STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345356	A. Building B. Wing	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rich Square Nursing & Rehabilitation Center	300 North Main Street Rich Square, NC 27869

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, and staff and Nurse Practitioner interviews, the facility failed to provide written information to the resident and/or resident representative pertaining to their right to accept or refuse medical/surgical treatment and the opportunity to formulate an Advance Directive for 1 of 7 sampled residents (Resident #1). The findings included: Resident #1 was admitted to the facility on [DATE] with diagnoses that included high blood pressure and a history of a stroke. A quarterly Minimum Data Set assessment dated [DATE] revealed Resident #1 was cognitively intact. Review of Resident #1's electronic medical record revealed a full code Physician order dated 4/22/2025. There was no documentation in the record for education regarding formulation of an advance directive and/or an opportunity to formulate an advance directive was offered to the resident or resident representative. An interview was completed on 7/1/2025 at 10:35 am with Resident #1. The Resident was unable to recall if she received education regarding the right to formulate an advance directive. An interview was completed on 7/2/2025 at 11:42 am with the Administrator. The Administrator revealed approximately 2 months ago the facility's Nurse Practitioner (NP) provided education regarding advance directives and treatment via phone call to Resident #1's Representative. The Administrator stated the NP revealed she had forgotten to document the conversation in Resident #1's medical record. The Administrator stated it was her expectation facility residents or resident representatives were educated on advance directives and those conversations documented in their medical record. An interview was completed on 7/2/2025 at 11:48 am with the facility's NP. The NP stated in May 2025 she had a telephone conversation with Resident #1's Representative and provided education on advance directives and treatment due to Resident #1's gradual decline in health. The NP stated she had forgotten to document the conversation in Resident #1's medical record. Attempts to contact Resident #1's Representative were unsuccessful.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and staff interviews, the facility failed to provide a Centers for Medicare and Medicaid Services (CMS) Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN) (form 10055) prior to discharge from Medicare Part A skilled services for 2 of 3 residents reviewed for beneficiary notification (Resident #19 and Resident #108). The findings included: 1. Resident #108 was admitted to the facility on [DATE]. Medicare Part A services began on 11/7/24. Review of a Notice of Medicare Non-Coverage (NOMNC) revealed the notice was discussed with Resident #108 on 1/28/25, which indicated Resident #108's Medicare Part A coverage for skilled services would end on 1/25/25. Resident #108 remained in the facility. Review of Resident #108's medical record revealed no evidence a SNF ABN was reviewed with or provided to Resident #108. An interview was conducted with the Business Office Manager 7/01/25 at 1:32 PM. He revealed that when Resident #108 was admitted from the hospital on [DATE], she was billed for the month of October 2024 and the first week of November 2024. However, the previous facility billing was not finalized yet, so they billed Resident #108 based on her recollection of admission history. The last day of coverage for Medicare Part A was 8/30/24, which needed a 60-day reset. Based on that history, she had cleared 60 days of reset for all 100 days to be available when she was admitted to the nursing facility. At the time, that was what the Business Office Manager thought was accurate. All services were provided and billed accordingly, and the last covered day was initially 1/25/25. When the claims for January and February were paid in March 2025, the Business Office Manager found out on 3/19/25 that she already had passed the 100 days 5 days earlier than they thought. The services from 9/1/24 through 9/6/24 were not included. Therefore, the last covered day had changed. The Business Office Manager stated that he then billed Medicare Part B instead of Medicare Part A. During a follow-up interview with the Business Office Manager on 7/01/25 at 11:00 AM, he stated the Social Worker (SW) was responsible for issuing the SNF ABN, and this was something the previous SW used to take care of it. The SW was interviewed on 7/01/25 at 11:02 AM. She stated that she was only responsible for the NOMNC document, and the Business Office Manager was responsible for issuing the SNF ABN. An interview was conducted with the Administrator on 7/01/25 at 11:06 AM. She stated that she began at the facility in March 2025, but it was her understanding that the SW was responsible for issuing all the Beneficiary Notices. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow-up interview with the Administrator on 7/02/25 at 10:04 AM, she revealed that she forgot to instruct the current SW to also provide the SNF ABN with the NOMNC when a resident remained in the facility. The previous SW must have included the SNF ABN in her workload, but that was not communicated to the current SW. 2. Resident #19 was admitted to the facility on [DATE]. Medicare Part A services began on 1/27/25. Review of a Notice of Medicare Non-Coverage (NOMNC) revealed the notice was discussed with Resident #19 on 3/3/25, which indicated Resident #19's Medicare Part A coverage for skilled services would end on 3/5/25. Resident #19 remained in the facility. Review of Resident #19's medical record revealed no evidence a SNF ABN was reviewed with or provided to Resident #19. An interview was conducted with the Business Office Manager on 7/01/25 at 11:00 AM, He stated the Social Worker (SW) was responsible for issuing the SNF ABN, and this was something the previous SW used to take care of it. The SW was interviewed on 7/01/25 at 11:02 AM. She stated that she was only responsible for the NOMNC document, and the Business Office Manager was responsible for issuing the SNF ABN. An interview was conducted with the Administrator on 7/01/25 at 11:06 AM. She stated that she began at the facility in March 2025, but it was her understanding that the SW was responsible for issuing all the Beneficiary Notices. During a follow-up interview with the Administrator on 7/02/25 at 10:04 AM, she revealed that she forgot to instruct the current SW to also provide the SNF ABN with the NOMNC when a resident remained in the facility. The previous SW must have included the SNF ABN in her workload, but that was not communicated to the current SW.

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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 staff interviews, the facility failed to notify the Ombudsman in writing of a resident transfer to the hospital for 2 of 2 residents reviewed for hospitalization (Resident #25 and Resident #57). The findings included: 1.a. Resident #25 was admitted to the facility on [DATE]. The nursing progress note dated 8/19/24 revealed Resident #25 was transferred to the hospital for further evaluation of chest pain and difficulty breathing. The medical record indicated Resident #25 was discharged from the facility on 8/19/24 and returned to the facility on 9/06/24. The facility was unable to provide documentation regarding notification to the Ombudsman of Resident #25's transfer to the hospital. b. The nursing progress note dated 9/13/24 revealed Resident #25 was transferred to the hospital for further evaluation of altered mental status and low blood pressure. The medical record indicated Resident #25 was discharged from the facility on 9/13/24 and returned to the facility on 9/18/24. The facility was unable to provide documentation regarding notification to the Ombudsman of Resident #25's transfer to the hospital. c. The nursing progress note dated 11/22/24 revealed Resident #25 was transferred to the hospital for further evaluation of shortness of breath. The medical record indicated Resident #25 was discharged from the facility on 11/22/24 and returned to the facility on [DATE]. The facility was unable to provide documentation regarding notification to the Ombudsman of Resident #25's transfer to the hospital. Attempts to conduct a telephone interview with the previous Social Worker on 7/01/25 at 12:25 pm and 7/02/25 at 11:34 am were unsuccessful. An attempt to conduct a telephone interview with the Ombudsman on 7/01/25 at 1:10 pm was unsuccessful. An interview was conducted with the Administrator on 7/01/25 at 11:40 am who revealed she was unable to locate the previous Social Worker's documentation regarding notification to the Ombudsman for Resident #25's hospitalizations because she believed the previous Social Worker took items when she left the facility. (continued on next page)

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	2. Resident #57 was admitted to the facility on [DATE]. The nursing progress note dated 5/21/25 revealed Resident #57 was transferred to the hospital for further evaluation of abnormal laboratory results. The medical record indicated Resident #57 was discharged from the facility on 5/21/25 and returned to the facility on 6/02/25. An interview was conducted with the Social Worker on 7/01/25 at 1:00 pm who revealed she was unable to locate the Ombudsman notification for Resident #57's transfer to the hospital on 5/21/25. The Social Worker stated she normally emailed the list to the Ombudsman but she was unable to find any record that information was sent to the Ombudsman for the May 2025 discharges and transfers. The Social Worker stated she must have just let it slip by without sending it to the Ombudsman. An attempt to conduct a telephone interview with the Ombudsman on 7/01/25 at 1:10 pm was unsuccessful. During an interview with the Administrator on 7/01/25 at 11:40 am she stated the facility was unable to locate any documentation that the Social Worker notified the Ombudsman of Resident #57's transfer to the hospital. The Administrator stated the Social Worker was responsible to submit the information to the Ombudsman as required.