STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. Building B. Wing	06/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ivy at Davenport	800 East Rusholme Street Davenport, IA 52803

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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** 49976 Based on observation, record review, policy review, and staff interview the facility failed to identify, assess and treat a skin tear in a timely manner (Res# 304). The facility reported a census of 60 residents. Findings include: The Minimum Data Set (MDS), dated [DATE], documented Resident #304 had a Brief Interview for Mental Status (BIMS) score of 3 out of 15, indicating severely impaired cognition. The MDS included diagnoses: stroke, non-Alzheimer's dementia, and hemiparesis (inability to move one half of the body). The Care Plan updated 5/14/24 included goals to maintain or develop clean or intact skin. Interventions instructed staff to follow facility protocols for treatment of injury, monitor/document location, size and treatment of skin injury, and conduct weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations. The Physician Order dated 6/05/24 instructed staff to complete a weekly skin evaluation every 7 days. A review of the weekly skin notes, dated 6/13/24, revealed no documentation of a skin tear on the resident's left arm. During an observation on 6/17/24 at 2:40 PM, Resident #304 was sitting in her wheelchair with her left arm contracted toward her chest. There was a large dark brown scabbed area on the top of the forearm. In an interview on 6/18/24 at 3:20 PM Staff D, Registered Nurse (RN) reported the facility does not have skin sheets, wound sheets, or incident sheets. They chart in the Electronic Health Record (EHR). She looked and could not find any documentation for the resident's skin tear. In an interview on 6/19/24 at 8:10 AM Staff E, RN checked the EHR and could not find any documentation for the resident's skin tear. (continued on next page)

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

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 6/19/24 at 8:15 AM the Director of Nursing (DON) explained the facility didn't know the resident had a skin tear. She was just made aware of it last night. The nurses didn't know it had happened or how it happened. During an interview on 6/19/24 at 3:55 PM the DON explained the nurses are supposed to do a skin assessment upon falls and any new open areas. The facility policy titled Skin Assessment, updated 9/2023 instructed staff to: 1. A full body, or head to toe, skin assessment will be conducted by a licensed or registered nurse upon admission/re-admission, and weekly thereafter. The assessment may also be performed after a change of condition or after any newly identified pressure injury. 2. Documentation of skin assessment: a. Include date and time of the assessment, your name, and position title. b. Document observations (e.g. skin conditions, how the resident tolerated the procedure, etc.). c. Document type of wound. d. Describe wound (measurements, color, type of tissue in wound bed, drainage, odor, pain). e. Document if resident refused assessment and why. f. Document other information as indicated or appropriate.

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37072 Based on record review, staff interview and policy review the facility failed to provide adequate assessment and intervention to prevent deterioration of a pressure wound for 1 out of 4 residents reviewed with a pressure sore. (Resident # 153). The facility reported a census of 60 residents. Findings include: The Minimum Data Set (MDS) dated [DATE] identified Resident #153 as mildly cognitively impaired with a BIMS (Brief Interview for Mental Status) score of 11 out of 15. The MDS listed the following diagnoses anemia, coronary artery disease, peripheral vascular disease, renal insufficiency and diabetes. It also identified Resident #153 required extensive staff assistance to total dependence of staff with bed mobility, transfers and toileting. The MDS indicated the resident received dialysis. The MDS indicated resident had a Stage 2 and a Stage 3 pressure ulcer. The Care Plan dated 1/23/24 indicated Resident #153 had a pressure ulcer upon admission. The Care Plan directed staff to provide wound cares as ordered by physician and treatment record. Staff to monitor dressing every shift to ensure it is intact and adhering. Report lose dressing to the treatment nurse. Staff to complete weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate. The nurse is to assess/record/monitor wound healing at least weekly. Measure length, width and depth where possible. Report declines and/or signs and symptoms of infection to