STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495002	A. Building B. Wing	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Roanoke Nursing and Rehabilitation	3823 Franklin Rd, SW Roanoke, VA 24014

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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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, clinical record review, and facility document review, the facility staff failed to provide written notification of the reason(s) for transfer and/or discharge to the resident and the resident's representative for one (1) of twenty-four (24) sampled residents, (Resident #59). The findings include: The facility staff failed to provide written notification of the reason for transfer and/or discharge to Resident #59 and to the resident's representative for a hospital discharge on [DATE]. Resident #59's diagnosis list indicated diagnoses that included but were not limited to Osteoarthritis, Alzheimer's Disease, Hypertension, Type 2 Diabetes Mellitus, Atrial Fibrillation, Chronic Kidney Disease-Stage 3, and History of Surgery on the Digestive System. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 4/9/25, assigned the resident a brief interview for mental status (BIMS) summary score of 6 out of 15 for cognitive abilities, indicating the resident was severely impaired in cognition. A review of the clinical record indicated Resident #59 was transferred to the hospital on 4/3/25. No evidence of written notification of the reason for transfer/discharge being provided to the resident and the resident's representative could be located. Surveyor requested evidence of written notification for the reason of transfer/discharge for Resident #59 and resident's representative for the transfer/discharge that occurred on 4/3/25. On 4/24/25 at 11:08 AM, administrative staff #4 (AS#4) informed surveyor she could not locate evidence of written notification of the reason for transfer/discharge being given to resident and resident's representative. This concern was discussed at the pre-exit meeting on 4/24/25 at 2:12 PM with the administrator, director of nursing, and regional nurse consultant. No further information was provided to the survey team prior to exit on 4/24/25.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, clinical record review, and facility document review, the facility staff failed to accurately determine a significant change in the resident's physical condition using the RAI (resident assessment instrument) process for one (1) of twenty-four (24) sampled residents, (Resident #59). The findings include: The facility staff failed to accurately determine Resident #59 had experienced a significant weight loss of 6. 1% in the past thirty days using the RAI process on a comprehensive assessment dated [DATE]. Resident #59's diagnosis list indicated diagnoses that included but were not limited to Osteoarthritis, Alzheimer's Disease, Hypertension, Type 2 Diabetes Mellitus, Atrial Fibrillation, Chronic Kidney Disease-Stage 3, and History of Surgery on the Digestive System. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 4/9/25, assigned the resident a brief interview for mental status (BIMS) summary score of 6 out of 15 for cognitive abilities, indicating the resident was severely impaired in cognition. Review of Section K (Swallowing/Nutritional Status) K0300 (Weight Loss) was coded as 0 indicating the resident had not experienced a weight loss of 5% or more in the last month. A review of the clinical record revealed the following documentation: A nurse's progress note dated 4/3/25 read in part, .Resident triggered for 6.1% weight loss in 30 days . On 4/24/25 at 8:29 AM, surveyor interviewed licensed practical nurse #1 (LPN#1) about the quarterly MDS completed on 4/9/25 for Resident #59 and reviewed the progress note dated 4/3/25 indicating a 6.1% weight loss in the past 30 days. LPN#1 consulted with the MDS consultant via phone conversation in presence of surveyor and discussed the findings. LPN#1 agreed the MDS should have been a significant change assessment related to the resident's significant weight loss and stated the weight loss should have been coded on the MDS. She stated she would do a modification of the MDS. On 4/24/25 at 9:07 AM, surveyor reviewed the clinical record and a significant change MDS dated [DATE] was observed to be in progress. This concern was discussed at the pre-exit meeting on 4/24/25 at 2:12 PM with the administrator, director of nursing, and regional nurse consultant. (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Centers for Medicare & Medicaid Services Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual Version 1.19.1 October 2024, read in part, .[page 2-24] .A significant change is a major decline .in a resident's status that: 1.Will not normally resolve itself without intervention by staff .2. Impacts more than one area of the resident's heal status .3. Requires interdisciplinary review .[page K-4] .K0300 Weight Loss .Loss of 5% or more in the last month .Start with the resident's weight closest to 30 days ago .[page K-5] .Code 2, yes .if the resident has experienced a weight loss of 5% or more in the past 30 days .and the weight loss was not planned and prescribed by a physician . No further information was provided to the survey team prior to exit on 4/24/25.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 3. For Resident #59, the facility staff failed to accurately code the resident's PRN (as needed) pain medication and failed to code the resident's weight loss of 6.1% on a minimum data set (MDS) assessment dated [DATE]. Resident #59's diagnosis list indicated diagnoses that included but were not limited to Osteoarthritis, Alzheimer's Disease, Hypertension, Type 2 Diabetes Mellitus, Atrial Fibrillation, Chronic Kidney Disease-Stage 3, and History of Surgery on the Digestive System. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 4/9/25, assigned the resident a brief interview for mental status (BIMS) summary score of 6 out of 15 for cognitive abilities, indicating the resident was severely impaired in cognition. Review of Section J (Health Conditions) J0100 (Pain Management) B. Received PRN pain medications was coded as 0 (No) indicating the resident did not receive any PRN pain medications in the past five days. Review of Section K (Swallowing/Nutritional Status) K0300 (Weight Loss) was coded as 0 (No) indicating the resident had not experienced a weight loss of 5% or more in the last month. A medical provider orders with a start date of 4/8/25 read in part, .Oxycodone .oral tablet 5 MG (milligrams) . Give 0.5 tablet by mouth every 4 hours as needed for pain . A review of the April 2025 medication administration record (MAR) revealed Resident #59 received the pain medication twice on 4/8/25 and received the pain medication three times on 4/9/25. A nurse's progress note dated 4/3/25 read in part, .Resident triggered for 6.1% weight loss in 30 days . On 4/24/25 at 8:29 AM, surveyor interviewed licensed practical nurse #1 (LPN#1) about the quarterly MDS completed on 4/9/25 for Resident #59. LPN#1 reviewed the oxycodone order and April 2025 MAR. LPN#1 agreed PRN pain medication should have been coded on the MDS dated [DATE] as the resident received the medication on 4/8/25 and 4/9/25. Surveyor and LPN#1 reviewed the progress note dated 4/3/25 that indicated the resident triggered for a 6/1% weight loss in 30 days. LPN#1 consulted with her consultant via phone conversation in the presence of this surveyor and discussed the findings. LPN#1 agreed the MDS should have been a significant change assessment related to the resident's significant weight loss and stated the weight loss should have been captured on the MDS. She stated she would do a modification of the MDS. On 4/24/25 at 9:07 AM, surveyor reviewed the clinical record and a significant change MDS dated [DATE] was noted to be in progress. This concern was discussed at the pre-exit meeting on 4/24/25 at 2:12 PM with the administrator, director of nursing, and regional nurse consultant. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Centers for Medicare & Medicaid Services Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual Version 1.19.1 October 2024, read in part, .[page J-1] .J0100 Pain Management .[page J-2] .Steps for Assessment 1. Review medical record to determine if a pain regimen exists .Coding instructions for J0100 B, Received PRN Pain Medication .Code 1, yes: if the medical record contains documentation that a PRN medication was either received OR was offered but declined .