the 11/29/22 entry had a 9 referring to the Progress Notes. A 1/29/22 Progress Note stated the resident's fludrocortisone was on order. The facility policy Medication Administration revised 2/27/20, directed staff to administer medications according to the Principles of Medication Administration including the right medication, resident, time, dose, and route and directed staff to perform needed evaluations such as pulse. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/6/22 at 12:19 p.m., the Director of Nursing (DON) stated the nurses needed retraining with regard to the pharmacy reordering process. She stated if a resident's pulse did not meet the criteria for administration of the medication, staff should hold the medication and notify the physician.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 45338 Based on clinical record review, interview, and facility policy review the facility failed to administer Coumadin, (an anticoagulant medication), per Physician Order for two of three residents reviewed for Coumadin use (Resident #14 and #15). The facility reported a census of 53 residents. Findings include: 1. Review of the Minimum Data Set (MDS) Assessment for Resident #14 dated 9/02/22 lacked assessment of the resident's cognition. Per this assessment, Resident #14 had taken an anticoagulant for seven of the last seven days. The Care Plan dated 3/8/22 documented Resident #14 required the use of an Anticoagulant medication. The intervention also dated 3/8/22 documented, Obtain and monitor labs as directed. Notify provider of results. Medical diagnoses for Resident #14 included cerebral infarction and atrial fibrillation. The eMAR- Progress Note dated 10/8/22 at 8:54 PM documented, Coumadin Tablet 6 milligrams (mg): a. Give 6 mg by mouth one time a day related to Chronic Pulmonary Embolism - Medication unavailable. The eMAR Progress Note dated 10/11/22 at 11:24 PM documented, Give 6 mg by mouth one time a day related to Chronic Pulmonary Embolism - Not available-hold. The Health Status Note dated 10/12/22 at 5:30 PM documented, PT/INR results relayed. Received verbal order to continue same dose of 6 mg nightly. The eMAR Progress Note dated 10/16/22 at 12:04 AM documented, Coumadin Tablet 6 MG Give 6 mg by mouth one time a day related to Chronic Pulmonary Embolism - reordered, medication not available. 2. Review of the MDS Assessment for Resident #15 dated 9/22/22 revealed Resident #15 scored 15 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated intact cognition. Per this assessment, Resident #15 had received anticoagulant medication for seven of the last seven days. Diagnoses for Resident # 15 included chronic pulmonary embolism (PE) and atrial fibrillation. The Care Plan for Resident #15 dated 12/28/21 documented, Resident #15 required the use of an Anticoagulant medication related to (r/t) diagnosis of chronic PE's and deep vein thrombosis (DVT). The intervention also dated 12/28/21 documented, administer medications as directed, monitoring for adverse reactions/effects to Anticoagulant therapy (i.e. fever, skin lesions, anorexia, nausea, vomiting, cramping, diarrhea, hemorrhage, hemoptysis, etc.). Notify provider as necessary. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Physicians Orders for Resident #15 revealed the resident currently prescribed Warfarin, also known as Coumadin. Review of the Physician Order dated 7/16/22 through 7/29/22 documented, Coumadin Tablet (Warfarin Sodium) Give 9 mg by mouth one time a day for chronic PE verify last INR prior to administering dose, if INR >4.0 hold and notify physician for further instruction. The Laboratory Report for Resident #15, collection date 7/22/22 at 7:10 AM, and reported date 7/22/22 at 2:09 PM, documented the resident's INR had been 2.2. The following had been written on the form: New Order (N.O.) 8 mg Coumadin. The order had not been signed or dated, and initials had not been present. The Laboratory Report for Resident #15, collection date 7/27/22 at 8:05 AM, reported 7/27/22 at 12:35 PM, documented the resident's INR had been 3.4. Hand written on the form had been, 8 mg Coumadin. Review of the Medication Administration Record (MAR) dated July 2022 documented the resident had received 9 mg of Coumadin daily between 7/16/22 through 7/26/22. The Health Status Note dated 8/3/22 at 5:41 PM documented, resident had labs drawn for an INR, results received called in to the Nurse Practitioner (NP) who gave a N. O. to start Coumadin 4 mg orally (po) x 2 days and repeat INR on 8/5/22, res INR was 4.4, the Responsible Party (RP) notified and no answer at this time, will continue to monitor. The August 2022 Treatment Administration Record (TAR) documented Resident #15 had their INR checked on 8/5/22. The INR lab reports for 8/1/22 to 8/5/22 had been requested from the facility, and lab documentation provided by the facility lacked information for the date range. Review of the MAR revealed Resident #15 did not receive Coumadin between 8/6/22 and 8/10/22. The Order Note dated 8/10/22 at 8:42 PM documented, the NP gave N.O. to continue on the same does of 4 mg recheck in one week. Continued review of Physician Orders for Resident #15 revealed the following two orders overlapped in time frame: a. Coumadin Tablet 5 MG (Warfarin Sodium) Give 5 mg by mouth one time a day related to other persistent atrial fibrillation (start date 9/23/22, stop date 10/6/22). b. Warfarin Sodium Tablet 5 MG Give 5 mg by mouth in the evening for blood thinner related to other persistent atrial fibrillation (start date 10/4/22, stop date 10/28/22). Review of the MAR for October 2022 revealed both orders had been signed as administered on 10/4/22. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/1/22 at 10:20 AM, the Director of Nursing (DON), who had been at the facility approximately 3 weeks, explained unsure when the facility had their Pyxis (automated medication dispensing machine) installed, however they had an emergency back-up box that always had Coumadin in it. Per the DON, this included multiple doses and different strengths. When queried as to what staff should do if the medication had been unavailable, the DON explained they would check the back up/emergency kit, and call the Pharmacy to have it sent out. The DON explained the facility's Pharmacy would work with a local Pharmacy, and medications were always available. Per the DON, the facility received two deliveries per day. On 12/1/22 at 10:26 AM when queried as to actions staff should take for duplicate orders, the DON explained the Medication Tech would go to the nurse, and as a nurse they would check the actual order and see what had been most current as to what they were supposed to do. If they could not figure it out, they were to go to their DON. Review of the Facility Policy titled Medication Administration dated 1/13 documented the following purpose: To administer the following according to the principles of medication administration, including the right medication, to the right resident/patient at the right time, and in the right dose and route.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 45338 Based on staff interview and facility policy review the facility failed to ensure Administration facilitated prompt payment to ensure coordination of laboratory services. The facility reported a census of 53 residents. Findings Include: During a phone interview on 11/15/22 at 11:26 AM, Staff E, former Director of Nursing (DON) stated the facility did not have lab services due to outstanding bills. On 11/22/22 at 2:32 PM, Staff A, Licensed Practical Nurse (LPN) had been queried about labs at the facility. Per Staff A, the lab had not been paid and had been lost entirely. Per Staff A, another location had been used, however staff had not filled out the information properly on the tubes. LPN A further explained in some instances an alternate location had been used as well, and said they believed the first lab had been supposed to resume in the current week. When queried if residents missed lab draws, Staff A explained sometimes they did as the first lab mentioned said they were done coming. Per Staff A, the resident would get drawn, and if they would miss the Wednesday then they would try to draw the lab late. When queried about International Normalized Ratio (INR) labs (used for residents who took the blood thinner medication (Warfarin), Staff A explained the Director of Nursing (DON) had been working to get things organized, explained usually the lab had been done on Wednesdays with lab coming Monday, Wednesday, and Friday, and if the lab had been missed on Wednesday they would try to get it on Friday. On 11/29/22 at 9:37 AM, Staff F, LPN explained the facility had paid the lab company and they were supposed to come tomorrow to draw missed labs. On 11/29/22 at 9:45 AM, Staff N, Administrator explained lab services would resume this week and the facility was going to start working with the lab company again. Per Staff N, the facility had been working with them to get payment so the company could start resuming services. Staff N further explained the lab company had been to the facility in the past. When queried as to why the lab had stopped coming, Staff N explained this had been due to a payment issue. Per Staff N, they had been in communication with the lab manager to get payment and get it restarted. When queried if there had been a period of time where the facility had no lab services, Staff N explained they would have gone to local hospitals. Per Staff N, if someone needed lab work they were sending them out to the hospital if labs needed to be completed. When queried if to their knowledge any residents had missed labs entirely, the Staff N explained not that they had been aware of, and acknowledged the back up plan had been to send residents to the emergency room . Staff N explained they were not sure what had been going on with payment, and they knew the invoices had been sent to corporate. When queried about payment concerns with vendors and services, Staff N acknowledged working to resolve all of those, and a lot of them had been paid. Per Staff N, there was a report of which bills had been paid. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/30/22 at 1:03 PM, Staff V, Nurse Practitioner (NP) explained the facility had not had a lab until today (11/30/22). Per Staff V, she had been told the lab company that came today (11/30/22) had being going to start back up. Per Staff V, she had been told there had been a billing issue. When later queried who had communicated this information, Staff V could not recall. Staff V explained when they had come in a month ago, the facility had stopped using [hospital name] for labs and it was a shoot on who could draw labs. Staff V explained she tried to do INR's and drew a few times, and the [hospital name] contract had ended. Per Staff V, the facility had been working on the first lab company named, and found [another hospital name]. Staff V explained she would draw labs and had a nurse who would help her. On 12/1/22 at 10:13 AM, the Director of Nursing (DON) explained they day that they had started the facility had said they were using [Hospital Name] lab. The DON explained they had drawn some labs and had sent them to [Hospital Name]. [Hospital Name] said that they didn't work with the facility any more due to improper documentation, and the lab orders and tubes had not been filled out correctly. Per the DON, it had been described as a safety issue to use had been discontinued. The DON explained they had been trying to fix this and asked if then they could continue to use [Hospital Name]. Per the DON, the response had been no. The DON explained she had called the facility's corporate staff and had said they needed a lab now. Per the DON, the current lab company had been coming in this current week and it would be the first week they were going to actually draw. When queried about a gap in labs, the DON acknowledged there had been a week and a half when the facility had not been able to draw labs from when they learned [Hospital Name] had not been drawing for the facility to when the current lab company had been coming in. The DON acknowledged they were unsure as to how long prior to when they took their position that the [Hospital Name] had not been accepting from the facility. The Facility Policy titled, Resident Rights & Responsibilities, dated 2/15, documented, The facility strives to assure that each resident/patient has a dignified existence, self-determination, and communication with, and access to, persons and services inside and outside the center.

