STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345432	A. Building B. Wing	06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Bend Health and Rehabilitation	213 Richmond Hill Drive Asheville, NC 28806

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and resident and staff interviews, the facility failed to invite a resident to participate and provide input in the care planning process for 1 of 2 sampled residents (Resident #16). Findings included: Resident #16 was readmitted to the facility on [DATE]. The annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #16 had intact cognition. Review of Resident #16's electronic medical record revealed no evidence he was invited to attend care plan meetings to discuss and provide input regarding his plan of care following the completion of a quarterly Minimum Data Set (MDS) assessment dated [DATE], a quarterly MDS assessment dated [DATE], a quarterly MDS assessment dated [DATE], and an annual MDS assessment dated [DATE]. During an interview on 06/09/25 at 2:11 PM, Resident #16 stated he had been invited and attended care plan meetings in the past but could not recall the last time one was held. Resident #16 expressed that he wanted to participate in the care plan meetings so he could communicate and provide input about his care. During interviews on 06/11/25 at 3:19 PM and 06/12/25 at 8:20 AM, the Social Worker (SW) explained after the facility's last recertification survey (06/27/24) they put processes in place for him to keep track of when care plan meetings were due so that residents and/or their Responsible Party were invited to participate. The SW stated he had not been consistent with documenting care plan meetings that were held in the resident's medical record. The SW stated he seemed to recall having a care plan meeting with Resident #16 sometime in September 2024 but he was unable to locate any documentation. The SW stated care plan meetings for Resident #16 had fell through the cracks and verified there had been no care plan meetings held for Resident #16 this year (2025). During an interview on 06/13/25 at 1:46 PM, the Administrator revealed the SW was responsible for keeping track of when care plan meetings were due and inviting residents to participate in the care plan meetings. The Administrator stated she would expect for care plan meetings to be scheduled and held with the resident and/or Responsible Party per the regulatory guidance.

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews with residents and staff, the facility failed to ensure a dependent resident's accessibility to the light switch located behind the bed for 1 of 1 resident reviewed for accommodation of needs (Resident #30). The findings included: Resident #30 was admitted to the facility on [DATE]. The quarterly Minimum Data Set (MDS) assessment dated [DATE] coded Resident #30 with severely impaired cognition. The MDS indicated he required partial to moderate assistance for walking between locations inside the room for more than 10 feet. During an observation conducted on 06/09/25 at 12:47 PM, the switch for the light fixture behind Resident #30's bed was attached with a broken cord 2.5 inches in length. It was 5 feet from the floor and 6 feet from the bed. Resident #30 was unable to reach the switch cord from the bed if needed. An interview was conducted with Resident #30 on 06/09/25 at 12:49 PM. He could not recall when the switch cord was broken. He stated that he did not have any control of the light fixture behind his bed as he could not stand up without assistance in reaching the broken switch cord on the wall. He had to rely on nursing staff to switch off the light fixture before sleeping. Resident #30 indicated it was inconvenient as he had to ask for assistance repeatedly. He wanted the maintenance staff to fix the switch cord immediately to accommodate his needs. During joint observation and subsequent interviews with Nurse Aide #2 (NA) and Nurse #4 on 06/09/25 at 3:05 PM, NA #2 stated she provided care for Resident #30 frequently in the past few days. However, she did not notice that the switch cord was broken as it was blocked by a tall table lamp standing next to it. Nurse #4 stated that she had provided care for Resident #30 frequently in the past few months, but she did not notice that the switch cord was broken and inaccessible for him. Both nursing staff acknowledged that the broken switch cord needed to be fixed as soon as possible to accommodate Resident #30's needs. An interview was conducted with the Maintenance Director on 06/10/25 at 3:49 PM. He stated he walked through the entire facility at least once weekly to identify repair needs. He also depended on nursing staff to report repair needs either verbally or through work order that were placed in each nurse's station. He acknowledged that Resident #30's broken switch cord needed to be fixed immediately to accommodate his needs. During an interview conducted on 06/11/25 at 11:47 AM, the Director of Nursing acknowledged that even though Resident #30 rarely used the switch cord to switch on the light fixture behind his bed, the facility should make the switch cord available and accessible. It was her expectation for all the residents to have full accessibility to their light fixture to accommodate their needs all the time. An interview was conducted with the Administrator on 06/13/25 at 1:15 PM. She expected the staff to be more attentive to residents' living environment and reported repair needs in a timely manner to ensure all the residents had full accessibility to their light fixture at all times.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, and staff and resident interviews the facility failed to post survey results in a location accessible to all residents and failed to post signage as to the location of the survey results in areas accessible to the public. This deficient practice occurred for 4 out of 5 days of the survey. The findings included: Observations made on 6/09/25 at 2:18 PM, 6/11/25 at 4:22 PM and 6/13/25 at 9:16 AM revealed the survey results were located in a binder on a side table in Waiting room [ROOM NUMBER]A, a room located in the lobby area of the facility. An observation of the first floor and ground floor resident hallways on 6/12/25 at 3:08 PM with the Social Worker, and an observation of the lobby area on 6/13/25 at 9:17 AM, revealed no signage indicating the location of the survey results binder. All resident rooms were located behind a locked door beyond the lobby area that required a code to open from either side. A Resident Council Meeting held on 6/11/25 at 2:57 PM revealed 5 of 5 residents who attended the meeting did not know where the survey results book was located (Resident #23, Resident #65, Resident #60, Resident #61 and Resident #19). After the residents were informed of the location of the survey results binder, 3 of the residents indicated if they wanted to get to the lobby where the survey results binder was located they had to ask a staff member to let them out through the locked and coded door. An interview with the Administrator on 6/11/25 at 4:17 PM confirmed the survey results binder observed on the side table in Waiting room [ROOM NUMBER]A was the only survey results binder in the facility. During a follow-up interview with the Administrator on 6/13/25 at 9:55 AM she indicated the current location of the survey results book was accessible to all residents. She revealed residents could ask a staff member to let them through the coded, locked door if they didn't know the code themselves. The Administrator agreed there was no signage in areas accessible to the public that indicated the location of the survey results.

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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 0580 Level of Harm - Actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and staff, resident, family, Physician, Medical Director, and Nurse Practitioner interviews, the facility failed to notify the Physician when a resident (Resident #69) reported she had fallen and was experiencing acute pain after the reported fall. Due to ineffective communication between staff a medical provider was not notified of the fall until the following day which delayed x-rays, medical interventions and an evaluation in the emergency department. Resident #69 sustained an acute proximal tibia and fibula fracture (breaks in the upper part of the shinbone (tibia) and the smaller bone of the lower leg (fibula) from the reported fall and required a two day hospitalization. Orthopedics recommended hinged knee brace with non-weight bearing status to the right lower extremity. This deficient practice occurred for 1 of 3 residents reviewed for notification of changes. Findings included: Resident # 69 was admitted to the facility on [DATE]. Her diagnoses included cerebral infarction (stroke) and hemiplegia (paralysis) affecting the dominant right side. An observation and interview were conducted with Resident #69 on 6/9/25 at 10:52 AM. Resident #69 was observed in her room in her bed covered with a sheet. She was noted to be grimacing. When spoken to by the surveyor Resident #69 replied in Spanish. The surveyor asked Resident #69 Habla Ingles (speak English?), Resident #69 replied no. Resident #69 was asked by the surveyor dolor (pain)? Resident #69 replied see (yes) mucho (a lot) and grabbed her right leg at the knee. Resident #69 proceeded to uncover her right leg. When she uncovered her right leg Resident #69 began grimacing, crying, and moaning. A pillow was observed under her lower right leg. There was light blue/ purple colored bruising along her right shin and to the top of her right knee. Her right lower leg and knee had visible swelling present. Resident #69 said pain was mucho, diez (a lot, 10). The bathroom was in front of Resident #69's bed. She pointed at her right leg and the bathroom and said bano (bathroom). Resident #69's roommate was in the room who was also Spanish speaking. The roommate approached Resident #69's bed while the surveyor was in the room. The roommate translated that Resident #69 stated she had fallen on Saturday in bathroom and had a lot of pain in her leg. An additional interview was conducted with Resident #69 on 6/12/25 at 2:13 PM with Physical Therapy Assistant (PTA) #1 providing translation. Resident #69 stated she had gone to the bathroom with two staff members. She reported when she was getting off the toilet, she was holding on to the assist rail, and all a sudden she started falling. Resident #69 said she fell onto her right knee and had pain in her right knee immediately but did not cry or scream out. She said the staff member in the bathroom could not reach her fast enough to keep her from falling. She explained that the staff member who was in the bathroom with her helped her up and sat her in her wheelchair. She reported two female staff members put her back into bed after. Resident #69 stated no one asked her if she was hurt or anything afterwards, that they just put her back into bed. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	A telephone interview was conducted with NA #6 on 6/10/25 at 3:35 PM. NA #6 reported that she worked the night shift (7:00 pm to 7:00 am) on Saturday 6/7/25. She said at the start of her shift around 7:00 PM she was doing rounds and Resident #69's roommate was in the doorway of their room and asked her to come into the room. The roommate told her Resident #69 was having bad pain in her right knee. NA #6 recalled Resident #69 was in bed. She stated she looked at Resident #69's right knee and the top of her kneecap was bruised. NA #6 explained that the roommate assisted with translating for Resident #69 and she asked what had happened. NA #6 stated Resident #69 said she had fallen earlier that day in the bathroom and that she had fallen on her knee. NA #6 reported she asked Resident #69 if she was by herself when she fell or if staff were helping her. Resident #69 told her two girls had been helping her in the bathroom, but she did know who they were. NA #6 said she went and reported what Resident #69 was saying to the day shift (7:00 am to 7:00 pm) Nursing Supervisor. She recalled the Nursing Supervisor said she did not know anything about Resident #69 falling and the Nursing Supervisor went to check on Resident #69. A telephone interview was conducted with the day shift weekend Nursing Supervisor on 6/10/25 at 11:50 AM. The Nursing Supervisor stated a Nurse Aide (NA) came and got her around shift change on Saturday (6/7/25) around 7:30 PM and asked her to check on Resident #69. She reported the NA told her Resident #69 was saying she had fallen and was having pain in her right knee. She said she could not remember the name of the NA who came and got her. The Nursing Supervisor explained she went to Resident #69's room to assess her. She said Resident #69 was in pain and said her knee was hurting when she saw her. She reported Resident #69's roommate was present in the room and provided translation for what Resident #69 said happened. The Nursing Supervisor said Resident #69 reported she had fallen about an hour prior while she was being assisted in the bathroom by staff. The Nursing Supervisor reported she asked the day shift nurse (Nurse #8) if Resident #69 had fallen during the shift. She said Nurse #8 reported she did not know anything about Resident #69 having a fall. The Nursing Supervisor stated she updated Nurse #8 on what Resident #69 was reporting and told her what she needed to do. The Nursing Supervisor said she explained to Nurse #8 what she needed to do for the fall and told her she needed to call the physician and the Director of Nursing (DON). The Nursing Supervisor stated she had also made the oncoming night shift nurse (Nurse #9) aware of what was going on and what Resident #69 had reported. The Nursing Supervisor said she did not call the physician on Saturday. The Nursing Supervisor stated she did not think Nurse #8 had called anyone or done anything for the fall because when she returned on Sunday there was no documentation to indicate the physician had been notified or about the fall. The Nursing Supervisor said she went to assess Resident #69 on Sunday around 11:00 AM and that she was still hurting. She said she knew she was in pain because she was grimacing and holding her right leg. She stated when she looked at Resident #69's knee on Sunday there was swelling and bruising to the top of her knee. The Nursing Supervisor said she talked to Nurse #10, who was Resident #69's assigned nurse on Sunday day shift to ask him if he got anything in report about Resident #69 falling. She stated she could not remember if Nurse #10 had said yes or no. The Nursing Supervisor said she spoke to Resident #69's Family Member on the phone on Sunday. She stated that the Family Member reported Resident #69 told him she had fallen last night and was having pain. The Nursing Supervisor explained that she contacted the on-call provider on Sunday about Resident #69's pain and the fall she reported. She stated the on-call provider ordered an x-ray of Resident #69's right leg and as needed ibuprofen for pain. The Nursing Supervisor said she called the mobile x-ray company and placed an order for them to come to the facility to complete the x-ray. The Nursing Supervisor stated she called Resident #69's Family Member back and updated him on the new orders for Resident #69. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	A telephone interview was conducted with Nurse #8 on 6/10/25 at 1:49 PM. Nurse #8 stated she was the assigned nurse for Resident #69 on day shift on Saturday 6/7/25. She reported she had given shift report to the oncoming night shift nurse (Nurse #9) around 7:00 PM. Nurse #8 explained the day shift Nursing Supervisor came to her around 7:35 PM and told her Resident #69 was reporting she had fallen one hour ago. She stated no one had reported to her that Resident #69 had fallen during her shift. Nurse #8 said she went to Resident #69's room to check on her and that Resident #69 indicated she was in pain. She reported when she touched Resident #69's right leg she showed an expression of pain that was indicated by facial grimacing. Nurse #8 said it was not a fall that was reported to her during her shift and that it was not reported until 7:35 PM. She explained she had already given report to the night shift nurse (Nurse #9). She reported after she assessed Resident #69 and noticed she was in pain, she communicated to the night nurse, Nurse # 9, what she had seen. Nurse #8 said she asked Nurse #9 to continue the assessment and to complete the post fall things. She stated she did not specifically tell Nurse #9 what she needed to do but said Nurse #9 should have known what to do. She reported Nurse #9 had said yes. Nurse #8 said she assumed Nurse #9 would contact the physician and complete the rest of the post fall documentation. Nurse #8 stated the day shift the Nursing Supervisor had not told her anything specific she needed to do related to the fall. A telephone interview was conducted with Nurse #9 on 6/10/25 at 2:15 PM. She reported she had been the assigned night shift for Resident #69 on 6/7/25. Nurse #9 recalled she had been in the middle of taking report from the off going day shift nurse (Nurse #8). She stated she was outside of Resident #69's room with Nurse #8 and could hear another nurse in the room talking to Resident #69 and her roommate. Nurse #8 stated she did not know who the nurse in the room was, but that she overheard the nurse asking how and when Resident #69 fell. She explained an NA, whose name she did not know, was also in the room and they were trying to figure out how Resident #69 had fallen. She stated she did not see Nurse #8 again after she received report from her. Nurse #9 said the fall had occurred on day shift and she assumed Nurse #8 notified the physician and completed the fall documentation. She stated the Nursing Supervisor had not told her anything she needed to do for the fall. A nursing note dated 6/8/25 at 1:30 PM by Nursing Supervisor read: [family member] called about getting an x-ray and getting something for pain at the right knee for his [Resident #69]. Resident stated she is having pain in her right knee. Nurse evaluated right knee. There was inflammation at site. This nurse spoke with the on call doctor to get an order for an x-ray, that order has been called in to mobile x-ray. Nurse on cart gave as needed (PRN) for pain. Will continue to follow up. A telephone interview was conducted on 6/9/25 at 3:19 PM with Resident #69's Family Member. The Family Member stated they received a phone call from Resident #69 on Sunday (6/8/25). He said resident #69 was crying and said she was hurting. He reported Resident #69 said she had fallen the night before. The Family Member explained he called and spoke with the Nursing Supervisor on Sunday afternoon to ask about the fall, pain medication, and if an x-ray was going to be done. The Family Member said the Nursing Supervisor indicated she was just aware and that she was going to call the physician. The Family Member said Resident #69 could not speak English but that she was alert and oriented. An x-ray report dated 6/8/25 read: There are nondisplaced fractures of the proximal tibia and fibular neck. There are no bony lesions. Degenerative changes are noted. Diffuse osteopenia is noted. The soft tissues are unremarkable. Impression: Acute proximal lower leg fractures. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	A telephone interview was conducted with the Nurse Practitioner (NP) #1 on 6/10/25 at 4:16 PM. NP #1 stated she was alerted by Nurse #4 on Monday morning (6/9/25) that she had received in report from night shift that Resident #69 had an acute fracture of her knee. NP #1 explained her company's on-call service had not been notified about Resident #69's fall or her having pain over the weekend. She explained that the Medical Director was part of a different physician service group and that sometimes the staff get confused and call the Medical Directors on call service. She said it was okay for staff to call the other physician service group because he was the Medical Director. NP #1 explained she had reviewed documentation for Resident #69 and could not see where a physician was notified about Resident #69's fall or her pain until around 1:00 PM on Sunday. NP #1 said the nursing staff should have called the on-call service Saturday night when Resident #69 reported she had fallen and was having acute pain. NP #1 explained she had spoken with Resident #69 this morning using an interpreter to provide translation because Resident #69 did not speak English. NP #1 said Resident #69 reported on Saturday night she was assisted by a NA to the bathroom and had fallen onto her right knee and that she was in pain all Saturday night and Sunday morning. NP #1's company was contacted on 06/13/25 at 9:58 AM. They stated all calls were logged and there were no calls from the facility on Saturday or Sunday regarding Resident #69. A hospital Discharge summary dated [DATE] indicated Resident #69 had a mechanical fall and was admitted to the hospital on [DATE] with a right nondisplaced proximal tibia and fibula fractures. The discharge summary stated orthopedics was consulted and felt her fractures were amenable to nonoperative management. Orthopedics recommended hinged knee brace with non-weight bearing status to the right lower extremity and close outpatient follow-up with orthopedic services in two weeks. An interview was conducted with the Medical Director on 6/12/25 at 12:00 PM. He stated he did not remember the facility contacting him over the weekend but that he has had a lot of calls since then. He reviewed his calls and stated he did not have a call from the facility. He stated he had been on vacation on Sunday. He said their service tracked all the calls physicians received and he would check to see if there was a log of the facility calling his services over the weekend and call the Surveyor back. A return call was not received from the Medical Director. An interview was conducted with Physician #1 on 6/12/25 at 1:59 PM. He stated he was the on-call provider for the Medical Director physician service group over the weekend. He explained there was a system that tracked all the calls and that he had not been called on Saturday or Sunday about Resident #69. An interview was conducted with the Director of Nursing (DON), Regional Clinical Director, and Administrator on 6/12/25 at 4:00 PM. The Regional Clinical Director said she would have expected the staff to reach out to the DON and Administrator about what Resident #69 was reporting and the pain she was having because the staff did not know what had happened and should have asked for guidance on what they should have done. The Administrator agreed the staff should call the DON to ask for guidance about what the Resident was reporting. They said if someone had that much pain, they would expect the nurse to call the physician. They stated the Medical Director had called back and said one of the on-call providers, part of his service group, had received a phone call on Sunday from the facility where the nurse called and reported the issues with Resident #69, and that was where the orders for the x-ray and ibuprofen had come from.

