STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445288	A. Building B. Wing	08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Huntsville Post-Acute and Rehabilitation Center	287 Baker Street Huntsville, TN 37756

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45837 Based on facility policy review, medical record review, observations, and interviews, the facility failed to protect a resident's dignity by not covering a urinary catheter collection bag for 1 resident (Resident #55) of 4 residents observed with indwelling urinary catheters. The findings include: Review of the facility's undated policy titled, Promoting Resident Dignity, revealed .The facility will .treat each resident with respect and dignity .When caring for residents with urinary catheters, place the resident's urinary bag in a privacy bag . Review of the medical record revealed Resident #55 was admitted to the facility on [DATE] with diagnoses including Bladder Neck Obstruction, Benign Prostatic Hyperplasia and Major Depressive Disorder. Review of a quarterly Minimum Data Set assessment dated [DATE], revealed Resident #55 scored a 15 on the Brief Interview for Mental Status assessment, which indicated the resident was cognitively intact. The resident had an indwelling urinary catheter and an active diagnosis of Obstructive Uropathy. Review of a comprehensive care plan for Resident #55 dated 4/23/2024, revealed .Urinary Catheterization Care Plan .Urinary catheter r/t [related to] bladder trauma . During an observation on 8/19/2024 at 12:16 PM, in Resident #55's room, the resident was resting in the bed by the door to the room and had an uncovered urinary collection bag hanging below the bladder level on a walker at the bedside. The bag could be seen from the door. During an observation and interview on 8/19/2024 at 12:29 PM, in Resident #55's room, Licensed Practical Nurse (LPN) F stated the resident's urinary catheter bag was hanging on the side of the walker which was just inside the resident's door and was clearly visible to anyone who was standing at the door of the room. The LPN confirmed the urinary collection bag was not covered with a dignity bag. During an interview on 8/20/2024 at 3:37 PM, the Director of Nursing (DON) stated it was her expectation that all urinary catheters have privacy bags over the collection bag. The DON confirmed the resident's dignity was not protected when the catheter bag was not covered.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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** 41782 Based on facility policy review, medical record review, facility investigation documentation review, and interviews, the facility failed to report an injury of unknown origin to the state designated authorities for 1 resident (Resident #24) of 24 residents reviewed for abuse. The findings include: Review of the facility's undated policy titled, Injury of Unknown Source, revealed .All unexplained injuries, including bruises, abrasions, and injuries of unknown source will be investigated .If an allegation of abuse is made or the injury is of unknown source, reporting and investigation procedures shall be implemented in accordance with the facility's abuse policies and procedures .An injury should be classified as an 'injury of unknown source' when both of the following conditions are met .The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and The injury is suspicious because of .The extent of the injury or .The location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or .The number of injuries observed at one particular point in time or .The incidence of injuries over time . Review of the facility's undated policy titled, Abuse, Neglect and Exploitation, revealed .Identification of Abuse, Neglect and Exploitation .Possible indicators of abuse include .Physical injury of a resident, of unknown source .Investigation .An immediate investigation is warranted .Reporting/Response .Reporting of all alleged violations to the Administrator, DON, state agency, adult protective services and to all other required agencies .Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury . Review of the medical record revealed Resident #24 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Displaced Comminuted Fracture of Shaft of Right Tibia (2/2/2024), Hemiplegia and Hemiparesis Following Cerebrovascular Disease Affecting Right Dominant Side, Lack of Coordination, Abnormalities of Gait and Mobility, Vascular Dementia, Major Depressive Disorder, Obsessive-Compulsive Disorder, Edema, Expressive Language Disorder, Aphasia, and Chronic Pain. Review of the comprehensive care plan for Resident #24 dated 10/10/2022, revealed . [NAME] had a cerebral vascular accident (CVA/Stroke) affecting right dominant side .impaired cognitive function or impaired thought processes r/t [related to] dementia .Impaired communication r/t [Resident #24] has difficulty expressing self or understanding others at times .hemiplegia/hemiparesis r/t CVA . Review of the comprehensive care plan for Resident #24 dated 1/9/2023, revealed .self care deficit related to hemiparesis s/p CVA [Cerebrovascular Accident] requires supervision/set up with ADLs [Activities of Daily Living] .facilitates via wheel chair independently . (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the comprehensive care plan for Resident #24 dated 6/26/2023, revealed . Fall Prevention Care Plan History of falls related to impaired balance, generalized weakness, assistance needed with transfers .to call for assist when transferring . Review of the annual Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #24 had unclear speech and was sometimes able to make self understood and sometimes able to understand others. Resident #24 had short and long term memory problems and had moderately impaired cognitive skills for daily decision making. Resident #24 exhibited no behavioral symptoms. Resident #24 had impaired range of motion on one side of the upper and lower extremities and required a wheelchair for mobility. The resident had no falls since Admission/Entry, Reentry, or Prior Assessment. Review of the Nurse Practitioner (NP) note for Resident #24 dated 1/26/2024, revealed the resident was seen by the Nurse Practitioner and it was noted .Chief Complaint/Nature of Presenting Problem .Follow-up on recent chest x-ray .Staff have no other concerns .Musculoskeletal .No reported redness or swelling .He is in no acute distress at this time . Review of a Nursing Note for Resident #24 dated 1/27/2024 at 4:38 PM, revealed Licensed Practical Nurse (LPN) C noted .Resident c/o [complains of] pain to right upper and lower extremity. Resident having difficulty standing. Swelling and redness noted to right ankle and calf. Tender to touch .NP notified. Ordered STAT x-ray to right leg . Review of a physician's order dated 1/27/2024, revealed .XRay to right hip, knee, and ankle STAT for Pain/Swelling . Review of the MOBILE IMAGES report for Resident #24 dated 1/27/2024, revealed a right ankle x-ray was obtained at the facility on 1/27/2024 at 6:13 PM. It was noted .IMPRESSIONS .Comminuted spiral fracture distal tibia . Review of the facility's incident report for Resident #24 dated 1/27/2024 at 7:30 PM, revealed .Resident c/o [complains of] pain to RLE [Right Lower Extremity]. Tender to touch. Swelling and redness noted. Xray report impressions: Comminuted spiral fracture distal tibia .Resident unable to give Description .Immediate Action Taken .Immobilized RLE. Xray ordered. NP notified of result, order to send resident to ER obtained. Sent resident to [named hospital] .Investigation pending .Level of Pain .Numerical: 10 .Level of Consciousness: Alert .Mobility: Wheelchair bound .Resident drags foot on the floor when propelling self in wheel chair .No Witnesses found . The Nurse Practitioner and Director of Nursing (DON) were notified. Review of a Nursing Note for Resident #24 dated 1/27/2024 at 8:00 PM, revealed .ems [Emergency Medical Services] here to transport resident to ER [emergency room] for eval [evaluation] and tx [treatment] related to right leg .D.O.N notified . Review of a witness statement from LPN C dated 1/27/2024, revealed .CNA's [Certified Nursing Assistant] reported to me [Resident #24] leg was swollen [and] red and he complained of Pain. No incident or injury reported . Review of a witness statement from CNA D dated 1/27/2024, revealed .was transferring [Resident #24] to bed and Noticed his leg when he complained of pain. Called Nurse to Room to see . (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a witness statement from CNA H dated 1/27/2024, revealed .[Resident #24] complained of pain in his leg when we were putting him in bed. I did not see anything happen to him . Review of the discharge MDS assessment dated [DATE] revealed Resident #24 had an unplanned discharge to a short term general hospital and return was anticipated. Resident #24 had no falls since Admission/Entry, Reentry, or Prior Assessment. Review of facility investigation documentation revealed the facility had a call with the management staff and members of corporate to discuss Resident #24's injury .Attendees on the Call .[Administrator] .[Risk Manager] .Resident name: [Residnet #24] .Medical History- condition: Depression, Aphasia, Expressive Language Disorder, Seizure .Short Term/Long Term Memory problems .DX: [Diagnosis] Cerebral Vascular Disease with R [right] Side Hemiparesis .Cognition .Alert and Oriented with expressive difficulties .Date of incident .1-27-24 .Time of incident: unknown .Location: unknown .What occurred .Right Lower extremity had moderate swelling, redness, and pain to touch .Witnesse(s): none .Resident does not use foot pedal on w/c [wheelchair] Gets angry when asked to use .Also refuses help [with] transfers .Is it reportable .No .DOH [Department of Health] .No .Police .No .01-27-2024 attempted to notify family x 3 .Root Cause analysis . Interventions for like residents: Ensure they are utilizing the foot rest on wheelchair .Status of resident .at hospital . Review of the hospital History and Physical dated 1/28/2024, revealed .Chief Complaint .AMS [Altered Mental Status] .RIGHT TIBIAL FRACTURES .presented to ED [Emergency Department] from [facility name] related to redness/swelling of RLE [Right Lower Extremity]. Findings in the ER showed the patient to have a distal tibial .fracture .appears acute however per the nursing staff .they aren't aware of any falls that he had had. They state that the patient is back [bad] to try to get up and ambulate by himself and he drags his right leg so they believe he may have twisted or fall without them knowing. Patient is very aphasic and is very frustrated during history and is unable to tell me if he's recently fell or not. He has significant pain of the right lower extremity and he has pain noted at the right femur and hip as well, x-rays have been ordered .Because of the swelling of the right lower extremity which is .likely related to the fracture of the distal tibia I am concerned of possible blood clot so I have ordered venous ultrasound to be completed prior to discharge back .in the morning .Radiology .XR [x-ray] right tib [tibia]/fib [fibula] .IMPRESSION .Comminuted fracture distal tibia .Exam .moderate distress .Extremities: Redness/swelling of RLE at the distal aspect of leg, pulse is 2+ in the right foot .Assessment and Plan .Acute Comminuted Fx [fracture] of the right tib/fib .Posterior splint to RLE .Non weight bearing .US [ultrasound] venous pending fo the AM [morning] r/t [related to] swelling/redness .will need outpatient Ortho follow up . Review of the 1/2024 Medication Administration Record for Resident #24 revealed the resident's pain was assessed every shift. Resident #24 reported a pain level of 5 out of 10 on 1/11/2024 at 8:15 PM and received Percocet-Acetaminophen (pain medication). The medication was effective. The resident reported a level of 0 out of 10 on all other pain assessments until 1/27/2024. Review of the medical record revealed no explanation of the injury or incidents to explain the resident's fracture. (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 8/21/2024 at 10:42 AM, the Administrator stated on 1/27/2024, Resident #24 was noted with pain, redness, and swelling to the right leg. The NP was notified and ordered a stat mobile image x-ray that showed a spiral fracture of the right distal tibia and the resident was sent to the ER for treatment. Resident #24 has expressive aphasia and was unable to communicate what had happened. The Administrator stated an investigation was started after being notified of the fracture. The Administrator stated he was told by the Risk Manager that a staff had witnessed Resident #24's leg get caught under the pedal of his wheelchair but was unaware what staff member witnessed it. The Administrator stated there was no witness statement in the investigation to show the resident got his leg caught underneath the wheelchair and Resident #24's medical record did not contain any information about the resident getting his leg caught up in foot pedal of the wheelchair. Resident #24 does not have osteoporosis. The Administrator stated Resident #24's injury was not reported because he believed the cause of the injury was due to the Resident getting his leg caught under the wheelchair pedal. The Administrator stated an injury was classified as unknown origin if it was not observed by any person or the source of the injury could not be explained and the injury was suspicious because of the extent of the injury, location of the injury, number of injuries, or incidence of injuries over time. During an interview on 8/21/2024 at 12:10 PM, the DON stated .the best that we could determine he had gotten caught in his foot pedal on his wheelchair . The DON stated she was unaware of any witnesses and stated the resident had no falls or incidents that anyone was aware of. Resident #24 had a history of getting his leg caught in the footrest so we .we assumed that is what had happened . The DON interviewed the staff who had provided care for him over the few days prior and no one was aware of any incidents that could have occurred. Residents were interviewed and were unaware of any issues. The resident has expressive aphasia and was unable to communicate what had happened. During an interview on 8/21/2024 at 12:30 PM, the Risk Manager stated she had investigated Resident #24's right spiral tibia fracture. Spiral fractures require torsion twisting and .through my investigation I have knowledge that he was refusing to his use his wheelchair pedal .we couldn't pinpoint any other incident . The Risk Manager confirmed there were no witnesses and was unaware of any witnessed incident that occurred