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and resident and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas of use of anticonvulsant medication (Resident #45), resident prescribed diet (Resident #6), and use of a hearing aid (Resident #25) for 3 of 21 residents whose MDS assessments were reviewed. The findings included: 1. Resident #45 was admitted to the facility on [DATE] with diagnoses which included Alzheimer's Disease and cerebrovascular disease. Resident #45 had a physician order dated 2/01/24 for gabapentin (an anticonvulsant medication also used to treat pain) capsule 300 milligrams (mg) give one capsule by mouth at bedtime for pain. Resident #45 had an active physician order dated 2/29/24 for divalproex sodium tablet delayed release (an anticonvulsant medication) 250 mg; give 2 tablets once time a day for mood disorder related to dementia. The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #45 had severe cognitive impairment and was not coded for the use of anticonvulsant medication. Review of the April 2025 Medication Administration Record (MAR) revealed Resident #45 was administered the gabapentin and divalproex sodium medications as ordered. An interview was conducted on 7/02/25 at 10:44 am with the MDS Nurse who confirmed Resident #45 was administered the anticonvulsant medication during the look back period of the MDS assessment. The MDS Nurse stated she must have just missed the anticonvulsant medication when she completed Resident #45 medication section of the MDS assessment. During an interview on 7/02/25 at 11:55 am with the Administrator she revealed the MDS Nurse was responsible to ensure Resident #45's medications were coded accurately. 2. Resident #6 was admitted to the facility on [DATE]. Resident #6 had an active physician order dated 4/28/25 for a regular diet, regular texture, thin (regular) liquid consistency. The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #6 was cognitively intact, had no swallowing issues, and was coded for a mechanically altered diet. During an observation of the lunch meal on 7/01/25 Resident #6 was observed to have a regular texture diet with thin liquids which was confirmed by the meal ticket. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the MDS Nurse on 7/02/25 at 10:44 am who revealed the Dietary Manager completed the section regarding diet for Resident #6. The MDS Nurse stated she was not responsible for coding Resident #6's diet and she was not responsible for reviewing the section since it was completed by the Dietary Manager. During an interview on 7/02/25 at 11:22 am the Dietary Manager confirmed Resident #6 did not have a mechanically altered diet but was ordered a regular diet. The Dietary Manager stated she coded Resident #6's diet in error when she completed the MDS assessment. The Administrator was interviewed on 7/02/25 at 11:55 am and revealed the Dietary Manager was responsible to ensure Resident #6's diet was coded accurately on the MDS assessment. 3. Resident #25 was admitted to the facility on [DATE] with diagnoses which included cognitive communication deficit. Review of the Minimum Data Set (MDS) annual assessment dated [DATE] revealed Resident #25 was cognitively intact and was not coded for use of a hearing aid. An observation and interview with Resident #25 was conducted on 6/30/25 at 10:48 am. Resident #25 was observed sitting in a wheelchair near the television with a hearing aid in the left ear and a hearing aid noted outside the right ear and attached to a clip. Resident #25 stated he normally took out the hearing aids when sleeping or he didn't want to hear all the noise, but he did use them throughout the day. An observation was conducted on 7/01/25 at 1:58 pm of Resident #25. Resident #25 was noted to be sleeping with his hearing aids in the charging station on the bedside table. An interview was conducted with the MDS Nurse on 7/02/25 at 10:35 am who revealed she did not recall Resident #25 with hearing aids when she completed the hearing section of the MDS assessment. The MDS Nurse stated she was not aware Resident #25 used hearing aids. An interview was conducted on 7/02/25 at 11:05 am with Nurse Aide (NA) #1 who revealed he was assigned to Resident #25 on the days he worked and knew the resident well. NA #1 stated Resident #25 had hearing aids that he used and was able to put them in and take them out as he liked. NA #1 stated Resident #25 was hard of hearing, and he had the hearing aids for as long as he could remember. During an interview on 7/02/25 at 11:55 am with the Administrator she revealed the MDS Nurse was responsible to ensure Resident #25's assessment was coded accurately.

