STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	305045	A. Building B. Wing	07/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasant View Center	239 Pleasant Street Concord, NH 03301

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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 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. Based on interview, record review, and policy review, it was determined that the facility failed to ensure residents could formulate for 2 of 2 residents reviewed for advance directive in a final sample of 29 residents. (Resident identifiers are #118 and #125.)Findings include:Review on 7/1/25 of the facility policy titled, Communication of Code Status, review date of 6/2025, revealed the following: .Policy: It is the policy of the facility to adhere to resident's rights to formulate advance directives. In accordance to these rights, this facility will implement procedures to communicate a resident's code status to those individual who need to know this information. Policy Explanation and Compliance Guidelines: . 2. When an order is written pertaining to a resident's presence or absence of an Advance Directive, the direction will be clearly documented in designated sections of the medical record .3. The nurse who notates the physician order is responsible for documenting the directions in all relevant sections of the medical record. 4. The designated sections of the medical record are: physician's order, resident header, eMAR [electronic Medication Administration Record] .6. The Social Service Director shall maintain a list of residents who have an Advance Directive on file .Resident #125Review on 6/30/25 of Resident #125's medical record revealed the resident header indicated a code status of Do Not Resuscitate (DNR), Do Not Intubate (DNI), and Do Not Hospitalize (DNH). Further review of the resident header revealed that under special instructions the resident had Full Code status (a medical term that indicates a resident's consent to receive all possible life-saving measures in the event of a cardiac or respiratory arrest).Review on 6/30/25 of Resident #125's active physician's order revealed a code status order dated 5/27/25 for DNR, DNI, and DNH. Review on 6/30/25 of Resident #125's active advanced directive care plan with a revision date of 12/23/24 revealed that Resident #125 had a Full Code status. Review on 7/1/25 of the 2nd floor code status binder, which has the 2nd floor resident's code status records (i.e. portable DNR form), revealed that the binder had Resident #125 face sheet with a Full Code status dated 6/13/24 and a pink portable DNR dated 5/27/25, respectively.Interview on 7/1/25 at 11:27 a.m. with Staff D (Licensed Practical Nurse) revealed that Staff D stated Resident #125 had a Full Code status. Staff D confirmed that Resident #125's the medical record had both Full Code status and DNR code status. Staff D also confirmed that Resident #125's current code status is DNR and not Full Code. Resident #118Review on 7/1/25 of Resident #118's physician orders revealed an order for DNR, dated 5/23/25.Review on 7/1/25 of Resident #118's care plan for advanced directives revealed Resident #118's code status to be Full Code, dated 3/4/25.Review on 7/1/25 of a letter from Resident #118's Guardian to the facility dated 5/23/25 revealed that Resident #118's Guardian approved a DNR/DNI order to be entered into Resident #118's medical record. Interview on 7/1/25 at 2:00 p.m. with Staff T (Licensed Practical Nurse) confirmed that Resident #118's code status was a DNR. Interview on 7/2/25 at 8:27 a.m. with Staff K (Director of Social Services) confirmed that Resident #118's care plan did not match the physician order.

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

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

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F 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. Based on observation, record review, and interview, it was determined that the facility failed to keep residents free from physical restraints for 1 of 1 residents reviewed for physical restraints in a final sample of 29 residents (Resident identifier is #146).Findings include:Observation on 7/2/25 between 9:12 a.m. to 9:25 a.m. on the third floor common room revealed Resident #146 was sitting in his/her pedal broda chair with his/her leg rest elevated parallel to the floor and 2 of the 4 wheels were in a lock position. Resident #146 had one leg off on each side of the leg rest and feet on the ground and struggling to propel forward and backwards. Further observation revealed Resident #146 was able to turn himself/herself in a quarter circle and appeared agitated. Interview on 7/2/25 at 9:25 a.m. with Staff L (Licensed Nursing Assistant (LNA)) confirmed that Resident #146 appeared agitated and was struggling to move their broda chair due to the 2 of the 4 wheels being locked. Interview on 7/2/25 at 10:11 a.m. with Staff M (LNA) revealed that he/she had brought Resident #146 into the common area and locked the wheels of Resident #146's pedal broda chair because Resident #146 would become antsy and try to move around. Review on 7/2/25 of Resident #146's physician's orders, assessments, and care plan revealed no orders, assessment, or care plan interventions in place for locking Resident #146's broda chair. Interview on 7/2/25 at 10:30 a.m. with Staff N (Director of Rehab) revealed that Resident #146 provided a pedal broda chair to use for mobility on the unit.