to explain the fracture. Resident #24 was unable to explain what had happened and staff that provided care for the resident were unaware of any specific incident to explain the fracture. The Risk Manager confirmed the injury was not observed and the resident was not able to explain the source of the injury. The Risk Manager confirmed Resident #24's right tibia fracture was not reported because we did not consider it an injury of unknown origin based off the kind of fracture it was. The Risk Manager stated .Those [spiral fractures] are hard fractures to get so I deduced the injury based off his history of not using his foot pedal . Resident #24's fracture was discussed with the corporate team via telephone and the facility was advised Resident #24's fracture was not a reportable event. During an interview on 8/21/2024 at 12:49 PM, LPN C stated she was the nurse providing care for Resident #24 the day the fracture was discovered. The CNAs notified LPN C that Resident #24 was complaining of right leg pain, redness and swelling. LPN C notified the NP and a stat x-ray showed a fracture. The LPN was present in the room during the x-ray and was made aware of the fracture and immediately notified the NP. The NP ordered transfer to the ER for evaluation. LPN C was unaware of any cause for the pain and Resident #24 had not had any falls or incidents that she was aware of that could have explained the injury. Resident #24 drags his foot and has to be encouraged to put it on the foot rest but LPN C was unaware of anytime the resident's foot had been caught up in the foot pedal of the wheelchair. (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 8/21/2024 at 12:45 PM, the NP stated she was familiar with Resident #24 and saw him often. She was made aware on 1/27/2024 that the resident was complaining of pain and had redness and swelling to the right lower extremity. The NP ordered an x-ray that revealed a distal tibial fracture and the resident was sent out to the ER for evaluation. The NP stated she was unaware of what the cause of the injury was and was unable to speculate about the cause. Resident #24 did not have a diagnosis of osteoporosis. Multiple observations during the survey period of the resident propelling self with his feet in a wheelchair. Right foot pedal present on wheelchair. During an observation on 8/21/2024 at 1:02 PM, revealed the resident was seated in a wheelchair propelling self through the hallway. Right foot resting on foot pedal while stopped. During an interview on 8/21/2024 at 2:10 PM, the Risk Manager stated video footage was reviewed of the hallways and no incident was observed to explain Resident #24's fracture. During an interview on 8/21/2024 at 2:58 PM, the Administrator stated he was told by the Risk Manager there was a witness that observed Resident #24 get his leg caught in the foot pedal of the wheelchair. The Administrator confirmed he did not know who the witness was and there was no documentation in the investigation for the witness. The Administrator confirmed an injury of unknown origin was to be reported to the state agency within 2 hours. The Administrator confirmed the incident was not reported because he thought the incident was witnessed.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45837 Based on facility policy review, medical record review, observation and interview, the facility failed to provide nail care during Activities of Daily Living (ADL) care for 1 resident (Resident #62) of 24 residents reviewed for ADL care. The findings include: Review of the facility's undated policy titled ADL CARE (Nails), revealed .policy will provide the facility with guidance related to provision of care to resident's nails for good grooming and health .nursing staff will provide routine cleaning and inspection of nails during ADL care on an ongoing basis . Review of the medical record revealed Resident #62 was admitted to the facility on [DATE] with diagnoses including Visual Loss, Both Eyes, Congestive Heart Failure, Lack of Coordination and Schizophrenia. Review of a quarterly Minimum Data Set assessment dated [DATE], revealed Resident #62 scored a 15 on the Brief Interview for Mental Status assessment, which indicated the resident was cognitively intact. The resident had a diagnosis of Traumatic Brain Injury and required assistance with ADLs. Review of a comprehensive care plan for Resident #62 dated 4/5/2024, revealed .[Resident #62] has an ADL self-care performance deficit r/t [related to] blindness .requires assistance by 1 staff with personal hygiene . Review of an ADL task history for Resident #62 revealed the resident had last received a bath by staff on 8/16/2024. During an observation and interview on 8/19/2024 at 11:27 AM, Resident #62 was lying in bed and had long rough finger nails with a brown substance under them. Resident #62 stated he would like to have his nails clipped but had not been asked by staff .in a while . During an observation on 8/20/2024 at 3:15 PM, Resident #62 was lying in bed. Resident #62's nails were long, rough, and noted with a brown substance under the nails. During an observation and interview on 8/20/2024 at 4:00 PM, in Resident #62's room, Licensed Practical Nurse (LPN) F confirmed the resident had long rough nails with a brown substance under them. The LPN stated usually the Certified Nursing Assistants (CNAs) cleaned them while bathing the resident. During an interview on 8/21/2024 at 1:59 PM, CNA G stated nail care was to be provided after he the resident's shower or a bed bath. During an interview on 8/20/2024 at 5:14 PM, the Director of Nursing (DON) stated nail care was supposed to be done during showers by CNAs, and nails should be short and clean. The DON confirmed the resident was not getting thorough ADL care when the nails were not checked and cleaned.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41782 Based on facility policy review, medical record review, facility document review, observations, and interviews, the facility failed to ensure smoking supplies and medications were secured properly for 1 resident (Resident #11) of 69 residents observed. The findings include: Review of the facility's undated policy titled, Smoking Policy - Resident, revealed .The facility shall establish and maintain safe resident smoking practices .All smoking products such as cigarettes, lighters .will be kept at the nurses station in a designated area, and no products are allowed to be kept on resident or in their possession including their room . Review of the facility's undated policy titled, Medication Storage guidelines, revealed .The facility will ensure all medications will be stored in the medication rooms/carts according to the manufacturer's recommendations .to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security .All drugs .will be stored in locked compartments (i.e. [that is], medication carts, cabinets, drawers, refrigerators, medication rooms) . Review of the medical record revealed Resident #11 was admitted to the facility on [DATE] with diagnoses including Pneumonia, Chronic Obstructive Pulmonary Disease (COPD), Acute and Chronic Respiratory Failure, Nicotine Dependence, Major Depressive Disorder, Anxiety Disorder, Malignant Neoplasm of Esophagus, and Tobacco Use. Review of a NURSING - Admission/Readmission Nursing Evaluation for Resident #11 dated 7/29/2024, revealed .Type of respiratory treatments ordered .Aerosol/nebulizer .Does the resident smoke or Vape .No . Review of the 7/2024 Medication Administration Record (MAR) for Resident #11 revealed an order dated 7/29/2024 for .Budesonide Inhalation Suspension [an inhaled medication used to decrease swelling and irritation in the airways to allow for easier breathing] 0.5 MG [milligrams]/2ML [milliliters] .2 ml inhale orally two times a day related to CHRONIC OBSTRUCTIVE PULMONARY DISEASE . The MAR was documented that Resident #11 received all scheduled doses of the medication from 7/29/2024 - 7/31/2024. Continued review showed an order dated 7/29/2024 for .Nicotine Transdermal Patch [a patch applied to the skin for smoking cessation] 24 Hour 21 MG/24 HR [hour] .Apply 1 patch transdermally one time a day for tobacco cessation and remove per schedule . Resident #11 received all scheduled doses. Review of a comprehensive care plan for Resident #11 dated 7/30/2024, revealed .uses tobacco products as evidenced by smokes cigarettes . Continued review revealed .COPD, chronic respiratory failure, and neoplasm of esophagus .Give medications as ordered by physician . Review of an admission Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #11 scored a 15 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident was cognitively intact. The resident exhibited no behavioral symptoms and was not currently using tobacco products. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the 8/2024 MAR for Resident #11 revealed an order dated 8/4/2024, for .Albuterol Sulfate [an inhaled medication used to prevent and treat wheezing and shortness of breath caused by breathing problems such as COPD] .Inhalation Aerosol Solution 108 (90 Base) MCG [micrograms]/ACT [actuation] . Resident #11 received all dose of the Nicotine Transdermal Patch and Budesonide Inhalation Suspension according to the physician's orders. Review of a Self-Administration Evaluation Record for Resident #11 dated 8/7/2024, revealed the section of the assessment that stated .Per above assessment results, this resident Would/Would Not (circle one) benefit from self-administration of medications . was incomplete. Review of the facility document titled, Release of Responsibility for leave of absence, revealed the resident's stepdaughter signed the resident out of the facility on 8/12/2024 at 11:15 AM and signed the resident back into the facility on [DATE] at 1:45 PM. During an observation and interview on 8/19/2024 at 11:17 AM, Resident #11 was lying in bed. The resident's bedside table contained 2 water pitchers, a large coffee can, napkins, cups (some with liquid and some empty) a blue cigarette lighter, an Albuterol Sulfate Inhalation Aerosol Inhaler and 1 unopened 0. 5mg/2ml vial of Budesonide Inhalation Suspension. There was a plastic grocery bag tied to Resident #11's bedrail that contained a pack of 24/7 Red cigarettes. The resident stated he had only smoked 1/2 cigarette since being at the facility with his daughter when she took him outside the facility. The resident would not answer questions about how he obtained the cigarettes or lighter and the resident refused to answer any further questions. During an observation and interview on 8/19/2024 at 11:37 AM, with the Director of Nursing (DON), in Resident #11's room, the DON confirmed the presence of the pack of cigarettes, lighter, Albuterol Sulfate inhaler, and vial of Budesonide Inhalation were at the resident's bedside. The DON stated cigarettes and lighters were to be kept secured in the cigarette box and not at the resident's bedside, and medications were to be secured in the medication cart unless the resident had been assessed as safe to self-administer medications. The DON removed the cigarettes, lighter, and medication from the bedside and explained to Resident #11 that medications and smoking supplies had to be secured appropriately. The DON explained the smoking policy and procedure to the resident. During an interview on 8/19/2024 at 11:45 AM, the DON stated the facility had been discussing allowing the resident to self-administer his medications and were waiting on a lockbox to store his medication safely. The DON stated there were no wandering residents that wandered in the resident's room. The DON stated Resident #11 had not been smoking while at the facility and was unaware how the resident obtained the lighter and cigarettes. Residents were not allowed to keep their cigarettes and lighters on them and they were kept secured in the cigarette box at all times. Cigarette boxes are kept secured in Activities office in between smoke times. The DON stated medication was to be administered under nurse supervision and not left at the residents' bedside. Resident #11 received Budosenide Inhalation Suspension 0.5 mg/2ml via inhalation twice daily for COPD and Albuterol Sulfate HFA Aerosol Solution 108 mcg/actuation 2 puffs via inhalation every 4 hours as needed for SOB (shortness of breath)/COPD. Resident #11 received a Nicotine Patch at the facility for smoking cessation. Review of a SMOKING - SAFETY SCREEN for Resident #11 dated 8/19/2024 at 11:58 AM, revealed .Can resident light own cigarette? .No .Does resident need facility to store lighter and cigarettes? .Yes .Resident is safe to smoke under supervision and staff to light his cigarette .Resident is safe to smoke with supervision and the facility to hold his cigarettes . (continued on next page)

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	445288	A. Building B. Wing	08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Huntsville Post-Acute and Rehabilitation Center	287 Baker Street Huntsville, TN 37756

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a facility document titled, ATTESTATION, dated 8/19/2024, revealed the the Social Services Director provided a typed statement that read, .After a call with [Resident #11]'s stepdaughter .she confirmed that she bought [Resident #11] the pack of cigarettes last Monday on 8/12/24 [2024] when she took him out of the facility. She also confirmed that half of the cigarette that was still in the pack was used when they were outside of the facility .I educated [Resident #11's stepdaughter] on the smoking policy and how the facility must store [Resident #11]'s on his behalf. [Resident #11's stepdaughter] verbalized understanding and apologized for the inconvenience . During an interview on 8/19/2024 at 12:17 PM, Hydration Aide E was unaware Resident #11 smoked and had never seen him smoke at the facility. Hydration Aide E was unaware Resident #11 had smoking supplies and medications at his bedside. Hydration Aide E stated there were no wandering residents that wandered into the resident room. During an interview on 8/19/2024 at 1:01 PM, Licensed Practical Nurse (LPN) C stated she was assigned to the resident today and provided care for Resident #11 often. LPN C sheated Resident #11's Budesonide breathing treatment had been administered earlier today and the LPN remained in the room for the duration of his treatment. LPN C stated she did not observe any smoking supplies or medications at Resident #11's bedside during her interactions with the resident and was unaware how he obtained them. LPN C stated, .he [Resident #11] gets Nicotine patches .I've never seen him smoke or ask to smoke . LPN C was unaware of any residents on the unit that wandered into