[page K-4] . K0300 Weight Loss .Loss of 5% or more in the last month .Start with the resident's weight closest to 30 days ago .[page K-5] .Code 2, yes .if the resident has experienced a weight loss of 5% or more in the past 30 days .and the weight loss was not planned and prescribed by a physician . No further information was provided to the survey team prior to exit on 4/24/25. 4. For Resident #70 the facility staff failed to accurately code the resident for Hospice services on an admission MDS dated [DATE]. Resident #70's diagnosis list indicated diagnoses that included but were not limited to Chronic Obstructive Pulmonary Disease, Polyneuropathy, Pressure-Induced Deep Tissue Damage of Sacral Region, Cognitive Communication Disorder, Prediabetes, and Muscle Wasting and Atrophy. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 3/11/25, assigned the resident a brief interview for mental status (BIMS) summary score of 13 out of 15 for cognitive abilities, indicating the resident was cognitively intact. Review of Section O (Special Treatments, Procedures, and Programs) O0100 K1. Hospice Care was coded as Z1. None of the Above. A medical provider orders with a start date of 3/5/25 read in part, .[name omitted] Hospice dx (diagnosis) COPD . A review of the comprehensive person-centered care plan contained a focus that read in part, .resident is under hospice services . On 4/24/25 at 8:29 AM, surveyor interviewed licensed practical nurse #1 (LPN#1) and licensed practical nurse #4 (LPN#4). LPN#1 reviewed the medical provider order for hospice dated 3/5/25 and reviewed section O of the admission MDS dated [DATE] and agreed it was coded incorrectly. LPN#4 stated she would make a modification of the admission MDS. On 4/24/25 at 9:04 AM, surveyor reviewed the clinical record and noted a modification of the admission MDS dated [DATE] was in progress. This concern was discussed at the pre-exit meeting on 4/24/25 at 2:12 PM with the administrator, director of nursing, and regional nurse consultant. A review of Centers for Medicare & Medicaid Services Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual Version 1.19.1 October 2024, read in part, .[page O-7] .O0110: Special Treatments, Procedures, and Programs .O0110K1, Hospice Care .Code residents identified as being in a hospice program . No further information was provided to the survey team prior to exit on 4/24/25. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, staff interview, and clinical record review, the facility staff failed to ensure accurate minimum data set (MDS) assessments for 4 of 24 residents in the survey sample, Residents #79, #30 #59, #70. The findings include. 1. For Resident #79, the facility staff coded a quarterly MDS assessment to indicate this resident used a limb restraint. Resident #79's diagnoses included osteoarthritis, congestive heart failure, and peripheral vascular disease. Section C (cognitive patterns) of Resident #79's quarterly MDS assessment with an assessment reference date (ARD) of 04/02/24 included a brief interview for mental status (BIMS) score of 12 out of a possible 15 points. Per the MDS manual a score of 12=moderately impaired in cognitive skills for daily decision making. Section P (physical restraints) was coded to indicate this resident used a limb restraint less than daily. On 04/22/25 at 1:35 p.m., the surveyor observed Resident #79 in their room. No restraints were observed. During an interview with Licensed Practical Nurse (LPN) #1 this staff stated Resident #79 did not have a restraint, the MDS had been coded for a restraint in error, and they would complete a modification of the MDS. On 04/24/25 at 2:15 p.m., during a meeting with the Administrator, Regional Nurse Consultant, and Director of Nursing the issue with the quarterly MDS assessment being coded to indicate this resident used a restraint was reviewed. Prior to the exit conference the facility staff provided the surveyor with paperwork to indicate a modification had been made to the MDS assessment. No further information regarding this issue was provided to the survey team prior to the exit conference. 2. The facility staff failed to ensure that Resident #30's minimum data set (MDS) assessments correctly captured the resident's functional limitations in range of motion of the lower extremities. Resident #30's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 2/26/25, was signed as completed on 2/28/25. Resident #30 was assessed as usually able to make self understood and as usually able to understand others. Resident #30's Brief Interview for Mental Status (BIMS) summary score was documented as a three (3) out of 15; this indicated severe cognitive impairment. Resident #30's MDS assessment, with an ARD of 4/17/24, had the resident's functional limitation in range of motion assessed as both lower extremities having impairment. Resident #30's MDS assessment, with an ARD of 2/26/25, had the resident's functional limitation in range of motion assessed as both lower extremities having impairment. These two (2) assessments differed from other MDS assessments which had Resident #30 assessed as having no functional limitations in range of motion. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/23/25 at approximately 3:20 p.m., the surveyor discussed, with Licensed Practical Nurse (LPN) #4, the aforementioned MDS assessments which assessed Resident #30 as having lower extremity impairment with functional limitation in range of motion. LPN #4 reported the two (2) MDS assessments with Resident #30 coded as both lower extremities having impairment with functional limitations in range of motion would be modified. Prior to the conclusion of the survey, the facility had modified Resident #30's two (2) MDS assessments in question to indicate Resident #30 did not have lower extremity impairment with functional limitations in range of motion. On 4/24/25 at 2:13 p.m., the survey team met with the facility's Administrator, Director of Nursing, and Regional Director of Clinical Services. During this meeting, the failure of the facility staff to correctly assess Resident #30's lower extremity functional range of motion was discussed.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 4. For Resident #34 the facility staff failed to develop and implement a comprehensive person-centered care plan to address the resident's preferences for no oral suction and no oxygen as indicated on an advance directive form. Resident #34's diagnosis list indicated diagnoses that included but were not limited to Hypertension, Type 2 Diabetes Mellitus, Alzheimer's Disease, Adult Failure to Thrive, Dementia, Glaucoma, History of Falling, Anxiety Disorder, Depression, and Mood Affective Disorder. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 1/20/25, assigned the resident a brief interview for mental status (BIMS) summary score of 4 out of 15 for cognitive abilities, indicating the resident was severely impaired in cognition. A medical provider orders with a start date of 1/14/25 read in part, .DNR (Do Not Resuscitate) . Surveyor requested evidence of Resident #34's advance directive and was provided with a facility document titled, Advanced Directives with an effective date of 1/14/25. Review of the advance directive form indicated Resident #34 did not wish to have Oral Suction and did not wish to have Oxygen. A review of the comprehensive person-centered care plan noted an intervention that read in part, .DNR (Do Not Resuscitate) Hospice . Further review of the interventions failed to provide evidence Resident #34's desire to have no oral suction and desire to have no oxygen were included in the plan of care. On 4/23/25 at 10:42 AM, this surveyor spoke with the resident's representative via phone conversation and asked him about the advance directive form for Resident #34 and he informed this surveyor this was the resident's wishes prior to her cognitive decline, as they had discussed her choices. This concern was discussed at the pre-exit meeting on 4/24/25 at 2:12 PM with the administrator, director of nursing, and regional nurse consultant. Surveyor requested and received a facility policy titled, Care Plans, Comprehensive Person-Centered that read in part, .1. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan .4. Each resident's comprehensive person-centered care plan is consistent with the resident's rights .including the right to .f. participate in determining the type .of care .13. The resident has the right to refuse to participate in .medical and nursing treatments . No further information was provided to the survey team prior to exit on 4/24/25. 5. For Resident #70 the facility staff failed to develop and implement a comprehensive person-centered care plan to address the resident's preferences for no oral suction and no oxygen as indicated on an advance directive form. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #70's diagnosis list indicated diagnoses that included but were not limited to Chronic Obstructive Pulmonary Disease, Polyneuropathy, Pressure-Induced Deep Tissue Damage of Sacral Region, Cognitive Communication Disorder, Prediabetes, and Muscle Wasting and Atrophy. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 3/11/25, assigned the resident a brief interview for mental status (BIMS) summary score of 13 out of 15 for cognitive abilities, indicating the resident was cognitively intact. A medical provider orders with a start date of 3/6/25 read in part, .DNR (Do Not Resuscitate) . Surveyor requested evidence of Resident #70's advance directive and was provided with a facility document titled, Advanced Directives with an effective date of 3/6/25. Review of the advance directive form indicated Resident #70 did not wish to have Oral Suction and did not wish to have Oxygen. A review of the comprehensive person-centered care plan noted an intervention that read in part, .DNR (Do Not Resuscitate) . Further review of the interventions failed to provide evidence Resident #70's desire to have no oral suction and desire to have no oxygen were included in the plan of care. On 4/23/25 at 9:47 AM, surveyor spoke with Resident #70 about the advance directive form and resident stated she did not want oxygen or oral suctioning when or if she gets really bad. This concern was discussed at the pre-exit meeting on 4/24/25 at 2:12 PM with the administrator, director of nursing, and regional nurse consultant. Surveyor requested and received a facility policy titled, Care Plans, Comprehensive Person-Centered that read in part, .1. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan .4. Each resident's comprehensive person-centered care plan is consistent with the resident's rights .including the right to .f. participate in determining the type .of care .13. The resident has the right to refuse to participate in .medical and nursing treatments . No further information was provided to the survey team prior to exit on 4/24/25. 2. For Resident #38, the facility staff failed to ensure the comprehensive person-centered care plan intervention for Dycem (a non-slip material) was present in the resident's wheelchair seat. Resident #38's diagnosis list indicated diagnoses, which included, but not limited to History of Traumatic Subdural Hemorrhage with Loss of Consciousness, Parkinsonism, Dementia, and Repeated Falls. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 3/26/25 assigned the resident a brief interview for mental status (BIMS) summary score of 2 out of 15 indicating the resident was severely cognitively impaired. Resident #38 was coded as being dependent on staff for transferring from sitting to standing and transferring from bed to chair. Resident #38's comprehensive person-centered care plan included a focus area stating [Resident #38] is high risk for falls r/t [related to] limited mobility, weakness and dementia and history of falls with an intervention initiated 12/12/24 for Dycem to his wheelchair. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/22/25 at 2:09 PM, 4/23/25 at 8:58 AM and 3:37 PM, surveyor observed Resident #38's wheelchair and there was no Dycem present above or below the wheelchair seat cushion. On 4/24/25 at 10:49 AM, surveyor spoke with the Unit Manager (UM) regarding the observations of the missing Dycem. UM stated she did not know why the Dycem was not in the wheelchair as it was a fall intervention for him. UM returned at 11:12 AM and stated she had spoken with another staff member who reviews falls and they think Resident #38 may be removing the Dycem himself and they will look at a new intervention for him. Surveyor requested and received the facility policy titled Managing Falls and Fall Risk which read in part . Resident-Centered Approaches to Managing Falls and Fall Risk 1. The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls . On 4/24/25 at 2:12 PM, the survey team met with the Administrator, Director of Nursing, and Regional Nurse Consultant and discussed the concern of staff failing to ensure Resident #38 had Dycem in his wheelchair. No further information regarding this concern was presented to the survey team prior to the exit conference on 4/24/25. 3. For Resident #46, facility staff failed to ensure the comprehensive person-centered care plan intervention for two person assist with mechanical lift transfers was followed. The resident experienced a fall during a mechanical lift transfer with one staff member present. Resident #46's diagnosis list indicated diagnoses, which included, but not limited to Hemiplegia affecting Left Dominate Side, Dementia, Generalized Muscle Weakness, and History of Falling. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 4/09/25 assigned the resident a brief interview for mental status (BIMS) summary score of 7 out of 15 indicating the resident was severely cognitively impaired. Resident #46 was coded as being dependent on staff for bed to chair transfers. Resident #46's comprehensive person-centered care plan included a focus area stating in part . [Resident #46] requires assistance from staff for daily ADL [activities of daily living] care needs and incontinent care r/t [related to] weakness and impaired mobility with an intervention stating Transfer: Dependent with Hoyer [mechanical] lift with 2 assist. Resident #46's clinical record included a nursing progress note dated 4/16/25 7:13 PM stating in part While staff was transferring resident from chair to bed with Hoyer lift, he slipped through to middle and went down to the floor .Assessed for injuries; none found . On 4/23/25 at 9:06 AM, surveyor spoke with Resident #46 who stated he did not know what caused the fall and provided no additional details. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/23/25 at 3:05 PM, surveyor spoke with Certified Nursing Assistant (CNA) #3 who stated she was transferring Resident #46 using a lift pad and Hoyer lift when the resident slid out from the bottom of the lift pad onto the floor landing on his bottom. She stated she was transferring the resident without the assistance of another staff member because she could not find anyone to help her because there was a shortage of staff that night and one person had called in. CNA #3 stated there should always be two staff members when using a Hoyer lift and she should have waited for someone to help her. On 4/24/25 at 8:41 AM, surveyor spoke with the Unit Manager (UM) who stated CNA #3 had not done as she was supposed to when transferring the resident and the CNA has received education and corrective action. UM further stated the unit was not short staffed at the time of the incident. Surveyor reviewed the daily staffing sheet for 4/16/25 which indicated there were two nurses and three CNAs present on the unit and six total CNAs in the facility at the time of the fall. Surveyor requested and received the facility policy titled Using a Mechanical Lifting Machine which read in part . 1. At least two (2) nursing assistants are needed to safely move a resident with a mechanical lift .Steps in the Procedure .2. Measure the resident for proper sling size and purpose, according to manufacturer's instructions . On 4/24/25 at 2:12 PM, the survey team met with the Administrator, Director of Nursing, and the Regional Nurse Consultant and discussed the concern of staff transferring Resident #46 without assistance using a mechanical lift. No further information regarding this concern was presented to the survey team prior to the exit conference on 4/24/25. Based on observations, interviews, clinical record review, and facility document review, the facility staff failed to develop and/or implement a comprehensive care plan (CCP) to address residents' needs and/or preferences for five (5) of 24 residents (Resident #2, Resident #34, Resident #38, Resident #46, and Resident #70). The findings include: 1. Resident #2's care plan failed to address the end-of-life care decision to not receive oxygen and/or oral suctioning. Resident #2's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 1/22/25, was signed as completed on 1/24/25. Resident #2 was assessed as usually able to make self understood and as usually able to understand others. Resident #2's Brief Interview for Mental Status (BIMS) summary score was documented as a 13 out of 15; this indicated intact or borderline cognition. Resident #2's clinical documentation included a form titled ADVANCED DIRECTIVES dated 3/25/24. This form indicated the resident was not to receive oxygen and/or oral suctioning as part of end-of-life care. This form had areas for signatures of (a) the resident, (b) the responsible party, and (c) a witness. (The individual who signed as the witness was the facility's social worker.) On 4/23/25 at 9:40 a.m., the Director of Nursing reported the facility did not have a written policy to specifically address the use of the ADVANCED DIRECTIVES form. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Roanoke Nursing and Rehabilitation	3823 Franklin Rd, SW Roanoke, VA 24014