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on record review, and staff, resident, family, Physician, Medical Director, and Nurse Practitioner (NP) interviews, the facility failed to protect a resident's right to be free from neglect after Resident #69 had a fall during a staff assisted transfer on 6/27/25 (Saturday). The Nursing Supervisor went to assess Resident #69 after a nurse aide told her the resident reported she had fallen and was having pain in her right knee. Resident #69 told the Nursing Supervisor she was in pain and said her knee was hurting. The Nursing Supervisor did not report the fall or pain to a medical provider. Resident #69 spoke Spanish and there was no evidence that staff utilized an interpreter to determine what had occurred or her level of pain. Due to ineffective communication between staff a medical provider was not notified of fall or pain until 6/8/25 at which time orders were received for an x-ray and ibuprofen (a nonsteroidal anti-inflammatory drug) for pain. The x-ray results received on 6/8/25 noted an acute proximal tibia and fibula fracture (breaks in the upper part of the shinbone (tibia) and the smaller bone of the lower leg (fibula) and were not communicated to a medical provider until 6/9/25 when NP #1 assessed the Resident, which further delayed medical interventions and treatment for the fracture. Through an interpreter Resident #69 told NP #1 she had fallen on Saturday and had been in pain all Saturday night and Sunday morning. NP #1 noted Resident #69 was in a lot of pain and crying and ordered an opioid pain medication to treat the pain for the acute fracture of her tibia and fibula. Resident #69 was sent to the hospital emergency room on 6/9/25 and required a two day hospitalization. Orthopedics recommended hinged knee brace with non-weight bearing status to the right lower extremity. Resident #69 stated through an interpreter several days after the fall that no one asked her if she was hurt or anything afterwards, that they just put her back into bed. This deficient practice occurred for 1 of 1 resident reviewed for neglect. Findings included: This tag is cross referred to: F 580- Based on record review, and staff, resident, family, Physician, Medical Director, and Nurse Practitioner interviews, the facility failed to notify the Physician when a resident (Resident #69) reported she had fallen and was experiencing acute pain after the reported fall. Due to ineffective communication between staff a medical provider was not notified of the fall until the following day which delayed x-rays, medical interventions and an evaluation in the emergency room. Resident #69 sustained an acute proximal tibia and fibula fracture (breaks in the upper part of the shinbone (tibia) and the smaller bone of the lower leg (fibula) from the reported fall and required a two day hospitalization. Orthopedics recommended hinged knee brace with non-weight bearing status to the right lower extremity. This deficient practice occurred for 1 of 3 residents reviewed for notification of changes. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	F684- Based on record review, and staff, resident, family, and Nurse Practitioner interviews, the facility failed to recognize a resident experienced a fall during a staff transfer that resulted in acute pain to her right knee/ leg on 6/7/25. The nurse aides did not report Resident #69 falling to a nurse and Resident #69 was not assessed by a nurse or medical provider before she was moved and transferred back to her bed. In addition, nursing staff did not complete or document comprehensive assessments of the resident and did not recognize Resident #69 needed medical evaluation and treatment. Due to ineffective communication between staff a medical provider was not notified of fall until the following day and x-ray results reported on 6/8/25 were not communicated to a medical provider until 6/9/25, which delayed medical interventions and an evaluation in the emergency department. Resident #69 sustained an acute proximal tibia and fibula fracture (breaks in the upper part of the shinbone (tibia) and the smaller bone of the lower leg (fibula) from the reported fall and required a two day hospitalization. Orthopedics recommended hinged knee brace with non-weight bearing status to the right lower extremity. This deficient practice occurred for 1 of 1 resident reviewed for quality of care (Resident #69). F689- Based on record review, and staff, resident, family, and Nurse Practitioner interviews, the facility failed to provide a safe transfer for a resident who reported she fell during a transfer with staff. Resident #69 stated she was assisted off the toilet by two staff members, had difficulty holding on to the assist rail because her right hand did not work, fell on her right knee and had pain her in right knee immediately. Resident #69 sustained an acute proximal tibia and fibula fracture (breaks in the upper part of the shinbone (tibia) and the smaller bone of the lower leg (fibula) from the reported fall and required a two day hospitalization. Orthopedics recommended hinged knee brace with non-weight bearing status to the right lower extremity. This deficient practice occurred for 1 of 5 residents reviewed for falls (Resident #69). F 697- Based on record review, and staff, resident, family, and Nurse Practitioner (NP) interviews, the facility failed to provide effective pain management for a resident who had acute pain after a reported fall on 6/27/25 (Saturday). Resident #69 spoke Spanish and reported through an interpreter two days after the fall she fell on her right knee during an assisted transfer and had pain immediately which she rated at a pain scale of 9 (Pain scale of 0 is no pain and pain scale of 10 is the worst pain). Due to ineffective communication between staff a medical provider was not notified of fall or pain until 6/8/25 at which time ibuprofen (a nonsteroidal anti-inflammatory drug) was ordered for pain. There was no evidence staff utilized an interpreter to determine an accurate level of pain or the effectiveness of pain medication. The first documented administration of pain medication was on 6/8/25 at 3:52 PM when Resident #69 received ibuprofen for a pain level of 10 which was ineffective. There was no evidence a medical provider was contacted for additional pain medication. NP #1 was notified of the x-ray results on 6/9/25 and assessed Resident #69 and documented the Resident was in a lot of pain and crying. Through an interpreter Resident #69 told NP #1 she had fallen on Saturday and had been in pain all Saturday night and Sunday morning. NP #1 ordered an opioid pain medication to treat the pain for the acute fracture of her tibia and fibula. Resident #69 received the first dose of opioid pain medication on 6/9/25 at 9:34 AM for a pain level of 7 which was documented as effective. This deficient practice occurred for 1 of 1 resident reviewed for pain (Resident #69). (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	F 777- Based on record review, and staff, resident, family, Physician, Medical Director, and Nurse Practitioner interviews, the facility failed to notify the Physician of radiology results for a resident who was experiencing acute pain after a reported fall on 6/7/25. Due to ineffective communication between staff x-ray results reported on 6/8/25 were not communicated to a medical provider until 6/9/25 which delayed medical interventions and an evaluation in the emergency room. Resident #69 sustained an acute proximal tibia and fibula fracture (breaks in the upper part of the shinbone (tibia) and the smaller bone of the lower leg (fibula) from the reported fall and required a two day hospitalization. Orthopedics recommended hinged knee brace with non-weight bearing status to the right lower extremity. This deficient practice occurred for 1 of 3 residents reviewed for notification of radiology results (Resident #69). An interview was conducted with the Director of Nursing (DON), Regional Clinical Director, and Administrator on 6/12/25 at 4:00 PM. They declined to comment on whether they felt like what happened with Resident #69 was neglect.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews with the Resident Representative and staff, the facility failed to ensure the basis for a resident's discharge from the facility met the discharge requirement criteria for 1 of 3 residents reviewed for discharge (Resident #189). On 01/28/25, Resident #189 was issued a 30-day notice for non-payment prior to a claim being submitted to the Managed Medicaid plan (private insurance company contracted to manage the provision of care and benefits) for payment of his stay. Findings included: Resident #189 was admitted to the facility on [DATE]. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #189 had intact cognition and there was no active discharge plan in place. A Nursing Home Notice of Transfer/Discharge form dated 01/28/25 revealed Resident #128 would be discharged from the facility on 02/28/25. The reason for the transfer/discharge was marked, you have failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at this facility. During a phone interview on 06/10/25 at 11:52 AM, Resident #189's Representative stated Resident #189 was issued a discharge notice by the facility on 01/28/25 due to non-payment which was unexpected because both she and Resident #189 had planned on him remaining in the facility a little longer to give her time to find other housing that would accommodate his wheelchair in order to safely bring him back home. The Representative stated since his discharge on [DATE], they had continued to receive monthly billing statements amounting to over $50,000.00 dollars. The Representative stated Resident #189 had medical insurance and they were told insurance would cover the first 90 days of his stay but she was not sure if insurance was billed or how much the insurance had paid since there was nothing listed on the billing statement. The representative stated the Administrator had told Resident #189 he could remain at the facility and not be discharged if he paid something toward the amount owed and he made a payment of $400.00 but was still issued the 30-day discharge notice. During an interview on 06/12/25/25 at 8:56 AM, the Business Office Manager (BOM) revealed she had only been employed at the facility for about 2 weeks. The BOM reviewed Resident #189's account and confirmed he had a balance due of $51,353.68. She stated he had insurance coverage through a Managed Medicaid plan but when she looked at his payer source in his medical record it was listed as private pay. She explained the facility had received approval from the Managed Medicaid Plan for Resident #189's nursing home stay for the period of 11/01/24 through 01/31/25 but because his payer source was listed as private pay, a claim was never submitted to insurance for payment. The BOM stated typically when a resident had insurance coverage through a Managed Medicaid Plan, the resident had to remain at the facility for a period of 90 days then Medicaid could be notified to start the process for the resident to be disenrolled from the Managed Medicaid plan and switched to long-term traditional Medicaid. She stated Medicaid should have been notified on 01/18/25 to start the process for Resident #189 to be switched to long-term traditional Medicaid but there was nothing documented in his account. She stated had this been done, Resident #189 would likely not have owed anything to the facility. (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/13/25 at 1:46 PM, the Administrator confirmed Resident #189 was issued a 30-day discharge notice on 01/28/25 due to non-payment. The Administrator was unaware that a claim was never submitted to Resident #189's Managed Medicaid plan for payment of his stay and could not provide an explanation why the insurance was not billed. She explained he was issued the discharge notice strictly for non-payment of his Managed Medicaid Plan co-payment amount and not for the entire balance owed to the facility. The Administrator stated she was told by the former BOM that Resident #189 had a monthly copay amount of $1,100 but was not sure how that amount was determined. The former Business Office Manager was unable to be interviewed during this investigation. During a follow-up interview on 06/13/25 at 3:02 PM, the BOM explained they typically didn't know if there was a co-payment amount owed until the claim was submitted to the Managed Medicaid Plan and reconfirmed a claim was never submitted to Resident #189's Managed Medicaid plan for his entire stay at the facility.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 complete a discharge summary that included a recapitulation of the resident's stay and final summary of the resident's status for 1 of 3 sampled residents reviewed for discharge (Resident #189). Findings included: Resident #189 was admitted to the facility on [DATE]. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #189 had intact cognition and there was no active discharge plan in place. The discharge MDS assessment dated [DATE] revealed Resident #189 discharged to the community. Review of Resident #189's electronic medical record on 06/11/25 revealed an assessment titled Discharge Summary (Recap [recapitulation] of Resident's Stay) dated 02/24/25 had a status of in progress. The discharge summary assessment consisted of 5 sections to complete: 1) Discharge Information such as location, date of discharge, referrals, and primary provider contact information, 2) Recap of Stay that included sub-sections for Nursing, Therapy, Dietary, Social Services, and Activity to document discharge summaries, 3) Reason for Discharge, 4) Medical Summary that included medical diagnosis, course of treatment, discharge plan, and date/time of follow-up appointment(s), and 5) Acknowledgement with a section for the resident or representative to sign and date and also included check boxes for documentation provided to the resident/representative at the time of discharge such as laboratory results, radiology results, consultation notes, medications sent with the resident, and a copy of the discharge summary. All sections except for the Therapy discharge summary were left blank. During an interview on 06/13/25 at 9:12 PM, the Social Worker (SW) explained when a resident was ready for discharge he (the SW) was the one who typically initiated the discharge summary-recapitulation of stay assessment for each department manager to complete their section. The SW confirmed Resident #189's discharge summary-recapitulation of stay assessment was opened on 02/24/25 and the Therapy discharge summary was the only section completed, all other sections of the assessment were left blank, including the Social Services section he was responsible for completing. The SW stated he was not always consistent with entering his documentation in a resident's medical record and although he did not have any documented evidence, a care plan meeting was held with Resident #189 and his representative on 02/24/25 to discuss his discharge plans and needs. The SW stated during the care plan meeting, prescriptions were provided to Resident #189's representative to have filled along with a cushion for his wheelchair and bedside commode for him to have once he discharged from the facility. The SW explained Resident #189 the completion of his discharge summary-recapitulation of stay assessment was just overlooked. During an interview on 06/13/25 at 1:46 PM, the Administrator was unaware Resident #189's discharge summary-recapitulation of stay assessment was not completed upon his discharge from the facility. The Administrator stated she would expect for discharge summary-recapitulation of stay assessments to be completed in their entirety with input from all disciplines per the regulatory guidelines.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 4. Resident #5 was admitted to the facility on [DATE]. His cumulative diagnoses included protein-calorie malnutrition and dysphagia (difficulty swallowing). A Speech Therapy (ST) evaluation and plan of treatment for the certification period 05/01/25 through 07/29/25 revealed at baseline, Resident #5 presented with mild oropharyngeal (middle part of the throat behind the mouth) dysphagia characterized by mildly impaired lingual (tongue)/labial (lips) range of motion/coordination, loss of bolus (soft mass of chewed food), and coughing/gagging. A nutrition evaluation dated 05/29/25 revealed Resident #5 had the following signs/symptoms of a swallowing disorder: loss of liquids/solids from mouth when eating or drinking, coughing or choking during meals or when swallowing medications, and complaints of difficulty or pain when swallowing. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #5 did not have signs and symptoms of a swallowing disorder. During an interview on 06/13/25 at 11:02 AM, the Regional MDS Consultant revealed the facility was currently without a MDS Coordinator and she had been filling in to assist with completing MDS assessments. The Regional MDS Consultant stated based on the ST evaluation, swallowing disorder should have been coded on Resident #5's MDS assessment dated [DATE] and it was an oversight. During an interview on 06/13/25 at 1:46 PM, the Administrator stated she expected MDS assessments to be coded correctly. Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas of pressure ulcers and dental status (Resident #4), restraints (Resident #18 and Resident #1), and swallowing disorders (Resident #5) for 4 of 30 residents reviewed for accuracy of assessments. Findings included: 1 a. Resident #4 was admitted to the facility on [DATE] with diagnoses including dementia and malnutrition. A review of the admission weekly skin evaluation dated 01/23/25 revealed Resident #4 had no skin issues. A review of the Wound Care Practitioner notes revealed on 02/26/25 Resident #4 was evaluated for two unstageable pressure ulcers located on the left hip and sacrum that were newly identified on 02/25/25. The Wound Care Practitioner continued weekly evaluations and treatments for two unstageable pressure ulcers located on the left hip and sacrum until 03/26/25. A review of the discharge MDS assessment dated [DATE] revealed Resident #4 was discharged to the hospital. The MDS assessment identified two unstageable pressure ulcers and incorrectly coded the ulcers were present on admission. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Wound Care Practitioner note dated 04/02/25 revealed Resident #4 was not seen due to being hospitalized on [DATE]. During an interview on 06/13/25 at 11:48 AM, the Regional MDS Consultant revealed MDS assessments were being completed remotely. After review of Resident #4's electronic medical records, the Regional MDS Consultant confirmed the pressure ulcers were identified after admission to the facility and the discharge MDS assessment dated [DATE] was coded incorrectly to indicate the ulcers were present on admission. During an interview on 06/13/25 at 2:43 PM, the Administrator revealed MDS assessments should accurately reflect Resident #4's pressure ulcers were not present on admission, and she expected MDS assessments were correctly coded for skin conditions. b. A review of the admission MDS assessment dated [DATE] indicated Resident #4 was not edentulous (no natural teeth). A review of the significant change in status MDS assessment dated [DATE] indicated Resident #4 was not edentulous (no natural teeth). During an observation of the lunch meal on 06/11/25 at 12:11 PM, Resident #4 was served pureed textured food and was edentulous. During an interview on 06/13/25 at 11:48 AM, the Regional MDS Consultant revealed MDS assessments were being completed remotely. After review of Resident #4's electronic medical records, the MDS Regional Consultant revealed a Speech Therapist evaluation dated 01/22/25 noted Resident #4 was edentulous upon admission to the facility on [DATE]. The Regional MDS Consultant stated the admission MDS assessment dated [DATE] and significant change in status MDS assessment dated [DATE] were coded incorrectly to indicate Resident #4 was not edentulous. She revealed the MDS Coordinator completed the assessments remotely and was expected to review the resident's medical records or contact the facility when more information was needed to accurately complete the assessment. During an interview on 06/13/25 at 2:43 PM, the Administrator revealed MDS assessments should accurately reflect Resident #4 had no natural teeth (edentulous) and she expected the assessment was correctly coded for dental status. 2. Resident #18 was admitted to the facility on [DATE] with diagnoses including congestive heart failure and history of cerebral infarction (loss of blood flow to an area of the brain). A review of quarterly MDS assessment dated [DATE] revealed Resident #18's cognition was intact. The MDS indicated bed rails were used daily and coded as a physical restraint. An interview and observation of Resident #18 was conducted on 06/09/25 at 2:26 PM. Resident #18 was resting in bed with bilateral quarter bed rails located at the head of the bed in an up position. Resident #18 revealed she used the bed rails for mobility to help reposition herself. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/13/25 at 12:17 PM, the Regional MDS Consultant revealed MDS assessments were being completed remotely and stated the facility was restraint free. After review of Resident #18's medical records, the Regional MDS Consultant stated the quarterly MDS assessment dated [DATE] was incorrectly coded to indicate bed rails were a physical restraint. The Regional MDS Consultant stated Resident #18 was cognitively intact and the bed rails did not restrict movement and were not a restraint. During an interview on 06/13/25 at 2:55 PM, the Administrator revealed MDS assessments should accurately reflect Resident #18's bed rails were not a restraint and confirmed the facility was restraint free. The Administrator revealed she expected the quarterly MDS assessment dated [DATE] was correctly coded to show no physical restraints were used. 3. Resident #1 was admitted to the facility on [DATE] with diagnoses including dementia and cerebrovascular disease. A review of the quarterly MDS assessment dated [DATE] revealed Resident #1's cognition was moderately impaired. The MDS indicated a physical restraint was used less than daily and coded as a chair that prevented Resident #1 from rising. During an interview on 06/11/25 at 4:56 PM, the Rehabilitation Director revealed after review of Resident #1's therapy notes she did not know why a chair restraint was coded on the quarterly MDS assessment dated [DATE]. An observation and interview was conducted on 06/12/25 at 4:34 PM with Resident #1. Resident #1 stated he was able to self-transfer without assistance from staff. Resident #1 revealed he used a wheelchair for mobility and there was no type of restraint used. Resident #1's wheelchair had a cushion on the seat and no type of seat belt or device used to prevent him from rising from the chair. During an interview on 06/13/25 at 12:13 PM, the Regional MDS Consultant revealed MDS assessments were being completed remotely. After review of Resident #1's medical records, the Regional MDS Consultant confirmed the quarterly MDS assessment dated [DATE] was incorrectly coded for the use of a chair restraint. The Regional MDS Consultant revealed the assessment was coded in error and a modification of Resident #1's quarterly MDS assessment dated [DATE] was sent on 06/11/25 to reflect no chair restraint was used. During an interview on 06/13/25 at 2:55 PM, the Administrator revealed the MDS assessment should accurately reflect Resident #1 did not use a chair restraint and confirmed the facility was restraint free. The Administrator revealed she expected the quarterly MDS assessment dated [DATE] was correctly coded to show no physical restraint was used.

