STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175490	A. Building B. Wing	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at Herington	2 E Ash Street Herington, KS 67449

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 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** 42966 The facility identified a census of 30 residents. The sample included three residents reviewed for dignity. Based on observation, record review, and interview, the facility failed to ensure Resident (R) 3 was treated with dignity. This deficient practice placed R3 at risk for impaired psychosocial well-being and decreased dignity and self-worth. Findings included: - The Diagnoses tab of R3's Electronic Medical Record (EMR) documented a diagnosis of nontraumatic intracerebral hemorrhage (an emergency condition in which a blood vessel in the brain ruptures and causes bleeding inside the brain). The Significant Change Minimum Data Set (MDS) dated [DATE] documented that R3 had a Brief Interview for Mental Status (BIMS) score of 14 which indicated intact cognition. The Cognitive Loss/Dementia (progressive mental disorder characterized by failing memory, confusion) Care Area Assessment (CAA) dated 02/26/24, documented R3 had physical and verbal behaviors directed at staff. R3's Care Plan dated 11/15/23, documented R3's preference to vape (using a device to inhale an aerosol, typically one containing nicotine) while at the facility and directed staff to observe R3 to make sure the smoking policy was followed correctly. R3's Care Plan dated 01/12/24, documented R3 had impaired communication related to aphasia (condition with disordered or absent language function) and directed staff to allow time for R3 to respond to communication and observe for nonverbal cues with communication. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175490	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at Herington	2 E Ash Street Herington, KS 67449

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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	In a statement typed by Administrative Nurse D on 03/12/24, R3 stated he was in his wheelchair in front of the building where he vapes because Licensed Nurse (LN) H took him outside. He stated LN H was throwing her cigarette away at her car when Administrative Staff A came outside and went over to LN H's car. R3 stated Administrative Staff A asked LN H why she brought R3 outside because it was not important at that time and Administrative Staff A needed coverage on the floor, not outside smoking. R3 stated LN H sat next to him and stated she wished Administrative Staff A did not talk to her that way and that R3 had just as much of a right as anyone else. R3 stated the interaction between Administrative Staff A and LN H made him feel insecure and unimportant. R3 stated a nurse helping a resident is important and the nurses were supposed to make the residents a priority. Licensed Nurse (LN) H's notarized Witness Statement on 03/13/24 stated on 02/29/24, she took R3 outside for his scheduled vape time and since her car was parked next to the area, she took the opportunity to sit in her car with the door open and have a smoke herself. She stated Administrative Staff A went to the parking lot and asked her what she was doing outside. LN H stated she brought R3 out to vape and was taking a short break herself. LN H stated Administrative Staff A then said R3's vaping was not a priority and LN H must not be too busy if she had time to bring R3 outside. LN H stated the conversation happened in front of R3 and he was upset and stated to LN H that Administrative Staff A should not have said that in front of him. On 04/03/24 at 11:22 AM, R3 lay in bed. He stated on 02/29/24, LN H took him outside to vape and Administrative Staff A came outside to confront LN H. R3 said Administrative Staff A stated his vaping was not a priority. R3 stated that the comment made him feel terrible, belittled, unwanted, and not important. On 04/03/24 at 03:51 PM, Administrative Staff A stated on 02/29/24, LN H took R3 outside and he was sitting by the front while she was in her car. She stated she went outside and asked LN H why she was smoking and told her she would not be able to get to R3 from her car if he started rolling away. Administrative Staff A stated she did not know how R3 heard the whole conversation. She stated she would not have said vaping was not important but if a resident heard that, it would be hurtful. The facility's Dignity policy, revised in February 2021, directed residents to be treated with respect and dignity at all times and the facility culture supported dignity and respect for residents by honoring resident goals, choices, preferences, values, and beliefs. The facility failed to ensure R3 was treated with dignity. This deficient practice placed R3 at risk for impaired psychosocial well-being and decreased dignity and self-worth.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175490	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2024
NAME OF PROVIDER OR SUPPLIER Legacy at Herington		STREET ADDRESS, CITY, STATE, ZIP CODE 2 E Ash Street Herington, KS 67449	

