STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445295	A. Building B. Wing	03/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holston Rehabilitation and Care Center	3641 Memorial Blvd Kingsport, TN 37664

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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** 41782 Based on facility policy review, medical record review, observation and interview, the facility failed to ensure medical information was not visible for 3 residents (#1, #27, and #31) of 122 residents observed and failed to ensure 1 resident (Resident #47) was assisted to the smoking area of 7 residents reviewed for smoking. The findings include: Based on the facility's undated policy titled, Resident Dignity, showed .It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity .All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights . Maintain resident privacy . Review of the facility's undated policy titled, Resident Rights, showed .The resident has a right to reside and receive services in the facility with reasonable accommodation of resident needs . Resident #1 was admitted to the facility on [DATE] with diagnoses including Hemiplegia, Depression, Dementia, Atrial Fibrillation, Anxiety, and Hypertension. Review of Resident #1's quarterly Minimum Data Set (MDS) assessment dated [DATE], showed the resident had moderate cognitive impairment. Review of Resident #1's comprehensive care plan showed no evidence the resident or resident's representative had requested for signage to be posted in the resident's room. During an observation and interview on 3/3/2024 at 11:35 AM, Resident #1 was lying in the bed resting. There was a sign posted above the resident's bed that read, [Resident #1's first and last name] needs to be at 35 to 45 degree angle sitting up at all times!! .Thank You (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 3/4/2024 at 12:40 PM, with Licensed Practical Nurse (LPN) #3, in Resident #1's room, there was a sign posted above the head of Resident #1's bed that read, [Resident #1's first and last name] needs to be at 35 to 45 degree angle sitting up at all times!! .Thank You LPN #3 confirmed the signage was visible to anyone that entered the room. LPN #3 stated the same sign had been posted in .several residents rooms . either because they get short of breath when lying flat or they were at risk for choking. The LPN stated an unknown staff member had posted the sign and confirmed the resident or resident's representative did not request for the signage to be posted. Resident #27 was admitted to the facility on [DATE] with diagnoses including Adult Failure to Thrive, Encounter for Attention to Gastrostomy, Vascular Dementia, Chronic Kidney Disease, Peripheral Vascular Disease, Depression, Hypertension, and Anxiety. Review of Resident #27's quarterly MDS assessment dated [DATE], showed the resident had severe cognitive impairment. Review of Resident #27's comprehensive care plan showed no evidence the resident or resident's representative had requested for signage to be posted in the resident's room. During an observation and interview on 3/3/2024 at 11:39 AM, Resident #27 was lying in the bed. There was a sign posted above the resident's bed that read, [Resident #27's first and last name] needs to be at 35 to 45 degree angle sitting up at all times!! .Thank You During an observation and interview on 3/4/2024 at 12:35 PM, with LPN #3, in Resident #27's room there was a sign posted above the head of Resident #27's bed that read, [Resident #27's first and last name] needs to be at 35 to 45 degree angle sitting up at all times!! .Thank You LPN #3 confirmed the signage was visible to anyone that entered the room. The LPN stated an unknown staff member had posted the sign and confirmed the resident or resident's representative did not request for the signage to be posted. Resident #31 was admitted to the facility on [DATE] with diagnoses including Hemiplegia and Hemiparesis following Cerebral Disease, Chronic Obstructive Pulmonary Disease, Vascular Dementia, and Dysphagia. Review of Resident #31's quarterly MDS assessment dated [DATE], showed the resident had moderate cognitive impairment. Review of Resident #31's comprehensive care plan showed no evidence the resident or resident's representative had requested for signage to be posted in the resident's room. During an observation and interview on 3/3/2024 at 11:39 AM, Resident #31 was lying in the bed resting. There was a sign posted above the resident's bed that read, [Resident #31's first and last name] needs to be at 35 to 45 degree angle sitting up at all times!! .Thank You Resident #31 stated he had not asked for the sign to be posted and was unaware why the sign was posted. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 3/4/2024 at 12:24 PM, with LPN #3, in Resident #31's room there was a sign posted above the head of Resident #31's bed that read, [Resident #31's first and last name] needs to be at 35 to 45 degree angle sitting up at all times!! .Thank You The LPN stated an unknown staff member had posted the sign and confirmed the resident or resident's representative did not request for the signage to be posted. During an interview on 3/4/2024 at 3:12 PM, the Director of Nursing (DON) confirmed signage was not to be posted in resident rooms to communicate resident care needs and confirmed signage posted in resident rooms was a dignity concern. The DON stated .we discovered the signs yesterday when surveyors started asking about the signs posted and all signs were removed from the building . The DON stated she was unaware who posted the signage. The DON stated if the resident or resident representative had requested the signage to be posted, it would be documented in the resident's care plan. The DON confirmed the residents' care plans did not reflect that the residents or resident representatives had requested the posted signs. Resident care needs were to be communicated to staff on the care plan and Certified Nursing Assistant (CNA) task sheet. Resident #47 was admitted to the facility on [DATE] with diagnoses including Chronic Obstructive Pulmonary Disease, Symptoms and Signs involving Cognitive Functions and Awareness, Protein Calorie Malnutrition, Type 2 Diabetes, Dementia/Moderate without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, Mood Disorder, and Anxiety. Review of Resident #47's comprehensive care plan dated 11/16/2023, showed .ADL [Activity of Daily Living] . MOBILITY .The resident has an ADL self-care performance deficit r/t [related to] impaired mobility . Encourage the resident to participate to the fullest extent possible with each interaction .Resident wishes to smoke and is designated as supervised smoker . Review of Resident #47's Smoking and Safety assessment dated [DATE], showed Resident #47 was safe to smoke with no safety concerns documented. Review of Resident #47's quarterly MDS assessment dated [DATE], showed the resident had moderate cognitive impairment. Further review showed the resident had a diagnosis of Non-Alzheimer's Dementia and had no impairment of the upper and lower extremities. During an interview on 3/3/2024 at 10:45 AM, Resident #47 stated he smoked and Certified Nursing Assistant (CNA) #1 refused to roll him to the smoking area (unable to give dates but stated it had happened multiple times). The resident also stated he was aware of the facility's scheduled smoke breaks and he had not missed a time he wanted to smoke due to CNA #1 not assisting him. During an interview on 3/3/2024 at 10:55 AM, CNA #1 stated she was aware Resident #47 smoked. The CNA also stated the resident was able to propel himself to the smoking area in the wheelchair. The resident had requested the CNA to assist him to the smoking area at times (unsure of the exact dates) and . management said if they [residents] was unable to propel to the smoking area on their [residents] own, they couldn't hold a cigarette .it was a safety concern . Continued interview showed CNA #1 was informed by Licensed Practical Nurse (LPN) #1 on 3/2/2024, if a resident was unable to propel themself to the smoking area, the staff were not to assist them, as this was a safety issue and the facility policy. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/3/2024 at 11:10 AM, LPN #1 stated Resident #47 smoked, staff assisted the resident into the wheelchair and the resident propelled himself to the smoking area. The LPN stated it was the facility's policy if a resident smoked, was unable to propel themselves to the smoking area, staff were not to assist the resident, it was a safety concern. LPN #1 was unable to verbalize what the safety concerns were. Resident #47 had not reported concerns of staff refusing to assist him to the smoking area. LPN #1 stated she had informed CNA #1 of the facility's smoking policy. During an observation on 3/3/2024 at 12:25 PM, Resident #47 was in the hallway and requested CNA #1 to assist him to the smoking area. The CNA informed the resident she was unable to assist him, the resident asked why, and the CNA responded .management said if you can't take yourself, you are not safe to smoke . Resident #47 informed the CNA he wanted to speak to management, CNA #1 informed the resident she would assist him to the smoking area this time and would talk to management about the rules. During an interview on 3/3/2024 at 12:29 PM, the Administrator and Director of Nursing (DON) stated when a resident wanted to smoke, was unable to propel themselves to the smoking area, it was their expectation for the resident to be assisted by staff. During an interview on 3/3/2024 at 5:17 PM, Resident #47 stated he had not informed anyone at the facility which included the Administration staff when CNA #1 would not assist him to the smoking area. During an interview on 3/4/2024 at 10:18 AM, the Social Worker stated Resident #47 had not complained of staff not assisting him to the smoking area. 49568 38810