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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 observations, record review, and resident and staff interviews, the facility failed to develop a person-centered care plan in the areas of use of side rails for positioning (Resident #45), and hearing loss with use of a hearing aid (Resident #25) for 2 of 21 residents whose care plans were reviewed. The findings included: 1. Resident #45 was admitted to the facility on [DATE] with diagnoses which included Alzheimer's Disease. The Side Rail Use assessment dated [DATE] revealed Resident #45 requested side rails related to weakness to assist with turning, repositioning, and transfers. Resident #45 was noted to have 1/4 side rails to the upper bed bilaterally (both sides) while in bed. Review of Resident #45's care plan reviewed and updated on 5/08/25 revealed no care plan for the use of side rails for positioning. Observations were conducted on 6/30/25 at 10:50 am, 7/01/25 at 12:35 pm, and 7/02/25 at 9:03 am and Resident #45 was observed to be in bed with side rails to the upper portion of the bed bilaterally. An interview was conducted with the MDS Nurse on 7/02/25 at 10:44 am who revealed she was responsible for the development of resident care plans. The MDS Nurse stated she was new to the facility and did not recall if she was notified of Resident #45's use of side rails. The MDS Nurse stated Resident #45's use of side rails should have had a care plan in place but she did not recall if there was a care plan in place in the past. During an interview on 7/02/25 at 11:13 am with the Director of Nursing (DON) who revealed the MDS Nurse was responsible for resident care plans. The DON stated resident care plans were reviewed during care plan meetings and Resident 45 should have had a care plan in place for the use of side rails. An interview was conducted with the Administrator on 7/02/25 at 11:55 am. The Administrator revealed the MDS Nurse was responsible to review and develop resident comprehensive care plans. The Administrator stated the MDS Nurse was responsible to develop Resident #45's care plan for the use of side rails. 2. Resident #25 was admitted to the facility on [DATE] with diagnoses which included dementia with other behavioral disturbances. The Minimum Data Set (MDS) annual assessment dated [DATE] revealed Resident #25 was cognitively intact, was coded for adequate hearing without the use of a hearing aid. Resident #25's care plan last reviewed on 6/22/25 revealed no care plan for hearing loss or use of hearing aids. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation and interview with Resident #25 was conducted on 6/30/25 at 10:48 am. Resident #25 was observed sitting in a wheelchair near the television with a hearing aid in the left ear and a hearing aid noted outside the right ear and attached to a clip. Resident #25 stated he normally took out the hearing aids when sleeping or he didn't want to hear all the noise, but he did use them throughout the day. An observation was conducted on 7/01/25 at 1:58 pm of Resident #25. Resident #25 was noted to be sleeping with his hearing aids in the charging station on the bedside table. An observation was conducted on 7/02/25 at 11:30 am of Resident #25 who was observed sitting in his room with both hearing aids in place watching television. An interview was conducted with the MDS Nurse on 7/02/25 at 10:35 am who revealed she did not recall Resident #25 with hearing aids when she completed the hearing section of the MDS assessment. The MDS Nurse stated she was not aware Resident #25 used hearing aids and she did not develop a care plan for the use of hearing aids or hearing impairment. An interview was conducted with the Director of Nursing (DON) on 7/02/25 at 11:13 am with the Director of Nursing (DON) who revealed the MDS Nurse was responsible to ensure Resident #25's care plan was developed for hearing loss and use of hearing aids. During an interview on 7/02/25 at 11:55 am with the Administrator she revealed the MDS Nurse was responsible to ensure Resident #25 had a care plan in place for the use of hearing aids.