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, it was determined that the facility failed to provide notice to the resident or the resident representative(s) of transfer and bed hold for 2 of 2 residents reviewed for hospitalizations in a final sample of 29 residents (Resident identifiers are #4 and #114).Findings include:Resident #4Review on 6/30/25 of Resident #4's medical record revealed Resident #4 was transferred to the hospital on 6/8/25 and 6/14/25. Further review revealed no documentation that a bed hold notice was provided to Resident #4 for either transfers to the hospital.Interview on 7/2/25 at approximately 11:00 a.m. with Staff Q (Business Manager) confirmed there was no evidence that a bed hold notice was provided to Resident #4 for either transfers to the hospital.Resident #114Review on 6/30/25 of Resident #114's medical record revealed Resident #114 was transferred to the hospital on [DATE]. Further review revealed no documentation that a transfer/discharge notice and bed hold notice was provided to Resident #114 for this transfer to the hospital. Interview on 7/2/25 at approximately 10:45 a.m. with Staff K (Social Worker) confirmed there was no evidence that a transfer/discharge notice was provided to Resident #114. Interview on 7/2/25 at approximately 11:00 a.m. with Staff Q (Business Manager) confirmed there was no evidence that a bed hold notice was provided to Resident #114.Review on 7/2/25 of facility policy titled, Bed Hold Notice ,revised 6/2025, revealed .3. The facility will keep a signed and dated copy of the bed-hold notice information given to the resident and/or resident representative in the resident's file and/or medical record .Review on 7/2/25 of facility policy titled, Transfer and Discharge (including AMA), revised 6/2025, revealed .3. The facility's transfer/discharge notice will be provided to the resident and resident's representative in a language and manner in which they can understand .5. The facility will maintain evidence that the notice was sent to the Ombudsman .

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined that the facility failed to ensure medications were available for 2 of 2 newly admitted residents reviewed in a final sample of 29 residents. (Resident identifiers are #254 and #258).Findings include:Resident #254Interview on 6/30/25 at approximately 9:45 a.m. with Resident #254 revealed they had not received all of their medications since admitting to the facility. Review on 6/30/25 of Resident #254's medical record revealed they had been admitted to the facility on [DATE]. Review on 7/1/25 of Resident #254's June 2025 Medication Administration Record (MAR) revealed the following medications were not given on 6/29/25:Arformoterol Inhaler give by nebulizer twice a day for COPD (Chronic Obstructive Pulmonary Disease);Atrovastatin Calcium 10 mg once a day;Budesonide Inhaler twice a day;Duloxetine 20 mg once a day for depression;Furosemide (Diuretic) 40 mg (milligrams) twice a day for heart failure;Ipratopium- Albuterol inhaler twice a day for COPD;Losartan Potassium 25 mg once a day for hypertension;Potassium Chloride 10 meq (millliequivilant) once a day for hypokalemia;Warfarin (anticoagulant) 3 mg once a day on Sunday for atrial fibrillation.Further review of June 2025 MAR revealed the following medications were not given on 6/30/25:Arformoterol Inhaler give by nebulizer twice a day for COPD (Chronic Obstructive Pulmonary Disease) missed the morning dose;Budesonide Inhaler twice a day, missed the morning dose;Buprenorphine Buccal Film 75 mcg (micrograms) 2 films in the evening;Duloxetine 20 mg once a day for depression.Review on 6/30/25 of Resident #254's medication progress notes, dated 6/29/25, revealed that the above medications had been ordered but not received from the pharmacy. Review on 7/2/25 of the facility's active medication inventory list (emergency medication supply) revealed the following medications were available in the facility on 6/29/25: Furosemide 20 mg, Potassium Cholride 10 meq, and Warfarin 1 mg. Interview on 7/1/25 at approximately 1:30 p.m. with Staff I (Registered Nurse) confirmed that the above listed medication was not given and there was no documented communication with a provider about Resident #254 not receiving their medications.Resident #258 Review on 6/30/25 of Resident #258's medical record revealed they had been admitted to the facility on [DATE]. Review on 7/1/25 of Resident #258's June 2025 Medication Administration Record (MAR) revealed the following medications were not given on 6/28/25:Amidarone (antiarrythmic) 200 mg once a day;Insulin Lispro 3 units