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48100 Based on facility policy review, review of the Resident Assessment Instrument (RAI) Manual 3.0, medical record review, observations, and interviews, the facility failed to accurately complete a Minimum Data Set (MDS) assessment for 2 residents (Residents #364 and #1) of 28 residents reviewed for MDS assessments. The findings include: Review of the Resident Assessment Instrument (RAI) Manual dated 10/2023 showed .The RAI process has multiple regulatory requirements .the assessment accurately reflects the resident's status .a registered nurse conducts or coordinates each assessment with the appropriate participation of health professionals .one of the most important functions .accurate picture of the resident's current health status .active diagnoses in the last 7 days .do not include conditions that have been resolved . Review of the facility's policy titled, Nursing Assessments, dated 12/18/2023, showed .the facility conducts a comprehensive .assessment of each resident functional capacity .based on the resident status .goals . preferences .information in the medication record, as documented by nursing personnel aids in the development of accurate plan . Resident #364 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Malignant Neoplasm of Left Breast, Hypertension, and Osteoporosis. Review of an admission MDS assessment dated [DATE], showed Resident #364 was cognitively intact and was edentulous (no natural teeth). Review of an Oral Cavity Observation assessment dated [DATE], showed .No natural teeth .edentulous . Review of a Clinical Admission assessment dated [DATE], showed .has dentures .full lower .full upper .no natural teeth .edentulous . Review of Resident #364's comprehensive care plan revised 9/4/2023, showed .dental: the resident is edentulous .provide mouth care . Review of a quarterly MDS assessment dated [DATE], showed Resident #364 had moderate cognitive impairment, had no presence of pain, had no weight loss, and had no marked entries for dental status. During an observation and interview on 3/3/2024 at 11:30 AM, Resident #364 stated she had one broken tooth to her front, right upper teeth and the tooth was broken prior to admission. Resident #364 stated she had no pain, no difficulty eating, and had no weight loss. Observation showed Resident #364 had natural teeth and had one broken tooth to her front, right upper teeth. During a telephone interview on 3/4/2024 at 3:15 PM, Resident #364's daughter stated the resident's right upper tooth had broken off prior to admission. Further interview showed the resident had not expressed any pain, weight loss, or difficulty eating from the broken tooth. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/4/2024 at 4:10 PM, Certified Nursing Assistant (CNA) #1 stated Resident #364 had her own teeth and did not have dentures. During an interview on 3/4/2024 at 4:15 PM, Licensed Practical Nurse (LPN) #3 stated Resident #364 had her own teeth and did not have dentures. During an interview on 3/5/2024 at 7:50 AM, the MDS Coordinator stated after reviewing the medical record, Resident #364 had natural teeth and did not wear dentures. The MDS Coordinator confirmed the admission Oral Cavity Observation and Clinical Admission assessments dated 8/24/2023 were inaccurate, the MDS assessment dated [DATE] was not accurate, and the quarterly MDS assessment dated [DATE] did not reflect Resident #364's natural teeth or dental issues. 49568 Resident #1 was admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including Hemiplegia, Asthma, Depression, Dementia, Atrial Fibrillation, Hypertension, and Peripheral Vascular Disease. Review of a quarterly MDS assessment dated [DATE], showed Resident #1 had an active diagnosis of Septicemia (infection of the bloodstream). During an interview on 3/3/2024 at 12:30 PM, LPN #3 stated Resident #1 was not receiving antibiotics for Septicemia. During an interview on 3/4/2024 at 10:30 AM, the MDS Coordinator stated Resident #1 was inaccurately coded on the MDS dated [DATE] for the active Septicemia diagnosis. During an interview on 3/4/2024 at 3:20 PM, the DON stated Resident #1 had not been treated for Septicemia. The DON reviewed the resident's medical record and stated the resident had not been treated for Septicemia in the 7 day look back period for the MDS dated [DATE]. The DON confirmed Resident #1's MDS assessment dated [DATE] had been coded inaccurately for Septicemia. During an interview on 3/5/2024 at 2:00 PM, the MDS Coordinator stated that Resident #1 did not have an active diagnosis for Septicemia in the 7 day look back period for the MDS assessment dated [DATE]. The MDS Coordinator confirmed Resident #1's MDS assessment dated [DATE] was inaccurate and the expectation was the MDS assessment would be coded accurately based upon the RAI manual.