STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035175	A. Building B. Wing	10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Desert Peak Care Center	8825 South 7th Street Phoenix, AZ 85042

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47910 Based on resident and staff interviews, the facility investigation report and documents, clinical record review, and policy review, the facility failed to ensure one resident (#123) was treated in a dignified manner. The deficient practice could negatively impact the psychosocial well-being of residents. The universe was 130 as all residents could be affected, the sample was one. Findings include: Resident (#123) was admitted to the facility on [DATE] with diagnoses that included Type I Diabetes Mellitus with Diabetic Neuropathy, Unspecified, Acquired absence of right leg below knee, Atherosclerosis of native arteries of extremities with intermittent claudication, bilateral legs, End-stage renal disease. During the initial part of the survey, an interview was conducted with resident (#123) on October 23, 2023 at 11:40 AM, who stated that CNA (certified nursing assistant) identified as (Staff #34) had come into his room, after he had turned on his call light. Resident (#123) stated the CNA turned off the call light and left without acknowledging him. The resident stated he turned his call light back on. Resident (#123) stated the same CNA, (Staff #34) came back into his room and proceeded to stare at him for a few minutes, without saying anything. Resident (#123) stated he asked the CNA why was she staring at him? Resident (#123) stated when he questioned her, the CNA started a high-pitched, cackling laugh sound directed at him. The resident stated she was near his bed, when she started staring and laughing at him. The resident stated he asked the CNA why was she laughing? The resident stated her reply was it's not against the law to laugh. Resident (#123) stated there was no reason for her laughter and felt disrespected, afraid and now felt that I have to keep one eye open when she works. Resident (#123) stated (LPN, Staff #355) was aware of the situation. Resident (#123) stated the CNA refuses to change him for hours and he will sometimes have to wait for the next shift to be changed. The resident stated the situation has stressed him out and has requested the Veterans Administration (VA) to locate another facility to reside in. Resident (#123) became tearful discussing the incident. On October 23, 2023 at 12:13 PM, the Administrator (staff #223) was notified of the resident's allegations and stated that she would begin the investigation process. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the comprehensive care plan dated August 9, 2023 and revision on August 10, 2023, revealed the following: ADL: requires extensive staff assistance with activities of daily living (ADL) with interventions that stated the resident is mostly dependent for all ADL with 1-2-person assistance due to self-care deficit related to right below the knee amputation. A Medicare 5-day MDS (minimum data set) assessment dated [DATE], revealed a Brief Interview of Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The assessment also revealed the resident required extensive assistance with bed mobility, personal hygiene, and required 1-2-person assistance with transfer, dressing, toilet use, and bathing. Review of nursing progress notes dated September 2023 through October 22, 2023, revealed no evidence that the resident or other staff had reported any concerns regarding the resident's care/treatment by the Certified Nursing Assistants (CNAs). Review of the facility investigation report dated October 26, 2023, revealed that October 23, 2023 resident (#123) stated to a surveyor that a CNA was not answering his call light in a timely manner and refused to give him iced water. The report included the facility DON (Director of Nursing/staff #80), social services (staff #341) and Administrator (staff #223) were notified, and social services visited the resident to discuss how the resident felt and obtain feedback. The report was currently ongoing and did not have a resolution documented on the grievance/complaint report. The investigation report included the following witness statements: Staff #341 (LPN) reported that CAN (staff #34) has a negative attitude, complaining about staff and residents, has never seen staff #34 argue with resident (#123) or refuse to assist him, finds staff #34 argumentative with staff and others at times and does not like to follow directions. Staff #297(LPN) reported that staff #34 does not answer call lights in a timely manner, is very negative, complaining and argumentative and refuses to follow nurses' directions at times. Staff #221 (RN) reported staff #34 is not professional, argumentative, and antagonistic with staff and others, does not follow directions from nursing leaders. Staff #136 (CNA) reported staff #34 is thorough and abrupt at times. Staff #342 (CNA) reported staff #34 can provide good care, is argumentative and negative, takes a while to answer call lights. The investigative report included staff #34's statement dated October 24, 2023 which included that she denied ever refusing to provide care for the resident or purposely not answering his call light. Hat she does not spend a lot of time with the resident and that resident (#123) will appear fine at the beginning of the shift then becomes rude, aggressive, and angry towards her so she has another CNA provide his care. She further stated she believed resident (#123) did not like her because she is African American. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility grievance documentation, revealed a formal Grievance/Complaint Report dated August 17, 2023 filed by resident (#123) and received by RN (Staff #221) revealed that resident (#123) had filed a formal grievance. The report states as follows: Resident reports that he doesn't like the CNA (Staff #34) laughs and doesn't seem to care for her. Actions taken to resolve grievance/complaint dated 08/21/23: Educate Staff (#34) about customer service; Not to assign staff (#34) to room unless absolutely necessary. Resolution of Grievance/Complaint checked yes states the following: Gave staff (#34) education in customer service, resident rights and giving care on time. Staff (#34) will not take care of the resident. The form was completed on August 18, 2023 and signed by the administrator (staff #223) and Director of Nursing (staff #80). On October 26, 2023 at approximately 10 AM the Administrator (staff #223) delivered requested staff #34's employee records and stated, based on interviews with staff, residents and violation of workplace policies, CNA (#34) had been terminated October 26, 2023. An interview was conducted on October 26, 2023 at 02:24 PM with the Administrator (staff #223 and Staff (RN Consultant #443) who stated that she was involved with Human Resources and thought CNA (staff#34) could be educated, but she could not. She stated that she did interview the CNA, and that staff #34 denied the allegations made. The Administrator stated nursing staff are responsible of making the room assignments, but had not been informed of any room restrictions for Staff (CNA#34). She further stated the understanding would be to keep Staff (CNA #34) on [NAME] Lane, but she would not take care of the resident (#123) unless necessary. The Administrator reviewed the grievance/complaint formed dated August 17, 2023. The Administrator acknowledged it was her signature on the form stating CNA (#34) would not provide care for resident (#123). The Administrator stated she needed to pay closer attention when signing documents. An interview was conducted on October 27, 2023 at approximately 10:00 AM with resident #123's roommate (resident #69), who stated that an unidentified CNA had treated him roughly, did not want to give him cleaning supplies and had accused him of playing in his feces. Resident stated he could not recall the date or the staff's name, but was not afraid or felt threatened in any way. Resident stated if he had any concerns he would tell his son. An interview was conducted via telephone on October 27, 2023 at 8:10 AM with LPN (staff #355), who stated that she has worked for the facility for four months on night shift in [NAME] Lane and is familiar with staff #34 and resident #123. She stated she was informed by administration that staff #34 was not to be assigned to resident #123's room. She further stated she had not seen anything concerning with the CNA and resident. She stated she would switch sections if CNA #34 was assigned to the resident's room, but there were times she would be assigned due to short staffing or due to others who could not assigned to a certain area. Staff #355 stated if she were assigned to the resident's room she would be monitored by the nurse or another CNA. She stated when she was unable to re-assign staff #34 she would inform the DON (staff #80). She stated she was unaware of any recent concerns and she could not recall if the resident had reached out to her regarding staff #34. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on October 27, 2023 at 11:36 AM with a CNA (staff #342), who stated that she had been unaware of any concerns, until recently when the resident had voiced his concerns. She stated she wrote the grievance and gave it to the administrator. She stated resident #123 had informed her that CNA #34 took a long time to answer his call light and would cackle at him. She also stated the resident told her he had asked for ice water and CNA #34 had told him he did not need ice water. She stated she was surprised the resident had not told anyone, as he is very vocal. She stated she did reassure him that he could always tell her and she would address the situation. She stated as Lead CNA, she should have been notified of the restrictions for CNA #34 and would have ensured this information was relayed to the nursing staff and not allowed her to be assigned to the resident. Review of the facility policy titled, Resident Rights, states employees shall treat all residents with kindness, respect, and dignity.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46606 Based on observations, and resident and staff interviews the facility failed to ensure a resident (#6) had the means to communicate with staff, by failing to ensure the call device was accessible to the resident. The deficient practice can result in residents' needs not being met in a timely manner. The universe was 130 and the sample was one. The findings include: Resident #6 was readmitted to the facility on [DATE] with diagnoses that included coronary artery disease, hypertension, gastroesophageal reflux disease, anxiety disorder, and manic depression. The admission Minimum Data Set assessment dated [DATE] revealed a Brief Interview for Mental Status score of 12 which indicated the resident had moderate impaired cognition. During the initial observation of resident #6 conducted on October 23, 2023 at 10:07 AM, the call device was observed on the top of the light fixture, and out of resident's reach. During an interview with the resident #6 conducted on October 23, 2023 at 10:07 AM, he stated that the call device was placed on the light fixture when they painted his room two weeks ago. An additional observation was conducted on October 25, 2023 at 8:34 AM. Staff was observed entering the resident's room and then shutting the door. After the staff left, the call device was observed still on top of the light fixture. An interview was conducted with resident #6 on October 25, 2023 at 8:42 AM. The resident stated that he does not normally use it but that the device needs to be placed where he can reach it, in the event he needs to use it. Resident #6 stated that currently, if he needs assistance he gets on his wheelchair and goes to the nurse's station to get help. He said that the call device has been on top of the light fixture a few nights. Another observation was conducted on October 26, 2023 at 1:09 PM. The call device was observed still up on the light fixture which was located on the wall on the left-hand side of the room by the foot of the bed. During the observation, the resident asked another surveyor to hand him the call device so he can place it where he can reach it. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with a Certified Nursing Assistant Lead (CNA Lead/staff #342) on October 27, 2023 at 9:50 AM. Staff #342 stated that CNAs are supposed to place the call light where residents can reach them. She said at the beginning of the shift CNAs are to lay eyes on residents and ensure they can access the call light. Staff #342 noted that there should never be a time when the call light is out of the resident's reach. The call device is normally attached to the bed. If the CNA is changing the sheets on the bed, they need to make sure that the device is placed back within the resident's reach. When asked if she noticed that these past few days, resident #6's call device was not accessible, she stated she had not noticed. She said that resident #6's call device was normally placed on his bed or on the side of his pillow. Staff #342 stated that the call device should not have been placed on the light figure indefinitely and should have been placed where the resident could reach it. She stated that she last checked the call device this past weekend. She said that CNAs should check that call devices are within the residents reach. However, she also noted that resident #6 comes out of his room and into the hallway to ask for assistance. An interview with a registry Licensed Practical Nurse (LPN/staff #125) was conducted on October 27, 2023 at 10:02 AM. Staff #125 noted that nursing staff makes sure that call light is within the residents' reach. She noted that she normally assigned to various units but was familiar with resident #6. When she was informed that resident #6's call device was stored on to of the light fixture, she stated that it was not supposed to be placed on the light fixture. Staff #125 stated that CNAs are supposed to ensure call device are within the residents' reach. She also noted that nurses are supposed to check as well that call devices are within resident's needs. However, she stated that resident #6 comes out of his room and lets the nurse know what he needs. She also stated that resident #6 had not mentioned anything about his call light. During an interview with the Director of Nursing (DON/staff #80) conducted on October 27, 2023 at 11:15 AM, she noted that she expects her nursing staff to ensure that call devices are within residents' reach each time they go into the residents' room. If staff has to move the call device for any reason during care or services, they should make sure that it is placed back within the residents' reach afterwards. She stated that the call device should not be out of the residents' reach. However, she noted that when it comes to resident #6, he is very independent and is capable of letting the staff know of his care needs.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40581 Based on clinical record review, staff interviews, and the facility policy and procedures, the facility failed to ensure one resident (#10) had the correct advance directive in place. The deficient practice could result in residents not being allowed to make their own medical decisions. The universe is 130 and the sample is one. Findings include: Resident #10 was admitted to the facility on [DATE] with diagnoses that included atherosclerotic heart disease, chronic kidney disease, and unspecified protein-calorie malnutrition. Review of the clinical record revealed an advanced directive statement dated February 26, 2022 for a do not resuscitate (DNR) status. Review of the clinical record also revealed an advanced directive statement form that was not completed, signed or dated with documentation of refusal to sign. Review of the order summary revealed an order dated August 5, 2022 for full code status. The care plan dated May 12, 2023 revealed that the resident was a full code status. Interventions included to call for help immediately and begin basic life support sequence. The minimum data set (MDS) dated [DATE] revealed that the brief interview score of 10 indicating the resident has a moderate cognitive impairment. Review of the advanced directive statement dated October 25, 2023 revealed that the resident did not want cardiopulmonary resuscitation and was (DNR) status. An interview was conducted on October 25, 2023 at 12:38 PM, with the Social Services Director (staff #66), who stated that the facility is responsible for reviewing the advanced directive form with the resident/power of attorney (POA) and ensuring that it is completed, signed and dated. She reviewed the clinical record for the resident and located: -an advanced directive dated 2022 documenting the resident was DNR, signed by the POA. -an advance directive form that was not dated, signed or completed. -an order for full code status dated August 5, 2022. During the interview, staff #66 called the resident ' s POA, who stated that she and the resident had already discussed it and had agreed that he wanted to be DNR status. Staff # stated that there is risk of doing the wrong thing when the documentation is not correct and a very dangerous position to put the family in. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview conducted on October 25, 2023 at 1:18 PM, with a licensed practical nurse (LPN/staff #341), she reviewed the orange binder labeled Advanced Directives and DNR located at the nurse station and said that she could not find the advanced directive for the resident. Then, she reviewed the electronic clinical record and stated that the resident was full code status. An interview was conducted on October 26, 2023 at 2:22 PM, with the Director of Nursing (DON/staff #80), who do not have the staff list stated that the resident/POA should complete the Advanced Directive form and it should be placed in the clinical record. She reviewed the resident ' s clinical record showing that the resident had three advanced directive forms: February 26, 2022 was a DNR status, the second form was not completed, signed or dated, and the third form dated October 25, 2023 was a DNR status, and she agreed that the full code status was incorrect. The facility's policy, Advance Directives date September 2022 states that the resident has the right to formulate an advance directive, including the right to accept or refuse medical or surgical treatment. Advance directives are honored in accordance with state law and facility policy.