STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255216	A. Building B. Wing	11/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverview Nursing & Rehabilitation Center	1600 West Claiborne Avenue Extended Greenwood, MS 38930

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. 47158 Based on observations, staff interviews and record reviews the facility failed to promote dignity as evidenced by a resident not being assisted with his meal immediately after nursing staff delivered the meal tray to his room for one (1) of eight (8) residents reviewed for dining. Resident #16 Findings Included: Record review of the facility policy titled, Residents' Rights with no revision date revealed Residents Rights Under Federal Law. The facility shall protect and promote the rights of each resident, including each of the following rights: 1. The resident has a right to a dignified existence, self-determination, communication with access to people and services inside and outside the facility . On 11/3/24 at 5:28 PM, during a continuous observation, Resident #16 was observed in bed as Certified Nursing Assistant (CNA) #8 delivered a meal tray to his room, placing it on the overbed table positioned against the wall and out of the resident's reach. The tray remained covered as CNA #8 exited the room without assisting Resident #16. She then delivered the meal tray to Resident #16's roommate, setting it up for the roommate to eat before leaving the room. Upon exiting, she informed Resident #16 that someone would be in shortly to assist him. Nursing staff were observed walking past the room but did not enter to assist Resident #16. At 5:34 PM on 11/3/24, Registered Nurse (RN) #1 entered the room and began assisting Resident #16 with his meal. She confirmed that Resident #16 could not feed himself and required assistance from the staff. She agreed that CNA #8 should have assisted Resident #16 when she brought the meal tray into the room, rather than leaving it and setting up the roommate's meal. She acknowledged that this could make the resident feel that his needs were not being prioritized. In an interview with CNA #8 on 11/3/24 at 5:40 PM, she explained that as long as the food remains covered, they usually leave the tray in the room and wait for someone to assist the resident. She mentioned that she was assigned to the room but was not specifically tasked with assisting Resident #16 with eating assistance, stating that no one is assigned specifically to assist residents; instead, staff members assist residents as they see the need. She confirmed she was aware that Resident #16 required assistance with eating. (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	An interview on 11/4/24 at 2:00 PM, with Licensed Practical Nurse (LPN) #2 indicated that the facility has a list of residents who require assistance with eating to inform staff. She stated that while no staff member is specifically assigned to assist residents with eating, all nursing staff are responsible for passing trays and assisting residents requiring help when delivering the tray. In a follow-up interview on 11/4/24 at 2:05 PM, the Director of Nursing (DON) verified that all nursing staff are responsible for passing trays and, when bringing a tray into the room of a resident who requires assistance, they are expected to assist the resident at that time rather than leaving the tray unattended. She agreed that CNA #8 should not have set up the roommate's meal while leaving Resident #16's tray without assistance, acknowledging this as a dignity concern. Record review of the Admission Record revealed that the facility admitted Resident #16 on 6/6/14 with diagnoses including Multiple Sclerosis. Record review of the Quarterly Minimum Data Set Assessment (MDS) with an Assessment Reference Date of 9/25/24 revealed, under Section GG Functional Abilities and Goals, Resident # 16 is dependent for eating.

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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. 47874 Based on resident and staff interview, record review, and facility policy review, the facility failed to honor a resident's right to make health care decisions for one (1) of 25 residents reviewed for advanced directives. Resident #58 Findings Include: Record review of the facility policy titled Advanced Directives with a revision date of 8/11 revealed under, Policy Interpretation and Implementation: 1. Prior to or upon admission of a resident to our facility, the Social Services Director or designee will provide written information to the resident concerning his/her right to make decisions concerning medical care including the right to accept or refuse medical or surgical treatment, and the right to formulate advance directives. Record review of the Advanced Directive Form for Resident #58 revealed a family member signed the form dated 4/23/24, with no signature from the resident. An interview with Resident #58 on 11/4/24 at 1:20 PM, revealed when he admitted to the facility, he did not sign his advanced directives form and explained that no one had spoken to him regarding his code status. He revealed he felt it was important that he make his own decisions because he might not feel the same way as his family members. An interview with Social Services (SS) #1 on 11/4/24 at 1:40 PM, confirmed Resident #58 did not sign his own advanced directive form. She revealed if a resident was cognitive and able to sign it, they should because the residents have a right to self-determination. An interview with the Director of Nursing (DON) on 11/5/24 at 7:59 AM, revealed Resident #58 was cognitive and could make his own health care decisions. She confirmed he should have been allowed to sign his own advanced directive form, ensuring his wishes were honored. Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/14/24 revealed, under section C, a Brief Interview for Mental Status (BIMS) summary score of 15, which indicated Resident #58 was cognitively intact. Record review of the Admission Record revealed the facility admitted Resident #58 on 4/23/24 with a medical diagnosis that included Nontraumatic Intracranial Hemorrhage.

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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. 46013 Based on observation, resident and staff interviews, and facility policy review, the facility failed to provide a safe, clean, and comfortable environment, as evidenced by an over-bed table with exposed jagged edging (Resident #4) and a sagging mattress (Resident #58) for two (2) of 61 residents. Findings include: Review of the facility policy titled Maintenance Service with a revision date of December 2009 revealed, Maintenance service shall be provided to all areas of the building, grounds, and equipment. J. Ensuring equipment is maintained in good, operational working order. Resident #4 An observation on 11/03/24 at 4:25 PM, revealed Resident #4 lying in bed with her overbed table pulled up to her. The overbed table edging was missing around the table, exposing chipped and jagged wood. An observation on 11/04/24 at 8:25 AM, revealed the overbed table remained in the same condition as the prior day. During an interview and observation on 11/04/24 at 1:30 PM, Certified Nurse Aide (CNA) #4 confirmed that Resident #4's overbed table was tattered and torn and revealed she had not reported the condition of the overbed table to anyone. She revealed that when they see equipment or anything that needs repair in a resident's room, they are supposed to notify the nurse or maintenance. In an interview and observation on 11/04/24 at 1:48 PM, the Director of Nurses (DON) confirmed that Resident #4's overbed table needed to be replaced and revealed that the resident could get hurt by the exposed wood around the edge of the table. She revealed that all department heads make rounds each morning and look at each room to ensure there are no issues. Record review of the Admission Record revealed the facility admitted Resident #4 on 06/22/2020 with medical diagnoses that included Parkinson's Disease with Dyskinesia. Resident # 58 An observation and interview with Resident #58 on 11/03/24 at 3:11 PM, revealed him lying in bed. He explained that his mattress was uncomfortable and had a sag in the middle. The resident revealed he had told all of the staff that entered his room that his mattress was uncomfortable. An observation and interview on 11/4/24 at 8:20 AM, with Resident #58 revealed, the resident lying on a raised perimeter mattress which the resident explained made it difficult for him to turn side to side in the bed. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation and interview with Licensed Practical Nurse (LPN) # 1 on 11/4/24 at 1:00 PM, revealed she was not aware of Resident #58's complaints regarding the mattress. She revealed the nursing staff were responsible for changing out the mattresses. LPN #1 confirmed the resident should be comfortable, and the equipment should be in good repair. An interview with the DON on 11/5/24 at 7:58 AM, revealed Resident #58 should have a regular mattress, but had a raised perimeter mattress because the facility did not have any regular mattresses on hand. She confirmed the resident should have a comfortable mattress. Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/14/24 revealed, under section C, a Brief Interview for Mental Status (BIMS) summary score of 15, which indicated Resident #58 was cognitively intact. Record review of the Admission Record revealed the facility admitted Resident #58 on 4/23/24 with a medical diagnosis that included Nontraumatic Intracranial Hemorrhage. 47874