other resident rooms. During an interview on 8/19/2024 at 2:56 PM, Certified Nursing Assistant (CNA) D stated she was assigned to Resident #11's unit today. CNA D was unaware that Resident #11 smoked and stated he had never gone out for smoke time at the facility that she was aware of. CNA D was unaware of Resident #11 had smoking supplies and medications at the bedside. CNA D was unaware of any residents on the unit that wandered into other resident rooms. During an interview on 8/20/2024 at 8:01 AM, the Activities Director stated the Activities department was responsible for filling resident cigarette boxes with the number of cigarettes they were allowed to smoke on each cigarette break. Cigarette boxes were kept locked in the dayroom cabinet and lighters were kept locked in the Activities Director's office. Residents were never provided lighters and cigarette boxes were distributed to the residents at the start of the smoke time and collected at the end. The Activities Director stated Resident #11 had not participated in smoke times. During an interview on 8/20/2024 at 11:07 AM, the Social Services Director stated he asked all residents about their smoking status on admission. Resident #11 reported that he smoked at home but was in the facility for Pneumonia and wasn't going to smoke until his Pneumonia cleared up. Resident #11 was set to discharge home on 8/12/2024 and decided to stay in the facility until he could better take care of himself. The Social Services Director stated he notified Resident #11's stepdaughter of the resident's wishes to remain in the facility. Resident #11's stepdaughter was already on the way to get him and came by the facility to visit. Resident #11's stepdaughter took the resident out of the facility that day (8/12/2024) to get something to eat and by his house and returned him to the facility. The Social Services Director stated he called Resident #11's stepdaughter on 8/19/2024 and asked her if she was aware how the resident obtained the cigarettes and lighter, and she stated she had brought them to the resident when she visited on 8/12/2024. The Social Services Director explained the facility's smoking policy to Resident #11's stepdaughter and she apologized and stated, .I didn't even think about that . Resident #11's stepdaughter had not visited the facility other than the 8/12/2024 visit. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Attempted telephone interview with Resident #11's stepdaughter on 8/20/2024 at 4:12 PM without success, a message was left with return contact information. Resident #11's stepdaughter did not return the call. During a telephone interview on 8/20/2024 at 4:14 PM, the Consultant Pharmacist stated Budesonide solution and Albuterol were inhalant medications used to treat COPD. The medication helps to open the airway. The Consultant Pharmacist stated if the medication was ingested, the gut may absorb some of it with no problems at all. Ingestion could potentially cause a minor increase in heart rate and blood pressure. The Consultant Pharmacist stated ingestion of 1 vial would not cause any significant harm and stated .You would have to ingest a large amount to have any serious problems . The Consultant Pharmacist stated Albuterol would be difficult to ingest from a handheld inhaler and stated, . it would be difficult for anyone to be able to even squeeze it . The Consultant Pharmacist stated ingestion of Albuterol was unlikely to cause any serious effects but could cause a minor increase in blood pressure and heart rate and had less risk than Budesonide and unlikely to cause any serious effects. The Consultant Pharmacist stated the risk related to ingestion of a small amount of either medication was low, and he had no concerns related to ingestion of a small amount of either medication. Observations during the survey period of 8/19/2024 - 8/21/2024 revealed no concerns related to residents wandering into other resident rooms.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41782 Based on facility policy review, medical record review, observation, and interview the facility failed to ensure nebulizer masks were stored appropriately for 2 residents (Residents #11 and #40) of 5 residents observed for respiratory care. The findings include: Review of the facility's undated policy titled, Respiratory Equipment Cleaning GUIDELINES, revealed .The facility will use these guidelines to manage respiratory equipment .Common respiratory equipment includes nebulizers .Cover respiratory items with plastic bag when not in use . Review of the medical record revealed Resident #11 was admitted to the facility on [DATE] with diagnoses including Pneumonia, Chronic Obstructive Pulmonary Disease (COPD), Acute and Chronic Respiratory Failure, Major Depressive Disorder, Anxiety Disorder, and Malignant Neoplasm of Esophagus. Review of a NURSING - Admission/Readmission Nursing Evaluation for Resident #11 dated 7/29/2024, revealed .Type of respiratory treatments ordered .Aerosol/nebulizer . Review of the Nurse Practitioner's History and Physical for Resident #11 dated 7/30/2024, revealed . admitted for skilled nursing services .recently presented to emergency department .found to have pneumonia and debility .treated with antibiotics .transferred to [facility name] . Review of the comprehensive care plan dated 7/30/2024, revealed .COPD, chronic respiratory failure, and neoplasm of esophagus .Give medications as ordered by physician . Review of the 8/2024 Medication Administration Record (MAR) for Resident #11 revealed the resident received nebulized medications including Budesonide Inhalation Suspension [an inhaled medication used to decrease swelling and irritation in the airways to allow for easier breathing] 0.5 milligrams/2 milliliters twice daily for COPD, Formoterol Fumarate Inhalation Nebulization Solution [an inhaled medication used to make it easier to breathe] 20 micrograms/2 milliliters every 12 hours for Pneumonia, and Ipratropium-Albuterol Solution [an inhaled medication used to treat airflow blockage] 0.5 - 2.5 (3) MG/3ML every 6 hours for COPD. During an observation and interview on 8/19/2024 11:17 AM, Resident #11 was lying in bed. Resident #11's nebulizer mask was lying on the bedside table uncovered and exposed to air. During an observation and interview on 8/19/2024 at 11:37 AM, with the Director of Nursing (DON), in Resident #11's room, the DON confirmed the resident's nebulizer mask was lying on the bedside table, uncovered and open to air. The DON stated nebulizer masks were to be stored in a plastic bag when not in use and confirmed Resident #11's nebulizer mask was not stored appropriately. 45837 Review of the medical record revealed Resident #40 was admitted to the facility on [DATE] with diagnoses including COPD, Encounter for Palliative Care, and Anxiety Disorder. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a quarterly MDS assessment dated [DATE], revealed Resident #40 scored a 14 on the Brief Interview for Mental Status (BIMS) assessment, which indicated the resident was cognitively intact. The resident had active diagnoses of COPD, Hypertension and Anxiety. Review of a comprehensive care plan for Resident #40 dated 4/8/2024, revealed .