STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Person Memorial Hospital	615 Ridge Road Roxboro, NC 27573

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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 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 20906 Based on observations, residents and staff interviews, the facility failed to post the notice of location and make accessible the facility survey results for residents in a wheelchair. This was observed on 4 of 5 days of the survey. The findings included: During initial tour on 9/15/24 at 9: 10 AM, an observation was made of the survey results located in a small hall area near the eye wash station. On a large bulletin board was a black caddy with the survey book, which was not wheelchair accessible. The caddy was in the center of the bulletin board out of reach of residents in wheelchairs. There was no signage posted throughout the facility regarding the availability and location of the recent survey results. Multiple observations were conducted from 9/15/24 to 9/18/24. Observations were made on 9/15/24 at 9:58 AM, on 9/16/24 10:30 AM, on 9/17/24 10:00 AM and on 9/18/24 at 11:02 AM. Observations revealed there was no notice posted in the facility regarding the availability and location of the recent survey results. The location of the survey remained unreachable for residents in wheelchairs. During the Resident Council Members meeting on 9/18/24 at 11:02 AM, the resident council members who attended the meeting (Resident #28, Resident #25; Resident #21; Resident #10; Resident #22; Resident #18; Resident #44; Resident #20; and Resident #3) stated they had no knowledge of the location of the survey result notebook. The members of the group further stated they were unaware of any signage posted indicating the location of the results. An interview was conducted on 9/18/24 at 11:45 AM, with the Social Worker and the Activity Director, who both confirmed there was no visible posting that informed residents and families where the survey results were located. They both staff stated the survey book was originally located under the bulletin board where the master activity calendar was posted with a sign informing residents/family and visitors. The facility administrator moved the book to the current location and did not post any information of where the book could be found. The Social Worker further stated all the public postings should be accessible to everyone and the previous location was visible upon entry to the facility, however things had been moved out of resident, visitor/family view by the administrator. (continued on next page)

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

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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 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	An interview was conducted on 9/18/24 at 11:56 AM, with the facility Administrator who confirmed the current location of the survey book was not accessible to the residents/families or visitors. He also confirmed there was no visible posting to inform residents/families or visitors of the location of the survey book.

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38077 Based on record review, family and staff interviews, the facility failed to provide a written grievance summary for 1 of 1 residents (Residents #24) reviewed for grievances. Finding included: Resident #24 was admitted to the facility on [DATE]. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated the Resident #24 was assessed as severely cognitively impaired. Review of the Grievance /Concern Form dated 6/24/24 indicated a concern that was reported by Resident #24's responsible party (RP) regarding bruising of the resident's left arm, left hand and right forearm. Action indicated was the management was notified, abuse investigation sheet completed, law enforcement was notified and the staff member in question was taken off of the schedule. The form indicated the grievance was under investigation. This was signed by Administrator indicating the grievance was received. There was no indication on the form that indicated the complainant, resident, or family was contacted to inquire if the grievance was resolved to their satisfaction. The grievance was not signed off as resolved. During an interview on 9/16/24 at 11:50 AM, Resident #24's RP indicated she had reported her concerns about the bruising on resident's arms to the Administrator and to the hospital management. The RP stated both the nursing home administration, and the hospital administration were in the same building and under same management. Resident #24's RP stated she had not been made aware as to how her allegation was investigated nor how it was resolved. She explained no written summary of the grievance investigation or resolution was provided to her. During an interview on 9/16/24 at 3:37 PM, the Social Worker (SW) indicated she was the grievance coordinator. When any grievance was received from any resident or family member by any staff, it was directed to the appropriate department for investigation and resolution. Once the grievance was investigated and a resolution was reached, it would be discussed in the morning team meeting with all nursing staff. The SW further indicated that she would notify the family about the resolution and that the resolution was to the satisfaction of the family/ resident. The resolved Grievance was placed in a folder and entered in the log. The Social Worker stated she was not aware of the grievance written on 6/24/24 from Resident #24's RP and hence not documented in the Grievance log. The SW stated the resident's RP concern was investigated as abuse investigation. Due to being investigated as abuse, the investigation was conducted by the Administrator. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/19/24 at 2:20 PM, the Administrator, stated he had spoken with the resident's RP regarding the abuse allegation 1-2 days after the grievance was received. The Administrator further stated the resident's RP was made aware that the abuse allegation was been investigated. The NA involved was suspended and would not be returning to the facility. The NA was an agency staff, and the agency was made aware about it. The Administrator stated he had not documented the resolution as it was an abuse investigation, nor did he record any information regarding his conversation with the family in the grievance form. The investigation findings were sent to the state. He further stated the family was aware of the outcome of the investigation. The family was made aware the allegation was unsubstantiated. The Administrator stated he did not provide them with any written documentation regarding the resolution. He indicated it was an abuse investigation and no findings were discussed with the family. With regards to the grievance given to the Hospital Quality Director, he indicated it was a different entity and unsure of the outcome.