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #2's comprehensive care plan failed to include the information found as part of the ADVANCED DIRECTIVES form which indicated the resident was not to receive oxygen and/or oral suctioning as part of end-of-life care. On 4/23/25 at 11:01 a.m., the surveyor asked Licensed Practical Nurse (LPN) #1 about the failure of the facility staff to care plan the information found as part of Resident #2's ADVANCED DIRECTIVES form dated 3/25/24. On 4/23/25 at 12:30 p.m., LPN #1 reported Resident #2's care plan had been revised to address the information from the ADVANCED DIRECTIVES form (e.g., declining oxygen and/or oral suctioning). The following information was found as part of a facility document titled Care Plans, Comprehensive Person-Center (with a revised date of March 2022): - A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. - The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. - The comprehensive, person-centered care plan . describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including: (1) services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment . The following information was found as part of a facility document titled Advance Directives (with a revised date of September 2022): - Advance care planning - a process of communication between individuals and their healthcare agents to understand, reflect on, discuss, and plan for future healthcare decisions for a time when individuals are not able to make their own healthcare decisions. - If the resident or representative refuses treatment, the facility and care providers will: . d. assess and document the stated reason for the refusal; e. advise the resident of the consequences and/or potential outcomes of refusal; . g. modify the care plan as appropriate, providing all other appropriate services (i.e., those that will allow him or her to maintain the highest practicable physical, mental and psychosocial well-being). On 4/24/25 at 2:13 p.m., the survey team met with the facility's Administrator, Director of Nursing, and Regional Director of Clinical Services. During this meeting, the failure of the facility staff to ensure Resident #2's comprehensive care plan addressed the resident's and/or the resident's responsible party's end-of-life care decisions related to the provision of oxygen and/or oral suctioning was discussed.

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on staff interview, clinical record review, and facility document review, the facility staff failed to provide care and services to meet professional standards of care for 1 of 24 sampled residents, Resident #46. The findings included: For Resident #46, facility staff failed to use the appropriately sized mechanical lift pad and failed to transfer the resident with the assistance of two staff members while using a mechanical lift resulting in a fall. Resident #46's diagnosis list indicated diagnoses, which included, but not limited to Hemiplegia affecting Left Dominate Side, Dementia, Generalized Muscle Weakness, and History of Falling. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 4/09/25 assigned the resident a brief interview for mental status (BIMS) summary score of 7 out of 15 indicating the resident was severely cognitively impaired. Resident #46 was coded as being dependent on staff for bed to chair transfers. Resident #46's comprehensive person-centered care plan included a focus area stating in part . [Resident #46] requires assistance from staff for daily ADL [activities of daily living] care needs and incontinent care r/t [related to] weakness and impaired mobility with an intervention stating Transfer: Dependent with Hoyer [mechanical] lift with 2 assist. Resident #46's clinical record included a nursing progress note dated 4/16/25 7:13 PM stating in part While staff was transferring resident from chair to bed with Hoyer lift, he slipped through to middle and went down to the floor .Assessed for injuries; none found . On 4/23/25 at 9:06 AM, surveyor spoke with Resident #46 who stated he did not know what caused the fall and provided no additional details. On 4/23/25 at 3:05 PM, surveyor spoke with Certified Nursing Assistant (CNA) #3 who stated she was transferring Resident #46 using a lift pad and Hoyer lift when the resident slid out from the bottom of the lift pad onto the floor landing on his bottom. CNA #3 stated she was using a lift pad with four loops. She stated she was transferring the resident without the assistance of another staff member because she could not find anyone to help her because there was a shortage of staff that night and one person had called in. CNA #3 stated there should always be two staff members when using a Hoyer lift and she should have waited for someone to help her. On 4/23/25 at 3:20 PM, surveyor spoke with CNA #4 who stated she kept up with the appropriately sized lift pads required for each resident and Resident #46 should be using a medium/purple lift pad with six loops. She stated the lift pads with only four loops were for larger residents like 200 to 300 pounds. CNA #4 stated there was a list at the nurse's desk which listed the correct lift pad size for each resident. CNA #4 showed surveyor the list which indicated Resident #46 required a medium/purple lift pad. According to Resident #46's clinical record, he currently weighed 159 pounds and was 77 inches tall. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/24/25 at 8:41 AM, surveyor spoke with the Unit Manager (UM) who stated CNA #3 had not done as she was supposed to when transferring the resident and the CNA has received education and corrective action. UM further stated the unit was not short staffed at the time of the incident. Surveyor reviewed the daily staffing sheet for 4/16/25 which indicated there were two nurses and three CNAs present on the unit and six total CNAs in the facility at the time of the fall. Surveyor requested and received the facility policy titled Using a Mechanical Lifting Machine which read in part . 1. At least two (2) nursing assistants are needed to safely move a resident with a mechanical lift .Steps in the Procedure .2. Measure the resident for proper sling size and purpose, according to manufacturer's instructions . On 4/24/25 at 2:12 PM, the survey team met with the Administrator, Director of Nursing, and the Regional Nurse Consultant and discussed the concern of staff transferring Resident #46 without assistance using a mechanical lift with the wrong sized lift pad resulting in a fall. No further information regarding this concern was presented to the survey team prior to the exit conference on 4/24/25.