STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445174	A. Building B. Wing	01/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Orchard View Post-Acute and Rehabilitation Center	2035 E Stonebrook Place Kingsport, TN 37660

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50480 Based on facility policy review, medical record review, and interview the facility failed to provide the required Notice of Medicare Non-Coverage (NOMNC) timely for 2 residents (Resident #5 and Resident #65) of 3 residents reviewed for beneficiary notification. The findings include: Review of the facility's undated policy titled, Medicare Eligibility, Coverage and Notices, revealed .Facility will provide the residents .[or] .representatives with timely notices regarding Medicare Eligibility and Coverage . (NOMNC) .shall be issued .when Medicare covered service(s) are ending . Review of the medical record revealed Resident #5 was admitted to the facility on [DATE] with diagnoses including Kidney Disease, Difficulty Walking, Lack of Coordination, and Seizures. Review of a Physical Therapy note for Resident #5 dated 11/28/2024, revealed the resident was discharged from Physical Therapy services on 11/28/2024. Review of an Occupational Therapy note for Resident #5 dated 11/28/2024, revealed the resident was discharged from Occupational Therapy services on 11/28/2024. Review of a facility document titled, NOTICE OF MEDICARE NON-COVERAGE, dated 11/28/2024, revealed the resident's last day of coverage was 11/28/2024, and the resident signed the document on 11/28/2024. Review of the medical record revealed Resident #65 was admitted to the facility on [DATE] with diagnoses including Dementia, Muscle Weakness, Need for Assistance with Personal Care, Difficulty Walking, and Difficulty Swallowing. Review of a Physical Therapy note for Resident #65 dated 11/26/2024 revealed the resident was discharged from Physical Therapy services on 11/26/2024. Review of an Occupational Therapy note for Resident #65 dated 11/26/2024 revealed the resident was discharged from Occupational Therapy services on 11/26/2024. (continued on next page)

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

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Speech Therapy note for Resident #65 dated 11/26/2024 revealed the resident was discharged from Speech Therapy services on 11/26/2024. Review of a facility document titled, NOTICE OF MEDICARE NON-COVERAGE, dated 11/26/2024, revealed the resident's last day of coverage was 11/26/2024, and the resident signed the document on 11/26/2024. During a record review and interview on 1/8/2025 at 10:00 AM, the Administrator reviewed the NOMNC document the facility provided to Resident #5 and Resident #65. The Administrator stated Resident #5 and Resident #65 received a NOMNC the same day services were discontinued, and the Administrator confirmed the NOMNCs were not served timely.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50480 Based on facility policy review, medical record review, facility investigation review, and interview, the facility failed to protect the residents' right to be free from physical abuse by another resident for 2 residents (Resident #30 and Resident #31) of 67 residents reviewed for abuse. The facility's failure to prevent resident to resident abuse resulted in actual HARM for Resident #31. The findings include: Review of the facility's policy titled, Abuse, Neglect, Misappropriation of Property, Exploitation, and Injuries of Unknown Source, revised 10/24/2022, revealed .organizations intention to prevent the occurrence of abuse . Abuse is the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish .stakeholder observes a resident exhibiting any form of abuse toward another resident the stake holder will intervene immediately and interrupt the incident and remove or separate the residents involved . Review of the medical record revealed Resident #30 was admitted to the facility on [DATE] with diagnoses including Anxiety, Seizures, Depression, and Stroke. Review of a comprehensive care plan for Resident #30 dated 6/30/2023, revealed the resident utilized a wheelchair for locomotion. Review of an annual Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #30 scored a 14 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident was cognitively intact. Further review revealed the resident utilized a wheelchair for locomotion. Review of a Nurse Practitioner note for Resident #30 dated 9/10/2024, revealed .Resident seen due to reports of him having an altercation with another resident last night .Resident states that he did hit another resident [Resident #31] yesterday .states he does not want to have another altercation . Review of a Psychiatric Nurse Practitioner note for Resident #30 dated 9/14/2024, revealed .Attempted to discuss recent altercation with peer [Resident #31] .