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. 47158 Based on observation, staff interview, record review and facility policy review, the facility failed to ensure residents were free from physical restraints as evidenced by a resident with full side rails to both sides of the resident's bed for one (1) of two (2) residents reviewed for restraints. Resident #44. Findings Include: A review of the facility policy titled Residents' Rights with no revision date revealed The facility shall protect and promote the rights of each resident, including each of the following rights: . The resident has a right to be free from any physical restraints imposed or psychoactive drugs administered for the purpose of discipline or convenience and not required to treat the resident's medical symptoms. During an observation on 11/03/24 at 3:35 PM, Resident #44 was observed in bed with side rails extending the length of the bed on both sides. In an interview on 1/4/24 at 1:12 PM, Certified Nursing Assistant (CNA) #3 stated that she did not know why Resident #44 had full side rails on his bed. During an interview on 1/4/24 at 1:17 PM, with a Licensed Practical Nurse (LPN) #1, she stated that Resident #44 has had full side rails for approximately two weeks. She noted that the full side rails were implemented to prevent the resident from getting out of bed, as he had previously used half (1/2) side rails but was climbing out. She mentioned that she contacted hospice to request full side rails, which have been in place since then. In an interview on 1/4/24 at 2:12 PM, the Director of Nursing (DON) verified that Resident #44's bed had full side rails extending the length of the bed on both sides and confirmed that the resident has a history of attempting to get out of bed. She acknowledged that the side rails act as a restraint, preventing the resident from getting out of bed. A record review of Resident #44's Order Summary revealed an order for Bilateral 1/2 Side Rails to Assist with Turning and Positioning with an onset date of 6/10/24. A record review of the Assessments for Resident #44 revealed no documentation of a side rail or restraint assessment. A record review of Resident #44's medical record indicated no consent for the use of the full side rails on the resident's bed. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a follow-up interview with the DON on 11/5/24 at 8:05 AM, she confirmed that Resident #44 did not have a side rail or restraint assessment, consent, or physician orders for full side rails on both sides of the bed. She stated that consent should have been obtained from the resident's representative and that education regarding side rail use should have been provided. Additionally, she acknowledged that an assessment should have been conducted to ensure the full side rails were safe for the resident. Record review of the Admission Record revealed that the facility admitted Resident #44 on 7/12/22 with diagnoses including Dementia.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 47158 Based on staff interview, record review, and facility policy review the facility failed to ensure that the Minimum Data Set Assessment (MDS) was coded accurately for one (1) of 22 sampled residents. Resident #19. Findings Included: Record review of the facility policy, titled Resident assessment Instrument revealed Policy Statement: A comprehensive assessment of a resident's needs shall be made within fourteen (14) days of the resident's admission. Policy Interpretation and Implementation .4. Information derived from comprehensive assessment helps the staff to plan care that allows the resident to reach his/her highest practicable level of functioning. 7. All persons who have completed any portion of the MDS Resident Assessment Form must sign such a document attesting to the accuracy of such information. Record review of Resident #19's Annual MDS with Assessment Reference Date (ARD) of 7/2/24, revealed in Section A 1500 coded as No, Is the resident currently considered by the state level II PASRR (Preadmission Screening and Resident Review) process to have serious mental illness and/or intellectual disability or a related condition? Record review of Resident #19's Summary of Findings Report, from the PASRR Office, dated 1/29/2019, under Mental Health revealed the individual meets criteria for having a diagnosis of mental illness as defined by PASRR. Interview with MDS Nurse on 11/5/24 at 1:15 PM, she verified that the Annual MDS with an ARD of 7/2/24, for Resident # 19 was coded incorrectly, because the resident does have a mental illness. She agreed that the MDS should be coded correctly to ensure that the resident is receiving the correct level of care. A record review of the Admission Record revealed Resident #19 was admitted by the facility on 1/14/19 with a diagnoses including Schizophrenia.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 47157 Based on resident and staff interviews, record review, and facility policy review the facility failed to complete a baseline care plan timely and provide a summary of the baseline care plan to the resident and their representative for two (2) of three (3) baseline care plans reviewed. Resident 59 and 166 Findings include: A review of the facility policy titled, Care Plans-Baseline, with a revision date of 12/2016 revealed Policy Interpretation and Implementation: 1.) To ensure that the resident's immediate care needs are met and maintained, a baseline care plan will be developed within forty-eight (48) hours of the resident's admission. 4.) The residents and their representatives will be provided with a summary of the baseline care plan . Resident #59 A record review of the Baseline Care Plan for Resident #59 revealed the care plan was completed on 8/22/24 with no signature of the resident or representative acknowledgement of receipt of the care plan summary findings. In an interview with Resident # 59 on 11/4/24 at 3:00 PM, she revealed that there were no staff that discussed her plan of care with her on admission. Record review of the Admission Record revealed the facility admitted Resident #59 on 8/22/24. Record review of Resident #59's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/29/24 revealed a Brief Interview for Mental Status (BIMS) score of 13, indicating the resident was cognitively intact. Resident #166 A review of the Baseline Care Plan for Resident #166 revealed the care plan was initiated on 11/1/24, the day of admission by staff but was not completed within 48 hours. Further review of the baseline care plan revealed there was no signature of family, resident or representative notification of the baseline care plan summary findings. In an interview with Resident #166 on 11/3/24 at 2:00 PM, he revealed that no one explained his plan of care to him when he was admitted . In an interview with the MDS nurse on 11/04/24 at 12:00 PM, she revealed she was unaware that the Baseline Care Plan needed to be completed within 48 hours or that the findings needed to be discussed with the resident or the representative. She then confirmed that they have not been discussing the Baseline Care Plan findings with the new admission residents or the representatives. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The MDS nurse revealed the purpose of the Baseline Care Plan is to identify resident needs and direct staff resident required care. In an interview with the Care Plan Nurse on 11/04/24 at 12:15 PM, she revealed that she was unaware of a timeframe for the Baseline Care Plan to be completed. She also revealed she was not aware that the facility was supposed to discuss the care plan findings with the resident/resident representative and confirmed she has not been discussing the baseline plan of care with any of the new admissions. In an interview with the Director of Nursing on 11/04/24 at 12:22 PM, she revealed she was unaware that the baseline care plan findings needed to be discussed with the resident/resident representative within 48 hours of admission. Review of the Admission Record revealed the facility admitted Resident #166 on 11/01/24. Record review of Resident #166's BIM Evaluation dated 11/01/24 revealed a BIMS score of 13, indicating the resident was cognitively intact.