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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** 2. Resident #5 was admitted to the facility on [DATE] with diagnoses that included cerebral palsy (group of disorders that affect movement, balance and posture). The admission Minimum Data Set (MDS) dated [DATE] revealed Resident #5 had intact cognition. He required partial/moderate to substantial/maximum staff assistance with self-care tasks and was dependent on staff for mobility and transfers. It was noted on the MDS assessment that Resident #5's activities of daily living functional/rehabilitation potential would be addressed in the care plan. The significant change MDS dated [DATE] revealed Resident #5 had intact cognition. He required supervision or touching assistance with eating and was dependent on staff for all other self-care tasks. He required substantial/maximum staff assistance with rolling left-to-right and from a sit-to-lying position and was dependent on staff with lying-to-sitting on the side of the bed and transfers. It was noted on the MDS assessment that Resident #5's activities of daily living functional/rehabilitation potential would be addressed in the care plan. Resident #5's comprehensive care plans, last revised on 04/01/25, included a plan that addressed his limited physical mobility related to weakness and cerebral palsy with the following interventions: invite him to activity programs that encourage physical activity/mobility, monitor/document/report as needed any signs/symptoms of immobility, and provide gentle range of motion as tolerated with daily care. There was no care plan that addressed his need for assistance with activities of daily living (ADL) such as transfers, bathing, personal and oral hygiene. During an interview on 06/09/25 at 11:36 AM, Resident #5 revealed he could eat independently with set-up assistance but was dependent on staff assistance for all other ADL tasks. Resident #5 stated staff used a mechanical lift when assisting him with transfers. During an interview on 06/13/25 at 11:02 AM, the Regional MDS Consultant revealed the facility was currently without a MDS Coordinator and she had been filling in to assist with completing MDS assessments and updating care plans as needed. She explained Resident #5's limited physical mobility was addressed in his comprehensive care plans; however, it did not address his care needs. She stated it was overlooked due to the facility not having a MDS Coordinator and there should have been a care plan developed with interventions that addressed his ADL care needs and transfer status which would be important information for staff to know. During an interview on 06/13/25 at 1:46 PM, the Administrator revealed she would expect care plans to be developed to accurately reflect the resident's ADL care needs and transfer status. Based on record review and staff interviews, the facility failed to develop care plans in the area of transfers, bathing, and personal and oral hygiene for 2 of 11 residents whose activities of daily living (ADL) care plans were reviewed (Resident #51 and Resident #5). Findings included: (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Resident #51 was admitted to the facility 04/01/25 with a diagnosis including acquired absence of right leg below knee. The admission Minimum Data Set (MDS) assessment dated [DATE] reflected Resident #51 was cognitively intact and required substantial/maximum assistance for transfers. Resident #51's comprehensive care plan initiated 04/21/25 for ADL self-care performance deficit related in part to a right below the knee amputation did not reflect his need for assistance with transfers. An interview with the Regional MDS Consultant on 06/13/25 at 11:14 AM revealed Resident #51's transfer status should be reflected on his care plan. She stated it was overlooked due to MDS staff having a personal emergency when Resident #51's care plan was initiated. The Regional MDS Consultant stated the transfer status of Resident #51 would be important information for staff to know. An interview with the Administrator on 06/13/25 at 2:46 PM revealed she expected care plans to be developed to accurately address the resident's transfer status.

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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 record review and interviews with the staff, resident and the Nurse Practitioner (NP), the facility failed to request a refill from the pharmacy prior to the last dose being administered resulting in a resident missing 3 doses of the scheduled medication for 1 of 9 residents reviewed for unnecessary medications (Resident #16). Findings included: Resident #16 was admitted to the facility on [DATE] with diagnosis that included hypertensive heart disease without heart failure. The annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #16 had intact cognition. A physician order dated 04/20/24 revealed Resident #16 was to receive prazosin hydrochloride (medication used to lower blood pressure) 5 milligrams (mg) at bedtime for blood pressure related to hypertensive heart disease without heart failure. A physician order dated 04/21/24 revealed Resident #16 was to receive amlodipine (medication used to lower blood pressure) 5 mg once a day at 9:00 AM for arterial hypertension related to hypertensive heart disease without heart failure. The Medication Administration Record (MAR) for the period of 06/07/25 through 06/11/25 revealed Resident #16 received his scheduled doses of amlodipine daily as physician ordered. Further review revealed Resident #16 received his last scheduled dose of prazosin hydrochloride medication on 06/07/25 at 9:00 PM. For the 06/08/25 scheduled dose of prazosin hydrochloride, Nurse #3 noted a chart code of 9=Other/See Progress Note to indicate the medication was not administered. For the 06/09/25 and 06/10/25 scheduled doses of prazosin hydrochloride, a chart code H was documented indicating the medication was held. It was further noted on the MAR under the medication order that the medication was held starting 06/09/25 at 9:00 PM to 06/10/25 at 1:28 AM and again from 06/10/25 at 7:23 PM to 06/11/25 at 7:22 PM. Further review revealed Resident #16 received his next scheduled dose of prazosin hydrochloride on 06/11/25 at 9:00 PM. Continued review of Resident #16's MAR for the period of 06/07/25 through 06/11/25 revealed his blood pressure (BP) vital signs were documented as follows: 06/07/25 during the day shift (7:00 AM to 7:00 PM) his BP was 141/78 and during the evening shift (7:00 PM to 7:00 AM) his BP was 138/74. 06/08/25 during the day shift his BP was 142/79 and during the evening shift his BP was 137/77. 06/09/25 during the day shift his BP was 166/97 and during the evening shift his BP was 164/98. 06/10/25 during the day shift his BP was 161/87 and during the evening shift his BP was 149/96. 06/11/25 during the day shift his BP was 177/99 and during the evening shift his BP was 147/86. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Bend Health and Rehabilitation	213 Richmond Hill Drive Asheville, NC 28806

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview on 06/13/25, Nurse #3 recalled when she went to administer Resident #16's prazosin hydrochloride medication on 06/08/25 there was none available on the medication cart. Nurse #3 stated when she clicked on the medication order, she saw that a refill had been requested from the pharmacy, so she marked the order as held on Resident #16's MAR. Nurse #3 stated she did not contact the pharmacy on 06/08/25 to inquire on the status of the refill request nor did she notify the Director of Nursing (DON). Nurse #3 stated when she worked her next scheduled shift on 06/11/25, the medication was available on the medication cart and Resident #16 was administered his scheduled dose. During an interview on 06/11/25 at 11:25 AM, Nurse #4 revealed her scheduled hours were 7:00 AM to 7:00 PM and she did not work over the weekend (06/07/25 or 06/08/25) but Resident #16 had informed her he did not receive his prazosin hydrochloride medication. Nurse #4 confirmed there was no prazosin hydrochloride medication currently available in the medication cart for Resident #16. A review of the pharmacy refill order for Resident #16's prazosin hydrochloride medication provided by the Director of Nursing on 06/11/25 at 4:24 PM revealed on 06/09/25 it was noted a medication order from the pharmacy was on hold. On 06/10/25 it was noted the medication was on still on hold pending clarification and receipt of a prescription from the NP. On 06/11/25 at 8:27 AM the pharmacy received a faxed prescription from the NP and the medication was dispensed to the facility (no time was listed). During interviews on 06/09/25 at 2:11 PM and 06/11/25 at 3:47 PM, Resident #16 was lying in bed displaying no signs of distress. He stated the prazosin hydrochloride medication was prescribed for his blood pressure. Resident #16 stated he thought it had been about 10 days since he had received the medication and his blood pressure had increased as a result. Resident #16 stated he spoke with the NP about why he hadn't gotten his medication on Monday (06/09/25) and she had told him that he had been receiving it all along; however, Nurse #3 told him on Sunday (06/08/25) that there was none on the cart to administer and she had put a stop on the medication. During an interview on 06/11/25 at 4:03 PM, the DON explained residents should never run out of their medications as nurses should request a refill from the pharmacy 5 to 7 days before the last dose was used so there was no gap in administration. She stated the pharmacy delivered twice daily; the first delivery between 3:30 PM to 4:00 PM and the second delivery around midnight. If a medication did run out, nurses were expected to request a refill and contact the pharmacy to see when the medication would be sent to the facility and then notify the provider for additional instructions if the resident would miss any scheduled doses of the medication. The DON stated the NP was notified and sent a prescription to the pharmacy on 06/10/25 to refill Resident #16's prazosin hydrochloride medication. The DON stated if a medication was ordered and did not arrive from the pharmacy, the nurse should have checked with the pharmacy and then notified her (DON) so she could follow up with the pharmacy. She stated no one had informed her that Resident #16's had missed scheduled doses of his prazosin hydrochloride medication because the medication had not been received from the pharmacy as requested and it was her expectation residents received their medications as ordered. During interviews on 06/12/25 at 12:55 PM and 1:20 PM, the NP confirmed she was notified Resident #16 had missed 3 doses of his prazosin hydrochloride medication. The NP stated she expected nurses to have a sense of urgency to reorder medication at least 7 days before the medication ran out, especially for controlled medications which could take longer to process, to avoid any gaps in medication administration. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/13/25 at 1:11 PM, the Administrator stated it was her expectation for nurses to have a sense of urgency to reorder medications at least 5 days before the medication ran out to ensure the resident had a continuous supply of medication as needed and ordered.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and staff, resident, family, and Nurse Practitioner interviews, the facility failed to recognize a resident experienced a fall during a staff transfer that resulted in acute pain to her right knee/ leg on 6/7/25. The nurse aides did not report Resident #69 falling to a nurse and Resident #69 was not assessed by a nurse or medical provider before she was moved and transferred back to her bed. In addition, nursing staff did not complete or document comprehensive assessments of the resident and did not recognize Resident #69 needed medical evaluation and treatment. Due to ineffective communication between staff a medical provider was not notified of fall until the following day and x-ray results reported on 6/8/25 were not communicated to a medical provider until 6/9/25, which delayed medical interventions and an evaluation in the emergency department. Resident #69 sustained an acute proximal tibia and fibula fracture (breaks in the upper part of the shinbone (tibia) and the smaller bone of the lower leg (fibula) from the reported fall and required a two day hospitalization. Orthopedics recommended hinged knee brace with non-weight bearing status to the right lower extremity. This deficient practice occurred for 1 of 1 resident reviewed for quality of care (Resident #69). Findings included: Resident # 69 was admitted to the facility on [DATE]. Her diagnoses included cerebral infarction (stroke) and hemiplegia (paralysis) affecting the dominant right side. The quarterly Minimum Data Set Assessment (MDS) dated [DATE] revealed Resident #69 was cognitively intact. The MDS documented that she was dependent on dressing, personal hygiene, toileting, and toilet transfers. The MDS indicated she required substantial/maximal assistance with sit to stand and chair to bed transfers. It was documented on the MDS Resident #69's preferred language was Spanish, and she needed an interpreter. An interview was conducted with Resident #69 on 6/12/25 at 2:13 PM with Physical Therapy Assistant (PTA) #1 providing translation. Resident #69 stated while staff members were assisting her in the bathroom to get off the toilet, she fell onto her right knee. Resident #69 reported she had pain in her right knee immediately but did not cry or scream out. She explained that the staff member who was in the bathroom with her helped her up and sat her in her wheelchair. Resident #69 said she could not see if it was one or two people who helped her off the toilet and back to her wheelchair because she could not see around the larger staff member to see who was in the bathroom with her. She reported two female staff members put her back into bed after. Resident #69 stated no one asked her if she was hurt or anything afterwards, that they just put her back into bed. An interview was conducted on 6/10/25 at 10:46 AM with Nurse Aide (NA) #7. She recalled assisting Resident #69 with toileting on Saturday afternoon (6/7/25); she could not recall the exact time. She stated NA #9 had assisted her with transferring Resident #69 off the toilet. NA #7 reported Resident #69 did not fall during the transfer. She did not recall Resident #69 twisting her leg or her leg getting caught on anything during the transfer. NA #7 was not aware of Resident #69 having pain after the transfer. NA #7 said after Resident #69 was finished in the bathroom, she assisted her back to her bed. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted with NA #9 on 6/10/25 at 12:41 PM. NA #9 reported NA #7 had asked her to assist with transferring Resident #69 off the toilet Saturday (6/7/25). She explained Resident #69 was not really able to sit on the toilet because she would lean and was unstable when she was sitting on the toilet. She stated she did not think it was a good idea for Resident #69 to sit on the toilet because she might fall off the toilet. She explained she had been called to assist with transferring Resident #69 off the toilet so Resident #69 would not fall off of the toilet because she was leaning. NA #9 reported she and NA #7 armed and armed her and put her in the wheelchair. She said they each took a side to help her stand up and put her back in the wheelchair. She said during the transfer Resident #69's leg did not give out, get twisted, or catch on anything. NA #9 reported Resident #69 did not have any signs of pain during or after the transfer. A telephone interview was conducted with NA #6 on 6/10/25 at 3:35 PM. NA #6 reported that she worked the night shift (7:00 pm to 7:00 am) on Saturday 6/7/25. She said at the start of her shift around 7:00 PM Resident #69's roommate was in the doorway of their room and asked her to come into the room. The roommate told her Resident #69 was having bad pain in her right knee. NA #6 recalled Resident #69 was in bed. She stated she looked at Resident #69's right knee and the top of her kneecap was bruised. NA #6 explained that the roommate assisted with translating for Resident #69 and she asked what had happened. NA #6 stated Resident #69 said she had fallen earlier that day in the bathroom and that she had fallen on her knee. NA #6 reported she asked Resident #69 if she was by herself when she fell or if staff were helping her. Resident #69 told her two girls had been helping her in the bathroom, but she did know who they were. NA #6 stated the night shift nurse (Nurse #9) was outside of the door when she was talking to Resident #69 and had heard the conversation. NA #6 stated Nurse #9 told her she did not get anything in report about Resident #69 falling. NA #6 said she went and reported what Resident #69 was saying to the day shift (7:00 am to 7:00 pm) Nursing Supervisor. She recalled the Nursing Supervisor said she did not know anything about Resident #69 falling and the Nursing Supervisor went to check on Resident #69. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	A telephone interview was conducted with the day shift weekend Nursing Supervisor on 6/10/25 at 11:50 AM. The Nursing Supervisor stated a Nurse Aide (NA) came and got her around shift change on Saturday (6/7/25) around 7:30 PM and asked her to check on Resident #69. She reported the NA told her Resident #69 was saying she had fallen and was having pain in her right knee. She said she could not remember the name of the NA who came and got her. The Nursing Supervisor explained she went to Resident #69's room to assess her. She said she did not see anything abnormal when she looked at Resident #69's knee. She did not recall her having bruising or swelling to her knee. She said Resident #69 was in pain and said her knee was hurting when she saw her. She reported Resident #69's roommate was present in the room and provided translation for what Resident #69 said happened. The Nursing Supervisor said Resident #69 reported she had fallen about an hour prior while she was being assisted in the bathroom by staff. The Nursing Supervisor said she updated the night shift Nurse (Nurse #9) about what was going on and then went to find the day shift nurse (Nurse #8). The Nursing Supervisor reported she asked Nurse #8 if Resident #69 had fallen during the shift and Nurse #8 reported she did not know anything about Resident #69 having a fall. The Nursing Supervisor further reported she asked Resident #69's assigned NA, NA #7 if Resident #69 had fallen. The Nursing Supervisor stated NA #7 told her Resident #69 had not fallen. She stated she went back to Nurse #8 and updated her on what Resident #69 was reporting and told her what she needed to do. The Nursing Supervisor said she explained to Nurse #8 what she needed to do for the fall and told her she needed to call the physician. She told Nurse #8 she needed to go talk to Resident #69 and her roommate because Resident #69 was reporting she had fallen. She said she told Nurse #8 she needed to call the physician because Resident #69 was in pain, and she only had as needed Tylenol ordered. The Nursing Supervisor stated she also told Nurse #8 she needed to call the Director of Nursing (DON) about what Resident #69 was reporting and the fall. The Nursing Supervisor stated Nurse #8 had said okay. The Nursing Supervisor stated she had also made the oncoming night shift nurse (Nurse #9) aware of what was going on and what Resident #69 had reported. The Nursing Supervisor stated she did not think Nurse #8 had called anyone or done anything for the fall because when she returned on Sunday there was no documentation to indicate anything had been done for Resident #69 or her reported fall and Resident #69 was still having pain. The Nursing Supervisor explained she went to assess Resident #69 on Sunday around 11:00 AM and that she was still hurting. The Nursing Supervisor stated she knew Resident #69 was in pain because she was grimacing and holding her right leg. She stated when she looked at Resident #69's knee on Sunday there was swelling and bruising to the top of her knee. The Nursing Supervisor said she talked to Nurse #10, who was Resident #69's assigned nurse on Sunday day shift to ask him if he got anything in report about Resident #69 falling. She stated she could not remember if Nurse #10 had said yes or no. The Nursing Supervisor explained that she contacted the on-call provider on Sunday about Resident #69's pain and the fall she reported had happened on Saturday. The Nursing Supervisor reported an x-ray was ordered for Resident #69 by the on-call physician on Sunday. She recalled the x-ray was completed and the results returned before the end of her shift on Sunday. She said she had spoken to the DON about the results and that she had told Nurse #10 and Nurse #3 about the x-ray results. She reported she wrote the on-call physician's phone number down for Nurse #10 but had not told him or Nurse #3 to call the physician and report the x-ray results. The Nursing Supervisor said she did not call the x-ray results to the physician. She stated she could not remember what she told Nurse #3 and Nurse #10 to do after that. Nurse #10 was unavailable for interview. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	A telephone interview was conducted with Nurse #8 (agency nurse) on 6/10/25 at 1:49 PM. Nurse #8 stated she was the assigned nurse for Resident #69 on day shift on Saturday 6/7/25. She reported she had given shift report to the oncoming night shift nurse (Nurse #9) around 7:00 PM. Nurse #8 explained the day shift Nursing Supervisor came to her around 7:35 PM and told her Resident #69 was reporting she had fallen one hour ago. She stated no one had reported to her that Resident #69 had fallen during her shift. Nurse #8 said she went to Resident #69's room to check on her and that Resident #69 indicated she was in pain. Nurse #8 said she assessed Resident #69 by touching areas of her body like her arms and legs. She reported when she touched Resident #69's right leg she showed an expression of pain that was indicated by facial grimacing. She said Resident #69 did not cry or yell out and that the resident did not have any bruising or swelling to her right leg that she recalled. Nurse #8 said it was not a fall that was reported to her during her shift and that it was not reported until 7:35 PM. She explained she had already given report to the night shift nurse (Nurse #9). She reported after she assessed Resident #69 and noticed she was in pain, she communicated to Nurse # 9, what she had seen. Nurse #8 said she asked Nurse #9 to continue the assessment and to complete the post fall things. She stated she did not specifically tell Nurse #9 what she needed to do but said Nurse #9 should have known what to do. She reported Nurse #9 had said yes. Nurse #8 said she assumed Nurse #9 would contact the physician and complete the rest of the post fall documentation. Nurse #8 said she had not done any vital signs, documentation, or incident report related to Resident #69's reported fall. Nurse #8 said if she had done all those things she would have been at the facility another hour and that her agency would not pay her if she was there longer than her scheduled shift. She stated the Nursing Supervisor had not told her anything specific she needed to do related to the fall. A telephone interview was conducted with Nurse #9 on 6/10/25 at 2:15 PM. She reported she had been the assigned night shift nurse for Resident #69 on Saturday night 6/27/25. Nurse #9 recalled she had been in the middle of taking report from the off going day shift nurse (Nurse #8). She stated she was outside of Resident #69's room with Nurse #8 and could hear another nurse in the room talking to Resident #69 and her roommate. Nurse #8 stated she did not know who the nurse in the room was, but that she overheard the nurse asking how and when Resident #69 fell. She explained an NA, whose name she did not know, was also in the room and they were trying to figure out how Resident #69 had fallen. Nurse #9 reported she had thought since it had happened on the day shift that the day shift nurse (Nurse #8) was going to do the fall stuff because it was her shift. Nurse #9 said the nurse who had been in the room talking with Resident #69 about the fall had not told her to do anything. She recalled after Nurse #8 gave her report Nurse #8 had said she was going to step away to do charting. She stated Nurse #8 never came back to talk to her after giving report. Nurse #9 indicated Nurse #8 did not come back and to tell her she had assessed Resident #69 or asked her to do anything related to the fall, she said she never saw Nurse #8 again after report. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted with Nurse #3 on 6/12/25 at 6:25 AM. She was the assigned night shift nurse on Sunday 6/8/25 for Resident #69. Nurse #3 reported she received in report from Nurse #10 that Resident #69 had a fractured knee. She also spoke with the day shift Nursing Supervisor who told her they had gotten the x-ray back and knew Resident #69 had a fracture. Nurse #3 stated she knew the day shift nurses had spoken with the Physician at some point, but she did not know if it was before or after they had received the x-ray results. She reported she had not seen the x-ray report. Nurse #3 explained she came in after they had done everything and they were just telling her what had happened. Nurse #3 stated they did not ask her to do anything or tell her she needed to do anything else. Nurse #3 recalled Resident #69's roommate came and got her during the night and let her know Resident #69 was having pain. She did not remember the time. Nurse #3 said she checked on Resident #69 and observed her having pain. She said Resident #69 was pointing at her right leg and she could tell she was having pain by her facial expression and that she was grimacing. Nurse #3 said she gave Resident #69 the PRN ibuprofen. Nurse #3 reported she went back and checked on Resident #69 again about an hour later and she was asleep. Review of Resident #69's medical record on 6/9/25 at 11:00 AM revealed there was no documentation or assessment information from Saturday 6/7/25 related to a fall. Resident #69's last progress note was documented on 6/6/25. There was no additional documentation for Resident #69 until 6/8/25 at 1:30 PM. A nursing note dated 6/8/25 at 1:30 PM by the Nursing Supervisor read: [family member] called about getting an x-ray and getting something for pain at the right knee for his [Resident #69]. Resident stated she is having pain in her right knee. Nurse evaluated right knee. There was inflammation at site. This nurse spoke with the on call doctor to get an order for an x-ray, that order has been called in to mobile x-ray. Nurse on cart gave as needed (PRN) for pain. Will continue to follow up. A telephone interview was conducted on 6/9/25 at 3:19 PM with Resident #69's Family Member. The Family Member stated they received a phone call from Resident #69 on Sunday (6/8/25). He said resident #69 was crying and said she was hurting. He reported Resident #69 said she had fallen the night before. Resident #69 had told him the staff members brought her back and put her into bed and that no one followed up to check on her. The Family Member said Resident #69 could not speak English but that she was alert and oriented. He stated he thought there would be a process for when someone fell and was injured, not just staff putting them back in bed, not contacting the doctor, or not doing any radiology screening. He reported it was around noon the next day when he spoke to the facility and nothing had been done. The Family Member indicated he thought someone would have made a report and called the Doctor. An x-ray report dated 6/8/25 read: There are nondisplaced fractures of the proximal tibia and fibular neck. There are no bony lesions. Degenerative changes are noted. Diffuse osteopenia is noted. The soft tissues are unremarkable. Impression: Acute proximal lower leg fractures. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	A progress note dated 6/9/25 by Nurse Practitioner (NP) #1 reported Resident #69 was being seen for right leg pain. The progress note indicated an interpreter had been used during the exam. The progress note said Resident #69 reported she had fallen onto her right knee while in the restroom with a NA Saturday night. The note further stated Resident #69 said she immediately had pain and the NA at the time got her up and helped her back to bed. NP #1's note indicated there was no documentation of the fall in the electronic computer system on 6/7/25. The progress note stated on 6/8/25 a nurse contacted the on-call physician who ordered an x-ray. The NP note stated the x-ray was reviewed this morning (6/9/25) by herself and showed a right nondisplaced fracture of the proximal tibia and fibular neck. The progress note indicated Resident #69 reported 8/10 pain to her right leg when attempting to move the leg. The NP progress note additionally said an ortho consult was ordered and non-weight bearing to the right leg was ordered. The progress note reported that NP#1 made the DON aware of what Resident #69 reported occurred Saturday and that there was no documentation. A telephone interview was conducted with the Nurse Practitioner (NP) #1 on 6/10/25 at 4:16 PM. NP #1 stated she was alerted by Nurse #4 on Monday morning (6/9/25) that she had received in report from night shift that Resident #69 had an acute fracture of her knee. She explained if Nurse #4 had not mentioned it to her she would never have known about it. NP #1 explained she reviewed the x-ray of Resident #69's right leg and it showed she had an acute fracture of her tibia and fibula. NP #1 explained she had spoken with Resident #69 this morning using an interpreter to provide translation because Resident #69 did not speak English. NP #1 said Resident #69 reported on Saturday night she was assisted by a NA to the bathroom, and she was attempting to hold onto the assist rail to get onto the toilet and felt weak. Resident #69 told her she missed the assist rail and had fallen onto her right knee and that she was in pain all Saturday night and Sunday morning. NP #1 said she had also spoken with Resident #69's Family Member who reported Resident #69 had called him Sunday and said she was in a lot of pain and had fallen. NP #1 said no one from the facility had contacted her or the company's on-call service over the weekend about Resident #69's fall, her pain, or the x-ray results. She said this morning was the first time she had learned about it. NP #1 explained if Resident #69's leg was not splinted or immobilized there was a risk that the fractures could become more displaced. A hospital Discharge summary dated [DATE] indicated Resident #69 had a mechanical fall and was admitted to the hospital on [DATE] with a right nondisplaced proximal tibia and fibula fractures. The discharge summary stated orthopedics was consulted and felt her fractures were amenable to nonoperative management. Orthopedics recommended hinged knee brace with non-weight bearing status to the right lower extremity and close outpatient follow-up with orthopedic services in two weeks. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Bend Health and Rehabilitation	213 Richmond Hill Drive Asheville, NC 28806