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F 0838 Level of Harm - Potential for minimal harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 45338 Based on document review, staff interview, and facility policy review the facility failed to ensure the Facility Assessment reviewed on an annual basis. The facility reported a census of 53 residents. Findings Include: On 11/28/22, review of the Facility Assessment provided by the facility documented the date of assessment or update as 10/25/21. On 11/29/22 at 2:19 PM, Staff N, Administrator, acknowledged they had not been involved with the Facility Assessment. On 12/05/22 at 1:44 PM, Staff O, Administrator from a sister facility, acknowledged the Facility Assessment was supposed to be reviewed yearly. The Facility Assessment Tool-[Facility Name Redacted], undated, documented, Nursing facilities will conduct, document, and annually review a facility-wide assessment, which includes both their resident population and the resources the facility needs to care for their residents.

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F 0839 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ staff that are licensed, certified, or registered in accordance with state laws. 45338 Based on personnel file review, interview, and facility policy review the facility failed to verify licensure for a nurse prior to working at the facility for one of one nurses reviewed for license verification (Staff F). The facility reported a census of 53 residents. Findings include: On 12/05/22, review of the Personnel File revealed a Contract for Professional Nursing Services for Staff F, Licensed Practical Nurse (LPN) active for the time period of 10/28/22 through 11/20/22. Review of Staff F's background check revealed the staff member's license had been verified on 11/9/22. On 12/5/22 at 1:45 PM, Staff O, Administrator from a sister facility, acknowledged licensure verification was to be done upon hire. The Facility Policy titled, Abuse Prevention Program & Reporting Policy dated 9/14, revised 8/19, documented, For those prospective employees and other individuals engaged to provide services who hold licenses (e.g.-Administrators, Nurses, Dieticians, Therapists, etc.) the facility will conduct a check with the appropriate licensing boards to assure that there are no disciplinary actions in effect against the applicant's professional license by any state licensure body as a result of a finding of abuse, neglect, exploitation, or mistreatment of residents or misappropriation of resident property.