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46013 Based on observation, resident and staff interview, record review and facility policy review, the facility failed to develop and/or implement a person-centered care plan for monitoring side effects of medications, range of motion (ROM) and providing nail care for 11 of 24 resident care plans reviewed. Resident #4, #9, #10, #17, #18, #19, #39, #44, #51, #55 and #58. Findings Include: Record review of the facility policy titled Comprehensive Assessments and the Care Delivery Process with a revision date of 12/16 revealed under, Policy Statement: Comprehensive assessments will be conducted to assist in developing person-centered care plans. Resident # 4 Record review of Resident #4's care plan revealed under focus, Closed fracture of right tibia and fibula, date initiated 05/01/2024. Interventions included Xarelto 10 milligram tablet, monitor for side effects such as abdominal pain, back pain, itching, dizziness, muscle spasms, trouble sleeping, and anxiety. Date initiated 5/6/2024. In an interview on 11/05/24 at 10:46 AM, the Director of Nurses (DON) confirmed that Resident #4 was on an anticoagulant medication and confirmed that Resident #4's care plan was not developed for anticoagulation medication, which should also include monitoring for bleeding and bruising. An interview on 11/06/24 at 9:50 AM, the Care Plan Nurse confirmed that Resident #4 did not have a care plan developed that addressed the potential outcomes associated with the use of an anticoagulant medication, which is bleeding and bruising and revealed it is so important to ensure that adequate monitoring of a blood thinner is being done. Record review of the Admission Record revealed the facility admitted Resident #4 on 06/22/2020 with medical diagnoses that included Parkinson's Disease with Dyskinesia. Resident #10 A review of the care plan titled Psychotropic medication use with a start date of 10/04/2024, revealed Interventions: Monitor and document side effects of medication every shift. During an interview on 11/06/24 at 08:57 AM, the DON confirmed they were not monitoring for the side effects of psychotropic medications, and they should have been. She revealed Resident #10's care plan was not being followed since the psychotropic medications were not being monitored or documented. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview on 11/06/24 at 10:42 AM, the Care Plan nurse revealed the purpose of the care plan is to inform staff on how to take care of each resident individually. She confirmed that according to Resident #10's care plan, she was on psychotropic medications. Since the nurses were not monitoring and documenting the side effects of the medication, the plan of care was not being followed. Record review of the Admission Record revealed Resident #10 was admitted to the facility on [DATE] with medical diagnoses that included Anxiety Disorder. A record review of the MDS with an ARD of 10/11/2024 revealed that Resident #10 had a BIMS score of 14, which indicated that the resident was cognitively intact. 47874 Resident #9 Record review of Resident #9's care plans revealed under, Focus: ADLS (activities of daily living): Alterations in ADL's R/T (related to) impaired mobility .Interventions/Tasks . Trim fingernails and toenails PRN (as needed). Date initiated 12/13/13. On 11/03/24 at 2:30 PM, observation revealed, Resident #9 lying in bed with long jagged nails on both hands, measuring approximately three-eighths (3/8) inch in length past the tips of the resident's fingers. An observation and interview with the DON on 11/4/24 at 1:10 PM, confirmed Resident #9's nails were long. An interview with the Care Plan Nurse on 11/6/24 at 10:02 AM revealed the purpose of the care plan was to ensure the resident's needs were taken care of. She confirmed the care plan was not followed for Resident #9's nail care. Record review of the Admission Record revealed the facility admitted Resident #9 on 12/13/13 with a medical diagnosis that included Dementia, unspecified. Resident #58 Record review of Resident #58's ADL Care Plan revealed a care plan was not developed for nail care. On 11/03/24 at 3:11 PM, observation and interview with Resident #58 revealed, long nails on both hands that measured approximately one-half (1/2) inch in length. The resident stated he was a diabetic and would like to have his nails cut because he does not like them long. An observation and interview with Licensed Practical Nurse (LPN) #1 on 11/4/24 at 1:04 PM, confirmed Resident #58 had long nails. An interview with the Care Plan Nurse on 11/6/24 at 10:02 AM, confirmed a nail care plan was not developed for Resident #58. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the Quarterly MDS with an ARD of 10/14/24 revealed, under section C, a Brief Interview for Mental Status (BIMS) summary score of 15, which indicated Resident #58 was cognitively intact. Record review of the Admission Record revealed the facility admitted Resident #58 on 4/23/24 with a medical diagnosis that included Nontraumatic Intracranial Hemorrhage. 47157 Resident # 17 On 11/04/24 at 12:50 PM, an observation of Resident #17 with Licensed Practical Nurse (LPN) #1 , she confirmed that Resident #17's right and left hands were contracted. A review of a care plan for Resident #17 titled, Risk for new contractures related to Cerebral Palsy, has contractures of left and right hand, revised 9/10/24 revealed no routine services to prevent worsening of the contractures. On 11/05/24 at 3:20 Pm, in an interview with the DON , she revealed after review of Resident #17's care plan related to the resident 's contracted hands, the care plan was not developed appropriately when range of motion was not added as an intervention. Record review of the Admission Record revealed the facility admitted Resident #17 on 9/11/15 with diagnoses of Cerebral Palsy and contracture to right and left hand. Record review of Resident #17's MDS with an ARD of 8/22/24 Section GG: 0115 functional limitation in range of motion was coded impairment on both sides of the upper and lower extremities. Resident #18 A review of the Order Summary Report for Resident # 18 revealed orders for Aripiprazole 30 mg (milligram) one tablet at bedtime related to schizoaffective disorder . Ativan (Lorazepam) one (1) mg tablet 0.5 mg in the morning for generalized anxiety for (4) four days . Ativan one (1) mg tablet 0.5 mg at bedtime for generalized anxiety for (4) four days . Olanzapine 10 mg one tablet at bedtime for schizoaffective disorder . Venlafaxine HCL (hydrochloride) extended one tablet by mouth one time a day related to Major Depressive disorder . A review of the Order Summary Report for Resident # 18 revealed no order to monitor for side effects of the multiple psychotropic medications ordered. Record review of a care plan for Resident #18 titled, Psychotropic medication use Antianxiety, Antidepressant, Antipsychotic, , revised 9/14/24 revealed Interventions: Monitor for effects and side effects of medication every shift Observe for signs of complications such as cognitive behavior problems, sedation, hypotension, gait disturbance, and tremors (continued on next page)

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	255216	A. Building B. Wing	11/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverview Nursing & Rehabilitation Center	1600 West Claiborne Avenue Extended Greenwood, MS 38930

