STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495013	A. Building B. Wing	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Richfield Health Center - Salem	3719 Knollridge Road Salem, VA 24153

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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. 22218 Based on resident interview, staff interview, facility document review, facility staff failed to ensure the resident was treated with dignity related to toileting for 1 of 23 current residents in the survey sample (Resident #89). Resident #89 was admitted to the facility with diagnoses which included aftercare joint replacement, anemia, hypertension, anticoagulants, abnormal gait, and a history of pulmonary embolism. On the most recent Minimum Data Set assessment, the resident scored 15/15 on the brief interview for mental status and was assessed as without signs of delirium, psychosis, or behavior affecting care. During initial tour on 5/13/2024, Resident #89 complained that she was left on the toilet for 2 1/2 hours on 5/12/24. On 5/14/24, the surveyor received the call Alarm History for the resident's room from 5/12/24 at 12:00 AM through 5/13/24 at 12 AM. The log documented a call from the bed active from 10:21:01 through 12:21:41 (duration 120 minutes). The log documented 7 calls from the bathroom starting at 12:41:27 and ending 14:44:48 (duration in minutes 7.55, 9.33, 2.78, 18.52, 38.28, 39.07, and 6.68) indicating the resident had been in the bathroom for 122 minutes. The surveyor discussed the Alarm History with the director of nursing (DON), stating that it appeared the resident had been left in the bathroom for a significant amount of time. Nursing staff working on 5/13 reported that neither of the nurses or aids working that day had worked on 5/12. The surveyor reported the concern to the director of nursing (DON) and asked to contact the nurse responsible for the resident's care on 5/12/24. On 5/14, the DON supplied the nurse's contact information, however, the nurse was unable to make contact with the nurse for an interview. Activity of daily living notes documented the resident used the toilet 1 time during the day shift on 5/12/24. The administrator and DON were notified of the ongoing concern during a summary meeting on 5/14/2024.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 42353 Based on staff interview, clinical record review, and facility document review, the facility staff failed to notify and consult with the medical provider following a significant weight loss for 1 of 23 current sampled residents, Resident #69. The findings included: For Resident #69, the facility staff failed to notify and consult with the medical provider following a significant weight loss identified on 3/11/24. Resident #69's diagnosis list indicated diagnoses, which included, but not limited to Alzheimer's Disease, Convulsions, Parkinson's Disease, Lymphedema, Essential Hypertension, and Second-Degree Atrioventricular Block. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 3/11/24 coded the resident as being severely impaired in cognitive skills for daily decision making with short-term and long-term memory problems. Resident #69 was coded as having had a significant weight loss without a physician-prescribed weight loss regimen. A review of Resident #69's weights revealed a weight of 160.6 on 3/01/24 and a weight of 148.6 on 3/11/24 revealing a 12-pound/7.47% loss in 10 days. The resident's most recent weight of 137.8 was obtained on 5/13/24. Surveyor reviewed Resident #69's clinical record and was unable to locate evidence of medical provider notification of the significant and sustained weight loss. Surveyor spoke with the Director of Nursing (DON) on 5/15/24 at 11:10 AM regarding Resident #69's significant weight loss. The DON was unable to provide evidence of medical provider notification of the weight loss. Surveyor requested and received the facility policy titled Weight Assessment and Intervention dated 10/2023 which read in part .3. Any significant weight changes since last weight assessment will be retaken for confirmation. If the weight is verified, nursing will notify the dietician and the physician/practitioner . On 5/15/24 at 3:15 PM, the survey team met with the Administrator and DON and discussed the concern of staff failing to notify the medical provider of Resident #69's significant weight loss. No further information regarding this concern was presented to the survey team prior to the exit conference on 5/15/24.