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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 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** 38077 Based on observation, staff interview and record review, the facility failed to provide fingernails and toenails care for 2 of 2 residents, dependent on staff for activities of daily living (ADL) care. (Resident # 37 and Resident #24) Findings included: 1. Resident #37 was admitted to the facility on [DATE] with diagnoses that included Parkinson disease. Review of the Annual Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was assessed as moderately cognitively impaired. The assessment indicated that Resident #37 was dependent on staff for Activities of Daily Living (ADL) including personal hygiene, toileting and showers/ bathe self. Review of the care plan dated 6/27/24 indicated the resident was care planned for ADL self-care performance deficit due to impaired balance, activity intolerance, and confusion. Interventions for bathing and showering included checking nail length, trimming and cleaning on bath day and as necessary. The resident was totally dependent on staff to provide bed bath and/or shower. The Skin monitoring: comprehensive Certified Nurse Aide (CNA) shower review for 9/12/24 and 9/16/24 were reviewed. On the form the question does the resident need his/her fingernails/toenails cut? Was marked as NO. Review of the ADL Tracking Documentation for August and September 2024 revealed bathing activity was marked on every Monday and Thursday of the week during the 3 PM- 11 PM shift. The resident was noted to be totally dependent on staff and needed one-person physical assistance. The documentation did not indicate if the resident received a bed bath or shower. During an observation and interview on 9/15/24 at 10:20 AM, Resident #37's fingernails on both her hands were observed to be about 1 to 1 and one fourth inch long from the nail bed. There was some light black deposit under the fingernails. The resident stated she preferred her fingernails trimmed, however there was on one who could trim her nails. During an interview on 9/16/24 at 10:33 AM, Resident #37 indicated she had asked a Nurse Aide (NA) to trim her nails in the morning. The NA had reported to her that her nails would be cleaned and trimmed at 2 PM that day. Resident indicated she wanted her nails cleaned and trimmed so she asked the NA who was assisting her with care that morning. During an observation on 9/17/24 at 8:25 AM, Resident #37 was observed propped up in her bed and turned to her left side. Observation revealed the resident's fingernails were not trimmed. Resident indicated no staff had come back to trim her nails on 9/16/24. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/17/24 at 8:38 AM, Nurse #5 was interviewed. Nurse #5 observed Resident #37's fingernails and indicated the resident's nails should have been trimmed. Nurse #5 stated when residents were provided a bed bath or shower, the assigned NA completed a skin and nails check. The NA should indicate on the shower sheets if the nails needed to be trimmed and/or if the nails were trimmed. Nurse stated if the resident was not diabetic then the NAs could trim their nails. However, if the resident was diabetic then the NA needed to inform the assigned nurse. Resident #37 was not diagnosed with diabetes mellitus and the NA should have trimmed her nails. Nurse#5 stated the resident received a completed bed bath the day prior (9/16/24) and should had her nails checked and trimmed. During an interview on 9/19/24 at 10:12 AM, NA #1 indicated she was assigned to Resident #37 and had offered a bed bath on 9/16/24. NA #1 stated the resident did not request her to trim her nails on the 9/16/24. NA indicated skin and nails check were completed during bed bath and/or shower. Nails were trimmed if needed. NA indicated she had not noticed the resident's fingernails and hence had not trimmed them. During an interview on 9/17/24 at 8:44 PM, the Director of Nursing (DON) stated the NAs were responsible to trim residents' finger and toenails when the residents were not diabetic residents. The DON further stated the NAs had to complete a full body check when bed bath or shower was offered. The DON observed Resident #37's fingernails and stated the assigned NAs should have trimmed her nails when a complete bed bath was offered. 2. Resident #24 was admitted to the facility on [DATE] with diagnoses that included secondary malignant neoplasm of the bone. Review of the quarterly Minimum Data Set (MDS) dated [DATE] indicated the resident was assessed as severely cognitively impaired. The assessment indicated that the resident was dependent on staff for Activities of Daily living. A revised care plan dated 8/9/24 indicated Resident #24 was care planned for ADL care due to diagnoses of cancer, dementia and depression. Interventions included providing a sponge bath when a full bath or shower was not tolerated. Resident was totally dependent on staff for showers and bed bath. NAs to provide skin inspection daily with care. On 9/15/24 at 10:06 AM, during an observation, Resident #24's toes nails on both feet were observed to be one and a half inches beyond the nail bed. The pinky toe nails on both feet had toenails growing into the toe next to it. On 9/17/24 at 1:25 PM, during the observation of incontinence care, Resident #24's toenails were observed clean and approximately one and a half inches long, with deformities. The resident did not have signs of discomfort. During an interview on 9/19/24 at 10:12 AM, NA #1 indicated she was assigned to Resident #24. NA stated the resident received bath and showers from both facility and hospice staff. NA indicated she did provide the resident a bed bath and had not looked at or noticed the resident's toenails. During an interview on 9/17/24 at 8:38 AM, Nurse #5 stated the resident was under hospice care. Both facility staff and hospice staff provided care for the resident. Nurse #5 stated the hospice staff were responsible for trimming resident's nails. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 9/19/24 at 8:23 AM, the hospice nurse stated the hospice NAs do not trim the resident's finger or toenails. It was the responsibility of facility nursing staff to provide nail care. During an interview on 9/17/24 at 8:44 PM, the Director of Nursing (DON) indicated the NAs were responsible to trim residents' finger and toenails when the residents were not diabetic residents. The DON further stated the NAs had to complete a full body check when bed bath or shower was offered. The DON stated the nursing staff should be checking and providing nail care to all residents as needed.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20906 Based on observations, staff interview and record review, the facility failed to provide an on-going activity program that met the individual interest and needs for 3 of 3 cognitively impaired residents reviewed for activities(Resident #22, Resident #27 and Resident #28). The findings included: 1.Resident #22 was admitted to the facility on [DATE] . The diagnoses included cognitive impairment and dementia. Resident #14 was coded on the annual Minimum Data Set(MDS) dated 8/24/24 as having cognition impairment and she needed assistance with activities. The MDS also coded Resident 22 's activity interest as very important to participate in favorite activities to include music, religious service and outside events. The resident was coded for total assistance with transfers and locomotion. The annual activity assessment dated [DATE] revealed Resident #'22s preference with interest in listening to music, religious services, and outside events. A focus area on the care plan dated 8/25/24 revealed Resident #22 was dependent on staff for meeting emotional, intellectual, physical, and social needs related to physical limitations. The goal included Resident #22 would maintain involvement in cognitive stimulation, social activities as desired. The interventions included to ensure the activities Resident #22 attended was compatible with physical and mental capabilities; compatible with known interests and preferences; adapted as needed (such as large print, holders if resident lacks hand strength, task segmentation), compatible with individual needs and abilities and age appropriate. Invite the resident to scheduled activities. Introduce the resident to other residents in similar activities. The facility developed a list on 8/20/24 of residents who needed assistance to be transported to activities and Resident #22 was identified as person who needed assistance to activities. Record review revealed there were no activity notes available after the assessment 8/24/24 for Resident #22. There were no documented notes of participation in activities for Resident #22 prior to 8/24/24. The activity calendar on 9/15/24 offered the following activities at 10:00 AM coffee time,10:30AM at 11:00 AM gospel hymns, 1:00 PM-2:00 PM, room visits movies and 2:00 PM-4:00 PM activities with Ladystany. Staff were observed passing by the resident's room and did not stop to offer the resident assistance to participate in the scheduled activity. An observation was conducted on 9/15/24 at 9:58 AM, there was an activity calendar posted on the resident's bulletin board where resident could see the events of the day. Resident #22 was observed in bed staring at the wall. Resident#22 reported she does like church/gospel events. She reported the activity person does ask but nursing staff does not usually ask. She indicated no one asked her this morning to go anywhere. The scheduled activity for 9/15/24 at 10:00 AM coffee time, 10:30AM at 11:00 AM gospel hymns, Resident #22 was not up or dressed to participate in any of the scheduled activity of her interest. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The activity calendar on 9/16/24 offered the following activities at 10:00 AM devotion, 11:00 AM bowling 11:30 AM snack activity and 2:00 PM-4:00 PM tic-tac-toe. Observations was conducted on 9/16/24 at 10:00 AM, the scheduled activity was devotion and 10:30 AM, Resident #22 was lying in bed, staring at the wall. The television was not on, and the resident reported she had attended some activities in the past but was not able to get herself up and ready for the activity. She stated she depended on staff. She reported staff don't get most residents up on the weekend. She reported she would have liked to participate in the devotion. Staff were observed in other resident rooms providing care. An interview was conducted on 9/16/24 at 1:45 PM, with the Activity Director who stated she developed a list of residents who needed staff assistance and transport to activities on 8/20/24 and provided the information to the management team. She indicated several residents who benefited and enjoyed activities were not ready or transported to activities when scheduled activities on their interest was being conducted. The Activity Director stated she would go room by room asking residents to participate and attend activities, but they would not be ready or get to the activity until nearly the end or not at all. She reported the concern was discussed in the management meetings and the plan was for all staff to ask residents if they wanted to participate and attend activities. The nursing team was in-serviced in August to get the identified resident up for activities and transport them to activities. She further stated was unable to escort all the residents, resulting in the identified residents not participating in activities. She further stated she was unaware she needed to document resident participation in the resident record. The Activity Director stated she only kept resident attendance and primarily the same residents attend the activities. She confirmed after review of the record there had been no documented activities notes since 2022 of resident participation in activities. Observation on 9/16/24 