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the DON on 11/04/24 at 2:45 PM, she confirmed after review of the psychotropic care plans for Resident #18 that staff were not following the care plan intervention for monitoring for side effects of the psychotropic medications. She stated that the purpose of the comprehensive care plan is to identify residents' specific needs and direct the individual care each resident needs. Review of the Admission Record revealed the facility admitted Resident #18 on 9/05/24 with diagnoses including Schizophrenia, Bipolar Disorder, and Anxiety Disorder. Record review of Resident #18's Section N: Medications of the Admission MDS with an ARD 9/12/24 revealed, N: 04115 : High-Risk Drug Classes: antipsychotic, antianxiety, and antidepressant coded yes for receiving the medications. Resident #51 A record review of the Order Summary Report for Resident # 51 revealed orders for Lorazepam oral concentrate two (2) mg/ml (milligram/milliliter): give .25 mg by mouth every four hours as needed anxiety with an order date of 8/27/24 with no stop date, Ativan 0.5 mg by mouth three times daily, related to anxiety, and Zoloft 50 mg tablet one tablet by mouth at bedtime related to Anxiety. A continued review of the Order Summary Report for Resident # 51 revealed no order to monitor for side effects of the multiple psychotropic medications ordered. A record review of a care plan for Resident #51 titled, Anxiety as exhibited by paranoia, revealed Interventions: Monitor effects and side effects of medication (sedation, drowsiness, agitation, headache) . In an interview with the DON on 11/05/24 at 7:35 AM, she revealed after review of Resident #51 ' s psychotropic care plan that staff were not following the intervention for monitoring for side effects. Review of the Admission Record revealed the facility admitted Resident # 51 on 11/30/23 with diagnoses of Mood disorder, and Anxiety. Record review of Resident #51's Section N: Medications of the Quarterly MDS with an ARD/Target Date of 11/18/24 revealed N: 04115 : High-Risk Drug Classes: antianxiety and antidepressant coded yes for receiving the medications. Resident #55 A record review of the Order Summary Report for Resident # 55 revealed orders for buspirone (5) five mg tablet twice daily for Anxiety, Risperdal (2) two mg at bedtime for bipolar disorder, and Risperdal 0.5 mg daily for bipolar disorder. A continued review of the Order Summary Report for Resident # 55 revealed no orders to monitor the side effects of the psychotropic medications. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of a care plan for Resident #55, date initiated 5/17/24 titled, Bipolar: impaired thought process, revealed, Interventions: Monitor for side effects such as feeling sleepy in the day or difficulty falling asleep at night, problems with movement, difficulty moving, stiff muscles with movements which are difficult to control, a slow shuffling walk, shakes and drooling, headaches, and putting on weight or changes in appetite. A record review of a care plan for Resident #55 date initiated 8/14/24 titled, Anxiety: risk for episodes of anxiety, revealed, Interventions: Monitor effects and side effects of medication (sedation, drowsiness, agitation, headache). In an interview with the DON on 11/04/24 at 2:40 PM, she revealed after reviewing the psychotropic drug care plans for Resident #55, staff were not implementing the care plan when there was no side effect monitoring. Record review of the Admission Record revealed the facility admitted Resident #55 on 3/01/24 with diagnoses of Bipolar Disorder, Anxiety Disorder, Borderline Personality Disorder, and Psychotic Disorder with Delusions. Record review of Resident #51's Section N: Medications of the Quarterly MDS with an ARD 8/23/24 revealed N: 04115 : High-Risk Drug Classes: antipsychotic and antianxiety coded yes for receiving the medications Resident #19 An observation on 11/03/24 at 4:00 PM revealed Resident #19 had limited range of motion (ROM) to first through fourth fingers of the left hand at the first finger joints. During an interview on 11/4/23 at 3:23 PM, with Certified Nursing Assistant (CNA) #10 she stated he is dependent for all care and cannot help at all. She stated that Resident #19 has contractures to his fingers and his legs. Record review of Resident #19's care plan revised 7/8/24 revealed Risk for contracture r/t (related to) limited mobility. Residents will not have new development of contractures in the next 90 days through participation with ADLS allow for rest periods. Interventions included: allow for rest periods as needed, bilateral half transfer bars to aid in turning and positioning , encourage and assist resident to turn and reposition at least q (every) 2 (two) hours ., encourage resident to attempt task during ADLs (Activities of Daily Living) which he can safely perform, praise resident for all efforts, wheelchair with built in cushion for mobility/locomotion. Record review and interview with Care Plan Nurse on 11/5/24 at 1:22 PM, of Resident # 19's care plan she verified that the care plan had no interventions developed, like ROM, that would help to prevent contractures for Resident #19. Record of the Admission Record revealed the facility admitted Resident #19 on 1/14/19 with diagnoses including Contracture, left hand. Record review of the Quarterly MDS with an ARD of 9/24/24, section GG, Functional Limitation in ROM revealed Resident # 19 had impairments to upper and lower extremities on one side. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #39 An observation of Resident # 39 on 11/03/24 at 4:07 PM, revealed Resident #39 had limited ROM of both arms with no braces or splints in use. During an interview on 11/4/23 at 3:24 PM, with CNA #10 she stated Resident #39 is dependent for all care and cannot help at all. She stated that Resident #39 has contractures to his arms and his legs. Record review of Resident # 39's care plan revealed there was no care plan developed related to the prevention of contractures. Record review and interview with Care Plan Nurse on 11/5/24 at 1:23 PM, of Resident #39's care plan she verified that a care plan had not been developed related to the prevention of contractures for Resident # 39. Record of the Admission Record revealed the facility admitted Resident #39 on 3/18/22 with a diagnosis of Disorders of Bone Density and Structure. Record review of the Annual MDS with an ARD of 8/22/24, section GG, Functional Limitation in ROM revealed Resident # 39 had impairment to upper and lower extremities on both sides. Resident #44 Record review of Resident #44's care plan revealed Focus: Restless/Agitation/Mood Disorder .Interventions included: Lexapro Oral tablet 5 mg (milligrams) .Monitor for SE (side effects) such as: Anxiety, irritability, or high or low mood Feeling restless Dizziness Confusion Headache Date Initiated: 06/10/2024. Lorazepam 2 mg/ml (milligrams per milliliter) .Monitor for SE such as: Drowsiness, dizziness, loss of coordination, headache, nausea, blurred vision, change in sexual interest/ability, constipation, heartburn, or change in appetite Date Initiated: 04/17/2024. Risperidone 0.25 mg .Monitor for SE such as: Drooling, nausea, weight gain. Date Initiated: 08/19/2023. Trazadone 50 mg .Monitor for SE such as N/V (nausea/vomiting), diarrhea, nervousness Date initiated 2/19/23 Record review of Resident #44's Electronic Medication Administrator Record (EMAR) revealed no documentation of monitoring for side effects of psychotropic medications prior to 11/4/24. Interview with the DON on 11/5/24 at 8:05 AM, she verified that Resident #44 had no documentation that he was being monitored for side effects of psychoactive medications. She stated she thought that the monitoring for side effects did not pull over when they changed computer systems. She stated failure to monitor for side effects could lead to over sedation, increased risk for falls. Interview with the Care Plan Nurse on 11/5/24 at 1:10 PM she agreed that Resident #44's care plan was not followed with regard to monitoring for side effects of psychotropic medications. Record review of the Admission Record revealed that the facility admitted Resident #44 on 7/12/22 with diagnoses including Dementia and Anxiety. 47158