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on staff interviews, clinical record review, and facility document review, the facility staff failed to perform neuro-checks and vital signs as ordered by a medical provider for one (1) of 24 residents (Resident #76). The findings include: The facility staff failed to complete Resident #76's neuro-checks and vital signs as ordered by a medical provider. Resident #76's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 3/12/25, was signed as completed on 3/18/25. Resident #76 was assessed as usually able to make self understood and as usually able to understand others. Resident #76's Brief Interview for Mental Status (BIMS) summary score was documented as a five (5) out of 15; this indicated severe cognitive impairment. Resident #76's clinical record included medical provider orders, dated 3/16/25 at 11:00 a.m., for neuro-checks and vital signs to be completed every four (4) hours due to a fall. Resident #76's March 2025 medication administration record (MAR) included an area for the neuro-checks and vital signs to be documented. Vital signs were documented as being completed every four (4) hours except for the 4:00 a.m. entry on 3/17/24; for this entry the resident was documented as sleeping. Neuro-checks were signed as completed every four hours except for the 4:00 a.m. entry on 3/17/24; for this entry the resident was documented as sleeping. The assessment findings/data obtained as part of the neuro-checks was neither found by nor provided to the surveyor. The following information was found in a facility document titled Neurological Assessment (with a revised date of October 2010): - The purpose of this procedure is to provide guidelines for a neurological assessment: 1) upon physician order; 2) when following an unwitnessed fall; 3) subsequent to a fall with a suspected head injury; or 4) when indicated by resident condition. - Neurological assessments are indicated: a. Upon physician order; b. Following an unwitnessed fall; c. Following a fall or other accident/injury involving head trauma; or d. When indicated by resident's condition. - Steps in the Procedure . 3. Perform neurological checks with the frequency as ordered or per falls protocol. 4. Determine resident's orientation to time, place and person. 5. Observe resident's patterns of speech and speech clarity. 6. Take temperature, pulse, respirations, blood pressure. 7. Check pupil reaction . 8. Determine motor ability: 9. Have resident move all extremities. 10. Ask resident to squeeze your fingers. Note strength bilaterally. 11. Have resident plantar and dorsiflex [sic]. Note strength bilaterally. Ask resident if he/she has any numbness or tingling in legs/feet/toes and document accordingly. 12. Determine sensation in extremities. Rub resident's arms at the same time to see if resident has decreased sensation in either arm. Check sensation in lower extremities also and document accordingly. 13. Check gag reflex with tongue depressor, if safe for resident. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	14. Have the resident smile to determine if there is any facial drooping and document accordingly. 15. Check eye opening, verbal, and motor responses using the Glasgow Coma Scale. Record observations . - The following information should be recorded in the resident's medical record: . All assessment data obtained during the procedure . On 4/23/25 at 4:25 p.m., the survey team met with the facility's Administrator, Director of Nursing, and Regional Director of Clinical Services. During this meeting, the failure of the facility staff to complete Resident #76's neuro-checks and vital signs as ordered by the medical provider was discussed. The Director of Nursing confirmed that Resident #76 should have been woken up to have the vital signs and neuro-checks completed on 3/17/25 at 4:00 a.m. On 4/24/25 at 2:13 p.m., the survey team met with the facility's Administrator, Director of Nursing, and Regional Director of Clinical Services. During this meeting, the failure of the facility staff to complete Resident #76's medical provider ordered neuro-checks and vital signs was discussed.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - 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. Based on observation, staff interview, clinical record review, and facility document review, the facility staff failed to ensure each resident receives the appropriate assistance and/or assistance devices to prevent accidents for 2 of 24 sampled residents (Resident #46 and Resident #38). The findings included: 1. For Resident #46, facility staff failed to use the appropriately sized mechanical lift pad and failed to transfer the resident with the assistance of two staff members while using a mechanical lift resulting in a fall. Staff also moved the resident from the floor to the bed prior to the nurse assessing the resident for injuries. Resident #46's diagnosis list indicated diagnoses, which included, but not limited to Hemiplegia affecting Left Dominate Side, Dementia, Generalized Muscle Weakness, and History of Falling. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 4/09/25 assigned the resident a brief interview for mental status (BIMS) summary score of 7 out of 15 indicating the resident was severely cognitively impaired. Resident #46 was coded as being dependent on staff for bed to chair transfers. Resident #46's comprehensive person-centered care plan included a focus area stating in part . [Resident #46] requires assistance from staff for daily ADL [activities of daily living] care needs and incontinent care r/t [related to] weakness and impaired mobility with an intervention stating Transfer: Dependent with Hoyer [mechanical] lift with 2 assist. Resident #46's clinical record included a nursing progress note dated 4/16/25 7:13 PM stating in part While staff was transferring resident from chair to bed with Hoyer lift, he slipped through to middle and went down to the floor .Assessed for injuries; none found . On 4/23/25 at 9:06 AM, surveyor spoke with Resident #46 who stated he did not know what caused the fall and provided no additional details. On 4/23/25 at 3:00 PM, surveyor spoke with Registered Nurse (RN) #3, Resident #46's nurse at the time of the fall. RN #3 stated she was giving medications and Certified Nursing Assistant (CNA) #3 came to her and said the resident had fallen. RN #3 stated when she arrived in the resident's room, CNA #3 had already moved the resident from the floor to the bed prior to an assessment. RN #3 stated she completed a head-to-toe assessment and there were no injuries. Surveyor asked RN #3 if it was the usual facility practice for a CNA to move a resident prior to a nursing assessment and she stated no. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/23/25 at 3:05 PM, surveyor spoke with CNA #3 who stated she was transferring Resident #46 using a lift pad and Hoyer lift when the resident slid out from the bottom of the lift pad onto the floor landing on his bottom. CNA #3 stated she was using a lift pad with four loops. She stated she was transferring the resident without the assistance of another staff member because she could not find anyone to help her because there was a shortage of staff that night and one person had called in. CNA #3 stated there should always be two staff members when using a Hoyer lift and she should have waited for someone to help her. On 4/23/25 at 3:20 PM, surveyor spoke with CNA #4 who stated she kept up with the appropriately sized lift pads required for each resident and Resident #46 should be using a medium/purple lift pad with six loops. She stated the lift pads with only four loops were for larger residents like 200 to 300 pounds. CNA #4 stated there was a list at the nurse's desk which listed the correct lift pad size for each resident. CNA #4 showed surveyor the list which indicated Resident #46 required a medium/purple lift pad. According to Resident #46's clinical record, he currently weighed 159 pounds and was 77 inches tall. CNA #4 and surveyor went back to Resident #46's room and observed the resident up in a reclining chair with a size large lift pad underneath him. CNA #4 stated the resident currently had the wrong sized lift pad underneath him and she had the correct sized lift pad in her arms and laid it on the resident's bed. On 4/24/25 at 8:41 AM, surveyor spoke with the Unit Manager (UM) who stated CNA #3 had not done as she was supposed to when transferring the resident and the CNA has received education and corrective action. UM further stated the unit was not short staffed at the time of the incident. Surveyor reviewed the daily staffing sheet for 4/16/25 which indicated there were two nurses and three CNAs present on the unit and six total CNAs in the facility at the time of the fall. On 4/24/25 at 8:59 AM, surveyor spoke with the UM and inquired why Resident #46 had a large lift pad underneath him the previous day. UM stated she was unsure but would find out. UM returned at 10:49 AM and stated his lift pad was in the wash yesterday. Surveyor requested and received the facility policy titled Using a Mechanical Lifting Machine which read in part . 