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F 0844 Level of Harm - Potential for minimal harm Residents Affected - Some	Follow rules about disclosure of ownership requirements and tell the state agency about changes in ownership and/or administrative personnel. 45338 Based on interview and Direct Care Worker Registry & Health Facility Database review, the facility failed to provide written notice to the State Agency upon a change in the facility's Administrator. The facility reported a census of 53 residents. Findings Include: On 11/14/22 at approximately 9:30 AM, Staff N, Administrator explained they had been the facility's Interim Administrator since 10/26/22, and explained they had filed for their Provisional License. On 11/30/22 at 12:13 PM, review of the Direct Care Worker Registry & Health Facility Database demographics section for the facility revealed the Administrator name and license number documented had been for a previous Administrator for the facility. On 12/1/22 at 2:54 PM, the written notice to the State Agency to reflect the change in Administrator to reflect the staff member currently in the role had been requested from the facility. On 12/1/22 at 4:09 PM, Staff G, Regional Nurse Consultant (RNC) explained via email that on 10/30/22, verbal notification had been given to a Surveyor onsite in regards to the change in Administrators.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35434 Based on interview and facility policy review, the facility failed to ensure an effective QAPI (Quality Assurance Performance Improvement) process to address previously identified quality deficiencies and concerns, resulting in multiple repeated concerns and deficiencies on the current survey which had been previously identified in 2022. The facility reported a census of 53 residents. Findings Include: 1. Review of the CMS 2567 form dated 9/26/22 revealed, in part, deficiencies identified with resident funds, following physician orders, medication administration, and the reconciliation of narcotics. The current survey, completed 12/8/22 also identified concerns with the same above areas. 2. The Minimum Data Set (MDS) Assessment Tool dated 4/22/22, listed the Resident #3's Brief Interview for Mental Status (BIMS) score as 7 out of 15, indicating severely impaired cognition. The MDS dated [DATE], listed diagnoses for Resident #3 which included non-Alzheimer's dementia, difficulty walking, and muscle weakness The MDS stated the resident was independent with transfers and walking. The MDS section on cognitive patterns was blank and lacked documentation regarding the resident's cognitive status. The MDS dated [DATE], lacked documentation staff completed the assessment. A 6/26/22 Progress Note stated the resident eloped from the building around 8:00 a.m. and a Certified Nursing Assistant (CNA) heard the alarm sounding and found the resident walking up the driveway. A 6/30/22 Progress Note stated the facility received an order for a WanderGuard (an electronic wanderer alert device). The resident's Elopement Risk, dated 7/5/22, stated the resident was at high risk for elopement. 8/9/22 Care Plan entries directed staff to check the placement and function of the WanderGuard each shift and stated if the resident was actively exit seeking staff should redirect his attention or walk with him outside. A 9/18/22 Progress Note stated the resident exited the facility and a Nurse and CNA saw him and ran out and caught him. A 10/31/22 Progress Note stated another resident notified the facility by phone that the resident was walking up the street. The note stated staff immediately went up the street in a car and saw the resident approximately 5 blocks to the left of the facility walking on the sidewalk. The staff members drove him back to the facility. The facility lacked documentation the QAPI Team discussed previous survey concerns identified or Resident #3's history of exiting the building in order to prevent a recurrence. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/28/22 at 9:15 a.m., Staff O, Administrator from a sister facility stated she could not locate documentation of QAPI meetings conducted in the last 6 months. The facility policy QAPI Meeting Management, revised 08/19, stated the QAPI Program was directed by the Administrator and would focus on improving resident care. During an interview on 12/8/22 at 10:33 a.m., Staff AA Administrator stated they should complete QAPI Meetings quarterly and the members would include the Director of Nursing (DON), Medical Director, Social Services, and front line Nursing Staff.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 35434 Based on staff interview and facility policy review, the facility failed to ensure the Quality Assessment and Assurance Performance (QAPI) Committee met on a quarterly basis. The facility reported a census of 53 residents. Findings Include: During an interview on 11/28/22 at 9:15 a.m., Staff O, Administrator from a sister facility, stated she could not locate documentation of the QAPI Meetings conducted in the last 6 months. The facility policy QAPI Meeting Management, revised 08/19, stated the QAPI Program was directed by he Administrator and would focus on improving resident care. During an interview on 12/8/22 at 10:33 a.m., Staff AA, Administrator stated they should complete QAPI meetings quarterly and the members would include the Director of Nursing(DON), Medical Director, Social Services, and front line Nursing Staff.

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program for all new and existing staff members. 35434 Based on personnel file review, policy review, and staff interview, the facility failed to implement trainings for multiple training topics for 5 of 5 staff reviewed(Staff A, B, I, L, Q). The facility reported a census of 53 residents. Findings Include: 1. Staff A, Licensed Practical Nurse's (LPN) New Hire Form listed a hire date of 3/26/19. 2. Staff B, Certified Nursing Assistant's (CNA) Performance Evaluation Form, dated 12/28/20, listed a hire date of 1/12/07. 3. Staff I, CNA's New Hire Form listed a hire date of 3/3/21. 4. The undated facility employee phone list listed a hire date for Staff L, CNA of 10/7/22. 5. Staff Q, LPN's New Hire Form listed a hire date of 8/16/18. Staff A, B, I, and Q's employee file lacked documentation of education regarding communication, Resident Rights, Quality Assurance, Infection Control, compliance, ethics, and behavioral health training. Staff L's employee file lacked documentation of education regarding communication, Quality Assurance, Infection Control, compliance, ethics, and behavioral health training. The facility policy 2022 Mandatory Education included the following topics: abuse and neglect, Infection Control, resident rights, behavior health, communication, Quality Assurance and Performance Improvement (QAPI) and compliance and ethics. During email correspondence on 11/22/22 at 1:53 p.m., the Regional Nurse Consultant stated she was unable to provide documentation of education completed. During an interview on 12/6/22 at 12:19 p.m., the Director of Nursing (DON) stated staff should be current on all education and inservices.