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47874 Based on observation, resident and staff interviews and record review, the facility failed to provide assistance with Activities of Daily Living (ADL) care to maintain hygiene as evidenced by: Resident # 9, # 17, #58 were observed with long jagged fingernails and Resident #12 was observed with unkept and greasy hair and an unkept beard for four (4) of 61 residents reviewed for ADL care. Residents #9, #12, #17 and #58. Findings Included: Record review of a statement on facility letterhead, undated, and signed by the Administrator revealed We do not have a direct policy ADLs. Resident #9 An observation on 11/03/24 at 2:30 PM revealed, Resident #9 lying in bed with long jagged nails on both hands, measuring approximately three-eighths (3/8) inch in length past the tips of the fingers with a brown substance underneath. An observation and interview with the Director of Nursing (DON) on 11/4/24 at 1:10 PM, confirmed Resident #9's nails were long and had a brown substance underneath. She revealed the treatment nurse was responsible for cutting and cleaning the residents' nails. She explained the facility did not have a task set up for the residents to get nail care on a routine basis. The DON revealed the long nails, and the brown substance underneath could cause an infection if the resident scratched herself. Record review of the Admission Record revealed the facility admitted Resident #9 on 12/13/13 with medical diagnoses that included Dementia, unspecified. Resident #12 An observation on 11/03/24 at 3:15 PM, revealed Resident #12's hair was unkept and greasy in appearance and his beard/facial hair was unkept and disheveled. An observation on 11/04/24 at 8:00 AM, revealed Resident #12's appearance was the same as the previous observation on 11/3/24 at 3:15 PM. In an observation of Resident #12 with Licensed Practical Nurse (LPN) #1 on 11/04/24 at 12:55 PM, she revealed that Resident # 12's hair appeared very oily and unkept, his face appeared oily, and his facial hair appeared unkept, and he needed to be shaved. She also revealed that Resident #12 had a strong body odor that was related to the need for a bath and good personal hygiene care. She stated that concerns from not bathing/shaving the resident could lead to dandruff build-up and skin concerns. In an interview with the DON on 11/05/24 at 7:15 AM, she revealed that staff failing to provide needed ADL care like bathing and grooming could lead to skin issues. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Admission Record revealed the facility admitted Resident #12 on 12/15/21 with diagnoses that included Epilepsy. Record review of Resident #12's Section GG: Self-Care of the MDS with an ARD of 9/25/24 was coded as dependent for personal hygiene. Resident #17 An observation on 11/03/24 at 2:44 PM, revealed Resident #17 fingernails were untrimmed and approximately (one) 1 inch in length past the tips of the fingers and jagged in appearance. In an observation of Resident #17 with LPN #1 on 11/04/24 at 12:50 PM, she confirmed Resident #17's fingernails on both hands were long and jagged. She stated that the nails being long and jagged could cause skin concerns such as breakdown. In an interview with the DON on 11/05/24 at 3:20 PM, she revealed staff not cutting the resident's nails could lead to skin concerns. Review of the Admission Record revealed the facility admitted Resident #17 on 9/11/15 with diagnoses that included Contractures to right and left hands. Record review of Resident #17's Section GG: Self-Care of the MDS with an ARD of 8/22/24 was coded as dependent for personal hygiene. Resident #58 An observation and interview on 11/03/24 at 3:11 PM, with Resident #58 revealed, long nails on both hands that measured approximately one-half (1/2) inch in length. The resident stated he was a diabetic and would like to have his nails cut because he does not like them long. An observation and interview with LPN #1 on 11/4/24 at 1:04 PM, confirmed Resident #58 had long fingernails. She revealed the resident was a diabetic and his nails must be cut by a nurse. LPN #1 revealed the nail care task was not set up to prompt staff to cut nails, and explained the facility did not have anyone who went around regularly to do nail care. She confirmed the resident could scratch himself or the staff. Record review of the Admission Record revealed Resident #58 was admitted to the facility on [DATE] with diagnoses that included Type 2 Diabetes Mellitus. Record review of the Quarterly MDS with an ARD of 10/14/24 revealed, under section C, a Brief Interview for Mental for Status (BIMS) summary score of 15, which indicated Resident #58 was cognitively intact. 47157

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 47157 Based on observation, staff interview, record review and facility policy review, the facility failed to provide the services needed for a resident to maintain and/or improve their level of range of motion (ROM) and mobility for four (4) of 32 residents reviewed for positioning and mobility. (Resident #17, # 19, #22, and #39). Findings include: Record review of facility policy titled Resident Mobility and Range of Motion with a revision date of 7/2017 revealed Policy Statement, 1. Residents will not experience an avoidable reduction in range of motion (ROM). 2. Residents with limited range of motion will receive treatment and services to increase and/or prevent a further decrease in ROM. 3. Residents with limited will receive appropriate services, equipment and assistance to maintain or improve mobility unless a reduction in mobility is unavoidable. Resident #17 An observation on 11/03/24 at 2:44 PM revealed Resident #17 to have a right and left-hand contracture with no device in place. In an observation of Resident #17 with Licensed Practical Nurse (LPN) #1 on 11/04/24 at 12:50 PM, she confirmed that Resident #17's left and right hands were contracted. A record review of the Order Summary Report for Resident # 17 revealed there were no orders for services for the right- and left-hand contractures. A record review of the Task Report for November 2024 for Resident # 17 revealed there was no documentation of services to be provided to the right and left-hand contractures. In an interview with the Occupational Therapist (OT) on 11/4/24 at 3:04 PM, he verified Resident #17 had contractures to bilateral hands. He stated that Resident #17 would benefit from ROM exercises to possibly prevent worsening of the contractures. In an interview with Certified Nurse Assistant (CNA) #1 on 11/04/24 at 3:13 PM, she revealed she was assigned to Resident #17, and confirmed she did not do any exercises or range of motion to his contracted hands. An interview with the Director of Nursing (DON) on 11/05/24 at 3:30 PM, revealed that staff not providing ROM to the contracted hands could lead to worsening of the contractures. In an interview with CNA #2 on 11/05/24 at 8:15 AM, she revealed she was assigned to Resident #17, and confirmed she did not do any exercise or ROM to his hands. She revealed they used to have a restorative program, but no longer have it right now. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the Admission Record revealed the facility admitted Resident #17 on 9/11/15 with a diagnosis of Contracture to Right and Left Hand. Record review of Resident #17's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/22/24 Section GG: 0115 functional limitation in range of motion was coded impairment on both sides of the upper and lower extremities Resident #19 On 11/3/24 at 4:00 PM, an observation and interview with Resident # 19 revealed that the resident had limited ROM to first through fourth fingers of the left hand at the first finger joints. Resident #19 stated he did not receive ROM exercises or braces. Record review of Resident #19's Electronic Medical Record (EMAR) revealed no documentation of that Resident #19 received ROM exercises or bracing. On 11/4/24 at 3:00 PM, an interview with OT verified Resident #19 had contractures at first finger joints of 1st through 4th fingers of left hand. He stated that the resident would benefit from ROM exercises and could have possibly prevented the contractures. During an interview with CNA #10 on 11/4/23 at 3:23 PM, she stated that Resident #19 is dependent for all care and cannot help at all. She stated that Resident #19 has contractures to his fingers and his legs, but she does not perform any type of ROM on the resident. Record review of the Admission Record revealed the facility admitted Resident #19 on 1/14/19 with a diagnosis of Multifocal Motor Neuropathy. Record review of the Quarterly MDS with an ARD of 9/24/24, section GG, Functional Limitation in ROM revealed Resident # 19 had impairments to upper and lower extremities on one side. Resident #39 On 11/03/24 at 4:07 PM, an observation of Resident # 39, revealed Resident #39 had limited ROM of both arms with no braces or splints in use. Record review of OT Plan of Care, dated 11/4/24 for Resident #39 revealed Exacerbation of BUE (bilateral upper extremity) AROM (Active Range of Motion). During an interview on 11/4/24 at 8:51AM, Resident #39's Representative stated the resident did not have contractures on admission and he had never received therapy and/or bracing. In an interview on 11/4/24 at 3:02 PM, the OT verified Resident #39 had contractures of his bilateral elbows. He stated that the resident would benefit from ROM exercises and bracing elbows and that ROM could have possibly prevented the contractures. On 11/4/23 at 3:24 PM, during interview CNA #10 stated that Resident # 39 is dependent for all care and cannot help at all. She stated that Resident #39 had contractures to his arms and his legs, but she does not perform any type of ROM on the resident. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record of the Admission Record revealed the facility admitted Resident #39 on 3/18/22 with a diagnosis of Disorders of Bone Density and Structure. Record review of the Annual MDS with an ARD of 8/22/24, section GG, Functional Limitation in ROM revealed Resident # 39 had impairment to upper and lower extremities on both sides. Resident #22 An observation of Resident #22 on 11/03/24 at 3:15 PM, revealed the resident lying in bed with his left arm drawn toward his chest. The resident was observed to be unable to move it on command. An interview with the OT on 11/4/24 at 2:50 PM, revealed Resident #22 was not receiving any therapy services related to the contracture and explained that he knew it had been a year since he had. He revealed the resident would benefit from passive range of motion (PROM) to prevent worsening of the contracture. An interview with the DON on 11/4/24 at 3:10 PM, revealed that the facility did not have a restorative nursing program. An interview with CNA #9 on 11/4/24 at 3:25 PM, revealed Resident #22 was able to move his arms by himself, so she did not do any exercises with him. She revealed the resident kept one of his legs bent and would holler out when it was moved. An interview with the DON on 11/05/24 at 3:20 PM, revealed that not providing PROM to Resident #22 could lead to worsening contractures. An interview with CNA #7 on 11/6/24 at 9:25 AM, revealed that she did not perform exercises with Resident #22 during daily care and confirmed it was not set up on the task for them to do. Record review of the Resident Care Kardex for Resident #22 revealed there was not a task set up for PROM. Record review of the MDS with an ARD of 8/30/24 revealed under, section GG, Resident #22 had upper and lower extremity impairment on one side. Record review of the Admission Record revealed the facility admitted Resident #22 on 6/29/23 with a medical diagnosis that included Hemiplegia and hemiparesis following Cerebral Infarction affecting the left non-dominant side. . 47158 47874

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 46013 Based on staff interviews, record review, and facility policy review, the facility failed to ensure sufficient weekend nursing staffing for the 3rd quarter payroll-based journal (PBJ) for one (1) of three (3) quarters reviewed. Findings include: Record review of the facility policy titled Staffing with a revised date of April 2007 revealed, . 1. Our facility maintains adequate staffing on each shift to ensure that our resident's needs and services are met. Record review of PBJ Staffing Data Report CASPER Report 1705D FY (Fiscal Year) Quarter 3 2024 (April 1-June 30), revealed Excessively Low Weekend Staffing-Triggered. Triggered=Submitted Weekend Staffing data is excessively low. An interview on 11/04/24 at 10:00 AM, the Assistant Director of Nurses (ADON) revealed she is responsible for staff development and scheduling. She revealed she was not employed as the ADON during the 3rd quarter dates of April-June 2024 but worked part-time for the facility. She revealed that the facility had an issue maintaining enough staff for the weekends during that time and confirmed that after she reviewed the weekend staffing for the third (3rd) quarter, it was due to low staffing. She revealed that they now have agency staffing to help ensure they are adequately staffed. During an interview on 11/05/24 at 1:45 PM, Human Resources (HR) confirmed the PBJ for the third quarter of 2024 was entered accurately. She revealed we were running low on staffing due to excessive call-ins and staff either clocking in late or out early. She stated that she is responsible for inputting the direct care hours into the dashboard and then submits to the corporate office. In an interview on 11/06/24 at 9:25 AM, the Administrator revealed she became the Administrator at the end of May 2024, and started working on ensuring they were adequately staffed to care for their residents. She revealed that they now have agency staff on board while actively trying to hire staff and feels like the staffing issue has improved with the help of the agency staff.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 46013 Based on staff interview, record reviews and facility policy review, the facility failed to monitor a resident receiving anticoagulant medication for side effects for one (1) of (10) residents on anticoagulant medications. Resident #4 Findings include: Record review of the facility policy titled Anticoagulation-Clinical Protocol with a revision date of September 2012 revealed . Monitoring and Follow-Up . 4. The staff and physician will monitor for possible complications in individuals who are being anticoagulated and will manage related problems. a. If an individual on anticoagulation therapy shows signs of excessive bruising, hematuria (blood in the urine), hemoptysis (vomiting blood), or other evidence of bleeding, the nurse will discuss the situation with the physician . Record review of the Order Summary Report with active orders as of 11/5/24 revealed an order with a start date of 6/10/24 for Xarelto Oral Tablet 10 mg (Rivaroxaban) Give 1 tablet by mouth one time a day. Record review of the Order Summary Report and the Medication Administration Record (MAR) for November 2024 revealed there was not a monitoring tool for staff to monitor for signs of bruising and bleeding with the anticoagulant (blood thinner) medication Xarelto. On 11/05/24 at 10:46 AM, an interview with the Director of Nurses (DON) confirmed that Resident #4 was on an anticoagulant and did not have adequate monitoring for the medication. She revealed that monitoring for side effects of bleeding and/or bruising is supposed to be under supplementary documentation in the actual physician orders and confirmed that it was not. She revealed inadequate monitoring of the anticoagulant medication places the resident at risk for bleeding. Record review of the Admission Record revealed the facility admitted Resident #4 on 06/22/2020 with medical diagnoses that included Parkinson's disease with Dyskinesia, History of Pulmonary Embolism, History of Transient Ischemic Attack (TIA), and Cerebral Infarction.

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Riverview Nursing & Rehabilitation Center	1600 West Claiborne Avenue Extended Greenwood, MS 38930

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 46013 Based on staff interview, record review, and facility policy review the facility failed to monitor for side effects and obtain a stop date for a psychotropic medication for five (5) of 40 residents receiving psychotropic medications reviewed. Resident #10, #18, #44, #51 and #55 Findings include: A review of the policy titled, Behavioral Assessment, Intervention and Monitoring, revised December 2016 revealed . Management: 10.) When medications are prescribed for behavioral symptoms, documentation will include a.) Rationale for use . h.) Monitoring for efficacy and adverse consequences . Resident #10 Record review of Resident #10's Order Summary Report with active orders as of 11/3/24 revealed an order dated 10/18/24 Buspirone HCl oral tablet 10 mg (milligrams) Give 2 tablets by mouth two times a day related to anxiety disorder. An additional order dated 10/7/24 revealed Venlafaxine HCl oral tablet 75 mg Give 1 tablet by mouth two times a day related to anxiety disorder. The order summary revealed there was not an order to monitor for side effects of the multiple psychotropic medications ordered. A record review of the Medication Administration Record (MAR) for the month of October 2024 revealed Resident #10 received Buspirone 10 mg and Venlafaxine 75 mg. There was no documentation on the MAR regarding monitoring for side effects of the psychotropic medications. On 11/06/24 at 8:57 AM, an interview the Director of Nurses (DON) confirmed they were not monitoring for side effects of psychotropic medications, and they should have been. She revealed it should have been on the physician's orders, which would then pull over to the MAR to ensure the nurses were adequately monitoring for side effects and documented accordingly. Record review of the Admission Record revealed the facility admitted Resident #10 on 10/04/2024 with medical diagnoses that included Anxiety Disorder. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/11/24 revealed Resident #10 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident is cognitively intact. Resident #18 (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Order Summary Report with active orders as of 11/3/24 revealed an order dated 9/5/24 for Aripiprazole 30 mg Give one tablet at bedtime related to schizoaffective disorder. An order dated 10/31/24 for Ativan (Lorazepam) one (1) mg tablet give 0.5 mg in the morning for generalized anxiety for (4) four days. An order dated 10/31/24 for Ativan (1) mg tablet give 0.5 mg at bedtime for generalized anxiety for (4) days . An order dated 10/23/24 for Olanzapine 10 mg Give one tablet at bedtime for Schizoaffective disorder . An order dated 9/5/24 for Venlafaxine HCL (hydrochloride) extended Give one tablet by mouth one time a day related to Major Depressive disorder . The order summary revealed there was not an order to monitor for side effects of the multiple psychotropic medications ordered. In an interview with the DON on 11/04/24 at 2:45 PM, she confirmed that Resident #18 did not have any monitoring in place for the side effects of the psychotropic medications. Review of the Admission Record revealed the facility admitted Resident #18 on 9/05/24 with diagnoses of Schizophrenia, Bipolar Disorder, and Anxiety Disorder. Record review of Resident #18's MDS, Section N, with an ARD of 9/12/24 revealed, N: 04115 : High-Risk Drug Classes: antipsychotic, antianxiety, and antidepressant coded yes for receiving the medications. Resident #51 A review of the Order Summary Report with active orders as of 10/3/24 revealed an order dated 8/27/24 for Ativan Oral Tablet 0.5 MG (Lorazepam) Give 1 tablet by mouth three times a day related to Anxiety disorder due to know physiological condition. An additional order dated 8/27/24 revealed Lorazepam oral concentrate two (2) mg/ml (milligram/milliliter): Give 0.25 mg by mouth every four hours as needed Anxiety disorder. The orders did not include a stop date. An order dated 9/19/24 revealed Zoloft 50 mg tablet give one tablet by mouth at bedtime related to Anxiety. The order summary revealed there was not an order to monitor for side effects of the multiple psychotropic medications ordered. In an interview with the DON on 11/04/24 at 2:00 PM, she revealed there were no monitoring tools in place to monitor for side effects of psychotropic medications for Resident #51. She revealed concerns from not monitoring the psychotropic medications is to watch for adverse reactions like sedation, tremors, and tardive dyskinesia. She also revealed she was unaware that prn (as needed) Ativan (Lorazepam) needed to have a stop date after 14 days to evaluate the residents' need for further use because the resident was on Hospice services. In an interview with Licensed Practical Nurse (LPN) #1 on 11/05/24 at 8:05 AM, she revealed all residents on psychotropic medications should be monitored for side effects and notify the provider of changes. She stated the monitoring used to be on the medication record but was no longer on it after the facility switched electronic medical record companies. Review of the Admission Record revealed the facility admitted Resident # 51 on 11/30/23 with diagnoses of Mood disorder and Anxiety. Record review of Resident #51's Quarterly MDS with an ARD 11/18/24,Section N, revealed in N: 04115 : High-Risk Drug Classes: antianxiety and antidepressant coded yes for receiving the medications. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #55 A review of the Order Summary Report with active orders as of 11/3/24 revealed an order dated 8/22/24 for buspirone oral tablet five (5) mg Give 1.5 tablet by mouth two times a day related to Anxiety Disorder. An additional order dated 6/19/24 revealed Risperdal Tab 0.5 mg Give 1 tablet by mouth at bedtime related to bipolar disorder. An additional order dated 5/16/24 revealed Risperidone Tab 0.5 mg Give (2) two mg at bedtime for bipolar disorder. The order summary revealed there was not an order to monitor for side effects of the multiple psychotropic medications ordered. On 11/04/24 at 2:40 PM, an interview with the DON revealed there were no monitoring tools in place to monitor for the psychotropic drugs for Resident #55. In an interview with LPN#2 on 11/5/24 at 3:00 PM, she confirmed that all residents on psychotropic medications should be monitored for side effects to identify adverse reactions from the medications. She revealed she was unsure why there was no monitoring in place. Review of the Admission Record revealed the facility admitted Resident #55 on 3/01/24 with diagnoses of Bipolar disorder, Anxiety Disorder, Borderline Personality Disorder, and Psychotic Disorder with Delusions. Record review of the Quarterly MDS with an ARD of 8/23/24, Section N, revealed in N:04115: High-Risk Drug Classes: antipsychotic and antianxiety coded yes for receiving the medications. Resident #44 Record review of Order Summary Report with active orders as of 10/31/24 revealed an order dated 8/18/23 for Risperidone Tab 0.25 MG (milligrams), Give 1 tablet orally one time a day related to Psychotic disorder with delusions. An additional order dated 11/17/22 for Risperidone Tab 1 MG, give 1 tablet orally one time a day related to Psychotic disorder with delusions. An order dated 2/3/23 for Trazodone HCl Tab 50 MG, give 1 tablet orally one time a day for related to Insomnia. An order dated 6/7/24 for Lexapro Oral Tablet 5 MG (Escitalopram Oxalate), Give 1 tablet by mouth one time a day for anxiety. An order dated 4/17/24 for Lorazepam Concentrate 2 MG/ML (milligrams per milliliter), Give 0.5 milliliter orally every four (4) hours as needed for restlessness and agitation with no stop date. The order summary revealed there was not an order to monitor for side effects of the multiple psychotropic medications ordered. During an interview with the DON on 11/5/24 at 8:05 AM, she verified that Resident #44 had an PRN order for Lorazepam with no stop date. She stated that she was not aware that residents on hospice had to have a 14-day stop date for Lorazepam. She also verified that Resident #44 had no documentation that he was being monitored for side effects of psychoactive medications. She stated she thought that the monitoring for side effects did not pull over when they changed computer systems. She agreed failure to have a stop date for lorazepam and to monitor for side effects could lead to over sedation and increased risk for falls. Record review of the Admission Record revealed that the facility admitted Resident #44 on 7/12/22 with diagnoses which included Dementia. 47157 (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	47158

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 47157 Based on observation, resident and staff interview, and facility policy review, the facility failed to accommodate a resident's food preference during one (1) of three (3) meal services observed. (Resident # 55) Findings Include: A review of the facility policy titled, Resident Nutrition Services, with a revision date of 11/2015 revealed, Policy Statement: Each resident shall receive meals, with preferences accommodated . A dining observation on 11/3/24 at 5:45 PM, revealed the Admission Nurse set the meal tray up for Resident #55. The meal tray was observed to have a ham and cheese sandwich with no observation of the Admission Nurse offering the resident condiments for the sandwich, and there were no condiments observed on the meal tray. An interview with the Admission Nurse on 11/3/24 at 5:48 PM, confirmed Resident # 55 did not have any condiments on her meal tray and that the residents were provided with condiments if they asked for them. In an interview with Resident #55 on 11/3/24 at 5:50 PM, she revealed she prefers both mayonnaise and mustard on her sandwiches. A continued dining observation on 11/3/24 at 6:00 PM revealed no observations of staff offering any condiments to Resident #55 for her ham and cheese sandwich. In an interview with the Dietary Manager (DM) on 11/4/24 at 8:50 AM, she confirmed that the condiments for Resident #55 's sandwich should have come out on her meal tray from the dietary department. She then stated that the staff passing the tray should have asked the resident what her preference of condiments was for her sandwich and asked the dietary staff for the condiments. An observation of a drawer in the dining room on 11/4/24 at 8:57 AM with the DM revealed a drawer full of condiments. She stated the staff working in the dining room always have access to this drawer and could have gotten the condiments needed. In an interview with the Admission Nurse on 11/04/24 at 1:13 PM, she confirmed she should have asked Resident #55 what type of condiment she would like on her sandwich during the evening meal on 11/3/24, but she just did not even think about it. In an interview with the Director of Nursing (DON) on 11/04/24 at 1:20 PM, she revealed that staff assisting Resident #55 with her evening meal tray on 11/3/24 should have asked the resident what she would like on her sandwich. She then revealed that by not doing so, it could cause the resident to not eat the food provided and lead to weight loss. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Admission Record revealed the facility admitted Resident #55 on 3/01/24 with diagnoses that included Unspecified dementia. Record review of Section C of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/23/24 revealed a Brief Interview for Mental Status (BIMS) score of 11, indicating the resident had moderate cognitive impairment.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46013 Based on observation, resident/staff interviews, and facility policy review, the facility failed to ensure snacks/nourishments were offered to residents for two (2) of four (4) survey days. Resident #10. Findings include: Review of the facility policy, Resident Nutrition Services, with a revised date of November 2015, revealed, . Policy Interpretation and Implementation .8 . Snacks are available to the residents 24 hours a day. The resident may request snacks as desired, or snacks may be scheduled between meals to accommodate the resident's typical eating patterns . During an interview on 11/03/24 at 03:45 PM, Resident #10 revealed that she often gets hungry, especially at bedtime. She revealed they put the snacks out at the nurse's station, but you must go up there if you want anything. They don't come around to your room and offer any snacks. She revealed that one night, I specifically asked my Certified Nursing Assistant (CNA) for cheese and crackers, but she didn't get anything for me. She may have forgotten about it. In an interview on 11/04/24 at 1:20 PM, Resident #10 revealed that she was not offered a snack last night, nor has she been offered one today. She revealed that she kept her cookie, soup and four packs of crackers from her supper last night, so she ate those before going to bed. In an interview on 11/04/24 at 1:35 PM, CNA #4 revealed that she was assigned to the resident today. She revealed that she passed out hydration but didn't ask the resident about a snack because CNA #5 usually passes out the snacks. During an interview and observation on 11/04/24 at 2:25 PM, CNA #6 revealed that usually CNA #5 passes out the daytime snacks, and the nurses or aides on the other shifts pass out the snacks. She revealed the aides typically pass out the bedtime snacks. An observation of a tray of snacks, consisting of marshmallows, graham crackers, and [NAME] buddy bars, was sitting on a tray at the nurse's station. An interview on 11/04/24 at 3:13 PM, CNA #5 revealed that she was passing out the snacks at one time and would get a tray for each hall and go down the hall and make sure everyone who was able to have a snack was getting one because if you didn't, the snack tray would sit at the nurse's station. The residents sitting around the desk would get several snacks, but the others didn't. She revealed that several months ago, a dietary aide told me she couldn't give me the tray, but it had to be put at the nurse's station, so now I think everyone is just supposed to be passing them out to their residents. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 11/04/24 at 3:25 PM, the Dietary Manager (DM) revealed snacks are passed out at 10 AM, 2 PM, and 7 PM, and the dietary aide takes them out to the nurse's station and leaves the tray and the CNA pass them out. She revealed that snacks should be offered three times a day in addition to their meals. During an interview on 11/04/24 at 3:35 PM, the Assistant Director of Nurses (ADON) revealed that the residents should receive hydration and snacks three times daily. She revealed CNA #6 was passing out the snacks, but she heard that a dietary aide had told her that they needed to be set up at the nurse's station, so honestly, the only ones who were getting the snacks would be those sitting around the nurse's station or if someone asked for one. She revealed to my understanding, they had stopped going around to each room and offering a snack. Record review of the Admission Record revealed Resident #10 was admitted to the facility on [DATE] with medical diagnoses that included anxiety disorder. A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/11/24 revealed Resident #10 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident was cognitively intact.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 47158 Based on observation, record review, staff interview and facility policy review the facility failed to prevent the possibility of the spread of infection during wound care for one (1) of two (2) treatments observed. Resident # 11. Findings Included: Record review of facility policy titled, Enhanced Barrier Precautions Checklist revised January 2012 revealed .Policy Interpretation and Implementation 1. Staff shall apply Enhanced Barrier Precautions to the care of all residents in high contact care activities regardless of suspected or confirmed presence of infectious disease . Record review of facility policy titled Pressure Ulcer Treatment revised September 2013, revealed . Steps in the Procedure 1. Clean bedside stand. Establish a clean field. 2. Place the clean equipment on the clean field .7. Put on clean gloves. Loosen tape and remove soiled dressing. 8. Pull glove over dressing and discard into plastic or biohazard bag. 9. Wash and dry your hands thoroughly .14. Put on clean gloves 16. Cleanse the wound with the ordered cleanser. Use a syringe to irrigate the wound, if ordered. If using gauze, use a clean gauze for each cleansing stroke. Clean from the least contaminated area to the most contaminated area (usually, from the center outward) . Record review of November 2024 Electronic Treatment Record (ETAR) revealed Resident # 11 had a Stage four (4) pressure ulcer to the right heel with a treatment to clean with wound cleanser, pat dry, apply Collagen with non-boarded super absorbent dressing and wrap with Kerlix and secure with tape daily. Observation of wound care for Resident #11 on 11/5/24 at 10:15 AM, performed by the Treatment Nurse (TN) revealed she failed to perform hand hygiene before gathering wound care supplies after propelling another resident down the hall in a wheelchair. The TN placed the wound care supplies (gloves, dermal wound cleanser bottle, scissors, collagen powder, abdominal pad and gauze packages) on top of the treatment cart without a barrier or cleaning the top of the cart. After entering the resident's room, the TN placed the wound care supplies and open gloves on an overbed table noted to be soiled with a clear substance without cleaning the table or placing a barrier on the table. The TN washed her hands and applied the gloves that had been sitting on the soiled overbed table. She then removed the old dressing and discarded it and began cleaning the wound without performing hand hygiene or changing gloves. She cleaned the wound by wiping over the wound bed with the same four by fours (4x4) four (4) times in a circular motion. Next, she discarded the soiled 4x4's and used a clean 4x4 to pat wound dry and began applying collagen to wound bed using a clean 4x4 , applied a clean 4x4, abdominal pad , gauze and secured the dressing with tape without removing soiled gloves or perform hand hygiene. The TN also failed to follow Enhanced Barrier Precautions (EBP) during wound care. Upon exiting the resident's room, the TN placed the contaminated dermal wound cleanser bottle and scissors on top of the treatment cart then placed them inside cart without sanitizing them. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/5/24 at 10:20 AM, the TN agreed that she contaminated wound care supplies by placing them on top of treatment cart and on the soiled overbed table without cleaning them or providing a barrier. She agreed that she used gloves that had been contaminated by the soiled overbed table, cleaned wound by wiping over the wound bed with the same 4x4 four (4) times, failed to remove soiled gloves and perform hand hygiene after removing the old dressing and before applying collagen & dressing, placed the dermal wound cleanser and scissors on top of the treatment cart then placed them inside cart without sanitizing them and did not follow EBP while performing wound care. She verified that this failure placed the resident at risk for infection. An interview with the Assistant Director of Nursing/Infection Preventionist (ADON/IP) on 11/5/24 at 10:25 AM, she verified that the treatment nurse's failure to follow infection control practices during wound care placed the resident at risk for infection. Record review of the Admission Record revealed that the facility admitted Resident # 11 on 3/19/14 with a diagnoses that included Pressure ulcer of right heel, Stage 4 and Hemiplegia and Hemiparesis following Cerebral Infarction affecting the right dominant side.