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and staff interviews, the facility failed to revise the care plan in the areas of pain management, hypertension management, and anticoagulant (blood thinner) medication use (Resident # 18) and the use of a wander/elopement alarm (Resident #45) for 2 of 21 residents whose care plans were reviewed. The findings include: 1. Resident #18 was readmitted to the facility on [DATE] with diagnoses which included end stage renal disease (ESRD) with dependence on hemodialysis (HD), hypertension (HTN), and diabetes. Resident #18's physician orders revealed the following: - 9/10/24 Roxicodone oral tablet 5 milligrams (mg), give 1 tablet by mouth every 4 hours as needed for pain - 1/10/25 Amlodipine Besylate tablet 10 mg, give 1 tablet by mouth at bedtime for HTN - 6/6/25 Eliquis oral tablet 2.5 mg, give 1 tablet by mouth two times a day for Pulmonary Embolism (blockage of a lung artery) Review of Resident #18's care plan reviewed and updated on 5/8/25 revealed no care plan for the use of pain, hypertensive, and anticoagulant medications. An interview was conducted with the Minimum Data Set (MDS) Nurse on 7/01/25 at 1:40 PM. She revealed that she began working at the facility in April 2025. She explained she was responsible for updating the nursing sections of resident care plans and gave examples of problems that would be added to the revised care plan: wounds, new pain, falls, HTN medication, anticoagulant medication, etc. The MDS Nurse stated that she received information for care plan updates from the daily clinical meetings. She confirmed that Resident #18's care plan was missing the topics for pain, HTN, and anticoagulant medications. These medications for Resident #18 should have been discussed in the daily clinical meeting. The pain and HTN medications were ordered prior to her start date in April of this year, so she was not involved when those medications were initiated. However, the anticoagulant medication was added on 6/6/25, but she could not recall if the new medication was discussed in the daily clinical meeting. During an interview with the Director of Nursing (DON) on 7/02/25 at 9:44 AM, she revealed that the MDS Nurse was responsible for updating the nursing section of the care plan, and updates were discussed in the daily morning meeting. She stated that the anticoagulant medication should have been entered into the care plan when it was ordered on 6/6/25. However, the HTN and pain medications should have been added when Resident #18 was readmitted . (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Administrator was interviewed on 7/02/25 at 10:00 AM. She revealed that the care plan for Resident #18 should have included the pain, HTN, and anticoagulant medications ordered by the physician. She indicated that all new initiated medications were discussed in the daily clinical meeting. The Administrator stated that she could not speak to why the pain and HTN medications were an issue because she started with the company on 3/27/25. However, the MDS Nurse told her that she missed the anticoagulant medication ordered for Resident #18 on 6/6/25 by mistake. The Administrator stated that the staff turnover in the nursing department could have also influenced communication. 2. Resident #45 was admitted to the facility on [DATE] with diagnoses which included Alzheimer's disease. Resident #45 had a physician order dated 3/05/24 for wander guard, check daily and ensure functioning properly every day, every shift for wandering. The wander guard order was discontinued on 4/16/25. The Minimum Data Set (MDS) quarterly assessment dated [DATE] completed by the MDS Nurse revealed Resident #45 had severe cognitive impairment and was not coded for the use of a wander/elopement alarm. The care plan last reviewed on 5/08/25 revealed Resident #45 was an elopement risk/wanderer related to exit seeking behavior with an intervention which included a wander guard to the left ankle. An observation of Resident #45 was conducted on 6/30/25 at 2:28 pm and no wander guard alarm was observed on Resident #45's ankles or wrists. An interview was conducted on 7/02/25 at 10:44 am with the MDS Nurse who revealed she completed the MDS assessment section related to the wander/elopement alarm and that Resident #45 did not have a wander guard in place when she completed the MDS assessment. The MDS Nurse stated she did review and revise Resident #45's care plan quarterly but she must have missed the care plan for the wander guard when the review was completed. The MDS Nurse stated she should have revised Resident #45's care plan to reflect the wander guard was no longer in use. During an interview on 7/02/25 at 11:13 am with the Director of Nursing (DON) she revealed Resident #45 no longer required a wander guard and the MDS Nurse was responsible to review and revise Resident #45's care plan to accurately reflect his care needs. An interview was conducted with the Administrator on 7/02/25 at 11:55 am who revealed the MDS Nurse should have revised Resident #45's care plan when last reviewed and the wander guard was no longer ordered.