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 0684 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted with the Director of Nursing (DON), Regional Clinical Director, and Administrator on 6/12/25 at 4:00 PM. They reported when a fall was reported staff were supposed to contact the DON, responsible party, provider, and follow the fall protocol. They explained the fall protocol was to assess for injury/ pain, document the assessment, and complete an incident report. The Regional Clinical Director said she would have expected the staff to reach out to the DON and Administrator about what Resident #69 was reporting and the pain she was having because the staff did not know what had happened and should have asked for guidance on what they should have done. The DON stated if the staff had reached out and called her, she would have told them to call the on-call provider to report that Resident #69 said she had a fall and had pain. The Administrator agreed the staff should call the DON to ask for guidance about what the Resident was reporting. The DON explained she was aware of Resident #69's x-ray results Sunday night. She reported the x-ray report pinged on her computer around shift change on Sunday night at 6:56 PM and she reviewed the report. The DON said she called the facility and spoke to the day shift Nursing Supervisor around 7:00 PM. The DON stated she had called the Nursing Supervisor to notify her and make sure she had the results as well. She reported that the Nursing Supervisor confirmed she had the x-ray results. The DON said she did not tell the Nursing Supervisor what she needed to do. The DON explained that the Nursing Supervisor was not a new nurse and had assumed she knew what to do and knew she needed to call the Physician. The DON said she felt it was common sense that the nurse would call the Physician about critical x-ray results. The DON explained she was hyper focused on trying to figure out the cause of the fractures because she did not know anything about the x-ray or why it had been ordered.