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 46606 Based on observations, staff interviews, and policy reviews, the facility failed to ensure that maintenance and comfortable interior was provided for 1 resident (#106). The deficient practice could result in resident rooms not having a homelike environment. The universe was 130 the sample was one. Findings include: An interview was conducted with resident #106 on October 23, 2023 at 11:42 AM. Resident # 106 stated that the baseboards in his room is coming off and that there is a huge cut out hole in his room where cockroaches are coming out. An observation was conducted of resident #106's room on October 23, 2023 at 11:42 AM. An area approximately 2-feet in high and 1-foot wide was discovered on the wall by the foot of the A-side bed. An additional observation was conducted of resident #106's room on October 25, 2023 at 8:24 AM. It revealed that the hole on the wall was still present. However, no evidence of pest coming out of the hole was found. An interview with a Certified Nursing Assistant (CNA/staff #118) was conducted on October 25, 2023 at 8:24 AM. Staff # 118 stated that the hole has been there for a few days. She noted that the resident has not complained to her about the hole. However, she did verify that the resident is aware that there is a hole on the wall in the room. Staff #118 stated that the hole was caused by the bed hitting the wall when staff was moving the bed. Review of work order log with a date range of October 1, 2022 thru October 22, 2023 did not reveal any work order regarding identifying the hole in the wall for resident's room. During a surveyor walk around conducted on October 25, 2023 at approximately 9:50 AM, staff #118 notified the surveyor that the hole in resident #106's room has been fixed. An interview was conducted with the Maintenance Director (staff #221) on October 25, 2023 at 9:54 AM. Staff #221 stated that work orders are normally placed by the nurse in TELS system to inform maintenance of issues that need to be resolved. Depending on the issue it is rated between low and critically high and transmitted to the maintenance team for resolution. He said that the maintenance team checks TELS often to check work orders. Staff #221 stated that nurses and staff are pretty vocal about building issues. Maintenance double checks with the staff to ensure issues are taken care. Alternatively, staff also contacts maintenance via phone call or text message. He indicated that a hole in the wall or a patch job is normally pretty high priority. Staff #221 stated that maintenance checks TELS daily to see what needs to be addressed depending on emergent status. When asked if he was aware of the hole in resident #106's room, he stated he is not sure and that he might not know if it was not on TELS. Staff #221 stated that the facility is pretty big so they relay on staff to report issues. During the interview the room in question was visited with staff #221. Staff #221 noted that since the hole was pretty big, it should have been fixed the same day as long as the supply is available and if not, the supply should have been obtained to fix the hole immediately. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with Maintenance Assistant (staff #198) on October 25, 2023 at 10:06 AM. Staff #198 stated that a work order was placed on TELS yesterday for resident #106's room. He said that the wall was prepped yesterday and completed today. An interview with a Licensed Practical Nurse (LPN/staff #125) was conducted on October 27, 2023 at 10:02 AM. Staff #125 stated that the facility utilizes a TELS system for work orders. She said that work order requests are normally completed within 24 hours and that if it was an emergency, it is fixed immediately. Staff #125 said that holes in the wall are normally fixed within 24 hours from when it was reported. She noted that part of the nursing staff's job when they do their rounds is to check the resident's room to make sure it is safe for the resident and that it is in good order. An interview with the Director of Nursing (DON/staff #80) was conducted on October 27, 2023 at 11:15 AM. Staff #80 stated that her expectations with regards to work orders needs and turnaround time is that work order needs are inputted into TELS and that staff inform maintenance right away of any work order needs. She said that she expects the maintenance team to be on the message thread regarding work orders. She also noted that she expects maintenance to take care of work order needs within a reasonable amount of time. The facility policy titled Maintenance Service revised December 2009 stated that maintenance service shall be provided to all areas of the building, grounds, and equipment. The policy indicated that the maintenance department is responsible for maintaining the building, grounds, and equipment in a safe and operable manner at all times. Additionally, it said that maintenance personnel should maintain the building in good repair and free from hazards. Review of the facility policy titled Work Orders, Maintenance revised April 2010 stated that maintenance work orders shall be completed in order to establish a priority of maintenance service. Furthermore, it noted that in order to establish a priority of maintenance service, work orders must be filled out and forwarded to the Maintenance Director. The policy also noted that the department directors are responsible for filling out and forwarding work orders to the Maintenance Director.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47910 Based on clinical record reviews, facility documentation, staff interviews, and policy review, the facility failed to ensure that allegations of misappropriation of resident property were reported to the State Agency and that the results of the investigations were submitted to the State Agency within the required time frame for one resident (#123). The universe was 130 the sample was one. Findings include: Resident (#123) was admitted to the facility on [DATE] with diagnoses that included Type I Diabetes Mellitus with Diabetic Neuropathy, Unspecified, Acquired absence of right leg below knee, Atherosclerosis of native arteries of extremities with intermittent claudication, bilateral legs, End-stage renal disease An admission MDS (Minimum Data Set) assessment dated [DATE] revealed the resident scored 15 on a BIMS (Brief Interview for Mental Status) assessment, which indicated the resident was cognitively intact. A progress note dated 09/30/2023 1:40 AM, revealed resident stated the last time he had seen his card was last night and it must have gone missing between last night and this morning. When he woke up for breakfast and his phone and wallet were no longer on the nightstand. The phone was found behind his roommate's TV and the credit cards were missing. When the resident called to report the missing cards and close the accounts the resident was informed a transaction was made in the amount of $321 dollars to an airline. A progress note dated 10/01/2023 17:19 states the police came out to complete incident report. Report # 23-1493202. American Airlines also states they will not hold him liable and will issue refund. A progress note dated 10/02/2023 1:28 PM, revealed social services interviewed the resident regarding his debit card being allegedly being used. The resident informed social services his phone/wallet (phone has a case on it where he can put his debit cards) on his night stand. The resident reported that sometimes he keeps it in his top drawer of his night stand but the previous night (Saturday 9/30) he believes it was on his nightstand. Resident reported to social services that he had not given consent for anyone to use his American Express card and had contacted the police. Social Services contacted the family who stated they did not have access to the resident's bank information. A progress note dated 10/02/2023 2:41 PM revealed social services attempted to speak with Frontier Airlines as well as American Airlines with resident (#123) but resident was asleep and would attempt the following day to see if the airlines will provide the name of who purchased the ticket. In an interview was conducted with the Executive Director (Staff #223) on October 25, 2023 at 09:20 AM, she stated that APS was notified regarding the incident, had investigated and provided a report number. Staff (#223) further stated that she was poorly advised and has since been educated on the process of reporting resident incidents. Staff (#223) stated she was the responsible party for notifying the state agency. (continued on next page)

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	035175	A. Building B. Wing	10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Desert Peak Care Center	8825 South 7th Street Phoenix, AZ 85042