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 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to receive visitors of his or her choosing, at the time of his or her choosing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42966 The facility identified a census of 30 residents. The sample included three residents reviewed for visitation rights. Based on observations, record review, and interviews, the facility failed to ensure Residents (R) 1 and R2 were able to exercise their right to receive visitors of their choosing at the time of the residents' choice. This deficient practice placed R1 and R2 at risk for impaired resident rights, impaired psychosocial well-being, and social isolation. Findings included: - The Diagnoses tab of R1's Electronic Medical Record (EMR) documented diagnoses of cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain) and weakness. The Annual Minimum Data Set (MDS) dated [DATE], documented that R1 had a Brief Interview for Mental Status (BIMS) score of three which indicated severe cognitive impairment. The Quarterly MDS dated [DATE], documented R1 had a BIMS score of six which indicated severe cognitive impairment. The Cognitive Loss/Dementia (progressive mental disorder characterized by failing memory, confusion) Care Area Assessment (CAA) dated 10/06/23, documented R1 had cognitive deficits and was able to make her wants and needs known to staff. R1's Care Plan dated 06/26/23, documented R1 had a potential for diversional activity due to cognitive impairment and/or physical assistance needed. The care plan documented an intervention, revised 11/22/23, that directed the facility to encourage ongoing family involvement and invite R1's family to attend special events, activities, and meals. On 04/03/24 at 02:58 PM, R1 sat in a chair in the day area next to other residents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175490	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2024
NAME OF PROVIDER OR SUPPLIER Legacy at Herington		STREET ADDRESS, CITY, STATE, ZIP CODE 2 E Ash Street Herington, KS 67449	

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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 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/03/24 at 12:11 PM, R1's representative stated she worked at the facility on 02/29/24 because the facility needed help. She relayed she had a situation on that date with R3 and Administrative Staff A. She said on 03/22/24, she visited R1 in the morning and then received a call that afternoon from Administrative Staff A and Administrative Nurse D. R1's representative stated the facility administrative staff told her that she had been found guilty of abuse by the State Agency (SA) and stated she could not visit R1 anymore unless she made an appointment with the facility and the visitation had to be away from other residents and had to be supervised by facility staff. R1's representative stated she called the SA and the Long-Term Care Ombudsman (LTCO) for further information. She stated R1 liked it when she visited at lunchtime, so she arrived at the facility on 04/02/24 at lunchtime and sat with R1. R1's representative stated Administrative Staff A went into the dining room, placed a hand on her (the representative's) shoulder, and directed R1's representative to leave or the facility would have her escorted out. R1's representative stated three law enforcement officers came in and one of them went into where she was visiting her mom. R1's representative stated she tried to keep the situation calm so R1 would not get upset. She said 04/02/24 had been her first visit since 03/22/24. On 04/03/24 at 03:00 PM, Administrative Nurse D stated the facility worked with the LTCO to set up visitation and said he was in the facility on 04/02/24 when R1's representative walked into the building at around 11:15 AM, before her scheduled visitation time at 01:00 PM. R1 was in the dining room along with the LTCO and R1's family sat with her. Administrative Nurse D confirmed that Administrative Staff A called law enforcement at that time. When the law enforcement officers arrived, they spoke to R1's representative outside. Administrative Nurse D stated R1's representative was supposed to call Administrative Staff A or Administrative Nurse D to schedule a visitation time and the facility offered to set up an empty room as a visitation room so R1 and her representative would both be comfortable. On 04/03/24 at 03:10 PM, Licensed Nurse (LN) G stated the only visitation restriction she knew of was for R1's representative. LN G said R1's representative was supposed to call ahead of time and schedule a visitation. On 04/03/24 at 03:15 PM, Administrative Nurse D stated the only abuse or neglect she could make out about R1's representative might be that R1's representative shared information with R3 or that she smoked in her car while R3 vaped outside. She stated she did not see R1's representative as a threat to the residents. Administrative Nurse D stated she did not think there should be restricted visitation and that R1's representative posed no threat but because of an email received from the SA, the facility staff were upset and did not know what to do. She stated she did not call the SA to clarify the email. On 04/03/24 at 03:51 PM, Administrative Staff A stated R1's representative made a complaint against her because of an incident on 02/29/24 with R3 and R1's representative and Administrative Staff A. Administrative Staff A stated she had left the state when the investigation was going on and when the facility received an email from the SA that mentioned substantiated neglect, the facility was instructed by corporate to set up restricted visitation for R1 related to R1's representative. Administrative Staff A stated the facility did not clarify the information with the SA before restricting R1's rights. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175490	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2024
NAME OF PROVIDER OR SUPPLIER Legacy at Herington		STREET ADDRESS, CITY, STATE, ZIP CODE 2 E Ash Street Herington, KS 67449	