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and staff, resident, family, and Nurse Practitioner interviews, the facility failed to provide a safe transfer for a resident who reported she fell during a transfer with staff. Resident #69 stated she was assisted off the toilet by two staff members, had difficulty holding on to the assist rail because her right hand did not work, fell on her right knee and had pain her in right knee immediately. Resident #69 sustained an acute proximal tibia and fibula fracture (breaks in the upper part of the shinbone (tibia) and the smaller bone of the lower leg (fibula) from the reported fall and required a two day hospitalization. Orthopedics recommended hinged knee brace with non-weight bearing status to the right lower extremity. This deficient practice occurred for 1 of 5 residents reviewed for falls (Resident #69). Findings included: Resident # 69 was admitted to the facility on [DATE]. Her diagnoses included cerebral infarction (stroke) and hemiplegia (paralysis) affecting the dominant right side. The quarterly Minimum Data Set Assessment (MDS) dated [DATE] revealed Resident #69 was cognitively intact. The MDS documented that she was dependent on dressing, personal hygiene, toileting, and toilet transfers. The MDS indicated she required substantial/maximal assistance with sit to stand and chair to bed transfers. It was documented on the MDS Resident #69's preferred language was Spanish, and she needed an interpreter. A care plan dated 1/12/25 read Resident #69 requires staff assistance for activity of daily living (ADL) care needs related to generalized weakness and history of stroke with right side weakness. The care plan interventions included to assist with ADL care needs as needed. The ADL care plan did not specify how Resident #69 transferred. A care Kardex (quick reference tool that summarizes important care information) for Resident #69 included she was dependent for transfers and required a total mechanical lift and two persons assist for transfers. The Kardex stated as of 6/9/25. An observation and interview were conducted with Resident #69 on 6/9/25 at 10:52 AM. Resident #69 was observed in her room in her bed covered with a sheet. She was noted to be grimacing. When spoken to by the surveyor Resident #69 replied in Spanish. The surveyor asked Resident #69 Habla Ingles (speak English?), Resident #69 replied no. Resident #69 was asked by the surveyor dolor (pain)? Resident #69 replied see (yes) mucho (a lot) and grabbed her right leg at the knee. Resident #69 proceeded to uncover her right leg. When she uncovered her right leg Resident #69 began grimacing, crying, and moaning. A pillow was observed under her lower right leg. There was light blue/ purple colored bruising along her right shin and to the top of her right knee. Her right lower leg and knee had visible swelling present. Resident #69 said pain was mucho, diez (a lot, 10). The bathroom was in front of Resident #69's bed. She pointed at her right leg and the bathroom and said bano (bathroom). Resident #69's roommate was in the room who was also Spanish speaking. The roommate approached Resident #69's bed while the surveyor was in the room. The roommate translated that Resident #69 stated she had fallen on Saturday in bathroom and had a lot of pain in her leg. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	An additional interview was conducted with Resident #69 on 6/12/25 at 2:13 PM with Physical Therapy Assistant (PTA) #1 providing translation. Resident #69 stated she had gone to the bathroom with two staff members. She reported when she was getting off the toilet, she was holding on to the assist rail, and all a sudden she started falling. She explained that one of the staff members helping her had left to go get her wheelchair. She said she was standing at the assist rail, and the other staff member was in the bathroom next to her but was not paying attention to her. She said the staff member was not looking at her and that she was looking out the bathroom door. She recalled the staff members had her hold onto the assist rail in the bathroom. She said she could not hold onto the rail with both her hands because her right hand does not work. Resident #69 reported she had said me estoy cayendo (I'm falling) but the staff members did not understand what she was saying. Resident #69 said she fell onto her right knee and had pain in her right knee immediately but did not cry or scream out. She said the staff member in the bathroom could not reach her fast enough to keep her from falling. She explained that the staff member who was in the bathroom with her helped her up and sat her in her wheelchair. Resident #69 said she could not see if it was one or two people who helped her off the toilet and back to her wheelchair because she could not see around the larger staff member to see who was in the bathroom with her. She reported two female staff members put her back into bed after. Resident #69 stated no one asked her if she was hurt or anything afterwards, that they just put her back into bed. An interview was conducted on 6/10/25 at 10:46 AM with NA #7. She reported she had been Resident #69's assigned NA on Saturday 6/7/25. She said she and NA #8 assisted Resident #69 to the toilet on Saturday. She could not recall the time they had taken her to the toilet but said it had been sometime after lunch and thought it was before dinner but could not remember exactly. She reported she held the back of the wheelchair while NA #8 assisted Resident #69 to transfer from the bed to her wheelchair doing a stand and pivot transfer. She recalled they took Resident #69 into the bathroom that was in her room. She said she stood behind the wheelchair while NA #8 had Resident #69 hold the assist rail in the bathroom with her hand and then assisted her to open her right hand and placed her right hand on the railing. She reported NA #8 assisted Resident #69 to pull up to a standing position using the bathroom railing and then assisted her with a pivot transfer to the toilet. NA #7 reported after the transfer was completed NA #8 left the room. NA #7 reported nothing unusual occurred during the transfer and Resident #69 did not have any indicators of pain during or after the transfer onto the toilet. NA #7 recalled she closed the bathroom door slightly but left it ajar to provide privacy to Resident #69 while she was on the toilet. She stated while Resident #69 was using the toilet she remained in the room and straightened her bed and chatted with the roommate. NA #7 reported when Resident #69 indicated she was finished using the toilet, she asked NA #9 from the doorway to help her transfer Resident #69. NA #7 said she and NA #9 transferred Resident #69 back to her wheelchair using a 2-person transfer. NA #7 again, said nothing unusual occurred during the transfer and that Resident #69 did not cry out or have any indicators of pain during or after the transfer. NA #7 said Resident #69's right leg did not give way, twist, get caught, or hit anything during the transfer. NA #8 reported they then transferred Resident #69 back to her bed. NA #7 said she was not aware of Resident #69 having any pain in her right knee/ leg during her shift on Saturday. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted with NA #8 on 6/10/25 at 10:21 AM. She reported she had assisted NA #7 with transferring Resident #69 to the toilet on Saturday. NA #8 was not sure what time they assisted her to the toilet but said it was some time after lunch. She thought it had been before dinner but was not exactly sure. NA #8 stated she had only assisted with transferring Resident #69 onto the toilet and had then left the room. She said nothing unusual happened during the transfer onto the toilet and that Resident #69 did not cry out or have any indicator of pain during or after the transfer to the toilet. An interview was conducted with NA #9 on 6/10/25 at 12:41 PM. NA #9 reported NA #7 had asked her to assist with transferring Resident #69 off the toilet. She explained Resident #69 was not really able to sit on the toilet because she would lean and was unstable when she was sitting on the toilet. She stated she did not think it was a good idea for Resident #69 to sit on the toilet because she might fall off the toilet. She explained she had been called to assist with transferring Resident #69 off the toilet so Resident #69 would not fall off of the toilet because she was leaning. NA #9 reported she and NA #7 armed and armed her and put her in the wheelchair. NA #9 stated Resident #4 was not able to hold onto the assist rail to pull herself up off the toilet. She reported Resident #69 was able to stand and pivot enough to get back into the wheelchair. NA #9 recalled the wheelchair was outside of the bathroom door. She said they each took a side to help her stand up and put her back in the wheelchair. NA #9 stated when they had Resident #69 up and turned/ pivoted her they moved the wheelchair under her and sat her down in the wheelchair. She said during the transfer Resident #69's leg did not give out, get twisted, or catch on anything. NA #9 reported Resident #69 did not have any signs of pain during or after the transfer. A telephone interview was conducted with NA #6 on 6/10/25 at 3:35 PM. NA #6 reported that she worked the night shift (7:00 pm to 7:00 am) on Saturday 6/7/25. She said at the start of her shift around 7:00 PM she was doing rounds and Resident #69's roommate was in the doorway of their room and asked her to come into the room. The roommate told her Resident #69 was having bad pain in her right knee. NA #6 recalled Resident #69 was in bed. She stated she looked at Resident #69's right knee and the top of her kneecap was bruised. NA #6 explained that the roommate assisted with translating for Resident #69 and she asked what had happened. NA #6 stated Resident #69 said she had fallen earlier that day in the bathroom and that she had fallen on her knee. NA #6 reported she asked Resident #69 if she was by herself when she fell or if staff were helping her. Resident #69 told her two girls had been helping her in the bathroom, but she did know who they were. NA #6 said she went and reported what Resident #69 was saying to the day shift (7:00 am to 7:00 pm) Nursing Supervisor. She recalled the Nursing Supervisor said she did not know anything about Resident #69 falling and the Nursing Supervisor went to check on Resident #69. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A telephone interview was conducted with the day shift weekend Nursing Supervisor on 6/10/25 at 11:50 AM. The Nursing Supervisor stated a Nurse Aide (NA) came and got her around shift change on Saturday (6/7/25) around 7:30 PM and asked her to check on Resident #69. She reported the NA told her Resident #69 was saying she had fallen and was having pain in her right knee. She said she could not remember the name of the NA who came and got her. The Nursing Supervisor explained she went to Resident #69's room to assess her. She said she did not see anything abnormal when she looked at Resident #69's knee. She did not recall her having bruising or swelling to her knee. She said Resident #69 was in pain and said her knee was hurting when she saw her. She reported Resident #69's roommate was present in the room and provided translation for what Resident #69 said happened. The Nursing Supervisor said Resident #69 reported she had fallen about an hour prior while she was being assisted in the bathroom by staff. The Nursing Supervisor said she updated the night shift Nurse (Nurse #9) about what was going on and then went to find the day shift (Nurse #8). The Nursing Supervisor reported she asked Nurse #8 if Resident #69 had fallen during the shift and Nurse #8 reported she did not know anything about Resident #69 having a fall. The Nursing Supervisor further reported she asked Resident #69's assigned NA, NA #7 if Resident #69 had fallen. The Nursing Supervisor stated NA #7 told her Resident #69 had not fallen. She stated she went back to Nurse #8 and updated her on what Resident #69 was reporting and told her what she needed to do. The Nursing Supervisor said she explained to Nurse #8 what she needed to do for the fall and told her she needed to call the physician and the Director of Nursing (DON). The Nursing Supervisor stated she had also made the oncoming night shift nurse (Nurse #9) aware of what was going on and what Resident #69 had reported. The Nursing Supervisor stated she did not think Nurse #8 had called anyone or done anything for the fall because when she returned on Sunday there was no documentation to indicate anything had been done for Resident #69 or her reported fall. The Nursing Supervisor said she went to assess Resident #69 on Sunday (6/8/25) around 11:00 AM and that she was still hurting. She said she knew she was in pain because she was grimacing and holding her right leg. She stated when she looked at Resident #69's knee on Sunday there was swelling and bruising to the top of her knee. The Nursing Supervisor said she talked to Nurse #10, who was Resident #69's assigned nurse on Sunday day shift to ask him if he got anything in report about Resident #69 falling. She stated she could not remember if Nurse #10 had said yes or no. The Nursing Supervisor said she spoke to Resident #69's Family Member on the phone on Sunday. She said the Family Member reported Resident #69 told him she had fallen and was having pain. The Nursing Supervisor explained that she contacted the on-call provider on Sunday about Resident #69's pain and the fall she reported. She stated the on-call provider ordered an x-ray of Resident #69's right leg and as needed ibuprofen for pain. The Nursing Supervisor said she called the mobile x-ray company and placed an order for them to come to the facility to complete the x-ray. The Nursing Supervisor stated she called Resident #69's Family Member back and updated him on the new orders for Resident #69. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A telephone interview was conducted with Nurse #8 (agency nurse) on 6/10/25 at 1:49 PM. Nurse #8 stated she was the assigned nurse for Resident #69 on day shift on Saturday 6/7/25. She reported she had given shift report to the oncoming night shift nurse (Nurse #9) around 7:00 PM. Nurse #8 explained the day shift Nursing Supervisor came to her around 7:35 PM and told her Resident #69 was reporting she had fallen one hour ago. She stated no one had reported to her that Resident #69 had fallen during her shift. Nurse #8 said she went to Resident #69's room to check on her and that Resident #69 indicated she was in pain. Nurse #8 said she assessed Resident #69 by touching areas of her body like her arms and legs. She reported when she touched Resident #69's right leg she showed an expression of pain that was indicated by facial grimacing. She said Resident #69 did not cry or yell out and that the resident did not have any bruising or swelling to her right leg that she recalled. Nurse #8 said it was not a fall that was reported to her during her shift and that it was not reported until 7:35 PM. She explained she had already given report to the night shift nurse (Nurse #9). She reported after she assessed Resident #69 and noticed she was in pain, she communicated to Nurse # 9, what she had seen. Nurse #8 said she asked Nurse #9 to continue the assessment and to complete the post fall things. She stated she did not specifically tell Nurse #9 what she needed to do but said Nurse #9 should have known what to do. She reported Nurse #9 had said yes. Nurse #8 said she assumed Nurse #9 would contact the physician and complete the rest of the post fall documentation. Nurse #8 said she had not done any vital signs, documentation, or incident report related to Resident #69's reported fall. Nurse #8 said if she had done all those things she would have been at the facility another hour and that her agency would not pay her if she was there longer than her scheduled shift. She stated the Nursing Supervisor had not told her anything specific she needed to do related to the fall. A telephone interview was conducted with Nurse #9 on 6/10/25 at 2:15 PM. She reported she had been the assigned night shift nurse for Resident #69 on Saturday night 6/27/25. Nurse #9 recalled she had been in the middle of taking report from the off going day shift nurse (Nurse #8). She stated she was outside of Resident #69's room with Nurse #8 and could hear another nurse in the room talking to Resident #69 and her roommate. Nurse #8 stated she did not know who the nurse in the room was, but that she overheard the nurse asking how and when Resident #69 fell. She explained an NA, whose name she did not know, was also in the room and they were trying to figure out how Resident #69 had fallen. Nurse #9 reported she had thought since it had happened on the day shift that the day shift nurse (Nurse #8) was going to do the fall stuff because it was her shift. Nurse #9 said the nurse who had been in the room talking with Resident #69 about the fall had not told her to do anything. She recalled after Nurse #8 gave her report Nurse #8 had said she was going to step away to do charting. She stated Nurse #8 never came back to talk to her after giving report. Nurse #9 indicated Nurse #8 did not come back and to tell her she had assessed Resident #69 or asked her to do anything related to the fall, she said she never saw Nurse #8 again after report. A nursing note dated 6/8/25 at 1:30 PM by the Nursing Supervisor read: [family member] called about getting an x-ray and getting something for pain at the right knee for his mom. Resident stated she is having pain in her right knee. Nurse evaluated right knee. There was inflammation at site. This nurse spoke with the on call doctor to get an order for an x-ray, that order has been called in to mobile x-ray. Nurse on cart gave as needed (PRN) for pain. Will continue to follow up. An x-ray report dated 6/8/25 read: There are nondisplaced fractures of the proximal tibia and fibular neck. There are no bony lesions. Degenerative changes are noted. Diffuse osteopenia is noted. The soft tissues are unremarkable. Impression: Acute proximal lower leg fractures. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A telephone interview was conducted on 6/9/25 at 3:19 PM with Resident #69's Family Member. The Family Member stated they received a phone call from Resident #69 on Sunday (6/8/25). He said resident #69 was crying and said she was hurting. He reported Resident #69 said she had fallen the night before. The Family Member explained he called and spoke with the Nursing Supervisor on Sunday afternoon to ask about the fall, pain medication, and if an x-ray was going to be done. The Family Member said the Nursing Supervisor indicated she was just aware and that she was going to call the physician. He reported Resident #69 had told him a staff member had taken her to the bathroom on Saturday evening. She told him when they were transferring her off the toilet back to her wheelchair, the staff members had told her to hold onto the railing, and she lost her balance and fell onto the floor. The Family Member said Resident #69 could not speak English but that she was alert and oriented. The Family Member reported he had spoken with a provider at the facility earlier today (6/9/25) who let him know about the x-ray results. A telephone interview was conducted with the Nurse Practitioner (NP) #1 on 6/10/25 at 4:16 PM. NP #1 stated she was alerted by Nurse #4 on Monday morning (6/9/25) that she had received in report from night shift (7pm-7am) that Resident #69 had an acute fracture of her knee. NP #1 explained she had asked for the radiology report because it was not in Resident #69 chart, and nothing was documented in her chart about a fall or the injury. She said when she reviewed the x-ray of Resident #69's right leg it showed she had an acute fracture of her tibia and fibula. NP #1 explained she had spoken with Resident #69 this morning using an interpreter to provide translation because Resident #69 did not speak English. NP #1 said Resident #69 reported on Saturday night she was assisted by a NA to the bathroom, and she was attempting to hold onto the assist rail to get onto the toilet and felt weak. Resident #69 told her she missed the assist rail and had fallen onto her right knee and that she was in pain all Saturday night and Sunday morning. NP #1 said she had also spoken with Resident #69's Family Member who reported Resident #69 had called him Sunday and said she was in a lot of pain and had fallen. NP #1 explained this morning she had given orders for pain medication, non-weight bearing status and to try to immobilize her right leg. She stated she had also given an order to refer Resident #69 to the orthopedic walk-in clinic. NP #1 reported she had spoken to the orthopedic office this morning, and they had said they could cast Resident #69 in the office, so she did not have to go the emergency room (ER). NP #1 explained she had been notified around 2:30 PM by the facility that they did not feel they could immobilize Resident #69's leg for transport to the orthopedic office. She said the facility had asked for Resident #69 to go to the ER and she had agreed. NP #1 stated the therapy department at the facility had not felt comfortable splinting or touching Resident #69's leg due to the fractures and that was when she had made the decision to send her out. She explained she had spoken to the facility at 2:55 PM to confirm the ER transfer orders. NP #1 explained if Resident #69's leg was not splinted or immobilized there was a risk that the fractures could become more displaced. NP #1 further explained, a displaced fracture created more issues and was harder to treat. She reported that a non-displaced fracture is treated by keeping the leg immobilized to heal and that a displaced fracture would need surgical interventions to fix it. A hospital Discharge summary dated [DATE] indicated Resident #69 had a mechanical fall and was admitted to the hospital on [DATE] with a right nondisplaced proximal tibia and fibula fractures. The discharge summary stated orthopedics was consulted and felt her fractures were amenable to nonoperative management. Orthopedics recommended hinged knee brace with non-weight bearing status to the right lower extremity and close outpatient follow-up with orthopedic services in two weeks. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted with the Director of Nursing (DON), Regional Clinical Director, and Administrator on 6/12/25 at 4:00 PM. The Regional Clinical Director said she would have expected the staff to reach out to the DON and Administrator about what Resident #69 was reporting and the pain she was having because the staff did not know what had happened and should have asked for guidance on what they should have done. The Administrator agreed the staff should call the DON to ask for guidance about what the Resident was reporting. The Regional Clinical Director stated Resident #69 was officially interviewed on Monday 6/9/25 by NP #1 using an interpreter for a more formal interview. She stated Resident #69 had also been interviewed by staff on Saturday and Sunday about what had happened, and all her statements, including the reports from the hospital, had been that she had fallen in the bathroom. The Regional Clinical Director said because Resident #69 had been constant in her statements that she had fallen they had determined her injury was from a fall.