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42353 Based on staff interview, clinical record review, and facility document review, the facility staff failed to provide a Skilled Nursing Facility (SNF) Advanced Beneficiary Notice of Non-coverage (ABN) notification for 1 of 3 residents selected for SNF Beneficiary Notification Review (BNR), Resident #69. The findings included: For Resident #69, the facility staff failed to provide a SNF ABN notification when the resident was discharged from Medicare Part A services with skilled benefit days remaining while continuing to reside in the facility. Resident #69's diagnosis list indicated diagnoses, which included, but not limited to Alzheimer's Disease, Convulsions, Parkinson's Disease, Lymphedema, Essential Hypertension, and Second-Degree Atrioventricular Block. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 3/11/24 coded the resident as being severely impaired in cognitive skills for daily decision making with short-term and long-term memory problems. Resident #69's clinical record included a social services progress note dated 3/18/24 10:36 AM which read in part, SW [social worker] spoke with [name omitted]/POA [power of attorney] via phone. Explained Notice of Non-coverage and appeal rights. Made aware of effective date of 3-20-24 as date of skilled services ending and date financial liability to begin on 3-21-24. Informed that a request for an immediate appeal should be made as soon as possible, but no later than noon on the day before the effective date. Provided QIO [Quality Improvement Organization] Contact # [number omitted]. Confirmed that the representative understood all information explained. Last skilled day will be 3-20-24 and will be discharged on [DATE]. A copy of the NOMNC [Notice of Medicare Non-Coverage] was mailed to [name omitted]. Surveyor requested to view notices that were provided to the resident's POA when discharged from Medicare Part A services. On 5/14/24 at 2:54 PM, the Administrator provided a copy of a NOMNC dated 3/18/24 and stated they could not locate an ABN notice for Resident #69. On 5/15/24 at 3:15 PM, the survey team met with the Administrator and Director of Nursing and discussed the concern of staff failing to issue Resident #69 a SNF ABN. No further information regarding this concern was presented to the survey team prior to the exit conference on 5/15/24.

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 28567 Based on resident interview, staff interview, and clinical record review, the facility staff failed to accurately complete a minimum data set (MDS) assessment for 2 of 23 residents, Resident #65 and #102. The findings included: 1. The facility staff failed to accurately complete a quarterly MDS assessment. The facility staff failed to mark the resident self-catheterization (intermittent catheterization). Resident #65's diagnoses included, obstructive and reflux uropathy, chronic kidney disease, and diabetes. Section C (cognitive patterns) of Resident #65's quarterly MDS assessment with an assessment reference date (ARD) of 04/10/24 included a brief interview for mental status (BIMS) score of 15 out of a possible 15 points. Section H (bladder and bowel) was coded always continent of urine. The box beside of intermittent catheterization was left blank (unchecked). On 05/13/24 during initial tour Resident #65 stated they did their own catheterization and had been doing so for a while. Resident #65's clinical record included a provider order dated 05/25/23 that read Resident to self cath 4 times a day. On 05/14/24 at 8:45 a.m., during an interview with MDS Coordinator/Registered Nurse #1 this staff reviewed the MDS and confirmed catheterization was not marked on the MDS. On 05/14/24 at 4:00 p.m., during an end of the day meeting with the Administrator and Director of Nursing (DON) the inaccurate MDS was reviewed. No further information regarding this issue was provided to the survey team prior to the exit conference. 42353 2. For Resident #102, the facility staff coded the resident as being discharged to a hospital when in fact the resident had been discharged home. Resident #102's diagnosis list indicated diagnoses, which included, but not limited to Wedge Compression Fracture of T11-T12 Vertebra, Syndrome of Inappropriate Secretion of Antidiuretic Hormone, Protein-Calorie Malnutrition, Cirrhosis of Liver, and Type 2 Diabetes Mellitus. The discharge minimum data set (MDS) with an assessment reference date (ARD) of 2/29/24 coded the resident as being discharged to a short-term general hospital. However, a 2/29/24 12:25 PM nursing progress note read in part Patient discharged home . (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #102's clinical record also included a medical provider order dated 2/29/24 stating D/C [discontinue] all meds [medications] and tx [treatment] pt [patient] discharged home. On 5/15/24 at 10:19 AM, surveyor spoke with the MDS Nurse and requested they review the MDS coding related to the resident's discharge location. The MDS Nurse returned at 1:34 PM and provided documentation indicating the 2/29/24 discharge MDS had been corrected to indicate Resident #102 was discharged home. On 5/15/24 at 3:15 PM, the survey team met with the Administrator and Director of Nursing and discussed the concern of the inaccurate MDS coding for Resident #102. No further information regarding this concern was presented to the survey team prior to the exit conference on 5/15/24.