before lunch hold if NPO (nothing by mouth);Insulin NPH 6 units with breakfast and dinner give 4 units if NPO; Losartan Potassium (anti-hypertensive)100 mg once a day;Metoprolol Succinate (beta blocker)50 mg twice a day;Potassium Chloride 20 meq once a day for 10 days; andVancomycin (Antibiotic) 1.25 grams IV (Intravenous) once a day until 7/14/25.Review on 7/1/25 of Resident #258's progress notes revealed that on 6/28/25 the above medications were unavailable. Further review of progress notes revealed no provider notification of missed medications.Interview on 7/1/25 at approximately 1:30 p.m. with Staff I (Registered Nurse) confirmed that the above listed medication was not given, and that there was no communication with a provider about the unavailable medications.Review on 7/2/25 of the facility's active medication inventory list revealed the following medications were available in the facility on 6/28/25: Potassium Chloride 10 meq. Review on 7/2/25 of facility policy titled, Unavailable Medications, revised 6/25, revealed the following: .A STAT supply of commonly used medications is maintained in- house for timely initiation of medications . Medications may be unavailable for a number of reasons. Staff should take immediate action when it is known that the medication is unavailable: a. Determine reason for unavailability, length of time medication is unavailable, and what efforts have been attempted by the facility or pharmacy to obtain the medication. b. Notify physician of inability to obtain medication upon notification or awareness that medication is not available. Obtain alternative treatment orders and/or specific orders for monitoring resident while medication is on hold .

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F 0637 Level of Harm - Potential for minimal harm Residents Affected - Some	Assess the resident when there is a significant change in condition Based on interview and record review, it was determined that the facility failed to ensure that a Significant Change in Status Minimum Data Set (MDS) was completed timely for 3 residents in a final sample of 29 residents. (Resident identifiers are #19, #42, and #85).Findings include:Resident #85Review on 7/2/25 of Resident #85's Hospice Certification of Terminal Illness form revealed that Resident #85 was admitted to hospice care on 5/31/25. Review on 7/2/25 of Resident #85's Significant Change in Status MDS, with an Assessment Reference Date of 6/5/25, revealed it was signed as completed on 6/22/25 by Staff A (MDS Coordinator).Interview on 7/2/25 at 12:49 p.m. with Staff A confirmed that the above MDS assessment for Resident #85 was completed late. Resident #19Interview on 6/30/25 at approximately 9:00 a.m. with Staff D (Licensed Practical Nurse) revealed that Resident #19 no longer was receiving hospice services. Review on 7/1/25 of Resident #19's Notice of Medicare Non-Coverage for hospice services revealed hospice service end date of 4/14/25. Review on 7/1/25 of Resident #19's MDS assessments revealed no Significant Change in Status MDS was completed for Resident #19's end of hospice services. Interview on 7/1/25 at approximately 2:26 p.m. with Staff C (Director of Nursing) confirmed that Resident #19 was discharge from hospice services on 4/14/25 and no Significant Change in Status MDS was completed. Resident #42Review on 6/30/25 of Resident #42's Hospice Certification and Plan of Care form revealed that Resident #42 was admitted to hospice care on 4/25/25. Review on 6/30/25 of Resident #42's MDS assessments revealed that there was no Significant Change in Status MDS completed within 14 days of Resident #42's admission to hospice services on 4/25/25. Interview on 7/2/25 at approximately 10:00 a.m. with Staff A confirmed that Resident #42 had admitted to hospice services on 4/25/25 and that a Significant Change in Status MDS was not completed.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on record review and interview, it was determined that the facility failed to develop and implement a comprehensive care plan for 7 residents in a final sample of 29 residents (Resident identifiers are #33, #47, #70, #97, #118, #146, and #11).Findings include:Resident #33Review on 7/2/25 of Resident #33's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/14/25 under section F0500 - Interview for Activity Preferences revealed that while Resident #33 was in the facility, that very important was coded for the following: to have books, newspapers, and magazines to read; listen to music; be around animals; keep up with the news; do your favorite activities, and participate in religious services or