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. 35434 Based on staff file review, policy review, and staff interview, the facility failed to ensure 5 of 5 staff members completed effective Communication Training (Staff A, B, I, L, Q) The facility reported a census of 53 residents. Findings Include: 1. Staff A, Licensed Practical Nurse's (LPN) New Hire Form listed a hire date of 3/26/19. 2. Staff B, Certified Nursing Assistant's (CNA) Performance Evaluation Form, dated 12/28/20, listed a hire date of 1/12/07. 3. Staff I, CNA's New Hire Form listed a hire date of 3/3/21. 4. The undated facility employee phone list listed a hire date for Staff L, CNA of 10/7/22. 5. Staff Q, LPN's New Hire Form listed a hire date of 8/16/18. Employee file review for Staff A, B, I, L, and Q revealed a lack of documentation of communication training. The facility policy 2022 Mandatory Education included the topic of communication. During email correspondence on 11/22/22 at 1:53 p.m., the Regional Nurse Consultant stated she was unable to provide documentation of education completed. During an interview on 12/6/22 at 12:19 p.m., the Director of Nursing (DON) stated staff should be current on all education and inservices.

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F 0942 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that staff members are educated on resident rights and facility responsibilities to properly care for its residents. 35434 Based on staff file review, policy review, and staff interview, the facility failed to ensure 4 of 5 staff members completed effective Resident Rights Training (Staff A, B, I, Q) The facility reported a census of 53 residents. Findings Include: 1. Staff A, Licensed Practical Nurse's (LPN) New Hire Form listed a hire date of 3/26/19. 2. Staff B, Certified Nursing Assistant's (CNA) Performance Evaluation Form, dated 12/28/20, listed a hire date of 1/12/07. 3. Staff I, CNA's New Hire Form listed a hire date of 3/3/21. 4. Staff Q, LPN's New Hire Form listed a hire date of 8/16/18. Employee file review for Staff A, B, I, and Q revealed a lack of documentation of resident rights training. The facility policy 2022 Mandatory Education included the topic of resident rights. During email correspondence on 11/22/22 at 1:53 p.m., the Regional Nurse Consultant stated she was unable to provide documentation of education completed. During an interview on 12/6/22 at 12:19 p.m., the Director of Nursing (DON) stated staff should be current on all education and inservices.

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. 35434 Based on staff file review, policy review, and staff interview, the facility failed to ensure 5 of 5 staff members completed Quality Assurance and Performance Improvement (QAPI) Training(Staff A, B, I, L, Q) The facility reported a census of 53 residents. Findings Include: 1. Staff A, Licensed Practical Nurse's (LPN) New Hire Form listed a hire date of 3/26/19. 2. Staff B, Certified Nursing Assistant's (CNA) Performance Evaluation Form, dated 12/28/20, listed a hire date of 1/12/07. 3. Staff I, CNA's New Hire Form listed a hire date of 3/3/21. 4. The undated facility employee phone list listed a hire date for Staff L, CNA of 10/7/22. 5. Staff Q, LPN's New Hire Form listed a hire date of 8/16/18. Employee file review for Staff A, B, I, L, and Q revealed a lack of documentation of QAPI Training. The facility policy 2022 Mandatory Education included the topic of QAPI. During email correspondence on 11/22/22 at 1:53 p.m., the Regional Nurse Consultant stated she was unable to provide documentation of education completed. During an interview on 12/6/22 at 12:19 p.m., the Director of Nursing (DON) stated staff should be current on all education and inservices.