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48100 Based on facility policy review, medical record review, observation, and interviews the facility failed to develop and implement a person-centered care plan for 2 residents (Resident #364 and #100) of 28 residents reviewed for care plans. The findings include: Review of the facility's policy titled, Person Centered Care Plans, dated 12/18/2023, showed .Person centered plans of care are developed by the interdisciplinary team, to coordinate and communicate care approaches and goals of the resident, consistent with the residents' rights . Resident #364 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Malignant Neoplasm of Left Breast, Hypertension, and Osteoporosis. Review of Resident #364's comprehensive care plan revised 9/4/2023, showed .dental: the resident is edentulous .provide mouth care . Review of an Oral Cavity Observation assessment dated [DATE], showed .No natural teeth .edentulous . Review of a Clinical Admission assessment dated [DATE], showed .has dentures .full lower .full upper .No natural teeth .edentulous . During an observation and interview on 3/3/2024 at 11:30 AM, Resident #364 stated she had a right, upper broken tooth and the tooth had been broken prior to admission. Resident #364 stated she had no dental pain, no difficulty eating, and had no weight loss. Observation showed Resident #364 had natural teeth and had one broken tooth to her front, right upper teeth. During a telephone interview on 3/4/2024 at 3:15 PM, Resident #364's daughter stated the resident's right, upper tooth had broken off prior to admission into the facility. During an interview on 3/4/2024 at 4:10 PM, Certified Nursing Assistant (CNA) #1 stated Resident #364 had her own teeth and did not have dentures. During an interview on 3/4/2024 at 4:15 PM, Licensed Practical Nurse (LPN) #3 stated Resident #364 had her own teeth and did not have dentures. During an interview on 3/5/2024 at 7:50 AM, the MDS Coordinator stated after reviewing the medical record, Resident #364 had natural teeth and did not wear dentures. The MDS Coordinator confirmed the admission comprehensive care plan was not developed to reflect natural teeth or dental issues. 50216 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #100 was admitted to the facility on [DATE] with diagnoses including Hemiplegia following a Cerebral Infarction, Aphasia, and Nontraumatic Intracerebral Hemorrhage. Review of an Activities Initial Review assessment dated [DATE], showed Resident #100 had no preference to participate in spiritual activities, and the resident did not wish to have clergy visits. Review of an admission MDS assessment dated [DATE], showed Resident #100 was severely impaired for decision making. Review of Resident #100's comprehensive care plan dated 1/9/2024, showed .spiritual distress .consult clergy as needed .determine resident's religion affiliation .determine spiritual beliefs regarding death . encourage [the] resident to continue to study spiritual beliefs . Review of Resident #100's Activity Attendance Record dated 2/18/2024 thru 3/4/2024, showed the resident had attended a spiritual activity on 2/22/2024 and 2/29/2024. During an observation and family interview on 3/3/2024 at 11:47 AM, Resident #100 was observed in room with a family member at bedside. The family member stated the resident had been unable to speak since her stroke. During the family interview the family member stated the resident did not have an affiliation to any religion and did not want to attend any religious activities. The family member stated they had visited on two occasions and found the resident was attending a church service. The family member had asked the staff not to take the resident to church because they did not have a religious belief. During an interview on 3/4/2024 at 4:00 PM, the Activities Director (AD) and the Memory Care Activities Director (MCAD) stated they were unaware of Resident #100's desire to not attend religious activities. The AD stated that if they had known the resident's preference, the resident would not have been taken to a church service. During an interview on 3/5/2024 at 8:03 AM, the AD stated she did not remember marking the Activities Initial Review assessment for the resident's preference of no spiritual activities and no clergy visits. The AD confirmed Resident #100's care plan had not been developed to address spiritual preferences outlined in the Activities Initial Review assessment. During an interview on 3/5/2024 at 9:06 AM, the Assistant Director of Nursing (ADON) stated she did not know who initiated the Spiritual Distress problem on the care plan. The ADON added the problem was a generic, as needed plan of care to be used in case the resident's spiritual preferences changed. During an interview on 3/5/2024 at 1:59 PM, the Director of Nursing (DON) confirmed the Spiritual Distress care plan problem was not person centered based on the resident's belief and desires.