practices. Review on 7/2/25 of Resident #33's care plan revealed there was no care plan for Resident #33's group or individual activity preferences or what Resident #33's likes to do.Interview on 7/2/25 with Staff V (Licensed Nursing Assistant (LNA)) revealed that he/she would look in a resident's care plan to see what a resident likes to do for an activity. Interview on 7/3/25 with Staff P (Activities Director) confirmed that there was no care plan in place for Resident #33's group or individual activity preferences.Resident #118Observation on 7/1/25 at 9:40 a.m. of the designated smoking area outside of the facility revealed that Resident #118 was smoking and being supervised by a staff member. Review on 7/2/25 of Resident #118's smoking/vaping screening assessment dated [DATE] revealed that Resident #118 required supervised smoking.Review on 7/2/25 of Resident #118's care plans revealed that there was no care plan for supervised smoking. Interview on 7/2/25 at 8:18 a.m. with Staff B (Unit Manager) confirmed that there was no care plan in place for supervised smoking for Resident #118.Review on 7/2/25 of the facility's policy, Resident Smoking revised 10/2022, revealed .10. All safe smoking measure will be documented on each resident's care plan and communicated to all staff, visitors, and volunteers who will be responsible for supervisign residents while smoking. Supervision will be provided as indicarwed on each resident's care plan .Resident #146Review on 7/2/25 of Resident #146's admission MDS with an ARD of 4/30/25 under section GG - Functional Abilities revealed that Resident #146 utilized a wheelchair for mobility and was dependent for eating, hygiene, and transfers.Review on 7/2/25 of Resident #146's care plan revealed no care plan for Resident #146's level of care for mobility, transfers, and assistance for care.Interview on 7/2/25 at 1:40 p.m. with Staff B confirmed that there was no care plan for Resident #146's mobility, transfers, and assistance for care. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #70Observation on 06/30/25 at 10:18 a.m. of Resident #70 in his/her bed revealed Resident #70's toes were pointed downward and there was no pillow under his/her calves and his/her heels were directly on the air mattress. Further observation revealed bilateral heel boots were on broda chair in his/her room. Review on 6/30/25 of Resident #70's orders revealed a physician's order, dated 3/21/25, to apply skin prep to bilateral heels and ensure that heels are offloaded. Monitor skin for changes to skin integrity. Review on 7/1/25 of Resident #70's skin integrity care plan, revision date 6/8/23, revealed an intervention to offload/float heels while in bed.Observation on 7/1/25 at 8:25 a.m and 1:54 p.m. in Resident #70's room revealed that Resident #70 was in his/her in bed and his/her heels were directly on the air mattress. Interview on 7/1/25 at approximately 1:54 p.m. with Resident #70 revealed that he/she does not often have a pillow under his/her calves to lift the heels off the bed. Resident #70 stated that he/she doesn't mind the pillow under [pronoun omitted] legs.Observation on 7/2/25 at approximately 2:40 p.m. in Resident #70's room revealed that Resident #70 was in his/her in bed and his/her heels were directly on the air mattress. Interview on 7/2/25 at approximately 02:45 p.m. with Staff G (LNA) and Staff H (LNA) revealed that Staff G and Staff H were unaware that Resident #70's heels needed to be offloaded per his/her care plan.Observation on 7/3/25 at approximately 8:26 a.m. Resident #70's room revealed that Resident #70 was in his/her in bed and his/her heels were directly on the air mattress. Interview on 7/3/25 at approximately 08:27 a.m. with Staff D (Licensed Practical Nurse) revealed that he/she was unaware of the physician's order to offload Resident #70's heels. Staff D confirmed the physician's order to offload Resident #70's heels. Resident #97Interview on 6/30/25 at approximately 11:25 a.m. with Staff D revealed that Resident #97 recently had his/her smoking privileges revoked.Review on 6/30/25 of Resident #97's medical record revealed that he/she was admitted to the facility on [DATE]. Further review revealed that Resident #97 had a smoking assessment dated [DATE] that identified Resident #97 as a supervised smoker. Review also revealed a smoking assessment dated [DATE] that stated Resident #97 may not smoke. Review on 6/30/25 of Resident #97's care plan revealed no care plan for smoking and the removal of smoking privileges.Interview on 7/2/25 at approximately 12:20 p.m. with Staff C (Director of Nursing) confirmed that Resident #97 did not have a care plan to address smoking or the removal of smoking privileges. Resident #47Review on 6/30/25 of Resident #47's medical record revealed they had started on Hemodialysis on 3/26/25. Further review of Resident #47's medical record revealed the following physician's orders:C-PAP (Continuous Positive Airway Pressure) apply at night, start date 4/17/25;Apixaban (anticoagulant) 5 mg (Milligrams)once a day, start date 6/3/25; Bupropion (antidepressant) 100 mg once a day, start date 6/14/25;Duloxetine (antidepressant) 60 mg once a day, start date 4/17/25;Hydromorphone (opiate) 2 mg every 4 hours as needed for pain, start date 4/17/25;Insulin Glargine 15 units a day for diabetes, start date 4/17/25; andInsulin Lispro sliding scale before meals and at bedtime, start date 4/17/25.Review on 7/1/25 of Resident #47's quarterly Minimum Data Set with Assessment Reference Date 5/20/25 revealed the following assistance is needed for activities of daily living:Toileting-supervision or touching assistance;Showers/bathing- partial/moderate assistance;lower body dressing- partial/moderate assistance;Personal Hygiene- partial/moderate assistance;Sit to stand-supervision or touching assistance; andToileting transfer-supervision or touching assistance.Review on 7/1/25 of Resident #47's care plan revealed care plan interventions for a code status (initiated on 5/27/25) and nutritional risk (initiated on 4/7/25). There were no other care plan interventions. Interview on 7/2/25 at approximately 10:00 a.m. with Staff C (Director of Nursing) confirmed that Resident #47's care plan did not address the resident's needs and services identified in the comprehensive assessment. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #11 Interview on 6/30/25 at approximately 10:30 a.m. with Staff R (Licensed Nursing Assistant) revealed that Resident #11 understood simple commands in English and staff used cueing to assist him/her. Staff R stated they were unaware of what primary language Resident #11 spoke.Review on 7/1/25 of Resident #11's Minimum Data Set with a Assessment Reference Date of 5/23/25 under section A revealed that Resident #11's primary language was Cambodian.Review on 7/1/25 of Resident #11's care plan revealed no communication care plan identifying English as a second language and no care plan identifying that Resident #11 only understood simple commands in English.Interview on 7/2/25 at approximately 10:00 a. m. with Staff I (Registered Nurse) confirmed that Resident #11 did not have a care plan identifying communication barriers.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to determine what may have caused or contributed to falls, and when necessary revise the resident's plan of care and/or facility practices, to reduce the likelihood of another fall for 1 of 2 residents reviewed for falls in a final sample of 29 residents (Resident identifier is #42).Findings include:Interview on 6/30/25 at approximately 12:00 p.m. with Resident #42's DPOA-HC (Durable Power of Attorney for Health Care) revealed that he/she have had repeated falls from their bed and from their wheelchair. Resident #42's DPOA-HC stated that Resident #42 sustained a fractured clavicle as a result of one of the falls.Review on 6/30/25 of Resident #42's progress notes from March 2025 to April 2025 revealed the following falls:3/23/25 slide out of bed on to sacrum;4/1/25 found on floor next to their bed;4/10/25 found on floor in the dinning room and was sent to the emergency room for shoulder pain;4/29/25- und sitting on floor in the hallway.Review on 7/1/25 of Resident #42's emergency room discharge instructions, dated [DATE], revealed a final diagnosis of a closed right clavicle fracture.Review on 7/2/25 of Resident #42's post fall reviews revealed the following:No post fall review for 3/23/25 fall;4/1/25 no description of what occurred and no root cause identified;4/10/25 no description of what occurred and no root cause identified;4/29/25 no description of what occurred and no root cause identified.Interview on 7/2/25 at approximately 1:30 p.m. with Staff C (Director of Nursing) confirmed that there were no post fall reviews for Resident #42's falls to identify root cause or potential interventions to prevent further falls or injury for the above listed falls. Review on 7/2/25 of facility policy titled, Fall Prevention Program, revised 6/25, revealed the following: .9. When a resident experiences a fall, the facility will: . b. Complete a post-fall assessment. c. Complete an incident report .e. Review the resident's care plan and update as indicated. f. Document all assessments and actions .