at 2:00 PM, tic -tac-toe in progress: Observation and interview were conducted and revealed Resident #22 remained in bed watching television. Resident #22 stated she would like to participate in activities, but staff did not get her out of bed, and she would have loved to see what was going on. An interview was conducted on 9/17/24 at 4:42 PM, with the Administrator who stated the nurse aides were responsible for asking resident daily if they wanted to get up and participate in facility activities. He reported there was a list of residents identified based on the quality improvement of residents who needed assistance with transport to activities. The identified residents included the residents who would participate in activities either morning or the afternoon scheduled activities. The Nurse Aides and Nursing should be asking all residents and assisting residents to the desire activities. The Nurses would document in the record the resident refusal to participate in activities. An interview was conducted on 9/18/24 at 8:40 AM, with the Staff Development Coordinator who stated all staff were in-serviced on 8/8/24 regarding the quality improvement plan to ensure staff were getting the identified residents who needed assistance with transport to activities up for scheduled activities. Staff were informed to notify the nurse and activity director when a resident refused to get up for an activity and document in the resident record. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 9/19/24 at 9:43 AM, with Nurse #1 who stated she worked the weekend and during the week stated and she did not receive a report from any of the aides that any resident on the activity list refused to participate in activities. She indicated the training consisted of aides reporting to nursing when a resident refused to get up or participate in activities and she would document in the record the resident refused activities. Staff were expected to assist and transport resident to activities. She indicated nursing would attempt to encourage the resident to participation. An interview was conducted on 9/18/24at 10:00 AM, the Nurse Aide#1 who was assigned to Resident #22 stated everyone was responsible for asking residents if they wanted to get up and participate in activities. She reported when she worked on 9/15/24 she did not report to nursing that any of the resident refused activities. An interview was conducted on 9/19/24 at 9:43 AM, the Director of Nursing stated the staff should be encouraging/offering and assisting residents to participate in their preferred activities of interest daily. The Nurse Aide should notify nursing and the Activity Director of any resident who refused activities.Nursing should be documenting in the resident chart when a resident refused participation in activities. An interview was conducted on 9/19/24 at 1:00 PM, with the Social Worker who stated the resident was identified in the quality improvement program as one of the residents who needed assistance to activities. Several meetings and discussions have been held with nursing and management staff about getting resident up and ready for activities and providing transport to the activities, however the nurses and aides continue to not assist residents. Nurse Aides and Nursing staff have received an in-service in August about assisting residents to activities and reporting directly to nurse when the residents on the identified list refused to get up for activities. Nursing would encourage residents to participate in activities and document in the resident record, however, there had been no consistent follow-up the quality improvement plan. 2. Resident #27 was admitted to the facility on [DATE] . The diagnoses included cognitive impairment and dementia. Resident #27 was coded on the Minimum Data Set(MDS) dated [DATE] as having cognition impairment and she needed assistance with activities. The MDS also coded Resident #27 's activity interest as very important to participate in favorite activities to include music and news and current events. The resident was coded for total assistance with transfers and locomotion. The annual activity assessment dated [DATE] revealed Resident #'27s preference with interest in listening to music, news, current events bingo, animals, religious events and outside activities. A focus area on the care plan dated revealed Resident #27 had little, or no activity involvement related to physical limitations and depression. The goal included Resident #27 would express satisfaction with type of activities and level of activity involvement when asked. The interventions included invite/encourage the resident's family members to attend activities with resident to support participation. The facility developed a list on 8/20/24 of residents who needed assistance to be transported to activities and Resident #27 was identified as person who needed assistance to activities. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review revealed there were no activity notes available after the assessment 5/10/24 for Resident #27. There were no documented notes of participation in activities for Resident #27 prior to 5/10/24. The activity calendar on 9/15/24 offered the following activities at 10:00 AM coffee time, 10:30AM at 11:00 AM gospel hymns, 1:00 PM-2:00 PM, room visits movies and 2:00 PM-4 PM activities with Ladystany. Staff were observed passing by the resident's room and did not stop to offer the resident assistance to participate in the scheduled activity. An observation was conducted on the hall at 9:55 AM-10:00 AM at 9/15/24 of the Nurse Aide#1 assigned to Resident #27. The Nurse Aide #1 stated the Aides should offer the resident the opportunity to get up and go to the activities of the day and assist with transport to the activity. The Nurse Aide #1 stated if the nurse aides were providing care, they were unable to take residents to activities at the start of the activities and maybe only able to take the residents toward