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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. 49622 Based on resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to implement a comprehensive person-centered activity care plan to provide one-to-one activity programming for two (2) of 23 sampled residents (Resident #34 and Resident #26). The findings include: 1. For Resident #34 (R34) the facility staff failed to implement a comprehensive person-centered activity care plan to provide one-to-one activities in her room two times per week. R34's diagnosis list indicated diagnoses that included, but were not limited to, Dementia, Abnormal Posture, Hemiplegia and Hemiparesis, Aphasia following Cerebral Infarction (stroke), Cognitive Communication Deficit, Depression and Epilepsy. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 02/17/24, coded the resident as having modified independence in cognitive skills for daily decision making with short and long-term memory problems. On 05/14/24 at 10:42 AM, surveyor interviewed R34 about activities and she conveyed activity staff do not do anything in her room with her. A review of the most recent comprehensive activity care plan dated 2/15/24, revealed, .enjoys independent activities in her room and does not prefer to get out of bed very often .will be encouraged to accept social and active one on one visits at least twice a week .Ensure frequent 1:1 visits to encourage participation in independent activities .Offer social one on one visits such .to help build rapport . The care plan revealed an initiated date of, 11/25/2015 and a revision date of, 9/5/2023 and no changes were identified for this Focus, Goal, or Interventions during these revisions. On 5/14/24 at 11:05 AM, surveyor interviewed Activity Director (AD) and asked what types of activities are provided for R34. AD stated R34 used to come to bingo, and he has been told she hasn't been feeling well and has not been attending bingo. AD stated she turns down supplies and he holds music twice a month, but she doesn't want to come to bingo now. Surveyor requested to see activity participation records for R34, and AD stated he has no documentation for any activities that he does, and he does not do activity participation records. AD was unable to provide evidence of one-on-one visits with R34. Surveyor requested and received a facility policy for care planning with no title, that revealed, The facility will develop a comprehensive care plan .which will include measurable objectives and timetables to meet the resident's .mental, and psychosocial needs .PROCEDURE: 1. The comprehensive plan of care .will be designed to: A. Address the needs, risks, strengths, and preferences of the resident . (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor also requested and received a facility policy titled, .Activities Program, that revealed, 4 .Activities are offered in several settings to include: (a) one-to-one programming .for residents who will not or cannot plan their own activity pursuits or residents needing specialized programming to enhance their overall quality of life .6 .staff must be assigned to assist with activity programming . This concern was discussed with the Administrator and DON (director of nursing) at the end of day meeting on 5/14/24 and at pre-exit meeting on 5/15/24. No further information was provided to the survey team prior to exit. 2. For resident #26 (R26) facility staff failed to implement a comprehensive person-centered activity care plan to ensure frequent one-to-one staff visits to encourage socialization. R26's diagnosis list indicated diagnoses that included, but were not limited to, Alzheimer's Disease, Vascular Dementia, Depression, Chronic Pain Syndrome, History of Falling, and Insomnia. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 04/14/24, coded the resident as being severely cognitively impaired for making decisions with short and long-term memory problems. A review of the most recent comprehensive activity care plan dated 4/12/24, revealed, .At risk for activity participation related to: cognitive deficit .Will attend/participate in 1 activity a week .Ensure frequent 1:1 staff visits to encourage socialization . The care plan revealed an initiated date of, 8/16/2022 and a revision date of, 7/14/2023 and no changes were identified for this Focus, Goal, or Interventions during these revisions. On 5/14/24 at 11:05 AM, surveyor interviewed the Activity Director (AD) and asked what types of activities he provides for R26. AD stated due to