[Resident #30] refused to provide details . Review of the medical record revealed Resident #31 was admitted to the facility on [DATE] with diagnoses including Dementia, Psychotic Disorder, Mood Disorder, Depression, Anxiety, and Difficulty Speaking. Review of the Medication Administration Record (MAR) for Resident #31 dated 6/1/2024 through 6/30/2024, revealed .Hydroxyzine .1 tablet by mouth three times a day related to ANXIETY DISORDER . Review of an admission MDS for Resident #31 dated 7/1/2024, revealed the resident was rarely/never understood. Staff assessment for mental status revealed Resident #31 experienced short and long-term memory problems and was severely impaired for daily decision-making skills. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of a Behavior note for Resident #31 dated 9/4/2024, revealed the resident's Hydroxyzine (antianxiety medication) was discontinued related to the resident's frequent refusal of the medication. Review of a Nurse Practitioner note for Resident #31 dated 9/6/2024, revealed .Resident seen due to aggressive behaviors .shoved a bedside table that was in front of another resident though the other resident was not hit .[Antipsychotic medication injection] administered .particular resident who is confused [Staff were unable to identify who this resident was] seemingly agitating him .Angry .not redirectable . Review of a facility investigation dated 9/9/2024, revealed a resident-to-resident altercation occurred between Resident #30 and Resident #31. Certified Nursing Assistant (CNA) G reported to the charge nurse [Licensed Practical Nurse (LPN) I] she observed Resident #31 crying and bleeding in the hallway. LPN I notified the Administrator of the resident-to-resident altercation. The Administrator reported to the building, reviewed the camera footage, and observed Resident #31 strike resident #30, who then struck back Resident #31 in the nose. Further review of the facility investigation revealed Resident #31 was sent to the hospital and was determined to have a fractured nose after the event occurred and returned to the facility the same day. The facility substantiated resident-to-resident abuse with injury in the investigation. Review of a Behavior note for Resident #31 dated 9/9/2024, revealed Resident #31 was transported to the hospital for an altercation [with Resident #30]. Review of a Computed Tomography (CT) scan result [a test that uses x-rays, and a computer to make detailed images of the body] for Resident #31 dated 9/9/2024, revealed a fractured nose. Review of a Nurse Practitioner note for Resident #31 dated 9/10/2024, revealed .[Resident #31] .resting in [wheelchair] .on 1:1 [one on one] supervision after an altercation with another resident [Resident #30] . [Resident #31] hit [Resident #30] on the arm .[Resident #30] then hit [Resident #31] in the face resulting in a broken nose .[Resident #31] was sent to ER [emergency room] and has returned to the facility .[Resident #31] frequently refuses medications which is within his right .[Resident #31] declined his medication today . Review of a comprehensive care plan for Resident #31 initiated 9/16/2024, revealed . inappropriate behaviors related to impaired communication .dementia .mood disorder .Resident gets agitated at times . During an interview on 1/7/2025 at 1:00 PM, Resident #30 was able to recall the event and stated Resident #31 hit him on the arm when he was sitting in his wheelchair waiting to go smoke and he was not harmed in the altercation. Resident #30 stated he hit Resident #31 back in the face. Resident #30 stated Resident #31 started bleeding and crying after Resident #30 hit Resident #31. Resident #30 denied any other altercations before or after this incident. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview on 1/7/2025 at 6:00 PM, CNA G stated on the night of the event she observed Resident #30, who was waiting to go smoke, sitting in his wheelchair in the hallway and later observed Resident #31 in his wheelchair approach Resident #30. CNA G stated nothing alarmed her about the approach. CNA G stated she entered a different resident's room to provide care and when she exited the room, CNA G observed Resident #31 bleeding and crying sitting in his wheelchair in the hallway next to Resident #30. CNA G stated that she separated the residents, remained in the area, and called the nurse, who then called the Administrator. CNA G stated Resident #30 told her he was hit by Resident #31, and he hit Resident #31 back. During a facility investigation review, medical record review, and interview on 1/8/2025 at 10:30 AM, the Administrator reviewed the facility's investigation of the altercation