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and staff, resident, family, and Nurse Practitioner (NP) interviews, the facility failed to provide effective pain management for a resident who had acute pain after a reported fall on 6/27/25 (Saturday). Resident #69 spoke Spanish and reported through an interpreter two days after the fall that she fell on her right knee during an assisted transfer and had pain immediately which she rated at a pain scale of 9 (Pain scale of 0 is no pain and pain scale of 10 is the worst pain). Due to ineffective communication between staff a medical provider was not notified of fall or pain until 6/8/25 at which time ibuprofen (a nonsteroidal anti-inflammatory drug) was ordered for pain. There was no evidence staff utilized an interpreter to determine an accurate level of pain or the effectiveness of pain medication. The first documented administration of pain medication was on 6/8/25 at 3:52 PM when Resident #69 received ibuprofen for a pain level of 10 which was ineffective. There was no evidence a medical provider was contacted for additional pain medication. NP #1 was notified of the x-ray results on 6/9/25 and assessed Resident #69 and documented the Resident was in a lot of pain and crying. Through an interpreter Resident #69 told NP #1 she had fallen on Saturday and had been in pain all Saturday night and Sunday morning. NP #1 ordered an opioid pain medication to treat the pain for the acute fracture of her tibia and fibula. Resident #69 received the first dose of opioid pain medication on 6/9/25 at 9:34 AM for a pain level of 7 which was documented as effective. This deficient practice occurred for 1 of 1 resident reviewed for pain (Resident #69). Findings included: Resident # 69 was admitted to the facility on [DATE]. Her diagnoses included cerebral infarction (stroke) and hemiplegia (paralysis) affecting the dominant right side. The quarterly Minimum Data Set Assessment (MDS) dated [DATE] revealed Resident #69 was cognitively intact. The MDS documented that she was dependent on dressing, personal hygiene, toileting, and toilet transfers. The MDS indicated she required substantial/maximal assistance with sit to stand and chair to bed transfers. It was documented on the MDS Resident #69's preferred language was Spanish, and she needed an interpreter. The MDS documented Resident #69 did not have pain. Resident #69 did not have a care plan in place for pain. An observation and interview were conducted with Resident #69 on 6/9/24 at 10:52 AM. Resident #69 was observed in her room in her bed covered with a sheet. She was noted to be grimacing. Resident #69 was asked by the surveyor dolor (pain)? Resident #69 replied see (yes) mucho (a lot) and grabbed her right leg at the knee. Resident #69 proceeded to uncover her right leg. When she uncovered her right leg Resident #69 began grimacing, crying, and moaning. A pillow was observed under her lower right leg. There was light blue/ purple colored bruising along her right shin and to the top of her right knee. Her right lower leg and knee had visible swelling present. Resident #69 said pain was mucho, diez (a lot, 10). Resident #69's roommate was in the room who was also Spanish speaking. The roommate approached Resident #69's bed while the surveyor was in the room. The roommate translated that Resident #69 stated she had fallen on Saturday in bathroom and had a lot of pain in her leg. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0697 Level of Harm - Actual harm Residents Affected - Few	An additional interview was conducted with Resident #69 on 6/12/25 at 2:13 PM with Physical Therapy Assistant (PTA) #1 providing translation. Resident #69 reported she fell in the bathroom when staff were assisting her off the toilet. She said she fell onto her right knee and had pain immediately, she rated the pain as 9/10. Resident #69 reported after she fell her knee had hurt with any movement and when it was at rest. She said it had felt like her knee was constantly being torn apart. A telephone interview was conducted with NA #6 on 6/10/25 at 3:35 PM. NA #6 reported that she worked the night shift (7:00 pm to 7:00 am) on Saturday 6/7/25. She said at the start of her shift around 7:00 PM she was doing rounds and Resident #69's roommate was in the doorway of their room and asked her to come into the room. The roommate told her Resident #69 was having bad pain in her right knee. NA #6 recalled Resident #69 was in bed and she looked at Resident #69's right knee and the top of her kneecap was bruised. NA #6 explained that the roommate assisted with translating for Resident #69 and she asked what had happened. NA #6 stated Resident #69 said she had fallen earlier that day in the bathroom on her knee. She stated Resident #69 was asking for something for pain. NA #6 stated the night shift nurse (Nurse #9) was outside of the door when she was talking to Resident #69 and had heard the conversation. NA #6 stated Nurse #9 told her she did not get anything in report about Resident #69 falling. NA #6 said she went and reported what Resident #69 was saying to the day shift Nursing Supervisor. She recalled the Nursing Supervisor said she did not know anything about Resident #69 falling. She said the Nursing Supervisor went to check on Resident #69. She recalled Resident #69 had pain during the night and that she reported it to Nurse #9. NA #6 said she went to Resident #69's room around 6:15 AM Sunday (6/8/25) to provide incontinent care. She reported when she changed the position of the bed and laid it flat to provide care, Resident #69 started shaking and indicated her knee was hurting. NA #6 stated Resident #69 indicated her knee was hurting by grabbing her knee, grimacing, and crying out. NA #6 stated it was shift change and she reported Resident #69 having pain to Nurse #9 and told the nurse she needed something for pain. An interview was conducted on 6/10/25 at 2:15 PM with Nurse #9. Nurse #9 recalled she went to Resident #69's room to give her nighttime medications Saturday night (6/7/25). She did not recall the time. Nurse #9 explained she asked Resident #69 if she was hurting and she did not get a response from her. She explained Resident #69 spoke Spanish and Nurse #9 stated she was not sure if Resident #69 understood or not when she had asked her about pain. Nurse #9 stated Resident #69 was not grimacing or crying and did not have any indicators of pain. Nurse #9 reported she checked on Resident #69 several times during the night and every time she checked on her Resident #69 was asleep. Nurse #9 stated Resident #69 slept the entire shift up until shift change and no one reported her having pain during the shift. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	A telephone interview was conducted with the day shift (7:00 am to 7:00 pm) weekend Nursing Supervisor on 6/10/25 at 11:50 AM. The Nursing Supervisor stated a Nurse Aide (NA) came and got her around shift change on Saturday (6/7/25) around 7:30 PM and asked her to check on Resident #69. She reported the NA told her Resident #69 was saying she had fallen and was having pain in her right knee. She said she could not remember the name of the NA who came and got her. The Nursing Supervisor explained she went to Resident #69's room to assess her. She said Resident #69 was in pain and said her knee was hurting when she saw her. The Nursing Supervisor said she updated the night shift nurse (Nurse #9) what was going on and then went to find the day shift nurse (Nurse #8). The Nursing Supervisor reported she asked Nurse #8 if Resident #69 had fallen during the shift and Nurse #8 reported she did not know anything about Resident #69 having a fall. She stated she updated Nurse #8 on what Resident #69 was reporting and told her what she needed to do. The Nursing Supervisor said she told Nurse #8 she needed to call the physician and the Director of Nursing (DON). The Nursing Supervisor stated she had also made the oncoming night shift nurse (Nurse #9) aware of what was going on and what Resident #69 was reporting. The Nursing Supervisor stated when she returned on Sunday there was no documentation to indicate anything had been done for Resident #69. The Nursing Supervisor said she went to assess Resident #69 on Sunday around 11:00 AM and that she was still hurting. The Nursing Supervisor stated she knew Resident #69 was in pain because she was grimacing and holding her right leg. She stated when she looked at Resident #69's knee on Sunday there was swelling and bruising to the top of her knee. The Nursing Supervisor said she talked to Nurse #10, who was Resident #69's assigned nurse on Sunday day shift and asked him if he got anything in report about Resident #69 falling. She stated she could not remember if Nurse #10 had said yes or no. The Nursing Supervisor indicated she spoke to Resident #69's Family Member on the phone on Sunday. She said the Family Member reported Resident #69 told him she had fallen and was having pain. The Nursing Supervisor explained that she contacted the on-call provider on Sunday about Resident #69's pain and the fall she reported. She stated the on-call provider ordered an x-ray of Resident #69's right leg and as needed ibuprofen for pain. The Nursing Supervisor stated she called Resident #69's Family Member back and updated him on the new orders for Resident #69. Multiple attempts were made to speak with Nurse #10. He was unavailable to be interviewed. An interview was conducted with NA #7 on 6/10/25 at 10:46 AM. She was assigned NA for Resident #69 on day shift Saturday and Sunday. She stated Resident #69 did not complain of any pain or have any indicators of pain during her shift on Saturday (6/7/25). NA #7 reported when she returned on Sunday Resident #69 was having pain. She recalled checking on Resident #69 between 8:30 am and 9:00 am on Sunday and that Resident #69 was complaining of pain in her right knee/ leg. She said Resident #69 was grimacing and grabbing her knee. NA #7 stated she told Nurse #10 Resident #69 was having pain in her right leg/ knee. NA #7 recalled Nurse #10 saying he had already given Resident #69 her morning medications and there had been Tylenol in her morning medication and that he would be there in a second. NA #7 reported Nurse #10 did go and check on Resident #69 about 15-20 minutes later. NA #7 stated she went to provide incontinent care to Resident #69 around 10:00 AM and that she could tell her knee was still hurting because of her facial expressions, she said Resident #69 was grimacing and closing her eyes. NA #7 stated Resident #69 did not cry or yell out but that she could tell she was hurting. NA #7 stated she went and told Nurse #10 that Resident #69 was still hurting and that Nurse #10 said okay. NA #7 stated she provided incontinent care to Resident #69 again after lunch and she was still having pain. NA #7 indicated she did not notice a change in Resident #69's level of pain from earlier in the shift and felt like it was about the same. She recalled Resident #69 was grabbing her right leg and grimacing, she reported she told Nurse #10 again and that Nurse #10 told her he would go check on Resident #69 and was going to talk to the Nursing Supervisor. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Resident #69's June 2025 medication administration record (MAR) revealed an every shift pain assessment. On 6/7/25 Resident #69's pain was documented as a 0 by Nurse #9 for the evening shift and night shift. A telephone interview was conducted on 6/9/25 at 3:19 PM with Resident #69's Family Member. The Family Member stated they received a phone call from Resident #69 on Sunday (6/8/25). He said resident #69 was crying and said she was hurting. He reported Resident #69 said she had fallen the night before and could not sleep all night because she was in a lot of pain. The Family Member explained he called and spoke with the Nursing Supervisor on Sunday and asked about the fall, pain medication, and if an x-ray was going to be done. The Family Member said the Nursing Supervisor indicated she would call the physician. A nursing note dated 6/8/25 at 1:30 PM by the Nursing Supervisor read: [family member] called about getting an x-ray and getting something for pain at the right knee for [Resident #69]. Resident stated she is having pain in her right knee. Nurse evaluated right knee. There was inflammation at site. This nurse spoke with the on call doctor to get an order for an x-ray, that order has been called in to mobile x-ray. Nurse on cart gave as needed (PRN) for pain. Will continue to follow up. An every shift pain assessment on Resident #69's June 2025 MAR, completed by Nurse #10 documented a pain level of 10 for 6/8/25 day shift and a pain level of 0 for the evening shift. A pain level of 2 was documented for the night shift on 6/8/25 by Nurse #8. Review of Resident #69's June 2025 Medication Administration Record (MAR) revealed the following orders: - An order dated 6/2/25 that read: Acetaminophen 325 milligram (mg) give two tablets by mouth every eight hours as needed for pain for 14 days. There was no documentation of the medication being administered from 6/7/25 through 6/9/25. -An order dated 6/8/25 that read: Ibuprofen 600 mg give one tablet by mouth every six hours as needed for inflammation for 5 days. The MAR indicated the order had been entered at 2:25 PM. The MAR documented the medication as administered by Nurse #10 on 6/8/25 at 3:52 PM for a pain level of 10. The MAR further documented the medication was ineffective. The MAR documented the medication was administered again on 6/8/25 at 11:34 PM by Nurse #3 for a pain level of 6 and that the medication was effective. An x-ray report dated 6/8/25 read: There are nondisplaced fractures of the proximal tibia and fibular neck. There are no bony lesions. Degenerative changes are noted. Diffuse osteopenia is noted. The soft tissues are unremarkable. Impression: Acute proximal lower leg fractures. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	A telephone interview was conducted with Nurse #3 on 6/12/25 at 6:25 AM. She stated she was Resident #69's assigned nurse on Sunday (6/8/25) during night shift . Nurse #3 said she received in report from the day shift nurse, Nurse #10 that Resident #69 had a fractured knee, and she had a new order for PRN pain medication had been put in for her. It was reported to her by Nurse #10 that Resident #69 had pain earlier during his shift and he had given her pain medication. Nurse #3 recalled Resident #69's roommate came and got her during the night and let her know Resident #69 was having pain. She did not remember the time. Nurse #3 said she checked on Resident #69 and observed her having pain. Resident #69 was pointing at her right leg and she could tell she was having pain by her facial expression. Nurse #3 said she gave Resident #69 the PRN ibuprofen. Nurse #3 reported she went back and checked on Resident #69 again about an hour later and she was asleep. Nurse #3 reported she went back to Resident #69's room to administer early morning medications to her roommate and Resident #69 was still asleep. Nurse #3 said she reported to the oncoming dayshift nurse (Nurse #4) Monday morning, what was going on with Resident #69, that she had a fracture, and what Resident #69 had listed PRN for pain. An interview was conducted with Nurse #4 on 6/9/25 at 11:01 AM. Nurse #4 stated she spoke with NP #1 this morning about Resident #69's fracture and pain. She stated NP #1 ordered PRN hydrocodone/ acetaminophen (pain medication) 5/325 mg for Resident #69. Nurse #4 reported she administered the pain medication this morning around 9:30 AM to Resident #69. A pain level of 7 was documented by Nurse #4 on Resident #69's June 2025 MAR every shift pain assessment for 6/9/25 day shift. An active order dated 6/9/25 entered at 9:00 AM was present on Resident #69's June 2025 MAR that read: hydrocodone-acetaminophen (pain medication) oral tablet 5-325 mg, every 8 hours as needed for right leg fracture for 7 days. The MAR documented the medication was administered at 9:34 AM by Nurse #4 for a pain level of 7. The MAR documented the medication as being effective. An interview was conducted with NP #1 on 6/10/25 at 4:16 PM. NP #1 reported she had seen Resident #69 on Monday morning (6/9/25) and had used an interpreter during the visit to translate what was being said. She stated Resident #69 reported she had fallen on Saturday. NP #1 explained she had reviewed the x-ray results of Resident #69 right leg this morning and she had an acute fracture of her tibia and fibula. NP #1 said Resident #69 told her she was in pain when she saw her this morning. She further stated Resident #69 told her she had been in pain all Saturday night and Sunday morning. NP #1 reported Resident #69 was in a lot of pain and crying when she saw her this morning. She stated she ordered the hydrocodone PRN every eight hours for Resident #69 this morning and Nurse #4 had given her a dose. NP #1 stated she told the staff to call her if every eight hours was not enough and she would adjust the frequency so Resident #69 could have pain medication every 4 or 6 hours. NP #1 did not think PRN ibuprofen was enough to treat pain from a fracture. She explained Nurse #4 called her around 3:03 PM asking for more pain medication for Resident #69 but NP #1 said she had just spoken to someone at the facility a few minutes before Nurse #4 called confirming orders to send Resident #69 to the emergency room (ER) for evaluation. An interview was conducted with the Director of Nursing (DON), The Regional Clinical Director, and the Administrator on 6/12/25 at 4:00 PM. They said if someone was having that much pain, they would expect the staff to call the provider about her pain. .

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and staff interviews, the facility failed to assess the risks of entrapment and complete bed rail assessments and failed to obtain informed consent prior to the installation for 2 of 3 residents reviewed for bed rails (Resident #4 and Resident #76). Findings Included: 1. Resident #4 was admitted to the facility 01/21/25 with diagnoses including dementia and Parkinson's disease (a brain disorder that can cause uncontrollable movements). A review of Resident #4's electronic medical records revealed no bed rail assessments had been completed since admission to the facility on [DATE]. The significant change in status Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #4 was rarely or never understood, and her cognition was severely impaired. The MDS indicated Resident #4's range of motion was impaired on both sides of the upper and lower extremities, and she was dependent on staff assistance to roll left and right. The MDS revealed Resident #4's ability to move from lying to sitting on the side of the bed was not attempted due to medical or safety concerns and bed rails were not used as a physical restraint. An active physician's order revealed a pressure-reduced mattress was ordered on 4/23/25. During an observation on 06/12/25 at 2:28 PM, Resident #4 was resting in bed. Bilateral quarter length bed rails located at the head of bed were in an up position. Resident #4 was being repositioned by Nurse Aide (NA) #3 and was able to follow cues to grab and hold on to the bed rails with assistance to roll left and right. An air mattress was in place and inflated. There was no space between the air mattress and bed rails and the rails were secured to the bed frame. During an interview on 06/12/25 at 2:28 PM, NA #3 revealed Resident #4 required one person assistance to roll from left to right for bed mobility. NA #3 revealed Resident #4 was able to understand simple cues to grab and hold on to the bed rail, but she was unsure the resident could physically use the bed rail without assistance. An interview was conducted on 06/13/25 at 1:12 PM with Nurse #2, the assigned nurse for Resident #4. Nurse #2 revealed Resident #4 required staff assistance to move side to side in the bed. Nurse #2 revealed bed rail assessments were included as part of the nurse's packet and completed upon admission and if used completed quarterly. Nurse #2 revealed Resident #4's cognition was impaired and for a resident cognitively impaired the Responsible Party would need to give consent for the use of bed rails. Attempt to interview Resident #4's Responsible Party on 06/13/25 at 9:55 AM was unsuccessful. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 06/12/25 at 11:15 AM with the Rehab Therapy Director. The Rehab Therapy Director revealed a resident with poor cognition was at risk for entrapment or injury and not a good candidate for the use of bed rails and needed to be evaluated based on individual needs and/or case by case. She further revealed if a resident's cognition was impaired and they were unable to consent for the use of bed rails the Responsible Party would need to give consent. She revealed therapy did complete bed rails assessments when nursing requested and she thought nursing completed ongoing bed rail assessments. She revealed she was new to the facility since 04/2025 and it was discussed there was a need to implement a process for bed rail assessments and therapy would complete assessments, but she had not heard anything else about the process since last discussed on 05/13/25. During an interview on 06/13/25 at 12:55 PM, the Director of Nursing (DON) revealed she was aware bed rail assessments were not completed. She revealed the completion of bed rail assessments was a collective effort that included therapy and nursing and were done as needed and when a request was made. A joint interview was conducted on 06/13/25 at 2:55 PM with the Administrator and Regional Clinical Director of Operations. The Regional Clinical Director of Operations revealed bed rail assessments should be completed prior to the bed rails being placed on the bed and then quarterly. The Regional Clinical Director of Operations revealed Resident #4's bed rail assessment would need to be completed by therapy and discussed with nursing. She further revealed that maintenance should inspect bed rails properly fit and were secured to the bed and ensure there was no space between the mattress and bed rails for a resident to become entrapped including when the air mattress was newly placed. The Administrator confirmed bed rails assessments should be completed prior to being placed on the bed, upon admission, and quarterly. 2. Resident #76 was admitted to the facility on [DATE] with diagnoses including non-displaced fracture of the right humerus and osteoporosis. A review of Resident #76's electronic medical records revealed she was her own Responsible Party. A review of Resident #76's electronic medical records revealed no bed rail assessments had been completed since admission to the facility on [DATE]. The admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #76 was rarely or never understood, and her cognition was moderately impaired. The MDS indicated Resident #76's range of motion was impaired on one side of her upper extremity and substantial to maximal assistance was needed to roll left to right and move from a lying to sitting on the side of the bed. The MDS revealed Resident #76 was able to walk 150 feet with supervision and bed rails were not used as a physical restraint. During an observation on 06/10/25 at 12:22 PM, Resident #76 was sitting upright in bed eating lunch with the head of the bed raised approximately 90 degrees. Quarter length bilateral bed rails located at the head of bed were in the up position. The bed rails were secured to the bed frame and there was no space between the mattress or rails. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 06/11/25 at 10:20 AM, Resident #76 walked around in her room and was able to stand from a sitting position off the side of the bed adlib (as desired) without assistance. Bilateral quarter bed rails were in the up position and Resident #76 did not use the rails when she stood up from the bed. Resident #76 did not verbally respond to questions and did not confirm she used the bed rails for mobility. The bed rails were secured to the bed frame and there was no space between the mattress or rails. During an interview on 06/13/25 at 2:29 PM, NA #3 revealed Resident #76 was able to roll left and right, stand up from the bed and walk adlib without staff assistance. An interview was conducted on 06/13/25 at 1:12 PM with Nurse #2, the assigned nurse for Resident #76. Nurse #2 revealed Resident #76 was able to roll left and right in bed and use the bed rails for mobility and walked about the facility without assistance. Nurse #2 revealed bed rail assessments were included as part of the nurse's packet and completed upon admission and if used completed quarterly. Nurse #2 revealed Resident #76's cognition was impaired and for a resident cognitively impaired the Responsible Party would need to give consent for the use of bed rails. An interview was conducted on 06/12/25 at 11:15 AM with the Rehab Therapy Director. The Rehab Therapy Director revealed a resident with poor cognition was at risk for entrapment or injury and not a good candidate for the use of bed rails and needed to be evaluated based on individual needs and/or case by case. She further revealed if a resident's cognition was impaired and they were unable to consent for the use of bed rails the Responsible Party would need to give consent. She revealed therapy did complete bed rails assessments when nursing requested and she thought nursing completed ongoing bed rail assessments. She revealed she was new to the facility since 04/2025 and it was discussed there was a need to implement a process for bed rail assessments and therapy would complete assessments, but she had not heard anything else about the process since it was discussed on 05/13/25. During an interview on 06/13/25 at 12:55 PM, the Director of Nursing (DON) revealed she was aware bed rail assessments were not completed. She revealed the completion of bed rail assessments was a collective effort that included therapy and nursing and were done as needed and when a request was made. A joint interview was conducted on 06/13/25 at 2:55 PM with the Administrator and Regional Clinical Director of Operations. The Regional Clinical Director of Operations revealed bed rail assessments should be completed prior to the bed rail being placed on the bed and then quarterly. She further revealed that maintenance should be inspecting bed rails properly fit and were secured to the bed to ensure there was no space between the mattress and bed rails for a resident to become entrapped. The Administrator confirmed bed rails assessments should be completed prior to being placed on the bed, upon admission, and quarterly.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and staff, resident, family, and Nurse Practitioner interviews, the facility failed to provide ongoing, consistent, effective means of communication for a resident (Resident #69) to be able to communicate. Resident #69's primary language was Spanish, and she did not speak English. This deficient practice occurred for 1 of 1 resident reviewed for medically related social services. Findings included: Resident #69 was admitted to the facility on [DATE]. Her diagnoses included cerebral infarction (stroke) and hemiplegia (paralysis) affecting the dominant right side. The quarterly Minimum Data Set Assessment (MDS) dated [DATE] revealed Resident #69 was cognitively intact. It was documented on the MDS Resident #69's preferred language was Spanish, and she needed an interpreter. A care plan dated 1/12/25 read: Resident #69 has a communication problem related to language barrier; resident speaks Spanish language. The care plan goal was for her to be able to make basic needs known. The care plan interventions included anticipating and meeting needs. To be conscious of position when in groups, activities, dining room to promote proper communication with others. Discuss with resident/ family concerns or feelings regarding communication difficulty. encourage resident to continue stating thoughts even if resident is having difficulty, focus on a word or phrase that makes sense, or respond to the feeling she is trying to express. Ensure/ provide a safe environment. Monitor/ record confounding problems. Monitor/ document physical/ nonverbal indicators of discomfort or distress, and follow-up as needed. Monitor/ document frustration level, wait 30 seconds before providing resident with word. Monitor/ document resident ability to express and comprehend language, speak on an adult level speaking clearly and slower than normal. An observation and interview were conducted with Resident #69 on 6/9/24 at 10:52 AM. Resident #69 was observed in her room in her bed covered with a sheet. She was noted to be grimacing. When the surveyor spoke to Resident #69, she started speaking in Spanish. The Surveyor asked Resident #69 habals ingles (you speak English)? and Resident #69 replied no. The roommate approached Resident #69's bed while the surveyor was in the room and translated what Resident #69 was saying. An additional interview was conducted on 6/12/25 at 2:13 PM with Physical Therapy Assistant (PTA) #1 providing translation. Resident #69 reported staff not being able to understand her and her not being able to let them know what she needs makes her feel very bad. When asked if she understood staff when they came to provide care, Resident #69 said no not really. Resident #69 reported that her roommate was the only one who helped her communicate and that sometimes her roommate got upset because she got asked too much. Resident #69 stated staff did not try to communicate with her using their phones to translate. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Bend Health and Rehabilitation	213 Richmond Hill Drive Asheville, NC 28806