her condition he usually tries to involve her in food-related programs. Surveyor asked what he does for one-to-one programming and lower-functioning programming/sensory programming and AD stated he does the best he can. Surveyor requested to see activity participation records for R26, and AD stated he has no documentation for any activities that he does, and he does not do activity participation records. AD was unable to provide evidence of one-on-one staff visits with R26. Surveyor requested and received a facility policy for care planning with no title, that revealed, The facility will develop a comprehensive care plan .which will include measurable objectives and timetables to meet the resident's .mental, and psychosocial needs .PROCEDURE: 1. The comprehensive plan of care .will be designed to: A. Address the needs, risks, strengths, and preferences of the resident . Surveyor also requested and received a facility policy titled, .Activities Program, that revealed, 4 .Activities are offered in several settings to include: (a) one-to-one programming .for residents who will not or cannot plan their own activity pursuits or residents needing specialized programming to enhance their overall quality of life .6 .staff must be assigned to assist with activity programming . This concern was discussed with the Administrator and DON at the end of day meeting on 5/14/24 and at the pre-exit meeting on 5/15/24. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No further information was provided to the survey team prior to exit.

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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. 28567 Based on resident interview, staff interview, and clinical record review, the facility staff failed to review and revise the residents comprehensive care plan (CCP) for 1 of 23 current residents, Resident #65. The findings included: The facility staff failed to review and revise the residents CCP to include their prophylactic antibiotic and their self-catheterization. Resident #65's diagnoses included, obstructive and reflux uropathy, chronic kidney disease, and diabetes. Section C (cognitive patterns) of Resident #65's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 04/10/24 included a brief interview for mental status (BIMS) score of 15 out of a possible 15 points. Section H (bladder and bowel) was coded to indicate this resident was always continent of urine. The box beside of intermittent catheterization was left blank (unchecked). On 05/13/24 during initial tour Resident #65 stated they did their own catheterization and had been doing so for a while. Resident #65's clinical record included provider orders to self-cath 4 times a day (05/25/23) and for the prophylactic antibiotic Macrobid 100 mg 1 capsule one time a day every Monday, Wednesday, and Friday (06/23/23). During the clinical record review, the surveyor was unable to locate a care plan that included either of these areas. On 05/14/24 at 8:45 a.m., during an interview with MDS Coordinator/Registered Nurse #1 this staff reviewed the clinical record and confirmed there was not a care plan in place for these areas. During and end of the day meeting with the Administrator and Director of Nursing (DON) on 05/14/24 at 4:00 p.m. the issue with Resident #65's CCP was reviewed. On 05/15/24 at 9:00 a.m., the Administrator and DON provided the surveyor with a copy of a revised care plan that included the focus areas alteration in bladder elimination has an order that they may self-cath up to 4 times a day. Receives a prophylactic antibiotic for urinary tract infections. No further information regarding this issue was provided to the survey team prior to the exit conference.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34307 Based on staff interview, clinical record review and facility document review the facility staff failed to follow physician's orders for the administration of medications for 2 of 23 residents, Resident #93 and Resident #312. The findings included: 1. For Resident #93 the facility staff failed to administer the medications tramadol and gabapentin per the physician's order. Resident #93's face sheet listed diagnoses which included but not limited to pain in left hip and unspecified dementia. Resident #93's most recent minimum data set with an assessment reference date of 02/17/24 coded the resident as having both long- and short-term memory loss with severely impaired cognitive skills for daily decision making. Resident #93's comprehensive care plan was reviewed and contained care