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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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. Based on interview and record review, it was determined that the facility failed to ensure that trauma survivors have identified triggers and interventions to eliminate or mitigate triggers that may cause re-traumatization for 1 of 2 residents reviewed for behavioral and emotional status in a final sample of 29 residents. (Resident identifier is #97).Findings include:Review on 6/30/25 of Resident #97's medical record revealed that Resident #97 had a diagnosis of Post Traumatic Stress Disorder (PTSD). Further review revealed that Resident #97 had an incomplete Social History and Trauma Assessment that was initiated on 5/16/25. Resident #97's care plan did not have a care plan for PTSD with identified triggers and interventions to eliminate or mitigate triggers that may cause re-traumatization. Interview on 7/2/25 at approximately 9:00 a. m. with Staff J (Licensed Nursing Assistant) revealed that he/she was unaware of any residents with diagnosis of PTSD and observed him/her defer to nursing for sources of this information. Interview on 7/2/25 at approximately 9:10 a.m. with Staff D (Licensed Practical Nurse) revealed that he/she was unaware that Resident #97 had a diagnoses of PTSD.Interview on 7/2/25 at approximately 9:50 a.m. with Staff K (Social Worker) confirmed that Staff K did not complete the Social History and Trauma Assessment that was initiated on 5/16/25. Staff K stated that he/she did not interview Resident #97's guardian about his/her past trauma and triggers. Interview on 7/25/25 at approximately 12:21 p.m. with Staff C (Director of Nursing) confirmed that Resident #97's care plan did not include any identified triggers or interventions for PTSD. Review on 7/2/25 of the facility's policy Trauma Informed Care, Date reviewed/revised 6/25 revealed .2. The facility will use a multi-pronged approach to identifying a resident's history of trauma, . This will include asking the resident about triggers that may be stressors or may prompt recall of previous traumatic events, . 6. The facility will identify triggers which may re-traumatize residents with history of trauma 10. In situations where a trauma survivor is reluctant to share their history, the facility will still try to identify triggers which may re-traumatize the resident, and develop care plan interventions which minimize or eliminate the effect of the trigger on the resident.Review on 7/2/25 of the facility's policy Comprehensive Care Plans, Date reviewed/revised 6/25 revealed .A trauma informed approach to care .incorporates knowledge about trauma into care plans, policies, procedures and practice to avoid re-traumatization 3.g. Individualized interventions for trauma survivors that recognizes the interrelation between trauma and symptoms of trauma Triggers-specific interventions will be used to identify ways to decrease the resident's exposure to triggered which re-traumatize the resident .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	305045	A. Building B. Wing	07/03/2025

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F 0777 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain x-rays/tests when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to obtain radiology services for 1 of 1 residents reviewed for radiological services in a final sample of 29 residents. (Resident identifier is #46.)Findings include:Interview on 7/3/25 at 10:00 a.m. with Resident #46 revealed they went to have a CT (Computed Tomography) scan done in March 2025 but left the appointment before it could be completed. Resident #46 did not recall the reason the CT scan was not done.Review on 7/3/25 of Resident #46's medical record revealed an Infectious Disease note, dated 1/3/25, .We decided to re-image the pubic area for any new collections, Pt [patient] is at a high risk for recurrence of infection and thus we opted to continue antibiotic therapy with [NAME] [Outpatient Parenteral Antimicrobial Therapy] until imaging is addressed .Orders Placed CT Abdomen & Pelvis w [with] Contrast . Further review of medical record revealed no results of follow up for the CT scan or radiology imaging.Interview on 7/3/25 at approximately 9:00 a.m. with Staff I (Registered Nurse) stated that Resident #46 went for a CT scan at a local hospital on 3/3/25 but it was rescheduled at another location for 3/7/25.Interview on 7/3/25 at approximately 11:00 a.m. with Staff C (Director of Nursing) stated that Resident #46 refused to go to the CT scan on 3/7/25 and that another appointment had not been made. Staff C stated that they had spoke to Infectious Disease on 7/3/25 and they were instructed to obtain CT scan as originally ordered.