STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495105	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lynchburg Health & Rehabilitation Center	5615 Seminole Avenue Lynchburg, VA 24502

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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. 41449 Based on observation and staff interview, the facility staff failed to distribute meals in a manner to maintain and enhance a residents dignity affecting several residents on one of three units. The findings included: The facility staff failed to distribute meal trays in a manner to uphold resident's dignity. On 9/9/24 at 12:58 p.m., the lunch meal was observed in the restorative room on the west wing. It was noted that R22 was sitting at a table with resident #9 (R9). R9 was served her meal and began eating. All the other residents in the dining room were served, including a tray sat between R22 and R9 for another resident who was not present in the dining room. CNA #4 was the only staff member remaining in the dining room after the trays had been served, and she was sitting to assist in feeding resident #55. The surveyor identified several concerns with regards to the consistency of pureed foods. LPN #6 was asked to verify that residents who were served pureed foods were not given a pureed consistency of food. LPN #6 then removed R9's tray to take it to the kitchen to be prepared at the correct consistency. In doing so, it left R9 and R22 in the dining room with all the other residents eating their meal with no food for them to eat. R22 was then observed to remove the coffee from the meal tray sitting between him and R9, as he had no beverages or food items. A few minutes later, R9 then removed the lid from the plate of food that had been put on the table between her and R22. CNA #4 came over and recovered the plate of food. The surveyor asked where R22's food was and CNA #4 said, it wasn't on the cart. At 1:18 p.m., R22 was served his meal tray that had been taken onto the unit in the meal cart. On 9/9/24 at 1:22 p.m., the resident whose tray had been sat on the table between R22 and R9 came into the dining room and was assisted to the table where his food that had been sitting since 12:58 p.m. This was the same tray that R22 had removed the coffee from and R9 had removed the cover from. On 9/10/24, during an end of day meeting with the facility administrator, director of nursing and corporate staff, the above findings were reviewed.

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: 495105	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/12/2024
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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. 41449 Based on observation, resident interview, staff interview, clinical record review and facility documentation review, the facility staff failed to ensure residents dignity was upheld for one resident, (Resident #99 - R99) in a survey sample of 33 residents. The findings included: 1. For R99, the facility failed to ensure the resident had adequate clothing and season approriate clothing to wear to ensure his dignity was maintained with regards to his personal appearance. On 9/09/24 at 12:45 p.m., R99 stopped the surveyor in the hallway. R99 was sitting outside his room in the hall and told the surveyor, Look what they dress us in, and pointed to his clothing. R99 was observed to be dressed in a flannel shirt and denim jeans which were cut off at the ankles and torn up the back of the calf. R99 reported he has lived at the facility for five years and had nice clothes when he came in, but they are all gone and, They give me clothes left over from other people, but they don't even fit. R99 went on to say he had a doctor's appointment outside of the facility and had to go, saying, This is how I looked. At this point, R99's nurse asked if the surveyor was done with R99 because he had an appointment and she needed to take him. On 9/10/24 at 8:41 a.m., R99 was interviewed in his room. R99 was observed to have the same clothes on he had on the prior day. R99 stated that all he has is winter clothes and that he must wear the same clothes for several days to stretch them out, because he is limited in what he has. When asked how this made him feel, R99 said, Horrible and like no one gives a [profanity]! Observations were made of R99's clothes in his closet, and it was noted he had 3 long-sleeve flannel shirts, a sweater, a winter coat, and two pair of denim pants. R99 pointed to a green pair of pants and said, They are 32, then pointed to the second pair of pants and said, They are 38, and I wear a 34. They have all of those jogging pants, but I carry a wallet, so I don't wear those. R99 reported he has family but hasn't seen them in a year. When asked if he had a bank account at the facility, R99 said he did but had very little funds. On 9/11/24 at approximately 8:30 a.m., R99 was again visited in his room. R99 was observed wearing the same clothes he had been wearing over the two days prior. On 9/11/24 at 9:03 a.m., an interview was conducted with the social services assistant (SSA). When asked what is done if a resident needs clothes, the SSA said, We look into if they have their own funds. I go to [housekeeping/laundry manager's name redacted] who oversees laundry. There is a large amount of clothing that is unclaimed and do not have names. I've gone to try to find clothing the size a resident may need or if items are missing, we try to find out when they disappeared. I am open to trying to assist them in buying clothes, we have a relationship with Walmart. I'm willing to go shopping. When asked about the residents who don't have money, the SSA said, I would go to administrator to see if there are extra funds. When informed of R99's clothing situation, the SSA said that he had not heard about that. The SSA accompanied the surveyor to R99's room and observed the clothing in the closet. The SSA said, I feel so bad for him. I will get to work on that right away. (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/11/24, during review of another survey task it was noted that R99 had a resident trust account with the facility that held a substantial amount of funds that could have been used to purchase R99 clothing. The surveyor made the SSA aware of this at approximately 11:30 a.m. On 9/11/24 at 4:35 p.m., during an end of day meeting held with the facility administrator, director of nursing, and corporate staff the above findings were discussed. On 9/12/24, at approximately 9:30 a.m., R99 was seen his in room wearing the same clothing as the three days prior. When questioned aboout this, R99 reported that no one had said anything else to him regarding the clothing situation. No additional information was provided.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. 49456 Based on observation, staff interview, and resident interview, the facility failed to accommodate the resident's preference to dine in the dining room affecting multiple residents on three of three units. The findings included: The facility staff failed to have their main dining room available for the residents to have their meals. On 9/9/24, during the initial tour of the facility, the main dining room was observed to be used as a storage area and not being used for residents dining. On 9/10/24, at 2:00 p.m., during a resident council meeting conducted with eight residents, all of the residents in attendance were complaining about not having the dining room open for use during mealtimes. Resident # 6, Resident # 19, Resident # 109, Resident # 64, Resident # 69, Resident #65, Resident #58, and Resident #38 were complaining about how long the dining room had been closed off to the residents and that it was being used as a storage area. On 9/10/24 at 3:15 p.m, Resident #64 stated,It was nice when we all could get together and talk in the dining room at meals, but now it is just a warehouse. On 9/10/24 at 3:15 p.m., Resident #69 stated, I miss being with everyone in the dining area and it is a shame they just put boxes and things in there where we cannot use it anymore For about 3 months, it's been this way. On 9/10/24 at 3:325 p.m., the director of nursing and regional director of clinical services were asked about the lack of resident access to the dining room. It was stated that arrangements were being made to have the boxes removed from the dining area and it would be opened back up as soon as the boxes and equipment were moved out of the area. 09/10/24 05:02 p.m., an end of day meeting was held with regional director of clinical services, vice president of operations, administrator, and the director of nursing, during which the above concerns were discussed with the administration staff of the facility. On 9/11/24 at 10:44 a. m, Resident #149 stated, I really think we need a place to eat other than our room for socialization. It can get depressing, just staying in your room all the time. On 9/12/24, the facility provided the survey team with evidence that they had ordered a shipping container to have onsite to store the items that were currently being stored in the dining room. Throughout the four days of survey, the dining room was observed to be unaccessible for the residents to use. No additional information was provided.

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. 41449 Based on Resident interview, staff interview, and facility documentation review, the facility staff failed to provide Residents with quarterly statements of their trust account/bank accounts and failed to allow residents to readily access their trust funds, affecting all 140 residents with trust accounts. The findings included: On 9/10/24, an interview was conducted with Resident #14- R14. During the interview, R14 expressed that he doesn't get any kind of statement regarding his trust account. On 9/10/24 at 2 p.m., a group interview was conducted with eight residents (Resident # 6, Resident # 19, Resident # 109, Resident # 64, Resident # 69, Resident #65, Resident #58, and Resident #38).When asked about trust account statements, the residents reported that they did not receive any kind of statement regarding their trust fund accounts. These residents also verbalized concerns that they can only withdraw funds from their trust account for two hours, Monday through Friday, and no longer have weekend access. On 9/10/24 at approximately 4:28 p.m., observations noted a sign posted near the front reception desk that read, Bank Hours: Monday-Friday 10am-12pm. Closed Saturday and Sunday. Thank you, Business Office. On 9/10/24 at approximately 4:30 p.m., an interview was conducted with other employee #9 (OE9), who was the front office assistant and who distributed resident's trust funds. OE9 explained that residents can access their money Monday through Friday from 10 a.m., until 12 noon. When asked about weekend access, OE9 said that they no longer do that and that they had sent out a letter to notify the residents. During the interview with OE9, the business office manager (BOM) walked up and joined in the conversation. When asked about account statements, OE9 stated that when residents withdraw money, she can let them know how much they have left. The BOM added that the statements go directly to the residents from the resident fund management system (RFMS). The BOM stated that the facility doesn't send out any statements. On 9/11/24 at 11:26 a.m., a telephone call was placed to RFMS, and the surveyor spoke with a representative regarding statements. The RFMS representative stated that each facility can choose if they receive the statements monthly or quarterly. The RFMS representative accessed their records and reported that this facility was set up to receive the statements quarterly. When asked if RFMS sends the statements to the residents, the RFMS representative said, They are made available to the facility and if the residents receive a copy is up to the facility. We don't mail them out to residents or families. (continued on next page)

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/11/24 at 11:40 a.m., an interview was conducted with the business office manager (BOM). The BOM was asked about the banking hours changing and why they decided on two hours per day Monday through Friday. The BOM said, It had a lot to do with speaking with other facilities and how their banking is handled. We were also trying to manage resident funds and the money we receive. We have residents that come daily and get their max out. [OE9's name redacted] is the guard-dog on that and keeps track of who comes daily and for their safety and to keep them from having the money we were going through doing it 7 days a week. We were doing it to manage the money better because we were constantly running out of money. During the above interview with , When asked if the facility had met with the residents and gotten their input on this change, the BOM stated, No, to be honest, we did not. And as residents came up, we were notifying them. The BOM was asked to provide the surveyor with a copy of the letter that was sent out. The BOM went on to say, We also had some staffing challenges, we had part-timers, and we were trying to limit how many hands were in the money. The clinical record for R14 was reviewed. There was no evidence that the resident had received a trust account statement. A review of the facility policy titled, Quarterly PFA [personal fund account] Statements, dated 6/1/22, was conducted. This policy read in part, A quarterly written Patient Trust Fund and Burial Trust Fund, if applicable, statement is issued to the patient or to his or her designated representative . The facility policy dated 6/1/22, which was titled, Banking Hours was reviewed. This policy read in part, 1. The center will establish banking hours to allow patients to have access to their patient funds for at least two hours during regular business working hours, and for a reasonable time on Saturdays and Sundays . 4. The center will establish a secure procedure for Saturday and Sunday patient access to cash withdrawals. On 9/10/24, during an end of day meeting, the facility Administrator, director of nursing, and corporate staff were made aware of the above findings. No additional information was received.