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45837 Based on facility policy review, medical record review and interviews, the facility failed to include the resident or resident's representative in the care planning process for 1 resident (Resident #106) of 28 residents reviewed for care planning. The findings include: Review of the facility's policy titled, Person Centered Care Plans, dated 12/18/2023, showed .According to federal regulations, the facility develops a comprehensive person centered plan of care for each resident . Conducting the Interdisciplinary Person Centered Care Plan Meeting .including the resident and their representative when possible .Existing goals and approaches should be reviewed and revised .When the resident is unable to participate in the care plan meeting .due to .cognitive impairment .the residents [resident's] family members should be encouraged to attend .Family participation should be recorded in the EMR [electronic medical record] . Resident #106 was admitted to the facility on [DATE] with diagnoses including Type 2 Diabetes Mellitus, and Obstructive Sleep Apnea. Review of the care plan for Resident #106 dated 1/26/2024, showed the resident had a knowledge deficit with an intervention of .Promote the importance of participation/compliance in treatment regimen . Review of a 5-day Minimum Data Set (MDS) assessment dated [DATE], showed Resident #106 had severe cognitive impairment. During a telephone interview on 3/3/2024 at 3:30 PM, Resident #106's daughter stated she had never been invited to a care plan meeting or had a discussion with anyone at the facility about her mother's plan of care. During an interview on 3/4/2024 at 8:52 AM, the Director of Social Services (DSS) stated Resident #106 had not yet had a care plan meeting held with the family. Typically, care conferences are set up by the admissions team within 48 hours, unless the admission fell on a weekend, then the goal was 72 hours. The DSS confirmed it was her expectation that a care conference was done within that time period and confirmed no care plan conference had been held with Resident #106 or the resident's representative.

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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** 50216 Based on facility policy review, medical record review, observations, and interview the facility failed to provide a safe environment by leaving medications unsecured at the bedside for 1 resident (Resident #419) of 28 residents observed. The findings include: Review of the facility policy titled, Medication Storage in the Facility, dated 1/2/2024, showed .Except for those requiring refrigeration or freezing, medications for internal use are stored in a medication cart or other designated area . Review of the facility policy titled, Preparation and General Guidelines .Self-Administration of Medications, dated 1/2/2024, showed .If the resident demonstrates the ability to safely self-administer medications, a further assessment of safety of bedside medications storage is conducted . Review of Resident #419's Medication Review Report showed the resident admitted to the facility on [DATE] with an order for Spiriva Handihaler Inhalation Capsules 18 microgram (mcg) inhale orally one time a day. There was not an order for antacid tablets on the report. Review of Resident #419's Social Service History & Initial assessment dated [DATE], showed the resident was cognitively intact. During an observation on 3/3/2024 at 12:15 PM, Resident # 419 was lying in his bed. The resident was awake and alert. On the overbed table a box of Tiotropium Bromide bronchodilator (Spiriva Handihaler) with a prescription label on it. Inside the box was an inhalation device and blister pack with 1 capsule remaining. On the nightstand next to the bed was a half full bottle of antacid tables. Resident #419 stated he needed the Tiotropium Bromide refilled so he had the box in the room to give his daughter the information to get it refilled. The resident stated he brought the antacid tablets from home, because when he gets indigestion, he needs them. The resident stated the bottle has been on the nightstand for a few days. There were no residents wandering in the hall during the time of this observation. During an observation on 3/3/2024 at 3:43 PM, the box of Tiotropium Bromide continued to be on the overbed table and the bottle of antiacid tablets continued to be on the nightstand. Continued observation showed there was a second box of Tiotropium Bromide still sealed on the overbed table. The resident stated his daughter brought those in when she came to visit. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 3/3/2024 at 3:47 PM, with Licensed Practical Nurse (LPN) #4 in Resident #419's room, LPN #4 stated medications are not supposed to be left in a resident room. All medications are to be locked up. LPN #4 stated she did not know there was a full capsule left in the Tiotropium Bromide box when she gave the box to the resident to get a refill. LPN #4 also stated she had not observed the bottle of antacid tablets. LPN #4 stated Resident #419 had not been assessed for self-administration of medication. The medications were removed from the room and locked up in the medication cart. During this observation and interview there were no residents wandering in the halls during the time of the observation. During an interview on 3/5/2024 at 7:36 AM, the Director of Nursing (DON) stated her expectation was the nurses should have educated the resident about not storing medications in the resident room and removed the medication from the room. If the resident refuses to allow the medications to be locked up, the nurse should contact me. The DON confirmed the medication should not have been left in Resident #419's room.