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and staff, Pharmacy Consultant and Nurse Practitioner (NP) interviews, the facility failed to clarify the physician orders for lidocaine 4% external pain patches that resulted in the pain patches remaining on the resident's skin over the manufacturer's recommended duration of 12 hours. This deficient practice was for 1 of 3 residents observed for medication administration (Resident #15). The findings included: Resident #15 was admitted to the facility on [DATE] with diagnoses which included pain unspecified and diabetes with neuropathy (nerve pain). Review of physician orders revealed an active physician order dated 2/18/24 for lidocaine 4% external pain patch. Apply to the left side topically one time a day for pain at 9:00 am; apply in the am and remove at bedtime and per schedule. The order noted the removal time as 8:59 am. In addition, there was an active physician order dated 4/30/25 for lidocaine external patch 4%. Apply to the right side topically one time a day for right side pain. The order did not specify a removal time. The manufacturer's instructions written on the Lidocaine 4% external pain patch package stated to use one patch for up to 12 hours and discard patch after single use. During a continuous medication administration observation on 7/01/25 at 8:14 am through 8:37 am, Nurse #1 was observed to prepare and date a lidocaine 4% external pain patch to apply to Resident #15's left side. Nurse #1 was then noted to remove a lidocaine external pain patch from Resident #15's left side dated 6/30/25 and throw the used patch in the trash can. Nurse #1 applied the new lidocaine 4% external pain patch to the same area of Resident #15's left side. Next, Nurse #1 was observed to prepare and date another lidocaine 4% external pain patch to apply to Resident #15's right side. Nurse #1 was then noted to remove a lidocaine external pain patch from Resident #15's right side dated 6/30/25 and throw the used patch in the trash can. Nurse #1 applied the new lidocaine 4% external pain patch to the same area of Resident #15's right side. Resident #15's skin was observed to be intact without redness or irritation. An immediate interview was conducted with Nurse #1 on 7/01/25 at 8:37 am who revealed she normally removed Resident #15's lidocaine 4% external pain patches from the previous day just before she applied the new one. She stated the time of removal for the left pain patch was listed for 8:59 am and the new patch was ordered to be administered at 9:00 am. Nurse #1 stated the right lidocaine external patch was not ordered to be removed at any certain time, so she removed it before she applied the new one. Nurse #1 stated she thought the lidocaine external patch was only supposed to be used for 12 hours but she did not clarify the orders with a physician to see if a removal time was needed. A telephone interview was conducted with the Pharmacy Consultant on 7/02/25 at 2:52 pm who revealed Resident #15's lidocaine 4% external pain patch was to be removed after 12 hours, and the next patch should not be placed for another 12 hours: 12 hours on 12 hours off. The Pharmacy Consultant stated that when a lidocaine 4% external pain patch remained in place continuously without the 12-hour time frame to remove the patch, the resident was at risk for skin rash or irritation at the site where the patch was applied. (continued on next page)

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	345356	A. Building B. Wing	07/02/2025

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the Nurse Practitioner (NP) on 7/02/25 at 9:27 am who revealed Resident #15's lidocaine 4% external pain patch order should have included a removal time of 12 hours after application. The NP stated she did not realize the order did not have a removal time so that Resident #15 would have 12 hours with the lidocaine 4% external pain patch off the skin. During an interview on 7/01/25 at 3:15 pm with the Director of Nursing (DON) she revealed the orders for Resident #15's lidocaine 4% external pain patches to the left and right side were not accurate and should have included to remove the patches after 12 hours. She stated the order should have specified to apply the patch at 9:00 am and remove at 9:00 pm. The DON stated physician orders were reviewed during the clinical meetings but she did not recall seeing that Resident #15's orders for the lidocaine 4% external pain patches did not include to remove after 12 hours of use.