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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** 41449 Based on staff interview, facility documentation review, and clinical record review, the facility staff failed to issue an ABN (Advanced Beneficiary Notice) to one resident (Resident #107-R107) in a survey sample of three residents reviewed for such notices. The findings included: For R107, who remained a resident of the facility, the facility staff failed to issue an ABN, which would have afforded the resident the opportunity to decide if they wanted to continue to receive skilled services and assume the financial responsibility or have the fiscal intermediary make the coverage determination. On 9/9/24, a sample of three residents was selected for review of beneficiary notices. According to the listing provided by the facility, R107 had remained in the facility following skilled services ending. On 9/10/24, the facility staff provided the survey team with the beneficiary notices issued to each resident and noted R107 was not provided an ABN because .he was short-term and was supposed to discharge. On 9/10/24 during a clinical record review, it was noted that R107 came off skilled care (Medicare Part A reimbursed stay) on 3/8/24, became self-pay on 3/9/24, and did not discharge from the facility until 8/28/24. R107 had been admitted to the facility on [DATE], and only used 45 of the 100 benefit days under Medicare Part A. According to the progress notes, a social services entry was made on 3/6/24 that read, Talked with daughter, [name redacted], in regards to apartment searching for her father. She stated that she has been continuing to look and would contact if she was in need of assistance for SWDC [social work/discharge] office. According to this note, the facility was aware that a discharge plan/location had not been yet arranged and the resident would remain at the facility. On 9/10/24 at 11:25 a.m., an interview was conducted with the Corporate Social Worker and Discharge Planner, who formerly worked at the facility. When asked about R107's not being issued an ABN, the Corporate Social Worker said, He was supposed to go home. We had started things and things changed, where he stayed longer. He never left until sometime later. He was an in and out case, this wasn't the first time he had been with us, previously he had an APS [adult protective services] case open, then wasn't on APS. His daughter was here and would try to help with housing and transport. He would say he wanted to stay a few days. Never knew if he really wanted to stay or go. [Employee's name redacted of former social worker] did the NOMNC and was sure he [R107] would change his mind before we got there. We didn't think far enough ahead, his plan wasn't to be here. When questioned if the 3/6/24 progress note, noting that the daughter was still looking for housing, indicated the need for issuing an ABN, the Corporate Social Worker said, He didn't have his own house. He had been living with his daughter. She was going to help with finding a place in the community and I assume it didn't really work out that away. I think it was an oversight and we thought he would change his mind. That's how he was every time he was here. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/10/24 at 2:08 p.m., an interview was conducted with the facility's director of social work and discharge planning (SWDC planner). The SWDC planner was asked about ABN's notices. The SWDC planner said, An ABN is when a long-term care patient is skilled and using Medicare benefits and switching back to long-term care, once they receive the NOMNC [notice of Medicare non-coverage] they also receive an ABN. When asked why the ABN is important, SWDC planner said, So they have the option, their choice. If they want their therapy to continue and they want to pay, it's their choice. On 9/10/24, in the afternoon, the corporate social worker and discharge planner provided the survey team with R107's progress notes to indicate his plan was to discharge. The notes included an entry dated 1/26/24, entered by the corporate social worker which was titled, Discharge Planning Note. The note read, DCP [discharge planner] was made aware that resident wanted to discuss dc plans. DCP explained what a safe dc plan looks like and steps needed to be taken. [R107's name redacted] stated that he understood. DCP also explained that she would speak with DOR [director of rehab] and clinical team about what timeframe would be appropriate for a potential dc [discharge] in the near future. There was another entry dated 1/31/24 by the corporate social worker and discharge planner in R107's chart. This note read, DCP spoke with resident for 45+ minutes today in regard to future dc plans. Resident states he does not recall any of our conversations previous to this point. Resident stated that he was frustrated. Writer explained that multiple conversations had been held between the two of them for the past several days. Resident stated guess I just forgot. DCP went through the process of a safe dc plan with resident. Resident then stated I don't need to tell you about where I'm going and that should be none of your concern. DCP notified ADON [assistant director of nursing] and NP [nurse practitioner] about situation. The facility also provided two progress notes from a medical provider that indicated: . length of stay: 3-5 weeks and . length of stay: 2-4 weeks. The facility policy dated 4/1/22, which was titled, Advanced Beneficiary Notice (ABN) was reviewed. The policy read in part, The Advanced Beneficiary Notice will be used to properly notify a Medicare Part A or Medicare Part B patient and/or Responsible Party of the clinical determination that the patient no longer meets the Medicare criteria for skilled services . 2. The social work and discharge planner or designee issues the notice to the beneficiary or their respresentative in person or by telephone of the upcoming non-coverage status based on clinical team recommendations . CMS defines the use of the SNF ABN in the section 70.3 of the Medicare Claims Processing Manual in chapter 30 on page 84, it read, A SNF ABN is evidence of beneficiary knowledge about the likelihood of a Medicare denial, for the purpose of determining financial liability for expenses incurred for extended care items or services furnished to a beneficiary and for which Medicare does not pay. If Medicare is expected to deny payment (entirely or in part) on the basis of one of the exclusions listed in S70 of this chapter for extended care items or services that the SNF furnishes to a beneficiary, a SNF ABN must be given to the beneficiary in order to transfer financial liability for the item or service to the beneficiary. The table on page 85 stated, In the situation in which a SNF proposes to stop furnishing all extended care items or services to a beneficiary because it expects that Medicare will not continue to pay for the items or services that a physician has ordered and the beneficiary would like to continue receiving the care, the SNF must provide a SNF ABN to the beneficiary before it terminates such extended care items or services. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On CMS.gov, instructions on the SNF ABN form were reviewed. These instructions read in part, .Medicare requires Skilled Nursing Facilities (SNFs) to issue the SNF ABN to Original Medicare, also called fee-for-service (FFS), patients prior to providing care that Medicare usually covers, but may not pay for in this instance because the care is: o not medically reasonable and necessary; or o considered custodial. The SNF ABN provides information to the patient so that s/he can decide whether or not to get the care that may not be paid for by Medicare and assume financial responsibility. SNFs must use the SNF ABN when applicable for SNF Prospective Payment System services (Medicare Part A) . On 9/11/24, during an end of day meeting, the facility administrator and corporate staff were made aware of the above findings. No further information was provided.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41449 Based on observation, resident interview, staff interview, clinical record review and facility documentation review, the facility staff failed to provide a homelike environment and clean medical equipment for resident use, affecting two residents (Resident #99- R99 and Resident #55- R55) in a survey sample of 33 residents. The findings included: 1. For R99, the facility staff failed to provide the resident with a closet in good repair, as a door was missing. On 9/9/24 at 12:45 p.m., R99 was visited in his room. Observations of the resident's room were made, and it was noted that the closet was missing a door. R99 was asked about the closet and R99 reported it had been like that ever since he moved into that room. On 9/10/24 at 8:41 a.m., R99 was visited again in his room by the surveyor, and it was noted that the closet was still missing a door. On 9/10/24 at 8:43 a.m., an interview was conducted with the certified nursing assistant (CNA #3). CNA #3 was asked about R99's closet not having a door and she confirmed it had been like that for months. On 9/10/24 at 9:18 a.m., an interview was conducted with other employee #13 (OE#13). OE #13 confirmed that she was responsible for conducting daily rounds which included R99's room. OE #13 explained that she has a form that she notes any problems, the form is then taken to the morning meeting by the department director, and it is discussed with the entire management team. OE#13 confirmed that R99's closet had been missing a door for the duration of the time she had been doing the rounds, which was approximately two months. On 9/10/24 at approximately 9:30 a.m., an interview was conducted with the unit manager. The unit manager said that R99 didn't have a closet door because they are getting new ones. On 9/10/24, a clinical record review was conducted of R99's chart. According to the census tab of the chart, R99 had moved into the currently assigned room on 4/23/24. On 9/11/24 at 9:18 a.m., an interview was conducted with the regional director of clinical services (RDCS). The RDCS confirmed that the managers make rounds daily which they call angel rounds. Then during the morning meeting any concerns identified are discussed and actions taken to resolve the identified concerns. The RDCS was asked to provide any evidence of when R99 closet, which was missing a door was first identified and what steps were taken to resolve it. The RDCS said this was unacceptable and she would ensure R99 was provided with a closet door. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/11/24, in the afternoon, an interview was conducted with the facility's maintenance director. The maintenance director reported that R99's closet had been brought to his attention and he had a door he was going to install. On the afternoon of 9/11/24, the facility's corporate staff provided the survey team with a copy of an email. The email read in part, our corporate cabinet shop has been making replacement doors and drawer fronts for the wardrobes since March of this year. We have approximately 20 more sets at the shop ready to be delivered when needed . On 9/11/24, during an end of day meeting, the facility administrator, director of nursing and corporate staff was made aware of the above findings. No additional information was provided. 21875 2. Resident #55's wheelchair was dirty and in disrepair. Resident #55 (R55) was admitted to the facility with diagnoses that included cerebral infarction, hypertension, cataracts, dysphagia, aphasia, dysarthria, dementia, psychotic disturbance, mood disturbance and anxiety. The minimum data set (MDS) dated [DATE] assessed R55 with severely impaired cognitive skills. On 9/9/24 at 4:25 p.m., R55 was observed in a specialized, padded wheelchair in the day room. The covering on both arm cushions was torn/missing with white fabric exposed. The wheelchair was dirty with crumbs, dust, debris, and dried drip substances observed on the support bars and wheels. On 9/10/24 at 2:50 p.m., accompanied by licensed practical nurse unit manager (LPN #3), R55's wheelchair was observed. The covering on both arms of the chair was torn/missing with white fabric visible. The wheelchair was observed with drips, crumbs, dust, and debris on the support bars and on the under-surface of the chair. The chair's seat cushion was worn with a patched area near the front of the cushion. LPN #3 was interviewed at this time about the condition of R55's wheelchair. LPN #3 stated that housekeeping was responsible for routine cleaning of resident equipment and that she would contact hospice about the needed chair repair. On 9/10/24 at 4:50 p.m., accompanied by the housekeeping supervisor (other staff #7), R55's wheelchair was observed. The housekeeping supervisor was interviewed at this time about the torn arm coverings and dirty condition of the chair. The housekeeping supervisor stated housekeepers were responsible for cleaning resident equipment at the time of discharge. The housekeeping supervisor stated routine cleaning of resident equipment was assigned to third shift aides/nurses. The housekeeping supervisor stated resident equipment, including wheelchairs was usually cleaned in the shower rooms during the night shift. The housekeeping supervisor stated R55's wheelchair needed cleaning and repair. The housekeeping supervisor stated he was not sure who could repair or replace the arm cushions. This finding was reviewed with the administrator, director of nursing and regional nurse consultants during a meeting on 9/10/24 at 5:15 p.m. with no further information presented prior to the end of the survey.

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Lynchburg Health & Rehabilitation Center	5615 Seminole Avenue Lynchburg, VA 24502

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 41449 Based on resident interview, staff interview, clinical record review and facility documentation review, the facility staff failed to report an allegation of abuse to the state survey agency and other officials as required for an incident involving two residents (Resident #14 - R14 and Resident #99 - R99) in a survey sample of 33 residents. The findings included: For R14 and R99, who had a physical altercation, resulting in injury to R14, the facility staff failed to have credible evidence that the incident of abuse and the investigation results were reported to the state survey agency and other officials. On 9/9/24 at 3:06 p.m., during an interview with R14, the resident reported that he had an incident with a prior roommate where the roommate was punching him and gave him a black eye. When asked what had happened to cause this, R14 said, He said the tv was too loud, but he never asked me to turn it down. On 9/10/24, the facility was asked to provide evidence of all events they had reported and addressed since January 2024. Review of the files revealed a one-page document that noted an event on 2/21/24 that indicated R14 had bruising/abrasion to left eye. The event summary details were noted as .residents had a verbal altercation which resulted in [R99's name redacted] hand making contact with [R14's name redacted] left eye. There was no evidence that this incident was reported to the state survey agency, adult protective services, or law enforcement. The facility was asked to provide any other evidence of this incident being reported or investigated to the survey team. On 9/10/24, a clinical record review was conducted of R14's chart. This review revealed a behavior progress note dated 2/21/24 at 6:10 p.m., that read, Writer was in the middle of doing med pass when yelling was heard down the hallway. Writer found resident in his bed with roommate nearby. Roommate had fallen on top of resident. Writer had asked what was going on, roommate said resident was running his mouth, resident had said something to roommate and then roommate had turned back and started punching resident in the face while on top of him. Male CNA was able to stand in between both residents enough to keep them from hitting each other any further. Was able to get roommate off resident and into chair. Separated both and called manager on duty. On 2/22/24, R14 was seen by the doctor who noted, . was involved in altercation yesterday and now has c/o left hand pain and swelling . left hand ecchymosis and soft tissue edema. mild ecchymosis of left orbit .Assessment and Plan: left hand pain- hand x-ray ordered. pain control with tramadol . X-rays were ordered of R14's left hand and elbow, which were negative for a fracture. On 9/11/24, the regional director of clinical services (RDCS) provided the survey team with a few written statements from staff regarding the 2/21/24 incident between R14 and R99. The RDCS confirmed that she did not have any evidence that the event, nor the event summary was reported to the required agencies. The RDCS confirmed that the event summary should include the steps taken by the facility and should have all been reported to adult protective services, the state survey agency and police. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the facility provided witness statements of staff who witnessed and/or intervened during the resident-to-resident altercation, both residents sustained injury. According to a statement from a licensed practical nurse, it noted, Nurse was in the middle of med pass when noted there was yelling down the hall. Went to room and saw [R99's name redacted] standing by [R14's name redacted] bed. Saw [R99's] pants sliding off and he fell over onto [R14]. Asked what was going on. [R99] stated that [R14] was running his mouth. [R14] had said something to [R99] then [R99] started punching [R14] in the face, at least 7-8 times. [R14] was also punching, hit [R99] in the face twice. CNA [name redacted] stood in between as much as possible to stop the fight. Was able to remove [R99] and put him back in his wheelchair. Noted bleeding from [R14]'s nose and reddening to left eye. [R99] has a elongated red mark going from left eye to forehead. Review of the facility's abuse policy titled; Reporting Requirements/Investigations was conducted. The policy read in part, 1. Immediately upon notification of any alleged violation involving abuse, neglect, exploitation, or mistreatments, including injuries of unknown source and misappropriation of resident property, the administrator will immediately report to the state agency, but not later than 2 hours after the allegation is made, if the events that caused the allegation involves abuse or results in serious bodily injury, or not later than 24 hours if the events that caused the allegation do not involve abuse and do not result in serious bodily injury. a. Notify the Adult Protective Services Agency, the local Ombudsman, and the appropriate local law enforcement authorities for any incident of patient abuse, mistreatment, neglect, or misappropriation of personal property or other reasonable suspicion of a crime . 2. The administrator and/or Director of Nursing will immediately initiate a thorough internal investigation of the alleged/suspected occurrence . 5. The administrator must thoroughly investigate and file a complete written report of the investigation of the submitted FRI [facility reported incident] to the state agency within five working days of the incident . On 9/10/24, during an end of day meeting, the facility administrator and corporate staff were made aware of the above findings. No additional information was provided.