[Resident #40] is at risk for impaired respiratory status r/t [related to] End stage COPD . During an observation and interview on 8/19/2024 at 11:14 AM, Resident #40 was sitting on the bed and stated she received breathing treatments, and she had a treatment about 8:45 AM that morning. The resident's nebulizer mask was lying uncovered on the nebulizer machine which was on the bedside table. During an observation and interview on 8/20/2024 at 1:09 PM, in Resident #40's room, the resident was sitting on the side of the bed and stated her last breathing treatment was at 11:00 AM that morning. The resident's nebulizer mask was sitting on her side table uncovered. During an observation and interview on 8/20/2024 at 4:48 PM, in resident #40's room, Licensed Practical Nurse (LPN) F confirmed Resident #40 had a respiratory nebulizer mask lying on the table uncovered. The LPN stated the mask should be in a bag when not in use. During an interview on 8/20/2024 at 5:05 PM, the DON stated it was her expectation that respiratory nebulizer masks were to be in a bag and covered when not in use. The DON confirmed the staff was not following the respiratory equipment policy by leaving the nebulizer mask lying uncovered on the table. During an interview on 8/21/2024 at 1:02 PM, the Family Nurse Practitioner (FNP) stated Resident #40 takes nebulizers for COPD that are ordered every 6 hours as needed. The resident was stable, took no antibiotics, and currently had no respiratory infections.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41782 Based on facility policy review, prior survey results review, medical record review, facility documentation review, observation, and interview, the facility failed to maintain an effective and ongoing Quality Assurance Performance Improvement (QAPI) program. The QAPI committee's failure resulted in continued deficient practice when medications were found at 1 resident's (Resident #11) bedside of 69 residents observed. The findings include: Review of the facility's policy titled, Quality Assurance and Performance Improvement (QAPI) Plan, revised 4/2014, revealed .The facility shall develop, implement, and maintain an ongoing, facility-wide QAPI Plan designed to monitor and evaluate the quality and safety of resident care .and resolve identified problems . objectives .Provide a means to identify and resolve present and potential negative outcomes related to resident care and services .Provide structure and processes to correct identified quality and/or safety deficiencies .Establish and implement plans to correct deficiencies, and to monitor the effects of these action plans .The owner and/or governing board (body) of our facility shall be ultimately responsible for the QAPI Program . Review of prior survey findings, revealed the facility was previously cited a deficiency of F689 on a complaint survey on 5/3/2024 at an Immediate Jeopardy level (IJ- A condition in which facility noncompliance with one or more conditions of participation has resulted in or is likely to result in serious injury, harm, impairment, or death and must be immediately corrected). Review of the medical record revealed Resident #11 was admitted to the facility on [DATE] with diagnoses including Pneumonia, Chronic Obstructive Pulmonary Disease (COPD), Acute and Chronic Respiratory Failure, Nicotine Dependence, Major Depressive Disorder, Anxiety Disorder, Malignant Neoplasm of Esophagus, and Tobacco Use. Review of the 7/2024 Medication Administration Record (MAR) for Resident #11 revealed an order dated 7/29/2024 for .Budesonide Inhalation Suspension [an inhaled medication used to decrease swelling and irritation in the airways to allow for easier breathing] 0.5 MG [milligrams]/2ML [milliliters] .2 ml inhale orally two times a day related to CHRONIC OBSTRUCTIVE PULMONARY DISEASE . Review of an admission Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #11 scored a 15 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident was cognitively intact. Review of the 8/2024 MAR for Resident #11 revealed an order dated 8/4/2024, for .Albuterol Sulfate [an inhaled medication used to prevent and treat wheezing and shortness of breath caused by breathing problems such as COPD] .Inhalation Aerosol Solution 108 (90 Base) MCG [micrograms]/ACT [actuation] . (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Self-Administration Evaluation Record for Resident #11 dated 8/7/2024, revealed the section of the assessment stated .Per above assessment results, this resident Would/Would Not (circle one) benefit from self-administration of medications . was incomplete. Review of the facility document titled, RAP (Resident Advocate Program) Surveys, for Resident #11 dated 8/12/2024, revealed no medications were observed at the resident's bedside. Review of the facility document titled, RAP (Resident Advocate Program) Surveys, for Resident #11 dated 8/19/2024, revealed no medications were observed at the resident's bedside. During an observation and interview on 8/19/2024 at 11:17 AM, Resident #11 was lying in bed. The resident's bedside table contained 2 water pitchers, a large coffee can, napkins, cups (some with liquid and some empty), an Albuterol Sulfate Inhalation Aerosol Inhaler, and 1 unopened vial of 0.5mg/2ml vial of Budesonide Inhalation Suspension. During an observation and interview on 8/19/2024 at 11:37 AM, with the Director of Nursing (DON), in Resident #11's room, the DON confirmed the presence of the Albuterol Sulfate inhaler and vial of Budesonide Inhalation vial on the resident's bedside table. The DON stated medications were to be secured in the medication cart unless the resident had been assessed as safe to self-administer medications. During an interview on 8/19/2024 at 1:01 PM, Licensed Practical Nurse (LPN) C stated she had administered Resident #11's morning dose of Budesonide Inhalation treatment and had remained in the room for the duration of the treatment. LPN C stated she did not observe any medications at Resident #11's bedside. During an interview on 8/21/2024 at 3:39 PM, the Administrator stated after the complaint survey on 5/3/2024, where the facility was cited Immediate Jeopardy related to medications at a resident's bedside, the facility implemented the RAP program where a member of management (the resident's advocate) visited residents daily Monday through Friday. One of the things the resident's advocate checked for during their visit was the presence of medications at the bedside. The Administrator stated Resident #11's advocate completed the RAP round on 8/19/2024 prior to the survey team entering the facility and no medications were observed at the bedside. The Administrator stated the facility's QAPI program was effective and stated . I don't know how that happened [medications at Resident #11's bedside] .finding things at the bedside .The program is working in comparison to where it was when I got here a year ago .