1. At least two (2) nursing assistants are needed to safely move a resident with a mechanical lift .Steps in the Procedure .2. Measure the resident for proper sling size and purpose, according to manufacturer's instructions . On 4/24/25 at 2:12 PM, the survey team met with the Administrator, Director of Nursing, and the Regional Nurse Consultant and discussed the concern of staff transferring Resident #46 without assistance using a mechanical lift with the wrong sized lift pad resulting in a fall. The concern of the CNA moving the resident following the fall prior to a nursing assessment was also discussed. No further information regarding this concern was presented to the survey team prior to the exit conference on 4/24/25. 2. For Resident #38, the facility staff failed to ensure placement of Dycem non-slip material in the resident's wheelchair seat as indicated on the resident's comprehensive person-centered care plan. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #38's diagnosis list indicated diagnoses, which included, but not limited to History of Traumatic Subdural Hemorrhage with Loss of Consciousness, Parkinsonism, Dementia, and Repeated Falls. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 3/26/25 assigned the resident a brief interview for mental status (BIMS) summary score of 2 out of 15 indicating the resident was severely cognitively impaired. Resident #38 was coded as being dependent on staff for transferring from sitting to standing and transferring from bed to chair. According to Resident #38's clinical record, he had fallen three times in the past three months, with the most recent fall occurring on 4/07/25. An 4/07/25 6:10 PM nursing progress note read in part Resident was observed standing up in his room [at] 6:05pm and was assisted to his wheelchair. At 6:10pm he was seen sitting upright on the floor behind his wheelchair .Checked for injuries; none found except small 1 cm skin tear left elbow . Resident #38 was seen by the medical provider on 4/10/25, the progress note read in part .Resident is moderate to high risk for additional falls and high risk for injury R/T [related to] fall . Resident #38's comprehensive person-centered care plan included a focus area stating [Resident #38] is high risk for falls r/t [related to] limited mobility, weakness and dementia and history of falls with an intervention initiated 12/12/24 for Dycem to his wheelchair. During the survey, surveyor observed Resident #38 on several occasions independently transferring from the bed to the wheelchair and from the wheelchair to standing/walking without assistance. On 4/22/25 at 12:27 PM, while the resident was independently walking in his room, a Certified Nursing Assistant (CNA) entered the room and stated he was not supposed to be walking without assistance. On 4/22/25 at 2:09 PM, 4/23/25 at 8:58 AM and 3:37 PM, surveyor observed Resident #38's wheelchair and there was no Dycem present above or below the wheelchair seat cushion. On 4/24/25 at 10:49 AM, surveyor spoke with the Unit Manager (UM) regarding the observations of the missing Dycem. UM stated she did not know why the Dycem was not in the wheelchair as it was a fall intervention for him. UM returned at 11:12 AM and stated she had spoken with another staff member who reviews falls and they think Resident #38 may be removing the Dycem himself and they will look at a new intervention for him. Surveyor requested and received the facility policy titled Managing Falls and Fall Risk which read in part . Resident-Centered Approaches to Managing Falls and Fall Risk 1. The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls . On 4/24/25 at 2:12 PM, the survey team met with the Administrator, Director of Nursing, and Regional Nurse Consultant and discussed the concern of staff failing to ensure Resident #38 had Dycem in his wheelchair. No further information regarding this concern was presented to the survey team prior to the exit conference on 4/24/25.

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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 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. Based on observation, staff interview and clinical record review, the facility staff failed to provide respiratory services for 1 of 23 Residents, Resident #65. The findings included: For Resident #65 the facility staff failed to consistently provide and/or document oxygen usage per the physician's order and the hospice plan. Resident #65's face sheet listed diagnoses which included but not limited to malignant neoplasm of unspecified part of unspecified bronchus or lung, chronic obstructive pulmonary disease, emphysema, and respiratory failure. Resident #65's most recent minimum data set with an assessment reference date of 03/16/25 assigned the resident a brief interview for mental status score of 15 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact. Resident #65's comprehensive care plan was reviewed and contained a plan for The resident has COPD (chronic obstructive pulmonary disease) and is on 8 L/Min (liters per minute) via nasal cannula every shift for lung CA (cancer). He removes and reapplies his nasal cannula. Resident #65's clinical record was reviewed and contained a physician's order summary which read in part, Oxygen @ 8 LPM (liters per minute) via NC (nasal cannula), may remove for ADL's (activities of daily living) every shift for Lung CA. Resident #65's electronic medication administration record for the month of April 2025 was reviewed and contained an entry as above. This entry has been initialed as completed per the physician's order. During a medication pass and pour observation with licensed practical nurse (LPN) #3 on 04/23/25 at 8:55 am, LPN #3 stated to surveyor they needed to check Resident #65's 02 sats, because hospice is trying to wean him off oxygen. Surveyor observed Resident #65's oxygen concentrator set on 5 LPM of oxygen. LPN #3 recorded resident's 02 sats as 98% on 3 LPM of oxygen. Surveyor observed Resident #65's oxygen concentrator set on 5 LPM on 04/24/25 at 9:50 am. Resident was lying across bed, asleep at this time. Surveyor spoke with LPN #6 on 04/24/25 at 9:55 am regarding Resident #65's oxygen. LPN #6 stated the resident's oxygen is supposed to be on 8 LPM, but hospice is trying to titrate it down to 5-6 LPM. Surveyor asked LPN #6 how they know what hospice wants done, and LPN #6 stated that hospice gives either a verbal or written order, which then gets entered into the electronic record. Surveyor reviewed Resident #65's hospice communication record and could not locate an order to titrate the oxygen. Hospice communication record contained hospice notes which read in part, 3/27 Decreased 02 to 5 L, tolerated well, 4-8 .decreased 02 to attempt to get to 5 L over next two weeks, 4-10 02 on 6 L, tolerating well, 4-17 tolerating 6 L 02, and 4-22 routine 02 to 5 L, will follow up on how he tolerates. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #65's clinical record contained nurses' progress notes which read in part, 03/29/2025 18:15 . Resident continues on 8 ltrs of 02 infusing via nasal cannula, 03/30/2025 14:38 .02 infusing at 8 ltrs continuously via nasal cannula ., 04/18/2025 18:14 .02 sats were 99% on 5 ltrs of 02 infusing via nasal cannula ., 04/19/2025 10:10 .oxygen at 3 L/NC ., 04/20/2025 02:48 .02 8LPM ., 04/20/2025 10:02 .on cont. (continuous) oxygen at 3 L/NC ., 04/21/2025 .02 sats were 99% on 02 infusing via nasal cannula at 6 ltrs continuous ., 04/22/2025 11:07 .On cont. oxygen at 3 L/NC ., and 04/23/2025 09:58 .oxygen at 3 L/NC . Surveyor spoke with the hospice nurse on 04/24/25 at 1:05 pm. Hospice nurse stated they had written the order and had it faxed to the facility, but did not know why it didn't get entered into the resident's clinical record. Hospice nurse stated they had the order faxed again today. Hospice nurse stated the order is to decrease the oxygen by 1 LPM every 24 hours as the resident tolerates. Hospice nurse provided the surveyor with a hospice care plan which read in part, Resident will be comfortable on 5 LPM. Hospice nurse also stated that resident has his own pulse oximeter, and will check his 02 stats himself, and adjust his oxygen as needed. The director of nursing provided surveyor with a copy of a hospice order for oxygen, which read in part, 03/27/25 12:45 02 titration: Titrate 02 down 1 L q (every) 24 hours as tolerated by pt (patient). note: ne (?) parameter as tolerance will be based on pt comfort/SOB (shortness of breath). Resident #65's clinical record was reviewed and contained vital signs record which