between Resident #30 and Resident #31 on 9/9/2024, reviewed Resident #30's CT scan results which revealed a fractured nose, and the Administrator confirmed resident-to-resident abuse with injury occurred. During an interview on 1/8/2025 at 3:00 PM, the Family Nurse Practitioner (FNP) stated she was familiar with Resident #30 and Resident #31. The FNP stated she evaluated both residents after the event and stated Resident #30 told her he was hit by Resident #31 first, and he hit Resident #31 back. The FNP also stated Resident #31 had expressive aphasia, and when the FNP asked Resident #31 if Resident #30's statement was true, Resident #31 shook his head indicating Resident #30's statement was true. Further interview revealed the FNP stated the resident-to-resident altercation was the cause of Resident #31's fractured nose.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41291 Based on facility policy review, facility documentation review, medical record review, and interview the facility failed to protect 1 resident (Resident #421) from exploitation of 67 residents reviewed for exploitation. The finding include: Review of the facility's undated policy titled, Abuse, Neglect and Exploitation, revealed .Exploitation .taking advantage of a resident for personal gain .Employee Training .will include .Prohibiting .preventing all forms of .exploitation .Identifying what constitutes .exploitation . Review of the medical record revealed Resident #421 was admitted to the facility on [DATE] with diagnoses including Chronic Obstructive Pulmonary Disease, Respiratory Failure, Chronic Pain Syndrome, Major Depressive Disorder, And Anxiety. Resident #421 was discharged from the facility 11/29/2024. Review of the Physician's Orders for Resident #421 dated 12/29/2023, revealed the resident was ordered Morphine ER (an extended-release pain medication) every 12 hours for chronic pain. The order was discontinued on 6/27/2024. Review of the Physician's Orders for Resident #421 dated 6/27/2024, revealed the resident was ordered Oxycodone (pain medication) 15 milligrams (MG) every 8 hours for chronic pain. The order was discontinued on 7/1/2024. Review of the Physician's Orders for Resident #421 dated 7/1/2024, revealed the resident was ordered Oxycodone 15 MG every 6 hours for chronic pain. The order was discontinued on 9/23/2024. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #421 scored a 15 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident was cognitively intact. Resident #421used a wheelchair for mobility and required partial to moderate assistance with transfers, toileting, and bathing. Resident #421 received opioid medications. Review of the Physician's Orders for Resident #421 dated 9/23/2024, revealed an order for Oxycodone Oral Concentrate 10 MG/0.5 milliliters (ML), administer 0.5 ML by mouth every 6 hours for chronic pain. Crush controlled medications until liquids are received and then discontinue tablets of oxycodone. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Incident Reporting System (IRS) document provided by the facility dated 9/23/2024, revealed Resident #421 reported to Certified Nursing Assistant (CNA) E that she (Resident #421) had given narcotic pain medications to CNA A in exchange for vaping materials (a handheld electronic device to breathe a mist vapor into your lungs). Resident #421 was interviewed by the Administrator and Assistant Director of Nursing (ADON) and admitted she had provided CNA A with pain medication she had pocketed under her tongue. Resident #421 was interviewed and assessed by the facility's Nurse Practitioner (NP) changes were made to the resident's pain medication formulation. CNA A admitted to accepting Resident #421's pain medication, then quit and walked out of the facility. The allegation was verified by evidence collected during the investigation (verbal admittance by Resident #421 and CNA A). Review of a typed statement by the NP dated 9/24/2024, revealed the NP had met with Resident #421 on 9/23/2024 with another nurse present. The resident admitted she had been .trading her oxycodone for vapes . with CNA A. Resident #421 gave CNA A 1 pain pill (Oxycodone) in exchange for 1 vape cartridge about every 3-4 days .for a few months . Resident #421 reported CNA A .had brought her some headphones a while back and they became friends . and at some point CNA A asked her what type of medications she was on, and discussed exchanging the pain medications for the vapes. In 6/2024, Resident #421's pain medication was changed to oxycodone due to insurance and that was when the exchange began. Resident #421 stated on 9/23/2024, she had asked CNA A to buy her a soft drink and the CNA then informed the resident they were no longer friends, because the last pill she had