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45837 Based on facility policy review, Reportable Diseases/Conditions list review, medical record review, observations, and interviews, the facility failed to report new COVID-19 infections for 7 residents (Residents #5, #24, #30, #34, #58, #59, and #66) to the local health department, failed to use appropriate infection control practices by allowing 2 residents (Residents #24 and #58) who were positive for COVID-19 to smoke with 2 residents (Residents #7 and #33) who did not have COVID-19 during 1 of 3 smoking activities observed, failed to ensure infection control practices were followed for 1 resident (Resident #24) of 7 resident's reviewed for transmission based precautions, failed to offer hand hygiene assistance to residents prior to meals for 4 residents (Residents #4, #48, #71, and #41) observed in 1 of 3 resident units observed for meal tray distribution. The findings include: Review of the facility's undated policy titled, Infection Prevention and Control Program, revealed . Surveillance data and reporting information is used to inform the committee of potential issues and trends . Outbreak Management is a process that consists of .reporting the information to appropriate public health authorities .Prevention of Infection .implementing appropriate isolation precautions when necessary . Review of the facility's undated policy titled, COVID-19 Transmission Based Precautions, revealed . Residents suspected or confirmed to have COVID-19 infection should not participate in communal .activities . and should remain in their rooms .unless medically necessary . Review of the facility's undated policy titled, COVID-19 Management of Residents, revealed .Transport and movement of the resident outside of the room will be limited to medically essential purposes .Staff will wear full PPE (N95 respirator, gown, gloves, eye protection) when providing care .Residents with confirmed COVID-19 will have in-room .activities until recovered . Review of the facility's undated policy titled, COVID-19 GUIDELINES, revealed .If a resident is suspected or confirmed to have COVID-19, HCP [Healthcare Provider] must wear an N95 respirator, eye protection, gown, and gloves . Review of the facility's undated policy titled, Hand Hygiene, revealed .'Hand Hygiene' is a general term for cleaning your hands by handwashing with soap and water or the use of an antiseptic hand rub, also known as alcohol-based hand rub (ABHR) .If residents need assistance with hand hygiene, staff should assist with washing hands after toileting, before meals . Review of the state Department of Health's 2024 Reportable Diseases/Conditions list revealed .These healthcare reporting requirements apply to all providers .Please report cases of diseases or conditions listed here .Disease/condition .Coronavirus disease (COVID-19) . Review of the medical record revealed Resident #5 was admitted to the facility on [DATE] with diagnoses including Traumatic Subdural Hemorrhage and Anxiety Disorder. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of an admission Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #5 scored a 13 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident was cognitively intact. Review of facility documentation of COVID-19 testing dated 8/10/2024, revealed Resident #5 had a positive COVID-19 test. Review of physician's order for Resident #5 dated 8/10/2024, revealed .Isolation precautions for Covid. All care to be provided in room . Review of the medical record revealed Resident #24 was admitted to the facility on [DATE] with diagnoses including Acute Respiratory Failure, Shortness of Breath and Vascular Dementia. Review of a quarterly MDS assessment dated [DATE], revealed Resident #24 had memory problems and unclear speech. Review of facility documentation of COVID-19 testing dated 8/10/2024, revealed Resident #24 had a positive COVID-19 test. Review of physician's order for Resident #24 dated 8/10/2024, revealed .Isolation precautions for Covid. All care to be provided in room . Review of the medical record revealed Resident #30 was admitted to the facility on [DATE] with diagnoses including Hydrocephalus (a collection of fluid in the brain) and Depression. Review of a quarterly MDS assessment dated [DATE], revealed Resident #30 scored a 13 on the BIMS assessment which indicated the resident was cognitively intact. Review of facility documentation of COVID-19 testing dated 8/10/2024, revealed Resident #30 had a positive COVID-19 test. Review of physician's order for Resident #30 dated 8/10/2024, revealed .Isolation precautions for Covid. All care to be provided in room . Review of the medical record revealed Resident #34 was admitted to the facility on [DATE] with diagnoses including Asthma and Morbid Obesity. Review of a quarterly MDS assessment dated [DATE], revealed Resident #34 scored a 15 on the BIMS assessment which indicated the resident was cognitively intact. Review of facility documentation of COVID-19 testing dated 8/10/2024, revealed Resident #34 had a positive COVID-19 test. Review of physician's order for Resident #34 dated 8/10/2024, revealed .Isolation precautions for Covid. All care to be provided in room . Review of the medical record revealed Resident #58 was admitted to the facility on [DATE] with diagnoses including Myocardial Infarction and Chronic Obstructive Pulmonary Disease (COPD). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a quarterly MDS assessment dated [DATE], revealed Resident #58 scored a 15 on the BIMS assessment which indicated the resident was cognitively intact. Review of facility documentation of COVID-19 testing dated 8/10/2024, revealed Resident #58 had a positive COVID-19 test. Review of physician's order for Resident #58 dated 8/10/2024, revealed .Isolation precautions for Covid. All care to be provided in room . Review of the medical record revealed Resident #59 was admitted to the facility on [DATE] with diagnoses including Anemia and Depressive Disorders. Review of an admission MDS assessment dated [DATE], revealed Resident #59 scored a 10 on the BIMS assessment which indicated the resident had moderate cognitive impairment. Review of facility documentation of COVID-19 testing dated 8/10/2024, revealed Resident #59 had a positive COVID-19 test. Review of physician's order for Resident #59 dated 8/10/2024, revealed .Isolation precautions for Covid. All care to be provided in room . Review of the medical record revealed Resident #66 was admitted to the facility on [DATE] with diagnoses including Multiple Sclerosis and COPD. Review of a quarterly MDS assessment dated [DATE], revealed Resident #66 scored a 13 on the BIMS assessment which indicated the resident was cognitively intact. Review of facility documentation of COVID-19 testing dated 8/10/2024, revealed Resident #66 had a positive COVID-19 test. Review of physician's order for Resident #66 dated 8/10/2024, revealed .Isolation precautions for Covid. All care to be provided in room . During an interview on 8/20/2024 at 5:05 PM, the Director of Nursing (DON) stated she failed to report the positive COVID results from 8/10/2024 to the state health department. She did not notify the state health department when Residents #5, #24, #30, #34, #58, #59, and #66 tested positive for COVID-19. The DON confirmed she notified the state agency on 8/20/2024, 10 days later. Review of the medical record revealed Resident #7 was admitted to the facility on [DATE] with diagnoses including COPD and Type 2 Diabetes Mellitus. Review of a quarterly MDS assessment dated [DATE], revealed Resident #7 scored a 15 on the BIMS assessment which indicated the resident was cognitively intact. Review of facility documentation of COVID-19 testing dated 8/15/2024, revealed Resident #7 had a negative COVID-19 test. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445288	A. Building B. Wing	08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Huntsville Post-Acute and Rehabilitation Center	287 Baker Street Huntsville, TN 37756