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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. 41449 Based on observation, staff interview, clinical record review and facility documentation review, the facility staff failed to develop a comprehensive resident-centered care plan for one resident (Resident #49-R49) in a survey sample of 33 residents. The findings included: For R49, who had bilateral hand contractures, the facility staff failed to develop a comprehensive resident centered care plan to identify the contractures and interventions. On 9/9/24 and 9/10/24, various observations were conducted of R49. R49 was noted on each observation to be non-verbal and had bilateral hand contractures. The resident was observed with no splint to the hands and no palm protectors. On 9/10/24 at 2:49 p.m., an interview was conducted with the therapy director (TD). The TD reported that R49 was on therapy caseload previously. The TD noted from 11/17/22-11/23/22, R49 was on occupational therapy caseload, and they were concerned about hand contractures. The therapy director noted that they had noted, Palm guards to right and left hands up to 4 hours and he was tolerating them 8 hours without any signs or symptoms of redness. The therapy director noted that every three months they do an audit of splints and in June they noted the splint was cleaned and continue the splint schedule 7 days a week with skin checks every 2 hours. During the above interview with the therapy manager, she was asked about the purpose of splints for contractures. She stated, to keep the hand open and not tight and closed. If they are tight, it can cause pressure, to keep minimally open, if tight a palm guard is to keep minimally open, to prevent pressure, moisture, anything like that in the hand. On 9/10/24 at 3:01 p.m., a licensed practical nurse (LPN #4) accompanied the surveyor to R49's room. The nurse confirmed that R49 did not have any splint device in use, and none was found in the room. On 9/10/24 at 3:07 p.m., an interview was conducted with the unit manager. The unit manager was asked about R49's splint. The unit manager said she recalled R49 had palm guards and reported sometimes the family takes them home and washes them. On 9/10/24 a clinical record review was conducted. This review revealed that R49's care plan was not comprehensive as it did not address that the resident had hand contractures or the use of palm guards. On 9/10/24 at 3:29 p.m., an interview was conducted with registered nurses (RN #2 and RN #5), both of whom were care plan coordinators. RN #5 explained that the care plan is a guide to facility staff to provide care to each resident that is individualized and should reflect their care needs. When asked if contractures would be indicated on the care plan RN #5 said yes. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/10/24, during an end of day meeting held with the facility administrator, director of nursing and corporate staff it was discussed that R49's care plan was not comprehensive as it did not address the bilateral hand contractures. No additional information as provided.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21875 Based on resident interview, staff interview and clinical record review, the facility staff failed to review and revise the comprehensive care plan for four of thirty-three residents in the survey sample (Residents #49, #66, #30 and #131). The findings include: 1. Resident #131's plan of care of was not revised with interventions in place for trauma related care. Resident #131 (R131) was admitted to the facility with diagnoses that included urinary tract infection, major depressive disorder, post-traumatic stress disorder, diabetes, spinal stenosis, anxiety and anemia. The minimum data set (MDS) dated [DATE] assessed R131 as cognitively intact. R131's clinical record documented a trauma assessment 4/19/24 indicating the resident had history of physical abuse, verbal abuse and misappropriation of personal property by an ex-boyfriend. The trauma assessment documented no other source of trauma and identified the resident's trauma was related to fear that the ex-boyfriend would enter the facility and harm her. R131's plan of care (revised 8/21/24) documented the resident reported history of trauma related to an ex-boyfriend that had assaulted her and stole her money. The care plan identified the trigger related to the resident's trauma history was that the ex-boyfriend would enter the facility and cause harm. The care plan interventions to prevent/minimize distress/anxiety from past traumatic experiences included refer to psych service as needed, schedule familiar staff with resident and trauma screen as indicated. The plan of care included no individualized interventions about preventing the ex-boyfriend from entering the facility or visiting the resident. On 9/10/24 at 2:11 p.m., the certified nurses' aide (CNA #1) caring of R131 was interviewed about any interventions related to the trauma history. CNA #1 stated she was aware the resident had an ex-boyfriend that was not supposed to visit. CNA #1 stated the ex-boyfriend's picture and name were posted at the reception desk and staff were not supposed to let him in the facility. On 9/10/24 at 2:23 p.m., the licensed practical nurse unit manager (LPN #8) was interviewed about interventions related to R131's traumatic stress disorder. LPN #8 stated the ex-boyfriend was not permitted to visit the resident or enter the facility. LPN #8 stated the ex-boyfriend's picture was posted at the front desk so staff could identify him and prevent his entrance. LPN #8 stated the interdisciplinary team was responsible for updating care plans. LPN #8 stated he was not sure why the interventions in place were not on the care plan. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/10/24 at 2:30 p.m., R131 was interviewed about interventions implemented by facility staff to prevent stress/fear related to her trauma history. R131 stated the ex-boyfriend tried to visit her once since her admission and this person was stopped at the front desk and denied entrance. R131 stated the ex-boyfriend had made no further attempts to contact or visit her. R131 stated, Staff have done a good job keeping him [ex-boyfriend] away. R131 stated she felt safe in the facility and relieved that she no longer had to deal with the ex-boyfriend. On 9/11/24 at 8:19 a.m., the service ambassador (other staff #6) working at the entrance desk was interviewed about interventions regarding R131's ex-boyfriend. The service ambassador was aware that R131's ex-boyfriend was not to enter the facility or visit the resident. The service ambassador pointed to a picture with name posted on the front desk. The service ambassador stated if this person attempted to enter the facility, she was to ask him to leave and if he would not leave, she was to call the police. On 9/11/24 at 8:36 a.m., the regional registered nurse (RN #2) responsible for MDS/care planning, was interviewed about R131's care plan not listing interventions in place regarding trauma care. RN #2 stated the interdisciplinary team was responsible for updates to care plans. RN #2 stated that social services was usually responsible for the trauma related care plan interventions. On 9/11/24 at 8:38 a.m., the social worker (other staff #3) was interviewed about R131's care plan not including interventions in place regarding trauma care. The social worker stated the care plan should be updated to include the interventions in place to prevent trauma related stress. The social worker stated R131's trauma assessment was last completed on 4/19/24 and the last formal care plan meeting took place on 7/10/24. The social worker stated the interventions in place should be on the plan of care. This finding was reviewed with the administrator, director of nursing and regional nurse consultants during a meeting on 9/11/24 at 4:40 p.m. with no further information provided prior to the end of the survey. 41449 2. For resident #49 (R49), the facility staff failed to review and revise the care plan to reflect a fall and bed rails that were in use. On 9/9/24 and 9/10/24m R49 was visited in his room. R49 was noted to be non-verbal and did not respond to verbal stimuli. R49 was noted to be on an air mattress and had 1/8 length bed rails to both sides of the bed. On 9/10/24, a clinical record review was conducted. This review revealed R49 had diagnosis which included, but were not limited to persistent vegetative state, obstructive hydrocephalus, cerebral palsy, and cerebral infarction due to unspecified intracranial injury with loss of consciousness of unspecified duration. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to a nursing note entry dated 7/26/24, R49 sustained a fall. The notes for that day read in part, Resident was lying in between the beds on his left side. No signs of pain or discomfort at this time, and This writer spoke with [R49's father's name redacted] to notify him of [R49's name redacted] fall. This writer informed patient's father that there were no injuries noted at this time but aware of new orders for x-rays. This writer also asked father if he consents to bed side rails. RP [responsible party] agreed. Review of R49's care plan was conducted. The care plan did not indicate that R49 had fallen on 7/26/24 and did not indicate the bed rails. On 9/12/24 at 9 a.m., an interview was conducted with the registered nurse (RN #5), who was a care plan coordinator for the facility. RN #5 reported that the care plan is developed by assessment, talking with the resident, family and staff to get the best plan of care for the residents. It helps staff know task involved and serves as a guide. RN#5 stated that falls are discussed daily during a clinical meeting and then the care plan is updated. She stated, we need to put interventions on the care plan as part of the care of the patient, it's how to keep them safe and what to look for. On 9/12/24, during a late morning meeting with the facility administrator, director of nursing and corporate staff, the above concerns were discussed. No additional information was provided. 3. For resident #30, R30, who had mental health diagnosis, the care plan was not revised to indicate that a level 2 pre-admission screening for mental health had been halted and not completed. On 9/10/24, a clinical record review was conducted of R30's chart. This review revealed diagnosis that included, but were not limited to, suicidal ideation, bipolar disorder, major depressive disorder, anxiety disorder, and Alzheimer's disease. On 9/10/24 a clinical record review was conducted. According to hospital records dated 4/10/24, that were under the documents tab of the chart, R30 was hospitalized with suicidal ideation prior to admission to this facility. According to the pre-admission screening, the level 1 screening for mental illness, intellectual disability or related conditions, indicated that a level 2 assessment was warranted. According to R30's care plan, it noted, Resident has a Level II PASRR. However, the level II PASRR was not able to be located within the chart. On 9/11/24, the facility administration was notified during an end of day meeting and again on the morning of 9/12/24, that the survey team wanted to see R30's level II pre-admission screening resident review form. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/12/24 at approximately 10:30 a.m., the survey team was provided with a letter from the department of behavioral health and developmental services division with the Commonwealth of Virginia that indicated the level II screening for R30 had been halted. The reason noted was the individual has a primary diagnosis of an organic disorder, dementia (including Alzheimer's disease) and does not have a diagnosis of ID [intellectual disability]. The letter was dated 9/11/2020. Upon being handed the document, the regional director of clinical services confirmed that the document had not been a part of R30's clinical chart and they had called to get the information faxed to the facility. On 9/12/24 at approximately 11 a.m., during a meeting held with the facility administration and corporate staff, the above findings were reviewed. No additional information was provided. 28106 4. Resident #66's care plan was not revised to reflect the intervention of heel protectors (bunny boots) for skin integrity. The findings include: Diagnoses for R66 included; Dementia, diabetes, osteoarthritis, and failure to thrive. The most current MDS (minimum data set) was a significant change assessment with an ARD (assessment reference date) of 8/8/24. R66 was assessed with a cognitive score of 00 indicating severe cognitive impairment. Review of R66's clinical record evidenced a physicians order dated 8/8/24 for Bunny boots bilaterally while in bed. R66's care plan was also reviewed and did not evidence interventions for bunny boots. On 9/10/24 multiple observations were made between 8:30 a.m. and 10:30 a.m. of R66 lying in bed without bunny boots in place. The bunny boots were observed on the bed-side dresser. On 9/10/24 at 10:39 a.m. license practical nurse (LPN #1) was asked to observe R66's heels while R66 was still in bed. LPN #1 observed R66 without heel protectors and when asked LPN #1 verbalized unawareness of the heel protector order. It was explained to LPN #1 the possible reason for not knowing about the order was because the order did not indicate documentation was needed (on the TAR, Treatment Administration Record) to ensure the bunny boots were in place. On 9/10/24 at approximately 2:00 p.m. review of R66's orders indicated the bunny boot order had been updated and entered in a way that the order transferred to the TAR. Review of R66's care plan also was updated to include bunny boots. On 9/10/24 at 3:29 p.m. registered nurse (RN #2, MDS coordinator) was interviewed regarding the intervention of bunny boots added to the care plan on 9/10/24. RN #2 reviewed the care plan and verbalized that it appeared that the director of nursing (DON) had updated the skin integrity care plan to include bunny boots on 9/10/24 and the care plan should have been updated when the order was placed on 8/8/24. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/11/24 at 4:41 p.m. the above finding was presented to the administrator, DON and nurse consultant. No other information was presented prior to exit conference on 9/12/24.

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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. 28106 Based on observation, staff interview, clinical record review and facility documentation review, the facility staff failed to follow professional standards of practice for three of 33 residents in the survey sample. (Residents #268, #134, #49). The findings include: 1. Resident #268 (R268) pressure ulcer dressing was not dated or initialed by the facility staff. Diagnoses for R268 included; Pressure ulcer stage three, sepsis, diabetes, malignant neoplasm of rectum, and anemia. The most current MDS (minimum data set) was a five day assessment with an ARD (assessment reference date) of 9/2/24. R268 was assessed with a cognitive score of 15 indicating cognitively intact. Review of R268's clinical record documented an order dated 9/6/24 to Cleanse sacrum wound with wound cleanser, apply medical grade honey and cover with a bordered foam every day shift. Review of R268's treatment administration record (TAR) indicated that the order was being carried out. On 9/10/24 at 9:45 a.m. R268 was interviewed regarding dressing changes to sacrum. R268 said that the staff haven't been doing the dressing changes everyday and didn't think it was done the day before. R268 gave permission to view the dressing and wound. On 9/10/24 at 10:16 a.m. license practical nurse (LPN #2) performed a dressing change to R268's sacrum. The dressing that was in place prior to performing the dressing change appeared clean and well intact, however it was not dated or initialed by the staff member that had completed the dressing change. The wound appeared to be clean and without drainage or odor. LPN #2 was asked about the dressing not being dated or initialed, LPN #2 verbalized the nurse should have dated and initialed the dressing at the time the dressing change was completed. On 9/10/24 at 5:06 p.m. the above finding was presented to the administrator, director of nursing, and nurse consultant. A facility policy titled General Wound Care/Dressing Changes was obtained and read in part 5. Licensed nurses will follow recognized standards of practice regarding dressing change(s), including date and initials on dressing. No other information was presented prior to exit conference on 9/12/24. 49456 2. For Resident #134 (R134) the facility staff failed to obtain a physician's order to apply Tubi grips (a compression type stocking) to bilateral lower extremities. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/12/24 at 10:51 a.m., observation of Resident #134 (R134) was performed. R134 was observed with Tubi grips on bilateral lower extremities and was observed to have the Tubi grips on bilateral lower extremities throughout each of the four days of survey. On 9/12/24 a clinical record review was conducted. R134 had no physician's order for Tubi grips to be applied to the bilateral lower extremities daily. On 9/12/24 at 11:00 a.m. an interview was conducted with a licensed practical nurse, LPN# 2 (LPN2). LPN2 went in R134's room and verified that the resident had Tubi grips on her bilateral lower extremities. LPN2 verified that R134 had no order in her clinical record for Tubi grips. On 9/12/24 at 11:15 a.m. interview was conducted with the regional director of clinical services (RDCS). The RDCS verified that R134 had no order in her clinical record for Tubi grips. On 9/12/24 a review of facility documentation was conducted. A policy titled, Physician's Orders, read in part, .a licensed nurse will notify the physician requesting and/or verifying physician's orders. On 9/12/24 at 11:25 a.m. the administrator and regional nurse consultant were made aware of the above concerns. No new information was provided 41449 3. For resident #49 (R49), who received nutrition through a gastronomy tube, the facility staff failed to follow professional standards of care by ensuring the resident's head was elevated while receiving tube feeding to minimize the risk of aspiration. On 9/10/24 at 2:57 p.m., observations were conducted of R49 in his room. R49 was noted to be non-verbal and didn't react to verbal stimuli. R49 was observed to be lying flat in bed, with the tube feeding pump at the bedside running at a rate of 55 ml per hour. On 9/10/24 at 3:01 p.m., the surveyor was accompanied to R49's room by a licensed practical nurse (LPN #4). LPN #4 confirmed that R49 had tube feeding infusing via peg tube and was positioned flat in the bed. LPN #4 elevated R49's head of the bed. When asked why this is important, LPN #4 said due to risk of aspiration. On 9/10/24, a clinical record review was conducted of R49's chart. This review revealed R49's care plan noted a focus area that indicated, .dependence on TF [tube feeding] for nutrition and hydration . and the resident is at risk for complications related to the need for an enteral tube feeding . The interventions included but were not limited to, HOB [head of bed] elevated during feedings per order, pause feedings during personal care as indicated . (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lynchburg Health & Rehabilitation Center	5615 Seminole Avenue Lynchburg, VA 24502