the end of the activity. The Nurse Aide#1 stated she would let the nurse know when a resident refused activities. Nurse Aide#1 did not state why she did not offer the resident assistance to get up for activities. An observation was conducted on 9/15/24 at 11:30 AM, Resident #27 was in bed she stated she does like to go to activities. She reported on Sunday afternoons her husband and son visits, so going in the morning was fine unless she did not feel well. She reported on the weekends, no one really asks, and she was no sure if activities were happening. She pointed to the calendar on the wall and stated she had not been asked to go to anything in the morning. The activity calendar on 9/16/24 offered the following activities at 10:00 AM devotion, 11:00 AM bowling 11:30 snack activity and 2:00 PM -4 PM tic-tac-toe. An observation was conducted on 9/16/24 at 10:30 AM the scheduled activity was devotion; Resident #27 was in her room and staff were observed passing by the resident's room and did not stop to offer the resident assistance to participate in the scheduled activity. Resident #27 was observed in bed humming some church songs in her room. She stated she really loved church services and music and food parties the facility had down in the activity room. She indicated no one came to and get her out of bed anymore for activities. She stated she could not take herself to activities without assistance so just ended up hanging out in bed. Resident #27 further stated she would have liked to go to the devotion activities, but no one asked her if she wanted to get up for activities. Nurse Aide #9 who was assigned to Resident #27 stated she was working with another resident and could not assist with taking resident to the activity. She indicated all residents should be asked if they wanted to participate in activities. She reported she was aware of the list of residents that needed assistance, however, due to care responsibilities she was unable to get residents up early enough prior to the activities. She does her best to get individuals to the remaining activities. (continued on next page)

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 9/16/24 at 1:45 PM, with the Activity Director who stated she developed a list of residents who needed staff assistance and transport to activities on 8/20/24 and provided the information to the management team. She indicated several residents who benefited and enjoyed activities were not ready or transported to activities when scheduled activities on their interest was being conducted. The Activity Director stated she would go room by room asking residents to participate and attend activities, but they would not be ready or get to the activity until nearly the end or not at all. She reported the concern was discussed in the management meetings and the plan was for all staff to ask residents if they wanted to participate and attend activities. The nursing team was in-serviced in August to get the identified resident up for activities and transport them to activities. She further stated was unable to escort all the residents, resulting in the identified residents not participating in activities. She further stated she was unaware she needed to document resident participation in the resident record. The Activity Director stated she only kept resident attendance and primarily the same residents attend the activities. She confirmed after review of the record there had been no documented activities notes since 2022 of resident participation in activities. The activity calendar on 9/17/24 offered the following activities at 10:00 AM pet therapy, 10:30 AM perfection , 11:00AM coffee activity and 2:00 PM-4:00 PM bowling. An interview was conducted on 9/17/24 at 1:46 PM, the scheduled activity was bowling at 2:00 PM. Resident #27 reported staff did not come and ask her if she wanted to participate in activities. She reported she enjoyed the bingo, music. There was an overhead announcement but of the activity, but no staff came to the room to ask if she wanted to get up and go to the activity. 3. Resident #28 was admitted to the facility on [DATE] . The diagnoses included cognitive impairment and dementia. Resident # 28 was coded on the admission Minimum Data Set(MDS) dated [DATE] as having cognition impairment and she needed assistance with activities. The MDS also coded Resident#28 's activity interest as very important to participate in favorite activities to include music, pets group activities, religious services and outside events. The resident was coded for total assistance with transfers and locomotion. The activity assessment dated [DATE] revealed Resident #'28s preference with interest include music, pets group activities, religious services and outside events. The resident was coded for total assistance with transfers and locomotion. The facility developed a list on 8/20/24 of residents who needed assistance to be transported to activities and Resident #28 was identified as person who needed assistance to activities. A focus area on the care plan dated 6/25/24 revealed Resident #28 was dependent on staff for meeting emotional, intellectual, physical, and social needs related to physical limitations. The goal included Resident #28 would maintain involvement in cognitive stimulation, social activities as desired. The intervention included invite the resident to scheduled activities. Staff would provide Resident #28 with an activities calendar. Notify resident of any changes to the calendar of activities. Resident #28 needs assistance/escort to activity functions. Record review revealed there were no activity notes available after the7/11/24 assessment for Resident #28. There were no documented notes or participation records for Resident #28 prior to the 7/11/24. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The activity calendar on 9/15/24 offered the following activities at 10:00 AM coffee time, 10:30AM at 11:00 AM gospel hymns, 1:00 PM-2:00 PM, room visits movies and 2:00 PM-4:00 PM activities with Ladystany. Staff were observed passing by the resident's room and did not stop to offer the resident assistance to participate in the scheduled activity. The activity calendar on 9/16/24 offered the following activities at 10:00 AM devotion, 11:00 AM bowling 11:30 AM snack activity and 2:00 PM-4 PM tic-tac-toe. An observation was conducted on 9/15/24 at 9:55 AM, Resident #28 was in her resident sitting up in bed. There was no television on, and the resident continued to ask what was going on in the hall area. She reported she liked to go to activities but had to wait for people to come get and get her up and take her down to the room. She indicated no one asked if she wanted to go to the activities. Resident #28 reported she liked to get up every day, enjoyed church music, table activities, bingo and food stuff. The resident was not asked to participate in the scheduled 10:00 AM coffee activity. The assigned Nurse Aide #13 was in another room, all other aides were in other rooms. Observation was conducted on 9/15/24 at 1:59 PM, Resident #28 resident was not in any activity, she was resident was in her room. She stated was not asked to be taken to any of the activities for the day. Resident #28 stated she did not know what was going on and would have like to go to activities, but no one got her out of bed. An observation was conducted on 9/16/24 at 10:30 AM, Resident #28 was in her room yelling out to get out of bed, the assigned Nurse Aide #9 was in another room. resident was not taken to the activity room until 11:30 AM. Nurse Aide #9 stated she was working with other residents and had not been able to get the resident up any early. She further stated the nurse aides should offer the resident the opportunity to get up and go to the activities of the day. The nurse aide stated if the nurse aides were providing care, they were unable to take residents to activities at the start of the activities and maybe only able to take the residents toward the end of the activity. She indicated the weekends were very difficult to get all residents to activities due to limited staff. An interview was conducted on 9/16/24 at 1:45 PM, with the Activity Director who stated she developed a list of residents who needed staff assistance and transport to activities on 8/20/24 and provided the information to the management team. She indicated several residents who benefited and enjoyed activities were not ready or transported to activities when scheduled activities on their interest was being conducted. The Activity Director stated she would go room by room asking residents to participate and attend activities, but they would not be ready or get to the activity until nearly the end or not at all. She reported the concern was discussed in the management meetings and the plan was for all staff to ask residents if they wanted to participate and attend activities. The nursing team was in-serviced in August to get the identified resident up for activities and transport them to activities. She further stated was unable to escort all the residents, resulting in the identified residents not participating in activities. She further stated she was unaware she needed to document resident participation in the resident record. The Activity Director stated she only kept resident attendance and primarily the same residents attend the activities. She confirmed after review of the record there had been no documented activities notes since 2022 of resident participation in activities. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 9/17/24 at 4:42 PM, with the Administrator who stated the nurse aides were responsible for asking the resident if they wanted to get up and participate in facility activities. He reported there was a list of residents identified based on the quality improvement of residents who needed assistance with transport to activities. The identified residents included the residents who would participate in activities either morning or the afternoon scheduled activities. The Nurse Aides and Nursing should be asking all residents and assisting residents to the desire activities. The Nurses would document in the record the resident refusal to participate in activities. An interview was conducted on 9/18/24 at 8:40 AM, with the Staff Development Coordinator who all staff were in-serviced on 8/8/24 regarding the quality improvement plan to ensure staff were getting the identified residents who needed assistance with transport to activities up for scheduled activities. Staff were informed to notify the nurse and activity director when a resident refused to get up for an activity and document in the resident record. An interview was conducted on 9/19/24 at 9:30 AM, Nurse Aide #13 stated she had been assigned to Resident #28 the weekend and was unable to transport resident to the activity due to assisting other residents. The Nurse Aide #13 stated staff should offer the resident the opportunity to get up and go to the activities of the day. The nurse aide stated if the nurse aides were providing care, they were unable to take residents to activities at the start of the activities and maybe only able to take the residents toward the end of the activity. Nurse [NAME] #13 stated she did not report any residents who refused activities on the weekend due to being busy providing care. An interview was conducted on 9/19/24 at 9:43 AM, the Director of Nursing stated the staff should be encouraging/offering and assisting residents to participate in their preferred activities of interest daily. The Nurse Aide should notify nursing and the Activity Director of any resident who refused activities. Nursing should be documenting in the resident chart when a resident refused participation in activities. An interview was conducted on 9/19/24 at 1:00 PM, with the Social Worker who stated the resident was identified in the quality improvement program as one of the residents who needed assistance to activities. Several meetings and discussions have been held with nursing and management staff about getting resident up and ready for activities and providing transport to the activities, however the nurses and aides continue to not assist residents. Nurse Aides and Nursing staff have received an in-service in August about assisting residents to activities and reporting directly to nurse when the residents on the identified list refused to get up for activities. Nursing would encourage residents to participate in activities and document in the resident record, however, there had been no consistent follow-up the quality improvement plan.