MD Review of the Nursing Admission assessment dated [DATE] revealed Resident #153 had a Stage 3 pressure ulcer on the sacrum measured 6 centimeter(cm) length by 4 cm width with a 4 cm depth. The Braden Scale for Predicting Pressure Ulcer Risk dated 1/22/24 revealed a score of 12 which indicates Resident #153 was high risk. The Nursing Admission assessment dated [DATE] revealed Resident #153 had a wound on his coccyx measured 7 cm length by 7 cm width. There was no depth documented and the documentation failed to reveal a Stage of the pressure ulcer. The Braden Scale for Predicting Pressure Ulcer Risk dated 1/22/24 revealed a score of 14 which indicates Resident #153 was moderate risk. The Weekly Skin Observation tool dated 3/20/24 noted a wound on the sacrum but failed to reveal measurements or the stage of the wound. The record revealed it was non pressure. The Braden Scale for Predicting Pressure Ulcer Risk dated 3/20/24 revealed a score of 07 which indicates Resident #153 was very high risk. The Wound Evaluation document dated 3/27/24 revealed a pressure type wound on the sacrum with a length of 12 cm. The evaluation lacked documentation of the width or depth of the wound. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of January 2024 Order Summary Report revealed the following order with a start date of 1/23/24: Dakins (1/4 strength) External Solution 0.125% (Sodium Hypochlorite) Apply to coccyx topically two times a day for wound cleanse with saline, pack with quarter strength dakins moistened 4 x 4's or kerlix, cover with aquacel sacral, change BID (twice daily) & as needed if loose or soiled. Review of February 2024 Order Summary Report revaled the following order with a start date of 2/7/24: Dakins (1/4 strength) External Solution 0.125% (Sodium Hypochlorite) Apply to coccyx topically two times a day for wound cleanse with saline, pack with Dakins moisten kerlix - being sure to pack into undermining from 12 o'clock to 12 o'clock, cover with silicone foam, change BID. Review of the January 2024 and February 2024 Treatment Administration Records lacked documentation of treatments completed for Resident #153 sacrum pressure sore. Review of the facility Progress Notes revealed a lack of documentation on any descriptions of the wound or condition report to physician to notify of the decline in the wound. The Physician Notes from an emergency department document on 4/12/24 at 9:41 AM revealed Resident #153 there with worsening hip/low back pain in addition to concerns for worsening sacral decubitus ulcer. Wound VAC found not to be working so was removed and replaced with wet-to-dry dressing. Patient not meeting septic criteria on presentation but his work-up showed significantly elevated inflammatory markers. Computed Topography scan (CT) concerning for new osteomyelitis (bone infection). Resident started on broad-spectrum antibiotics and admitted to hospital with infectious disease for consult. Results of CT from hospital on 4/12/24 revealed new osseous (relating to bone) findings and increased soft tissue loss overlying the sacrum compatible with infection and osteomyelitis. Chronic changes seen in both hips and lower lumbar spine. Wound care nursing note from hospital admitted d 4/12/24 revealed pressure wound to sacrum Stage 4 measured 11.5 cm length by 10.5 cm width, The depth of the wound 4 cm with undermining at 6-10 o'clock with max of 4 cm depth. On 06/20/24 at 12:19 PM Staff H, Licensed Practical Nurse (LPN) stated when there is a pressure ulcer the nurse should provide treatments per the physician order. The wound measurements are done by the wound physician if there was something new I would do the measurement myself. The wound physician does a measurement every week. If someone had a wound vac the nurse should be checking every shift to make sure there is no beeping and there is a good seal and if the canister is full. I also would provide the dressing change for it as ordered. If there was an issue I would reach out to supervisors and let them know. There has been issues getting supplies for wound vac in the past. It has taken about a week to get the proper supplies. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 06/20/24 01:00 PM Staff D, Registered Nurse (RN) stated the nurse should measure wounds on admission and then every time you change the dressing. Follow the physician order for treatment and if no treatment contact the physician to get an order. If there is a wound vac the nurse should be change the dressing every 3 days and if the canister is full it will alarm. The nurse should be looking at them in between time to make sure still intact. I remember Resident #153 he had a wound on his coccyx it would come up often we would change it 2-3 x day due to the spot it was in. I believe he had the wound vac but he also at times had a wet to dry dressing. We document the dressing changes on the treatment administration record. On 06/20/24 at 3:41 PM the Assistant Director of Nursing (ADON) stated the expectation is for pressure wounds to be documented and measured weekly and they are dressing changes done weekly. There were wound treatment orders for Resident # 153. On 6/20/24 at 3:41 PM the Director of Clinical Services stated if their is a change in condition with a wound they should be notify the family and the physician and if needed their is appropriate referral made to the wound clinic to be seen by a physician. The end goal is for the wound to heal. On 06/20/24 04:05 PM reviewed the wound sheets with the ADON and she stated there was no documentation for the wound after the initial admission documentation. She states the expectation is to have wound measurements completed on admission, readmission and then weekly. The nurse completing the readmission should have measured the wound and notified the physician of changes in the wound. The facility provided a policy titled Pressure Injury Prevention and Management with revision date of December 2022 which stated the facility shall establish and utilize a systematic approach for pressure injury prevention and management, including prompt assessment and treatment; intervening to stabilize, reduce or remove underlying risk factors; monitoring the impact of the interventions; and modifying the interventions as appropriate. The policy directed licensed nurses to conduct a full body skin assessment on all residents upon admission/re-admission, weekly, and after any newly identified pressure injury. Findings will be documented in the medical record. The policy revealed assessments of pressure injuries will be performed by a licensed nurse and documented. The staging of pressure injuries will be clearly identified to ensure correct coding on the MDS. Nursing assistants will inspect skin during bath and will report any concerns to the resident ' s nurse immediately after the task. Training in the completion of the pressure injury risk assessment, full body skin assessment, and pressure injury assessment will be provided as needed.

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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** 45775 Based on observations, clinical record review, facility policy review, resident and staff interviews the facility failed to identify and respond to an elopement in a timely manner for 1 of 1 residents (Resident #474). Resident #474 eloped from the facility on 6/8/24 at approximately 2:55 PM and was found 5.6 miles from the facility by a bystander at approximately 6:38 PM. Facility staff initially identified the resident was missing at 4:00 PM, notified management at 6:00 PM and called 911 at 6:03 PM. The facility failed to utilize equipment for resident safety for 2 of 2 residents (Resident #19 and Resident #48) during assistance with mobility/transfers. The facility reported a census of 60 residents. The State Agency informed the facility of the Immediate Jeopardy (IJ) on 6/12/24 at 5:47 PM. The IJ began on 6/8/24. Facility staff removed the Immediate Jeopardy on 6/14/24. The facility staff removed the Immediate Jeopardy by implementing the following actions: 1. Complete visual headcount of every resident at Ivy at [NAME] to ensure all were present and safe. 6/8/24 2. Residents residing in the community were re-evaluated for elopement 6/8/24. 3. 1:1 supervision placed on (Resident #474) 6/8/24 upon return to the facility until front door code can be changed and all systems for elopement in place 4. The weekend receptionist was given education on 6/9/24 when she returned to work. 5. An order was placed in Tels for the front door to be assessed for recording. 6. All staff education initiated on 6/8/24 on the facility protocol for elopement and the requirement to validate with Nurse or Management who an individual is, if unsure, before helping them exit the facility. Education will be ongoing until all staff have been educated. Facility staff, new hires, and contract staff will not be allowed to work until education is completed. 7. New Admissions will have wandering/elopement risk assessments completed and when/if identified at risk for elopement will be placed in the elopement risk binders. For admissions after normal business hours the admitting nurse will utilize the instant camera in R hallway medication cart to immediately place photo and demographic sheet in the binders accessible to staff at receptionist desk and other nursing elopement binders. The other two books will be updated next business day. The elopement books will contain a face sheet with photo of residents residing in the facility. The Admissions Director/Designee will provide communication to non-clinical staff of new admissions or anticipated new admission either during the week during normal business hours and during after -hour and weekends. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	8. Staff education was completed in regard to after hours admission or weekends for residents identified at risk for elopement will have instant camera photo taken as well as the Resident identified book at the reception area to communicate non-clinical staff of current residents as well as any new admits and/or potential after hours of weekend admissions, Began on 6/13/24 with completion on 6/14/24. The scope was lowered from a J to a D at the time of the survey after ensuring the facility implemented education. Findings include: 1. A review of the Electronic Health Record (EHR) revealed Resident #474 admitted to the facility on [DATE] after a hospitalization . The diagnoses documented in the EHR included: Unspecified sequelae of cerebral infarction (stroke); unspecified dementia, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety; and type 2 diabetes mellitus. The Baseline Care Plan, dated 6/7/24, indicated the resident at risk for falls, cognitively impaired, required one person physical assistance for transfers and walking in room and corridor, and utilizes a manual wheelchair and walker. A Progress Note, dated 6/8/24 at 1:17 PM, documented the resident is A&Ox2 (alert and oriented times two - aware of who they are and where they are at), resident has been wandering throughout the day from her room to the dining room. Resident is pleasant and orient[ed] call light. Resident ate meals today in the dining room. Resident denies pain or discomfort at this time. BP (blood pressure) 120/81, P (pulse) 80, RR (resting respirations) 18, T (temperature) 98.0, O (oxygen saturation) 98%. A Progress Note, dated 6/8/24 at 9:40 PM, documented family notified of elopement, no concerns at this time and they are grateful and stated these things happen, she has run away before she was in a nursing home, and she's very quick and sneaky. family coming from [redacted] to meet resident at ER (emergency room) and are bringing her back OT (Occupational Therapy) the facility after the evaluation. A document titled, Initial Federal Report, dated 6/8/24, revealed on 6/8/24 at approximately 5:50 PM the Administrator and ADON (Assistant Director of Nursing) were notified by Nurse [redacted] who reports that resident [name redacted (Resident #474)] could not be found in the facility. Facility Nursing Staff report searching the entire facility and not able to find her. The Director of Clinical Services was notified. The Administrator was notified and immediately called 911 to report the facility had been unable to find this resident. The Initial Federal Report revealed when the ADON notified the family of the incident, the family member said she was not surprised and reported that she [the resident] ran away before while living in her apartment. When asked if the family had mentioned anything about her [the resident] running away prior to admission when they completed her admission documentation, the Social Services Director stated they did not say anything. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Initial Federal Report continued, stating the resident was found by local police at/near the police station on [NAME] Street at approximately 6:45 PM. The Initial Federal Report documented after being found the resident transferred to a local emergency room for evaluation. Then transported back to the facility following treatment for UTI (urinary tract infection), minor scarp to her upper lip and chin. Hospital ED (emergency department) records show she didn ' t ' need sutures and scans were negative for major injury including fractures. Upon return, the resident was placed on 1:1 supervision by staff. During an interview on 6/12/24 at 12:53 PM, the Administrator stated the front door of the facility is armed with an alarm. The Administrator demonstrated the alarm will sound if a code is not entered. The door is equipped with a two inch 15 second delayed egress. Meaning the door will open approximately two inches and stop. The alarm will sound, building in intensity, until a staff answers the alarm. The system also announces the location of the open door. The door will remain stopped at two inches unless the alarm is not answered after 15 seconds, when it will open all of the way. An observation on 6/12/24 at 1:01 PM, found Resident #474 in her room, in bed with the covers over her head. Staff Q, Certified Nursing Assistant (CNA) sat outside