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a facility policy titled Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating states All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46606 Based on closed record review and staff interviews the facility failed to ensure that all transfer/discharge notifications were made for one resident (#13). The deficient practice could lead to notifications of resident transfer/ discharge not being made to all required parties. The universe was 130 the sample was 1. Findings include: Resident #13 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that includes schizophrenia, bipolar disorder, dementia, anxiety disorder, personality disorder, and pseudobulbar affect. A nurse practitioner order dated September 22, 2023 revealed an order to send the resident to the hospital immediately for hypoxia. Review of the resident's clinical record did not reveal that a transfer to hospital form (e-Interact) was completed for the incident on September 22, 2023. A progress note dated September 22, 2023 revealed that the resident was sent to the emergency room immediately and that the Director of Nursing and Administrator were notified of changes. An additional progress note dated September 23, 2023 indicated that the resident was admitted inpatient (to the hospital) for diagnosis of pna (pulmonary nodular amyloisosis) with possible aspiration. The progress note stated that all parties made aware. However, it did not indicate who all parties were. Continued review of the clinical record revealed no further documentation related to this incident found. There was no evidence found in the clinical record that the resident's representative/s or Ombudsman were notified of the resident's transfer to the hospital on September 22, 2023. The discharge minimum data set (MDS) dated [DATE] revealed that the resident's discharge was coded as an unplanned discharge, return anticipated. During a document request for Ombudsman notification on October 24, 2023 at 9:01 AM, the Administrator (staff #223) stated that they do not have an ombudsman notification log. She said that the ombudsman is normally in the building every 2 weeks and that is when they inform her of discharge/hospital transfers. She said she will try her best to put one together from emails. Review of the documents the facility put together as ombudsman notification equivalent revealed an Ombudsman visit log/sign in logs and a separate transfer/discharge log. The logs did not document that the transfer/discharge were discussed during the visits. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with Licensed Practical Nurse (LPN/staff #125) was conducted on October 27, 2023 at 10:02 AM. The LPN stated that if a resident is sent to the hospital the provider, family, POA (power of attorney), and public fiduciary are notified. She stated that as a nurse she does not provide the family or ombudsman anything in writing but does call. Staff #125 sated that an e-Interact is completed for all transfers to the hospital. If the transfer is an emergency/911 event then the e-Interact is completed following the event and documented on PCC (Point Click Care). When asked what all parties notified mean she stated that she does not know what it means and that it is not sufficient documentation. Staff #125 said that documentation regarding the transfer notification should be specific and indicate that the family, physician, POA, Director of Nursing, and administrator were notified. Review of the Social Services e-mail notification indicated that a notification was sent to resident #13's public fiduciary regarding her hospitalization but there was no evidence that a copy was sent to the Ombudsman. During an interview with the Director of Nursing (DON/staff 80) conducted on October 27, 2023 at 11:15 AM, the DON stated that if a resident goes out to the hospital emergent, then the notification is conducted after the fact. If not then notification for the family and ombudsman is supposed to happen as the incident is going on. She indicated that nurse is supposed to notify the ombudsman and if not then Social Services should notify or email the ombudsman. A policy regarding ombudsman notification was requested on October 25, 2023 at 12:20 PM but was not provided. Instead an Admission Handbook for the State of Arizona was provided which indicated that during transfer/discharge, the facility will notify the appropriate state agency. Additionally, it noted that if the resident was transferred because of an emergency situation, the facility will provide the required notice a soon as reasonable.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46606 Based on clinical record review, an interview, and policy, the facility failed to provide one resident (#13) and/or the resident's representative with bed-hold policy information before a transfer to the hospital. The deficient practice could result in residents being unaware of their bed-hold rights. The universe is 130 the sample is one. Findings include: Resident # 13 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that includes schizophrenia, bipolar disorder, dementia, anxiety disorder, personality disorder, and pseudobulbar affect. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] indicated that the resident had a Brief Interview for Mental Status (BIMS) score of 4, which indicated severe cognitive impairment. Review of nursing note dated September 22, 2023 revealed that the resident left with Emergency Medical Services (EMS) and that the resident was sent to the hospital. A progress note dated September 23, 2023 indicated that the resident was admitted inpatient (to the hospital) for diagnosis of pna (pulmonary nodular amyloisosis) with possible aspiration. The progress note stated that all parties made aware. However, it did not indicate who all parties were. Continued review of the clinical record did not reveal documentation that the facility provided the resident and the resident representative written notice of the facility's bed-hold policy when the resident was transferred to the hospital on September 22, 2023. Review of the entry MDS assessment dated [DATE] indicated that the resident reentered the facility that day. An interview with the Director of Nursing (DON/staff #80) was conducted on October 27, 2023 at 11:15 AM. Staff #80 stated that she is not sure that notification of bed hold policy is part of the transfer process. She said that residents are notified of the policy during admission-it is part of the admission packet. Staff #80 said that to her knowledge bed hold is automatic since residents are in long term care. Review of the facility policy titled Bed-Holds and Returns revised March 2017 indicated that prior to transfers and therapeutic leaves, residents or resident representatives will be informed in writing of the bed-hold and return policy. Furthermore, the policy stated that prior to a transfer, written information will be given to residents and resident representatives that explains in detail the rights and limitations of the resident regarding bed holds; the reserve bed payment policy; the facility per diem rate required to hold a bed or to hold a bed beyond the state bed-hold period; and the details of the transfer.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46606 Based on clinical record reviews, staff interviews and facility policy and procedures, the facility failed to ensure that a Preadmission Screening and Resident Review (PASRR) level I was completed accurately and a level II was sent to the state for determination for one resident (#13). The deficient practice could result in specialized services not being identified and provided to residents. The Universe was 22 the sample was 1. Findings include: Resident #13 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that includes schizophrenia, bipolar disorder, dementia, anxiety disorder, personality disorder, and pseudobulbar affect. Review of the resident's facesheet revealed the following new diagnoses and date of onset: dementia, with other behavioral disturbance dated January 3, 2023 and undifferentiated schizophrenia dated January 15, 2023. Review of the PASRR Level I Screening Tool dated March 5, 2023 revealed the form was not adequately filled out. Section B. Mental Illness pertaining to the question does the individual have any of the following mental disorders was left unanswered. The question does the individual have a substance related disorder was also left unanswered. The symptoms portion under the area interpersonal with the question has the individual exhibited interpersonal symptoms or behaviors was left unanswered. Additionally, the concentration/task related symptoms portion was left answered. Furthermore, Section D. Referral Determination was also left unanswered. Review of the annual Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 4, indicating that the resident has severe cognitive impairment. Section I. Active Diagnoses indicated that the resident's diagnoses included Non-Alzheimer's Dementia, anxiety disorder, bipolar disorder, and schizophrenia. A care plan initiated on September 28, 2023 indicated that the resident has a behavior problem related to undifferentiated schizophrenia. Interventions indicated to assist the resident to develop more appropriate methods of coping and interacting, encourage to express feelings appropriately, and ensure needs are met in order to reduce agitation. A care plan initiated on September 28, 2023 revealed that the resident has impaired cognitive function/dementia or impaired thought process. Interventions include communicate with the resident/family/caregivers regarding resident's capabilities and needs. Further review of the clinical record did not reveal a PASRR Level I after the PASRR Level I dated March 5, 2023. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Social Services Director (staff #66) was conducted on October 26, 2023 at 11:32 AM. Staff #66 stated that the PASRR process entails reviewing existing PASRR for new admits to screen diagnoses, verify primary diagnoses, indicators of behavior to cause harm, and indicators that will prevent them from thriving. Staff #66 also noted that diagnoses such as schizophrenia and violent behaviors usually triggers level II. She stated that residents must have a level I PASRR. She said that she reviews level I from prior facility and if the form is complete then she takes it and uses it. If the resident have new updates then it prompts a new level I depending on the diagnoses or it can also be a level II. Staff #66 noted that they have a resource person that provides her guidance regarding PASRR so she can get better. She stated that it is a work in progress to get the facility's PASRR process solidified. She noted that there was an audit conducted by Corporate approx. 1 to 2 weeks ago. She stated that completed PASRR goes to medical records for then to upload into PCC (Point Click Care). When there is a level II she would send it to the state point of contact but she was informed that the individual is no longer there so there is an PASRR email it is sent to and that she can only send 2 a day. When asked about resident #13, she noted that looking at her PASRR it is not current. However, she does not need one since there is one on file from 2009. When asked if new diagnoses pertaining to mental illness or intellectual disability would have triggered a need for new PASRR, staff #66 then said that resident #13 should have a new level II PASRR. She admitted that resident #13 does not have a current level II. When asked to pull up resident #13's PASRR from March 2023, she said that looking at it, it was not complete. She said she was not properly trained at that time and that is why it was not completely filled out. An interview with the Director of Nursing (DON/staff #80) was conducted on October 27, 2023 at 11:15 AM. Staff #80 stated that her expectation is that PASRR are completed in a timely manner and according to policy. She noted that PASRR is a work in progress with her social services still learning. Review of the facility's policy titled Behavioral Assessment, Intervention and Monitoring revised March 2019 stated that all residents will receive a level I PASRR screen prior to admission. If the level I screen indicates that the individual may meet criteria for a mental disorder, intellectual disability or related condition then the resident will be referred to the state PASRR representative for the level II determination. Additionally, new onset or change in behavior that indicate newly evident or possible serious mental disorder, intellectual disability, or a related disorder will be referred for a level II evaluation. The facility policy titled Admission Criteria revised March 2019 noted that all new admissions and readmissions are screened for mental disorder, intellectual disabilities or related disorders per the Medicaid Pre-Admission Screening and Resident Review (PASRR). Additionally, it stated that the social worker is responsible for making referrals to the appropriate state-designated authority.

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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** 47910 1. Based on clinical record review, staff interviews and contract review, the facility failed to ensure one resident (#43) received treatment and care in accordance with professional standards of practice. The facility failed to ensure communication was provided to the family of the care and services provided by hospice. This failure has the potential for confusion between resident's family, the facility and the hospice provider. The universe is 130 the sample was 2. Findings: Resident (#43) was admitted to the facility on [DATE] with diagnosis that included, Unspecified Dementia, Unspecified severity; without behavioral disturbance, Psychotic Disturbance, Mood Disturbance and anxiety, Cerebrovascular disease; unspecified, Hemiplegia and Hemiparesis following cerebral infarction affecting left non-dominant side. Review of the quarterly MDS dated [DATE] Section O - Special Treatments, Procedures, and Programs revealed resident (#43) is receiving Hospice Care. Review of the physicians orders revealed resident admitted to Stillwater Hospice for CVA on January 26, 2022. A review of the Care Plan dated October 18, 2023 revealed the following, resident (#43) is at nutrition risk related to diagnosis of dementia, dysphagia, cerebrovascular disease, Type II diabetes, COPD, Hypertension, hyperlipidemia, underweight BMI and hospice. Review of the hospice agency binder for resident (#43) failed to indicate documentation that hospice had provided updated information regarding the care and services Resident (#43) was receiving from the hospice provider. On October 25. 2023 at 12:05 PM, an interview was conducted with Licensed Practical Nurse (LPN) (Staff # 341). Staff (341) stated she has worked for the facility for almost six years and has provided care for resident (#43) for three or four years. Staff (#341) stated the nurse assigned to the resident is responsible for monitoring hospice and the care they are providing for the resident. She stated the assigned nurse communicates directly with the hospice nurse or CNA regarding the residents needs. Staff (#341) stated that care provided to the resident is documented in the hospice blue binder for the resident. She stated services provided to the resident are showers and medications and the facility is alerted that they are visiting the resident. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Staff (#341) stated Hospice is responsible in communicating with the family what care they are providing. She stated hospice had informed her that they would update the daughter anytime there was a change of condition and that the assigned nurse does not have any way to ensure that hospice is communicating with the family, other than a verbal communication that they would. Staff (#341) stated the family had complained to her approximately six months prior about not being informed that the resident had fallen. She stated she provided the family with the information, but failed to notify or document that the daughter (POA) had not been contacted. Staff (#341) stated the nurse assigned and hospice were both responsible, in notifying the family that the resident had fallen. Staff (341) could not recall the date the resident had fallen. Resident (#43) has had multiple falls while in the facility. On October 25. 2023 at 01:38 PM, an interview was conducted with Social Services Director (Staff #66) who stated social services is in attendance with Hospice for the first meeting with the family to know how services are coordinated, any communication with the family, how this is going to happen and how often. Staff (#66) stated that until a family member communicates they are not being informed or provided updates she has no way of knowing it is not occurring. Staff (#66) further stated it was a trust partnership that was verbally communicated between hospice and the facility, given that the contract between the facility and hospice provider is very bland and does not indicate when they are to communicate with the family. Staff (#66) review the hospice binder for resident #43) and stated she did not see a communication trail where hospice has spoken to the family; there were only 2 or 3 notes from the hospice team and the resident has been on hospice for almost 2 years. She stated she was concerned that she has to dissect the communication and agreement. Staff (#66) stated she was unaware that there was no documentation, further stating she had been in contact with Stillwater Hospice because this is a huge problem. Staff (#66) stated I have a family member who feels they are let down by two entities; hospice and the facility. It is clear that there has been no communication with the family regarding the residents care. Staff (#66) stated the risks associated in not providing the family with information regarding the resident can cause worry for the family in not knowing, contraindications if a family should bring something in for the resident that may interfere with their medications. Staff (#66) further stated it is about the continuity of care and when the facility and hospice are not communicating effectively, it can interfere in the resident's care. She further stated she believed the hospice social worker had contacted the family once or twice, but was unsure and believes there may have been some difficulty contacting the family. On October 26, 2023 at 12:01 PM an interview was conducted with Stillwater Hospice Registered Nurse (RN #444) who stated she has been providing care for resident (#43) for two months. She stated it is the responsibility of the herself, the hospice social worker and the social worker for the facility in providing the family with updates regarding the resident's care and services. She further stated she has attempted to reach out to the family once, since assigned to the resident. She also stated she checks in with the facility social worker every time she is in the facility. She stated she speaks to the nurse assigned to the resident and the CNA's. Additionally stated both she and the hospice social worker work, closely together and during their Interdisciplinary team meetings discuss the residents plan of care and that by having conversations with the facility social worker, is how they maintain a continuum of care. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Staff #444 stated her responsibilities in providing care and services for resident (#43) are the seen by the RN one time per week and the CNA visits one time a week. Additionally she stated she completes the resident's vital signs, assesses the residents skin condition, cognitive decline, by mouth intake, last bowel movement, review medications for refills, check if the residents has pain, any change of condition or any check if any changes need to made. She stated If a there are any changes with the resident, this is reported to the facility nurse and social worker and to the family, to keep them in loop. She stated resident (#43) has been stable, with no decline or progression. Continent of bowel and bladder, is able to get to the bathroom. She added notification or updates to the family depends on the family member and in her experience, it is a collaborative approach between the facility social worker, the hospice RN and the hospice social worker. An interview was conducted with the Director of Nursing (Staff #80) on October 27, 2023 at 10:06 AM. She stated the facility collaborates the resident care with hospice by having meetings with the hospice staff, the hospice nurses and the hospice case manager will communicate with her directly. She stated if a resident is receiving hospice services, it is the hospice provider who is responsible in providing notifications to the family. She further stated it is her expectations that once the hospice nurse has provided a report to the facility and has also informed the facility they will reach out to the family, that she will also ask the floor nurse to update the family of any concerns or changes. She stated these notifications have not been documented as there have been issues with documentation from staff. She further stated these notifications to the family would come from the facility social services and hospice. Staff (#80) stated the risks of not providing the family with updates regarding the resident's care provided by hospice is if there were a significant change the family may not be informed of the resident's current condition. According to the facility's Stillwater Hospice Services contract effective October 12, 2022, Article III Responsibilities of Facility 3.7 Coordination of Care and Communication. states Facility (i) actively participate in the coordination of the Hospice Patients' care in accordance with current professional standards and practice, including participating in Hospice's ongoing interdisciplinary comprehensive assessments, developing and evaluating the Plan of Care, and contributing to patient and family counseling and education; and (ii) participate in meetings with Hospice under Section 4.6. A review of the facility policy titled Hospice Program states Hospice services are available to residents at the end of life. 13. Coordinated care plans for residents receiving hospice services will include the most recent hospice plan of care as well as the care and services provided by our facility (including the responsible provider and discipline assigned to specific tasks) in order to maintain the resident highest practicable physical, mental, and psychosocial well-being. 48488 2. Based on observations, clinical record review and staff interviews the facility failed to ensure medications were administered by a physician for one resident. The census was 130. This deficient practice could result in adverse effects to the resident. Findings include: Resident #16 was admitted on [DATE] with diagnosis that included dementia and unspecified hearing loss. The resident was edentulous. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The minimum data set (MDS) assessment dated [DATE] revealed a brief interview of mental status (BIMS) score of 04 that indicated the resident had severe cognitive impairment. The MDS revealed the resident had no hearing aid used and the ability to hear is with a moderate difficulty. The MDS revealed the resident had no broken or loosely fitting full or partial denture. The minimum data set (MDS) assessment dated [DATE] revealed a brief interview of mental status (BIMS) score of 08 that included the resident had moderate cognitive impairment. The MDS revealed the resident used hearing aids and had a high hearing impairment. The MDS revealed the resident no broke or loosely fitting full or partial denture. The baseline care plan dated September 5, 2022 revealed the resident was edentulous and coordinated arrangements for dental care are to be provided as ordered. The baseline care plan revealed monitoring, documentation, and reporting as needed of any signs and symptoms of oral dental problems needing attention. The baseline care plan revealed the facility did not address the resident's hearing difficulty or use of hearing appliances. A review of the resident's dental notes revealed: June 16, 2022 states House call, no teeth, dentures soaking in glass - wiped mouth with [ineligible] rinse, brushed, wiped dentures, put in mouth with Fixodent. September 26, 2022 states, rinsed and cleaned dentures, *needs upper dentures adjusted hurts. March 29, 2023 states, Can someone help [resident] look everywhere for her dentures? She cannot find dentures. April 20, 2023 states, Pt has [history] of dentures. She was not wearing them today. July 7, 2023 states, Pt says her dentures are lost A review of the resident's progress note revealed: November 14, 2022 at 6:50 PM, Social Services Note Text: DENTAL VISIT: The resident was seen onsite by [NAME] Dental on 11-14-22. The dental note was sent to Medical Records and a copy will be kept in the Social Services department. December 7, 2022 at 1:04 PM, Social Services Note Text: DENTAL VISIT: The resident was seen by the dental hygienist from [NAME] Dental. The assessment notes have been sent to Medical Records to be uploaded to the record and a copy maintained in the Social Services office. March 29, 2023 at 12:56 PM, Social Services Note Text: ONSITE DENTAL VISIT: The resident was seen by [NAME] Dental Services today, 03-29-2023. Dental Notes have been given to Medical Records to upload to the residents EMR through PCC. April 20, 2023 at 2:48 PM, Social Services Note Text: ONSITE DENTAL EXAM was completed with the resident on 04-20-23 by [NAME] Dental. Dental Notes were given to Medical Records to be uploaded to the resident's chart in PCC and a copy maintained in Social Services for up to one (1) year. July 7, 2023 at 9:52 AM, Social Services Note Text: The resident was seen by [NAME] Dental on July 7, 2023 by the dental hygienist. The hygienist will follow up regarding denture replacement for the resident once she gets back to the office. October 11, 2023 at 2:26 PM, Social Services Note Text: The resident was seen by [NAME] Dental on October 10, 2023 by the dental hygienist. Dental notes were forwarded to Medical Records and a copy maintained in Social Services for up to one (1) year. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on conducted on October 25, 2023 at 3:45 PM with a Certified Nursing Assistant (CNA staff #342), she stated that the resident broke her lower dentures but didn't know when or how. The CNA presented a hand-held white plastic container that the resident's first name labeled on the lid. The CNA stated that the container contained the resident's upper denture. Inside the container, observed what appeared to be one denture for either the upper or lower mouth, the denture was immersed in a clear odorless liquid. The CNA also presented a hand-held gray container that she stated was the resident's hearing aids. Inside the container, observed what appeared to be a pair of hearing aids, one for a right ear and one for a left ear, they were neatly stored in the container's hearing appliance form. During an interview on conducted on October 25, 2023 at 3:45 PM with Social Services Director (staff #66), she stated she was familiar with the resident (resident #16) and her physical needs in hearing impairment and memory deficit. For her dental needs, she stated that she is aware of the resident's dental needs based on the resident's complaints. For dental record reviews, the Social Services Director stated that her assistant reviews the dental examination notes and she is her assistant's direct supervisor. In regards to reviewing the resident's dental notes, she stated that she'll have to look at the notes and ask my assistant. After reviewing the resident's treatment notes, she stated you are correct about the dental note statements documenting the resident's denture concerns. The Social Services Director stated, for the resident's July visit, I have a Social Services note in her electronic medical record that the [NAME] Hygienist needs to replace her dentures and I haven't followed up. The Social Services Director stated that after reviewing her July note, this note is the last reference and I have to follow-up with [NAME] dental about her dentures. I'll send them an email right now. When asked about the care plan for her hearing the Social Services Director stated, the care plan should address hearing appliances and it's not showing in her care plan, but I will correct her care plan as soon as possible.