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. Based on interview, record review, and policy review, it was determined that the facility failed to implement the facility's antibiotic stewardship program and antibiotic use protocols for 1 of 1 month of antibiotic line list reviewed. (Resident identifier is #41.)Findings include:Review on 7/1/25 of the facility policy title, Antibiotic Stewardship Program, review date of 6/2025, revealed the following: .Antibiotic Stewardship Program leaders utilize existing resources to support antibiotic stewards' effort by working with the following partners: a. Infection Preventionist - utilizes expertise and data to inform strategies to improve antibiotic use to include tracking of antibiotic starts, monitoring adherence to evidence-based published criteria during the evaluation and management of treated infections, and reviewing antibiotic resistance patterns in the facility to understand which infections are caused by resistant organisms .3. Licensed nurses participate in the program through assessment of residents and following protocols as established by the program. 4. The program included antibiotic use protocols and a system to monitor antibiotic use. a. Antibiotic use protocols:I. Nursing staff shall assess residents who are suspected to have an infection and notify the physician.ii. Laboratory testing shall be in accordance with current standards of practice .iv. The Loeb Minimum Criteria may be used to determine whether to treat an infection with antibiotics .vi. Whenever possible, narrow-spectrum antibiotics that are appropriate for the condition being treated shall be utilized.b. Monitoring antibiotic use:I. Monitor response to antibiotics, and laboratory results when available, to determine if the antibiotic is still indicated or adjustments should be made (e.g. antibiotic time-out) .12. Data obtained from antibiotic stewardship monitoring activities is discussed in the facility's QAPI [Quality Assurance Performance Improvement] .Review on 7/1/25 of the facility's June 2025 antibiotic line list revealed that there were 25 residents on antibiotics. Further review of the June 2025 antibiotic line list revealed that the list included the resident's name, infection, antibiotic, antibiotic start date, and antibiotic end date. The June 2025 antibiotic line list did not indicate if the antibiotics were appropriate for use nor the antibiotic use protocol (i.e. Loeb Minimum Criteria) was utilized. Review of the June 2025 antibiotic line list also revealed that Resident #41 was on Bactrim DS (antibiotic) on 6/1/25 to 6/8/25 and Nitrofurantoin (antibiotic) 50 milligrams (mg) for Urinary Tract Infection (UTI) prophylaxis (prevention). Review on 7/2/25 of Resident #41's medical record revealed no documentation of the Loeb's minimum criteria evaluation for the initiation of antibiotic on 6/1/25. Interview on 7/1/25 at approximately 1:00 p.m. with Staff S (Infection Preventionist) revealed that the facility uses the Loeb's minimum criteria for the initiation of antibiotics. Staff S was unable to explain or to provide documentation if the Loeb's criteria was used for the antibiotic use for the month of June 2025.Interview on 7/2/25 at approximately 2:30 p.m. with Staff S confirmed the above findings for the June 2025 antibiotic line list. Staff S also confirmed that the Loeb's minimum criteria was not initiated during the initiation of antibiotics for Resident #41. Staff S revealed that QAPI was held twice a month and that he/she has not discussed any data regarding resident infections and antibiotic use in QAPI since he/she started on February 2025. Interview on 7/3/25 at approximately 8:37 a.m. with Staff W (Administrator) confirmed that there was no discussion about resident infections and antibiotic use by Staff S in their recent QAPI meetings.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and policy review, it was determined that the facility failed to implement their pneumococcal vaccine policy for 2 of 5 residents reviewed for immunizations. (Resident identifiers are #97 and #120.)Findings include:Review on 7/1/25 of the facility policy titled, Pneumococcal Vaccine, review date of 6/2025, revealed the following: .1. Each resident will be assessed for pneumococcal immunizations upon admission. Self-reported immunizations shall be accepted. Any additional efforts to obtain information shall be documented, including efforts to determine date of immunizations or type of vaccine received. 2. Each resident will be offered a pneumococcal immunizations unless it is medically contraindicated or resident has already been immunized. Following assessment for any medical contraindications, the immunizations may be administered in accordance with physician-approved standing orders. 3. Prior to offering the pneumococcal immunizations, each resident or the resident's representative will receive education regarding the benefits and potential side effects of the immunizations with the education documented in the clinical record .6. The type of pneumococcal vaccine (PCV15 [Pneumococcal Conjugate Vaccine], PCV20, PCV21, or PPSV23 [Pneumococcal Polysaccharide Vaccine] offered will depend upon the recipient's age, having certain risk conditions, and previously received pneumococcal vaccines, in accordance with current CDC guidelines and recommendations .Resident #97Review on 7/1/25 of Resident #97's immunization record revealed no documentation of pneumococcal vaccine history and no assessment of eligibility for the pneumococcal vaccine. Review on 7/1/25 of Resident #97's medical record revealed that Resident #97 was admitted to