in the hallway outside of the residents room During an interview on 6/12/24 at 1:02 PM, Staff Q stated Resident #474 is receiving 1:1 supervision after having eloped on 6/8/24. Staff Q stated she is covering the 10:00 AM to 2:00 PM shift. Staff Q stated she did not know when the 1:1 supervision started. During an interview on 6/12/24 at 1:15 PM, Staff M stated she worked the morning of 6/8/24. She stated someone entered the code to the front door, and Resident #474 left the facility. Staff M stated she did not know who entered the alarm. Staff M stated she Resident #474 was found at a local park, approximately a mile from the facility. During an interview on 6/12/24 at 1:44 PM, Staff O, Receptionist stated there have been a lot of discharges and new admissions lately. Staff O stated there is an Elopement book at the front desk. Staff O stated the book includes residents who need supervision. A sheet for each resident includes their name and a picture. A description of height, weight and color of hair is also listed. Staff O stated the book was last a few days ago. Staff O stated she did not know if Resident #474 had been added to the book prior to 6/8/24. An observation on 6/12/24 at 2:15 PM, found Resident #474 in her room, in bed sleeping. The resident noted to have abrasions on her upper lip, and the left side of her chin. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 6/12/24 at 3:08 PM, Staff N, LPN stated on 6/8/24 at approximately 4:15 PM a staff informed her Resident #474 could not be found. Staff N stated she checked her assigned hallway and after not being able to find the resident called a Code Silver. Staff N explained a Code Silver means everyone needs to stop doing what they are doing and do a headcount of the residents on each hallway. Staff N stated she did not know the last time the resident had been seen. Staff N stated after the headcount, all nurses met in the center hallway and reported the headcount results. Staff N stated only Resident #474 could not be accounted for. The team decided to check all empty rooms and connected bathrooms and meet again in the center hall. Staff N stated after the nurses reconvened and confirmed they could not find Resident #474, she called the ADON. Staff N stated she was unsure of the time. But knows she text the height and weight of Resident #474 to the ADON at 4:51 PM During an interview on 6/12/24 at 3:34 PM, when queried about reviewing the facility investigation notes, the Administrator stated all notes are found in the EHR. The Administrator stated he did not complete staff interviews. The Administrator added during his investigation he reviewed camera footage of the front door area of the facility. He stated the footage revealed on 6/8/24 at 2:55 PM Resident #474 walked to the front door, wearing a red and black fleece coat, carrying a white plastic shopping bag. The Administrator stated the weekend receptionist, entered the alarm code to the front door, and Resident #474 exited the building. The Administrator stated staff started looking for the resident at 5:30 PM, and he called 911 at 6:03 PM upon being informed the resident could not be found. The Administrator stated he was notified at 7:31 PM, the resident was found by local police. When queried as to where the resident had been found the Administrator stated he believed the resident to have been found at the police station on [NAME] Street, approximately 2.2 miles from the facility. During an interview on 6/13/24 at 8:55 AM, a local police department officer stated they received a call on 6/8/24 at 6:03 PM from the facility regarding a missing resident. When queried on the location the resident was found, the police officer stated the missing persons report remains open as the department had not found the resident, or been informed the resident has been found. During an interview on 6/13/24 at 9:06 AM, a local emergency department confirmed Resident #474 was brought to the hospital on 6/8/24 at approximately 7:38 PM. The ED staff stated they have no information as to where the resident had been found. The staff stated the resident came to the hospital by ambulance. The local hospital document, titled ED Provider notes, dated 6/8/24, revealed Resident #474 presented to the ED by ambulance for AMS (altered mental status). Initial patient evaluation time 7:38 PM. Patient found on the side of the road by EMS (Emergency Medical Services). She has abrasions to her face likely from a fall today. Clinical Impressions included: At high risk for elopement; abrasion of chin; abrasion of lip, fall, and cystitis (urinary tract infection). During an interview on 6/13/24 at 9:13 AM, a dispatch staff from the local EMS provider stated Resident #474 was found at the side of the road at the intersection of [NAME] and [NAME] Drive. The dispatch stated a bystander saw Resident #474 on the side of the road, became concerned, pulled over help her and called 911. The bystander assisted the resident into their car until the ambulance arrived. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Emergency Medical Service provider report titled, A Patient Care Report - Final, dated 6/8/24 revealed: a. A call received at 6:38 PM b. Dispatched at 6:39 PM c. At scene at 6:49 PM d. At destination (local emergency room) at 7:29 PM. Per a global positioning system, the [NAME] and [NAME] Drive intersection, depending on the route taken, is 5.5 to 5.8 miles from the facility. During an interview on 6/13/24 at 12:50 PM, Staff P, Receptionist stated on 6/8/24 she worked from 8:00 AM to 3:00 PM. She stated she did not know she had opened the door for Resident #474 until 6/9/24, when the Administrator showed her the video. Staff P stated she opened the door for the resident and let her out before the end of her shift. Staff P stated she thought that was around 2:50 PM. Staff P stated she was trained by the full time receptionist. She stated she was trained to ask people who they are before letting them in or out of the facility. Staff P stated she had never met Resident #474 prior to the incident. Staff P stated after watching the video she remembered the resident, and assumed she was a family member visiting a resident. Staff P stated she finds out who is a new resident by word of mouth, or from the full time receptionist. She stated there was an Elopement book at the front desk, but it has not been updated with Resident #474 picture/information. Staff P stated the book is now updated. During an interview on 6/13/24 at 4:20 PM, the Director of Clinical Services stated the facility waited too long to contact 911 after realizing Resident #474 was not in the building. She stated after the initial headcount, and the resident identified as missing administration should have been notified and 911 called immediately. When queried as to where the resident was found, the Director of Clinical Services stated she did not know the exact location where the police found Resident #474. On 6/13/24 at 5:00 PM, a drive from the facility to the intersection of [NAME] and [NAME] Drive revealed: a. [NAME] to [NAME] Street is heavily trafficked with cars and semi-trucks. b. The speed limit varies between 25 to 35 miles per hour depending on school zones. c. The pedestrian sidewalk ends at the intersection of [NAME] and Wisconsin Avenue. d. The intersection of [NAME] and Wisconsin Avenue is 0.6 miles from the [NAME] Drive intersection. (continued on next page)

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	165436	A. Building B. Wing	06/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ivy at Davenport	800 East Rusholme Street Davenport, IA 52803

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	e. The speed limit at Wisconsin Avenue increases to 45 miles per hour. f. After Wisconsin Avenue, the side of the road is paved with gravel. A facility policy, revised date of 3/2024, titled Elopements and Wandering Residents documented the facility ensures that residents who exhibit wandering behavior and/or at risk for elopement receive adequate supervision to prevent accidents and receive care in accordance with their person centered plan of care addressing the unique factors contributing to wandering or elopement risk. Policy Guidelines included: 5. Procedure for Locating Missing Resident a. Any staff members becoming aware of a missing resident will alert personnel using facility approved protocol b. The designed facility will look for the resident. c. If the resident is not located in the building or on the grounds, administrator or designee will notify the police department and serve as the designated liaison between the facility and the policy department. The administrator or designee should also notify the company ' s corporate office. d. DON (Director of Nursing) or designee shall notify the physician and family member or legal representative. e. Policy will be given a description and information about the resident; include any photos. f. All parties will be notified of the outcome once the resident is located. g. Appropriate reporting requirements to the State Survey agency will be conducted. 