given her was only a partial pill. The resident admitted CNA A had done this (refused to get her requested items) to her before to get an extra pill from her and now she (Resident #421) .had enough and was tired of her taking advantage of her . Resident #421 reported the last time she gave CNA A a pill was between 9/18/2024-9/20/2024. Review of the NP note for Residsent #421 dated 9/24/2024, revealed .a situation occur [occurred] regarding resident diverting her medications to a staff member .Resident does report that she has been trading an oxycodone for vape cartridges with one of the CNAs . Review of the comprehensive care plan for Resident #421 revised 10/24/2024, revealed the resident had care plan interventions for behaviors, smoking, being resistant to care, fabricating stories, and chronic pain with history of substance abuse. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/7/2024 at 2:16 PM, the ADON stated when she arrived at the facility on 9/23/2024, CNA E reported to her (ADON), Resident #421 had been trading her pain medication with CNA A for vaping cartridges. The ADON immediately reported the alleged incident to Administrator F (previous Administrator) and began an immediate investigation of the alleged incident. Resident #421 informed the ADON and Administrator F she had been trading her pain medication (Oxycodone) for vaping cartridges with CNA A but was unable to state how long the exchange had taken place. Resident #421 was tearful and stated it was her (Resident #421) mistake and knew what she had done was wrong. The ADON stated Resident #421 had been caught numerous times vaping in her room in the past several months and had been talked to several times about the dangers of vaping in her room. The ADON stated she was present in Administrator F's office when CNA A was questioned about the alleged incident, .at first [CNA A] denied it and said she would never do anything like that . CNA A was informed by Administrator F she was going to be suspended pending further investigation and the police were going to be notified, then CNA A admitted she had been trading pain medication from Resident #421 in exchange for vaping cartridges. CNA A then stated she quit, got up, and walked out the Administrator's office and exited the facility. The ADON stated during the investigation Resident #421's medications were reviewed and compared with the narcotic sheets with no discrepancies noted. During an interview on 1/7/2024 at 2:35 PM, CNA E stated she was unsure of the exact date Resident #421 had informed her she (Resident #421) had been trading her pain pills with CNA A for vaping cartridges. CNA E stated Resident #421 had shown her a picture on her personal cell phone from CNA A of a partially dissolved unknown pill (indicating CNA A did not get a whole pill from Resident #421). CNA E stated Resident #421 informed her after she was administered her pain medication (Oxycodone), she held the pill in her mouth, after the nurse would leave, she would spit the medication out, and put it away for CNA A. CNA E stated she immediately reported the incident to her supervisor and the ADON. CNA E stated CNA A visited Resident #421 frequently and never suspected any wrong doing between the two and thought they were just friends. Resident #421 did not tell CNA E how long the exchanges of pain medication for vaping cartridges had occurred.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50407 Based on facility policy review, medical record review, facility investigation documentation review, and interviews, the facility failed to report an allegation of abuse to the required state entities within 2 hours for 2 residents (Residents #52 and #30) of 67 residents reviewed for abuse. The findings include: Review of the facility's undated policy titled, Abuse, Neglect, Misappropriation, Exploitation, revealed .It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse .of resident .The facility will designate .in the facility who is responsible for reporting allegations or suspected abuse .to the state survey agency .in accordance with state law .facility will follow State and federal guidelines for .reporting . Review of the medical record revealed Resident #52 was admitted to the facility on [DATE] with diagnoses including Cellulitis, Diabetes, and Intellectual Disabilities. Review of an admission Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #52 was never/rarely understood. Review of a fall investigation report dated 12/8/2024 revealed Resident #52 had a fall to the floor from a Geri-chair (a chair used for residents with mobility issues who have difficulty sitting upright in a conventional wheelchair) due to improper staff assistance/resident care. Review of the fall incident description dated 12/8/2024, revealed, .Person Preparing Report .