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 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Visitation policy, revised in September 2022, directed residents were permitted to have visitors of their choosing at the time of their choosing and the facility provided 24-hour access to individuals visiting with the consent of the resident. The facility failed to ensure R1 was able to exercise her right to receive visitors of her choosing at the time of her choice. This deficient practice placed R1 at risk for impaired resident rights, impaired psychosocial well-being, and social isolation. - The Diagnoses tab of R2's Electronic Medical Record (EMR) documented diagnoses of unsteadiness on feet and need for assistance with personal care. The Admission Minimum Data Set (MDS) dated [DATE], documented R2 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. It was very important to R3 that the family was involved in discussions about her care and very important for R3 to do her favorite activities. The Quarterly MDS dated [DATE], documented R2 had a BIMS score of 15 which indicated intact cognition. The Psychosocial Well-Being Care Area Assessment (CAA) dated 11/14/23, documented that R2 reported little interest or pleasure in doing things. R2's Care Plan dated 11/15/23, documented R2 had a potential for diversional activity due to cognitive impairment and/or physical assistance needed. The care plan directed the facility encouraged ongoing family involvement and invited R2's family to attend special events, activities, and meals. On 04/03/24 at 10:56 AM, R2 sat up in her bed and conversed with the surveyor. She stated the facility told her husband he could not come up to the dining room and if he went into the dining room, the facility would call law enforcement. She stated her husband no longer feels comfortable coming to the facility and she felt like her visitation was restricted. R2 stated she felt uncomfortable in the facility and her husband made her feel comfortable. R2 began crying. On 04/03/24 at 03:15 PM, Administrative Nurse D stated that R2's family was paying to eat at the facility, and Administrative Staff A gave him his money back and told him he could not eat at the facility anymore. She stated a dietary staff member felt uncomfortable with R2's family being in the dining room in the evenings because of an outburst that occurred. She stated R2's family was told he could not go into the dining room with R2 and that he had to wait until R2 was done eating. On 04/03/24 at 03:51 PM, Administrative Staff A stated R2's family wanted three meals a day and was told he could pay for food. They had set it up where R2's family was paying for meals. She stated last week, dietary staff came into her office crying because R2's family told her he wanted seconds and dietary staff told him all of the residents had not been fed yet. She stated R2's family got mad when he did not get seconds. Administrative Staff A stated she told R2's family that he could visit but he was not allowed in the dining room and R2 and he could eat in the living room if he brought food. She stated the facility gave R2's family the money back that he paid for meals and said to just call it even, but he was not to eat at the facility. She denied giving any alternative options before restricting visitation. (continued on next page)

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	175490	A. Building B. Wing	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at Herington	2 E Ash Street Herington, KS 67449

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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 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Visitation policy, revised in September 2022, directed residents were permitted to have visitors of their choosing at the time of their choosing and the facility provided 24-hour access to individuals visiting with the consent of the resident. The facility failed to ensure R2 was able to exercise her right to receive visitors of her choosing at the time of her choice. This deficient practice placed R2 at risk for impaired resident rights, impaired psychosocial well-being, and social isolation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175490	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2024

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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 0564 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform each resident of his or her visitation rights and ensure that all visitors enjoy equal visitation privileges. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42966 The facility identified a census of 30 residents. The sample included three residents reviewed for visitation rights. Based on observations, record review, and interviews, the facility failed to inform Resident (R) 1 and R2 and/or their representative of their visitation rights and any visitation restrictions placed on them. This deficient practice placed R1 and R2 at risk for impaired resident rights, impaired psychosocial well-being, and social isolation. Findings included: - The Diagnoses tab of R1's Electronic Medical Record (EMR) documented diagnoses of cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain) and weakness. The Annual Minimum Data Set (MDS) dated [DATE], documented R1 had a Brief Interview for Mental Status (BIMS) score of three which indicated severe cognitive impairment. The Quarterly MDS dated [DATE], documented R1 had a BIMS score of six which indicated severe cognitive impairment. The Cognitive Loss/Dementia (progressive mental disorder characterized by failing memory, confusion) Care Area Assessment (CAA) dated 10/06/23, documented R1 had cognitive deficits and was able to make her wants and needs known to staff. R1's Care Plan dated 06/26/23, documented R1 had a potential for diversional activity due to cognitive impairment and/or physical assistance needed. The care plan documented an intervention, revised 11/22/23, that directed the facility to encourage ongoing family involvement and invite R1's family to attend special events, activities, and meals. Upon request, the facility was unable to provide evidence a notice was issued to R1's durable power of attorney (DPOA- legal document that named a person to make healthcare decisions when the resident was no longer able to) stating that her visitation was restricted, what the restrictions were and why. On 04/03/24 at 02:58 PM, R1 sat in a chair in the day area next to other residents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175490	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2024
NAME OF PROVIDER OR SUPPLIER Legacy at Herington		STREET ADDRESS, CITY, STATE, ZIP CODE 2 E Ash Street Herington, KS 67449	