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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. 40606 Based on facility policy review, observation, and interview the facility failed to maintain sanitary kitchen equipment which had the potential to effect 120 of the 122 residents in the facility. The findings include: Review of the facility's undated policy titled, Cleaning and Sanitizing Dietary Areas and Equipment, showed . All kitchen areas and equipment shall be maintained in a sanitary manner and be free of build-up of food, grease, or other soil . During the initial kitchen observation on 3/3/2024 at 10:55 AM, with the Certified Dietary Manager (CDM), showed the facility's gas stove griddle had a layer of dried brownish-black food debris observed on the top and the right-side lip of the metal splashguard of the griddle. During an interview on 3/3/2024 at 11:12 AM, the CDM confirmed she was responsible for the oversight of the dietary department. The CDM stated the kitchen equipment was cleaned daily and deep cleaned weekly. The CDM confirmed the stove griddle was in an unsanitary condition and could use further cleaning.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48100 Based on facility policy review, medical record review, observations, and interviews, the facility failed to accurately transcribe an admission order for 1 resident (Resident #48) of 3 residents reviewed for admission orders and the facility failed to ensure admission assessments were accurate for 1 resident (Resident #364) of 28 sampled residents. The findings include: Review of the facility's policy titled, Nursing Assessments, dated 12/18/2023, showed .information in the medication record, as documented by nursing personnel aids in the development of accurate plan . Review of the facility's policy titled, Medication Reconciliation, dated 1/25/2024 .Medication reconciliation refers to the process of verifying that the resident's current medication list matches the physician's orders for the purpose of providing the correct medications to the resident at all points throughout his or her stay . Medication reconciliation involves collaboration with the resident/representative and multiple disciplines, including admission liaisons, licensed nurses, physicians, and pharmacy staff .Pre-Admission Processes . Obtain current medication list from referral source .Obtain current medication/admission orders .Verify resident identifiers .Forward to nursing unit accepting the resident .Admission Processes .Verify resident identifiers on the information received .Compare orders to hospital records; Obtain clarification orders as needed .Transcribe orders in accordance with procedures for admission orders .Have a second nurse review transcribed orders for accuracy and cosign the orders, indicating the review . Resident #48 was admitted to the facility on [DATE] with diagnoses including Giant Cell Arteritis (inflammation of certain arteries, especially those near the temples), Chronic Obstructive Pulmonary Disease (COPD), and Asthma. Review of an admission Minimum Data Set (MDS) assessment dated [DATE], showed Resident #48 was cognitively intact. Review of the hospital discharge orders for Resident #48 dated 1/2024 showed an order for .Prednisone [steroid] .Take 8 tablets (8 mg [milligrams] total) by mouth daily for 10 days .Dispense 80 tablet . Review of Resident #48's Medication Administration Record (MAR) showed .predniSONE Oral Tablet 10 mg (Prednisone) Give 8 tablet by mouth one time a day for inflammation for 10 days . Continued review showed Prednisone 80 mg was administered to Resident #48 on 1/10/2024 at 8:00 AM (and not the ordered 8 mg). During an interview on 3/4/2024 at 9:50 AM, the Director of Nursing (DON) confirmed the order for Prednisone was transcribed as 80 mg daily instead of 8 mg daily and confirmed the order was transcribed incorrectly. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/4/2024 at10:38 AM, the Medical Director stated she was notified Resident #48 had received 1 dose of Prednisone 80 mg instead of 8 mg. The Medical Director stated the resident had severe COPD .so I don't think that would cause problems for the resident . The Medical Director stated the resident had no negative side effects, she didn't receive reports the resident had not slept that evening. During continued interview the Medical Director stated she did not consider that an excessive dose. During an interview on 3/4/2024 at 11:15 AM, Registered Nurse (RN) #2 confirmed the order was transcribed as 80 mg daily and the orders was transcribed incorrectly. Resident #364 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Malignant Neoplasm of Left Breast, Hypertension, and Osteoporosis. Review of an Oral Cavity Observation dated 8/24/2023, showed .No natural teeth .edentulous . Review