plans for . is at risk for altered levels of pain r/t (related to) a dx (diagnosis) of left hip and vertebrae fx (fracture). She has scheduled and prn (as needed) ordered. Resident #93's clinical record was reviewed and contained a physician's order summary which read in part, tramadol HCl Oral Tablet 50 mg (Tramadol HCl). Give 1 tablet by mouth four times a day for pain and Gabapentin capsule 100 mg. Give 1 capsule by mouth every 8 hours for neuropathy. Resident's clinical record also contained a physician's order which read in part, tramadol HCl 50 mg. Give 0.5 tablet by mouth two times a day for pain. Resident #93's electronic medication administration record (eMAR) for the months of March, April, and May 2024 were reviewed and contained entries as above. On 03/18/24, the entry for tramadol was coded 9 at 2 pm and blank at 8 pm. On 03/19/24, the tramadol was coded [NAME] at 8 pm. On 04/05/24 the gabapentin was coded 5 at 2 pm. On 04/15/24 and 04/30/24 the tramadol was coded [NAME] at 8 pm. On 05/04/24 the gabapentin was coded [NAME] at 10 pm. On 05/05/24 the gabapentin was coded [NAME] at 6 am and 9 at 10 pm. Chart coded 5 is equivalent to Hold/See Progress Note. Chart code 9 is equivalent to Other/See Nurses Notes Effective. Surveyor spoke with the director of nursing (DON) on 05/15/24 at 9:15 am, and asked DON what [NAME] on the eMAR meant. DON stated, Medication unavailable. Resident #93's nurse's progress notes were reviewed and contained notes which read in part, 3/19/2024 21:32 tramadol HCl Oral Tablet 50 mg. Give 0.5 tablet by mouth two times a day for pain med on order, 4/5/2024 13:23 Gabapentin capsule 100 mg. Give 1 capsule by mouth every 8 hours for Neuropathy. On hold until arrival from pharmacy. MD notified, 4/15/2024 22:30 tramadol HCl Oral Tablet 50 mg. Give 1 tablet by mouth three times a day for pain no tramadol in narc box per nurse that report was taken from she reordered no pain noted at this time and MD was made aware, and 5/52024 21:50 Gabapentin capsule 100 mg. give 1 capsule by mouth every 8 hours for Neuropathy. Medication unavailable at this time. There was no note for 05/04/24. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor spoke with registered nurse (RN) #3 on 05/14/24 at 11:30 am regarding unavailability of medications. RN #3 stated that if a medication is unavailable, they check the medication cart, then check to see if the medication is available in the facility Cubex (emergency medication supply). If not available in the Cubex, notify the pharmacy and call the physician. Surveyor requested a list of medications available in the facility Cubex. The medications tramadol 50 mg and gabapentin 100 mg were both listed as available. Surveyor requested and was provided with a facility policy entitled Ordering and Procuring Extra Doses (XD) of Medication which read in part, Policy: A nurse may be required to request an extra dose (XD) of medication for the following reasons: b. Missing dose. Procedure: 1. If a medication is not available in the 24 hour unit dose supply, the nurse will check the next day's bag (same resident and time pass) and remove the unit dose medication from the bag to administer. Document on the outside of the bag that medication was removed and by whom. Also document on the bag that an XD was ordered. 2. The nurse will fax the pharmacy indicating that an extra dose (XD) is required using the 'Extra Dose Request Order Form.' The concern of not following physician's orders for Resident #93 was discussed with the DON and administrator on 05/15/24 at 3:15 pm No further information was provided prior to exit. 2. For Resident #312 the facility staff failed to administer the medications diazepam and oxycodone per the physician's orders. Resident #312's face sheet listed diagnoses which included but not limited to anxiety disorder, long-term (current) use of opiate analgesic and chronic pain syndrome. Resident #312's most recent minimum data set with an assessment refer date of 05/07/24 assigned the resident a brief interview for mental status score of 8 out of 15 in section C, cognitive patterns. This indicates that the resident is moderately cognitively impaired. Resident #312 is a new admission; therefore, the comprehensive care plan has not been completed. Resident #312's clinical record was reviewed and contained a physician's order summary which read in part, diazepam Oral Tablet 5 mg (Diazepam). Give 2.5 mg every morning and at bedtime for anxiety and oxycodone HCl Oral Tablet 5 mg (Oxycodone HCl). Give 1 tablet by mouth every morning and at bedtime for pain management. Resident #312's electronic medication administration record (eMAR) for the month of May 2024 was reviewed and contained entries as above. The entry for diazepam was coded [NAME] on 05/10/24 at 9 am and the entry for oxycodone was coded 9 on 05/11/24. Chart code 9 is the equivalent of Hold/See Nurses Note Effective. Surveyor spoke with the director of nursing (DON) on 05/15/24 at 9:15 am, and asked DON what [NAME] on the eMAR meant. DON stated, Medication unavailable. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Richfield Health Center - Salem	3719 Knollridge Road Salem, VA 24153