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, and staff, Nurse Practitioner and Registered Dietitian (RD) interviews, the facility failed to provide nutritional supplements to prevent further weight loss as recommended by the RD and prescribed by physician (Resident #45) for 1 of 3 residents reviewed for nutrition. The findings included: Resident #45 was admitted to the facility on [DATE] with diagnoses which included Alzheimer's disease and diabetes. An active physician order dated 6/22/24 to add ice cream to lunch tray every day to aid with prevention of further significant weight loss per RD recommendation. An active physician order dated 11/03/24 to add nutritional shake supplement to lunch tray daily to aid in the prevention of further weight loss per RD recommendation. An active physician order dated 4/28/25 for a consistent carbohydrate (CCD), no added salt (NAS) diet. Regular texture, thin (regular) liquid consistency. Review of Resident #45's electronic health record revealed the following weights were recorded: 6/20/25 185.6 pounds 5/10/25 186.4 pounds 4/13/25 185 pounds 3/20/25 188.8 pounds 2/13/25 190.2 pounds 1/17/25 189 pounds 12/16/24 192.6 pounds 11/11/24 207.4 pounds 10/12/24 212 pounds The RD visit note dated 3/25/25 revealed Resident #45's current base weight was 188.8 pounds and Resident #45 had a 10.9% weight loss for the last 159 days. Resident #45 was noted to have a CCD, NAS regular texture diet with ice cream and nutritional shake once daily. The RD visit note further recorded that Resident #45's diet order with additional supplements met requirements and the RD would continue to monitor Resident #45 per protocol. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #45 had severe cognitive impairment. Resident #45 was coded for a therapeutic diet, was not coded for any signs and symptoms of a swallowing disorder, was independent for eating. Resident #45 was coded for weight loss of 5% or more in the last month or loss of 10% or more in the last 6 months, not on physician-prescribed weight-loss regimen. The care plan was last reviewed and updated on 5/08/25. Resident #45 had a nutritional problem related to diet restrictions with a goal to maintain adequate nutritional status. The interventions included explaining and reinforcing the importance of maintaining the diet ordered and encouraging compliance. An observation was conducted on 6/30/25 at 12:49 pm of Resident #45 during the lunch meal. The meal ticket on the lunch tray revealed Resident #45 was to receive ice cream and nutritional shake. No ice cream or nutritional shake were noted on the lunch tray. An attempt to conduct a telephone interview on 7/02/25 at 9:59 am with Dietary Aide #1 who worked on 6/30/25 during the lunch meal tray line was unsuccessful. An observation of Resident #45's lunch meal was conducted on 7/01/25 at 12:33 pm. No ice cream or nutritional shake were noted on the lunch tray. An interview was conducted on 7/02/25 at 11:07 am with Dietary Aide #2 who worked on 7/01/25 during the lunch meal tray line revealed the ice cream was normally added to Resident #45's lunch tray just before the meal tray cart goes to the unit and the nutritional shake would be put on the tray during the meal tray line. Dietary Aide #2 stated she must have forgotten to put the ice cream and nutritional shake on Resident #45's lunch tray. An interview was conducted on 7/01/25 at 2:51 pm with the Dietary Supervisor who revealed when a resident had supplements ordered on the diet ticket the dietary department was responsible to supply the supplements. The Dietary Supervisor stated when the meal tray line was in progress the Dietary Aides were responsible to review the meal tickets and ensure all supplements listed on the meal ticket were added to the meal tray. An interview was conducted on 7/01/25 at 12:38 pm with the Dietary Manager who revealed the Dietary Aides were responsible to place the ice cream and nutritional shake on Resident #45's lunch tray as ordered and noted on the meal ticket. A telephone interview with the facility's Registered Dietitian (RD) was conducted on 7/01/25 at 3:32 pm. The RD revealed she recommended the ice cream and nutritional shakes to be added to Resident #45's meal tray due to a recent significant weight loss. The RD stated Resident #45 was at risk for additional weight loss by not receiving the nutritional supplements as recommended and ordered. An interview was conducted on 7/02/25 at 9:05 am with the Nurse Practitioner (NP) who revealed Resident #45 was ordered the nutritional supplements due to weight loss and the supplements should have been provided as ordered. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Administrator on 7/02/25 at 11:57 am she revealed the Dietary Department was responsible for ensuring that Resident #45 received the dietary supplements as ordered by the physician.