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the physician orders, there was an active order which was entered 2/22/24 that read, Elevate HOB 30 to 45 degrees at all times during feeding and for at least 1 hour after the feeding is stopped. There was also an active order that read, Enteral Feed Order: every shift Osmolite 1.5 @ 55ml/hr. via peg tube for total volume of 1210 ml of formula (may hold feeding 1-2 hours per day for ADLS, therapy, etc.). The facility policy titled, Enteral Feeding Tubes ws reviewed. The policy did not address the positioning of a resident while enteral feeding is infusing. On 9/10/24, during an end of day meeting, the facility administrator, director of nursing and corporate staff was made aware of the above findings. No additional information was provided.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41449 2. For resident #92 (R92), the facility staff failed to provide activities to meet the psychosocial well-being of the resident and in accordance with resident preferences. On 9/9/24 at approximately 11:45 p.m., the surveyor was approached by a certified nursing assistant (CNA #3) who reported for the surveyor to not enter a room [which the CNA identified as R92's room]. CNA #3 reported the resident had behaviors and could be extremely combative. On 9/9/24 at approximately 12:30 p.m., R92 was observed in his room. It was noted that the room was dark, the curtains were pulled, no lights were on, and the resident was sitting in a wheelchair in the middle of the room. The room was noted to be empty with no personal possessions, no television, no radio, no books, magazines or other things for the resident to do to occupy his time. On 9/9/24 at approximately 2:30 p.m., facility activity staff were observed to deliver the resident a cup of Kool aide in his room. On 9/10/24 and 9/11/24, various observations were conducted at varying times of the day, and on each observation R92 was noted to be sitting in the room in the dark. The lights in the room were off, the curtains were pulled, there was no television, radio or any other items to engage the resident in any type of leisure activity. Interviews were conducted with R92, and he was noted to confused. When asked what he liked to do to pass by time, he gave a non-sensical response. On 9/9/24, in the afternoon, the maintenance assistant was asked about televisions. The maintenance assistant reported the facility does provide tv's and accompanied the surveyor to R92's room. When asked about the lack of a television the maintenance director reported that R92 had been challenging and went on to say that the resident had ripped two tv's off the wall and most recently had done this, the weekend prior. On 9/10/24 and 9/11/24, a clinical record review was conducted of R92's chart. There were no progress notes with regards to R92 removing televisions from the wall. On 9/11/24 at 2:09 p.m., an interview was conducted with two activity assistants, (Other Employee #15- OE15 and Other Employee #16- OE16), who were sitting at a table in the activity room coloring and talking to each other. When asked about R92, they said, snacks calm him down, he likes old school tv shows like [NAME] and sons, once in here if someone looks at him, he will go off. When the surveyor mentioned that R92 didn't have anything in his room, the activity assistants said, I don't see anyone come see him either and he doesn't have anything. According to an activities assessment dated [DATE] and again on 7/23/24. Both assessments noted that R92 answered the following questions: how important is it to you to listen to music you like? How important is it to you to be around animals such as pets? and How important is it to you to do things with groups of people? How important is it to you to do your favorite activities? How important is it to you to go outside to get fresh air when the weather is good? How important is it to you to participate in religious services or practices? as being somewhat important. R92 reported on this same assessment that how important is it to you to keep up with the news? as being very important. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to R92's care plan for activities, it read, The resident prefers or requires 1:1 activity due to being unable or unwilling to participate in other activities. The resident may engage in conversation occasionally. The interventions for this care plan focus area read, Provide 1:1 activities in the room or location that is the residents preference as needed and review activities preferences with the resident or resident representative if the resident is unable as needed. The activity care plan focus area and interventions were last revised on 1/22/24. Review of R92's activity attendance record revealed that the resident had attended 12 activities in Sept, eight of which were snacks or hydration. Of the thirty activities R92 was listed at attending in the month of August, twenty-two were snacks or beverages being provided to the resident. 3. For resident #121 (R121), the facility staff failed to provide, invite and assist the resident to group activities based on her preferences. On 9/9/24 at 2:51 p.m., an interview was conducted with R121. R121 reported she used to go to activities. The resident said they [the staff] would come around and get her but they no longer do that, so she just stays in her room tending to the baby, (she has a doll on her bed that she refers to as the baby). On 9/10/24, a clinical record review was conducted of R121's chart. According to an Activities Assessment with an effective date of 7/11/24, with regards to R121's activity preferences were obtained by facility staff. According to that assessment, R121 was not assessed for her past activity interests as indicated by section 2, questions a-h not being answered. According to R121's significant change MDS (minimum data set, an assessment tool) with an assessment reference date of 7/6/24, R121's activity preferences were recorded in section F. According to that assessment R121 felt it was very important to: listen to music you like, do your favorite activities, go outside to get fresh air when the weather is good, and to participate in religious services. R121 reported it was somewhat important to be around animals such as pets, and to do things with groups of people. R121's care plan with a date of 1/26/24, read, 1:1 ACTIVITIES: the resident prefers or requires 1:1 activity due to being unable or unwilling to participate in other activities. The associated interventions read, provide 1:1 activities in the room or location that is the residents preference as needed and review activities preferences with the resident or resident representative if the resident is unable as needed. There was an additional activity focus area on R121's care plan that was revised on 1/18/24, and read, Support the residents self-directed, independent leisure pursuits and activities. The resident likes music and dancing receives one on one activities 1-2 times weekly. Each of the interventions for this focus area were revised on 12/26/23, and read, Honor patient's preferences of leisure activities, provide meaningful involvement and sense of purpose, Support patient's preference to spend time alone and introspectively. On 9/11/24 at 2:06 p.m., an interview was conducted with two of the activity assistants (OE15 and OE16). When asked about R121's attendance in activities, they said, she doesn't really come to activities anymore, we do one on ones. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Throughout the duration of the survey conducted 9/9/24-9/12/24, observations were made on each day, at varying times of the day of the activity programing. Each day two activity staff were observed in the activity room coloring with residents watching television, talking to each other and doing word search puzzles and coloring activities. On 9/ On 9/11/24 at 3:05 p.m., an interview was conducted with the activities director (AD). The AD was asked how residents know about activities or are invited. The AD said, the nurses and CNA's [certified nursing assistants] know we have activities and the calendar in the room is an invitation. When I do my room rounds, I tell them. The AD was asked if anyone goes around prior to the activity to let residents know what is taking place and assist them to the activity room and the AD said, nursing brings them down, most of the girls know what they want to do. When the AD was made aware that activities had been observed throughout the days of survey and scheduled activities were not provided at the scheduled times and the activity staff were observed coloring each time observations were made, the AD said, they were coloring pages to take to residents in their rooms and we try to stick to the calendar but if the residents want to do something different they will change it. On the morning of 9/12/24, interviews were conducted with various nursing staff, which included three CNA's and one nurse. When asked if anyone goes around and invites the residents to activities or assists them in getting to the activity room, they reported that they [the nursing staff] assist residents who want to go. Review of the job description for the Recreation Assistant was conducted. The Essential Duties & Responsibilities included but were not limited to, . communicates to residents and support staff the daily schedule of planned activities and ensure residents are transported safely and appropriately to and from activities . The job description for the Director of Recreation was reviewed. It read in part, Essential Duties & Responsibilities . Direct all activity functions and services in the department, provide a plan of activities appropriate to the needs of the residents, complete a comprehensive resident activity assessment according to resident background, past and present leisure interests . Review of the facility policy titled; Activities Programming was conducted. The policy read in part, 1. Activities programming must include a minimum of four activities per day, with three activities after 5 pm per week. These activities must: reflect the schedule, preferences, goals, choices, and rights of the patients . are productive, are age appropriate, are related to patient's previous work, life roles, life-long interests, culture, spiritual preference . are routine on consistent days, give the patient a sense of purpose or belonging, encourage independence and interaction . On 9/12/24, during a mid-day meeting with the facility administrator, director of nursing and corporate staff the above concerns were discussed. No additional information was provided. 49456 (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, staff interviews, resident interviews, clinical record reviews and facility documentation the facility staff failed to provide activities to meet the residents interest and needs for three residents, (Resident #92 (R92), Resident # 121 (R121) and Resident #149 (R149)) in a survey sample of 33 residents. The findings included: 1. The facility staff failed to provide the activities as per the schedule and calendar posted in the resident's rooms. On 9/9/24 at 2:00 p.m. an observation of activities was conducted. The activity on the calendar was courtyard social. During the observation, the only residents in the courtyard were the residents who smoked, and no activity staff was present in the courtyard for the social. The activity room had approximately six residents and they were listening to rap like music and coloring and the activity staff was sitting at a table in the back of the room. The activity staff were not interacting with the residents in the courtyard or in the activity room. On 9/10/24 at 3:30 p.m. an observation was conducted of the activities. The calendar had that at 3:3 p.m., the scheduled activity was- The Fall Focus Group. There were only two residents in the activity room watching the television and no activity staff was interacting with the residents. There were no changes made on the activity calendar that a different activity was being conducted, nor that the scheduled activity had been cancelled. On 9/11/24 at 10:44 a.m. an interview was conducted with R149. R149 stated, the calendar for activities never match what is going on in the activity room. I would like to attend but when I go there it is not the activity on the calendar. She stated, I like the activity staff but there needs to be more activities for interaction and socialization then just coloring all the time. On 9/11/24 at 11:00 a.m. an observation was conducted, and music bingo was not being conducted at 11:00 a.m. per activity calendar and no changes were made on the calendar for a different activity to be conducted. The dry erase board listing the daily activities noted a change for the 2:00 p.m. activity and it noted a 911 Remembrance. Observations at 2:00 p.m., revealed the 911 remembrance activity was not being conducted, and several residents had come to the activity room for this activity and left due to this activity was not going on at the time scheduled. At 3:00 p.m. music bingo was on the activity calendar and there were approximately six residents in the activity room coloring and there were no changes made to the activity calendar and no interaction between the activity staff and residents. On 09/11/24 at 3:21 p.m. an interview was conducted with the activity director. The activity director stated, we try to stay on schedule but there are times we don't. The activity director said that he invites residents to activities on room rounds but we don't always go to their rooms and invite the residents to each activity. He said that they depend on the nursing staff to get the residents to the activity and the calendar posted in their rooms. The surveyor let him know that all the activities on the calendar had not been conducted throughout the survey days and he stated, if the residents in the dayroom want to do another activity rather than the one on the calendar, then they will change the activity without letting all residents know. The activity director stated, we will just have to do better. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/11/24 04:35 p.m. end of day meeting was held with the regional director of clinical services, the administrator, the director of nursing and the vice president of operations and the above concerns were discussed. On 9/12/24 at 8:23 a.m. an interview was conducted with R149. R149 stated, I went to the activity room for the 911 Remembrance yesterday and it was not being done so several of us just left the room. No new information was provided.