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #312's nurse's progress notes were reviewed and contained notes which read in part, 5/10/2014 11:36 diazepam Oral Tablet 5 mg. Give 2.5 mg every morning and at bedtime for anxiety. Medication unavailable in stat box. This nurse does not have access to the Omnicell (emergency medication supply). New prescriptions requested by this nurse to be sent in by . (name omitted) NP (nurse practitioner) and 5/11/2024 12:27 oxycodone HCl Oral Tablet 5mg. Give 2.5 mg every morning and at bedtime for pain management. Medication is not available, MD is aware. Surveyor spoke with registered nurse (RN) #3 on 05/14/24 at 11:30 am regarding unavailability of medications. RN #3 stated that if a medication is unavailable, they check the medication cart, then check to see if the medication is available in the facility Cubex (emergency medication supply). If not available in the Cubex, notify the pharmacy and call the physician. Surveyor requested a list of medications available in the facility Cubex. The medications diazepam 5 mg and oxycodone mg were both listed as available. Surveyor requested and was provided with a facility policy entitled Ordering and Procuring Extra Doses (XD) of Medication which read in part, Policy: A nurse may be required to request an extra dose (XD) of medication for the following reasons: b. Missing dose. Procedure: 1. If a medication is not available in the 24-hour unit dose supply, the nurse will check the next day's bag (same resident and time pass) and remove the unit dose medication from the bag to administer. Document on the outside of the bag that medication was removed and by whom. Also document on the bag that an XD was ordered. 2. The nurse will fax the pharmacy indicating that an extra dose (XD) is required using the 'Extra Dose Request Order Form.' The concern of not following physician's orders for Resident #312 was discussed with the DON and administrator on 05/15/24 at 3:15 pm No further information was provided prior to exit.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 28567 Based on staff interview and clinical record review, the facility staff failed to follow up on pharmacy recommendations for 2 of 5 residents chosen for the unnecessary medication task, Residents #7 and #26. The findings included: 1. For Resident #7, the facility staff did not follow up on a pharmacy recommendation dated 03/20/24 until 05/02/24. Resident #7's diagnoses included, but were not limited to, insomnia and major depressive disorder. Section C (cognitive patterns) of Resident #7's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 03/15/24 included a brief interview for mental status summary score of 13 out of a possible 15 points. On 03/20/24 the pharmacist documented Monthly medication regimen and chart review. Please see pharmacist report for recommendation. The surveyor was unable to find this recommendation in the clinical record. On 05/14/24 at 4:00 p.m., during an end of the day meeting with the Administrator and Director of Nursing (DON) the missing pharmacy recommendation was reviewed. On 05/15/24, the DON provided the surveyor with a copy of a pharmacy recommendation dated 03/20/24 requesting the provider to consider a gradual dose reduction (GDR) of the medications Ramelteon and Buspar. This recommendation was unsigned and the boxes that read agree, disagree, or other were all unchecked. The clinical record included the following provider orders Ramelteon 8 mg 1 tablet by mouth at bedtime for insomnia date of order 08/17/23 and Buspirone (Buspar) 15 mg 1 tablet by mouth three times a day for depression date of order 07/16/23. The clinical record also included a progress note documented by the Nurse Practitioner on 05/02/24 that read GDR for ramelteon and buspar not recommended at this time. Current regimen is necessary to maintain the residents function. Indicating the recommendation was not followed up on from 03/20/24 until 05/02/24. The medication Ramelteon was discontinued by the provider on 05/15/24. No further information regarding this issue was provided to the survey team prior to the exit conference. 