of a Clinical Admission assessment dated [DATE], showed .has dentures .full lower .full upper .no natural teeth .edentulous . Review of an admission MDS assessment dated [DATE], showed Resident #364 was cognitively intact and was edentulous (no natural teeth). During an observation and interview on 3/3/2024 at 11:30 AM, Resident #364 stated she had a broken tooth on her upper teeth and had not experienced any pain, weight loss, or difficulty eating. Further interview showed the tooth was broken prior to admission. Observation showed Resident #364 had natural teeth and had one broken tooth to her front, right upper teeth. During a telephone interview on 3/4/2024 at 3:15 PM, Resident #364's daughter stated the resident's right upper tooth had broken off prior to admission into the facility. Resident #364's daughter stated the resident had not expressed any pain, weight loss, or difficulty eating from the broken tooth. During an interview on 3/4/2024 at 4:10 PM, Certified Nursing Assistant (CNA) #1 stated Resident #364 had her own teeth and did not have dentures. During an interview on 3/4/2024 at 4:15 PM, Licensed Practical Nurse (LPN) #3 stated Resident #364 had her own teeth and did not have dentures. During an interview on 3/5/2024 at 7:50 AM, the MDS Coordinator stated after reviewing the medical record, Resident #364 had her own teeth and did not wear dentures. The MDS Coordinator confirmed the admission Oral Cavity Observation and Clinical Admission assessments dated 8/24/2023 were inaccurate and did not reflect the resident's natural teeth or dental issues (broken tooth) in the medical record. During an interview on 3/5/2024 at 8:50 AM, LPN #4 stated the Oral Cavity Observation and Clinical Admission assessments completed on 8/24/2023 were inaccurate and edentulous with dentures was marked in error. LPN #4 stated Resident #364 did not wear dentures and had her own teeth at the time of admission. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	36003

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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 (Resident #60) of 4 residents reviewed for hospice. The findings include: Review of the facility's hospice contract with Resident #60's hospice provider dated 4/11/2018, showed .Plan of Care .the Skilled Nursing Facility shall provide services in accordance with the Hospice plan of care . Resident #60 was admitted to the facility on [DATE] and readmitted from the hospital on 1/22/2024 with diagnoses including Hemiplegia and Hemiparesis following Cerebral Infarction Affecting Right Dominant Side, Complete Traumatic Amputation at Level Between Left Hip and Knee, Asthma, Diabetes Mellitus, Atrial Fibrillation, Hypertension, and Post Traumatic Stress Disorder. Review of the facility's policy titled, Hospice, dated 5/15/2023, showed .policy of this facility to provide and/or arrange for hospice services .A Communication process, including how the communication will be documented between the facility and the hospice provider .ensure that .resident's written plan of care includes. Recent hospice plan of care .the most recent plan of care .description of services provided . Review of the medical record showed Resident #60 was admitted to hospice services on 2/2/2024. Continued review showed there was no hospice plan of care in Resident #60's medical record. Review of the significant change Minimum Data Set (MDS) assessment dated [DATE], showed Resident #60 was cognitively intact and received hospice care. During an interview on 3/3/2024 at 3:22 PM, Licensed Practical Nurse #3 stated Resident #60 received hospice services. LPN #3 stated she was unaware where hospice's documentation and plan of care was located. During an interview on 3/5/2024 at 7:25 AM, LPN #5 stated Resident #60 was a hospice resident. The LPN was unaware how to locate the resident's hospice plan of care. During an interview on 3/5/2024 at 2:40 PM, Registered Nurse (RN) #1 stated hospice documentation and plan of care was located either in the resident's physical chart at the nurse's station or in the electronic medical record. RN #1 confirmed Resident #60's hospice plan of care was not available to view in the physical chart at the nurse's station. During an interview on 3/5/2024 at 3:00 PM, RN #1 confirmed Resident #60's hospice plan of care was not available to view in the electronic medical record. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/5/2024 at 5:10 PM, the Director of Nursing (DON) stated it was her expectation that the hospice provider's plan of care was available in the resident's medical record either in the computerized chart or in their chart at the nurses' station so that facility staff could provide coordinated care with the hospice company and confirmed the resident's hospice plan of care was not available.