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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 - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28106 Based on observation, staff interview, clinical record review, and facility document review, the facility staff failed to follow physician orders for five of thirty-three residents in the survey sample (Residents #66, #159, #99, #149, and #92). The findings include: 1. Resident #66's heel protectors (bunny boots) were not applied as ordered. The findings include: Diagnoses for R66 included; Dementia, diabetes, osteoarthritis, and failure to thrive on hospice. The most current MDS (minimum data set) was a significant change assessment with an ARD (assessment reference date) of 8/8/24. R66 was assessed with a cognitive score of 00 indicating severe cognitive impairment. Review of R66's clinical record evidenced a physicians order dated 8/8/24 for Bunny boots bilaterally while in bed. The order indicated no documentation was needed. On 9/10/24 multiple observations were made between 8:30 a.m. and 10:30 a.m. of R66 lying in bed without bunny boots in place. The bunny boots were observed on the bed-side dresser. On 9/10/24 at 10:39 a.m. license practical nurse (LPN #1) was asked to observe R66's heels while R66 was still in bed. LPN #1 observed R66 without heel protectors and when asked LPN #1 verbalized unawareness of the heel protector order. When it was explained to LPN #1 the possible reason for not knowing about the order was because the order did not indicate documentation was needed (on the TAR, Treatment Administration Record) to ensure the bunny boots were in place, LPN #1 agreed. R66's heels were assessed at this time and showed dry, peeling skin to the right heel with a finger-tip size dark area. The left heel showed dry skin. On 9/10/24 at approximately 2:00 p.m. review of R66's orders indicated the bunny boot order had been updated and entered in a way that the order transferred to the TAR, requiring documentation. On 9/10/24 at 5:06 p.m., the above finding was presented to the administrator, DON, and nurse consultant. No other information was presented prior to exit conference on 9/12/24. 2. Resident #159's feeding tube was not anchored as ordered. The Findings Include: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Diagnoses for R159 included; Displacement of esophageal anti-reflux device (tracheostomy), chronic obstructive pulmonary disease, esophageal obstruction, cellulitis of abdominal wall, feeding tube. The most current MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 7/2/24, which assessed R159 with a cognitive score of 15 out of 15, indicating intact cognition. Review of R159's clinical record evidenced a physicians order, dated 6/21/24, to Anchor feeding tube every shift. On 9/10/24 at 2:30 p.m., R159 was interviewed regarding an anchor being applied to the feeding tube. R159 verbalized that an anchor was not being used and showed that the feeding tube was not anchored. On 9/10/24 at 2:45 p.m., registered nurse (RN #1, assistant director of nursing) joined the surveyor to observe R159's feeding tube, that was without a feeding tube anchor. RN #1 said that she thinks the anchor is the balloon that holds the tube in. On 9/10/24 at 5:05 p.m., RN #1 reported that she had found the anchors for the feeding tubes and verbalized being unaware that the facility had them. On 9/10/24 at 5:06 p.m., the above finding was presented to the administrator, DON, and nurse consultant. 21875 3. Resident #99 was administered two tablets of acetaminophen ER (extended release) 650 mg (milligrams) when the physician's order required two tablets of acetaminophen 325 mg. A medication pass observations was conducted on 9/10/24 at 7:51 a.m. with licensed practical nurse (LPN) #4 administering medications to Resident #99 (R99). Among the medications administered were two tablets of acetaminophen ER 650 mg. R99's clinical record documented a physician's order dated 8/2/24 for acetaminophen 325 mg with instructions to give two tablets every 4 hours as needed for pain/headache. On 9/10/24 at 8:45 a.m., LPN #4 was interviewed about the incorrect dose of acetaminophen administered to R99. LPN #4 stated she was nervous and pulled the wrong bottle of Tylenol (acetaminophen). LPN #4 stated she was not used to being watched. This finding was reviewed with the administrator, director of nursing and regional nurse consultants during a meeting on 9/10/24 at 5:15 p.m. with no further information presented prior to the end of the survey. 49456 4. For Resident #149, the facility staff failed to follow a physician's order to apply ted hose every morning. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #149 (R149) was admitted to the facility on [DATE]. R149's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 7/28/24 coded R149 with no cognitive impairment. On 9/9/24 at 3:33 p.m. an observation was made of R149 sitting outside without ted hose on bilateral extremities. R149 was wearing ankle socks and tennis shoes. On 09/10/24 at 11:00 a.m. an observation was made of R149. R149 was walking around the nursing units at the facility and was not wearing her ted hose. R149 was wearing bedroom slippers. On 9/11/24 at 10:44 a.m. an observation was made of R149. R149 was observed walking around the facility hallways with flip flops on and her ted hose were not being worn. On 09/12/24 at 8:25 a.m. an interview was conducted with a licensed practical nurse, LPN # 2 (LPN2). LPN2 stated, the resident can put the ted hose on independently and she typically likes things a certain way. LPN2 walked with the surveyor to R149's room and there was no ted hose in R149's room. On 9/12/24 at 8:25 a.m. an interview was conducted with R149 concerning her ted hose. R149 stated that she could put the ted hose on by herself, but sometimes she needed help. R149 stated that she only had the black socks that the supply clerk gave her because she was unable to find ted hose at the store, so the supply clerk bought these socks. On 9/12/24 at 8:45 a.m. an interview was conducted with the supply clerk. The supply clerk stated that she did not have the correct size for R149, so she went to the store and bought the black socks and was not aware the socks were not ted hose. The supply clerk stated she has had R149's size in the ted hose for 2 weeks and will give the ted hose to R149 today. On 9/12/24 a clinical record review was conducted. R149 had a physician's order dated 7/29/24 to apply ted hose in the am and remove in the pm written by the nurse practitioner. On 9/12/24 a review of a facility policy was conducted. The facility's policy titled, Physician's Orders, read in part, .Admission Physician's orders must be provided for every patient at the time of admission to activate a medical plan of care. Other orders indicated by patient's condition with specific directions. On 9/12/24 at 10:25 a.m. the administrator and regional nurse consultant was made aware of the above concerns. No new information was provided. 41449 5. For resident #92 (R92), the facility staff failed to obtain a valproic acid level lab in accordance with the physicians orders. On 9/10/24, a clinical record review was conducted. This review revealed that according to the diagnosis tab of the chart, R92 had a diagnosis of epilipsy. R92's medications included Depakote delayed release, which was indicated as being for siezure disorder. According to a physician order dated 8/9/24, it read, Valproic acid level one time only for labs until 08/10/2024. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of R92's results tab of the chart revealed that on 8/10/24, a uric acid level lab had been obtained. On 9/11/24, during an end of day meeting, the facility administrator, director of nursing and coproate staff were made aware of the above findings. On 9/12/24, the survey team was provided a copy of the lab slip which was completed by a nurse at the facility, and they stated, the wrong test was noted on the lab sheet.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 28106 Based on staff interview, and clinical record review, the facility staff failed to implement interventions for care/treatment of pressure ulcer for one of 33 residents in the survey sample (Resident #268). The findings include: Resident #268 (R268) had no treatment orders implemented for a pressure ulcer until seven days after the ulcer was identified. Diagnoses for R268 included; Pressure ulcer stage three, sepsis, diabetes, malignant neoplasm of rectum, and anemia. The most current MDS (minimum data set) was a five day assessment with an ARD (assessment reference date) of 9/2/24. R268 was assessed with a cognitive score of 15 indicating cognitively intact. R268's weekly skin assessments were reviewed. Out of 5 skin assessments completed from 8/31/24 through 9/11/24, three skin assessments (8/31/24, 9/6/24, and 9/11/24) document R268 having a stage three sacral pressure ulcer, and two skin assessments dated 9/2/24 and 9/9/24 did not have any documentation of the pressure ulcer. The skin assessments did indicate that the wound was improving. A wound assessment report (from a wound clinic) with a date of service of 9/5/24 documented a stage three pressure ulcer to the sacrum was present upon admission and gave treatment orders. Review of 268's physician orders documented an order dated 9/6/24 to Cleanse sacrum wound with wound cleanser, apply medical grade honey and cover with a bordered foam every day shift. According to the treatment administration record the treatments were started on 9/7/24. There were no other physician orders to treat the pressure ulcer prior to this order. On 9/10/24 at 10:16 a.m. license practical nurse (LPN #2) performed a dressing change to R268's sacrum. The wound appeared to be the size of a nickel, clean and without drainage or odor. On 9/12/24 at 10:28 a.m. the director of nursing (DON) and nurse consultant were interviewed regarding treatments of R268's pressure order. The DON and nurse consultant both reviewed R268's clinical record for treatment of the pressure ulcer and was unable to to find any treatments/physician orders prior to 9/6/24. On 9/12/24 at 11:07 a.m. the above finding was presented to the administrator, director of nursing and nurse consultant. No other information was presented prior to exit conference on 9/12/24.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. 41449 Based on observation, resident interview, staff interview, clinical record review and facility documentation review, the facility staff failed to provide services to maintain good foot health of two residents (resident #49-R49 and resident #30-R30) in a survey sample of 33 residents. The findings included: 1. For R49 the facility failed to provide care and treatment to maintain good foot health as evidenced by the resident's toenails being approximately 3/4 of an inch long past the toes. On 9/10/24 at 3:01 p.m., the surveyor is accompanied to R49's room by a licensed practical nurse (LPN #3). During review of the resident LPN pulled back the sheets, exposing R49's feet. It was noted that R49 had not had foot/nail care performed in a long time as evidenced by the nails extending approximately 3/4 of an inch past the end of the toes. LPN #3 confirmed and agreed that R49 was in need of toenail care. Upon exit of the resident's room, LPN #3 was asked about nail care. LPN #3 said, we do reminders to the CNA's [certified nursing assistants] to trim nails and a podiatrist comes monthly. On 9/10/24 at 3:07 p.m., an interview was conducted with the unit manager. The unit manager said the podiatrist comes every three months. When asked about nail care, the unit manager said, I usually get the nurses to check nails, usually about once every two weeks. I get them to cut, and CNA's can if they are not diabetic. The unit manager went on to report R49 had received a shower earlier in the day. On 9/10/24 at approximately 3:10 p.m., an interview was conducted with the director of social services (DSS). The DSS confirmed that a podiatrist comes monthly, and she maintained that listing. The surveyor asked for a copy of the podiatry list for the year 2024. On the afternoon of 9/10/24, the survey team was provided a listing of residents requested to be seen by the podiatrist. Review of the list noted that R49's name was not on the list any of the months in 2024. The list for May 15, 2024, noted 38 residents and of the 38, 24 were noted to refuse. On 9/10/24, during an end of day meeting held with the facility administration and corporate staff the above concerns were discussed. They were also shown the podiatry list for May 2024, which noted 24 residents had refused. The assistant director of nursing (ADON) reported that the podiatrist was elderly and when he got tired or wasn't going to see anyone else, he would note refused and ask that they be put on the list the following month. 2. For R30, the facility staff failed to ensure the resident received routine foot care to maintain foot health. On 9/11/24 at approximately 3 p.m., R30 was visited in her room. R30 reported that she had a sacral wound and confirmed she doesn't get out of bed. R30 agreed to the surveyor observing her feet. R30's toenails were noted to be extremely long and turning to curl under the toes. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/11/24 at 3:43 p.m., the regional director of clinical services (RDCS) was asked to accompany the surveyor to R30's room. The RDCS observed R30's toenails and confirmed she was in need of nail care. Also, on the bottom/plantar of the resident's foot it was noted with extremely dry skin that appeared as a crust on the soles of both feet. Upon exiting the resident's room, the RDCS asked the evening supervisor to see if he could cut R30's toenails and to add the resident to the podiatry list. The RDCS went on to say that they had been relying on the podiatrist to provide all toenail care but would be training nursing staff to do it going forward. The podiatry list for 2024 was reviewed and revealed that R30 was never put on the list by facility staff to be seen by the podiatrist. The facility's podiatry contract was reviewed, and it revealed no information with regards to the frequency of visits to the facility or number of residents that could be seen. No additional information was provided.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 41449 Based on observation, staff interview, and clinical record review, the facility staff failed to implement interventions for a resident with contractures, to prevent the worsening of contractures for one resident (Resident #49-R49) in a survey sample of 33 residents. The findings included: On 9/9/24 at 3:28 p.m., R49 was observed in bed. R49 was noted to be non-verbal and had bilateral hand contractures. The resident was observed with no splint to the hands and no palm protectors. R49's fingernails were observed to be long. On 9/10/24 at 8:54 a.m., R49 was observed again, and no splint, palm guard or wash cloth was noted in the hands to prevent the worsening of the contractures. On 9/10/24 at 2:49 p.m., an interview was conducted with the therapy director (TD). The TD reported that R49 was on therapy caseload previously. The TD noted from 11/17/22-11/23/22, R49 was on occupational therapy caseload, and they were concerned about hand contractures. The therapy director noted that they had noted, Palm guards to right and left hands up to 4 hours and he was tolerating them 8 hours without any signs or symptoms of redness. The therapy director noted that every three months they do an audit of splints and in June they noted the splint was cleaned and continue the splint schedule 7 days a week with skin checks every 2 hours. During the above interview with the therapy manager, she was asked about the purpose of splints for contractures. She stated, to keep the hand open and not tight and closed. If they are tight, it can cause pressure, to keep minimally open, if tight a palm guard is to keep minimally open, to prevent pressure, moisture, anything like that in the hand. On 9/10/24 at 2:57 p.m., R49 was observed again, and no palm guards or splint devices were in use. On 9/10/24 at 3:01 p.m., a licensed practical nurse (LPN #4) accompanied the surveyor to R49's room. The nurse confirmed that R49 did not have any splint device in use, and none was found in the room. R49's right hand was opened by LPN #4 so that the surveyor could observe that the skin in the palm was intact. LPN #4 was unable to open R49's left hand due to the contracture for observations to be conducted. On 9/10/24 at 3:07 p.m., an interview was conducted with the unit manager. The unit manager was asked about R49's splint. The unit manager said she recalled R49 had palm guards and reported sometimes the family takes them home and washes them. On 9/10/24 at 3:12 p.m., the therapy manager was made aware that no palm guards were noted in R49's room. The therapy director stated she had added R49 to the schedule to be evaluated the following day. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/10/24 a clinical record review was conducted. This review revealed that R49's care plan did not address that the resident had hand contractures or the use of palm guards. Review of the Occupational Therapy discharge summary dated 11/23/22, read in part, . Pt [patient] caregiver educated on techniques to decrease risk for skin breakdown and further contracture formation. Pt has responded favorably to OT [occupational therapy] skilled services and is expected to maintain gains made, per excellent implementation of RNP [restorative nursing program] . The facility policy regarding contracture management was requested. A policy titled; In-Services was received. The policy indicated that therapy would provide education to staff regarding splint application and use of adaptive equipment. On 9/10/24, during an end of day meeting held with the facility administrator, director of nursing and corporate staff the above findings were reviewed. No additional information as provided.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 28106 Based on observation, staff interview, clinical record review, and facility document review, the facility staff failed to ensure suction was in place for respiratory care of a tracheostomy for one of 33 residents, Resident #159 (R159). The findings include: R159 did not have emergency suctioning device at bedside for the care of a tracheostomy. Diagnoses for R159 included; Displacement of esophageal anti-reflux device (tracheostomy), chronic obstructive pulmonary disease, esophageal obstruction, cellulitis of abdominal wall, feeding tube The most current MDS (minimum data set) was a quarterly assessment, with an ARD (assessment reference date) of 7/2/24, which assessed R159 with a cognitive score of 15 out of 15 indicating intact cognition. On 9/10/24 at 11:15 a.m., R159's room was observed for emergency suctioning due to R159 having a tracheostomy. There was no suctioning device observed. R159 was interviewed at this time and verbalized that there hadn't been any suctioning in the room and not having to use suctioning so far. When asked about the medical device inserted into the neck, R159 went on to say that the tracheostomy was needed to be able to breath. On 9/10/24 at 11:28 a.m., registered nurse (RN #1) also observed R159's room for the suctioning equipment, due to the resident having the artificial airway. Confirming that no suctioning equipment was present for emergency use, RN #1 stated that she would get the suction set up. On 9/10/24 at 5:06 p.m., the above finding was presented to the administrator, DON, and nurse consultant. A policy titled Tracheostomy Care & Management was provided and read in part, 4. Emergency sterile tracheostomy equipment of the correct size will be available at the bedside. 5. Manual resuscitator (bag valve mask, Ambu bag) is readily available. No other information was provided prior to exit conference on 9/12/24.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21875 Based on resident interview, staff interview, facility document review, and clinical record review, the facility failed to provide physician ordered dialysis services and failed to share/communicate care provided during a dialysis treatment for one of thirty-three residents (Resident #2). The findings include: Resident #2 (R2) was admitted to the facility with diagnoses that included end stage renal disease (ESRD), gastroesophageal reflux disease, protein-calorie malnutrition, obstructive uropathy, anxiety, anemia, and COVID-19. The minimum data set (MDS) dated [DATE] assessed R2 as cognitively intact. a) R2 missed two scheduled hemodialysis treatments due to lack of transportation to the dialysis center. R2's clinical record documented a physician's order dated 9/1/24 for hemodialysis three times per week with scheduled days listed as Tuesday, Thursday and Saturday. R2's clinical record documented R2 was diagnosed with COVID-19 on 8/26/24. The physician assessed R2 on 8/27/24, documented treatment of COVID-19 symptoms, and recommended continued hemodialysis as scheduled each Tuesday, Thursday and Saturday. R2's clinical record documented no transfer for dialysis treatment on Tuesday, 8/27/24 as scheduled. The record included a change of condition note dated 8/29/24 documented, .Resident is covid positive, alert with intermittent confusion .Two scheduled dialysis missed due to transport issues . [NP] notified. New order received and noted to transport resident to [emergency department] . R2's hospital discharge summary dated 9/1/24 documented, .History of ESRD on dialysis Tuesday Thursday Saturday . She had 2 recent missed hemodialysis sessions due to dialysis transportation issues given COVID infection . Fortunately, not hyperkalemic . No respiratory distress and not hypoxemic. does not seem to warrant emergent dialysis. Admit under observation . Patient was seen in consultation by nephrology on 8/30 and underwent hemodialysis same day . underwent hemodialysis again on 8/31 to resume her usual hemodialysis. Patient has remained medically stable with COVID clearance on 9/1 . R2 was discharged back to the nursing facility on 9/1/24 and resumed her hemodialysis schedule on Tuesday 9/3/24. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/11/24 at 11:02 a.m., R2 was interviewed about the missed dialysis treatments on 8/27/24 and 8/29/24. R2 stated she missed two treatments in a row because the transport company refused to take her due to the COVID-19 diagnosis. R2 stated she had hemodialysis at a dialysis center each Tuesday, Thursday, and Saturday. R2 stated she had previously had no issues with transportation. R2 stated she was not aware that transportation was an issue until she got ready to get on the van on the morning of 8/27/24. R2 stated on Thursday (8/29/24) the transportation issue had not been resolved, so the nurse practitioner sent her to the hospital for evaluation and dialysis treatment. R2 stated she was still making urine and had no symptoms from the missed dialysis treatments. R2 stated her only symptoms when transferred to the hospital were cough and congestion related to COVID-19. R2 stated, They got me to the hospital before I had any problems. On 9/11/24 at 11:09 a.m., the licensed practical nurse (LPN #7) caring for R2 was interviewed about the missed dialysis treatments. LPN #7 stated R2 went to dialysis on Saturday (8/24/24) and was diagnosed with COVID-19 on Monday (8/26/24). LPN #7 stated on Tuesday (8/27/24), she called the dialysis center and advised them of R2's COVID-19 diagnosis with the dialysis center confirming that the resident could come and complete the hemodialysis. LPN #7 stated when the transportation van showed up, the transport staff made R2 get off the van, and refused to take her to dialysis due to the COVID-19 diagnosis. LPN #7 stated the transport vendor indicated that R2 had to be transported via stretcher due to COVID + status. LPN #7 stated she understood the resident was going to dialysis on Thursday (8/29/24) but when Thursday came, there were no arrangements made for stretcher transport. LPN #7 stated the nurse practitioner was notified and sent the resident to the hospital on 8/29/24 for dialysis. LPN #7 stated R2 had coughing, and head congestion related to COVID-19 but did not exhibit any symptoms from the missed dialysis treatments. On 9/11/24 at 1:30 p.m., the nurse practitioner (NP - other staff #4) caring for R2 was interviewed about the missed hemodialysis treatments. The NP stated she initially thought arrangements would be made for stretcher or whatever transport was needed due to COVID-19 status. The NP stated she sent R2 to the hospital on 8/29/24 to get hemodialysis because arrangements had not been made to transport the resident to the dialysis center. The NP stated R2 had COVID symptoms but was not in any type of distress. The NP stated R2 was still producing urine and had no symptoms from the missed hemodialysis treatments. The NP stated that she wanted the resident to get dialysis prior to any symptoms. The NP stated the resident's labs were at baseline and the resident did not require emergency dialysis upon arrival at the hospital on 8/29/24. The NP stated R2 had refused a treatment or two along the way and had no outcome from missed treatments. The NP stated transportation should be available so that dialysis treatments were not missed. The NP stated that transportation was part of patient care and had to be provided when needed. The NP stated arrangements should have been in place for COVID + residents so that care/services were not missed. On 9/11/24 at 1:56 p.m., the transportation scheduler (other staff #5) was interviewed about R2's missed dialysis treatments on 8/27/24 and 8/29/24. The scheduler stated R2 had COVID-19, and the transport service was not set up for COVID. The scheduler stated for COVID + residents, a stretcher transport service was usually arranged. The scheduler stated that nobody made her aware R2 had COVID-19 until the transportation service refused to take her to dialysis on 8/27/24. The scheduler stated she tried to find a stretcher service on Wednesday (8/28/24) but was unable to make arrangements. The scheduler stated she had one contracted provider of stretcher service that handled COVID + residents. The scheduler stated she was not made aware ahead of time to make the necessary arrangements for R2's transport to dialysis. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/11/24 at 2:27 p.m., the director of nursing (DON) was interviewed about R2's missed dialysis treatments. The DON stated all she knew was that transportation would not take the resident due to the COVID-19 + status. When asked about how COVID-19 + residents were to get required hemodialysis, the DON stated she was not sure and that the transportation vendors needed to take patients for needed treatments. The Nursing Home Dialysis Transfer Agreement (2022) with R2's dialysis center documented concerning transportation, .Facility shall have the responsibility for arranging suitable transportation of the Designated Resident to and from Center, including the selection of the mode of transportation, qualified personnel to accompany the Designated Resident and transportation equipment usually associated with this type of transfer . b) There was no communication from R2's dialysis center regarding the resident's status/response during hemodialysis on 9/5/24 and 9/10/24. There was no communication from the dialysis center to the facility regarding the administration of the medication Benadryl during R2's dialysis treatment on 9/10/24. Facility staff made no attempts to contact/communicate with the dialysis center in response to incomplete documentation on the communication sheets on these dates. On 9/11/24 at 11:02 a.m., R2 was interviewed about her dialysis treatments. R2 stated she started itching during the dialysis session yesterday (9/10/24). R2 stated the dialysis nurse administered Benadryl during the session and the itching resolved. R2's clinical record, including the dialysis communication form, made no mention that the resident was administered Benadryl during the 9/10/24 dialysis treatment. R2's dialysis communication forms dated 9/5/24 and 9/10/24 documented no information from the dialysis center regarding the resident's status during and/or after the hemodialysis. Section B, to be completed by the dialysis center, had no information recorded in spaces provided for pre-dialysis weight, vital signs, lab results, meal eaten during treatment, medications administered, time dialysis started, time dialysis completed, post-dialysis weight, post-dialysis vital signs, occurrences during dialysis and signature of dialysis staff. The nursing facility nurse assessing R2 upon return from dialysis (section C on form) had not signed and/or dated either of these forms. On 9/11/24 at 11:09 a.m., the licensed practical nurse (LPN #7) caring for R2 was interviewed. LPN #7 stated the dialysis communication forms were used to communicate/share information with the dialysis center. LPN #7 stated the facility completed the top section (section A), the dialysis center completed section B and then the facility completed/signed section C upon the resident's return from dialysis. LPN #7 stated she was not aware the dialysis center administered the resident Benadryl on 9/10/24. LPN #7 stated there was nothing documented from the dialysis center on 9/10/24. On 9/11/24 at 2:27 p.m., the director of nursing (DON) was interviewed about the incomplete communication with R2's dialysis center. The DON stated the facility, and the dialysis center were supposed to document required information about each dialysis session that included care and/or medications provided. The DON stated if the dialysis center failed to record information about the session, nurses were expected to call the dialysis center for any needed information. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/11/24 at 3:10 p.m., the DON stated she confirmed with the dialysis center that R2 was administered Benadryl during the 9/10/24 session for itching and that the center failed to communicate that information to the facility. The facility's policy titled Hemodialysis (effective 1/29/24) documented regarding outpatient hemodialysis, . The Dialysis Communication Form will be initiated prior to sending patient for dialysis .Patient reports received from dialysis center will be uploaded to the medical record . This finding was reviewed with the administrator, director of nursing, and regional nurse consultants during a meeting on 9/11/24 at 4:40 p.m. with no further information provided prior to the end of the survey.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care or services that was trauma informed and/or culturally competent. 49456 Based on observation, staff interviews, resident interviews, clinical record reviews, and facility documentations the facility staff failed to provide trauma informed care for six residents, (Resident #30-R30, Resident #39-R39, Resident #105-R105, Resident #134-R134, Resident #149-R149 and Resident #367-R367) out of a survey sample of 33 residents. The findings included: 1. The facility staff failed to identify triggers related to trauma and did not provide interventions to address trauma-informed care on the care plans for R39, R105, R134 and R149. 1a. According to the clinical record R39 had diagnosis of psychotic disturbance, mood disturbance, and anxiety disorder. On 9/11/24 at 8:29 a.m. an interview was conducted with R39. R39 stated that she has increased anxiety with the way some staff speak to her at times. R39 stated, When the staff are rude with me or raise their voice, I become anxious. On 9/11/24, a clinical record review was conducted for R39. R39 had a trauma screen that was completed on 10/27/23, which identified trauma areas of physical abuse, homicide attempt, and domestic violence. The trauma screen documented that R39's ex-boyfriend tried to kill her by smashing her head. The care plan documented that R39 had reported trauma during their trauma screening related to past relationships and abuse. Care plan interventions were listed as referred to psych services as indicated and trauma screen as indicated. No triggers were identified on the care plan for staff to be aware of/to avoid and there were no interventions for staff related to trauma and/or trauma-informed care were noted. 1b. According to R134's clinical record, they had a diagnosis of anxiety disorder, borderline personality disorder, and major depressive disorder. On 9/11/24 at 9:24 a.m., an interview was conducted with R134. R134 stated that their triggers included, mean people and things upset me. On 9/11/24 a clinical record review was conducted for R134. R134 had a trauma screen that was completed on 7/16/24, which identified trauma areas of physical abuse, domestic violence, and a traumatic divorce. The care plan documented that R134 reported trauma during their trauma screening related to having an alcoholic father, a traumatic divorce, and a violent car accident. Care plan interventions were listed as referred to psych services as indicated and trauma screen as indicated. No triggers were identified on the care plan for staff to be aware of/ to avoid and there were no interventions for staff related to trauma-informed care. 1c. R149's clinical record noted diagnoses of anxiety disorder, borderline personality disorder and psychoactive substance abuse. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/11/24 at 10:44 a.m. an interview with R149 was conducted. R149 stated that,Loud noises and violence on television are the things that bother me. On 9/11/24 a clinical record review was conducted for R149. R149 had a trauma screen that was completed on 7/24/24, which identified trauma areas of physical abuse, gun violence, stalking, and abuse of drugs. The trauma screen documented that R149 had been shot with a gun. The care plan documented that R149 reported trauma during their trauma screening related to being physically, sexually, and mentally abused. Care plan interventions were listed as to have familiar staff to take care of R149, to refer to psych services as indicated, and trauma screen as indicated. No triggers were identified on the care plan for staff to be aware of/to avoid and there were no interventions for staff related to trauma trauma-informed care. 1d. According to R367's record, their diagnoses included anxiety disorder and major depressive disorder. On 9/11/24 at 9:08 a.m. an interview was conducted with R367. R367 stated, Medical procedures and being held down is a trigger. On 9/11/24 a clinical record review was conducted for R367. R67 had a trauma screen that was completed on 9/6/24, which identified trauma areas of physical abuse, homicide attempt, suicide attempt, and domestic violence. R367's care plan had no reference to the trauma screening. No triggers were identified on the care plan for staff to be aware of/to avoid and there were no interventions for staff related to trauma-informed care. On 9/11/24 at 9:34 a.m., an interview was conducted with the regional social work and discharge planning specialist (RSWDCP). The RSWDCP stated, We give [residents] the option to talk about their trauma and we try to be sensitive I agree, it should be more on the trauma screening and more options should be addressed on the care plan. The RSWDCP stated, I was not aware that the diagnosis of post-traumatic stress disorder had to be addressed on the care plan, with goals and triggers, for staff to know what triggers the patient. 2. The facility staff failed to identify triggers related to post traumatic stress disorder and failed to provide trauma-specific interventions on the care plan. According to the clinical record, R105 had diagnosis to include major depressive disorder, bipolar disorder, and post-traumatic stress disorder. On 9/11/24 at 8:33 a.m. an interview was conducted with R105. R105 stated, I have very bad anxiety at times. The way staff speaks and the way they act will make me escalate with my anxiety and I have nightmares at times. Just some things make me more anxious than others. On 9/11/24 at 9:34 a.m., an interview was conducted with the regional social work and discharge planning specialist (RSWDCP). The RSWDCP stated, We give [residents] the option to talk about their trauma and we try to be sensitive I agree, it should be more on the trauma screening and more options should be addressed on the care plan. The RSWDCP stated, I was not aware that the diagnosis of post-traumatic stress disorder had to be addressed on the care plan, with goals and triggers, for staff to know what triggers the patient. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Lynchburg Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 5615 Seminole Avenue Lynchburg, VA 24502	