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with Nurse #4 on 6/9/25 at 11:01 AM. Nurse #4 stated Resident #69's roommate could speak English and Spanish and usually could interpret what Resident #69 needed. She stated the roommate would ring the bell if Resident #69 needed something and told staff what she needed. Nurse #4 reported sometimes there were NAs (Nurse Aides) who could speak Spanish and that one of the therapists knew Spanish. Nurse #4 said if no one was around that spoke Spanish then she looked for non-verbal cues such as facial grimacing for pain. She said sometimes Resident #69 would use gestures and point at her mouth if she was hungry. Nurse #4 said there was an app on her phone for translation but that she had never used it. An interview was conducted with NA #8 on 6/10/25 at 10:21 AM. NA #8 said she had cared for Resident #69 and reported she understood a little Spanish and could understand a little bit of what Resident #69 said. She said it depended on what Resident #69 was talking about whether she could understand her or not. NA #8 explained if she did not understand Resident #69, she would ask her roommate. She said her roommate was usually in the room. NA #8 said if the roommate was not in the room she would try to use google translate. NA #8 stated the facility had not told her how or what to do to communicate with Resident #69. An interview was conducted with NA #7 on 6/10/25 at 10:46 AM. She was assigned NA for Resident #69 on day shift (7:00 am to 7:00 pm) on Saturday (6/7/25) and Sunday (6/8/25). NA #7 stated she spoke very little Spanish. She explained Resident #69's roommate also spoke Spanish and could speak English as well. She said Resident #69's roommate rang the bell if Resident #69 needed something and lets the staff know what Resident #69 needs. NA #7 reported she communicated with Resident #69 by using gestures to indicate the type of care she was going to provide. NA #7 said she has a translation app on her phone that she used to communicate with Resident #69 sometimes. She explained that if Resident #69's roommate was in the room she used her to communicate, but if she was not in the room, she would use the app. The Surveyor asked if Resident #69's roommate was reliable to provide translation, NA #7 replied that she had dementia and said she gets confused sometimes. A telephone interview was conducted with the day shift weekend Nursing Supervisor on 6/10/25 at 11:50 AM. The Nursing Supervisor stated she used Resident #69's roommate to communicate with Resident #69. She reported the facility had not provided her with information or told her of any translation services that she should be used to communicate with individuals who did not speak English. An interview was conducted on 6/10/25 at 1:49 PM with Nurse #8. Nurse #8 said she had worked day shift on 6/7/25 and had been the assigned nurse for Resident #69. She explained Resident #69 spoke Spanish and did not speak English. Nurse #8 reported she had not been told how to communicate with Resident #69 and she stated she had used gestures to communicate with Resident #69. An interview was conducted on 6/10/25 at 2:15 PM with Nurse #9. She explained she worked night shift (7:00 pm to 7:00 pm) Saturday 6/7/25 and had been Resident #69's assigned nurse. She explained Resident #69 spoke Spanish and did not understand English. Nurse #9 reported no one had told her how to communicate with Resident #69. A telephone interview was conducted with NA #6 on 6/10/25 at 3:35 PM. NA #6 reported Resident #69 spoke very few English words and that her roommate translated for her a lot. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with Nurse #3 on 6/12/25 at 6:25 AM. She stated she was Resident #69's assigned nurse on Sunday during night shift. Nurse #3 said she tried to use the app on her phone to communicate with Resident #69, but it was hard to use it for communication. Nurse #3 reported the facility had not told her how to communicate with Resident #69. Nurse #3 reported she used what she had so she could communicate as much as possible with Resident #69 but that she had not gotten anything specific from the facility on what to use to communicate with her. An interview was conducted with NP #1 on 6/10/25 at 4:16 PM. NP #1 reported she used an interpreter service to translate when she saw Resident #69. She reported she was familiar with Resident #69's roommate. NP #1 reported the roommate was not a reliable interpreter for staff to be using and the roommate was not medical. NP #1 stated staff should be using a translator service to communicate with Resident #69. NP #1 explained when she saw Resident #69 this morning, she had said no one had spoken to her in Spanish and she had asked the Administrator about it. She reported Resident #69 had been asking for pain medication and for staff to elevate her leg and that staff did not understand. NP #1 stated the Administrator had told her the facility had a translator service, but NP #1 stated she had never seen anyone use it. An interview was conducted with the Social Worker (SW) on 6/11/25 at 10:25 AM. The SW reported he was not sure who would set up translation services or what services staff were supposed to use to communicate with non-English speaking residents. He said he was not sure but would find out. The SW indicated he personally did not know how staff communicated with Resident #69 or what was supposed to be in place for communication for her but that he would find out. The SW stated Resident #69's roommate was Spanish speaking but was stronger with Spanish than English communicating. The SW reporter said Resident #69 roommate did have a diagnosis of dementia and that he did not know if she would be reliable for translation. The SW stated when he had done Resident #69's assessments he had used her family member to translate. The SW explained he had not been told by the facility about any translation services that should be used. He said there should be a defined way for staff to communicate with Resident #69 and was not really sure why there was not. An interview was conducted with the Director of Nursing (DON), The Regional Clinical Director, and the Administrator on 6/12/25 at 4:00 PM. They acknowledged there should be translation services in place to communicate with Resident #69. The Regional Clinical Director stated there was nothing in place but that it was in the process of getting set up now. The Regional Clinical Director stated they had started working on that this week.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews with the staff and the Nurse Practitioner (NP), the facility failed to have effective systems in place for acquiring a scheduled opioid pain medication when nursing staff failed to request a prescription from the medical provider to avoid a gap in medication administration when refilling a controlled medication, and failed to utilize pharmaceutical resources in Pyxis (an automated dispensing machine that provided secure medication storage) which resulted in Resident #139 missing 3 days of a scheduled pain medication. This deficient practice occurred for 1 of 8 residents reviewed for pharmacy services (Resident #139). The findings included: Resident #139 was admitted to the facility on [DATE] with diagnoses including osteoporosis. She expired in the facility on [DATE]. The physician's order dated [DATE] revealed Resident #139 had an order to receive 1 tablet of tramadol (an opioid pain medication used to treat moderate to severe pain) 50 milligrams (mg) by mouth once daily in the evening for generalized pain. The [DATE] Medication Administration Record (MAR) revealed the last tablet of Resident #139's tramadol was administered by Nurse #5 on [DATE] around 5:00 PM. Resident #139 did not receive her scheduled daily tramadol from [DATE] to [DATE] as it was initialed by Nurse #6 with a 9 on the MAR which coded as see progress notes on [DATE]; and initialed by Nurse #2 with a 9 again on [DATE] and [DATE]. A review of Resident #139's medical records revealed no progress notes were documented on [DATE]. A review of nurse's progress note documented by Nurse #2 on [DATE] revealed Nurse #2 had initiated the refilling process and was waiting for the NP to sign the prescription for Resident #139's tramadol. On [DATE] at 6:25 PM, Nurse #2 documented she called the pharmacy to follow up with the status of Resident #139's tramadol. She was told by the pharmacy staff that Resident #139's tramadol would be delivered on the next run, and it would arrive around midnight. A review of Pyxis records and inventory list for [DATE] revealed 250 different medications were kept in the Pyxis for emergency uses. Further review of the Pyxis Inventory Replenishment Report dated [DATE] revealed the facility had 13 tablets of tramadol 50 mg in the Pyxis. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview conducted on [DATE] at 10:47 AM, Nurse #2 acknowledged that she provided care for Resident #139 on [DATE] and [DATE] on the first shift from 7:00 AM to 7:00 PM and confirmed Resident #139 did not receive her scheduled daily tramadol from [DATE] to [DATE]. She recalled when she tried to administer tramadol for Resident #139 on [DATE] around 5:00 PM, she found that the last tablet was administered by Nurse #5 on [DATE]. Nurse #2 stated she initiated the refilling process through the pharmacy immediately that evening and had the whole process set up except needing the NP's signature. Then, she checked Pyxis for a tablet of tramadol for Resident #139 and unfortunately, she had issues logging in to Pyxis as she had not logged in for a while. She requested 2 other nurses working on the same shift to assist and log in to Pyxis, but they were unsuccessful. Nurse #2 acknowledged that she did not notify the Director of Nursing (DON) about the issue related to Pyxis. Nurse #2 stated she communicated with the oncoming nurse (Nurse #7) regarding the incident during shift transition. Before she started passing the evening medication around 4:00 PM on [DATE], Nurse #2 found out that the pharmacy had not delivered Resident #139's tramadol. She called the pharmacy again at 4:30 PM and was told that the pharmacy had received the prescription, and Resident #139's tramadol would be delivered on the next run arriving around midnight. She indicated Nurse #5 who had administered the last tablet of Resident #139's tramadol on [DATE] should have requested the prescription for the scheduled tramadol. Nurse #2 indicated she was shocked to learn that Nurse #6 who worked on the first shift from 7:00 AM to 7:00 PM on [DATE], did not request the prescription for Resident #139's tramadol when it had run out. Otherwise, Resident #139 would not have to be out of the scheduled tramadol for 3 days in a row. Nurse #2 explained she did not try to fill the prescription through the local back-up pharmacy on [DATE] as the pharmacy told her that they were on the way to deliver the ordered tramadol. A phone interview was attempted with Nurse #5 on [DATE] at 12:30 PM. Nurse #5 worked first shift on [DATE] and administered the last tablet of tramadol for Resident #139. Nurse #5 stated she was busy when she answered the call and requested the Surveyor to call back at 8:00 PM in the evening. When the Surveyor called again on [DATE] at 8:00 PM, Nurse #5 did not answer the call, and a voice message was left. Nurse #5 did not return the call. During a phone interview conducted on [DATE] at 12:36 PM, Nurse #6 who worked on first shift on [DATE] stated he could not remember the incident related to Resident #139's tramadol that ran out in [DATE] and unable to provide any pertinent information as he was an agency nurse. He recalled picking up a few shifts in the facility early [DATE]. During an interview conducted on [DATE] at 12:55 PM, the NP stated the missing of Resident #139's once daily scheduled tramadol for 3 days in a row could have been avoided if the staff had a sense of urgency to request a prescription for the scheduled tramadol at least 7 days before it ran out. The NP further stated she expected nursing staff to fully utilize the pharmaceutical resources in Pyxis, or the local back-up pharmacy as needed as indicated. It was her expectation for all the nurses to start the refilling process earlier to avoid any gaps in medication administration. An interview was conducted with the DON on [DATE] at 10:12 AM. She stated all the nurses should start the refilling process at least 5-7 days before the last pill was used up to avoid gaps in medication administration, especially for those controlled medications that could take a longer time. She stated the pharmacy delivered 2 times daily at 4:00 PM and mid-night. The root cause of this incident was lack of a sense of urgency among nursing staff. It was her expectation for all the residents to receive their medications as ordered in a timely manner. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview conducted on [DATE] at 1:11 PM, the Administrator expected all the nurses to have a sense of urgency to start the refilling process at least 5-7 days before the medication ran out to ensure continuous supply of medication as needed as indicated. She indicated the incident was caused by multiple factors. She expected nursing staff to fully utilize the resources in Pyxis and the local back-up pharmacy as needed to meet the pharmaceutical needs of the residents.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews with the staff and the Nurse Practitioner (NP), the facility failed to prevent a significant medication error when nursing staff failed to administer tramadol (opioid pain medication) to Resident #139 for three consecutive days. This deficient practice occurred for 1 of 9 residents reviewed for significant medication errors (Resident #139). The findings included: Resident #139 was admitted to the facility on [DATE] with diagnoses including osteoporosis. She expired in the facility on [DATE]. The quarterly Minimum Data Set (MDS) dated [DATE] coded Resident #139 with severely impaired cognition. She had adequate vision and hearing with clear speech. The MDS indicated Resident #139 received both scheduled and as needed pain medications including opioid during the 7-day review period. The care plan for pain initiated on [DATE] revealed Resident #139 was at risk of pain. The goals were to remain free of interruptions in normal activities due to pain through the review date. Interventions included administering analgesia (pain relievers) as ordered by the physician and notifying the physician if interventions were unsuccessful. The physician's order dated [DATE] revealed Resident #139 had an order to receive 1 tablet of tramadol (used to treat moderate to severe pain) 50 milligrams (mg) by mouth once daily in the evening for generalized pain. On [DATE], the physician initiated an order for Resident #139 to receive 2 tablets of Acetaminophen (Tylenol) 325 mg by mouth once every 8 hours as needed (PRN) for pain. The [DATE] Medication Administration Record (MAR) revealed the last tablet of Resident #139's tramadol was administered by Nurse #5 on [DATE] around 5:00 PM. Resident #139 did not receive her scheduled daily tramadol from [DATE] to [DATE] as it was initialed by Nurse #6 with a 9 on the MAR which coded as see progress notes on [DATE]; and initialed by Nurse #2 with a 9 again on [DATE] and [DATE]. Further review of the [DATE] MAR revealed when Resident #139 was out of tramadol from [DATE] through [DATE], the MAR indicated she had received 2 PRN Tylenol 325 mg tablets on [DATE] in the evening. The MAR documented Resident #139 with a pain scale of 0 out of 10 on [DATE], 2 out of 10 on [DATE], and 0 out of 10 on [DATE]. (Pain scale of 0 means no pain and a pain scale of 10 is the worst pain). A review of Resident #139's medical records revealed no progress notes were documented on [DATE]. A review of nurse's progress notes documented by Nurse #2 on [DATE] revealed Resident #139 had received 2 Tylenol 325 mg tablet on [DATE] at 6:09 PM. Nurse #2 documented that she had initiated the refilling process and was waiting for the NP to sign the prescription for Resident #139's tramadol. On [DATE] at 11:39 PM, Nurse #7 followed up with the PRN Tylenol and documented it was effective with the pain scale of 0 out of 10. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 6:25 PM Nurse #2 documented she called the pharmacy to follow up with the status of Resident #139's tramadol. She was told by the pharmacy staff that Resident #139's tramadol would be delivered on the next run, and it would arrive around midnight. A review of Pyxis records and inventory list for [DATE] revealed 250 different medications were kept in the Pyxis for emergency uses. Further review of the Pyxis Inventory Replenishment Report dated [DATE] revealed the facility had 13 tablets of tramadol 50 mg in the Pyxis. During an interview conducted on [DATE] at 10:47 AM, Nurse #2 acknowledged that she provided care for Resident #139 on [DATE] and [DATE] on the first shift from 7:00 AM to 7:00 PM and confirmed Resident #139 did not receive her scheduled daily tramadol from [DATE] to [DATE]. She recalled when she tried to administer tramadol for Resident #139 on [DATE] around 5:00 PM, she found that the last tablet was administered by Nurse #5 on [DATE]. Nurse #2 stated she initiated the refilling process through the pharmacy immediately that evening and had the whole process set up except needing the NP's signature. She updated Resident #139 about what had happened and asked her if she had any pain. Initially, Resident #139 stated she was fine. However, when she rechecked Resident #139 about one hour later, Resident #139 stated she had a pain scale of 2 out of 10 and would like to have some pain medication. She offered Resident #139's the PRN Tylenol, and it was accepted by Resident #139 and administered. After she administered the Tylenol, she continued to monitor, and Resident #139 did not show any physical signs of pain or voice pain that needed more pain medication. When she checked Resident #139 before leaving on [DATE] at 7:00 PM, Resident #139 was lying in the bed relaxed without any complaint of pain. She communicated with the oncoming nurse (Nurse #7) regarding the incident during shift transition. Before she started passing the evening medication around 4:00 PM on [DATE], Nurse #2 found out that the pharmacy had not delivered Resident #139's tramadol. She called the pharmacy again at 4:30 PM and was told that the pharmacy had received the prescription, and Resident #139's tramadol would be delivered on the next run arriving around midnight. A phone interview was attempted with Nurse #5 on [DATE] at 12:30 PM. Nurse #5 worked first shift on [DATE] and administered the last tablet of tramadol for Resident #139. Nurse #5 stated she was busy when she answered the call and requested the Surveyor to call back at 8:00 PM in the evening. When the Surveyor called again on [DATE] at 8:00 PM, Nurse #5 did not answer the call, and a voice message was left. Nurse #5 did not return the call. During a phone interview conducted on [DATE] at 12:36 PM, Nurse #6 who worked on first shift on [DATE] stated he could not remember the incident related to Resident #139's tramadol that ran out in [DATE] and unable to provide any pertinent information as he was an agency nurse. He recalled picking up a few shifts in the facility early [DATE]. During an interview conducted on [DATE] at 12:55 PM, the NP stated missing the once daily scheduled tramadol for 3 days in a row was a significant medication error and pointed out that the incident could have been avoided. She recalled she was notified of the error on [DATE] and assessed Resident #139 who denied having any pain. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the Director of Nursing (DON) on [DATE] at 10:12 AM. The DON stated all the nurses should start the refilling process at least 5-7 days before the last pill was used up to avoid gaps in medication administration, especially for those controlled medications that could take a longer time. She denied the incident was a significant medication error as Resident #139 did not suffer any pain. It was her expectation for all the residents to receive their medications as ordered in a timely manner. During an interview conducted on [DATE] at 1:11 PM, the Administrator stated Resident #139 did not suffer any pain and was unsure whether this incident should be coded as a significant medication error.