the facility on [DATE]. Further review of Resident #97's medical record revealed an immunization consent letter signed by Resident #97's guardian on 6/3/25 indicating consent for the administration of the pneumococcal vaccine. Review also revealed that there was no documentation that pneumococcal vaccine was administered to Resident #97. Interview on 7/1/25 at 10:48 a.m. with Staff S (Infection Preventionist) confirmed the above findings and that Resident #97 had not received a pneumococcal vaccine at the facility. Staff S was unable to provide documentation of an assessment for Resident #97's eligibility for the pneumococcal vaccine. Resident #120Review on 7/1/25 of Resident #120's immunization record revealed that Resident #120 had no history of receiving a pneumococcal vaccine. Further review also revealed that Prevnar 20 (pneumococcal vaccine) was refused on 11/30/23 and that there was no education provided to Resident #120 or Resident #120's representative about the pneumococcal vaccine. Review on 7/1/25 of Resident #120's medical record revealed that Resident #120 was initially admitted to the facility on [DATE]. Further review revealed no other documentation that Resident #120 or Resident #120's representative was provided education about the pneumococcal vaccine prior or after the refusal on 11/30/23. Interview on 7/1/25 at 10:48 a.m. with Staff S confirmed the above findings for Resident #120.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and policy review, it was determined that the facility failed to implement their COVID-19 vaccine policy for 3 of 5 residents reviewed for immunizations. (Resident identifiers are #4, #97 and #120.)Findings include:Review on 7/1/25 of the facility policy titled, COVID-19 Vaccine, review date of 6/2025, revealed .Policy: It is the policy of this facility to minimize the risk of acquiring, transmitting, or experiencing complications from COVID-19 (SARS-CoV-2) by educating and offering our residents and staff the COVID-19 vaccine .Up-to-date is defines as receiving a 2024-2025 updated COVID-19 vaccine (as per CDC) .COVID-19 vaccinations currently in use include the updated 2024-2025 mRNA [messenger Ribonucleic Acid] COVID-19 vaccines .The number of updated 2024-2025 COVID-19 vaccines doses and individual needs is based on age and vaccination history. For people who are not moderately or severely immunocompromised (See Table 1) .Table 1. Routine COVID-19 vaccine schedule, October 31, 2024 .Age 12-64 years .Unvaccinated: Initiate vaccination with 2024-2025 vaccine .Number of 2024-2025 doses indicated 1 [dose] .Recommended 2024-2025 vaccine and interval between doses 2024-2025 Dose 1 (Moderna or Pzifer-BioNTech): Day 0 .Age 65 years and older .Previously vaccinated before 2024-2025 vaccine: Receive 2 doses of 2024-2025 vaccine 1 or more doses mRNA vaccine (Moderna or Pfizer BioNTech) .Number of 2024-2025 doses indicated .2 [doses] .Recommended 2024-2025 vaccine and interval between doses .2024-2025 Dose 1 (Moderna, Novavax, or Pfizer BioNTech): At least 8 weeks after last dose2024-2025 Dose 2 (Moderna, Novavax, or Pfizer BioNTech): 6 months)minimum interval 12 months) after 2024-2025 Dose 1 .Resident #4Review on 7/1/25 of Resident #4's immunization record revealed that Resident #4 received 2023-2024 COVID-19 vaccine on 11/28/23 and 2024-2025 COVID-19 vaccine on 10/12/24. Review also revealed no documentation of a second dose of 2024-2025 COVID-19 vaccine being administered to Resident #4. Review on 7/1/25 of Resident #4's medical record revealed that Resident #4 was in his/her 70's (age). Review also revealed an immunization consent letter signed by Resident #4 on 5/9/25 consenting to the administration of the COVID-19 vaccine. Resident #97Review on 7/1/25 of Resident #97's medical record revealed that Resident #97 was admitted to the facility on [DATE] and that Resident #97 was in his/her 60's and under 65 (age). Further review of Resident #97's medical record revealed an immunization consent letter signed by Resident #97's guardian on 6/3/25 indicating consent for the administration of the COVID-19 vaccine. Review on 7/1/25 of Resident #97's immunization record revealed no documentation of COVID-19 vaccine administration, history, and no assessment of eligibility for the COVID-19 vaccine. Resident #120Review on 7/1/25 of Resident #120's immunization record revealed that Resident #120 received 2023-2024 COVID-19 vaccine on 11/1/23 and 2024-2025 COVID-19 vaccine on 10/7/24. Review also revealed no documentation of a second dose of 2024-2025 COVID-19 vaccine being administered to Resident #120. Review on 7/1/25 of Resident #120's medical record revealed that Resident #120 was in his/her 80's (age). Review also revealed no documentation of a second dose of 2024-2025 COVID-19 vaccine being offered and no education provided to Resident #120 or Resident #120's representative. Interview on 7/1/25 at 10:48 a.m. with Staff S (Infection Preventionist) confirmed the above findings for Resident #4, Resident #97, and Resident #120. Further interview with Staff S revealed that there was no shortage of 2024-2025 COVID-19 vaccines and that they can order individual 2024-2025 COVID-19 vaccine doses from the pharmacy.