49622 (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. For Resident #26, the facility staff failed to provide evidence of the 1/25/24 and 3/19/24 drug regimen reviews being reported to and acted upon by the medical provider. Resident #26's diagnosis list indicated diagnoses, which included, but not limited to Alzheimer's Disease, Vascular Dementia, CHF (congestive heart failure), Depression, History of Falling and CKD (chronic kidney disease) Stage 2 (two) Mild. Section C (cognitive patterns) of Resident #26's most recent minimum data set (MDS) with an assessment reference date (ARD) of 4/14/24, coded the resident as being rarely/never understood with short/long-term memory problems and indicated the resident was severely cognitively impaired and never/rarely making decisions. A review of the Resident #26's clinical record revealed progress notes which indicated drug regimen reviews were completed on 1/25/24 and 3/19/24, each with recommendations. Surveyor was unable to locate the recommendation reports in the resident's clinical record. On 5/15/24, surveyor requested and received the drug regimen review recommendation reports completed by the pharmacist on 1/25/24 and 3/19/24 from the Director of Nursing (DON). The 1/25/24 Note to Attending Physician/Prescriber read in part .Resident has an order for Abilify 2 (two) mg (milligrams) BID (two times per day). This medication is intended to be dosed QD (once a day). Please evaluate for possible QD dosing . The 1/25/24 Note to Attending Physician/Prescriber report had not been signed by the medical provider indicating review and the boxes that read .agree, disagree, or other . were all unchecked. A review of the physician's orders included the following order dated 1/16/24, Abilify Oral Tablet 2 mg (Aripiprazole) Give 1 (one) tablet by mouth two times a day for mood disorder . A new physician's order dated 5/2/24, revealed, Abilify Oral Tablet 2 mg (Aripiprazole) Give 2 tablet by mouth one time a day for mood disorder . The pharmacy recommendation dated 03/19/24 requesting the provider to consider a gradual dose reduction (GDR) of the medications Sertraline and Mirtazapine, had not been signed by the medical provider indicating review and the boxes that read .agree, disagree, or other . were all unchecked. On 5/15/24 at 10:58 AM, the survey team met with the Administrator and DON, and discussed the concern of staff failing to address Resident #26's January and March drug regimen reviews. Surveyor requested but did not receive the facility policy for Medication Drug Regimen Review, as the DON stated she was not sure if there was a policy, and if there was, she was unable to locate it. No further information regarding this concern was presented to the survey team prior to the exit conference on 5/15/24.

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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. 34307 Based on staff interview, clinical record review and facility document review the facility staff failed to ensure a complete and accurate clinical record for 1 of 23 residents, Resident #93. The findings included: 1. For Resident #93 the facility staff failed to ensure the electronic medication administration record (eMAR) and electronic treatment administration record (eTAR) were complete. Resident #93's face sheet listed diagnoses which included but not limited to pain in left hip and unspecified dementia. Resident #93's most recent minimum data set with an assessment reference date of 02/17/24 coded the resident as having both long- and short-term memory loss with severely impaired cognitive skills for daily decision making. Resident #93's comprehensive care plan was reviewed and contained care plans for . is at risk for altered levels of pain r/t (related to) a dx (diagnosis) of left hip and vertebrae fx (fracture). She has scheduled and prn (as needed) ordered, . has the potential for/impaired skin integrity r/t recent hip fx with limited mobility, dementia and overall weakness. Stage 3- POA- wound vac in place- see MAR/TAR, and . is at risk for nutritional decline 2' (secondary to) hx (history) dysphagia, needs modified diet. She has increased nutrient needs 2' wounds/wound healing. Hx hip fx, dementia, CKD (chronic kidney disease). She has had significant wt (weight) loss and wt gain. Resident #93's