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medical record revealed Resident #33 was admitted to the facility on [DATE] with diagnoses including Dementia and Impulse Disorder. Review of an annual MDS assessment dated [DATE], revealed Resident #33 scored a 9 on the BIMS assessment which indicated the resident had moderate cognitive impairment. Review of facility documentation of COVID-19 testing dated 8/15/2024, revealed Resident #33 had a negative COVID-19 test. During an observation on 8/20/2024 at 9:00 AM, Residents #7, #33 (COVID-19 negative), and Residents #24 and #58 (COVID-19 positive), were gathered 1-2 feet apart from one another at the end of the hall waiting to go outside to smoke. Resident #33 was wearing a mask on his face. Residents #7, #24, and #58 were not wearing masks. Once outside, all 4 residents did not have masks on while smoking. Continued observation showed the residents were distanced approximately 6 feet apart during the smoking activity. During an interview on 8/20/2024 at 9:05 AM, Residents #7 and #33 stated they were aware of other residents (Residents #24 and #58) who tested positive for COVID-19 and participated in the smoking activity. The residents stated they did not have concerns about the COVID-19 positive residents participating in the activity and stated they not seated near them during the smoke times in the smoking area. During an interview on 8/20/2024 at 9:10 AM, CNA B confirmed that Residents #24 and #58 had tested positive for COVID-19 and were in transmissions based precautions. During an interview on 8/20/2024 at 5:05 PM, the DON stated the facility had coordinated that smoking activity at the end of that hall because, in her opinion, all the residents had already been exposed alreadyconfirmed staff failed to take COVID-19 positive residents out separately from residents not infected with COVID-19. 41782 Review of the medical record revealed Resident #24 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Abnormalities of Gait and Mobility, Type 2 Diabetes Mellitus, Vascular Dementia, Major Depressive Disorder, Obsessive-Compulsive Disorder, Expressive Language Disorder, Anxiety, Seizures, and Aphasia. Review of facility documentation revealed Resident #24 tested positive for COVID-19 on 8/10/2024. Review of the Order Summary Report for Resident #24 revealed a physician's order dated 8/10/2024 for . Isolation precautions for Covid. All care to be provided in room . Review of the care plan dated 8/12/2024, revealed .positive for COVID on 8/10/24 .Quarantine for 14 days . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 8/19/2024 at 2:53 PM, Resident #24 was lying in the bed and Certified Nursing Assistant (CNA) D was at the bedside obtaining the resident's blood pressure in the left arm. CNA D wore an N95 mask during the interaction and no other Personal Protective Equipment (PPE). There was signage on Resident #24's door that read, .PPE must be donned correctly before entering the patient area .PPE must remain in place and be worn correctly for the duration of work in potentially contaminated areas .Preferred PPE .N95 or Higher Respirator .Faceshield or goggles .One pair of clean, non-sterile gloves .Isolation gown . Acceptable Alternative PPE .Facemask .Faceshield or goggles .One pair of clean, non-sterile gloves . isolation gown . There was a container on the door that contained masks, gloves, gowns, and faceshields. During an interview on 8/19/2024 at 2:56 PM, CNA D confirmed Resident #24 was positive for COVID-19. CNA D stated signage on the door told staff what PPE was required for a resident in isolation. Residents that were COVID positive required a gown, N95 mask, face shield or goggles, and gloves during resident care. CNA D confirmed she had not worn a faceshield or goggles, gown, or gloves during the direct care interaction with Resident #24. During an interview on 8/20/2024 at 2:22 PM, the DON stated staff were to wear a gown, N95 mask, gloves, and a faceshield or goggles during care for residents with COVID-19. The DON confirmed appropriate infection control practices were not maintained during the resident care interaction. Review of the medical record revealed Resident #4 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Osteoarthritis, Dementia, and Cognitive Communication Deficit. Review of a significant change MDS assessment dated [DATE], revealed Resident #4 scored a 5 on the BIMS assessment which indicated the resident had severe cognitive impairment. During an observation on 8/19/2024 at 12:46 PM, CNA D delivered the lunch tray to Resident #4 and exited the room without offering hand hygiene assistance to the resident. Review of the medical record revealed Resident #48 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Dementia, Osteoarthritis, and Schizophrenia. Review of a quarterly MDS assessment dated [DATE], revealed Resident #48 scored a 5 on the BIMS assessment which indicated the resident had severe cognitive impairment. During an observation on 8/19/2024 at 12:47 PM, CNA D delivered the lunch tray to Resident #48. CNA D set up Resident #48's tray and exited the room without offering hand hygiene assistance to the resident. Review of the medical record revealed Resident #71 was admitted to the facility on [DATE] with diagnoses including Hemiplegia and Hemiparesis, Vascular Dementia, and Mild Cognitive Impairment. Review of an admission MDS assessment dated [DATE], revealed Resident #71 scored a 7 on the BIMS assessment which indicated the resident had severe cognitive impairment. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 8/19/2024 at 12:49 PM, CNA D delivered the lunch tray to Resident #71. CNA D set up Resident #71's tray and exited the room without offering hand hygiene assistance to the resident. Review of the medical record revealed Resident #41 was admitted to the facility on [DATE] with diagnoses including Adjustment Disorder, Osteoarthritis, Other Symptoms and Signs Involving Cognitive Functions and Awareness, and Need for Assistance with Personal Care. Review of a quarterly MDS assessment dated [DATE], revealed Resident #41 scored a 9 on the BIMS assessment which indicated the resident had moderate cognitive impairment. During an observation on 8/19/2024 at 12:50 PM, CNA D delivered the lunch tray to Resident #41. CNA D assisted Resident #41 to set up the lunch tray and exited the room without offering hand hygiene assistance to the resident. During an interview on 8/19/2024 at 12:52 PM, CNA D confirmed she had not offered hand hygiene assistance prior to the meal for Residents #4, #48, #71, and #41. CNA D stated .sometimes I do . when this surveyor asked if she offered hand hygiene assistance to residents prior to meals. CNA D confirmed residents were to be offered hand hygiene prior to meals with either a .rag or hand sanitizer . During an interview on 8/20/2024 at 2:24 PM, the DON confirmed staff were to offer hand hygiene assistance to residents prior to meals with either hand sanitizer, soap and water, or a clean damp cloth. All residents should be offered hand hygiene prior to meals and assistance provided for the resident's that need it. The DON confirmed infection control practices were not followed when hand hygiene was not offered to residents prior to meals.