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on staff interview and review of the Facility Assessment the facility failed to ensure the required parties were involved in the development the Facility Assessment, failed to: have an accurate facility assessment that recorded the current administrative staff and Medical Director, ensure the staffing plan considered specific staffing needs for each unit and shift as required, provide information regarding the skills and competencies that were required for licensed nursing staff and Certified Nurse Aides (CNAs), and have an accurate staff type and position list. This deficient practice had the potential to affect 54 of 54 residents. The findings included: The Facility Assessment was reviewed and was noted to have been updated and reviewed with the facility's Quality Assurance Performance and Improvement (QAPI) committee on 1/28/25. The persons involved in completing the assessment were listed as the Administrator, the Director of Nursing (DON), the Medical Director, Social Service Director, Dietary Manager, Therapy Director, and a Governing Board Member. There was no indication that direct care staff were involved in completing the assessment or that the facility solicited and considered input from residents, resident representatives and family members. The Facility Assessment was noted to have the former Administrator, the former Medical Director, and the former Social Worker listed under the administrative personnel. Further review of the Facility Assessment revealed that the staffing plan listed the number of Nurses (Registered Nurse or Licensed Practical Nurse), and CNAs noted as the desired number FTE (full-time equivalent, the total number of full-time employees working in an organization) of staff and the professional requirement for those staff members. However, the staffing plan did not address staffing needs for each shift and weekends, or address staffing needs in these areas based on changes to the resident population as required. The staff type and position list recorded the facility had provided 1 FTE for a Staff Development Coordinator (SDC). The Facility Assessment did not provide information regarding the skills and competencies that were required for licensed nursing staff and CNAs. An interview was conducted with the Administrator on 7/02/25 at 11:59 am who revealed she was not employed by the facility when the current Facility Assessment was reviewed and updated. The Administrator confirmed the facility did not have an SDC and that the staff position list was inaccurate. The Administrator stated she had not yet reviewed or updated any information in the Facility Assessment since she started at the facility in March 2025. The Administrator was unable to provide any further documentation at the time of survey exit regarding the Facility Assessment.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, record review, and staff interviews, the facility failed to implement their infection prevention program policies and procedures when Nurse #2 failed to perform hand hygiene between glove changes during the observation of medication administration for 1 of 4 staff observed for infection control practices (Nurse #2). The findings included: The facility's Infection Prevention and Control Program (IPCP) policy implemented 10/04/23 and reviewed annually indicated in part that the facility established and maintained an (IPCP) to prevent the development and transmission of communicable diseases and infections. The policy further noted that hand hygiene shall be performed in accordance with the facility's established hand hygiene procedures. Review of the facility's Hand Hygiene Policy, no date, indicated that all staff would perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. The policy further noted that the use of gloves did not replace hand hygiene and that staff were to perform hand hygiene prior to donning gloves, and immediately after removing gloves. A continuous observation was conducted on 7/01/25 from 8:54 am through 8:58 am of medication administration for Resident #260. At 8:54 am Nurse #2 donned clean gloves without performing hand hygiene and was observed to use her gloved hands to spread open Resident #260's eye lids to administer eye drops to both eyes. Nurse #2 then removed the gloves, donned clean gloves without performing hand hygiene, removed Resident #260's oxygen tubing from the nose and administered nasal spray to both nostrils. Nurse #2 removed the gloves and did not perform hand hygiene. Nurse #2 then adjusted Resident #260's oxygen tubing with her ungloved hands and handed the resident a medicine cup with pills. Nurse #2 donned clean gloves without performing hand hygiene and placed a pain patch on Resident #260's right shoulder. Nurse #2 removed the gloves and performed hand hygiene when she exited Resident #260's room. An immediate interview was conducted with Nurse #2 on 7/01/25 at 8:58 am who revealed she should have used hand sanitizer between the glove changes during the medication administration but she just forgot. During an interview with the Director of Nursing (DON) on 7/01/25 at 3:13 pm she revealed she was also the facility's Infection Preventionist and was responsible for the IPCP. The DON stated Nurse #2 should have performed hand hygiene before she put on clean gloves and immediately after she took the gloves off.