listed resident's 02 sats as ranging from 94-100% on 8 LPM of oxygen from 03/13-03/25/25 and from 90-98% on 3 LPM of oxygen from 04/19-04/23/25. From 03/26-04/01/25 02 sats ranged from 93-99% with no amount of oxygen recorded. No data was documented from 04/01-04/19/25. The concern of not consistently providing and documenting oxygen usage per the physician and hospice orders was discussed with the administrator, director of nursing and regional director of clinical services on 04/24/25 at 3:00 pm. No further information was provided prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495002	A. Building B. Wing	04/24/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interviews, and facility document review, the facility staff failed to adequately prevent hair from contacting food in the facility kitchen. The findings were: Facility staff failed to consistently wear a beard net while preparing food in the kitchen. On 04/22/25 at 4:15 p.m. the surveyor returned to the kitchen for observations while staff prepared residents' food trays. One cook (Food Service Aide - Other Employee #2) with visible facial hair was observed without a net over the facial hair. The acting director of food and nutrition was present and when asked, reported the food service aide should have their facial hair covered. The director instructed Other Employee #2 to apply a beard net. In the morning of 04/23/25, the regional director of clinical services (RDCS) and the administrator were informed of the observation of Other Employee #2 preparing food in the kitchen without a beard net on 04/22/25. During an end of day meeting on 04/23/25 at 4:28 p.m. with the administrator, director of nursing (DON), and RDCS, the observation was discussed. The RDCS provided a policy titled, Preventing Foodborne Illness - Employee Hygiene and Sanitary Practices. The policy statement read, Food and nutrition services employees follow appropriate hygiene and sanitary procedures to prevent the spread of foodborne illness. The policy interpretation and implementation read in part, .Hair Nets 15. Hair nets or caps and/or beard restraints are worn when cooking, preparing or assembling food to keep hair from contacting exposed food, clean equipment, utensils and linens . On 04/24/25, the administrator provided a document dated 04/23/25 and signed by the acting director of food and nutrition which indicated the acting director had provided education to the kitchen staff. The topics discussed read, Proper use of hair net and beard guard. The objective read, Apply knowledge to keep food safe from any foreign objects including hair. Five dietary staff members which included Other Employee #2 had signed the education document. No further information was provided prior to the exit conference.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on resident interview, family interview, staff interview, clinical record review, and facility document review, the facility staff failed to maintain complete and/or accurate clinical records for 21 of 24 sampled residents (Resident #34, Resident #70, Resident #2, Resident #76, Resident #30, Resident #73, Resident #32, Resident #3, Resident #36, Resident #38, Resident #46, Resident #7, Resident #24, Resident #59, Resident #15, Resident #31, Resident #60, Resident #22, Resident #35, Resident #71, and Resident #79). The findings include: 1. For Resident #34 the facility staff failed to document verbal communication with the resident and/or resident's representative that addressed the resident/representative reason/reasons for refusal of oral suction and oxygen as indicated on an advance directive form and facility staff failed to document education was provided to the resident and/or resident representative of the consequences and/or potential outcomes related to refusal of oral suction and oxygen. Resident #34's diagnosis list indicated diagnoses that included but were not limited to Hypertension, Type 2 Diabetes Mellitus, Alzheimer's Disease, Adult Failure to Thrive, Dementia, Glaucoma, History of Falling, Anxiety Disorder, Depression, and Mood Affective Disorder. The most recent minimum data set (MDS) with an assessment reference date (ARD) of [DATE], assigned the resident a brief interview for mental status (BIMS) summary score of 4 out of 15 for cognitive abilities, indicating the resident was severely impaired in cognition. A medical provider orders with a start date of [DATE] read in part, .DNR (Do Not Resuscitate) . A review of the comprehensive person-centered care plan noted an intervention that read in part, .DNR (Do Not Resuscitate) Hospice . Surveyor requested evidence of Resident #34's advance directive and was provided with a facility document titled, Advanced Directives with an effective date of [DATE]. Review of this advance directive form indicated Resident #34 did not wish to have Oral Suction and did not wish to have Oxygen. This surveyor was unable to locate documented evidence in the clinical record of facility staff assessment and/or documentation of reason/reasons for the resident/resident's representative refusal of oral suction and oxygen and was unable to locate evidence of facility staff education to Resident #34/resident's representative of the consequences and/or potential outcomes of the resident's refusal of oral suction and oxygen. On [DATE] at 10:42 AM, this surveyor spoke with the resident's representative via phone conversation and asked him about Resident #34's advance directive form and he informed this surveyor this was the resident's wishes prior to her cognitive decline, as they had discussed her choices. On [DATE] at 3:41 PM, the administrator informed this surveyor that advance directive education is verbal, and nothing is documented about these verbal discussions in the clinical record. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	This concern was discussed at the pre-exit meeting on [DATE] at 2:12 PM with the administrator, director of nursing, and regional nurse consultant. Surveyor requested and received a facility policy titled, Advance Directives that read in part, .Refusing or Requesting Treatment .3. If the resident or representative refuses treatment, the facility and care providers will .c. document specifically what the resident/representative is refusing d. assess and document the stated reason for the refusal e. advise the resident of the consequences and/or potential outcomes of refusal . No further information was provided to the survey team prior to exit on [DATE]. 2. For Resident #70 the facility staff failed to document verbal communication with the resident and/or resident's representative that addressed the resident's reason/reasons for refusal of oral suction and oxygen as indicated on an advance directive form and facility staff failed to document education was provided to the resident and/or resident representative of the consequences and/or potential outcomes related to refusal of oral suction and oxygen. Resident #70's diagnosis list indicated diagnoses that included but were not limited to Chronic Obstructive Pulmonary Disease, Polyneuropathy, Pressure-Induced Deep Tissue Damage of Sacral Region, Cognitive Communication Disorder, Prediabetes, and Muscle Wasting and Atrophy. The most recent minimum data set (MDS) with an assessment reference date (ARD) of [DATE], assigned the resident a brief interview for mental status (BIMS) summary score of 13 out of 15 for cognitive abilities, indicating the resident was cognitively intact. A medical provider orders with a start date of [DATE] read in part, .DNR (Do Not Resuscitate) . A review of the comprehensive person-centered care plan noted an intervention that read in part, .DNR (Do Not Resuscitate) . Surveyor requested evidence of Resident #70's advance directive and was provided with a facility document titled, Advanced Directives with an effective date of [DATE]. Review of this advance directive form indicated Resident #70 did not wish to have Oral Suction and did not wish to have Oxygen. This surveyor was unable to locate documented evidence in the clinical record of facility staff assessment and/or documentation of reason/reasons for the resident/resident's representative refusal of oral suction and oxygen and was unable to locate evidence of facility staff education to Resident #70/resident's representative of the consequences and/or potential outcomes of the resident's refusal of oral suction and oxygen. On [DATE] at 9:47 AM, surveyor spoke with Resident #70 about her advance directive and resident stated she did not want oxygen or oral suctioning when or if she gets really bad. On [DATE] at 3:41 PM, the administrator informed this surveyor that advance directive education is verbal, and nothing is documented about these verbal discussions in the clinical record. This concern was discussed at the pre-exit meeting on [DATE] at 2:12 PM with the administrator, director of nursing, and regional nurse consultant. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor requested and received a facility policy titled, Advance Directives that read in part, .Refusing or Requesting Treatment .3. If the resident or representative refuses treatment, the facility and care providers will .c. document specifically what the resident/representative is refusing d. assess and document the stated reason for the refusal e. advise the resident of the consequences and/or potential outcomes of refusal . No further information was provided to the survey team prior to exit on [DATE]. 3. The facility staff failed to document the details of the education provided to Resident #2's responsible party related to the decision to decline oxygen and oral suctioning as part of the end-of-life care choices documented on the resident's ADVANCED DIRECTIVES form. Resident #2's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of [DATE], was signed as completed on [DATE]. Resident #2 was assessed as usually able to make self understood and as usually able to understand others. Resident #2's Brief Interview for Mental Status (BIMS) summary score was documented as a 13 out of 15; this indicated intact or borderline cognition. Resident #2's clinical documentation included a form titled ADVANCED DIRECTIVES dated [DATE]. This form indicated the resident was not to receive oxygen and/or oral suctioning as part of end-of-life care. This form had areas for signatures of (a) the resident, (b) the responsible party, and (c) a witness. (The individual who signed as the witness was the facility's social worker.) The surveyor was unable to find documentation that detailed Resident #2's responsible party's notification of the benefits and risk related to declining oxygen and/or oral suctioning as part of the resident's end-of-life care. On [DATE] at noon, the Assistant Director of Nursing provided the surveyor with documentation that indicated Resident #2's advanced directives and code status was reviewed as part of the care planning process on: (a) [DATE] at 6:05 p.m., (b) [DATE] at 1:09 p.m., and (c) [DATE] at 4:33 p.m.; these notes did not detail education being provided related to the benefits and risk of declining to receive oxygen and/or oral suctioning as part of end-of-life care. The following information was found as part of a facility document titled Advance Directives (with a revised date of [DATE]): - Advance care planning - a process of communication between individuals and their healthcare agents to understand, reflect on, discuss, and plan for future healthcare decisions for a time when individuals are not able to make their own healthcare decisions. - If the resident or representative refuses treatment, the facility and care providers will: . d. assess and document the stated reason for the refusal; e. advise the resident of the consequences and/or potential outcomes of refusal; . On [DATE] at 2:13 p.m., the survey team met with the facility's Administrator, Director of Nursing, and Regional Director of Clinical Services. During this meeting, the failure of the facility staff to document the information/education provided to Resident #2 or Resident #2's responsible party related to oxygen and oral suctioning as part of end-of-life care was discussed. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. The facility staff failed to complete the ADVANCED DIRECTIVES form, according to the form's instructions, for 21 of 24 sampled residents (Resident #2, Resident #3, Resident #7, Resident #15, Resident #22, Resident #24, Resident #30, Resident #31, Resident #32, Resident #34, Resident #35, Resident #36, Resident #38, Resident #46, Resident #59, Resident #60, Resident #70, Resident #71, Resident #73, Resident #76, and Resident #79). The aforementioned residents' clinical documentation included a completed ADVANCED DIRECTIVES form. The ADVANCED DIRECTIVES form included the following information: - Health care advance directives are legal documents that communicate a person's wishes about health care decisions in the event the person becomes incapable of making health care decisions. - Policy: It is the policy of (the facility's company name omitted) to ascertain and honor the resident/resident representative's wishes for end of life. - Procedure: Advanced Directives are used to honor the resident/resident representative wishes for care when they are no longer able to make those decisions for themselves. - Please initial are [sic] areas that you authorize in the event the resident is no longer able to make decisions for themselves. - The following are the areas that could be initialed to guide the residents' end-of-life care: No Hospitalizations, No Weights, No Laboratory Testing, No Tube Feeding (to include, G Tube, J Tube, Dobhoff Tube), No IV Fluids, Pain Medications, Antibiotic Use, Oral Suction, Oxygen, HemoDialysis, CPR, and Do Not Resuscitate. For the ADVANCED DIRECTIVES forms in the clinical documentation of the 21 aforementioned residents, the facility staff failed to ensure the desired areas were initialed by the individual providing the information; instead, the desired areas were either marked by a checkmark or an x. On [DATE] at 2:13 p.m., the survey team met with the facility's Administrator, Director of Nursing, and Regional Director of Clinical Services. During this meeting, the failure of the facility staff to ensure the ADVANCED DIRECTIVES forms were completed per the form instructions (requiring the individual providing the information to initial desired areas) was discussed.

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F 0922 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have enough backup water supply for essential areas of the nursing home. Based on staff interviews and facility document review, the facility staff failed to develop procedures to detail the facility's process to ensure availability of water in response to a loss of the facility's normal water supply. The findings include: The facility staff failed to have a written procedure to: (a) address the facility's water needs if the facility experiences a loss in the normal water supply and (b) detail the process to ensure water availability if the facility experiences a loss in the normal water supply. The surveyor reviewed the facility's process/procedure to ensure water availability in response to the loss of normal water supply; this was reviewed as part of the facility's emergency preparedness program. The facility staff failed to have written policies to address facility's water needs in response to a water outage. On 4/24/25 at 12:18 p.m., the Administrator reported the plan is for 64 ounces of water per day for three (3) days for 90 residents and 40 staff members (this was not written). The surveyor, with the Administrator present, completed observations of the facility's emergency water storage; the emergency water storage consisted of 60 gallons of water. The Administrator reported the facility had an agreement for water delivery. The following information was found in a document provided by the company with which the facility had an agreement for water delivery: Product allocations are likely as demand increases and supplies diminish. We commit to monitor and replenish inventory levels as quickly as possible throughout any disaster scenario. Estimated needs are 64 oz per day (8-8 oz) for each patient, resident, employee and/or visitors. A three-day supply is recommended should such a need arise. The estimated purified drinking water needs were identified in this document as 100 gallons. This document did not provide recommendations for the facility's non-drinkable water needs. On 4/24/25 at 2:13 p.m., the survey team met with the facility's Administrator, Director of Nursing, and Regional Director of Clinical Services. During this meeting, the surveyor discussed the failure of the facility staff to have a written process: (a) detailing the facility's drinkable and non-drinkable water needs and (b) detailing the provision of water in the case of the loss of the normal water supply.