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F 0777 Level of Harm - Actual harm Residents Affected - Few	Provide or obtain x-rays/tests when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and staff, resident, family, Physician, Medical Director, and Nurse Practitioner interviews, the facility failed to notify the Physician of radiology results for a resident who was experiencing acute pain after a reported fall on 6/7/25. Due to ineffective communication between staff x-ray results reported on 6/8/25 were not communicated to a medical provider until 6/9/25 which delayed medical interventions and an evaluation in the emergency department. Resident #69 sustained an acute proximal tibia and fibula fracture (breaks in the upper part of the shinbone (tibia) and the smaller bone of the lower leg (fibula) from the reported fall and required a two day hospitalization. Orthopedics recommended hinged knee brace with non-weight bearing status to the right lower extremity. This deficient practice occurred for 1 of 3 residents reviewed for notification of radiology results (Resident #69). Findings included: An interview was conducted on 6/12/25 at 2:13 PM with Resident #69. PTA #1 provided translation. Resident #69 stated she fell on Saturday (6/7/25) in the bathroom. She explained she fell onto her right knee and felt pain immediately. Resident #69 stated her right knee, and leg has been hurting the entire time since she fell. She said it had felt like her knee was constantly getting torn apart. Resident #69 said her knee had hurt really bad when they moved her and when she was at rest and her leg was not being moved. A telephone interview was conducted with the day shift (7:00 am to 7:00 pm) weekend Nursing Supervisor on 6/10/25 at 11:50 AM. The Nursing Supervisor stated Saturday 6/7/25 around 7:35 PM Resident #69 was in pain and said her knee was hurting. The Nursing Supervisor said Resident #69 reported she had fallen about an hour prior while she was being assisted in the bathroom by staff. The Nursing Supervisor said she went back to assess Resident #69 on Sunday around 11:00 AM and that she was still hurting. The Nursing Supervisor explained that she contacted the on-call provider on Sunday about Resident #69's pain and the fall she reported. She stated the on-call provider ordered an x-ray of Resident #69's right leg. The Nursing Supervisor said she called the mobile x-ray company and placed an order for them to come to the facility to complete the x-ray. The Nursing Supervisor could not remember what time the mobile x-ray came to the facility to complete the x-ray but stated it was sometime in the afternoon after lunch. The Nursing Supervisor reported the x-ray results came back before she left at the end of her shift. She did not remember what time the x-ray results had come back. The Nursing Supervisor stated she did not call the x-ray results to the physician. The Nursing Supervisor explained she told Nurse #10 the x-ray results and wrote the Physician's number down and gave it to him. The Nursing Supervisor stated she had also told the oncoming night shift (7:00 pm to 7:00 am) nurse (Nurse #3) the results. She said she had not told Nurse #10 or Nurse #3 to call the Physician to report the x-ray results. Nurse #10 was unavailable for interview. (continued on next page)

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F 0777 Level of Harm - Actual harm Residents Affected - Few	An x-ray report dated 6/8/25 read: There are nondisplaced fractures of the proximal tibia and fibular neck. There are no bony lesions. Degenerative changes are noted. Diffuse osteopenia is noted. The soft tissues are unremarkable. Impression: Acute proximal lower leg fractures. At the bottom of the x-ray report a statement read: the report has been successfully faxed, emailed, delivered and/or viewed by the client at [facility] at 2025-06-08 20:02:20 (8:20 PM) central time. Receipt of report was confirmed and read back was given. An interview was conducted with Nurse #3 on 6/12/25 at 6:25 AM. She was the assigned night shift nurse on Sunday 6/8/25 for Resident #69. Nurse #3 reported she received in report from Nurse #10 that Resident #69 had a fractured knee. She also spoke with the day shift Nursing Supervisor who told her they had gotten the x-ray back and knew Resident #69 had a fracture. Nurse #3 stated she knew the day shift nurses had spoken with the Physician at some point, but she did not know if it was before or after they had received the x-ray results. She reported she had not seen the x-ray report. Nurse #3 explained she came in after they had done everything and they were just telling her what had happened. Nurse #3 stated they did not ask her to do anything or tell her she needed to do anything else. An interview was conducted with Nurse #4 on 6/9/25 at 11:01 AM. She was Resident #69's assigned day shift nurse on 6/9/25. She stated she received in report from Nurse #3 that Resident #69 had a fractured knee. Nurse #4 said she notified NP #1 this morning (6/9/25). A telephone interview was conducted with the Nurse Practitioner (NP) #1 on 6/10/25 at 4:16 PM. NP #1 stated she was alerted by Nurse #4 on Monday morning (6/9/25) that she had received in report from night shift that Resident #69 had a fractured knee. She said when she reviewed the x-ray report, the report said Resident #69 had acute fractures of the tibia and fibula. NP #1 explained her company's on-call service had not been notified about Resident #69's x-ray results over the weekend. She explained that the Medical Director was part of a different physician service group and that sometimes the staff got confused and called the Medical Director's on call service. She said it was okay for staff to call the other physician service group because he was the Medical Director. NP #1 explained she had reviewed documentation for Resident #69 and could not see where a physician was notified of Resident #69's x-ray results. NP #1 said the nursing staff should have called the on-call service on Sunday when Resident #69's x-ray results returned. NP #1 reported if they had called the on-call service, with it being the weekend, they would most likely have given orders to send Resident #69 to the Emergency Department to be evaluated. NP #1 said if she had been the one who received the call over the weekend, she would have been okay waiting to see if she could get her into see an orthopedic first thing Monday morning to save her from an ER visit. She said knowing she had acute fractures she would have ordered something stronger than Ibuprofen to manage her pain. NP #1 explained this morning she had given orders for pain medication, non-weight bearing status and to try to immobilize her right leg. NP #1's company was contacted on 06/13/25 at 9:58 AM. They stated all calls were logged and there were no calls from the facility on Saturday or Sunday regarding Resident #69. A hospital Discharge summary dated [DATE] indicated Resident #69 had a mechanical fall and was admitted to the hospital on [DATE] with a right nondisplaced proximal tibia and fibula fractures. The discharge summary stated orthopedics was consulted and felt her fractures were amenable to nonoperative management. Orthopedics recommended hinged knee brace with non-weight bearing status to the right lower extremity and close outpatient follow-up with orthopedic services in two weeks. (continued on next page)

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F 0777 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted with the Medical Director on 6/12/25 at 12:00 PM. He stated he did not remember the facility contacting him over the weekend but that he has had a lot of calls since then. He reviewed his calls and stated he did not have a call from the facility. The Medical Director stated he was on vacation on Sunday. He said their service tracked all the calls received. He reported he would check to see if there was a log of the facility calling over the weekend and call the Surveyor back. A return call was not received from the Medical Director. An interview was conducted with Physician #1 on 6/12/25 at 1:59 PM. He stated he was the on-call provider for the Medical Director physician service group over the weekend. He explained there was a system that tracked all the calls and that he had not been contacted about Resident #69. Physician #1 stated if he had been called about the x-ray results on Sunday, he would have sent Resident #69 to the ER. Physician #1 said he was not sure if Resident #69's fractures were displaced or non-displaced but that it did not matter, he would have sent her to the hospital for evaluation for orthopedics to see her. He explained at the ER orthopedist would be consulted and decide if Resident #60 needed surgical intervention or if the fractures could be treated with casting or immobilization. Physician #1 indicated unless the family refused there was no reason not to send Resident #69 to the hospital. An interview was conducted with the Director of Nursing (DON), Regional Clinical Director, and Administrator on 6/12/25 at 4:00 PM. The DON explained she was aware of Resident #69's x-ray results Sunday night (6/8/25). She reported the x-ray report pinged on her computer around shift change on Sunday night at 6:56 PM and she reviewed the report. The DON said she immediately forwarded the results to the Administrator and then called the facility and spoke to the day shift Nursing Supervisor at around 7:00 PM. The DON stated she had called the Nursing Supervisor to notify her and make sure she had the results as well. She reported that the Nursing Supervisor confirmed she had the x-ray results. The DON said she did not tell the Nursing Supervisor what she needed to do. The DON explained that the Nursing Supervisor was not a new nurse and she had assumed the Nursing Supervisor knew what to do and knew she needed to call the Physician. The DON said she felt it was common sense that the nurse would call the Physician about critical x-ray results. The DON explained later that night around 8:30 PM herself, the Administrator, and the Regional Clinical Director got together on a three-way call to discuss the situation. They said their conversation was more around trying to figure out what had happened. The DON explained she was hyper focused on trying to figure out the cause of the fractures because she did not know anything about the x-ray or why it had been ordered. They all agreed that the physician should have been notified of the x-ray results.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, interviews with the Speech Therapist and staff, the facility failed to provide fluids of a nectar thick consistency as ordered by the physician for 1 of 8 residents reviewed for nutrition (Resident #20). Findings included: Resident #20 was admitted to the facility on [DATE] and his current diagnoses included dementia and dysphagia (difficulty swallowing). The care plan last revised on 04/21/25 identified Resident #20 nutritional status was at risk related to advanced age, dementia, and dysphagia. Interventions included assist with meal setup, eating, and drinking as needed. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #20's cognition was severely impaired. The MDS assessment indicated Resident #20 had upper extremity impairment on one side, needed partial to moderate assistance with eating, received a mechanically altered diet, and had no signs or symptoms of a swallowing disorder. A review of the active diet order dated 04/24/25 revealed Resident #20 was to receive nectar thick liquids. A continuous observation of the lower unit dining room lunch meal service was conducted on 06/09/25 from 11:59 AM through 12:18 PM. Resident #20 had already received a meal tray that included a cup of tea with a lid. The tea was of a thin liquid consistency. Nurse Aide (NA) #2 removed the tea from Resident #20's hand and stated, I don't think you can have that, then placed the cup back on the tray. The Business Office Manager approached Resident #20 and asked if he wanted a straw and at 12:16 PM she returned with a straw and placed it in the cup of tea. Resident #20 picked up the cup of tea and took a sip and was noted to cough once. At 12:18 PM, NA#2 removed the cup of tea and Resident #20 continued to eat lunch with no further signs of choking or coughing. During an interview on 06/09/25 at 12:19 PM, NA #2 revealed she did not serve the lunch tray or cup of tea to Resident #20. NA #2 revealed she took the tea away from Resident #20 because he was not supposed to have thin liquids and showed the diet card read nectar thick liquids. When asked why she did not remove the cup of tea off the meal tray and out of reach, NA #2 revealed she did not think Resident #20 would reach and grab the cup. NA #2 revealed she reviewed the diet card to ensure the meal served matched the diet card. An interview was conducted with Business Office Manager on 06/09/25 at 12:27 PM. The Business Office Manager revealed sometimes she helped in the dining room and confirmed she got a straw for Resident #20's tea because he was messing with the lid and having trouble getting the tea. The Business Office Manager revealed she did not notice the diet card on the meal tray noted Resident #20 received thickened liquids nor was she aware he was to receive thickened liquids. The Business Office Manager revealed she thought it was okay Resident #20 had thin liquids because the cup of tea was on the meal tray. The Business Office Manager revealed she did not serve the lunch meal tray to Resident #20. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Speech Therapist and observation of Resident #20's lunch meal was conducted on 06/10/25 at 11:53 AM. The Speech Therapist revealed she was assisting Resident #20 with eating to complete a trial for his ability to tolerate thin liquids. She further revealed Resident #20 tolerated thin liquids when assisted by therapy, but the diet order was for thickened liquids and should be served with meals. The Speech Therapist further revealed Resident #20's diet order for nectar thick liquids was provided to help prevent the risk of aspiration. During an interview on 06/13/25 at 2:55 PM, the Administrator revealed she was told the NA recognized the tea given to Resident #20 was of a thin liquid consistency and removed it. It was explained the NA removed the cup of tea from Resident #20 but not out of reach and the resident took a drink. The Administrator revealed she expected Resident #20 received fluids of a nectar thick consistency as ordered by the physician.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review, and staff, resident, family, and Nurse Practitioner interviews, the facility failed to document a reported fall with acute pain in a resident's medical record. This deficient practice occurred for 1 of 1 resident record reviewed for accuracy of documentation (Resident #69). Findings included: An interview was conducted with Resident #69 on 6/12/25 at 2:13 PM with Physical Therapy Assistant (PTA) #1 providing translation. Resident #69 stated she had gone to the bathroom with two staff members and fell onto her right knee when she was being assisted off the toilet Saturday. Resident #69 reported she had pain in her right knee immediately but did not cry or scream out. Review of Resident #69's medical record revealed there was no documentation or assessment information from Saturday 6/7/25 about the reported fall. The last documented progress note in Resident #69's medical record was documented on 6/6/25. There was no additional documentation for Resident #69 until 6/8/25 at 1:30 PM. A telephone interview was conducted with the day shift (7:00 am to 7:00 pm) weekend Nursing Supervisor on 6/10/25 at 11:50 AM. The Nursing Supervisor stated on Saturday (6/7/25) around 7:30 PM Resident #69 had reported she had fallen and was having pain in her right knee. The Nursing Supervisor explained she went to Resident #69's room to assess her. She said Resident #69 was in pain and said her knee was hurting when she saw her. She reported Resident #69's roommate was present in the room and provided translation for what Resident #69 said happened. The Nursing Supervisor said Resident #69 reported she had fallen about an hour prior while she was being assisted in the bathroom by staff. The Supervisor said the fall would have occurred around 6:30 PM. The Nursing Supervisor said she updated the night shift (7:00 pm to 7:00 am) nurse (Nurse #4) about what was going on and then went to find the day shift (7:00 am to 7:00 pm) nurse (Nurse #3) and updated her on what Resident #69 was reporting and told her what she needed to do. The Nursing Supervisor said she explained to Nurse #3 what she needed to do for the fall. The Nursing Supervisor stated Nurse #3 had said okay. The Nursing Supervisor stated when she returned on Sunday (6/8/25) there was no documentation to indicate anything had been done for Resident #69 or her reported fall and Resident #69 was still having pain. A telephone interview was conducted with Nurse #3 on 6/10/25 at 1:49 PM. Nurse #3 stated she was the assigned nurse for Resident #69 on day shift (7:00 am to 7:00 pm) on Saturday 6/7/25. She reported she had given shift report to the oncoming night shift (7:00 pm to 7:00 am) nurse (Nurse #4) around 7:00 PM. Nurse #3 explained the Nursing Supervisor came to her around 7:35 PM on 6/7/25 and told her Resident #69 was reporting she had fallen one hour ago, she stated it would have been around 6:30 PM. Nurse #3 said it was not a fall that was reported to her during her shift and that it was not reported until 7:35 PM. She explained she had already given report to Nurse #4. She reported after she assessed Resident #69 and noticed she was in pain, she communicated to the night nurse (Nurse #4) what she had seen. Nurse #3 said she asked Nurse #4 to continue the assessment and to complete the post fall things. She stated she did not specifically tell Nurse #4 what she needed to do but said Nurse #4 should have known what to do. She reported Nurse #4 had said yes. Nurse #3 said she assumed Nurse #4 would contact the physician and complete the rest of the post fall documentation. Nurse #3 said she had not done any vital signs, documentation, or incident report related to Resident #69's reported fall. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A telephone interview was conducted with Nurse #4 on 6/10/25 at 2:15 PM. She reported she had been the assigned Resident #69 on night shift on 6/7/25. Nurse #4 reported she had thought since the fall had happened on the day shift that the day shift nurse (Nurse #3) was going to do the fall stuff because it was her shift. An interview was conducted with the Director of Nursing (DON), Regional Clinical Director, and Administrator on 6/12/25 at 4:00 PM. They reported when a fall was reported staff were supposed to contact the DON, responsible party, provider, and follow the fall protocol. They explained the fall protocol was to assess for injury/ pain. They said the assessment, who had been notified, what had happened, and what had been done for Resident #69 should be documented in the chart.

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and resident and staff interviews the facility failed to provide an influenza vaccine to 1 of 5 residents reviewed for immunizations (Resident #23). The findings included: Resident #23 was admitted to the facility on [DATE]. The quarterly Minimum Data Set Assessment (MDS) dated [DATE] revealed Resident #23 was cognitively intact. The MDS indicated Resident #23 had not received the influenza vaccine and indicated the reason as not offered. Review of Resident #23's medical record revealed she had not received an influenza vaccine since October 2023. An influenza vaccine informed consent form signed by Resident #23 was present in the medical record and indicated Resident #23 wanted to receive the influenza vaccine. The consent form was not dated. An interview was conducted on 6/13/25 at 11:50 AM with Resident #23. She stated the facility had offered her the flu vaccine and she remembered completing the consent form but that she had never received the flu vaccine. Resident #23 said someone had come and talked to her today (6/13/25) about her flu vaccine and that she thought she was going to receive it now. Resident #23 reported she had evidently been out at an eye appointment when the facility had administered the flu vaccine to residents. Resident #23 stated she always took the flu vaccine and did not care if it was summer or winter that she still wanted it. An interview was conducted with the Director of Nursing (DON)on 6/12/25 at 10:00 AM. The DON reviewed Resident #23's medical record and confirmed there was a consent signed for Resident #23 to receive the influenza vaccine. The DON was unable to locate documentation that an influenza vaccine had been administered to Resident #23. She thought Resident #23 had maybe been out of the facility at an appointment during the facility's influenza vaccination clinic that was held in February 2025. The DON explained the facility had used an outside company for its influenza vaccination clinic. She reported if a resident was not present or was admitted after the vaccination clinic they would be placed on the list for the next vaccination clinic. The DON explained the next influenza vaccine clinic would be in October 2025. A follow up interview was conducted with the DON and Regional Clinical Director on 6/13/25 at 10:46 AM. The Regional Clinical Director reported the vaccination clinics were a new process the facility had decided to use because it was overwhelming for staff to manage. The Regional Clinical Director clarified that the facility had influenza vaccines available at the facility and was able to provide vaccinations to residents outside of the scheduled vaccination clinics. The DON and Regional Clinical Director explained there had been a change in leadership at the facility and that with all the changes Resident #23's influenza vaccine had been missed.