clinical record was reviewed and contained a physician's order summary which read in part, Geri sleeves as tolerated to BUE (bilateral upper extremities), heel protectors on while in bed, group 2 mattress check for function, wound vac to sacrum continuously @ 125mmhg every shift for wound care, House Supplement 2 ounces three times a day for supplement, Pro-Stat Oral Liquid (Amino Acids-Protein Hydrolysate). Give 30 ml by mouth two times a day for wound healing, and Tylenol Oral Tablet 325 mg (Acetaminophen). Give 2 tablet by mouth four times a day for pain. Resident #93's eMAR for the month of March 2024 was reviewed and contained entries for House Supplement, Pro-Stat, and Tylenol. These entries were blank on 03/03/24 at 5 pm. Resident #93's eTAR for the month of May 2024 was reviewed and contained entries for geri sleeves, check mattress, heel protectors, and wound vac. These entries were blank on 05/05/24 on evening shift. Surveyor requested and was provided with a facility policy entitled Nursing Documentation which read in part, Purpose: 1. To substantiate daily care, communicate the resident's needs and care received. Procedure: 1. All observations, medications administered, services performed, etc., must be documented in the resident's clinical records. The concern of leaving blanks on the resident's eMAR/eTAR was discussed with the administrator and director of nursing on 05/15/24 at 3:15 pm. (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No further information was provided prior to exit.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42353 Based on staff interview, clinical record review, and facility document review, the facility staff failed to offer a pneumococcal vaccine in accordance with nationally recognized standards for 1 of 5 sampled residents reviewed for immunizations, Resident #99. The findings included: For Resident #99, the facility staff failed to offer the resident a pneumococcal conjugate vaccine 15 (PCV15) or a pneumococcal conjugate vaccine 20 (PCV20) following admission to the facility. A review of the Centers for Disease Control and Prevention (CDC) guideline titled, Pneumococcal Vaccination: Summary of Who and When to Vaccinate last reviewed 9/22/23 read in part that adults [AGE] years or older that have never received any pneumococcal vaccine should receive one dose of PCV15 or PCV20. Resident #99's diagnosis list indicated diagnoses, which included, but not limited to Metabolic Encephalopathy, Traumatic Subdural Hemorrhage, Dementia, Acute Kidney Failure, and Atrial Fibrillation. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 4/14/24 assigned the resident a brief interview for mental status (BIMS) summary score of 6 out of 15 indicating the resident was severely cognitively impaired. Resident #99 was over the age of [AGE] years when admitted to the facility. Resident #99's clinical record included their Virginia Immunization Information System (VIIS) Record dated 4/20/24. According to this record, Resident #99 had not received a pneumococcal vaccine prior to admission to the facility. Surveyor reviewed the resident's clinical record and was unable to locate evidence of Resident #99 being offered a PCV15 or a PCV20 following admission to the facility. On 5/15/24 at 1:00 PM, surveyor spoke with the Director of Nursing/Infection Preventionist (DON) regarding Resident #99's pneumococcal vaccine history. DON was unable to provide evidence of the resident being offered a pneumococcal vaccine following admission to the facility. Surveyor requested and received the facility policy titled, Influenza/Pneumococcal/COVID-19 Immunization and Education which read in part, Purpose: To provide a means for the facility to track .pneumococcal immunization administration and education ensuring all eligible residents receive immunization as recommended by the Center for Disease Control .1. Upon admission the resident or their responsible party will be provided the option for the resident to receive the .pneumococcal .immunization .10. Persons sixty-five (65) years of age and older who have not received the pneumococcal vaccine is [sic] the past five (5) years should receive another dose of vaccine . On 5/15/24 at 3:15 PM, the survey team met with the Administrator and DON and discussed the concern of the facility staff failing to offer Resident #99 a pneumococcal vaccine following admission. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No further information regarding this concern was presented to the survey team prior to the exit conference on 5/15/24.