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. 35434 Based on staff file review, policy review, and staff interview, the facility failed to ensure 5 of 5 staff members completed Infection Control Training (Staff A, B, I, L, Q) The facility reported a census of 53 residents. Findings Include: 1. Staff A, Licensed Practical Nurse's (LPN) New Hire Form listed a hire date of 3/26/19. 2. Staff B, Certified Nursing Assistant's (CNA) Performance Evaluation Form, dated 12/28/20, listed a hire date of 1/12/07. 3. Staff I, CNA's New Hire Form listed a hire date of 3/3/21. 4. The undated facility employee phone list listed a hire date for Staff L, CNA of 10/7/22. 5. Staff Q, LPN's New Hire Form listed a hire date of 8/16/18. Employee file review for Staff A, B, I, L, and Q revealed a lack of documentation for Infection Control Training. The facility policy 2022 Mandatory Education included the topic of Infection Control. During email correspondence on 11/22/22 at 1:53 p.m., the Regional Nurse Consultant stated she was unable to provide documentation of education completed. During an interview on 12/6/22 at 12:19 p.m., the Director of Nursing (DON) stated staff should be current on all education and inservices.

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F 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide training in compliance and ethics. 35434 Based on staff file review, policy review, and staff interview, the facility failed to ensure 5 of 5 staff members completed Compliance and Ethics training (Staff A, B, I, L, Q). The facility reported a census of 53 residents. Findings Include: 1. Staff A, Licensed Practical Nurse's (LPN) New Hire Form listed a hire date of 3/26/19. 2. Staff B, Certified Nursing Assistant's (CNA) Performance Evaluation Form, dated 12/28/20, listed a hire date of 1/12/07. 3. Staff I, CNA's New Hire Form listed a hire date of 3/3/21. 4. The undated facility employee phone list listed a hire date for Staff L, CNA of 10/7/22. 5. Staff Q, LPN's New Hire Form listed a hire date of 8/16/18. Employee file review for Staff A, B, I, L, and Q revealed a lack of documentation for Compliance and Ethics Training. The facility policy 2022 Mandatory Education included the topic for Compliance and Ethics. During email correspondence on 11/22/22 at 1:53 p.m., the Regional Nurse Consultant stated she was unable to provide documentation of education completed. During an interview on 12/6/22 at 12:19 p.m., the Director of Nursing (DON) stated staff should be current on all education and inservices.

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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. 35434 Based on staff file review, policy review, and staff interview, the facility failed to ensure the completion of of 12 hours of inservices for 2 of 2 Certified Nursing Assistants (CNAs) reviewed (Staff B and Staff I). The facility reported a census of 53 residents. Findings Include: 1. Staff C, Certified Nursing Assistant's (CNA) Performance Evaluation Form, dated 12/28/20, listed a hire date of 1/12/07. Staff C's file lacked documentation of inservices completed during the last year. 2. Staff I, CNA's New Hire Form listed a hire date of 3/3/21. Staff I's file lacked documentation of inservices completed during the last year. The facility policy 2022 Mandatory Education included the following topics: abuse and neglect, Infection Control, Resident Rights, behavior health, communication, Quality Assurance and Performance Improvement (QAPI) and compliance and ethics. During email correspondence on 11/22/22 at 1:53 p.m., the Regional Nurse Consultant stated she was unable to provide documentation of education completed. During an interview on 12/6/22 at 12:19 p.m., the Director of Nursing (DON) stated staff should be current on all education and inservices.

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide behavior health training consistent with the requirements and as determined by a facility assessment. 35434 Based on staff file review, policy review, and staff interview, the facility failed to ensure 5 of 5 staff members completed Behavioral Health Training (Staff A, B, I, L, Q) The facility reported a census of 53 residents. Findings Include: 1. Staff A, Licensed Practical Nurse's (LPN) New Hire Form listed a hire date of 3/26/19. 2. Staff B, Certified Nursing Assistant's (CNA) Performance Evaluation Form, dated 12/28/20, listed a hire date of 1/12/07. 3. Staff I, CNA's New Hire Form listed a hire date of 3/3/21. 4. The undated facility employee phone list listed a hire date for Staff L, CNA of 10/7/22. 5. Staff Q, LPN's New Hire Form listed a hire date of 8/16/18. Employee file review for Staff A, B, I, L, and Q revealed a lack of documentation of Behavioral Health Training. The facility policy 2022 Mandatory Education included the topic for Behavior Health. During email correspondence on 11/22/22 at 1:53 p.m., the Regional Nurse Consultant stated she was unable to provide documentation of education completed. During an interview on 12/6/22 at 12:19 p.m., the Director of Nursing (DON) stated staff should be current on all education and inservices.