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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 0564 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/03/24 at 12:11 PM, R1's representative stated she worked at the facility on 02/29/24 because the facility needed help. She relayed she had a situation on that date with R3 and Administrative Staff A. She said on 03/22/24, she visited R1 in the morning and then received a call that afternoon from Administrative Staff A and Administrative Nurse D. R1's representative stated the facility administrative staff told her that she had been found guilty of abuse by the State Agency (SA) and stated she could not visit R1 anymore unless she made an appointment with the facility and the visitation had to be away from other residents and had to be supervised by facility staff. R1's representative stated she called the SA and the Long-Term Care Ombudsman (LTCO) for further information. She stated R1 liked it when she visited at lunchtime, so she arrived at the facility on 04/02/24 at lunchtime and sat with R1. R1's representative stated Administrative Staff A went into the dining room, placed a hand on the representative's shoulder, and directed R1's representative to leave or the facility would have her escorted out. R1's representative stated three law enforcement officers came in and one of them went into where she was visiting her mom. R1's representative stated she tried to keep the situation calm so R1 would not get upset. She said 04/02/24 had been her first visit since 03/22/24. On 04/03/24 at 03:00 PM, Administrative Nurse D stated the facility worked with the LTCO to set up visitation and said he was in the facility on 04/02/24 when R1's representative walked into the building at around 11:15 AM, before her scheduled visitation time at 01:00 PM. R1 was in the dining room along with the LTCO and R1's family sat with her. Administrative Nurse D confirmed that Administrative Staff A called law enforcement at that time. When the law enforcement officers arrived, they spoke to R1's representative outside. Administrative Nurse D stated R1's representative was supposed to call Administrative Staff A or Administrative Nurse D to schedule a visitation time and the facility offered to set up an empty room as a visitation room so R1 and her representative would both be comfortable. On 04/03/24 at 03:10 PM, Licensed Nurse (LN) G stated the only visitation restriction she knew of was for R1's representative. LN G said R1's representative was supposed to call ahead of time and schedule a visitation. On 04/03/24 at 03:51 PM, Administrative Staff A stated the facility did not send a notice out to R1's DPOA, informing him of R1's restricted visitation. The facility's Visitation policy, revised in September 2022, directed residents were permitted to have visitors of their choosing at the time of their choosing and the facility provided 24-hour access to individuals visiting with the consent of the resident. The facility failed to notify R1 and/or her DPOA of her restricted visitation as required. This deficient practice placed R1 at risk for impaired resident rights, impaired psychosocial well-being, and social isolation. - The Diagnoses tab of R2's Electronic Medical Record (EMR) documented diagnoses of unsteadiness on feet and need for assistance with personal care. The Admission Minimum Data Set (MDS) dated [DATE], documented R2 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. It was very important to R3 that the family was involved in discussions about her care and very important for R3 to do her favorite activities. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Legacy at Herington		STREET ADDRESS, CITY, STATE, ZIP CODE 2 E Ash Street Herington, KS 67449	

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 0564 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Quarterly MDS dated [DATE], documented R2 had a BIMS score of 15 which indicated intact cognition. The Psychosocial Well-Being Care Area Assessment (CAA) dated 11/14/23, documented R2 reported little interest or pleasure in doing things. R2's Care Plan dated 11/15/23, documented R2 had a potential for diversional activity due to cognitive impairment and/or physical assistance needed. The care plan directed the facility encouraged ongoing family involvement and invited R2's family to attend special events, activities, and meals. Upon request, the facility was unable to provide evidence a notice was issued to R2 and her representative that her visitation was restricted. On 04/03/24 at 10:56 AM, R2 sat up in her bed and conversed with the surveyor. She stated the facility told her husband he could not come up to the dining room and if he went into the dining room, the facility would call law enforcement. She stated her husband no longer feels comfortable coming to the facility and she felt like her visitation was restricted. R2 stated she felt uncomfortable in the facility and her husband made her feel comfortable. R2 began crying. On 04/03/24 at 03:15 PM, Administrative Nurse D stated R2's family was paying to eat at the facility, and Administrative Staff A gave him his money back and told him he could not eat at the facility anymore. She stated a dietary staff member felt uncomfortable with R2's family being in the dining room in the evenings because of an outburst that occurred. She stated R2's family was told he could not go into the dining room with R2 and that he had to wait until R2 was done eating. On 04/03/24 at 03:51 PM, Administrative Staff A stated R2's family wanted three meals a day and was told he could pay for food. They had set it up where R2's family was paying for meals. She stated last week, dietary staff came into her office crying because R2's family told her he wanted seconds and dietary staff told him all of the residents had not been fed yet. She stated R2's family got mad when he did not get seconds. Administrative Staff A stated she told R2's family that he could visit but he was not allowed in the dining room and R2 and he could eat in the living room if he brought food. She stated the facility gave R2's family the money back that he paid for meals and said to just call it even, but he was not to eat at the facility. She denied giving any alternative options before restricting visitation. She stated she should have given a notice to R2 or her representative regarding her restricted visitation. The facility's Visitation policy, revised in September 2022, directed residents were permitted to have visitors of their choosing at the time of their choosing and the facility provided 24-hour access to individuals visiting with the consent of the resident. The facility failed to notify R2 and/or her representative of her restricted visitation as required. This deficient practice placed R2 at risk for impaired resident rights, impaired psychosocial well-being, and social isolation.