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/11/24, a clinical record review was conducted for R105. R105 had a trauma screen that was completed on 9/21/23, which identified trauma areas of physical and emotional abuse. Care plan interventions for R105 included psychiatry referral, familiar staff, and trauma screening as indicated. No triggers were identified on the care plan related to her post traumatic stress disorder for staff to be aware of or to avoid and there were no trauma-informed care interventions for staff. On 9/11/24 at 4:35 p.m. an end of day meeting was conducted with the administrator, regional director of clinical services, the director of nursing, and the vice president of operations. The above findings were discussed, and the regional director of clinical services stated that an 100% audit of the trauma screening, post-traumatic stress disorder management, and care plans has been initiated. No new information was provided. 41449 3. For resident #30 (R30) who had a history of trauma, the facility staff failed to provide trauma-informed care. On 9/9/24 and 9/10/24, R30 was visited in their room, but appeared to be asleep and did not actively engage in conversation with the surveyor. On 9/10/24 a clinical record review was conducted. According to hospital records dated 4/10/24, that were under the documents tab of the chart, R30 was hospitalized with suicidal ideation prior to admission to this facility. According to a trauma screen completed 4/22/24, R30 had suffered sexual assault. According to the form it indicated, resident was sexually assaulted by father at a young age. The trauma screen also indicated that R30 .feels fears and anxieties stemming from the sexual abuse committed against her . According to the clinical record, R30 had only been seen by psychiatric services three times since her admission to the facility in April. The visits occurred on 5/21/24, 7/31/24 and 8/14/24. Each of the notes revealed the only mention of the prior suicidal ideation was in the past medical history and read, suicidal behavior onset 1/24/24, with attempted self-injury . The prior sexual assault trauma was not noted. The focus of the visit was to address, .concern of intermittent refusal of care. The note did indicate that R30 denied suicidal and/or homicidal ideations at that time. Diagnosis included bipolar disorder, dementia with behavioral disturbance, major depressive disorder- recurrent- moderate, and insomnia. Recommendations included, but were not limited to: . maintain a quiet stress-free environment, encourage participation in planned activities and social gatherings, gentle redirection and reassurance, identify, address and eliminate underlying causes for distress, and approach the patient in a way that doesn't escalate distress or result in behavioral dysregulation . According to R30's care plan, trauma was addressed with interventions, which read as, refer to psych services as indicated and trauma screen as indicated. There was no indication that the facility staff had talked with the resident to identify triggers that increase the resident's fears or anxiety, nor steps the facility staff were to take to minimize re-traumatization. The care plan did not address the prior suicidal ideation. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/11/24 at approximately 3:30 p.m., R30 was interviewed by the surveyor. R30 did acknowledge that she had been sexually abused previously but was not willing to discuss it with the surveyor. R30 only acknowledged the abuse had not occurred in the facility. On 9/12/24 at 9 a.m., an interview was conducted with the registered nurse (RN #5), who was a care plan coordinator for the facility. RN #5 reported that the care plan is developed by assessment, talking with the resident, family and staff to get the best plan of care for the residents. It helps staff know task involved and serves as a guide. Review of the facility policy titled; Trauma Informed Care was conducted. The policy read in part, . 2. Through available medical records review and by interviewing the patient, indicate any diagnosis of PTSD or any history of trauma on the Trauma Informed Screen Assessment. 3. If a patient is diagnosed with PTSD, or indicates a history of trauma, encourage the patient to disclose known systems, triggers, and coping mechanisms so that the center can best accommodate those needs in a way that makes the patient feel safe and respected. a. Symptoms may include but are not limited to agitation, anxiety, nightmares, isolation, decreased interest in activities. b. Triggers may include but are not limited to sounds, lights, smells. c. Coping mechanisms may include but are not limited to attending group meetings, deep breathing, mindfulness, physical activity. Immediately update the care plan to reflect information about trauma gathered from the patient and alert the IDT of identified symptoms, triggers, and coping mechanisms. On 9/12/24, the above concerns were discussed with the facility administration and corporate staff. No other information was provided prior to exit.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. 41449 Based on observation, staff interview, clinical record review, and facility documentation review, the facility staff failed to attempt alternatives prior to implementing the use of bed rails for one resident (Resident #49-R49) in a survey sample of 33 residents. The findings included: For R49, who was in a persistent vegetative state and had a fall, the facility staff applied bed rails without attempting other alternatives and without assessing the risk of entrapment. On 9/9/24 and 9/10/24, R49 was visited in their room. R49 was noted to be non-verbal and did not respond to verbal stimuli. R49 was noted to be on an air mattress and had 1/8 length bed rails to both sides of the bed. On 9/10/24, a clinical record review was conducted. This review revealed R49 had diagnosis which included, but were not limited to, persistent vegetative state, obstructive hydrocephalus, cerebral palsy, and cerebral infarction due to unspecified intracranial injury with loss of consciousness of unspecified duration. According to a nursing note entry dated 7/26/24, R49 sustained a fall. The notes for that day read in part, Resident was lying in between the beds on his left side. No signs of pain or discomfort at this time, and This writer spoke with [R49's father's name redacted] to notify him of [R49's name redacted] fall. This writer informed patient's father that there were no injuries noted at this time but aware of new orders for x-rays. This writer also asked father if he consents to bed side rails. RP [responsible party] agreed. A bed side rail tool was completed on 7/26/24 and it indicated the following: 1. Does the patient need bed rails for positioning and/or rising from supine to sitting/standing position as mobility enabler? yes. 2. bed rails are: indicated and serve as an enabler, 3. Are bed rails a patient/resident representative preference? yes . 7. Explain the plan and update the care plan and question 7 was blank. There was no evidence that the assessment included the risk of entrapment being assessed. There was an additional bed side rail tool completed 8/21/24 that indicated the bed rails were not being used as an enabler. Review of R49's care plan was conducted. According to the care plan, . Communication: resident is non-verbal . the resident is at risk for falls related to cognitive impairment, related to muscle weakness, chronic conditions . The interventions for the fall risk were noted as .anticipate and meet the resident's needs, broda chair as needed, grip safe to mattress, place bed in lowest position while resident is in bed. The care plan also indicated that R49 requires assistance with ADLS [activities of daily living] relate [sic] to history of deficits from a cva [cerebral vascular incident], inability to perform ADLs . 2 person assist for bed mobility . There was no indication that R49 was able to participate or provide any assistance to staff in his daily care. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/11/24 at approximately 3:20 p.m., an interview was conducted with certified nursing assistant (CNA #3). CNA #3 reported to the surveyor that R49 did not talk and was total care for all care. CNA #3 said that when providing care and turning the resident, the mattress would slide on the bed frame. When asked if R49 can use the bed rails to assist with care, CNA #3 reported that R49 is not able to participate or assist with care in any way and is totally dependent upon staff. On 9/11/24 at 4:18 p.m., the above concerns were shared with the regional director of clinical services (RDCS). The RDCS was shown the bed rail assessment and that it indicated R49 was able to use the rails as an enabler. The RDCS said, He leans. I don't know what else we could have done. The RDCS went on to say that R49 is able to use his arm/elbow to hold onto the railing during care. The RDCS accompanied the surveyor to R49's room and reported that R49 could talk. It was observed that R49 did not respond to the RDCS when she was talking to him. The RDCS checked the mattress and was not able to find the grip safe which was reportedly a non-skid surface, which is placed between the mattress and fitted sheet, to prevent the resident from sliding. Review of the facility's event summary regarding R49's fall revealed that R49 was bed ridden, unable to give any description of the incident, and was found lying on his left side between the beds. No injuries were evident following the fall, but the medical provider ordered x-rays. On the afternoon of 9/11/24, the facility's maintenance director accompanied the surveyor to R49's room. The maintenance director stated that he recalled installing the bed rails shortly after he started working at the facility, which was in July. The maintenance director was asked to provide a copy of the maintenance work order for the bed rails to be installed, as well as the bed and railing manufacturer's user manual(s). A review of the facility's policy titled, bed system audits was conducted. The policy read in part, . 2. Maintenance will also conduct an intermittent audit immediately upon notification by nursing of any individual change of a bed frame, an assistive device, a mattress, or a bed rail. Maintenance and nursing will collaborate in order to identify gaps, ensure a tight fit of mattress to the bed system and, if appropriate, to inspect for mattress compressibility. 3. Any bed rail and/or mattress changes implemented and/or newly purchased separately from the bed frame system, will be assessed collaboratively for compatibility in width and length and with adherence to the manufacturer's recommendation and specifications . On 9/11/24, during an end of day meeting, the above findings were shared with the facility administration and corporate staff. On 9/12/24, the facility's administration notified the survey team they were unable to locate the maintenance work order of when the rail was requested to be installed. The facility also failed to provide the manufacturer's user manual for the bed and bed rails, as requested. No additional information was provided.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21875 Based on resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to ensure a medication was available for administration for one of thirty-three residents in the survey sample (Resident #79). The findings include: Resident #79 (R79) was admitted to the facility with diagnoses that included atherosclerotic heart disease, generalized anxiety, depression, polyneuropathy, atrial fibrillation, chronic pain, mild cognitive impairment, hypertension, anemia, and migraine headache. The minimum data set (MDS) dated [DATE] assessed R79 as cognitively intact. On 9/9/24 at 12:38 p.m., R79 was interviewed about quality of care in the facility. R79 stated during this interview that she had recently missed doses of her anti-anxiety medication. R79's clinical record documented a physician's order dated 2/23/24 for the medication Xanax 0.5 mg (milligrams) to be administered twice per day for management of anxiety. R79's medication administration record documented the Xanax 0.5 mg was not administered as scheduled on 9/8/24 at 9:00 a.m. and on 9/8/24 at 5:00 p.m. A nursing note dated 9/8/24 at 8:00 a.m. documented that the Xanax was not available, and nursing was unable to retrieve the medicine from the back-up supply. This note documented pharmacy and the nurse practitioner were notified. A nursing note dated 9/8/24 at 5:58 p.m. documented regarding the scheduled Xanax, .Medication not available. Rx [prescription] is on file at pharmacy and pharmacy states it will come on next run. Not able to remove out of Omnicell [back-up supply] . On 9/11/24 at 2:03 p.m., licensed practical nurse (LPN #4) that cared for R79 on 9/8/24 was interviewed. LPN #4 stated the Xanax script had been faxed to the pharmacy twice during the week prior to 9/8/24. LPN #4 stated when she reported to work on Sunday (9/8/24) the Xanax had run out with no supply on the medication cart. LPN #4 stated she called pharmacy to get a code to retrieve an emergency dose and pharmacy stated an entire new script was required before a code could be issued. LPN #4 stated she left work on 9/8/24 at 3:00 p.m. and the medication nor a code for the back-up supply had been provided. LPN #4 stated she communicated about the unavailable Xanax to the evening shift nurse. LPN #4 stated the evening shift nurse documented the Xanax nor code were available on 9/8/24 for the 5:00 p.m. dose. On 9/11/24 at 2:23 p.m., the unit manager (LPN #3) was interviewed about R79's unavailable Xanax. LPN #3 stated nurses tried to get the required scripts to pharmacy prior to running out of the medication. LPN #3 stated pharmacy did not send the medication and nurses were unable to get a code to retrieve the medication from the back-up supply. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/11/24 at 2:35 p.m., the director of nursing (DON) was interviewed about R79's missed Xanax. The DON stated she did not know why pharmacy failed to provide the medication timely. The DON stated nurses were expected to let the nurse practitioner know about unavailable medicines and print out scripts for the provider to sign. The facility's policy titled Medication Unavailability (effective 1/29/24) documented, .A licensed nurse discovering a medication on order that is unavailable will initiate appropriate steps to ensure medical treatment is provided as ordered .A licensed nurse will notify the provider of the unavailability of medication and discuss an alternative order, if necessary .If alternate medication is ordered and is not available, the licensed nurse will activate the backup pharmacy process . This finding was reviewed with the administrator, director of nursing and regional nurse consultants during a meeting on 9/11/24 at 4:40 p.m. with no further information provided prior to the end of the survey.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 21875 Based on observation, staff interview and facility document review, the facility staff failed to label an insulin pen when opened on one of three units (West unit). The findings include: On 9/11/24 at 3:53 p.m., accompanied by licensed practical nurse (LPN) #5, medications stored in cart #2 on the [NAME] unit were inspected. Stored in the medication cart was an opened Fiasp (insulin aspart) flextouch insulin pen labeled for a current resident. The insulin pen had no date written on the label indicating when the pen was opened. LPN #5 was interviewed at this time about the storage of opened insulin pens. LPN #5 stated all insulin pens were supposed to be dated when opened. The facility's policy titled Storage of Medications (revised 08/2024) documented, .When the manufacturer has specified a usable duration after opening (i.e. beyond use date), the nurse shall place a 'date opened' sticker on the medication and record the date opened and the new date of expiration. The expiration date of the vial or container will be 30 days from opening, unless the manufacturer recommends another date or regulations/guidelines require different dating . Fiasp manufacturer's prescribing information documented the Fiasp FlexTouch pen should be discarded 28 days after opening if stored at room temperature or if refrigerated. (1) This finding was reviewed with the administrator, director of nursing and regional nurse consultants during a meeting on 9/11/24 at 4:40 p.m. with no further information provided prior to the end of the survey. (1) Fiasp insulin aspart. Prescriber information. NovoCare. 9/13/24. https://www.novocare.com/diabetes/products/fiasp.html.