[Director of Nursing (DON)] .Nursing Description .CNA [Certified Nursing Assistant] J made report that resident had fallen from Geri-chair that was in upright position due to another CNA K grabbing the resident by (L) [left] forearm and pulling her [Resident #52] up, upon doing that resident slide out onto the floor on .buttocks . Immediate Action Taken .[CNA J] called for the RN [Registered Nurse L] and reported to the RN of what just occurred . No injuries were noted. Review of the facility document titled, Reportable Incident Summary, revealed .Resident [Resident #52] . Incident date & time: December 8, 2024 . Review of the facility form Incident Reporting System (IRS) report, revealed the alleged abuse occurred on 12/8/2024 at 8:00 AM and was reported on 12/9/2024 at 8:30 AM. (This was one day after the incident occurred.) Review of the facility's investigation for Resident #52 revealed the ombudsman was notified of the alleged abuse which occurred on 12/8/2024 on 12/9/2024. (This was one day after the incident occurred.) Review of a Progress note for Resident #52 revealed the alleged abuse was reported to Adult Protective Services (APS) on 12/10/2024. (This was 2 days after incident occurred.) (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/7/2025 at 10:07 AM, the Interim Administrator stated RN L was terminated due to not reporting the alleged abuse involving Resident #52. During an interview on 1/7/2025 at 1:20 PM, the DON stated she recalled the alleged abuse regarding Resident #52. The DON further stated the incident which involved Resident #52 occurred on 12/8/2024 but was not reported to DON or Administrator until 12/9/2024. The DON stated the alleged abuse was reported to the state agency 24 hours after the incident occurred. The DON further stated the charge nurse, RN L was terminated due to failure to report the alleged abuse. During an interview on 1/8/2025 at 10:15 AM, the Interim Administrator confirmed the alleged abuse involving Resident #52 was not reported timely according to federal regulations. 50480 Review of the medical record revealed Resident #30 was admitted to the facility on [DATE] with diagnoses including Anxiety, Seizures, Depression, and Stroke. Review of an annual MDS assessment dated [DATE], revealed Resident #30 scored a 14 on the BIMS assessment which indicated the resident was cognitively intact. Review of a Nurse Practitioner's note for Resident #30 dated 9/10/2024, revealed .Resident seen due to reports of him having an altercation with another resident last night .Resident states that he did hit another resident [Resident #31] yesterday . Review of the medical record revealed Resident #31 was admitted to the facility on [DATE] with diagnoses including Stroke, Dementia, Psychotic Disorder, Mood Disorder, Depression, Anxiety, and Difficulty Speaking. Review of an admission MDS assessment for Resident #31 dated 7/1/2024, revealed the resident scored a 0 on the BIMS assessment which indicated the resident could not complete the interview and had severe cognitive impairment. Review of a Behavior note for Resident #31 dated 9/9/2024, revealed resident #31 was transported to the hospital for an altercation [with Resident #30]. Review of a Nurse Practitioner's note for Resident #31 dated 9/10/2024, revealed .[Resident #31] .resting in [wheelchair] .on 1:1 [one on one] supervisor after an altercation with another resident [Resident #30] . [Resident #31] hit [Resident #30] on the arm .[Resident #30] then hit [Resident #31] in the face resulting in a broken nose . Review of a facility investigation dated 9/9/2024, revealed a resident-to-resident altercation between Resident #30 and Resident #31 had occurred. Further review of the facility investigation revealed Resident #31 was sent to the hospital and was determined to have a fractured nose after the event occurred and returned to the facility the same day. The facility substantiated resident-to-resident abuse in the investigation. Further review revealed the resident-to resident altercation was reported to APS on 9/13/2024, which was 3 days after the incident had occurred. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review and interview on 1/8/2025 at 10:30 AM, the Administrator reviewed the facility's investigation of Resident #30 and Resident #31's altercation which occurred on 9/9/2024 and confirmed APS was not notified until 9/13/2024. The Administrator confirmed the resident-to-resident altercation was not reported timely per state and federal regulations. During a telephone interview on 1/8/2025 at 1:00 PM, the APS consultant confirmed the facility reported the resident-to-resident altercation which occurred on 9/9/2024, between Resident #30 and Resident #31, on 9/13/2024.