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 38077 Based on record reviews and staff interviews, the facility failed to schedule a Registered Nurse (RN) for at least 8 consecutive hours a day for 2 of the 33 days reviewed for staffing. The findings included: A review of the daily posted nursing staff forms, daily nursing staff assignment sheets, and staff clock-in sheets from 8/17/24 through 9/18/24 was conducted on 9/19/24. A. On 8/24/24 the daily staff posting indicated 1 RN working day shift (7 AM - 3PM). Daily posting also indicated 2 Licensed Practical Nurse (LPN) and 2 NA working night shift (11PM - 7 AM). Review of the nursing staff assignment sheet for 8/24/24 indicated the RN, Nurse #9, working from 7 AM - 7 PM. The RN, Nurse #9, was also assigned to work as a Nurse Aide from 11 PM to 7 AM. Review of the staff clock-in sheet revealed no RN working from 7 AM - 3 PM shift. Further review revealed there was no RN working for the period of 3 PM -11 PM. An RN, Nurse #9, had clocked in at 11:00 PM. There was only one NA clocked in at 11 PM. During an interview on 9/19/24 at 3:15 PM, Nurse #9 indicated she was a Registered Nurse and worked as an NA when needed. She indicated on 8/24/24 she had worked on the floor as an NA and not as an RN. She indicated her assignment was indicated in the assignment sheet. She stated she was not in the facility from 7 AM - 7 PM on 8/24/24. B. On 8/25/24 the daily staff posting indicated 1 RN working day shift (7 AM- 3 PM) and 2 LPNs working evening (3 PM - 11 PM) and night shift (11 PM- 7 AM). Review of the staff clock-in sheet revealed no RN working from 7 AM - 7 PM shift. Review of the nursing assignment sheet did not indicate an RN working the 7 AM -7 PM shift. During an interview on 9/19/24 at 3:44 PM, the scheduler indicated the facility did not have any agency Nurse aides. They however had contract with an agency for nurses. The scheduler stated on days when there was an NA call out and the slot was unable to be filled by another NA then a nurse was called into fill the slot. The scheduler indicated as there was a RN in the building, the regulations for RN for 8 hours a day was met, During an interview on 9/19/24 at 4:34 PM, the Administrator indicated the call out policy was for staff to call the management 2 hours prior to their shift. The scheduler ensures that the call out slots were filled by staff who were willing to work overtime or by another staff not on assignment that day. The Administrator further indicated the facility had no NAs who were from agency. They however had agency nurses working for them. The Administrator stated nurses (both Registered nurse and License Practical Nurse) were called to fill in assigned NA shifts when needed. These Nurses worked as NAs and helped with patient care. The Administrator further stated when there was only one RN in the building and was assigned NA duty, the RN was also responsible to complete her duties as both a Nurse and Nurse Aide. The Administrator stated the requirement for RN for 8 hours was met, when the RN was in the facility and was working a NA.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Post nurse staffing information every day. 38077 Based on observation and staff interviews, the facility failed to post the daily nurse staffing information for residents and visitors on 1 of the 4 days of the survey period. The facility also failed to update the daily staffing information to reflect actual staffing changes for 6 of 33 days reviewed for posted nurse staffing information. Finding included: 1. On 9/15/24 (Sunday) during the facility initial tour at 9:20 AM and for multiple observations throughout the day including 1:30 PM and 3 PM, the daily nurse staffing sheet posted near the facility elevator was dated 9/13/24 (Friday). The posting was not updated to reflect the current date, census, and staffing information. During an interview on 9/17/24 at 8:09 AM, the scheduler stated she was responsible for posting the daily staff posting during the weekdays. The scheduler stated she completed the staffing form for the weekend and left the posting sheet in a folder near the nurse's station. She explained the weekend nurses were responsible for posting and updating the daily staffing sheets on the weekend. During an interview on 9/17/24 at 9:49 AM, the Minimum Data Set (MDS) Nurse stated she was the nurse working on 9/15/24. She indicated all nurses over the weekend were responsible for ensuring the staff posting was updated near the elevator. The MDS Nurse stated she forgot to look at the posting and post an updated staff posting. During an interview on 9/17/24 at 1:59 PM, Nurse #3 stated she was hired 3 weeks ago and worked on 9/15/24. She added she was not aware that as a weekend nurse she was responsible for changing the staff posting over the weekend. During an interview on 9/19/24 at 1:14 PM, Nurse #1 stated she was the charge nurse over the weekend of 9/14/24 and 9/15/24. She added she was not aware she was responsible for changing the staff posting over the weekend. 