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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. 48488 Based on observations, staff interview, and policy reviews, the facility failed to ensure pharmaceutical services were adequately provided for medication administration for four residents. The census was 130. This deficient practice could result in adverse effects in the facilities residents. Findings include: During observation of medication pass with a Licensed Practical Nurse (LPN/staff #297) conducted on October 24, 2023 at 7:00 AM, the LPN administered medications to four residents (#82, #28, #58, #127). In each medication prep on the cart, the LPN verified the right resident from the resident's electronic medial record photograph, right medication, right dose, and right route per the order. In each bedside encounter, the LPN kindly greeted each resident and assisted each resident in sitting in a fowlers or semi-Fowlers position but the LPN did not verify each resident's identity by checking the identification band at bedside before giving the resident medications. A review of each resident's face sheet, BIMS score, and orders revealed: Resident #82: Admission October 20, 2020 with the diagnosis of dementia, mood disorder, benign prostatic hyperplasia, human immunodeficiency (HIV) disease, and a brief interview of mental status (BIMS) score of 10 (moderate cognitive impairment). Resident #28: Admission March 02, 2023 with the diagnosis of acquired absence of right and left leg above knee, peripheral vascular disease, type 2 diabetes, hemiplegia and hemiparesis following cerebral infarction affecting right dominate side, and a brief interview of mental status (BIMS) score of 15 (intact cognition). Resident #58: Admission February 24, 2023 with the diagnosis of multiple sclerosis, schizoaffective disorder, bipolar type, anxiety disorder, actinic keratosis, dorsalgia, Parkinson's disease without dyskinesia, and a brief interview of mental status (BIMS) score of 05 (severe cognitive impairment). Resident #127: Admission October 9, 2023 with the diagnosis of essential hypertension, benign prostatic hyperplasia, anemia, gout, and a brief interview of mental status (BIMS) score of 15 (intact cognition) An interview with the Director of Nursing (DON) on October 25, 2023 at 12:15 PM, the DON stated that the facility verifies the identity of the resident with the photograph on the electronic medical record and verbally at bedside. Review of the facility policy Administering Medication and revealed the paragraphs; The individual administering medications verifies the resident's identity before giving the resident his/her medications. Methods of identifying the resident include: (a) checking identification band; (b) checking photograph attached to medical record; and (c) if necessary, verifying resident identification with other facility personnel., The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40581 Based on clinical record review, resident and staff interviews, and the facility policy and procedures, the facility failed to ensure one resident (#10) received required specialized services. The deficient practice could result in residents not being able to obtain the services needed to achieve medical/therapy goals. The Universe was 130, the sample is 1. Findings include: Resident #10 was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes, chronic kidney disease, and acquired absence of left leg below the knee. The minimum data set (MDS) dated [DATE] revealed that the brief interview score of 10 indicating the resident has a moderate cognitive impairment. It also included that the resident used a wheelchair and received training on walking with prostheses for 3 days out of the 7-day look-back period. Review of the order summary report revealed: September 2, 2022, cleanse right stump daily with 1/4 Dakin's soaked gauze apply thin layer of medihoney to medial and lateral open areas cover with roller gauze every day. September 27, 2022, patient to wear bilateral lower extremities (BLE) prostheses for 4-6 hours per day as tolerated. August 14, 2023, physical therapy (PT) evaluation and treat as indicated. August 14, 2023, PT evaluation completed, resident is now receiving PT services, 24 visits over 8 weeks. October 10, 2023. Resident needs eval/treat for prosthetic fit-needs socket replacement for bilateral Trans-Tibial (TT) limbs due to volume and weight gains discontinued. October 25, Resident needs eval/treat for prosthetic fit-needs socket replacement for bilateral Trans-Tibial limbs due to volume and weight gains discontinued. One year to 6 visits. Review of the notes dated September 18, 2023 from the certified/licensed prosthetist revealed that the patient was seen for follow-up on bilateral trans-tibial (TT) prostheses and reports excessive toe out on right lower extremity and pain when standing in both right and left prosthesis. The resident received new legs in October 2022, gained weight and limb volume increased drastically. The resident could not get into his legs and needs new sockets. The resident will need to be scheduled with the primary care physician at the facility to obtain an order for socket replacements for bilateral (TT) limbs due to volume and weight gain. Once an order and clinical notes are obtained from the primary care physician, the prosthetist can submit for insurance authorization. In the interim, temporary new castings were made for the resident, but are substantially too loose and the resident will need to be refitted with new castings for proper weight distribution and fit/function. Excessive pressure over bony prominence is consistent with poor socket fit and although a 5-ply sock was added to each side today, they are still too loose with poor pressure distribution. The physical therapy discharge summary dated September 27, 2023 revealed a goal, once standing , the patient will improve ability to safely ambulate at least 10 feet in a room, corridor, or similar space with adequate toe clearance, functional posture and functional dynamic balance using a four-wheel walker. Resident needs new prosthetics and is unable to tolerate standing and walking at this time. Will continue with RNA until new ones are fitted and ready. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a written statement from a Licensed Practical Nurse (LPN/staff #202), revealed that on October 9, 2023, the resident wanted to know the status of his legs. Staff #202 assisted the resident with calling the prosthetist and was told that the insurance authorization was still pending. Review of a physician note dated October 10, 2023 revealed the resident was seen face to face for order of prosthetics. The resident has gained weight since getting the original prosthetic for bilateral legs and limb volume increased. He is not able to use current prosthetics. A new order for socket replacements for bilateral TT limbs was placed. During an interview conducted on October 23, 2023 at 9:09 AM with resident #10, he stated that he is supposed to be working on walking in therapy and is not getting it regularly. He stated that he is given pain medication for the pain in the right knee due to the prosthetic rubbing, but doesn't always work and has told staff. Observed the resident in a wheelchair and that right prosthetic does not fit and moves from side to side. He stated that when it moves, the prosthesis rubs on the bone, knee area. An interview was conducted on October 25, 2023 at 10:23 AM with the Director of Therapy (staff #516), who stated that the resident was evaluated on August 9, 2023 for physical therapy (PT) and was recommended for treatment, 24 times over an 8-week period. She stated that the resident did not meet his goal, to stand and walk because his prosthetics didn' t fit due to weight gain. The resident has temporary new