34821 4. The MDS for Resident #19 dated 5/24/24, listed diagnoses of cerebrovascular accident (CVA), hypertension (high blood pressure) and diabetes mellitus (DM). The BIMS reflected a score of 4 out of 15, indicating severely impaired cognition. The MDS assessed Resident #19 required substantial staff assist for transfers. The Care Plan for Resident #19 dated 12/4/23, directed he required assist of 1 and gait belt for all transfers. The Care Area Assessment (CAA) dated 5/24/24, revealed Resident #19's needed max to dependent assist of staff with most activities of daily (ADL's) for task completion due to impaired mobility and weakness. Resident is at risk for falls due to impaired mobility and weakness. He required max to dependent assist of staff with transfers. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an observation on 06/17/24 at 10:54 AM, Staff C, CNA took Resident#19 from under his arm as he stood on the one leg and turned him (stand pivot transfer) from his bed to his scooter. Staff C failed to use a gait belt with the transfer. During an interview on 06/20/24 at 9:58 AM Staff G, CNA described her transfer of Resident # 19, she sat him up on the side of the bed applied a gait belt, made sure his foot is on the pivot disk before she helped him stand and turned him to the scooter. During an interview on on 6/20/24 at 1:05 PM, Staff F Licensed Practical Nurse (LPN) reported R#19 required assist of 1, and a gait belt for a transfer out of bed. The policy titled Safe Resident Handling/Transfers revised 10/4/23 identified, it is the policy of this facility to ensure that residents are handled and transferred safely to prevent or minimize risks for injury and provide and promote a safe, secure and comfortable experience for the resident while keeping the employees safe in accordance with current standards and guidelines. Guidelines of the policy included: a. The interdisciplinary team or designee will evaluate and assess each resident's individual mobility needs, taking into account other factors as well, such as weight and cognitive status. b. Handling aids may include gait belts, transfer boards, and other devices. c. Staff members are expected to maintain compliance with safe handling/transfer practices. Failure to maintain compliance may lead to disciplinary action up to and including termination of employment. d. Resident lifting and transferring will be performed according to the resident's individual plan of care. 48888 5. The MDS dated [DATE], revealed a BIMS score of 5 out of 15, indicating severely impaired cognition. Resident #48 utilized wheelchair for mobility and dependent on staff assistance to transfer to and from chair. Once sat in wheelchair, Resident #48 able to self propel wheelchair 150 feet independently. Diagnoses included encephalopathy and difficulty in walking. Resident #48 had 2 or more falls without injury since prior assessment. The Care Plan, initiated 02/27/24, revealed Resident #48 had an impaired ability to independently move or navigate wheelchair. An intervention, initiated 02/27/24, instructed staff that Resident #48 does some of the work to move or navigate the wheelchair, but usually required assistance of a helper to provide more than half the effort in moving the wheelchair from one place to another. During an observation on 06/18/24 at 12:32 PM, Staff M, Certified Nursing Assistant (CNA), pushed Resident #48 from the main C hallway into north dining room, no foot pedals in place on wheelchair, Resident #48 held his feet up approximately 1 to 2 inches from the floor during transportation. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 06/20/24 at 01:17 PM, Staff M, CNA, revealed that foot pedals must always be used when a resident is pushed in wheelchair and stated if she saw a resident pushed in wheelchair without pedals, she would stop. Staff M indicated transportation of residents in wheelchair without foot pedals may result in fall or injury to the resident. During an interview on 06/20/24 at 01:17 PM, Director of Nursing (DON) stated she would expect foot pedals are applied to wheelchairs before staff assist a resident with wheelchair transportation. The DON confirmed Resident #48 required occasional staff assistance with wheelchair transportation. During an interview on 06/20/24 at 01:20 PM, the Director of Clinical Services, revealed that many residents who self propel in wheelchair had pedal bags added to the back for foot pedal storage.