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Orchard View Post-Acute and Rehabilitation Center	2035 E Stonebrook Place Kingsport, TN 37660

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 51371 Based on facility policy review, observation, and interview, the facility failed to ensure dented cans (3 of 3) were discarded and not available for resident use, which had the potential to affect 67 of 67 residents. The findings include: Review of the facility's undated policy titled, Food Safety Requirements, revealed .when food arrives damaged or concerns are noted .remove these foods from use .dented cans are returned to the vendor upon delivery .if dented cans are identified after delivery, the staff will not use the canned goods for food preparation and will be separated (to be returned to the vendor or will be discarded) . During an observation and interview on 1/6/2025 at 11:37 AM, in the dry storage room, with the Certified Dietary Manager (CDM), revealed two 6.88-pound cans of pork and beans and one 7.312-pound can of cranberry sauce was dented on the side of each can. The CDM stated the kitchen staff if any dented cans were observed, they were to be discarded. The CDM confirmed the dented cans of pork and beans and cranberry sauce were available for resident use and should have been discarded.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49568 Based on facility contract review, facility policy review, medical record review, and interview, the facility failed to ensure a coordinated plan of care with the hospice provider was available in the medical record for 1 residents (Resident #19) of 3 residents reviewed for hospice services. The findings include: Review of the facility's hospice contract titled, Hospice Care Guidelines, dated 2/2023, revealed .policy of this facility to provide and/or arrange .hospice services .obtain the following information from hospice .most recent plan of care . Review of the medical record revealed Resident #19 was admitted to the facility on [DATE] with diagnoses including Diabetes Mellitus, Chronic Obstructive Pulmonary Disease, and Adult Failure to Thrive. Review of a Physician's Order for Resident #19 dated 8/27/2024, revealed .Admit to Hospice. Review of the comprehensive care plan dated 8/27/2024, revealed Resident #19 .under hospice care . Review of the hospice communication binder (located at the nurses' station) revealed the hospice plan of care for Resident #19 had a .Certification date .8/27/2024 to 11/24/2024 . Continued review revealed no further documentation of a new recertification period for hospice service and no revised care plan after 11/24/2024. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #19 scored a 11 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had moderate cognitive impairment. Further review revealed the resident received hospice services. During an interview on 1/8/2025 at 8:05 AM, the Social Services Director (SSD) stated she was the hospice coordinator for the facility. The SSD stated there were hospice plan of care binders located at each nurse station for each resident that received hospice services. The SSD confirmed Resident #19 remained on hospice service and the hospice plan of care had not been updated for Residents #19.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50407 Based on policy review, medical record review, and interviews, the facility failed to ensure proper infection control practices were followed during a noon and a breakfast meal for 2 residents (Residents #67 and #17) and during housekeeping services for 2 residents (Residents #16 and #54) of 21 residents reviewed for COVID-19 Transmission-Based Precautions. The findings include: Review of the facility's undated policy titled, Covid 19 Management of Residents, revealed .appropriate isolation signage, and staff wearing N95 respirator, eye protection, gown, and gloves upon entry to the room . The door will be kept closed .Residents with Confirmed COVID-19 .Isolate using Transmission-Based Precautions . Review of the medical record revealed Resident #67 was admitted to the facility on [DATE] with diagnoses including Hemiplegia, Chronic Obstructive Pulmonary Disorder, Acute Respiratory Failure, and Stroke. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #67 was rarely/never understood. Review of the Nurse's Notes for Resident #67 dated 12/30/2024, revealed . rapid Covid [test used to diagnosis COVID-19 infection] (+) [positive]. NP [Nurse Practitioner] and daughter aware of positive test . Review of a comprehensive care plan for Resident #67 revised 12/31/2024 revealed the resident had an Isolation care plan for an active Covid-19 infection. Review of the Physician's Orders for Resident #67 dated 12/31/2024, revealed .Isolation Precautions due to confirmed COVID-19 . During an observation on 1/6/2025 at 12:35 PM, Droplet Precaution signage and personal protective equipment (PPE) including masks, gowns, eye protection to include goggles/face shields, and gloves was hanging on Resident #67's door. CNA D delivered the lunch meal tray to Resident #67 and was not wearing eye protection to deliver the meal tray. CNA D stated Resident #67 had COVID-19. CNA D stated she was unaware to don eye protection to include a face shield or goggles before entering the room to deliver the lunch meal tray. CNA D confirmed she had not donned eye protection before entering the resident's room to deliver the lunch meal tray. 41291 Review of the medical record revealed Resident #17 was admitted to facility on 6/14/2023 with diagnoses including Parkinsonism, Protein-Calorie Malnutrition, Cirrhosis of Liver, and Chronic Viral Hepatitis C. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Nurse's Notes for Resident #17 dated 12/30/2024, revealed the resident's representative was notified of possible exposure to COVID-19. Review of the Physician Orders for Resident #17 dated 12/31/2024, revealed the resident was placed in isolation due to exposure to COVID-19. Review of the Medication Administration Note for Resident #17 dated 12/31/2024, 1/3/2025, 1/4/2025, and 1/7/2025, revealed the resident had negative COVID-19 test results. During an observation on 1/7/2025 at 7:45 AM, CNA B was observed in Resident #17's room assisting with the breakfast meal. CNA B was sitting on the edge of the resident's bed with her N-95 mask pulled down under her nose. Further observation revealed CNA B was not wearing a gown, gloves, or eye protection. On the outside of the door signage was posted for Droplet Precaution, Enhanced Barrier Precautions, and Sequence for Putting on Personal Protective Equipment (PPE). There was a yellow cloth pocket over the door container with gowns, gloves, masks, and eye protection. Continued observation revealed CNA B exited Resident #17's room with the breakfast tray in her hands and placed the breakfast tray on the dirty food tray cart at the end of the hallway, then pulled her N-95 mask back over her nose. During an interview and observation on 1/7/2025 at 7:47 AM, CNA B stated she was unaware Resident #17 was in isolation. CNA B walked to Resident #17's room and confirmed there was a signage on the resident's door indicating Resident #17 was in isolation precautions. CNA B confirmed she had her N-95 mask pulled down under her nose and was not wearing the recommended PPE (gowns, gloves, or eye protection) while assisting Resident #17 with his breakfast meal. Review of the medical record revealed Resident #16 was admitted to the facility on [DATE] with diagnoses including Cerebral Infarction, Chronic Bronchitis, and Covid-19 (added 1/6/2025). Review of the Nurses Note for Resident #16 dated 1/4/2025, revealed the resident had a positive COVID-19 test result. Review of the Physician's Order for Resident #16 dated 1/4/2025, revealed .Isolation precautions due to confirmed COVID-19 .for 10 days . Review of the medical record revealed Resident #54 was admitted to the facility on [DATE] with diagnoses including Dementia, and Adult Failure to Thrive. Review of the Physician's Orders for Resident #54 dated 1/2/2025, revealed .Isolation precautions due to confirmed COVID-19 .for 10 days . Review of the MAR for Resident #54 dated 1/3/2025, revealed the resident had a positive COVID-19 test result on 1/2/2025 and was placed in isolation. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 1/7/2025 at 7:55 AM, Housekeeper C was in Residents #16 and #54's room with the door open. On the outside of the residents doors signage was posted for Droplet Precaution, Enhanced Barrier Precautions, and Sequence for Putting on Personal Protective Equipment (PPE). There was a yellow cloth pocket container on the residents doors with gowns, gloves, masks, and eye protection. Housekeeper C was observed wiping both residents over bed tables, the sink, and bathroom door handle. Housekeeper C was observed not [NAME] an N9 (wore a surgical mask), no eye protection (had on eyeglasses), and no gown, with a cleaning rag in one hand and bottle of disinfectant in the other hand. During an interview on 1/7/2025 at 7:57 AM, Housekeeper C stated she was not aware Residents #16 and #54 were in isolation. She confirmed she was not wearing the appropriate PPE (N-95, gown, or eye protection) and had not changed her gloves prior to exiting Residents #16 and #54's room. During an interview on 1/8/2025 at 8:26 AM, Family Nurse Practitioner (FNP) stated her expectation was for all staff to wear the recommended PPE when entering isolation rooms. During an interview on 1/8/2025 at 1:12 PM, the Infection Control Preventionist (ICP) stated it was her expectation for employees to follow the guidance posted on isolation room doors and to wear the recommended PPE; for droplet precaution rooms that would include gowns, gloves, N-95 mask, and eye protection.