castings, but they are too big. She stated that she called the prosthetic company to follow up on the prosthetic evaluation that was completed on September 18, 2023, the week of the evaluation or the following week after the evaluation, and was told that the evaluation was already sent to the facility and the resident would need an order to be fitted for new prosthetics. She stated that there is not a designated person who is responsible for getting the order and she has nothing to do with the process, she just relayed that an order was needed to the facility team members. She reviewed the clinical record and stated there was an order for new prosthetics dated was October 10, 2023. An interview was conducted on October 25, 2023 at 11:19 a.m. with the unit clerk (staff #444), who stated that she was responsible for scheduling appointments for the residents. She stated that the Director of Nursing, Assistant Director of Nursing and Director of Therapy let her know when she needs to schedule an appointment for a resident, and she checks to see if there is an order for the resident and faxes it to the specialist. She stated that the resident saw the prosthetist on September 18, 2023 and needs the doctor to assess the resident for socket replacements with new liners and once the assessment is completed, the prosthetist will obtain the order. Then she reviewed the resident's clinical record and stated that the resident was seen by the doctor on October 10, 2023, but doesn't have an order for the resident's new prosthetics. She stated that the appointment has been delayed and should happened sooner and she was going to follow up with a nurse. An interview was conducted on October 25, 2023 at 11:55 a.m. with a Licensed Practical Nurse (LPN/staff #297), who stated that medical records posts appointments on the bulletin board and she reviews it weekly, and she was not aware of an appointment needing to be scheduled with the prosthetist. She stated that the nurse would be responsible for getting the order from the physician. She reviewed the progress note dated October 10, 2023 and stated that the resident needs socket replacements for prosthetics and states an order was placed. Then, she reviewed the orders and stated there was not an order for the replacement of prosthetics and would follow up on the matter. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy, Physician Medication Orders dated October 2021 states that verbal orders must be transcribed immediately in the resident's chart by the person receiving the order and must include the date and time of the order.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 49199 Based on observations, staff interviews, and policy review, the facility failed to ensure staff followed infection control standards related to personal protective equipment (PPE). The deficit practice could result in transmission of infection. Universe was 130. Findings include: An observation was conducted on October 24, 2023 at 9:00 AM, of multiple resident rooms with enhanced barrier precautions. Observation revealed glove boxes and hand sanitizing stations were on walls in the hallway, but no PPE carts were outside of rooms. It was also observed that within these rooms were two washable PPE gowns hanging on hooks. However, some rooms had multiple gowns stacked on top of each other hanging from hooks. All gowns were touching each other in every room. Further observations showed that neither the hooks or the gowns were labeled. It was observed that a Licensed Practical Nurse (LPN staff# 297) told (CNA staff #342), to get a hazard bag and remove the gowns from the room. An Interview was conducted on October 25, 2023 at 8:29 AM, with Regional Resource Nurse/Infection Control Preventionist, Registered Nurse (RN staff #443). She stated that enhanced barrier precautions were the only precautions within the building at that time. If someone was contact, or airborne precautions, PPE carts would be out in front of the room. There is not a need for a PPE cart for enhanced barrier precautions. She states this guidance of reusing the washable gowns came from the Centers for Disease Control (CDC). The facility's process is to label the hooks A and B, and to label the gown for who is using it for the day. One gown is for the CNA and the other gown is for the nurse. The same gown is to be used throughout the day for the same resident. At the end of shift, the gown is discarded, and it goes to laundry and new gowns are hung in the rooms. RN (staff #443) also stated that (staff #90), from central supply, checks the enhanced barrier precaution rooms in the mornings. She ensures new gowns have been placed. She also stated there should only be one gown per hook. Gowns should never be touching each other because that would be cross contamination. An Interview was conducted on October 25, 2023 at 9:30 AM, with Director of Nursing, (DON staff #80). Enhanced barrier precaution signage is posted on the residents door. The expectation is no more than one staff member wearing the same gown. When a staff member begins there shift, if a gown is hanging, it should be considered dirty and replaced with a new gown. Gowns should be changed every shift, or immediately if they are soiled. She also stated if gowns are touching each other, it isn't an issue because the gowns are for the same resident. However, she also stated, that if the outside of a gown is touching the inside of another gown, that is an issue of cross contamination. She stated there should only be one gown per hook. If both residents in the room require gowns, they each have their own set. CNAs should remove the gowns from the room if a resident discharges or goes on a leave of absence to the hospital. An interview was conducted on October 24, 2023 at 10:20 AM, with Lead Certified Nursing Assistant, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(CNA staff #342). She stated that the gowns are used by the CNA throughout the day when they provide care to the resident. At the end of the shift, the gowns are collected and sent to laundry, and new gowns are put in the resident's room. Since the gowns are washable, they may reuse them during the day for the same resident, unless they are visibly soiled. Gowns are hung on the side of the room depending on which resident they need them for. Recommendations from the CDC for, Consideration for Use of Enhanced Barrier Precautions in Skilled Nursing Facilities dated July 28, 2021 are as follows: Framework for Applying Enhanced Barrier Precautions in Skilled Nursing Facilities Implementation Approaches: General implementation considerations for EBP are available from the CDC.20 The application of EBP to routine care of residents with wounds or indwelling medical devices requires that staff participate in initial and on-going training on the facility's expectations about hand hygiene and gown and glove use, along with proof of competency regarding appropriate use and donning and doffing technique for PPE. Facilities should develop a method to identify residents with wounds or indwelling medical devices, and post clear signage outside of resident rooms indicating the type of PPE required and defining high risk resident care activities. Gowns and gloves should be available outside of each resident room, and alcohol-based hand rub should be available for every resident room (ideally both inside and outside of the room). A trash can (or laundry bin, if applicable) large enough to dispose of multiple gowns should be available for each room. Facilities with rooms containing multiple residents should provide staff with training and resources to ensure that they change their gown and gloves and perform hand hygiene in between care of residents in the same room. Neither extended use nor re-use of gowns and gloves is recommended for mitigating shortages in the context of EBP.