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49976 Based on observation, policy review, and resident and staff interviews the facility failed to keep the facility free from vermin. The facility reported a census of 60 residents. Findings include: 1. During an observation on 6/17/24 at 2:40 PM a hole in the outside soffit (underside of roof overhang) measuring roughly 2 feet by 2 feet on the right side of the entrance was found. In an interview on 6/18/24 at 11:59 AM Staff D, Registered Nurse (RN) remarked she had heard things in the ceiling and assumed they were raccoons. In an interview on 6/18/24 at 12:31 PM Staff I, Occupational Therapist noted she had heard residents complain about raccoons in the ceiling. She reported there is a crawl space attic above the front of the building. In an interview on 6/18/24 at 1:30 PM the Director of Maintenance stated he started working at the facility about three months ago. At that time, he put all the soffit back up that had fallen down. He reported there were raccoons in the facility before he started. He was just made aware of the hole on the right side of the entrance yesterday. He thought it was probably squirrels this time. He stated the pest control service did come yesterday to set and move mouse traps in the building. In an interview on 6/20/24 at 10:07 AM the vermin control professional reported there were two holes in the outside soffit. He noted there was an actual raccoon entrance hole on the [NAME] of the front entrance. He explained the only thing that makes holes like that are raccoons and reported the facility definitely had raccoons going up there. In an interview on 6/20/24 at 12:42 PM the Director of Maintenance explained the pest control company had been there every month, twice this month putting mouse traps out and moving them around the building. He noted mice have been in the building since he started in March. 37072 2. The MDS dated [DATE] for Resident #20 revealed a BIMS score of 15 out of 15, indicating intact cognition. On 06/17/24 at 11:20 AM Resident #20 stated I have seen mice. I saw them down where we go out to smoke in the dining room going under a heater vent. I think it is because people drop their food on the floor. 2. The MDS dated [DATE] for Resident #154 revealed a BIMS score of 15 out of 15 indicating intact cognition. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 06/17/24 at 11:46 AM Resident #154 stated there are mice in the building and I see them everyday. He pointed out a mouse trap in the corner of his room in the corner. There is a hole by the front door. You can hear the raccoons up in the room. Mice run out in front of you at night. On 06/20/24 12:09 PM Staff L, Certified Nursing Assistant (CNA) stated I saw a mouse in the women's bathroom on L hall just on Saturday. They have had the problem a while, I have seen exterminator in the building and there also one down in a residents room. I seen a mouse on L hall and also on C hall. On 06/20/24 12:17 PM Staff H, Registered Nurse (RN) stated I saw a mouse one about a week ago on A hall. I reported it to the Administrator I haven't seen anything being done that I am aware of but only here two days a week. The facility provided a policy titled Pest Control with a revision date of 4/5/21 revealed staff facility- wide pest-control strategies are developed emphasizing kitchens, cafeterias, laundries, central sterile supply areas, loading docks, construction activities, and other regions prone to pest infestations. Guidelines included: 1. On-going measures are taken to prevent, contain, and eradicate common household pests such as roaches, ants, mosquitoes, flies, mice, and rats. 2. General measures to decrease pests include the elimination of cracks and crevices, proper lighting and ventilation, use of screens on windows and doors, and use of self-closing doors. 3. Monitor for breaks in screens and doors on a routine basis. 4. Food stored in the dietary area is kept in a designated area in securely covered containers, is off the floor and away from the walls. 5. Any food items kept in residents ' rooms stored in covered containers or sealed bags, except uncut fruits such as bananas or oranges. Review resident plan of care for non-compliance with food storage and provide education as needed. 6. Maintain garbage storage area(s) in a sanitary condition to prevent the harborage and feeding of pests. 7. A contract with a pest control company may be elected to assure regular inspection and application of chemical pesticides. 8. The facility will contract for routine pest control service by a credentialed pest-control specialist. The pest control contractor shall have knowledge of pest control treatment methods for healthcare facilities. 9. Facility employees shall not handle or apply pesticides. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	10. Regular inspections by the local and county sanitation departments are part of the pest control program. 11. The facility will follow applicable state and local regulations on regular pest control. 12. Maintenance Director or designee will maintain records of pest control program and applicable contracts with pest control services, including applicable SDS (Safety Data Sheets) for pesticides applied. 13. The facility shall maintain a method for staff to notify the Maintenance department when pests are identified.