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F 0803

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 49456

Based on observation, staff interview, resident interview, and clinical record the facility staff failed to provide food in accordance with the menu for one, (Resident #39, R39) out of 33 residents in the survey sample.

The findings included:

The facility staff failed to serve R39 the food that was on her menu ticket at lunch time.

R39 was admitted to the facility on [DATE]. Diagnoses for R39 included but are not limited to unspecified protein-calorie malnutrition. R39's Minimum Data Set (an assessment protocol), with an Assessment Reference Date of 6/17/24, coded R39 with moderate cognitive impairment.

On 9/9/24 the R39's meal ticket read in part, .Mechanical advanced/chopped baked pork chop - 4oz, mushroom gravy - 2 oz, mechanical advanced/chopped orange twist - 1 Ea, steamed summer squash - 1/2 cup, black eyed peas- 4 oz, dinner roll - 1 ind, and margarine - 1 pkt.

On 9/9/24 at 12:37 p.m. an observation of the lunch time meal was conducted. During the observation, R39's meal tray was missing mushroom gravy 2 oz, black-eyed peas 4 0z and mechanical advanced/chopped baked pork chop 4 oz and magic cup was not on the ticket or meal tray, which were listed onthe meal ticket. The only food items on R39's tray was the squash and a roll.

On 9/9/24 at 12:37 p.m. an interview was conducted with R39. R39 stated, Things are always missing from my meal.

On 9/9/24 at 1:06 p.m. an interview was conducted with a certified nursing assistant, CNA#2 (CNA2). CNA2 stated, It happens often that we don't have on here what should be on the tray. We will go to the dietary and sometimes it is replaced but most of the time they say they don't have it.

On 9/11/24 a clinical record review was conducted. R39's dietary order was Regular diet, Dysphagia Advanced texture, Thin Liquids consistency, magic cup at lunch, which was an active order since 7/17/24.

On 9/10/24 at 5:02 p.m. an end of the day meeting was conducted with the regional director of clinical services, administrator, vice president of operations, and the director of nursing, during which the above concerns were discussed.

09/11/24 at 2:52 p.m. an interview was conducted with the dietary manager. The dietary manager stated, Some pork chops appeared not to have gravy, but they did have some, even though you couldn't see it on the tray. I don't know why but the other items should have been on the tray.

No new information was provided.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 28106 Based on observation, resident interview, and staff interviews the facility staff failed to provide food preferences for one of 33 residents. Resident # 69 (R69) was not provided side salads as requested. The findings include: Diagnoses for R69 included; Diabetes, and obesity. The most current MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 7/2/24. R69 was assessed with a cognitive score of 15 indicating cognitively intact. During an interview conducted on 9/09/24 at 11:40 a.m. R69 verbalized concerns regarding food preferences saying we are no longer getting side salads like we used to. R69 went onto say the dietary manager is saying we no longer are providing salads as an option. R69 mentioned being a diabetic and prefers to have fresh fruits and vegetables. On 9/11/24 at 11:37 a.m. the dietary manager (other staff, OS #2) was interviewed. OS #2 said that corporate had recently changed to a different seasonal menu, and corporate office were no longer purchasing salad ingredients due to the change in the new menu. The kitchen refrigerator and dry food storage were observed with fresh lettuce, peppers, onions, celery, and shredded cheese. When asked about these items, OS #1 said that these items are for ingredients for meals. OS #1 went onto say that R69 could have a chef salad as a substitute for a meal but corporate has stopped side salads. On 9/11/24 at 4:41 p.m. the above finding was presented to the administrator, director of nursing, nurse consultant, and vice president of operations. The vice president shook his head and verbalized the resident should be allowed to get a side salad. No other information was presented prior to exit conference on 9/12/24.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. 41449 Based on observation, staff interview, clinical record review, and facility documentation review, the facility staff failed to provide a therapeutic diet as ordered by the physician for four residents (Resident #139, #55, #9, and #30), in a survey sample of 33 residents. The findings included: 1. For Residents #139, 55, and 9, all who had therapeutic diets ordered, the facility kitchen failed to provide the appropriate diet. On 9/9/24 at 12:58 p.m., the lunch meal was observed in the restorative room on the west unit. It was noted that R139's meal ticket indicated she was to receive chopped meats. R139's meal tray included a whole/intact pork chop, which nursing staff had to cut up into bite size pieces, which was not a chopped consistency. R139 was observed to not eat the pork chop and verbalized several times, it's too tough. R24 and R9's meal ticket indicated they were to receive pureed foods. The meat on the tray was not a smooth consistency and appeared more like ground meat. Several staff members, to include LPN #6, LPN #3 and CNA #4 all agreed the pureed meat was not a pureed consistency. LPN #6 took R9's tray back to the kitchen to get a replacement. CNA #4 was assisting to feed R55, confirmed the resident was not only to receive pureed foods but was to receive double portions and none of his meal items were double portions. On 9/9/24 at approximately 1:05 p.m., the unit manager, LPN #3 was asked to accompany the surveyor into the restorative room where residents were eating. LPN #3 was shown each of the resident's trays, R139, 55 and 9. LPN #3 confirmed the above findings. LPN #3 went on to stay she had spoken to the kitchen previously for the same concerns with regards to portion sizes and therapeutic diets not being served. On 9/9/24, clinical record reviews were conducted for each of the residents named above. The records revealed the following: R9's diet order dated 7/17/24, read, Regular diet Dysphagia Pureed texture, Thin Liquids consistency, magic cup with lunch, large portions of dessert. R55's diet order dated 7/17/24 read, Regular diet Dysphagia Pureed texture, Thin Liquids consistency, Large portions. R139's diet order from the physician dated 7/17/24, read, Regular diet Regular texture, Thin Liquids consistency, Chopped meats. 2. For Resident #30 (R30), who had experienced weight loss, the facility staff failed to provide nutritional supplements as ordered. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lynchburg Health & Rehabilitation Center	5615 Seminole Avenue Lynchburg, VA 24502

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/11/24, R30's breakfast meal was observed. According to the meal ticket, R30 was to receive a health shake with breakfast. The shake was not on the tray. When asked, R30 said she likes the strawberry shakes, not the chocolate, but doesn't get them often. On 9/11/24, other employee #13 (OE13), who conducted daily rounds on R30's room was asked to step into the room. OE13 confirmed that R30's meal ticket indicated she was to receive a health shake at breakfast, but it was not present. On 9/11/24 at approximately 9 a.m., the unit manager, LPN #3 was shown the above, that R30 did not receive the health shake. LPN #3 and the surveyor went to the kitchen and LPN #3 notified the kitchen staff R30 did not get her shake. The kitchen staff immediately provided LPN #3 with a health shake that she then took to R30. The dietary manager was asked why R30 wasn't provided the health shake on the tray as ordered, and she didn't have an answer. According to R30's physician order dated 7/30/24, it read, Regular diet Regular texture, Thin Liquids consistency, large portions at lunch and dinner, health shake at breakfast for to prevent malnutrition/promote wt. [weight] maintenance. The facility provided the survey team with the requested facility policy titled, Therapeutic Diets. The policy read in part, .3. Diets will be offered as ordered by the physician or designee . On 9/11/24, all the above findings were reviewed with the facility administrator, director of nursing and corporate staff. No additional information was provided.