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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** 38810 Based on facility policy review, medical record review, observations, and interviews the facility failed to assist 4 residents (Residents #20, #75, #614, and #39) with hand hygiene before meals on 1 of 5 hallways observed for meal service. The findings include: Review of the facility's policy titled, Nursing Procedures Manual, dated 6/1/2023, showed .Basic Care Procedures .Serving a Meal .Prepare .serving area for mealtime and make sure hands .are clean . Resident #20 was admitted to the facility on [DATE] with diagnoses including Parkinsonism, Chronic Obstructive Pulmonary Disease, and Anxiety Disorder. Review of a quarterly Minimum Data (MDS) assessment dated [DATE], showed Resident #20 had moderate cognitive impairment. During an observation on 3/3/2024 at 12:02 PM, Resident #20 was served the lunch meal and staff did not offer or assist the resident with hand hygiene. Resident # 75 was admitted to the facility on [DATE] with diagnoses including Type 2 Diabetes, Chronic Kidney Disease, and Anxiety Disorder. Review of a quarterly MDS assessment dated [DATE], showed Resident #75 was cognitively intact. During an observation on 3/3/2024 at 12:05 PM, Resident #75 was served the lunch meal and staff did not offer or assist the resident with hand hygiene. Resident #614 was admitted to the facility on [DATE] with diagnoses including Type 2 Diabetes, Hypothyroidism, and Hypertension. Review of a 5-day MDS assessment dated [DATE], showed Resident #614 was cognitively intact. During an observation on 3/3/2024 at 12:08 PM, Resident #614 was served the lunch meal and staff did not offer or assist the resident with hand hygiene. Resident #39 was admitted to the facility on [DATE] with diagnoses including Type 2 Diabetes, Vascular Dementia, Delusional Disorders, and Hypertension. Review of a quarterly MDS assessment dated [DATE], showed Resident #39 had moderate cognitive impairment. During an observation on 3/3/2024 at 12:10 PM, Resident #39 was served the lunch meal and staff did not offer or assist the resident with hand hygiene. (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 of the 200 hallway lunch meal tray distribution on 3/3/2024, showed the Social Services Assistant, Director of Social Services, and Certified Nursing Assistant (CNA) #1 distributing resident meal trays. During an interview on 3/3/2024 at 12:13 PM, the Social Service Assistant stated she had not offered or assisted residents with hand hygiene prior to the meal. During an interview on 3/3/2024 at 12:16 PM, the Director of Social Services stated she had not offered or assisted residents with hand hygiene prior to the meal. During an interview on 3/4/2024 at 8:20 AM, CNA #1 stated she was not aware hand hygiene was to be offered to the residents prior to meal service. The CNA also stated she was aware to offer hygiene now and offered or assisted residents with hand hygiene this morning. During an interview on 3/5/2024 at 4:32 PM, the Director of Nursing stated it was her expectation for residents to be offered or assisted with hand hygiene prior to meals.