2. Review of the daily nursing staff postings from 8/17/24 through 9/18/24 and staff clock in sheets for the same period was conducted on 9/19/24. The daily posted staffing indicated the facility did not update the posting to reflect staffing changes for the following: - On 8/24/24 the daily staff posting indicated 1 Registered Nurse (RN) and 3 Licensed practical Nurses (LPN) for day shift (7 AM-3 PM). Review of the staff clock in sheets revealed no RN and 2 LPNs were working for day shift. - On 8/25/24 the daily staff posting indicated 1 RN and 3 LPNs for day shift. Night shift (11 PM - 7 AM) indicated 4 Nurse Aides (NA). Review of the staff clock in sheets revealed no RN and 2 LPNs working for day shift. There were only 2 NAs working for the night shift. - On 8/30/24 the daily staff posting indicated 4 NAs working the evening shift (3PM - 11PM). Review of the staff clock in sheet revealed only 3 NAs working. (continued on next page)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- On 8/31/24 the staff posting indicated 2 RNs working the day shift. Review of the staff clock in sheet revealed only 1 RN working for the day shift. - On 9/1/24 the daily staff posting indicated 4 NAs for day shift, 5 NAs for evening shift and 3 NAs for night shift. Review of the staff clock in sheets revealed 3 NAs working for both day and evening shift. The night shift had only 2 NAs working. - On 9/14/24, the daily staff posting indicated 2 LPNs working the day shift. Review of the staff clock-in sheets revealed only 1 LPN working for the day shift. During an interview on 9/19/24 at 3:44 PM, the scheduler stated the staff schedule was made a month ahead. If any staff had a call out, then the staff posting needed to be updated. She indicated if she was in the facility, she would try to make the changes. During an interview on 9/19/24 at 5:00 PM, the Administrator stated posting should be checked by the charge nurse, scheduler or MDS clerk were responsible for oversight for posted during the weekday. The charge nurse was responsible over the weekend for ensuring that the daily nurse staffing sheet was accurately and was posted daily The Administrator stated the daily staffing sheet should be updated by the scheduler or the charge nurse to reflect the accurate staff working in the facility.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 33778 Based on record review, observations and staff interviews, the facility failed to remove an expired multi-dose vial of insulin for 1 of 3 medication administration carts, failed to date opened multi-dose vials of insulin medication for 2 of 3 medication administration carts, and discard loose pills in the medication cart drawer for 2 of 3 medication administration carts (rehabilitation hall, short and long halls). Findings Included: 1a. On 9/15/24 at 9:15 AM, an observation of the medication administration Rehabilitation Hall cart with Nurse #1 revealed one opened and undated multi-dose vial of Insulin Glargine. A review of the manufacturer's literature indicated to discard Glargine multi-dose vial 28 days after opening. 9/15/24 at 9:40 AM, during an interview, Nurse #1 indicated that the nurses, who worked on the medication carts, were responsible to discard expired multi-dose vials. The nurse stated that she had not checked the date of opening on insulin vials in her medication administration cart at the beginning of her shift. The nurse did not administer expired insulin this shift. b. 9/15/24 at 9:40 AM, an observation of the Long Hall medication administration cart with Nurse #2 revealed one, opened undated, half-empty multi-dose vial of Novolog insulin, one expired Basaglar Kwik Pen Insulin, opened on 8/15/24, one expired Humalog Pen (insulin), opened on 8/3/24, and one expired Insulin Aspart Flex pen, opened on 9/1/24. A review of the manufacturer's literature indicated to discard the insulin multi-dose vial 28 days after opening. On 9/15/24 at 9:40 AM, during an interview, Nurse #2 indicated that the nurses, who worked on the medication carts, were responsible to discard expired multi-dose vials. The nurse stated that she had not checked the date of opening on insulin vials in her medication administration cart at the beginning of her shift. The nurse did not administer expired insulin this shift. On 9/16/24 at 9:30 AM, during an interview, the Director of Nursing (DON) indicated that all the nurses were responsible for putting the date of opening on multi-dose medication containers, checking all the medications in medication administration carts for expiration date and remove expired medications every shift. He expected that no expired items or loose pills be left in the medication carts. 2a. On 9/15/24 at 9:15 AM, an observation of the medication administration Rehabilitation Hall cart with Nurse #1 revealed in the second draw of the medication cart there were noted two white loose capsules and one pink round shape loose pills. On 9/15/24 at 9:20 AM, during an interview, Nurse #1 indicated that she could not identify what each of the pills were but stated the nurses were responsible for checking and cleaning their medication administration carts each shift. Nurse #1 did not clean the cart before her shift. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. On 9/15/24 at 9:25 AM, an observation of the medication administration Short Hall cart with Nurse #3 revealed in the first draw of the medication cart there was one white and three pink round shape loose pills. On 9/15/24 at 9:25 AM during an interview, Nurse #3 indicated that she could not identify what each of the pills were but stated the nurses were responsible for checking and cleaning their medication administration carts each shift. Nurse #3 did not clean the cart before her shift. On 9/16/24 at 9:30 AM, during an interview, the Director of Nursing (DON) expected that no loose pills be left in the medication carts. On 9/16/24 at 10:50 AM, during an interview, the Administrator indicated that all the nurses were responsible for putting the date of opening on multi-dose medication containers, checking all the medications in medication administration carts for expiration date and remove expired medications every shift. He expected that no expired items or loose pills be left in the medication carts.