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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 - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 21875 Based on observation, staff interview, and facility document review, the facility staff failed to store, prepare and serve food in a sanitary manner from the main kitchen and on one of three units (West unit). The findings include: a) The walk-in refrigerator and freezer in the main kitchen had out-of-date and/or unsealed food items. Stainless prep pans were stored nested and wet. The bench mounted can opener was dirty with accumulated debris. Flies were observed in the kitchen during meal prep near the exit door beside the handwashing sink. On 9/9/24 at 10:41 a.m., accompanied by the dietary manager (other staff #2), the main kitchen was inspected during the initial tour of the facility. Stored in the walk-in refrigerator was a package of sliced turkey labeled with a use by date of 9/5/24. There was an opened 46-ounce carton of thickened cranberry cocktail with no label indicating when opened. A package of slice turkey, with no manufacturer's label was stored and available for use. There was no identification on the packaged turkey indicating a use by or expiration date. A box with 18 pasteurized eggs was stored with a use by date of 7/11/24. In the walk-in freezer was stored an unsealed bag of frozen sausage patties and an unsealed bag of frozen French fries. Seven stainless quarter-sized pans were observed stored nested and wet. The bench mounted manual can opener near the 3-compartment sink was dirty with accumulated black/brown debris on the blade and bracket. The dietary manager (other staff #2) was interviewed at the time of the observations about the out-of-date and unsealed food items stored in the refrigerator and freezer. The dietary manager stated all food items were supposed to be labeled with a date opened and a discard date. The dietary manager stated foods were supposed to be stored in sealed containers. The dietary manager stated the package of slice turkey with no identification should not have been removed from the original box/packaging. The dietary manager stated the prep pans were supposed to air dry on a rack prior to nesting. The dietary manager stated the can opener needed to be soaked and cleaned. On 9/9/24 at 11:32 a.m., lunch preparation was observed. Flies were observed in the kitchen near the handwashing sink located beside an exit door. Several flies were observed near the convection ovens. Kitchen staff members were observed exiting and re-entering the through the exit door, multiple times during meal preparation/service. An air curtain positioned over the exit door did not activate when the door was opened. The dietary manager was interviewed at this time about the flies and the non-functioning air curtain. The dietary manager stated the air curtain at the exit door did not come on automatically when the door was opened. The dietary manager stated she had to turn the air curtain on at the breaker box. The dietary manager stated she usually turned the air curtain on when the door stayed open for deliveries. The dietary manager stated she did not routinely run the air curtain during meal prep. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/9/24 at 11:55 a.m., a warming oven in use was inspected. The front of the unit was dirty with drips, fingerprints, and smudges on the glass door. The bottom of the unit had accumulated crumbs, spills, and debris. The control panel near the floor was dirty with crumbs and debris. b) On 9/10/24 at 2:53 p.m., accompanied by licensed practical nurse (LPN) #4, the [NAME] unit nutrition/snack refrigerator was inspected. Stored in the refrigerator was an opened 32-ounce carton of Med Pass supplement. There was no date or label indicating when the Med Pass was opened. LPN #4 was interviewed at this time. LPN #4 stated she was not sure how long the Med Pass had been opened because there was no label indicating the date opened. LPN #4 stated nurses were supposed to label supplements when opened. The facility's policy titled Food Storage: Cold (Oct. 2019) documented, .It is the center policy to insure all Time/Temperature Control for Safety (TCS), frozen and refrigerated food items, will be appropriately stored in accordance with guidelines of the FDA Food Code .The Dining Services Director/Cook(s) insures that all food items are stored properly in covered containers, labeled and dated and arranged in a manner to prevent cross contamination . The facility's food storage chart (referencing Food Code 2017) documented that ready-to-eat foods and leftovers may be stored for up to 7 days after preparation or opening. The facility's policy titled Ware Washing (policy 22) documented, .It is the center policy that all dishware and service ware will be cleaned and sanitized after each use . The Dining Services Director ensures that all dishware is air dried and properly stored . The facility's policy titled Equipment (policy 27) documented, .It is the center policy that all food service equipment is clean, sanitary, and in proper working order .The Dining Services Director will ensure that all equipment is routinely cleaned and maintained in accordance to manufacturer directions and training materials .The Dining Service Director will ensure that all food contact equipment is cleaned and sanitized . The Dining Services Director will submit requests for maintenance or repair to the Administrator and/or Maintenance Director as needed . This finding was reviewed with the administrator, director of nursing and regional nurse consultants during a meeting on 9/10/24 at 5:15 p.m. with no further information presented prior to the end of the survey.

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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.

28106

Based on staff interview and clinical record review, the facility staff failed to provide a complete and accurate clinical record for three of thirty-three residents in the survey sample (Resident #268, #30 and #149).

The findings include:

1. Resident 268's (R268) sacral wound was not properly identified on daily skilled progress notes and skin assessments.

Diagnoses for R268 included; Pressure ulcer stage three, sepsis, diabetes, malignant neoplasm of rectum, and anemia. The most current MDS (minimum data set) was a five day assessment with an ARD (assessment reference date) of 9/2/24. R268 was assessed with a cognitive score of 15 indicating cognitively intact.

Review of R268's daily skilled progress notes dated 8/31/24 through 9/7/24 documented no wounds. Another skilled progress note dated 9/7/24 indicated there was a sacral wound. On 9/8/24 two skilled notes were entered one of the notes indicating there was a wound the other indicting there were no wounds. A skilled progress note dated 9/9/24 again indicated there was not a wound.

R268's weekly skin assessments were then reviewed. Out of 5 skin assessments completed from 8/31/24 through 9/11/24, three skin assessments (8/31/24, 9/6/24, and 9/11/24) document R268 having a stage three sacral pressure ulcer, and two skin assessments dated 9/2/24 and 9/9/24 did not have any documentation of the pressure ulcer.

A wound assessment report (from a wound clinic) with a date of service of 9/5/24 did document a stage three pressure ulcer to the sacrum was present upon admission and gave treatment orders.

On 9/11/24 at 4:41 p.m. the above finding was presented to the administrator, director of nursing (DON) and nurse consultant. The DON verbalized R268 did have a pressure ulcer to the sacrum upon admission.

On 9/12/24 at 9:15 a.m. the nurse consultant verbalized that the facility has recognized problems with improper skin assessments and is currently working on education.

No other information was presented prior to exit conference on 9/12/24.

41449

2. For resident #30, R30, who had mental health diagnosis, the clinical record was incomplete and didn't accurately reflect that a level II pre-admission screening for mental health had been halted and not completed.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/10/24, a clinical record review was conducted of R30's chart. This review revealed diagnosis that included, but were not limited to, suicidal ideation, bipolar disorder, major depressive disorder, anxiety disorder, and Alzheimer's disease. On 9/10/24 a clinical record review was conducted. According to the pre-admission screening, the level 1 screening for mental illness, intellectual disability or related conditions, indicated that a level 2 assessment was warranted. According to R30's care plan, it noted, Resident has a Level II PASRR. However, the level II PASRR was not able to be located within the chart. On 9/11/24, the facility administration was notified during an end of day meeting and again on the morning of 9/12/24, that the survey team wanted to see R30's level II pre-admission screening resident review form. On 9/12/24 at approximately 9:30 a.m., during an interview with the social services director (SSD), the SSD received a telephone call, and she was noted to be requesting the information with regards to R30's level II PASRR. On 9/12/24 at approximately 10:30 a.m., the survey team was provided with a letter from the department of behavioral health and developmental services division with the Commonwealth of Virginia that indicated the level II screening for R30 had been halted. The reason noted was the individual has a primary diagnosis of an organic disorder, dementia (including Alzheimer's disease) and does not have a diagnosis of ID [intellectual disability]. The letter was dated 9/11/2020. Upon being handed the document, the regional director of clinical services confirmed that the document had not been a part of R30's clinical chart and they had called to get the information faxed to the facility. On 9/12/24 at approximately 11 a.m., during a meeting held with the facility administration and corporate staff, the above findings were reviewed. No additional information was provided. 49456 3. The facility staff failed to apply Resident 149's ted hose every morning and signed it off in the treatment administration record daily as being completed. On 9/9/24 at 3:33 p.m. an observation was made of R149 sitting outside without ted hose on bilateral extremities. R149 was wearing ankle socks and tennis shoes. On 09/10/24 at 11:00 a.m. an observation was made of R149. R149 was walking around the nursing units at the facility and was not wearing her ted hose. R149 was wearing bedroom slippers. On 9/11/24 at 10:44 a.m. an observation was made of R149. R149 was observed walking around the facility hallways with flip flops on and ted hose were being worn. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/12/24 at 8:25 a.m. an interview was conducted with a licensed practical nurse, LPN # 2 (LPN2). LPN2 walked with the surveyor to R149's room and there was no ted hose in R149's room. LPN2 confirmed that R149's had no ted hose on bilateral lower extremities. On 9/12/24 at 8:25 a.m. an interview was conducted with R149 concerning her ted hose. R149 stated that she only had the black socks that the supply clerk gave her because she was unable to find ted hose at the store, so the supply clerk bought these socks. R149 stated, I forget some days to put the socks on. On 9/12/24 a clinical record review was conducted. The treatment administration record (TAR) showed the nurses signed off daily on the order that read, apply ted hose in the AM and remove in the PM every 12 hours for Swelling. The TAR was signed off on 9/9/24, 9/10/24 and 9/11/24 that the order was completed, indicating the ted hose were applied. On 9/12/24 at 10:25 a.m. the administrator and regional nurse consultant were made aware of the above concerns. No new information was provided.

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F 0880

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide and implement an infection prevention and control program.

49456

Based on observation, staff interviews, clinical record review and facility documentation review the facility staff failed to provide a negative urinalysis prior to removing contact isolation for one resident, Resident #134 (R134) in a survey sample of 33 residents.

The findings included:

The facility staff failed to obtain a negative urine after completion of the antibiotic therapy for ESBL (Extended-spectrum beta-lactamases) before discontinuing contact isolation precautions.

On 9/9/24 at 11:00 a.m. a tour of the facility south nursing unit was conducted. R134 had an enhanced barrier isolation sign on the outside of the room door.

On 9/12/24 at 8:39 a.m. an interview was conducted with license practical nurse, LPN#2 (LPN2). LPN2 said she remembered R134 being on contact isolation precautions for ESBL (extended spectrum beta-lactamase) when she was admitted . LPN2 said that when R134 moved to the room she is in now, that she was on enhanced barrier precautions. LPN2 stated the protocol for ESBL is, they have to stay in room if incontinent, we have to recheck a urine after antibiotic is completed and they can come off isolation after a clear urine.

On 9/12/24 at 8:46 a.m. an interview was conducted with the infection preventionist, RN #3 (RN3). RN3 said that when someone is admitted with ESBL that if labs were done, I collect the results, set up room with appropriate bins and any antibiotics gets plugged in for sensitivities. ESBL needs one negative culture to be able to come off isolation. We try to obtain the urinalysis 24 hours after antibiotic is completed. RN3 said that the enhanced barrier sign on the resident's room was not for R134, it was for the previous resident in that room.

On 9/12/24 a clinical record review was conducted. R134's progress note written by the nurse practitioner and read in part, . ESBL UTI- Plan: Is receiving cephalexin 500 mg 4 times a day through7/23. Infection caused by extended spectrum beta-lactamase producing bacteria. Z16.12: Extended spectrum beta lactamase (ESBL).

On 9/12/24 R134's care plan was reviewed and read in part, .Isolation/ Precautions: the resident required isolation/precautions related to ESBL in urine created on 7/16/24.

On 9/12/24 a clinical record review was conducted. R134's physician orders had an order that read in part, . cephalexin oral capsule 500 mg give 1 capsule by mouth four times a day every 7 days related to urinary tract infection.

On 9/12/24 at 10:16 a.m. a meeting with the administrator and regional director of clinical services (RDCS) was conducted. The above concerns were discussed. The RDCS stated, I am unable to find a follow up urine on the resident. No follow up urine results were in R134's clinical record.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/12/24 a review of the facility documentation was conducted. The facility policy titled, Extended Spectrum Beta-Lactamase, read in part, .Contact precautions in addition to standard precautions in accordance with physician orders and patient's condition, Patients will remain on TBP's [transmission base precautions] until they have been off antibiotics and depending on the original positive site, have had negative cultures as indicated: Urine: one negative culture. No new information was provided.

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. 41449 Based on staff interview and facility documentation review, the facility staff failed to implement a bed safety program for the entire facility affecting all residents residing on 3 of 3 units. The findings included: On 9/11/24, in the afternoon an interview was conducted with the facility's maintenance director. When asked about the bedrails on Resident #49's (R49) bed, the maintenance director stated that he had put the railings on the bed not long after he started working at the facility, approximately two months ago. The maintenance director was asked to provide a copy of the maintenance work order where that was done. On 9/11/24, the facility staff was asked to provide any evidence of an inspection being conducted on R49's bed and bedrails. On 9/12/24, the regional director of clinical services (RDCS) reported to the survey team that they were not able to locate the maintenance work order regarding the application of bedrails for R49. The RDCS also showed the survey team a 3-ring binder that was the bed safety program and said, I'm not going to even open it, indicating it was not complete. On 9/12/24 at approximately 11 a.m., the surveyor reviewed the bed management binder and there was what appeared to be a bed inventory listing dated April 2023, that listed bed frame model numbers. There was no indication of an actual inspection being conducted. When the surveyor asked the corporate team who was in the office, the RDCS confirmed that was accurate, there was no indication of any inspections being performed. Review of the facility policy titled; Bed System Audits was conducted. This policy read in part, 1. Maintenance will identify each center bed by number and will conduct a full bed audit on each bed a minimum of annually. The audit will include the frame, the deck, the headboard, the footboard, the mattress, and any installed bed rails and/or assistive devices . 4. Annual and intermittent bed audits will reference the FDA's Seven Zones of Entrapment, the dimensional criteria as established by the HBSW (Hospital Bed Safety Workgroup) guidelines, and other areas of potential safety risk within the bed system . No additional information was provided.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 21875 Based on observation, staff interview, and facility document review, the facility staff failed to maintain effective pest control. The findings include: Flies were observed during the survey on the [NAME] unit dining/day room and in the main kitchen during food preparation. On 9/9/24 at 11:32 a.m., lunch preparation was observed in the main kitchen. Flies were observed in the kitchen near the handwashing sink located beside an exit door. Several flies were observed near the convection ovens. Kitchen staff members were observed exiting and re-entering through the exit door multiple times during meal preparation/service. An air curtain positioned over the exit door did not activate when the door was opened. The dietary manager was interviewed at this time about the flies and air curtain. The dietary manager stated the air curtain at the exit door did not come on automatically when the door was opened. The dietary manager stated she had to turn on the air curtain at the breaker box. The dietary manager stated she usually turned the air curtain on when the door stayed open for deliveries. The dietary manager stated she did not routinely run the air curtain during meal prep. On 9/9/24 at approximately 12:00 p.m., residents on the [NAME] unit were observed eating lunch in the day room. Multiple flies were observed in the day room while residents were eating and/or being fed lunch. On 9/9/24 at 4:26 p.m., Resident #55 (R55) was observed seated in a wheelchair in the [NAME] unit day room. Several flies were observed on and/or around the resident. Flies were observed flying/landing on the resident's shirt, the resident's head/forehead, and on R55's hands/forearms. On 9/11/24 at 10:23 a.m., the assistance maintenance director (other staff #1) was interviewed about the observed flies and the facility's pest control. The assistant maintenance director stated that a pest control vendor came each month and treated the facility for pests including flies. The assistant maintenance director stated he was not aware that flies were in the [NAME] unit day/dining room. The assistant maintenance director stated the air curtain in the main kitchen was not working properly. The assistant maintenance director stated he did not know what was wrong with the air curtain and that the air curtain was supposed to come on automatically when the door was opened to prevent flying insects from entering. The assistant maintenance director presented monthly reports from a contracted pest control vendor. The most recent report dated 8/28/24 documented treatment for ants, glue boards for flies and treatment for fruit flies in the kitchen. The report made no mention of the non-functional air curtain in the kitchen or of any targeted treatment for flies in the kitchen and/or [NAME] unit dining room. This finding was reviewed with the administrator, director of nursing and regional nurse consultants during a meeting on 9/11/24 at 4:40 p.m. with no further information provided prior to the end of the survey.